KERN HEALTH SYSTEMS

REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, December 15, 2022
at
8:00 A.M.

At
Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, CA 93308

The public is invited.

For more information - please call (661) 664-5000.

AGENDA

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, December 15, 2022

8:00 A.M.

All agenda item supporting documentation is available for public review on the Kern Health Systems website: https://www.kernfamilyhealthcare.com/about-us/governing-board/
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 on the KHS website.

PLEASE SILENT CELL PHONES AND OTHER ELECTRONIC DEVICES DURING THE MEETING

BOARD TO RECONVENE

Directors: Watson, Thygerson, Patel, Martinez, Abernathy, Bowers, Deats, Flores, Garcia, Hoffmann, McGlew, Meave, Nilon, Patrick, Singh, Turnipseed
ROLL CALL:

1) Board Resolution to Allow Virtual Board Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) -
APPROVE

ADJOURN TO CLOSED SESSION

CLOSED SESSION

2) Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) –

8:15 A.M.

BOARD TO RECONVENE

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO MEMBER OF THE BOARD 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 BOARD CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

3) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board 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 Board at a later meeting. Also, the Board 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. THE MEETING FACILATATOR WILL INDICATE WHEN THERE IS 15 SECONDS REMAINING TO YOUR PRESENTATION TIME!

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

4) On their own initiative, Board 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 (Government Code section 54954.2(a)(2))

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on October 13, 2022 (Fiscal Impact: None) –
APPROVE

CA-6) Minutes for Kern Health Systems Board of Directors special meeting on October 13, 2022 (Fiscal Impact: None) –
APPROVE

7) Welcome New Board Member to the Kern Health Systems Board of Directors (Fiscal Impact: None) –
RECEIVE AND FILE

8) Report from Local Health Plans of California, overview (Fiscal Impact: None) –
RECEIVE AND FILE

CA-9) Proposed amended Conflict of Interest Code for Kern Health Systems (Fiscal Impact: None) –
APPROVE; REFER TO KERN COUNTY BOARD OF SUPERVISORS

CA-10) Report on Kern Health Systems investment portfolio for the third quarter ending September 30, 2022 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-11) Proposed policy renewal with HM Life Insurance for reinsurance to mitigate costs incurred by Kern Health Systems for members with high dollar inpatient admissions from January 1, 2023 through December 31, 2023 in an amount not to exceed $0.22 per member per month (Fiscal Impact: $914,969 estimated; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

12) Proposed Kern Health Systems 2023 Operating and Capital Budgets (Fiscal Impact: None) –
APPROVE

13) Proposed Budget Request for 2023 Project Consulting Professional Services, from January 1, 2023 through December 31, 2023 (Fiscal Impact: $15,066,478; Budgeted) –
APPROVE

CA-14) Proposed Agreement with Kern County Department of Human Services to facilitate Medi-Cal outreach and enrollment and Medi-Cal renewal assistance for Kern County Medi-Cal enrollees; total cost not to exceed $425,000 per year with a maximum not to exceed $850,000 over the 2-year term of the agreement (Fiscal Impact: $425,000 annually; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-15) Report on COVID-19 Kern Health Systems Final Report (Fiscal Impact: None) –
RECEIVE AND FILE

16) Report on Kern Health Systems Quality Improvement (QI) 2021 Program Evaluation, 2022 QI Program Description and the 2022 QI Program Work Plan (Fiscal Impact: None) –
APPROVE

17) Report on Kern Health Systems 2021 Utilization Management (UM) Program Evaluation and the 2022 UM Program Description (Fiscal Impact: None) –
APPROVE

CA-18) Proposed Amendment with OptumInsight, Inc., to provide Claims Edit Platform Solution, from December 22, 2022 through December 21, 2027 (Fiscal Impact: $3,845,563; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-19) Proposed Agreement with CDW, for the renewal of our Nutanix hardware and software solution with three years of support and maintenance, from January 1, 2023 through December 31, 2025 (Fiscal Impact: $1,328,560.25; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-20) Report on 2022 State Legislation and Budget Overview (Fiscal Impact: None) –
RECEIVE AND FILE

CA-21) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

22) Report on Kern Health Systems financial statements for September 2022 and October 2022 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-23) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for September 2022 and October 2022 and IT Technology Consulting Resources for the period ended September 30, 2022 (Fiscal Impact: None) –
RECEIVE AND FILE

24) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) –
RECEIVE AND FILE

25) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) –
RECEIVE AND FILE

26) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) –
RECEIVE AND FILE

CA-27) Miscellaneous Documents –
RECEIVE AND FILE

A) Minutes for Kern Health Systems Finance Committee meeting on October 7, 2022

ADJOURN TO FEBRUARY 16, 2023 AT 8:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 2900 Buck Owens Boulevard, Bakersfield, California 93308 or by calling (661) 664-5010. 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.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: December 15, 2022

Re: AB 361 Remote Meeting Resolution

Background

The Governor's executive order suspending certain requirements of the Brown Act regarding board meetings has expired, but the proclamation of a state of emergency is still in place. The Legislature has amended Govt Code 54953 to include provisions allowing remote meetings during a state of emergency under certain conditions. The attached resolution allows the Board to continue meeting remotely until the state of emergency is lifted and social distancing is no longer recommended or required. If the Board adopts the resolution, it will have to renew the resolution every 30 days.

Recommended Action

The Board adopt the resolution and continue with remote meetings during the month of December 2022 or until the state of emergency is lifted.

KERN HEALTH SYSTEMS

RESOLUTION

In the matter of:

A RESOLUTION OF THE BOARD OF DIRECTORS OF KERN HEALTH SYSTEMS PROCLAIMING A LOCAL EMERGENCY, RATIFYING THE PROCLAMATION OF A STATE OF EMERGENCY, AND AUTHORIZING REMOTE TELECONFERENCE MEETINGS FOR THE MONTH OF DECEMBER 2022

Section 1. WHEREAS

(a) Kern Health Systems is committed to encouraging and preserving public access and participation in meetings of the Board of Directors; and

(b) Government Code section 54953, as amended by AB 361, makes provisions for remote teleconferencing participation in meetings by members of a legislative body, without compliance with the requirements of Government Code section 54953, subject to the existence of certain conditions; and

(c) a required condition is that there is a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing; and

(d) Governor Newsom declared a State-wide state of emergency due to the Covid-19 pandemic on March 4, 2020, which declaration is still in effect, and state and local health officials continue to recommend social distancing; and

(e) the Board of Directors does hereby find that the resurgence of the Covid-19 pandemic, particularly through the Delta variant, has caused, and will continue to cause, conditions of peril to the safety of persons that are likely to be beyond the control of services, personnel, equipment, and facilities of Kern Health Systems, and desires to proclaim a local emergency and ratify both the proclamation of state of emergency by the Governor of the State of California and the Kern County Health Department guidance regarding social distancing; and

(f) based on the above the Board of Directors of Kern Health Systems finds that in-person public meetings of the Board would further increase the risk of exposure to the Covid-19 virus to the residents of the Health Authority, staff, and Directors; and

WHEREAS, as a consequence of the local emergency, the Board of Directors does hereby find that it shall conduct Board meetings without compliance with paragraph (3) of subdivision (b) of Government Code section 54953, as authorized by subdivision (e) of section 54953, in compliance with the requirements to provide the public with access to the meetings as prescribed in paragraph (2) of subdivision (e) of section 54953; and

WHEREAS, all meetings of Board of Directors will be available to the public for participation and comments through virtual measures, which shall be fully explained on each posted agenda.

Section 2. NOW, THEREFORE, BE IT RESOLVED that the Board of Directors of Kern Health Systems hereby finds, determines, declares, orders, and resolves as follows:

1. This Board finds that the facts recited herein are true and further finds that this Board has jurisdiction to consider, approve, and adopt the subject of this Resolution.

2. Proclamation of Local Emergency. The Board hereby proclaims that a local emergency now exists throughout the Health Authority, as set forth above.

3. Ratification of Governor's Proclamation of a State of Emergency. The Board hereby ratifies the Governor's Proclamation of State of Emergency, effective as of its issuance date of March 4, 2021.

4. Remote Teleconference Meetings. The Chief Executive Officer, staff, and Board of Directors are hereby authorized and directed to take all actions necessary to carry out the intent and purpose of this Resolution including conducting open and public meetings in accordance with Government Code section 54953(e) and other applicable provisions of the Brown Act.

5. Effective Date of Resolution. This Resolution shall take effect on December 15, 2022 and shall be effective until the earlier of January 14, 2023, or such time the Board of Directors adopts a subsequent resolution in accordance with Government Code section 54953(e)(3) to extend the time during which Kern Health Systems may continue to teleconference without compliance with paragraph (3) of subdivision (b) of section 54953.

6. Termination of this Resolution. This Resolution will automatically terminate on the day that both the Governor's Declaration of Emergency and any local agency guideline for social distancing are no longer in effect.

The Clerk of the Board of Directors shall forward copies of this Resolution to the following:

Office of Kern County Counsel

Kern Health Systems

I, Sheilah Woods, Clerk of the Board of Directors of Kern Health Systems, hereby certify that the following resolution, on motion of Director _____, seconded by Director _____, was duly and regularly adopted by the Board of Directors of Kern Health Systems at an official meeting thereof on the 15th day of December 2022, by the following vote and that a copy of the resolution has been delivered to the Chairman of the Board of Directors.

AYES:

NOES:

ABSENT:

_____
Sheilah Woods, Clerk
Board of Directors
Kern Health Systems

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, October 13, 2022

8:00 A.M.

BOARD RECONVENED

Directors: Watson, Thygerson, Patel, Martinez, Abernathy, Bowers, Deats, Flores, Garcia, Hoffmann, McGlew, Meave, Nilon, Patrick, Singh
ROLL CALL: 10 Present; 5 Absent – Abernathy, Deats, Garcia, Hoffmann, Singh

NOTE: The vote is displayed in bold below each item. For example, Patel-Deats denotes Director Patel made the motion and Director Deats seconded the motion.

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

BOARD ACTION SHOWN IN CAPS

1) Board Resolution to Allow Virtual Board Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) -
APPROVED
Nilon-McGlew: 10 Ayes; 5 Absent – Abernathy, Deats, Garcia, Hoffmann, Singh

ADJOURNED TO CLOSED SESSION
Patrick

NOTE: DIRECTOR SINGH ARRIVED AT 8:09 A.M. DURING CLOSED SESSION

CLOSED SESSION

2) Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – SEE RESULTS BELOW

NOTE: DIRECTOR ABERNATHY ARRIVED AT 8:10 A.M. AFTER CLOSE SESSION

8:15 A.M.

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING SEPTEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON ABUHAMAD, ADVENTIST HEALTH DELANO, CROSBY, KARUMAN, MOON, SIKAVI; DIRECTOR PATEL ABSTAINED FROM VOTING ON BRADLEY

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING OCTOBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON LOUIE, SINGHAVONG, TALAMANTEZ, TRAN, TRUJILLO, USSEF

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING SEPTEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON KITT, TAWANSY, HUYNH, MITCHELL

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING OCTOBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON ANDERSON, BAKERSFIELD MEMORIAL HOSPITAL, MERCY HOSPITAL BAKERSFIELD, MADHANAGOPAL, NANDHAGOPAL, QUILLATUPA

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

3) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board 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 Board at a later meeting. Also, the Board 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. THE MEETING FACILATATOR WILL INDICATE WHEN THERE IS 15 SECONDS REMAINING TO YOUR PRESENTATION TIME!
NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

4) On their own initiative, Board 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 (Government Code section 54954.2(a)(2))
NO ONE HEARD

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on August 11, 2022 (Fiscal Impact: None) –
APPROVED
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

6) Welcome New Board Members to the Kern Health Systems Board of Directors (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Patrick: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

7) Appreciation recognition of Cindy Stewart for 9+ years of dedicated service as a member of the Kern Health Systems Board of Directors (Fiscal Impact: None) –
RECEIVED AND FILED
Patrick-Patel: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-8) Proposed revisions to Policy 4.35-P, Provider Hearings (Fiscal Impact: None) –
APPROVED
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-9) Proposed revisions to Policy 4.48-P, Provider Disciplinary Action (Fiscal Impact: None) –
APPROVED
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-10) Proposed revisions to Policy 100.12-I, Contracting Policy for Administrative Contracts (Fiscal Impact: None) –
APPROVED
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-11) Proposed Agreement with Mihalik Group, for NCQA Accreditation Consulting Services, from January 1, 2023, through December 31, 2023 (Fiscal Impact: $243,720; Budgeted) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-12) Proposed Agreement with Change Healthcare, for Electronic Claims Clearing House Services, from October 20, 2022, through October 19, 2025, in an amount not to exceed $0.18 Per Claim Fee (Fiscal Impact: $310,000 estimated annually; Budgeted) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-13) Proposed Agreement with ZeOmega, Inc., for Medical Management Platform, from November 1, 2022, through October 31, 2027 (Fiscal Impact: $3,918,001; Budgeted) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-14) Proposed Agreement with Health Dialog, for 24/7 Nurse Triage Services for KHS members, from November 2, 2022, through November 1, 2025 (Fiscal Impact: $1,495,200 estimated; Budgeted) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

15) Report on Kern Health Systems financial statements for July 2022 and August 2022 (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Flores: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-16) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for July 2022 and August 2022 and IT Technology Consulting Resources for the period ended July 31, 2022 (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-17) Report on Kern Health Systems 2022 Corporate Goals for 3rd Quarter (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

CA-18) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

19) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) –
RECEIVED AND FILED
Patel-Flores: 12 Ayes: 3 Absent – Deats, Garcia, Hoffmann

20) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Thygerson: 12 Ayes: 3 Absent – Deats, Garcia, Hoffmann

CA-21) Miscellaneous Documents –
RECEIVED AND FILED
Nilon-McGlew: 12 Ayes; 3 Absent – Deats, Garcia, Hoffmann

A) Minutes for Kern Health Systems Finance Committee meeting on August 5, 2022

ADJOURN TO OCTOBER 13, 2022 AT 9:30 A.M.
Bowers

/s/ Vijaykumar Patel, M.D., Secretary
Kern Health Systems Board of Directors

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Special Meeting
Thursday, October 13, 2022

9:30 A.M.

BOARD RECONVENED

Directors: Watson, Thygerson, Patel, Martinez, Abernathy, Bowers, Deats, Flores, Garcia, Hoffmann, McGlew, Meave, Nilon, Patrick, Singh
ROLL CALL: 11 Present; 4 Absent – Deats, Garcia, Hoffmann

NOTE: The vote is displayed in bold below each item. For example, Patel-Deats denotes Director Patel made the motion and Director Deats seconded the motion.

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

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board 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 Board at a later meeting. Also, the Board 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. THE MEETING FACILATATOR WILL INDICATE WHEN THERE IS 15 SECONDS REMAINING TO YOUR PRESENTATION TIME!
NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Board 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 (Government Code section 54954.2(a)(2))
NO ONE HEARD

3) Board of Directors strategic planning session – BOBBIE WUNSCH, PACIFIC HEALTH CONSULTING GROUP AND JAYCEE COOPER, DEPARTMENT OF HEALTH CARE SERVICES HEARD; PRESENTATION HEARD

ADJOURN TO DECEMBER 15, 2022 AT 8:00 A.M.
McGlew

/s/ Vijaykumar Patel, M.D., Secretary
Kern Health Systems Board of Directors

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Kristen Beall Watson, Chairman

Date: December 15, 2022

Re: New and Reappointed Members to Kern Health Systems Board of Directors

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Background

On November 8, 2022, the Kern County Board of Supervisors reappointed the following member to Kern Health Systems Board of Directors:

- Kristen Beall Watson – 3rd District Community Representative

Also, on November 8, 2022, a new member was appointed to the Kern Health Systems Board of Directors:

- Michael Turnipseed - 5th District Community Representative

Current members of the Kern Health Systems Board of Directors would like to welcome our newest member to the Board. The complete roster of Kern Health Systems Board members is shown on the attached document.

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

BOARD OF DIRECTORS

Kristen Beall Watson, Ed.D., ***Chairman***
Chief of Staff to the President,
California State University Bakersfield
3rd District Community Representative

Rural PCP Representative
Vijaykumar B. Patel, M.D., ***Secretary***
Physician,
Comprehensive Medical Group

1st District Community Representatives
1) Elsa Martinez, ***Treasurer***
Chief Financial Officer, County of Kern
2) Michael Bowers, Vice President of Public Affairs and Government Relations, Centric Healthcare

Traditional Medi-Cal Primary Care Representative (Metro Bakersfield)
Sarabjett Singh, M.D.
Centric Healthcare, Central Cardiology Medical Clinic

2nd District Community Representatives
1) John Nilon, Retired
2) Cathy Abernathy, Cathy Abernathy Consultants

Safety Net Care Provider Representative
Olga Meave, M.D.
Chief Executive Officer
Clinica Sierra Vista

3rd District Community Representatives
1) Jeff Flores, Chief of Staff, County of Kern
2) Kristen Beall Watson, Ed.D.
Chief of Staff to the President
California State University, Bakersfield

Rural Hospital Representative
Timothy McGlew, Chief Executive Officer
Kern Valley Healthcare District

4th District Community Representatives
1) Wayne L. Deats, Jr., Retired
2) Barbara Patrick, Retired

Pharmacist Representative
Kimberly Hoffmann, PharmD, BCPP
Clinical Pharmacist
Pacific Pharmacy Practice PC, Owner

5th District Community Representatives
1) Alex Garcia, Councilmember, City of Wasco
2) Michael Turnipseed, Executive Director
Kern County Taxpayers Association

Kern Medical Representative
Scott Thygerson, ***Vice Chairman***
Chief Executive Officer
Kern Medical

Rev. 11.18.2022
By: S.Woods

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: December 15, 2022

Re: Local Health Plans of California Update

Background

Kern Health Systems is a member of the Local Health Plans of California (LHPC), a California trade association. The primary focus of this association is to represent the interests of the local initiative Medi-Cal health plans. There are 16 local health plans in the state that operate in 36 counties and constitute approximately 70% of the Medi-Cal enrollees. LHPC is instrumental in advocating for the local health plans in all aspects and work closely with our governing agencies.

Linnea Koopmans, Chief Executive Officer of LHPC will present to the KHS Board of Directors.

Requested Action

Receive and File.

LHPC
Local Health Plans of California

Alameda Alliance for Health
CalOptima Health
CalViva Health
CenCal Health
Central CA Alliance for Health
Community Health Group
Contra Costa Health Plan
Gold Coast Health Plan
Health Plan of San Joaquin
Health Plan of San Mateo
Inland Empire Health Plan
Kern Health Systems
L.A. Care Health Plan
Partnership HealthPlan of CA
San Francisco Health Plan
Santa Clara Family Health Plan

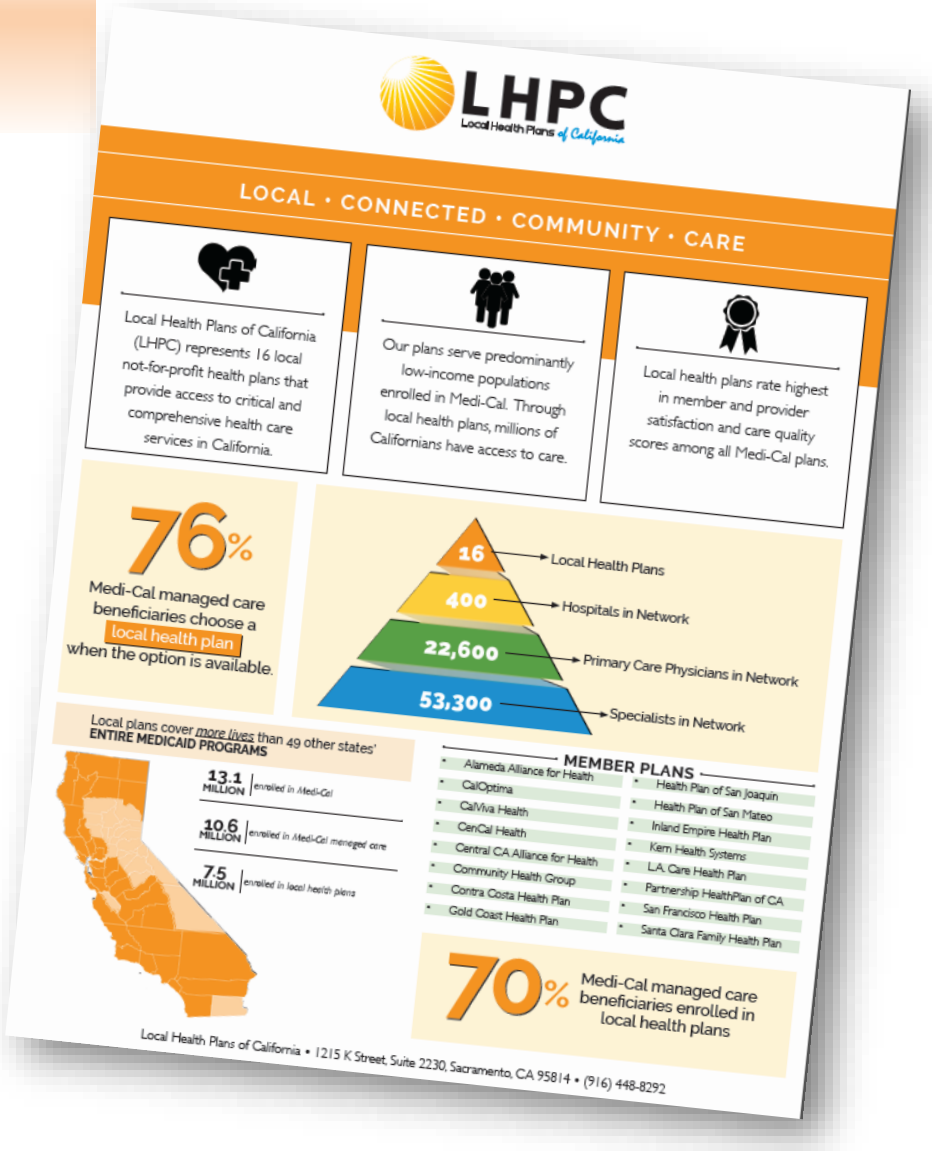
Local Plans & the 2023 Medi-Cal Landscape

December 15, 2022

Linnea Koopmans, CEO

About Us

- Local Health Plans of California (LHPC) represents **16** local health plans.
- Our plans serve predominantly low-income populations enrolled in Medi-Cal.
- Cover over **70%** of Medi-Cal Managed Care enrollees.
- Local Health Plans, created by their counties and safety net leaders, are all community-based & not-for-profit.
- All LIs and COHS are publicly operated & governed.



Legislative & Policy Advocacy

LHPC advocates on behalf of local plans within the Legislature and the Administration.

Political Landscape

- New legislative session with over 30 new members in the Legislature.
- Assembly Speaker change.
  - Transition from Speaker Rendon to incoming Speaker Rivas in July.
  - Anticipated changes in Assembly Committee Chairs.
- On Senate side, awaiting appointment of new Senate Health Committee Chair.
- Changes in key staff in the Governor's Office and Department of Finance.

Medi-Cal Environment

New Benefits and Programs	Oversight and Accountability	Preparing for 2024
CalAIM (many components!)	Quality measures and standards	Procurement changes
Housing and homelessness	Access to care	Managed care model change
Student behavioral health	Transparency and reporting	Statewide Kaiser contract
CHW benefit	Sanctions	Overhauled MCP contract
Doula services	Delegation oversight	Medi-Cal expansion
Data exchange requirements		Regional rates (?)

All of the above against a backdrop of…

- Presumed end of the federal public health emergency in Spring 2023 and resumption of Medi-Cal redeterminations.
- Continued workforce shortages.
- Expectations to implement many new programs while simultaneously improving quality and access, without regard to the long-term impacts of the pandemic.
- State Budget uncertainty and potential implications for recent investments.

Questions?

Thank you!

Linnea Koopmans, CEO
lkoopmans@lhpc.org

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: December 15, 2022

Re: Amended KHS Conflict of Interest Code

Background

The Kern Health Systems conflict of interest code was reviewed by the KHS legal counsel, as required by Government Code Section 87306.5, to determine whether a change in the code is necessitated. Recommendations were made, as shown on the redlined copy attached. Changes were necessary to designate KHS as the sole custodian of all Form 700s, so that two agencies are not tracking the same information.

If a revision to the code is necessitated by changed circumstances, we are required to submit an amended conflict of interest code in accordance with Section 87302 and Section 87303 of the Government Code to the Board of Supervisors, the code reviewing body for Kern County agencies, for approval.

Requested Action

Approve the amended KHS conflict of interest code for submittal to the Board of Supervisors.

CONFLICT OF INTEREST CODE FOR
KERN HEALTH SYSTEMS

The Political Reform Act requires state and local government agencies which includes KHS to adopt and promulgate conflict of interest codes. (Gov. Code, §§ 81000 et seq.) The Fair Political Practices Commission has adopted a regulation, which contains the terms of a standard conflict of interest code. (Cal. Code Regs., tit. 2, § 18730.) Incorporation by reference of the terms of the regulation constitutes the adoption and promulgation of the conflict of interest code of KHS Therefore the terms of Cal. Code Regs. Tit. 2 § 18730, along with the designed covered individuals and disclosure categories set forth in Attachment A are hereby incorporated by reference. The requirements of this conflict of interest code are in addition to other requirements of the Political Reform Act, such as the general prohibition against conflicts of interest contained in Section 87100, and to other state or local laws pertaining to conflict of interest.

Designated Covered Individuals identified in Attachment A shall file statements of economic interest annually with KHS; The Executive Services Coordinator will make the statements available for public inspection and reproduction. (Gov. Code, § 81008.) ~~Upon receipt of the statements of the Chairman and Members of the Board of Directors of KHS, the KHS Executive Services Coordinator shall make and retain a copy and forward the original of these statement to the Board of Supervisor of the County of Kern.~~ Statements for all other Covered Individuals will be retained by the KHS Executive Services Coordinator.

Attachment A

CONFLICT OF INTEREST CODE
KERN HEALTH SYSTEMS
DESIGNATED COVERED INDIVIDUALS

Chairman and Members of the Board of Directors – Category 1
Chief Executive Officer – Category 1
Chief Operating Officer – Category 2
Chief Financial Officer – Category 2
Chief Information Officer – Category 3
Chief Medical Officer – Catetory 2
Committee Members not otherwise designated as a covered individual above – Category 2
Consultants * - Category 1

* Consultants shall be included in the list of designated Covered Individuals and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation: The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements described in the Conflict of Interest Code. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as the Conflict of Interest Code.

DISCLOSURE CATEGORIES

1. All investments and business positions in business entities, sources of income (including receipt of gifts, loans and travel payments) and real property located in the state of California.

2. Investments and business positions in business entities and sources of income (including receipt of gifts, loans and travel payments) if the business entity or source provides medical or health care related facilities, products, equipment, vehicles, machinery, or services (including training or consulting services), including physician, hospital, or ancillary entities/sources.

3. Investments and business positions in business entities and sources of income (including receipt of gifts, loans and travel payments) if the business entity or source provides information technology or telecommunication goods, products or services, including computer hardware or software companies, computer consultant services, IT training companies, data processing firms and media services.

CONFLICT OF INTEREST CODE FOR
KERN HEALTH SYSTEMS

The Political Reform Act requires state and local government agencies which includes KHS to adopt and promulgate conflict of interest codes. (Gov. Code, §§ 81000 et seq.) The Fair Political Practices Commission has adopted a regulation, which contains the terms of a standard conflict of interest code. (Cal. Code Regs., tit. 2, § 18730.) Incorporation by reference of the terms of the regulation constitutes the adoption and promulgation of the conflict of interest code of KHS Therefore the terms of Cal. Code Regs. Tit. 2 § 18730, along with the designed covered individuals and disclosure categories set forth in Attachment A are hereby incorporated by reference. The requirements of this conflict of interest code are in addition to other requirements of the Political Reform Act, such as the general prohibition against conflicts of interest contained in Section 87100, and to other state or local laws pertaining to conflict of interest.

Designated Covered Individuals identified in Attachment A shall file statements of economic interest annually with KHS; The Executive Services Coordinator will make the statements available for public inspection and reproduction. (Gov. Code, § 81008.) Statements for all other Covered Individuals will be retained by the KHS Executive Services Coordinator.

Attachment A

CONFLICT OF INTEREST CODE
KERN HEALTH SYSTEMS
DESIGNATED COVERED INDIVIDUALS

Chairman and Members of the Board of Directors – Category 1
Chief Executive Officer – Category 1
Chief Operating Officer – Category 2
Chief Financial Officer – Category 2
Chief Information Officer – Category 3
Chief Medical Officer – Catetory 2
Committee Members not otherwise designated as a covered individual above – Category 2
Consultants * - Category 1

* Consultants shall be included in the list of designated Covered Individuals and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation: The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements described in the Conflict of Interest Code. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as the Conflict of Interest Code.

DISCLOSURE CATEGORIES

1. All investments and business positions in business entities, sources of income (including receipt of gifts, loans and travel payments) and real property located in the state of California.

2. Investments and business positions in business entities and sources of income (including receipt of gifts, loans and travel payments) if the business entity or source provides medical or health care related facilities, products, equipment, vehicles, machinery, or services (including training or consulting services), including physician, hospital, or ancillary entities/sources.

3. Investments and business positions in business entities and sources of income (including receipt of gifts, loans and travel payments) if the business entity or source provides information technology or telecommunication goods, products or services, including computer hardware or software companies, computer consultant services, IT training companies, data processing firms and media services.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: December 15, 2022

Re: Quarterly Review of Kern Health Systems Investment Portfolio

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Background

The Kern Health Systems ("KHS") Investment Policy stipulates the following order of investment objectives:

- Preservation of principal
- Liquidity
- Yield

The investment portfolios are designed to attain a market-average rate of return through economic cycles given an acceptable level of risk. KHS currently maintains the following investment portfolios:

Short-Term Portfolio (Under 1 year)

Funds held in this time frame are typically utilized to pay providers, meet operating expenses and fund capital projects**.** Additionally, extra liquidity is maintained in the event the State is late with its monthly capitation payment.

Long-Term Portfolio (1-5 years)

Funds held in this time frame are typically for reserves and to take advantage of obtaining higher yields.

Requested Action

Receive and File.

Kern Health Systems
Investment Portfolio
September 30, 2022

Short Term Portfolio (under 1 year)

Funds held in this time frame are typically utilized to pay providers, meet operating expenses, distribute pass-through monies waiting for additional approvals and/or support to be paid and monies owed to the State for MCO Taxes. Extra liquidity is maintained in the event the State is late with its monthly capitation payment.

Description			Dollar Amount	% of Portfolio	Maximum Allowed Per Policy	Approximate Current Yield	Liquidity	Principal Fluctuation
Wells Fargo - Cash		(1)	$ 2,800,000	0.74%	100%		1 Day	None
Money Market Accounts	(A)	(1)	$ 65,500,000	17.29%	40%	2.98%	1 Day	None
Local Agency Investment Fund (LAIF)	(B)	(2)	$ 74,300,000	19.61%	50%	1.29%	2 Days	None
US T-Bills & Federal Agencies at Wells Fargo		(1)	$ 176,900,000	46.70%	100%	2.55%	1 Day	Subject to Interest Rate Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)	(1)	$ 5,500,000	1.45%		1.81%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 325,000,000	85.80%		2.31%		

Long Term Port Folio (1 - 5 years)

Funds held in this time frame are typically for reserves and to take advantage of obtaining higher yields.

UBS Managed Portfolio	(D)		$ 48,900,000	12.91%		4.64%	3 Days	Subject to Interest Rate and Credit Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)		$ 4,900,000	1.29%		4.00%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 53,800,000	14.20%		4.58%		
Total Portfolio			$ 378,800,000	100.00%		2.64%		

Yield Curve	Treasuries	Yield Curve AA Corporate Bonds	A Corporate Bonds	CD's
1 year	4.50%	4.59%	4.75%	4.20%
2 year	4.51%	4.72%	4.99%	4.45%
3 year	4.52%	4.80%	5.10%	4.50%
5 year	4.31%	4.89%	5.22%	4.55%

(A) Money market fund comprised of US Treasury and Repurchase Agreement Obligations.
(B) LAIF is part of a $223 Billion Pooled Money Investment Account managed by the State Treasurer of CA. Majority of portfolio is comprised of Treasuries, CD's, Time Deposits and Commercial Paper.
(C) High quality diversified portfolio comprising commercial paper, corporate bonds and notes.
(D) High quality diversified portfolio comprising certificate of deposits, corporate bonds and notes, municipal securities and US Treasury Securities. Includes investments maturing in less than 1 year that will be re-invested for over 1 year at maturity.

(1) Funds are utilized to pay providers, meet operating expenses, distribute pass-through monies waiting for additional approvals and/or support, amounts owed to the State for MCO Taxes, potential State premium recoupments and for amounts owed under various Risk Corridors. Extra liquidity is maintained in the event the State is late with its monthly capitation payment.
(2) Funds are primarily utilized to fund various Grant Programs and 2022 capital projects.

UBS

Branch office:
9201 Camino Media
Suite 230
Bakersfield, CA 93311

Financial Advisor:
The Cohen Group
(661) 663-3233

UBS Client Review

as of September 30, 2022

Prepared for

Kern Health Systems

Accounts included in this review

Account	Name	Type
EX XX120	• BOND PORTFOLIO	• Portfolio Management Program
Risk profile:	Conservative	
Return Objective:	Current Income	

What's inside

UBS

Portfolio review

as of September 30, 2022

EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for **Kern Health Systems**
Risk profile: Conservative
Return Objective: Current Income

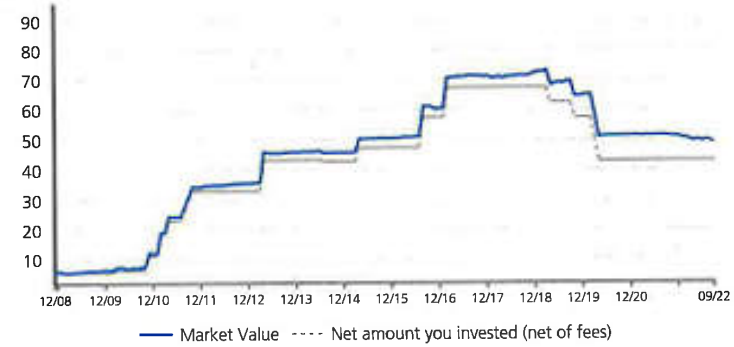
Asset allocation review

		Value on 09/30/2022 ($)	% of Portfolio
A	**Cash**	**1,003,433.09**	**2.05**
	Cash	1,003,433.09	2.05
	US	1,003,433.09	2.05
B	**Fixed Income**	**47,888,218.15**	**97.95**
	US	47,888,218.15	97.95
	Government	3,822,492.22	7.82
	Corporate IG Credit	44,065,725.93	90.13
C	**Equity**	**0.00**	**0.00**
D	**Commodities**	**0.00**	**0.00**
E	**Non-Traditional**	**0.00**	**0.00**
F	**Other**	**0.00**	**0.00**
	Total Portfolio	**$48,891,651.24**	**100%**

Balanced mutual funds are allocated in the 'Other' category

Sources of portfolio value

$ Millions



Portfolio value and investment results

	Performance returns (annualized > 1 year)			
	For the period of 12/31/2021 to 03/31/2022	For the period of 03/31/2022 to 06/30/2022	For the period of 06/30/2022 to 09/30/2022	YTD 12/31/2021 to 09/30/2022
Opening value	**51,044,313.37**	**49,921,494.38**	**49,436,575.37**	**51,044,313.37**
Net deposits/withdrawals	-16,286.52	-15,979.52	-16,089.16	-48,355.20
Div./interest income	153,776.90	292,223.52	183,397.34	629,397.76
Change in accr. interest	75,535.73	-57,125.76	65,091.19	83,501.16
Change in value	-1,335,845.10	-704,037.25	-777,323.50	-2,817,205.85
Closing value	**49,921,494.38**	**49,436,575.37**	**48,891,651.24**	**48,891,651.24**
Net Time-weighted ROR	-2.20	-0.97	-1.10	-4.22

Net deposits and withdrawals include program and account fees.

Summary of gains and losses

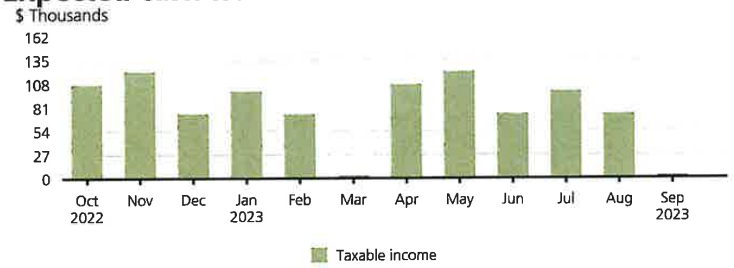
	Short term ($)	Long term ($)	Total ($)
2021 Realized gains and losses	**227.34**	**48,939.49**	**49,166.83**
Taxable	227.34	48,939.49	49,166.83
Tax-deferred	0.00	0.00	0.00
2022 Year to date	**0.00**	**-60,398.10**	**-60,398.10**
Taxable	0.00	-60,398.10	-60,398.10
Tax-deferred	0.00	0.00	0.00

Past performance does not guarantee future results and current performance may be lower/higher than past data presented.

Report created on: November 02, 2022

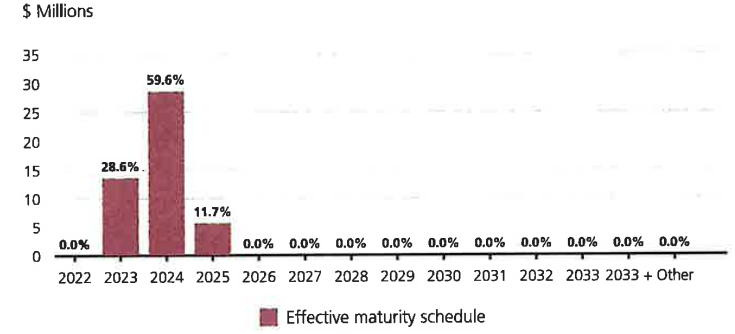
Portfolio review - as of September 30, 2022 (continued)

Expected cash flow



Total taxable income: $973,125.00
Total expected cash flow: $973,125.00
Cash flows displayed account for known events such as maturities and mandatory puts.

Bond maturity schedule



Cash, mutual funds and some preferred securities are not included.

Equity sector analysis

Compared to S&P 500 index

	Value on 09/30/2022 ($)	Actual (%)	Model (%)	Gap (%)
Communication Services	0.00	0.00	7.60	-7.60
Consumer Discretionary	0.00	0.00	11.25	-11.25
Consumer Staples	0.00	0.00	7.40	-7.40
Energy	0.00	0.00	5.30	-5.30
Financials	0.00	0.00	11.03	-11.03
Health Care	0.00	0.00	15.11	-15.11
Industrials	0.00	0.00	8.16	-8.16
Information Technology	0.00	0.00	25.90	-25.90
Materials	0.00	0.00	2.50	-2.50
Real Estate	0.00	0.00	2.41	-2.41
Utilities	0.00	0.00	2.72	-2.72
Total classified equity	**$0.00**			
Unclassified Securities	0.00			

Past performance does not guarantee future results and current performance may be lower/higher than past data presented.

UBS

EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for **Kern Health Systems**
Risk profile: Conservative
Return Objective: Current Income

Portfolio review - as of September 30, 2022 (continued)

Summary of performance by account

		Performance start date	Value on 09/30/2022 ($)	% of portfolio		Performance returns (annualized > 1 year) For the period of 12/31/2021 to 03/31/2022	For the period of 03/31/2022 to 06/30/2022	For the period of 06/30/2022 to 09/30/2022	YTD 12/31/2021 to 09/30/2022
EX XX120	BOND PORTFOLIO•PMP•The Cohen Group Fixed Income - PIV Risk profile: Conservative Return objective: Current Income	Dec 08, 2008	48,891,651.24	100.00%	Net time-weighted	-2.20%	-0.97%	-1.10%	-4.22%
Total Portfolio		**Dec 08, 2008**	**$48,891,651.24**	**100%**	**Net time-weighted**	**-2.20%**	**-0.97%**	**-1.10%**	**-4.22%**

Benchmarks - Annualized time-weighted returns	For the period of 12/31/2021 to 03/31/2022	For the period of 03/31/2022 to 06/30/2022	For the period of 06/30/2022 to 09/30/2022	YTD 12/31/2021 to 09/30/2022
Blended Index	-2.48%	-0.81%	-1.36%	-4.59%
Blended Index 2	-1.21%	-0.47%	-0.58%	-2.24%
US Treasury Bill - 3 Mos	0.03%	0.12%	0.47%	0.63%
BBG US Agg (1-3 Y)	-2.50%	-0.64%	-1.50%	-4.58%
S&P 500	-4.60%	-16.10%	-4.88%	-23.87%

Blended Index:11/04/2019 - Current: 45% BBG US Corp 1-3Y Incp76; 55% BBG US Agg Gvt & CR 1-3 Y **Blended Index 2:Start - Current:** 30% BofA 1Y Trs Note; 40% BofA US Corp 1-3Y A-AAA; 30% US Treasury Bill - 3 Mos
Past performance does not guarantee future results and current performance may be lower/higher than past data presented.

Report created on: November 02, 2022

Asset allocation by account

as of September 30, 2022

	Cash ($/%)	Equities ($/%) U.S.	Equities ($/%) Global	Equities ($/%) International	Fixed Income ($/%) U.S.	Fixed Income ($/%) Global	Fixed Income ($/%) International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	Total
	1,003,433.09	**0.00**	**0.00**	**0.00**	**47,888,218.15**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$48,891,651.24**
Total Portfolio	**2.05**	**0.00**	**0.00**	**0.00**	**97.95**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**

	1,003,433.09	0.00	0.00	0.00	47,888,218.15	0.00	0.00	0.00	0.00	0.00	**$48,891,651.24**
	2.05	0.00	0.00	0.00	97.95	0.00	0.00	0.00	0.00	0.00	**100.00%**

EX XX120 . BOND PORTFOLIO . BSA PMP

Risk profile: Conservative
Return objective: Current Income

	Cash ($/%)	Equities ($/%) U.S.	Equities ($/%) Global	Equities ($/%) International	Fixed Income ($/%) U.S.	Fixed Income ($/%) Global	Fixed Income ($/%) International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	Total
	1,003,433.09	**0.00**	**0.00**	**0.00**	**47,888,218.15**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$48,891,651.24**
Total Portfolio	**2.05**	**0.00**	**0.00**	**0.00**	**97.95**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**

Balanced mutual funds are allocated in the 'Other' category

UBS

Asset allocation review

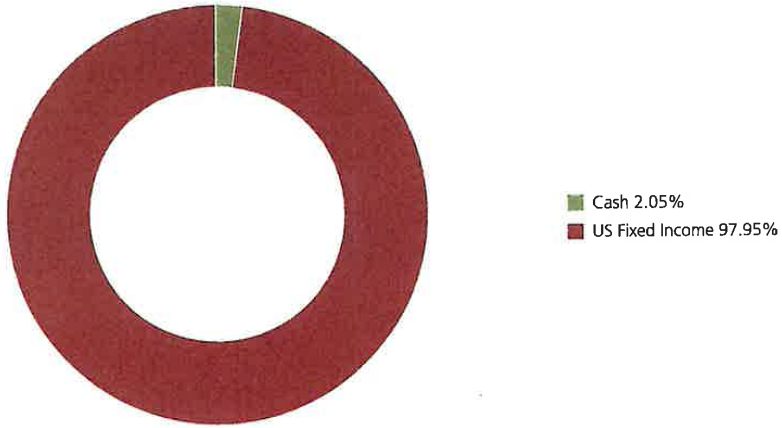
as of September 30, 2022

EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for **Kern Health Systems**
Risk profile: Conservative
Return Objective: Current Income

Summary of asset allocation

	Market value ($)	% of Portfolio
Cash	**1,003,433.09**	**2.05**
Cash	**1,003,433.09**	**2.05**
US	1,003,433.09	2.05
Fixed Income	**47,888,218.15**	**97.95**
US	**47,888,218.15**	**97.95**
Government	3,822,492.22	7.82
Corporate IG Credit	44,065,725.93	90.13
Equity	**0.00**	**0.00**
Commodities	**0.00**	**0.00**
Non-Traditional	**0.00**	**0.00**
Other	**0.00**	**0.00**
Total Portfolio	**$48,891,651.24**	**100%**

Balanced mutual funds are allocated in the 'Other' category



UBS

Bond summary

as of September 30, 2022

Bond overview

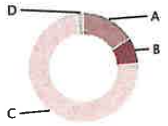
Total quantity	49,550,000
Total market value	$47,587,641.00
Total accrued interest	$300,577.15
Total market value plus accrued interest	$47,888,218.15
Total estimated annual bond interest	$973,125.00
Average coupon	1.97%
Average current yield	2.04%
Average yield to maturity	4.64%
Average yield to worst	4.64%
Average modified duration	1.62
Average effective maturity	1.70

Investment type allocation

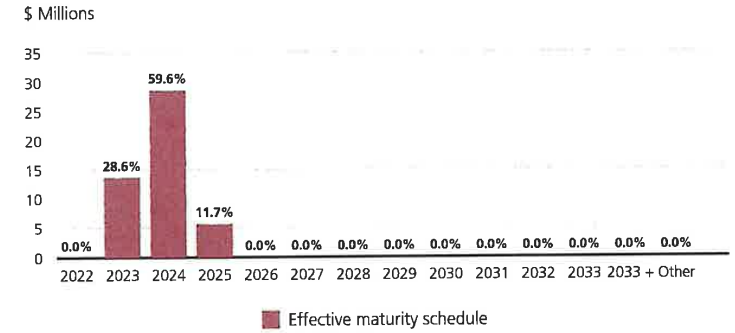
Investment type	Taxable ($)	Tax-exempt / deferred ($)	Total ($)	% of bond port.
U.S. corporates	44,065,725.93	0.00	44,065,725.93	92.02
U.S. federal agencies	3,822,492.22	0.00	3,822,492.22	7.98
Total	**$47,888,218.15**	**$0.00**	**$47,888,218.15**	**100%**

Credit quality of bond holdings

Effective credit rating		Issues	Value on 09/30/2022 ($)	% of port.
A	Aaa/AAA/AAA	5	7,657,139.64	16.05
B	Aa/AA/AA	2	3,733,300.42	7.81
C	A/A/A	24	35,532,285.59	74.14
D	Baa/BBB/BBB	1	965,492.50	2.01
E	Non-investment grade	0	0.00	0.00
F	Certificate of deposit	0	0.00	0.00
G	Not rated	0	0.00	0.00
Total		**32**	**$47,888,218.15**	**100%**



Bond maturity schedule



Cash, mutual funds and some preferred securities are not included.

Includes all fixed income securities in the selected porfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.

Report created on: November 02, 2022

UBS

Bond holdings

as of September 30, 2022

EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for **Kern Health Systems**
Risk profile: Conservative
Return Objective: Current Income

Summary of bond holdings

Maturity Year	Issues	Quantity	Est. annual income ($)	Current yield (%)	Yield to maturity (%)	Yield to worst (%)	Modified duration	Adjusted cost basis ($)	Unrealized gain/loss ($)	Mkt. value ($)	% of bond portfolio maturing
2022	0	0			NA	NA	NA				
2023	8	14,100,000	69,150.00	0.51%	4.35 %	4.35 %	0.87	14,114,559.27	-499,455.27	13,639,096.08	28.61%
2024	20	29,650,000	708,225.00	2.50%	4.71 %	4.71 %	1.83	30,247,684.27	-1,863,391.27	28,626,396.82	59.65%
2025	4	5,800,000	195,750.00	3.50%	4.97 %	4.97 %	2.35	5,950,857.69	-362,613.69	5,622,725.25	11.74%
2026	0	0			NA	NA	NA				
2027	0	0			NA	NA	NA				
2028	0	0			NA	NA	NA				
2029	0	0			NA	NA	NA				
2030	0	0			NA	NA	NA				
2031	0	0			NA	NA	NA				
2032	0	0			NA	NA	NA				
2033	0	0			NA	NA	NA				
2034	0	0			NA	NA	NA				
2035	0	0			NA	NA	NA				
2036	0	0			NA	NA	NA				
2037	0	0			NA	NA	NA				
2038	0	0			NA	NA	NA				
2039	0	0			NA	NA	NA				
2040	0	0			NA	NA	NA				
2041	0	0			NA	NA	NA				
2042	0	0			NA	NA	NA				
2043	0	0			NA	NA	NA				
2044	0	0			NA	NA	NA				
2045	0	0			NA	NA	NA				
2046	0	0			NA	NA	NA				
2047	0	0			NA	NA	NA				
2048	0	0			NA	NA	NA				
2049	0	0			NA	NA	NA				
2050	0	0			NA	NA	NA				
2051	0	0			NA	NA	NA				
2051 +	0	0			NA	NA	NA				
Other	0	0			NA	NA	NA				
Total	**32**	**49,550,000**	**$973,125.00**	**2.04%**	**4.64 %**	**4.64 %**	**1.62**	**$50,313,101.23**	**$-2,725,460.23**	**$47,888,218.15**	

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.

Report created on: November 02, 2022

Bond holdings - as of September 30, 2022 (continued)

Details of bond holdings

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Total Bond Portfolio		**49,550,000**	**1.97%**	**06/13/2024**	**NA**	**$973,125.00** **2.04%**	**4.64%** **4.64%**	**1.62**	**$50,313,101.2** **$-2,725,460.23**	**NA**	**$47,587,641.00** **$300,577.15** **$47,888,218.15**	**100%**
Maturing 2023												
PEPSICO INC NTS B/E 00.750% 050123 DTD050120 FC110120 CALL@MW+10BP	A1/WD/A+ NR/NR/NR	1,500,000	0.75%	05/01/2023		11,250.00 0.76%	4.06% 4.06%	0.57	1,503,831.68 -32,271.68	98.104	1,471,560.00 4,656.25	3.09%
APPLE INC NTS B/E 00.750% 051123 DTD051120 FC111120 CALL@MW+10BP	Aaa/NR/AA+ NR/NR/NR	3,000,000	0.75%	05/11/2023		22,500.00 0.77%	4.13% 4.13%	0.59	3,007,909.78 -68,689.78	97.974	2,939,220.00 8,687.50	6.18%
JOHN DEERE CPTL CORP 00.700% 070523 DTD060420 FC010521 MED TERM NTS	A2/A/A NR/NR/NR	1,000,000	0.70%	07/05/2023		7,000.00 0.72%	4.30% 4.30%	0.74	1,002,631.27 -29,431.27	97.320	973,200.00 1,652.78	2.05%
PACCAR FINANCIAL CORP 00.350% 081123 DTD081120 FC021121 MED TERM NTS	A1/NR/A+ NR/NR/NR	2,000,000	0.35%	08/11/2023		7,000.00 0.36%	4.37% 4.37%	0.84	2,000,000.00 -67,460.00	96.627	1,932,540.00 952.78	4.06%
PEPSICO INC NTS B/E 00.400% 100723 DTD100720 FC040721	A1/NR/A+ NR/NR/NR	600,000	0.40%	10/07/2023		2,400.00 0.42%	4.22% 4.22%	0.99	601,037.21 -23,693.21	96.224	577,344.00 1,153.33	1.21%
FFCB BOND 00.290 % DUE 110223 DTD 110220 FC 05022021	NR/AAA/AA+ NR/NR/NR	2,000,000	0.29%	11/02/2023		5,800.00 0.30%	4.56% 4.56%	1.06	1,998,818.00 -88,618.00	95.510	1,910,200.00 2,384.44	4.01%
FANNIE MAE NTS 00.310 % DUE 111623 DTD 111620 FC 05162021	Aaa/AAA/AA+ NR/NR/NR	2,000,000	0.31%	11/16/2023	11/16/2022 100.00	6,200.00 0.33%	4.56% 4.56%	1.10	1,999,800.00 -92,200.00	95.380	1,907,600.00 2,307.78	4.01%
BANK OF NY MELLON CORP 00.350% 120723 DTD120720 FC060721 NTS B/E	A1/AA-/A NR/NR/NR	2,000,000	0.35%	12/07/2023	11/07/2023 100.00	7,000.00 0.37%	4.58% 4.58%	1.15	2,000,531.33 -97,091.33	95.172	1,903,440.00 2,197.22	4.00%
Total 2023		**14,100,000**	**0.49%**	**08/22/2023**		**$69,150.00** **0.51%**	**4.35%** **4.35%**	**0.87**	**$14,114,559.2** **$-499,455.27**		**$13,615,104.00** **$23,992.08**	**28.61%**
Maturing 2024												
US BANCORP MED TERM NTS 03.375% 020524 DTD020419 FACTOR 1.000000000000	A2/A+/A+ NR/NR/NR	300,000	3.38%	02/05/2024	01/05/2024 100.00	10,125.00 3.44%	4.73% 4.73%	1.29	311,507.64 -16,775.64	98.244	294,732.00 1,546.88	0.62%

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.

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EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for **Kern Health Systems**
Risk profile: Conservative
Return Objective: Current Income

Bond holdings - as of September 30, 2022 (continued)

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2024												
MICROSOFT CORP NTS B/E 02.875% 020624 DTD020617 FC080617 CALL@MW+12.5BP	Aaa/AAA/AAA NR/NR/NR	500,000	2.88%	02/06/2024	12/06/2023 100.00	14,375.00 2.93%	4.42% 4.42%	1.29	516,172.14 -26,222.14	97.990	489,950.00 2,156.25	1.03%
COMCAST CORP NTS B/E 03.700% 041524 DTD100518 FC041519 CALL@MW+15BP	A3/A-/A- NR/NR/NR	1,500,000	3.70%	04/15/2024	03/15/2024 100.00	55,500.00 3.76%	4.85% 4.85%	1.45	1,526,569.24 -51,949.24	98.308	1,474,620.00 25,437.50	3.10%
APPLE INC NTS B/E 2.850% 051124 DTD051117 FC111117 CALL@MW+12.5BP	Aaa/NR/AA+ NR/NR/NR	400,000	2.85%	05/11/2024	03/11/2024 100.00	11,400.00 2.92%	4.43% 4.43%	1.53	415,366.35 -25,134.35	97.558	390,232.00 4,401.67	0.82%
AMAZON COM INC NTS B/E 00.450% 051224 DTD051221 CALL@MW+2.5BP	A1/AA-/AA NR/NR/NR	2,000,000	0.45%	05/12/2024		9,000.00 0.48%	4.49% 4.49%	1.57	1,997,660.00 -122,360.00	93.765	1,875,300.00 3,450.00	3.94%
JPMORGAN CHASE & CO NTS 03.625% 051324 DTD051314 FC111314 B/E	A1/AA-/A- NR/NR/NR	1,800,000	3.63%	05/13/2024		65,250.00 3.69%	4.72% 4.72%	1.52	1,886,529.95 -117,003.95	98.307	1,769,526.00 24,831.25	3.72%
US BANCORP NTS B/E 02.400% 073024 DTD072919 FC013020	A2/A+/A+ NR/NR/NR	2,000,000	2.40%	07/30/2024	06/28/2024 100.00	48,000.00 2.50%	4.73% 4.73%	1.75	1,967,640.00 -48,600.00	95.952	1,919,040.00 8,000.00	4.03%
BB&T CORP NTS B/E 02.500% 080124 DTD072919 FC020120	A3/A/A- NR/NR/NR	1,000,000	2.50%	08/01/2024	07/01/2024 100.00	25,000.00 2.61%	4.92% 4.92%	1.75	1,035,460.35 -77,510.35	95.795	957,950.00 4,097.22	2.01%
UNITEDHEALTH GROUP INC 02.375% 081524 DTD072519 CALL@MW+10BP NTS	A3/A/A+ NR/NR/NR	2,250,000	2.38%	08/15/2024		53,437.50 2.47%	4.58% 4.58%	1.79	2,265,886.47 -104,086.47	96.080	2,161,800.00 6,679.69	4.54%
JOHN DEERE CAPITAL CORP 00.625% 091024 DTD091021 FC031022 NTS B/E	A2/A/A NR/NR/NR	1,400,000	0.63%	09/10/2024		8,750.00 0.67%	4.45% 4.45%	1.89	1,401,209.15 -99,993.15	92.944	1,301,216.00 486.11	2.73%
PAYPAL HOLDINGS INC NTS 02.400% 100124 DTD092619 FC040120 CALL@MW+15BP	A3/A-/A- NR/NR/NR	2,250,000	2.40%	10/01/2024	09/01/2024 100.00	54,000.00 2.51%	4.80% 4.80%	1.89	2,275,856.70 -127,646.70	95.476	2,148,210.00 26,850.00	4.51%
SIMON PPTY GROUP LP B/E 03.375% 100124 DTD091014 FC040115 CALL@MW+15BP	A3/WD/A- NR/NR/NR	1,900,000	3.38%	10/01/2024	07/01/2024 100.00	64,125.00 3.48%	4.94% 4.94%	1.87	1,990,828.63 -146,821.63	97.053	1,844,007.00 31,884.38	3.87%
BK OF NY MELLON CORP NTS 00.850% 102524 DTD102521 FC042522 B/E	A1/AA-/A NR/NR/NR	1,500,000	0.85%	10/25/2024	09/25/2024 100.00	12,750.00 0.92%	4.76% 4.76%	1.99	1,501,455.50 -115,800.50	92.377	1,385,655.00 5,489.58	2.91%
BB&T CORP MED TERM NTS 02.850% 102624 DTD102617 FC042618 B/E	A3/A/A- NR/NR/NR	1,000,000	2.85%	10/26/2024	09/26/2024 100.00	28,500.00 2.97%	4.84% 4.84%	1.95	1,042,653.44 -81,463.44	96.119	961,190.00 12,191.67	2.02%
PNC FINL SERV GRP INC WT 02.200% 110124 DTD110119 FC050120 EXP NTS B/E	A3/A/A- NR/NR/NR	2,000,000	2.20%	11/01/2024	10/02/2024 100.00	44,000.00 2.32%	4.73% 4.73%	1.98	2,069,171.46 -168,651.46	95.026	1,900,520.00 18,211.11	3.99%
GENERAL DYNAMICS CORP 02.375% 111524 DTD091417 FC051518 CALL@MW+10BP	A3/WD/A- NR/NR/NR	1,750,000	2.38%	11/15/2024	09/15/2024 100.00	41,562.50 2.49%	4.76% 4.76%	2.01	1,810,156.27 -143,666.27	95.228	1,666,490.00 15,585.94	3.50%

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.

Bond holdings - as of September 30, 2022 (continued)

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2024												
ORACLE CORP NTS B/E 02.950% 111524 DTD110917 FC051518 CALL@MW+15BP	Baa2/BBB+/BBB NR/NR/NR	1,000,000	2.95%	11/15/2024	09/15/2024 100.00	29,500.00 3.09%	5.24% 5.24%	1.99	1,042,346.78 -87,916.78	95.443	954,430.00 11,062.50	2.01%
TRUIST BANK NTS B/E 02.150% 120624 DTD120619 FC060620	A2/A+/A NR/NR/NR	2,000,000	2.15%	12/06/2024	11/06/2024 100.00	43,000.00 2.28%	5.02% 5.02%	2.07	2,006,517.91 -124,017.91	94.125	1,882,500.00 13,616.67	3.96%
WAL MART STORES INC NTS 02.650% 121524 DTD102017 FC061518 CALL@MW+10BP	Aa2/AA/AA NR/NR/NR	1,900,000	2.65%	12/15/2024	10/15/2024 100.00	50,350.00 2.74%	4.16% 4.16%	2.09	1,981,316.42 -141,451.42	96.835	1,839,865.00 14,685.42	3.87%
STATE STREET CORP B/E 03.300% 121624 DTD121514 FC061615	A1/AA-/A NR/NR/NR	1,200,000	3.30%	12/16/2024		39,600.00 3.39%	4.62% 4.62%	2.08	1,203,379.87 -36,319.87	97.255	1,167,060.00 11,440.00	2.45%
Total 2024		**29,650,000**	**2.40%**	**09/06/2024**		**$708,225.00** **2.50%**	**4.71%** **4.71%**	**1.83**	**$30,247,684.2** **$-1,863,391.27**		**$28,384,293.00** **$242,103.82**	**59.65%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2025												
JPMORGAN CHASE & CO B/E 03.125% 012325 DTD012315 FC072315	A1/AA-/A- NR/NR/NR	2,400,000	3.13%	01/23/2025	10/23/2024 100.00	75,000.00 3.26%	5.03% 5.03%	2.18	2,515,384.80 -214,048.80	95.889	2,301,336.00 13,958.33	4.84%
BK OF NY MELLON CORP B/E 03.000% 022425 DTD022415 FC082415	A1/AA-/A NR/NR/NR	1,300,000	3.00%	02/24/2025	01/24/2025 100.00	39,000.00 3.12%	4.65% 4.65%	2.27	1,341,904.89 -90,199.89	96.285	1,251,705.00 3,900.00	2.63%
PNC BK B/E 03.250% 060125 DTD060115 FC120115	A2/A+/A NR/NR/NR	300,000	3.25%	06/01/2025	05/01/2025 100.00	9,750.00 3.39%	4.95% 4.95%	2.48	295,368.00 -8,019.00	95.783	287,349.00 3,222.92	0.60%
MORGAN STANLEY B/E 04.000% 072325 DTD072315 FC012316 CALL@MW+25BP	A1/A/A- NR/NR/NR	1,800,000	4.00%	07/23/2025		72,000.00 4.12%	5.12% 5.12%	2.60	1,798,200.00 -50,346.00	97.103	1,747,854.00 13,400.00	3.67%
Total 2025		**5,800,000**	**3.38%**	**04/04/2025**		**$195,750.00** **3.50%**	**4.97%** **4.97%**	**2.35**	**$5,950,857.69** **$-362,613.69**		**$5,588,244.00** **$34,481.25**	**11.74%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Total Bond Portfolio		**49,550,000**	**1.97%**	**06/13/2024**	**NA**	**$973,125.00** **2.04%**	**4.64%** **4.64%**	**1.62**	**$50,313,101.2** **$-2,725,460.23**	**NA**	**$47,587,641.00** **$300,577.15** **$47,888,218.15**	**100%**

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.

Additional information about your portfolio

as of September 30, 2022

Benchmark composition

Account EX XX120

Blended Index
Start - 05/15/2017: 50% BBG US Gvt 1-3 Y; 50% BBG USAgg GvtCr 1-5Y
05/15/2017 - 05/31/2018: 100% BBG Agg Bond
05/31/2018 - 11/04/2019: 100% BBG Agg Bond
11/04/2019 - Current: 45% BBG US Corp 1-3Y Incp76; 55% BBG US Agg Gvt & CR 1-3 Y

Blended Index 2
Start - Current: 30% BofA 1Y Trs Note; 40% BofA US Corp 1-3Y A-AAA; 30% US Treasury Bill - 3 Mos

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Disclosures applicable to accounts at UBS Financial Services Inc.

This section contains important disclosures regarding the information and valuations presented here. All information presented is subject to change at any time and is provided only as of the date indicated. The information in this report is for informational purposes only and should not be relied upon as the basis of an investment or liquidation decision. UBS FS account statements and official tax documents are the only official record of your accounts and are not replaced, amended or superseded by any of the information presented in these reports. You should not rely on this information in making purchase or sell decisions, for tax purposes or otherwise.

UBS FS offers a number of investment advisory programs to clients, acting in our capacity as an investment adviser, including fee-based financial planning, discretionary account management, non-discretionary investment advisory programs, and advice on the selection of investment managers and mutual funds offered through our investment advisory programs. When we act as your investment adviser, we will have a written agreement with you expressly acknowledging our investment advisory relationship with you and describing our obligations to you. At the beginning of our advisory relationship, we will give you our Form ADV brochure(s) for the program(s) you selected that provides detailed information about, among other things, the advisory services we provide, our fees, our personnel, our other business activities and financial industry affiliations and conflicts between our interests and your interests.

In our attempt to provide you with the highest quality information available, we have compiled this report using data obtained from recognized statistical sources and authorities in the financial industry. While we believe this information to be reliable, we cannot make any representations regarding its accuracy or completeness. Please keep this guide as your Advisory Review.

Please keep in mind that most investment objectives are long term. Although it is important to evaluate your portfolio's performance over multiple time periods, we believe the greatest emphasis should be placed on the longer period returns.

Please review the report content carefully and contact your Financial Advisor with any questions.

Client Accounts: This report may include all assets in the accounts listed and may include eligible and ineligible assets in a fee-based program. Since ineligible assets are not considered fee-based program assets, the inclusion of such securities will distort the actual performance of your accounts and does not reflect the performance of your accounts in the fee-based program. As a result, the performance reflected in this report can vary substantially from the individual account performance reflected in the performance reports provided to you as part of those programs. For fee-based programs, fees are charged on the market value of eligible assets in the accounts and assessed quarterly in advance, prorated according to the number of calendar days in the billing period. When shown on a report, the risk profile and return objectives describe your overall goals for these accounts. For each account you maintain, you choose one return objective and a primary risk profile. If you have questions regarding these objectives or wish to change them, please contact your Financial Advisor to update your account records.

Performance: This report presents account activity and performance depending on which inception type you've chosen. The two options are: (1) All Assets (Since Performance Start): This presents performance for all assets since the earliest possible date; (2) Advisory Assets (Advisory Strategy Start) for individual advisory accounts: This presents Advisory level performance since the Latest Strategy Start date; if an account that has never been managed is included in the consolidated report, the total performance of that unmanaged account will be included since inception.

Time-weighted Returns for accounts / SWP/AAP sleeves (Monthly periods): The report displays a time weighted rate of return (TWR) that is calculated using the Modified Dietz Method. This calculation uses the beginning and ending portfolio values for the month and weighs each contribution/withdrawal based upon the day the cash flow occurred. Periods greater than one month are calculated by linking the monthly returns. The TWR gives equal weighting to every return regardless of amount of money invested, so it is an effective measure for returns on a fee based account. All periods shown which are greater than 12 months are annualized. This applies to all performance for all assets before 09/30/2010, Advisory assets before 12/31/2010 and SWP sleeves before 04/30/2018.

Time-weighted Returns for accounts / SWP/AAP sleeves (Daily periods): The report displays a time weighted rate of return (TWR) that is calculated by dividing the portfolio's daily gain/loss by the previous day's closing market value plus the net value of cash flows that occurred during the day, if it was positive. The TWR gives equal weighting to every return regardless of amount of money invested, so it is an effective measure for returns on a fee based account. Periods greater than one day are calculated by linking the daily returns. All periods shown which are greater than 12 months are annualized. For reports generated prior to 01/26/2018, the performance calculations used the account's end of day value on the performance inception (listed in the report under the column "ITD") and all cash flows were posted at end of day. As a result of the change, the overall rate of return (TWR) and beginning market value displayed can vary from prior generated reports. This applies to all performance for all assets on or after 09/30/2010, Advisory assets on or after 12/31/2010, SWP/AAP sleeves on or after 04/30/2018 as well as all Asset Class and Security level returns.

Money-weighted returns: Money-weighted return (MWR) is a measure of the rate of return for an asset or portfolio of assets. It is calculated by finding the daily Internal Rate of Return (IRR) for the period and then compounding this return by the number of days in the period being measured. The MWR incorporates the size and timing of cash flows, so it is an effective measure of returns on a portfolio.

Annualized Performance: All performance periods greater than one year are calculated (unless otherwise stated) on an annualized basis, which represents the return on an investment multiplied or divided to give a comparable one year return.

Cumulative Performance: A cumulative return is the aggregate amount that an investment has gained or lost over time, independent of the period of time involved.

Net of Fees and Gross of Fees Performance: Performance is presented on a "net of fees" and "gross of fees" basis, where indicated. Net returns do not reflect Program and wrap fees prior to 10/31/10 for accounts that are billed separately via invoice through a separate account billing arrangement. Gross returns do not reflect the deduction of fees, commissions or other charges. The payment of actual fees and expenses will reduce a client's return. The compound effect of such fees and expenses should be considered when reviewing returns. For example, the net effect of the deduction of fees on annualized performance, including the compounded effect over time, is determined by the relative size of the fee and the account's investment performance. It should also be noted that where gross returns are compared to an index, the index performance also does not reflect any transaction costs, which would lower the performance results. Market index data maybe subject to review and revision.

Benchmark/Major Indices: The past performance of an index is not a guarantee of future results. Any benchmark is shown for informational purposes only and relates to historical performance of market indices and not the performance of actual investments. Although most portfolios use indices as benchmarks, portfolios are actively managed and generally are not restricted to investing only in securities in the index. As a result, your portfolio holdings and performance may vary substantially from the index. Each index reflects an unmanaged universe of securities without any deduction for advisory fees or other expenses that would reduce actual returns, as well as the reinvestment of all income and dividends. An actual investment in the securities included in the index would require an investor to incur transaction costs, which would lower the performance results. Indices are not actively managed and investors cannot invest directly in the indices. Market index data maybe subject to review and revision. Further, there is no guarantee that an investor's account will meet or exceed the stated benchmark. Index performance information has been obtained from third parties deemed to be reliable. We have not independently verified this information, nor do we make any representations or warranties to the accuracy or completeness of this information.

Blended Index - For Advisory accounts, Blended Index is designed to reflect the asset categories in which your account is invested. For Brokerage accounts, you have the option to select any benchmark from the list.

For certain products, the blended index represents the investment style corresponding to your client target allocation. If you change your client target allocation, your blended index will change in step with your change to your client target allocation.

Blended Index 2 - 8 - are optional indices selected by you which may consist of a blend of indexes. For advisory accounts, these indices are for informational purposes only. Depending on the selection, the benchmark selected may not be an appropriate basis for comparison of your portfolio based on it's holdings.

For strategies that are highly customized, such as Concentrated Equity Solutions (CES), benchmarks are broad market indices included for general reference and are not intended to show comparative market performance or potential portfolios with risk or return profiles similar to your account. Benchmark indices are shown for illustrative purposes only.

Custom Time Periods: If represented on this report, the performance start date and the performance end date have been selected by your Financial Advisor in order to provide performance and account activity information for your account for the specified period of time only. As a result, only a portion of your account's activity and performance information is presented in the performance report, and, therefore, presents a distorted representation of your account's activity and performance.

Net Deposits/Withdrawals: When shown on a report, this information represents the net value of all cash and securities contributions and withdrawals, program fees (including wrap fees) and other fees added to or subtracted from your accounts from the first day to the last day of the period. When fees are shown separately, net deposits / withdrawals does not include program fees (including wrap fees). When investment return is displayed net deposits / withdrawals does not include program fees (including wrap fees). For security contributions and withdrawals, securities are calculated using the end of day UBS FS price on the day securities

UBS

Disclosures applicable to accounts at UBS Financial Services Inc. (continued)

are delivered in or out of the accounts. Wrap fees will be included in this calculation except when paid via an invoice or through a separate accounts billing arrangement. When shown on Client summary and/or Portfolio review report, program fees (including wrap fees) may not be included in net deposits/withdrawals. PACE Program fees paid from sources other than your PACE account are treated as a contribution. A PACE Program Fee rebate that is not reinvested is treated as a withdrawal.

Deposits: When shown on a report, this information represents the net value of all cash and securities contributions added to your accounts from the first day to the last day of the period. On Client Summary Report and/or Portfolio Review Report, this may exclude the Opening balance. For security contributions, securities are calculated using the end of day UBS FS price on the day securities are delivered in or out of the accounts.

Withdrawals: When shown on a report, this information represents the net value of all cash and securities withdrawals subtracted from your accounts from the first day to the last day of the period. On Client summary and/or portfolio review report Withdrawals may not include program fees (including wrap fees). For security withdrawals, securities are calculated using the end of day UBS FS price on the day securities are delivered in or out of the accounts.

Dividends/Interest: Dividend and interest earned, when shown on a report, does not reflect your account's tax status or reporting requirements. Use only official tax reporting documents (i.e. 1099) for tax reporting purposes. The classification of private investment distributions can only be determined by referring to the official year-end tax-reporting document provided by the issuer.

Change in Accrued Interest: When shown on a report, this information represents the difference between the accrued interest at the beginning of the period from the accrued interest at the end of the period.

Change in Value: Represents the change in value of the portfolio during the reporting period, excluding additions/withdrawals, dividend and interest income earned and accrued interest. Change in Value may include programs fees (including wrap fees) and other fees.

Fees: Fees represented in this report include program and wrap fees. Program and wrap fees prior to October 1, 2010 for accounts that are billed separately via invoice through a separate account billing arrangement are not included in this report.

Performance Start Date Changes: The Performance Start Date for accounts marked with a '^' have changed. Performance figures of an account with a changed Performance Start Date may not include the entire history of the account. The new Performance Start Date will generate performance returns and activity information for a shorter period than is available at UBS FS. As a result, the overall performance of these accounts may generate better performance than the period of time that would be included if the report used the inception date of the account. UBS FS recommends reviewing performance reports that use the inception date of the account because reports with longer time frames are usually more helpful when evaluating investment programs and strategies. Performance reports may include accounts with inception dates that precede the new Performance Start Date and will show performance and activity information from the earliest available inception date.
The change in Performance Start Date may be the result of a performance gap due to a zero-balance that prevents the calculation of continuous returns from the inception of the account. The Performance Start Date may also change if an account has failed one of our performance data integrity tests. In such instances, the account will be labeled as 'Review Required' and performance prior to that failure will be restricted. Finally, the Performance Start Date will change if you have explicitly requested a performance restart. Please contact your Financial Advisor for additional details regarding your new Performance Start Date.

Closed Account Performance: Accounts that have been closed may be included in the consolidated performance report. When closed accounts are included in the consolidated report, the performance report will only include information for the time period the account was active during the consolidated performance reporting time period.

Important information on options-based strategies: Options involve risk and are not suitable for everyone. Prior to buying or selling an option investors must read a copy of the Characteristics & Risks of Standardized Options, also known as the options disclosure document (ODD). It explains the characteristics and risks of exchange traded options. The options risk disclosure document can be accessed at the following web address: www.optionsclearing.com/about/publications/character-risks.

Concentrated Equity Solutions (CES) managers are not involved in the selection of the underlying stock positions. The Manager will advise only on the options selection in order to pursue the strategy in connection with the underlying stock position(s) deposited in the account. It is important to keep this in mind when evaluating the manager's performance since the account's performance will include the performance of the underlying equity position that is not being managed. CES use options to seek to achieve your investment objectives regarding your concentration stock position. Options strategies change the potential return profile of your stock. In certain scenarios, such as call writing, the call position will limit your ability to participate in any potential increase in the underlying equity position upon which the call was written. Therefore, in some market conditions, particularly during periods of significant appreciation of the underlying equity position(s), the CES account will decrease the performance that would have been achieved had the stock been held long without implementing the CES strategy.

Portfolio: For purposes of this report "portfolio" is defined as all of the accounts presented on the cover page or the header of this report and does not necessarily include all of the client's accounts held at UBS FS or elsewhere.

Percentage: Portfolio (in the "% Portfolio / Total" column) includes all holdings held in the account(s) selected when this report was generated. Broad asset class (in the "% broad asset class" column) includes all holdings held in that broad asset class in the account(s) selected when this report was generated.

Tax lots: This report displays security tax lots as either one line item (i.e., lumped tax lots) or as separate tax lot level information. If you choose to display security tax lots as one line item, the total cost equals the total value of all tax lots. The unit cost is an average of the total cost divided by the total number of shares. If the shares were purchased in different lots, the unit price listed does not represent the actual cost paid for each lot. The unrealized gain/loss value is calculated by combining the total value of all tax lots plus or minus the total market value of the security.

If you choose to display tax lot level information as separate line items on the Portfolio Holdings report, the tax lot information may include information from sources other than UBS FS. The Firm does not independently verify or guarantee the accuracy or validity of any information provided by sources other than UBS FS. As a result this information may not be accurate and is provided for informational purposes only. Clients should not rely on this information in making purchase or sell decisions, for tax purposes or otherwise. See your monthly statement for additional information.

Pricing: All securities are priced using the closing price reported on the last business day preceding the date of this report. Every reasonable attempt has been made to accurately price securities; however, we make no warranty with respect to any security's price. Please refer to the back of the first page of your UBS FS account statement for important information regarding the pricing used for certain types of securities, the sources of pricing data and other qualifications concerning the pricing of securities. To determine the value of securities in your account, we generally rely on third party quotation services. If a price is unavailable or believed to be unreliable, we may determine the price in good faith and may use other sources such as the last recorded transaction. When securities are held at another custodian or if you hold illiquid or restricted securities for which there is no published price, we will generally rely on the value provided by the custodian or issuer of that security.

Cash: Cash on deposit at UBS Bank USA is protected by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 in principal and accrued interest per depositor for each ownership type. Deposits made in an individual's own name, joint name, or individual retirement account are each held in a separate type of ownership. Such deposits are not guaranteed by UBS FS. More information is available upon request.

Asset Allocation: Your allocation analysis is based on your current portfolio. The Asset Allocation portion of this report shows the mix of various investment classes in your account. An asset allocation that shows a significantly higher percentage of equity investments may be more appropriate for an investor with a more aggressive investment strategy and higher tolerance for risk. Similarly, the asset allocation of a more conservative investor may show a higher percentage of fixed income investments.

Separately Managed Accounts and Pooled Investment Vehicles (such as mutual funds, closed end funds and exchanged traded funds): The asset classification displayed is based on firm's proprietary methodology for classifying assets. Please note that the asset classification assigned to rolled up strategies may include individual investments that provide exposure to other asset classes. For example, an International Developed Markets strategy may include exposure to Emerging Markets, and a US Large Cap strategy may include exposure to Mid Cap and Small Cap, etc.

Mutual Fund Asset Allocation: If the option to unbundle balanced mutual funds is selected and if a fund's holdings data is available, mutual funds will be classified by the asset class, subclass, and style breakdown of their underlying holdings. Where a mutual fund or ETF contains equity holdings from multiple equity sectors, this report will proportionately allocate the underlying holdings of the fund to those sectors measured as a percentage of the total fund's asset value as of the date shown.

This information is supplied by Morningstar, Inc. on a daily basis to UBS FS based on data supplied by the fund which may not be current. Mutual funds change their portfolio holdings on a regular (often daily) basis. Accordingly, any analysis that includes mutual funds may not accurately reflect the current composition of these funds. If a fund's underlying holding data is not available, it will be classified based on its corresponding

overall Morningstar classification. All data is as of the date indicated in the report.

All pooled investment vehicles (such as mutual funds, closed end mutual funds, and exchange traded funds) incorporate internal management and operation expenses, which are reflected in the performance returns. Please see relevant fund prospectus for more information. Please note, performance for mutual funds is inclusive of multiple share classes.

Ineligible Assets: We require that you hold and purchase only eligible managed assets in your advisory accounts. Please contact your Financial Advisor for a list of the eligible assets in your program. These reports may provide performance information for eligible and ineligible assets in a fee-based program. Since ineligible assets are not considered fee-based program assets, the inclusion of such securities will distort the actual performance of your advisory assets. As a result, the performance reflected in this report can vary substantially from the individual account performance reflected in the performance reports provided to you as part of those programs. For fee-based programs, fees are charged on the market value of eligible assets in the accounts and assessed quarterly in advance, prorated according to the number of calendar days in the billing period. Neither UBS nor your Financial Advisor will act as your investment adviser with respect to Ineligible Assets.

Variable Annuity Asset Allocation: If the option to unbundle a variable annuity is selected and if a variable annuity's holdings data is available, variable annuities will be classified by the asset class, subclass, and style breakdown for their underlying holdings. Where a variable annuity contains equity holdings from multiple equity sectors, this report will proportionately allocate the underlying holdings of the variable annuity to those sectors measured as a percentage of the total variable annuity's asset value as of the date shown.

This information is supplied by Morningstar, Inc. on a weekly basis to UBS FS based on data supplied by the variable annuity which may not be current. Portfolio holdings of variable annuities change on a regular (often daily) basis. Accordingly, any analysis that includes variable annuities may not accurately reflect the current composition of these variable annuities. If a variable annuity's underlying holding data is not available, it will remain classified as an annuity. All data is as of the date indicated in the report.

Equity Style: The Growth, Value and Core labels are determined by Morningstar. If an Equity Style is unclassified, it is due to non-availability of data required by Morningstar to assign it a particular style.

Equity Capitalization: Market Capitalization is determined by Morningstar. Equity securities are classified as Large Cap, Mid Cap or Small Cap by Morningstar. Unclassified securities are those for which no capitalization is available on Morningstar.

Equity Sectors: The Equity sector analysis may include a variety of accounts, each with different investment and risk parameters. As a result, the overweighting or underweighting in a particular sector or asset class should not be viewed as an isolated factor in making investment/liquidation decisions; but should be assessed on an account by account basis to determine the overall impact on the account's portfolio.

Classified Equity: Classified equities are defined as those equities for which the firm can confirm the specific industry and sector of the underlying equity instrument.

Estimated Annual Income: The Estimated Annual Income is the annualized yearly per share Dividends/interest paid and multiplied by the quantity of shares held in the selected account(s). For savings product & sweep funds this value is not calculated and is displayed as 0.

Current Yield: Current yield is defined as the estimated annual income divided by the total market value.

Bond Rating: These ratings are obtained from independent industry sources and are not verified by UBS FS. Securities without rating information are left blank. Rating agencies may discontinue ratings on high yield securities.

NR: When NR is displayed under bond rating column, no ratings are currently available from that rating agency.

High Yield: This report may designate a security as a high yield fixed income security even though one or more rating agencies rate the security as an investment grade security. Further, this report may incorporate a rating that is no longer current with the rating agency. For more information about the rating for any high yield fixed income security, or to consider whether to hold or sell a high yield fixed income security, please contact your financial advisor or representative and do not make any investment decision based on this report.

Credit/Event Risk: Investments are subject to event risk and changes in credit quality of the issuer. Issuers can experience economic situations that may have adverse effects on the market value of their securities.

Interest Rate Risk: Bonds are subject to market value fluctuations as interest rates rise and fall. If sold prior to maturity, the price received for an issue may be less than the original purchase price.

Reinvestment Risk: Since most corporate issues pay interest semiannually, the coupon payments over the life of the bond can have a major impact on the bond's total return.

Call Provisions: When evaluating the purchase of a corporate bond, one should be aware of any features that may allow the issuer to call the security. This is particularly important when considering an issue that is trading at a premium to its call price, since the return may be negatively impacted if the issue is redeemed. Should an issue be called, investors may be faced with an earlier than anticipated reinvestment decision, and may be unable to reinvest their principal at equally favorable rates.

Effective Maturity: Effective maturity is the expected redemption due to pre-refunding, puts, or maturity and does not reflect any sinking fund activity, optional or extraordinary calls. Securities without a maturity date are left blank and typically include Preferred Securities, Mutual Funds and Fixed Income UITs.

Yields: Yield to Maturity and Yield to Worst are calculated to the worst call.

Accrued Interest: Interest that has accumulated between the most recent payment and the report date may be reflected in market values for interest bearing securities.

Bond Averages: All averages are weighted averages calculated based on market value of the holding, not including accrued interest.

Tax Status: "Taxable" includes all securities held in a taxable account that are subject to federal and/or state or local taxation. "Tax-exempt" includes all securities held in a taxable account that are exempt from federal, state and local taxation. "Tax-deferred" includes all securities held in a tax-deferred account, regardless of the status of the security.

Cash Flow: This Cash Flow analysis is based on the historical dividend, coupon and interest payments you have received as of the Record Date in connection with the securities listed and assumes that you will continue to hold the securities for the periods for which cash flows are projected. The attached may or may not include principal paybacks for the securities listed. These potential cash flows are subject to change due to a variety of reasons, including but not limited to, contractual provisions, changes in corporate policies, changes in the value of the underlying securities and interest rate fluctuations. The effect of a call on any security(s) and the consequential impact on its potential cash flow(s) is not reflected in this report. Payments that occur in the same month in which the report is generated – but prior to the report run ("As of") date – are not reflected in this report. In determining the potential cash flows, UBS FS relies on information obtained from third party services it believes to be reliable. UBS FS does not independently verify or guarantee the accuracy or validity of any information provided by third parties. Although UBS FS generally updates this information as it is received, the Firm does not provide any assurances that the information listed is accurate as of the Record Date. Cash flows for mortgage-backed, asset-backed, factored, and other pass-through securities are based on the assumptions that the current face amount, principal pay-down, interest payment and payment frequency remain constant. Calculations may include principal payments, are intended to be an estimate of future projected interest cash flows and do not in any way guarantee accuracy.

Expected Cash Flow reporting for Puerto Rico Income Tax Purposes: Expected Cash Flow reporting may be prepared solely for Puerto Rico income tax purposes only. If you have received expected cash flow reporting for Puerto Rico income tax purposes only and are NOT subject to Puerto Rico income taxes, you have received this reporting in error and you should contact your Financial Advisor immediately. Both the Firm and your Financial Advisor will rely solely upon your representations and will not make the determination of whether you are subject to Puerto Rico income taxes. If you have received this reporting and you are NOT subject to Puerto Rico income taxes, the information provided in this reporting is inaccurate and should not be relied upon by you or your advisers. Neither UBS FS nor its employees or associated persons provide tax or legal advice. You should consult with your tax and/or legal advisors regarding your personal circumstances.

Bond sensitivity analysis: This analysis uses Modified Duration which approximates the percentage price change of a security for a given change in yield. The higher the modified duration of a security, the higher its risk.Â For callable securities, modified duration does not address the impact of changing interest rates on a bond's expected cash flow as a result of a call or prepayment.

Gain/Loss: The gain/loss information may include calculations based upon non-UBS FS cost basis information. The Firm does not independently verify or guarantee the accuracy or validity of any information provided by sources other than UBS FS. In addition, if this report contains positions with unavailable cost basis, the gain/(loss) for these positions are excluded in the calculation for the Gain/(Loss). As a result these figures may not be accurate and are provided for informational purposes only. Clients should not rely on this information in making purchase or sell decisions, for tax purposes or otherwise. Rely only on year-end tax forms when preparing your tax return. See your monthly statement for additional information.

Gain/Loss reporting for Puerto Rico Income Tax Purposes: Gain/(Loss) reporting may be prepared solely for Puerto Rico income tax purposes only. If you have received gain/(loss) reporting for Puerto Rico income tax

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Disclosures applicable to accounts at UBS Financial Services Inc. (continued)

purposes only and are NOT subject to Puerto Rico income taxes, you have received this reporting in error and you should contact your Financial Advisor immediately. Pursuant to the Puerto Rico Internal Revenue Code (PRIRC) long-term capital gains are derived from the sale or exchange of capital assets held longer than six (6) months. For the purposes of this report only, long term gains and losses are represented by assets held for a period of more than six (6) months. Both the Firm and your Financial Advisor will rely solely upon your representations and will not make the determination of whether you are subject to Puerto Rico income taxes. If you have received this reporting and you are NOT subject to Puerto Rico income taxes, the information provided in this reporting is inaccurate and should not be relied upon by you or your advisers for purposes other than determining realized gain/loss for Puerto Rico income tax purposes. Neither UBS FS nor its employees or associated persons provide tax or legal advice. You should consult with your tax and/or legal advisors regarding your personal circumstances.

Gain/Loss 60/40: Index options listed in this report may be subject to IRS Tax Code - section 1256 categorizing them as broad-based index options. If so, the index may be eligible to be treated as 60% long term and 40% short terms for tax purposes. Please contact your tax professional to determine eligibility.

Accounts Included in this Report: The account listing may or may not include all of your accounts with UBS FS. The accounts included in this report are listed under the "Accounts included in this review" shown on the first page or listed at the top of each page. If an account number begins with "@" this denotes assets or liabilities held at other financial institutions. Information about these assets, including valuation, account type and cost basis, is based on the information you provided to us, or provided to us by third party data aggregators or custodians at your direction. We have not verified, and are not responsible for, the accuracy or completeness of this information.

Account name(s) displayed in this report and labels used for groupings of accounts can be customizable "nicknames" chosen by you to assist you with your recordkeeping or may have been included by your financial advisor for reference purposes only. The names used have no legal effect, are not intended to reflect any strategy, product, recommendation, investment objective or risk profile associated with your accounts or any group of accounts, and are not a promise or guarantee that wealth, or any financial results, can or will be achieved. All investments involve the risk of loss, including the risk of loss of the entire investment.

For more information about account or group names, or to make changes, contact your Financial Advisor.

Account changes: At UBS, we are committed to helping you work toward your financial goals. So that we may continue providing you with financial advice that is consistent with your investment objectives, please consider the following two questions:
1) Have there been any changes to your financial situation or investment objectives?
2) Would you like to implement or modify any restrictions regarding the management of your account?
If the answer to either question is "yes," it is important that you contact your Financial Advisor as soon as possible to discuss these changes. For MAC advisory accounts, please contact your investment manager directly if you would like to impose or change any investment restrictions on your account.

ADV disclosure: A complimentary copy of our current Form ADV Disclosure Brochure that describes the advisory program and related fees is available through your Financial Advisor. Please contact your Financial Advisor if you have any questions.

Important information for former Piper Jaffray and McDonald Investments clients: As an accommodation to former Piper Jaffray and McDonald Investments clients, these reports include performance history for their Piper Jaffray accounts prior to August 12, 2006 and McDonald Investments accounts prior to February 9, 2007, the date the respective accounts were converted to UBS FS. UBS FS has not independently verified this information nor do we make any representations or warranties as to the accuracy or completeness of that information and will not be liable to you if any such information is unavailable, delayed or inaccurate.

For insurance, annuities, and 529 Plans, UBS FS relies on information obtained from third party services it believes to be reliable. UBS FS does not independently verify or guarantee the accuracy or validity of any information provided by third parties. Information for insurance, annuities, and 529 Plans that has been provided by a third party service may not reflect the quantity and market value as of the previous business day. When available, an "as of" date is included in the description.

Investors outside the U.S. are subject to securities and tax regulations within their applicable jurisdiction that are not addressed in this report. Nothing in this report shall be construed to be a solicitation to buy or offer to sell any security, product or service to any non-U.S. investor, nor shall any such security, product or service be solicited, offered or sold in any jurisdiction where such activity would be contrary to the securities laws or other local laws and regulations or would subject UBS to any registration requirement within such jurisdiction.

Performance History prior to the account's inception at UBS Financial Services, Inc. may have been included in this report and is based on data provided by third party sources. UBS Financial Services Inc. has not independently verified this information nor does UBS Financial Services Inc. guarantee the accuracy or validity of the information.

Important information about brokerage and advisory services. As a firm providing wealth management services to clients, UBS Financial Services Inc. offers investment advisory services in its capacity as an SEC-registered investment adviser and brokerage services in its capacity as an SEC-registered broker-dealer. Investment advisory services and brokerage services are separate and distinct, differ in material ways and are governed by different laws and separate arrangements. It is important that clients understand the ways in which we conduct business, that they carefully read the agreements and disclosures that we provide to them about the products or services we offer. For more information, please review client relationship summary provided at **ubs.com/relationshipsummary**.

UBS

Your Financial Advisor:
THE COHEN GROUP
Phone: 661-653-3200/800-628-8022

Kern Health Systems

Account Number: EBXXX20

Filtered by: Entry Date 06/30/2022-09/30/2022, Call/Redemption

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
09/30/22	09/30/22	CALL REDEMPTION	AFLAC INC B/E 03.625% 111524 DTD110714	656XB1	900,000.00	REDEMPTION	900,000.00
08/19/22	08/19/22	CALL REDEMPTION	HONEYWELL INTL INC NTS 00.483% 081922 DTD081920	6574M1	200,000.00	REDEMPTION	200,000.00
07/15/22	07/15/22	CALL REDEMPTION	UNITEDHEALTH GROUP INC 03.350% 071522 DTD072315	8846W9	1,700,000.00	REDEMPTION	1,700,000.00

Filtered by: Entry Date 06/30/2022-09/30/2022, Bought

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
08/22/22	08/24/22	BOUGHT	PNC BK B/E 03.250% 060125 DTD060115	8158Z6	300,000.00	$98.456	297,615.92
07/18/22	07/20/22	BOUGHT	MORGAN STANLEY B/E 04.000% 072325 DTD072315	659525	1,800,000.00	$99.900	1,833,600.00

WELLS FARGO SECURITIES

Wells Fargo Bank, N.A.
333 SOUTH GRAND AVENUE
8TH FLOOR
LOS ANGELES CA 90071

JONATHAN CHUANG
1-213-253-6202

Bank Account Statement
Wells Fargo Bank, N.A.

Statement Period
09/01/2022 - 09/30/2022

KERN HEALTH SYSTEMS
2900 BUCK OWENS BOULEVARD

Account Number [redacted]

Account Value Summary *USD*

This summary does not reflect the value of unpriced securities. Repurchase agreements are reflecte at par value.

	Amount Last Statement Period	Amount This Statement Period	% Portfolio
Cash	$ 0.00	$ **0.00**	0%
Money Market Mutual Funds	60,233,255.82	**65,506,766.05**	26%
Bonds	161,672,762.96	**187,264,160.57**	74%
Stocks	0.00	**0.00**	0%
Total Account Value	$ **221,906,018.78**	$ **252,770,926.62**	**100%**

Value Change Since Last Statement Period	$ **30,864,907.84**
Percent Increase Since Last Statement Period	**14%**
Value Last Year-End	$ **158,053,433.16**
Percent Increase Since Last Year-End	**60%**

Income Summary *USD*

	This Period	Year-To-Date
Interest	$ 0.00	$ 635,011.24
Dividends/Capital Gains	0.00	0.00
Money Market Mutual Funds Dividends	133,810.23	341,398.51
Other	0.00	0.00
Income Total	$ **133,810.23**	$ **976,409.75**

Interest Charged *USD*

Description	This Period
Debit Interest For September 2022	0.00
Total Interest Charged	$ **0.00**

Money Market Mutual Funds Summary *USD*

Description	Amount
Opening Balance	$ **60,233,255.82**
Deposits and Other Additions	215,000,000.00
Distributions and Other Subtractions	(209,860,300.00)
Dividends Reinvested	133,810.23
Change in Value	0.00
Closing Balance	$ **65,506,766.05**

Important Information

This statement is provided to customers of Wells Fargo Securities, LLC ("WFS"), broker dealer 0250. Statements are provided monthly for accounts with transactions and/or security positions. The account statement contains a list of securities held in safekeeping by WFS as of the statement date and provides details of purchase and sale transactions, the receipt and disbursement of cash and securities, and other activities relating to the account during the statement period.

For WFS customers who choose to maintain a safekeeping account at Wells Fargo Bank, N.A. ("Bank"), this statement is accompanied by a separate Bank safekeeping statement. The Bank safekeeping statement, if applicable, contains a list of securities held in safekeeping by the Bank as of the statement date.

Pricing: Security and brokered certificate of deposit ("CD") prices shown on the statement are obtained from independent vendors or internal pricing models. While we believe the prices are reliable, we cannot guarantee their accuracy. For exchange-listed securities, the price provided is the closing price at month end. For unlisted securities, it is the "bid" price at month end. The price of CDs that mature in one year or less are shown at last price traded. The price of CDs that mature in greater than one year and of other instruments that trade infrequently are estimated using similar securities for which prices are available. Prices on the statement may not necessarily be obtained when the asset is sold.

Brokered CD Pricing: Like bonds, brokered CDs are subject to price fluctuation and the value of a CD, if sold prior to maturity, may be less than at the time of its purchase. Significant loss of principal could result. While WFS generally makes a market in CDs it underwrites, the secondary market for CDs that it does not underwrite may be very limited. In those cases, WFS will use its best efforts to help investors find a buyer.

SIPC: WFS is a member of the Securities Investor Protection Corporation ("SIPC"). In the event of insolvency or liquidation of WFS, securities held in safekeeping at WFS are covered by SIPC against the loss, but not investment risk, up to a maximum of $500,000 per customer, which includes a $250,000 limit on claims for cash held in the account. SIPC protection does not provide any protection whatsoever against investment risk, including the loss of principal on an investment. This coverage does not apply to securities held in safekeeping by the Bank. Additional information about SIPC, including a SIPC brochure, may be obtained by visiting www.sipc.org or by calling SIPC at 1-202-371-8300.

FINRA BrokerCheck Program: WFS is a member of the Financial Industry Regulatory Authority (FINRA). Under its BrokerCheck program, FINRA provides certain information regarding the disciplinary history of broker/dealers and their associated persons. Information can be obtained from the FINRA BrokerCheck program hotline number (1-800-289-9999) or the FINRA website (www.finra.org). A brochure describing the FINRA BrokerCheck program will be furnished upon written request.

Free Credit Balances: Any customer free credit balances may be used in the business of WFS subject to limitation of 17 CFR Section 240 § 15c(3)-3 under the Securities Exchange Act of 1934. In the course of normal business operations, a customer has the right to receive delivery of the following: any free credit balances to which he or she is entitled, any fully paid securities to which he or she is entitled, and any securities purchased on margin upon full payment of indebtedness to WFS.

Equity Order Routing: WFS will generally route equity and listed options orders taking into consideration among other factors, the quality and speed of execution, as well as the credits, cash or other payments it may receive from any exchange, broker-dealer or market center. This may not be true if a customer has directed or placed limits on any orders. Whenever possible, WFS will route orders in an attempt to obtain executions at prices equal or superior to the nationally displayed best bid or offer. WFS will also attempt to obtain the best execution regardless of any compensation it may receive. The nature and source of credits and payments WFS receives in connection with specific orders will be furnished to a customer upon request. WFS prepares quarterly reports describing its order routing practices for non-directed orders routed to a particular venue for execution. A printed copy of this report along with other compliance and regulatory information is available upon written request or by visiting: https://www.wellsfargo.com/com/securities/regulatory.

Equity Extended Hours Trading: See important information relating to equities trading before and after regular trading hours at: www.wellsfargo.com/com/securities/regulatory.

Equity Open Orders: Open orders will remain in effect until executed or canceled by you. Failure to cancel an open order may result in the transaction being executed for your account. WFS has no responsibility to cancel an open order at its own initiative.

Dividend Reinvestment: In any dividend reinvestment transaction, WFS acted as agent. Additional information regarding transactions of this nature will be furnished to a customer upon written request.

Account Transfers: A fee will be charged to customers transferring their existing WFS account to another broker/dealer or any other financial institution.

Non-deposit investment products recommended, offered or sold by WFS, including mutual funds, are not federally insured or guaranteed by or obligations of the Federal Deposit Insurance Corporation ("FDIC"), the Federal Reserve System or any other agency; are not bank deposits; are not obligations of, or endorsed or guaranteed in any way by any bank or WFS; and are subject to risk, including the possible loss of principal, that may cause the value of the investment and investment return to fluctuate.

When the investment is sold, the value may be higher or lower than the amount originally invested. WFS is a subsidiary of Wells Fargo & Company, is not a bank or thrift, and is separate from any other affiliated bank or thrift. WFS is a registered broker-dealer and member of FINRA. No affiliate of WFS is responsible for the securities sold by WFS.

Mutual Funds: The distributor of Wells Fargo Funds is affiliated with WFS/Wells Fargo Securities, LLC.

Institutional Prime and Institutional Tax Exempt money market mutual funds are required to price and transact at a net asset value ("NAV") per share that fluctuates based upon the pricing of the underlying portfolio of securities and this requirement may impact the value of those fund shares. Additionally, Institutional Prime and Institutional Tax Exempt funds may be subject to redemption fees and/or gates that can affect the availability of funds invested.

Mutual funds are sold by prospectus, which includes more complete information on risks, charges, expenses and other matters of interest. Investors should read the prospectus carefully before investing.

Financial Statements: WFS financial statements are available upon request.

Trade Confirmations: Investment purchases and sales are subject to the terms and conditions stated on the trade confirmation relating to that transaction. In the event of a conflict between the trade confirmation and this statement, the trade confirmation will govern.

Listed Options: Commissions and other charges related to the execution of listed option transactions have been included in confirmations of such transactions that have been previously furnished and are available upon request. Promptly advise your WFS sales representative of any material change in your investment objectives or financial situation.

Customer Complaints and Reporting Discrepancies: Customer complaints, statement reporting inaccuracies or discrepancies should be promptly reported in writing to:

Customer Service
90 South 7th Street
5th Floor, MAC N9305-05F
Minneapolis, MN 55402
wfscustomerservice@ wellsfargo.com

Customers may also report complaints, inaccuracies or discrepancies by calling 1-800-645-3751 option 5. To further protect their rights, including rights under the Securities Investor Protection Act, customers should also re-confirm in writing to the above address any oral communications with WFS relating to the inaccuracies or discrepancies.

Wells Fargo Bank, N.A. Institutional Deposit: Funds invested in the Institutional Deposit are on deposit at Wells Fargo Bank, N.A. and balances are insured by the Federal Deposit Insurance Corporation ("FDIC") up to the full amount allowable by law. Institutional Deposit balances are not insured by the Securities Investor Protection Corporation ("SIPC"). For further details, see the Institutional Deposit Product Description.

KERN HEALTH SYSTEMS
Account Number: [redacted]

Portfolio Holdings *Security positions held with Wells Fargo Bank N.A.*

Security ID	Description	Maturity Date	Coupon	Current Par / Original Par	Market Price*	Market Value	Original Par Pledged**	Callable
Bonds *USD*								
313385J23	FED HOME LN DISCOUNT NT	10/03/22	0.000%	40,000,000.000	100.0000	40,000,000.00		N
912796YC7	UNITED STATES TREASURY BILL	10/04/22	0.000%	80,000,000.000	99.9933	79,994,657.60		
912796YD5	UNITED STATES TREASURY BILL	10/11/22	0.000%	15,000,000.000	99.9457	14,991,851.55		
69448XKE1	PACIFIC LIFE SHORT TERM 4(2) DISCOUNTED COMMERCIAL PAPER	10/14/22	0.000%	2,500,000.000	99.8804	2,497,010.43		
313313M21	FED FARM CRD DISCOUNT NT	10/27/22	0.000%	12,000,000.000	99.8012	11,976,143.76		N
313385N77	FED HOME LN DISCOUNT NT	11/09/22	0.000%	15,000,000.000	99.6768	14,951,518.05		N
90331HNL3	US BANK NA CINCINNATI	01/23/23	2.850%	3,000,000.000	99.6218	2,988,654.18		Y
3130AS4V8	FEDERAL HOME LOAN BANK	03/09/23	2.000%	10,000,000.000	99.2560	9,925,603.10		Y
3130AT2E6	FEDERAL HOME LOAN BANK	06/15/23	3.330%	5,000,000.000	99.8742	4,993,710.65		Y
3134GXS88	FREDDIE MAC	02/28/25	4.000%	5,000,000.000	98.9002	4,945,011.25		Y
				187,500,000.000		187,264,160.57	0.00	

**See important information regarding security pricing on Page 2.*

***Total amount that is pledged to or held for another party or parties. Refer to the Pledge Detail Report for more information.*

Daily Account Activity

Your investment transactions during this statement period.

Transaction / Trade Date	Settlement / Effective Date	Activity	Security ID	Description	Par / Quantity	Price	Principal Amount	Income Amount	Debit / Credit Amount
Transaction Activity *USD*									
09/06/22	09/07/22	Security Receipt	912796YC7	UNITED STATES TREASURY BILL	50,000,000.00	99.8245000	(49,912,250.00)	0.00	(49,912,250.00)
08/18/22	09/15/22	Security Receipt	3130AT2E6	FEDERAL HOME LOAN BANK	5,000,000.00	100.0000000	(5,000,000.00)	0.00	(5,000,000.00)
09/27/22	09/27/22	Security Receipt	313313M21	FED FARM CRD DISCOUNT NT	12,000,000.00	99.7583330	(11,971,000.00)	0.00	(11,971,000.00)
09/27/22	09/27/22	Security Receipt	313385N77	FED HOME LN DISCOUNT NT	15,000,000.00	99.6345000	(14,945,175.00)	0.00	(14,945,175.00)
09/28/22	09/28/22	Security Receipt	313385J23	FED HOME LN DISCOUNT NT	40,000,000.00	99.9625000	(39,985,000.00)	0.00	(39,985,000.00)
09/28/22	09/29/22	Security Receipt	69448XKE1	PACIFIC LIFE SHORT TERM 4(2)	2,500,000.00	99.8750000	(2,496,875.00)	0.00	(2,496,875.00)
09/27/22	10/26/22	Security Receipt	3130ATJB4	FEDERAL HOME LOAN BANK	5,000,000.00	100.0000000	(5,000,000.00)	0.00	(5,000,000.00)
Income / Payment Activity *USD*									
09/07/22	09/07/22	Matured	91411UJ71	UNIVERSITY CALIF REVS TAXABLE			3,000,000.00		3,000,000.00
09/07/22	09/07/22	Matured	91411UJ71	UNIVERSITY CALIF REVS TAXABLE	(3,000,000.00)				
09/13/22	09/13/22	Matured	313385F68	FED HOME LN DISCOUNT NT			20,000,000.00		20,000,000.00

KERN HEALTH SYSTEMS
Account Number: [redacted]

Daily Account Activity (Continued)

Your investment transactions during this statement period.

Income / Payment Activity *USD*

Transaction / Trade Date	Settlement / Effective Date	Activity	Security ID	Description	Par / Quantity	Price	Principal Amount	Income Amount	Debit / Credit Amount
09/13/22	09/13/22	Matured	313385F68	FED HOME LN DISCOUNT NT	(20,000,000.00)		3,000,000.00		3,000,000.00
09/14/22	09/14/22	Matured	48306BJE6	KAISER FOUNDATION HOSP	(3,000,000.00)		15,000,000.00		15,000,000.00
09/20/22	09/20/22	Matured	313385G59	FED HOME LN DISCOUNT NT	(15,000,000.00)		20,000,000.00		20,000,000.00
09/23/22	09/23/22	Matured	313385G83	FED HOME LN DISCOUNT NT	(20,000,000.00)		20,000,000.00		20,000,000.00
09/27/22	09/27/22	Matured	313385H41	FED HOME LN DISCOUNT NT	(20,000,000.00)		3,000,000.00		3,000,000.00
09/27/22	09/27/22	Matured	23102VJT8	CUMMINS INC 4(2) DISCOUNTED	(3,000,000.00)		15,000,000.00		15,000,000.00
09/28/22	09/28/22	Matured	313313H50	FED FARM CRD DISCOUNT NT	(15,000,000.00)				

Cash Activity *USD*

Transaction / Trade Date	Settlement / Eff. Date	Activity	Description	Debit Amount / Disbursements	Credit Amount / Receipts
09/01/22	09/01/22	ACH/DDA Transaction	DESIGNATED DDA		4,000,000.00
09/07/22	09/07/22	ACH/DDA Transaction	DESIGNATED DDA	4,000,000.00	
09/07/22	09/07/22	ACH/DDA Transaction	DESIGNATED DDA	10,000,000.00	
09/08/22	09/08/22	ACH/DDA Transaction	DESIGNATED DDA		75,000,000.00
09/08/22	09/08/22	ACH/DDA Transaction	DESIGNATED DDA		75,000,000.00
09/13/22	09/13/22	ACH/DDA Transaction	DESIGNATED DDA	18,000,000.00	
09/14/22	09/14/22	ACH/DDA Transaction	DESIGNATED DDA	16,000,000.00	
09/15/22	09/15/22	ACH/DDA Transaction	DESIGNATED DDA	15,000,000.00	
09/19/22	09/19/22	ACH/DDA Transaction	DESIGNATED DDA	17,000,000.00	
09/20/22	09/20/22	ACH/DDA Transaction	DESIGNATED DDA	15,000,000.00	
09/27/22	09/27/22	ACH/DDA Transaction	DESIGNATED DDA	25,000,000.00	
09/30/22	09/30/22	ACH/DDA Transaction	DESIGNATED DDA	250,000.00	
09/30/22	09/30/22	ACH/DDA Transaction	DESIGNATED DDA	3,300,000.00	

Money Market Fund Activity

	Dividend paid this period	7 day* simple yield	30 day* simple yield
Morgan Stan TreasSvc 8314			
*As of September 30, 2022			
USD	0.02	2.720%	2.230%

Statement Ending: September 30, 2022

KERN HEALTH SYSTEMS
Account Number: [redacted]

Money Market Fund Activity (Continued)

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**12.53**		**12.53000**
09/01/22	Reinvest	0.02000			0.02	12.55000
	Ending Balance		**1.0000**	**12.55**		**12.55000**

Goldman FS Tr Ob Ins 468
*As of September 30, 2022
USD

Dividend paid this period	7 day* simple yield	30 day* simple yield
86,762.01	2.910%	2.410%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**50,024,871.35**		**50,024,871.35000**
09/01/22	Purchase	4,000,000.00000		4,000,000.00		54,024,871.35000
09/01/22	Reinvest	86,762.01000			86,762.01	54,111,633.36000
09/07/22	Redemption	(49,912,250.00000)		(49,912,250.00)		4,199,383.36000
09/07/22	Purchase	3,000,000.00000		3,000,000.00		7,199,383.36000
09/07/22	Redemption	(4,000,000.00000)		(4,000,000.00)		3,199,383.36000
09/08/22	Purchase	75,000,000.00000		75,000,000.00		78,199,383.36000
09/13/22	Purchase	20,000,000.00000		20,000,000.00		98,199,383.36000
09/14/22	Purchase	3,000,000.00000		3,000,000.00		101,199,383.36000
09/14/22	Redemption	(16,000,000.00000)		(16,000,000.00)		85,199,383.36000
09/15/22	Redemption	(5,000,000.00000)		(5,000,000.00)		80,199,383.36000
09/15/22	Redemption	(15,000,000.00000)		(15,000,000.00)		65,199,383.36000
09/20/22	Purchase	15,000,000.00000		15,000,000.00		80,199,383.36000
09/23/22	Purchase	20,000,000.00000		20,000,000.00		100,199,383.36000
09/27/22	Redemption	(3,916,175.00000)		(3,916,175.00)		96,283,208.36000
09/28/22	Redemption	(24,985,000.00000)		(24,985,000.00)		71,298,208.36000
09/29/22	Redemption	(2,496,875.00000)		(2,496,875.00)		68,801,333.36000
09/30/22	Redemption	(3,300,000.00000)		(3,300,000.00)		65,501,333.36000
	Ending Balance		**1.0000**	**65,501,333.36**		**65,501,333.36000**

JPMorgan UST Plus Inst 3918
*As of September 30, 2022
USD

Dividend paid this period	7 day* simple yield	30 day* simple yield
47,048.20	2.590%	2.100%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**10,208,371.94**		**10,208,371.94000**

KERN HEALTH SYSTEMS
Account Number: [redacted]

Money Market Fund Activity (Continued)

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
09/01/22	Reinvest	47,048.20000			47,048.20	10,255,420.14000
09/07/22	Redemption	(10,000,000.00000)		(10,000,000.00)		255,420.14000
09/08/22	Purchase	75,000,000.00000		75,000,000.00		75,255,420.14000
09/13/22	Redemption	(18,000,000.00000)		(18,000,000.00)		57,255,420.14000
09/19/22	Redemption	(17,000,000.00000)		(17,000,000.00)		40,255,420.14000
09/20/22	Redemption	(15,000,000.00000)		(15,000,000.00)		25,255,420.14000
09/27/22	Redemption	(25,000,000.00000)		(25,000,000.00)		255,420.14000
09/30/22	Redemption	(250,000.00000)		(250,000.00)		5,420.14000
	Ending Balance		**1.0000**	**5,420.14**		**5,420.14000**

PMIA/LAIF Performance Report as of 10/14/22

PMIA Average Monthly Effective Yields[1]

September	**1.513**
August	1.276
July	1.090

Quarterly Performance Quarter Ended 09/30/22

LAIF Apportionment Rate[2]:	1.35
LAIF Earnings Ratio[2]:	0.00003699565555327
LAIF Fair Value Factor[1]:	0.980760962
PMIA Daily[1]:	1.63%
PMIA Quarter to Date[1]:	1.29%
PMIA Average Life[1]:	304

Pooled Money Investment Account Monthly Portfolio Composition [1] 09/30/22 $222.9 billion

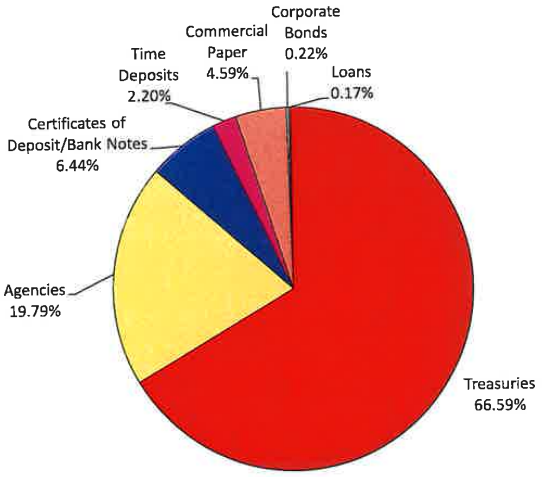

Chart does not include $3,917,000.00 in mortgages, which equates to 0.002%. Percentages may not total 100% due to rounding.

Daily rates are now available here. **View PMIA Daily Rates**

Notes: The apportionment rate includes interest earned on the CalPERS Supplemental Pension Payment pursuant to Government Code 20825 (c)(1) and interest earned on the Wildfire Fund loan pursuant to Public Utility Code 3288 (a).

Source:
[1] State of California, Office of the Treasurer
[2] State of Calfiornia, Office of the Controlier

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: December 15, 2022

Re: Annual Renewal of the Reinsurance Policy

Background

Kern Health Systems ("KHS") has purchased a reinsurance policy to mitigate the costs of catastrophic cases since the plan's inception. The KHS population has changed significantly over the last several years with SPD members incurring high medical costs. Additionally, KHS will continue to be at risk for major organ transplants. This may pose an increase in catastrophic claims in 2023 along with the unknown longer term medical expenses relating to Covid-19.

Discussion

Over the last 3 completed years, KHS reinsurance recoveries have been lower than the reinsurance claim payments. For the policy years 2019, 2020 and 2021 KHS recovered approximately $354,000 in net reinsurance claims while paying reinsurance premiums of approximately $3.4 million. **These 3 years represent a 10% ratio of recoveries to expense.**

Based on information **through September 30, 2022,** KHS has requested approximately $1,202,788 in recoveries (which has been applied towards the annual aggregate deductible of $483,990) against approximately $670,140 in premiums paid. This represents a **107% ratio for this period and an overall cumulative ratio 26% for all periods.** We have until December 31, 2023 to turn in claims for the 2022 policy period.

The current 2022 Reinsurance Policy is with IOA Re (AM Best Rating A+ Superior Financial Rating; Financial Size Category X) and has a deductible of $350,000, a blended rate of $.18 pmpm and an aggregate deductible of $.13 pmpm with an estimated total exposure of $1,154,130. (This is comprised of $670,140 for premiums and $483,990 for the aggregate deductible).

Fiscal Impact

The lowest quote for renewal is with the carrier HM Life Insurance Company (AM Best Rating A Excellent Financial Rating; Financial Size Category XV) at a blended rate of $.22 per member with the current deductible of $350,000 per member and a $.16 pmpm aggregate deductible for an overall expected reinsurance cost of $1,580,401 (This is comprised of $ 914,969 for premiums and $665,432 for the aggregate deductible). All 2023 rates now include coverage for outpatient services. For this renewal, IOA Re originally requested an increase of 0% but after receiving $1.2 million in claims, changed their renewal proposal to a 61% increase. After several negotiation discussions, our insurance broker, Arthur J Gallagher & Co, was able to secure an increase of 24% with alternate insurer HM Life. The savings achieved with HM Life is $499,074 less than the renewal offered by IOA Re. IOA Re has been the reinsurance carrier since 1/1/2020. HM Life would be a new carrier.

KHS can lower the HM Life premium to a blended rate of $.15 pmpm and a $.11 pmpm aggregate deductible by increasing the deductible to $400,000. This would save approximately $529,027 of reinsurance costs but would cost KHS an additional $50,000 per member that reaches the reinsurance deductible. The savings of $529,027 would be lost if the members reaching the $400,000 deductible exceeds 10 ($529,027 savings/$50,000 increase in deductible = 10.58 members). Based on utilization data exceeding $400,000, there were 2 members in 2019, 2 members in 2020, 2 members in 2021 and 6 members through November 18, 2022. Management expects the 2023 utilization to be more than 10 members as the prior years of 2019-2021 did not include the new Major Organ Transplant benefit that began in 2022. Accordingly, management does not recommend increasing the deductible to $400,000 and lowering the blended rate to $.15 pmpm and lowering the aggregate deductible to $.11 pmpm.

The 2023 Budget includes estimated reinsurance premium payments at a blended rate of $.22 pmpm and reinsurance recoveries at a blended rate of $.22 pmpm. Estimated fiscal dollar impact is $914,969.

Risk Assessment

Based on the continued expense of the SPD population and the additional utilization from COVID-19 complications and the risk for major organ transplants, management believes that binding reinsurance coverage is warranted for 2023 and is recommending the HM Life option at a blended rate of $.22 pmpm and keeping the deductible at $350,000.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: December 15, 2022

Re: 2023 Budget

Background

The 2023 Budget supports the KHS 2023 Corporate and Department Goals, the 2023 Corporate Projects and contributes to the 2023-2026 Strategic Plan Initiatives. Such goals take into consideration and prioritize the continued support afforded to the Safety Net Providers. The scope of the 2023 Corporate Goals reflect the expanded role Medi-Cal Managed Care health plans will be responsible for under the CalAIM initiative continuing during 2023.

Specifically, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform

Major CalAIM initiatives that will continue during 2023 include:

- Enhanced Care Management (ECM) is a comprehensive approach to address the clinical and non-clinical needs of high-need, high-cost members through coordination of services and comprehensive care management. Over the years, more Medi-Cal members will qualify for Enhanced Care Management through expansion among existing qualified enrollees or adding of new member eligibility categories
- Community Support Services (CSS) also formerly referred to as In Lieu of Services or ILOS, are services provided as a substitute for, or used to avoid, other more costly covered services, such as a hospital or skilled nursing facility admission or a discharge delay. Such service may or may not be medically related but by their proper use should reduce medical cost

At its conclusion, CalAIM will transform Medi-Cal Managed Care health plans to provide a broader range of benefits through an integrated delivery system comprised of traditional medical services, behavior health services (including specialty mental health) substance use disorder services (detox and therapeutic) and dental care.

Since 2012, we have witnessed an increase in membership from expansion in eligibility, adoption of the affordable care act and inclusion of a variety of new coverage categories and programs like Seniors and Persons with Disabilities (SPDs), Community Based Adult Services (CBAS), childless adults, children with autism and undocumented children and young adults.

Newly eligible populations present unique challenges. KHS expanded its network of providers, both in scope and depth, so that the appropriate level and type of services would be available to treat new members often with medically complex conditions. Much of what has been developed and implemented over the past 10 years relates to the creation and administration of these new programs and the additional benefits and expanded services that accompany them. Enrollment in KHS has increased over 300% during that time to where today, KHS serves approximately 340,000+ of Kern County's residents.

Setting the Stage

In 2022 there were several new or modified Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) requirements that impact the 2023 Budget including:

- **Long Term Care** responsibilities will include transitioning and retaining members who are placed in Long Term Care (custodial) facilities, versus previous requirement of managed care plan disenrollment to Fee for Service Medi-Cal. The Plan will now be clinically and fiscally responsible for care coordination, LTC management, and alternate setting placements when appropriate.
- **Incentive Programs** created to promote health plan and provider participation in ECM and CSS will be continue. The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. The CalAIM Incentive Payment Program supports the implementation and expansion of ECM and Community Supports by incentivizing managed care plans (MCPs) to drive MCP delivery system investment into provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports. KHS was allocated $14.2M in performance-based incentive funding.

- **Housing and Homelessness Incentive Program**, (HHIP), is another Incentive Program that will continue during 2023. HHIP is a part of the state's overarching home and community-based services (HCBS) spending plan, whereby MCPs can earn these incentive payments for investments and progress in addressing homelessness as a social determinant of health and keeping individuals housed. HHIP is a voluntary incentive program that will enable Medi-Cal managed care plans (MCPs) to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health. The program is effective January 1, 2022 – December 31, 2023, with the possibility of extended project timelines. KHS was allocated $19M in performance-based incentive funding.
- **School-Based Behavioral Health** (SBHIP) is an additional Incentive Program that was initiated in 2022 to increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for TK-12 children in schools through coordination and partnership with the Local Education Agency (LEA), KHS, Kern County Behavioral Health and Recovery Services (KHBRS), and other community-based organizations and health plans in Kern County. The Governor's budget allocated $398 million for Medi-Cal plan incentives with Kern County receiving $13.2 million from January 2022 to December 2024. This initiative will be the foundation for a broader focus on developing and maintaining a school-linked fee schedule for outpatient Mental health and Substance use disorder services for ages 25 and younger by January 2024 under the Children and Youth Behavioral Health Initiative
- **Telehealth Services** has shown to be an effective method for maintaining the physician / patient relationship during the pandemic. DHCS modified its benefits to include telehealth as an alternative to office visits during the stay-at-home order. This will allow expansion of synchronous, asynchronous, audio-visual, and telephonic provision of care to meet network adequacy and foster member satisfaction
- **Population Health Management** preparation will continue through 2023 to develop and maintain a whole system, person centered population health management strategy for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes for 2023 readiness
- **Expanded Regulatory Oversight** for quality-of-care measures and timely access to care standards. DHCS and DMHC are releasing an increasing volume of guidance/directives/reporting requirements – with increased complexity - both through and outside of APLs. Along the same lines, increased scrutiny/oversight from regulators (through Audits, other DHCS/DMHC oversight activities), which requires Corrective Action Planning, follow up, and internal audits
- **New or Expanded Data and Analytic Reporting Requirements**, including integration of various data sources not historically captured for member risk stratification and segmentation. DHCS is also requiring integration and participation in a universal Medi-Cal platform to capture social determinate of health with further alignment for a count specific Health Information Exchange

- **Increase in the Application of Supplemental Payments** pertaining to Hospital Directed Payments, Proposition 56 payments, GEMT, HYDE as well as other supplemental payment arrangements for physician and hospitals
- **Other New Benefits and Programs** included in the State Budget (i.e., dyadic services and doula services,)
- **Mandatory Managed Care Enrollment Phase 2** members transitioning to Managed Care
- **Expansion of Undocumented Adults** ages 26-49 effective 1/1/2024

New 2023 Key Initiatives for KHS

Besides these State mandated changes impacting the 2023 budget, several internal initiatives are scheduled for next year including:

- Implementation of a new 3-year Corporate Strategic Plan
- D-SNP preparations for all Managed MCAL plans to align enrollment of Medicare eligible members to promote more integrated care and ensure continuity of care protections
- NCQA accreditation preparation standardizing quality assurance and clinical practice protocols across all Managed MCAL plans to comply with state and federal requirements
- Expand the Enhanced Care Management network to include new sites and operational models to serve the new populations of focus in 2023
- Long Term Care will be a covered benefit for KHS members
- Expand partnerships with new community-based organizations and integrate into the current Community Services Referral System that will allow CSS services to be referred, authorized, and monitored
- Health Services staffing restructure to support Population Health Management program
- Creation of a Behavioral Health department within KHS to increase collaboration for coordinating KHS member's behavioral health needs through Medication Assisted Treatment (MAT) and Substance Use Disorders and detoxification centers
- Ongoing administration of the DHCS Behavioral Health / Integrated Care Grant
- Continued administration of the KHS Provider and Community Grant program supporting the CalAIM initiatives defined by Department of Health Care Services (DHCS)
- Broad focus on healthcare equity, inclusion, and diversity across the health plan and network, i.e., reporting, population identification, and program implementation to address specific population needs based on race, ethnicity, and other social determinants of health that improve the clinical outcomes for our members.
- Continued partnership with Kern County Department of Human Services with assisting KHS members in completing their redetermination packages correctly and on time

- Corporate projects for improving processes, initiating new programs or enhancing services such as:
  - Enhance Care Management Expansion and Incentive Payment Program
  - Community Support Services Program adding new CS benefits on January 1, 2023, Respite Services, Sobering Centers, and Medically-Supportive Food/Meals/Medically Tailored Meals. Then July 1, 2023 we will implement Nursing Facility Transition/Diversion, Community Transition Services/Nursing Facility Transition to a Home and Personal Care & Homemaker Services
  - Long Term Care Benefit will incorporate new services historically carved out of KHS responsibility including intermediate care facilities for developmentally and intellectually delayed individuals, pediatric and adult subacute care, and other long term care settings
  - JIVA Medical Management System Upgrade to integrate new and improve existing functionality as our clinical platform for population management. New modules and other integrative functions will improve KHS ability to approach care coordination through a holistic lens
  - Milliman Clinical Guidelines (MCG) Update performed annually to align with current evidence-based standards of care and new technologies and treatments, required for clinical authorizations and provider oversight
  - QNXT/NetworX/Optum Core Claims System Upgrade
  - Population Health Management Program Development will include the Model of Care and Program readiness for identification of member risk, stratification of severity, and segmentation of program eligibility through a health equitable lens
  - Expansion of Health Information Exchange (HIE) which allows health care professionals and patients to appropriately access and securely share a patient's medical information electronically
  - JIVA Grievance Module Implementation will remove bifurcated documentation in different systems to manage member grievance processes between UM, QI, and Member services departments
  - NCQA Consultant and Readiness Review will begin in 2023 to bring in field expertise to assist KHS with document preparation, mock audit, and final submissions in its pursuit of NCQA accreditation on or before 2026
  - 2024 DHCS Contract Amendment to complete DHCS Operational Readiness deliverables and implement internal processes needed to support the 2024 Contract
  - D-SNP Consultant and Readiness Review will begin in 2023 in preparation of going live with a D-SNP line of business on January 1, 2026
- Continued development of Provider Performance Based reimbursement arrangements
- Expansion of Member incentive program across new or existing programs for enterprise-wide eligibility including a solution for real-time delivery of incentives and robust tracking mechanisms
- Identify and mitigate social determinants of health and reduce health disparities or inequities
- Expansion of department dashboards for operational metric transparency

- Define/refine Medical Loss Ratio dashboard for monitoring and Executive transparency for budgeting considerations
- Comply with State mandated coordination of benefits to help mitigate unwarranted cost and recovery including retro eligibility activity based on state information

Support for Existing Programs and Initiatives in 2023

Other major responsibilities annually performed by KHS that will impact the 2023 budget include:

- Continue work with Kern Medical through the joint operations committee to explore collaboration opportunities and address operation issues and development of new chronic condition programs for Population Health
- Continue to work with Dignity hospitals (Memorial, Mercy & Mercy Southwest) to ensure mutual success assuming risk via DRG agreement
- Strengthen collaboration with, Kern County Behavioral Health and Recovery Services (KHBRS)and the GATE team for Substance Use Disorders and resource/referral coordination
- Expand the Transitional Care Program with local hospitals or independent KHS provider network
- Palliative Care program expansion
- Continue with managing the Major Organ Transplant benefit that took place on January 1, 2022 with the inclusion of Heart, Lung, Liver and Pancreas transplants
- Expand Telehealth Specialty Care services to all eligible service sectors
- Implement efficiencies across the health services departments through automation and robot technology to streamline process and reduce manual intervention
- Development of home bound program to deliver care directly to members' home for vulnerable populations
- Broad focus on Potentially Preventable Admissions with hospital and provider network collaboration as defined in the ER Navigation Program
- Expand the Diabetic Prevention Programs to provider settings focused on lifestyle changes for diabetes prevention
- Ongoing support for the School based Wellness Programs
- Collaboration with Kern County Community Alliance for Tobacco Cessation
- Expand the Population Health Management Programs, including homelessness outreach, ER overutilization, and care coordination efforts to support CalAIM and low utilization members
- Enhancing Managed Care Accountability Set (MCAS) Tracking and Reporting, including expanded electronic data collection
- Expansion of mobile services for preventative care and gaps in care closures
- Implement a year-round direct member outreach program to improved minimal performance levels (MPL) requirements for MCAS measures
- Continue with Pay for Performance incentives to reward providers who demonstrate improved MCAS outcomes and other non-MCAS preventative care measures

- Expand pregnancy related programs to improve pre and postnatal compliance to promote healthy babies with increased focus on maternal mental health and depression
- Expand provider support and education for collection of data for social determinants of health (SDoH) and provision of Basic Population Health Management through preventative screenings and assessments, e.g., PHQ-2; PHQ-9 (psychiatric health questionnaire), ACE (Adverse Childhood Events), EPSDT (Early Prevention Screening and Diagnostic Testing), IHA (Initial Health Assessment), HRA (Health Risk Assessment), etc.
- Design an in-house Medication Therapy Management Program for eligible members not deemed eligible in an Enhanced Care Management provider setting
- Use the Care Gradient Analysis Predictive Modeling tool to identify populations for diagnoses specific engagement schemes to differentiate care requirements for enhanced, complex, basic, and unmet healthcare needs of our members
- Continue to monitor and measure member and provider satisfaction independently via satisfaction surveys
- Expand design and implementation of department specific outcome metrics
- Broaden audits across all departments to proactively identify process or performance gaps to allow for corrective actions to foster compliance with DHCS and DMHC requirements
- Continue monitoring of Fraud, Waste, and Abuse and delegated oversight of contracted providers and community partners
- Strengthen departmental policy and procedures review process to ensure the documents reflect current or new processes accurately
- Expand COPD program to include other chronic cardio-pulmonary diagnoses such as Congestive Heart Failure (CHF) and Hypertension (HTN)
- Continued recruitment and retention of talent to meet the ongoing changes and initiatives with CalAIM
- Develop and provide training and support for KHS staff into each new phase of CalAIM
- Continue to enhance the Business Intelligence systems with a new data lineage tool.
- Routine hardware and software upgrades and replacements to maintain systems.

Budget - Resources for Collaboration to Enhance Member or Provider Experience

Finally, the 2023 budget will provide resources to support a variety of programs administered either directly or through collaboration with outside organizations. Examples include:

- Provider/Member Portal for notification and education to network providers
- Implement Claims Department Call Center to directly service all Provider inquiries
- Autism Spectrum Disorder Behavioral Therapy, including Non-Autism diagnoses
- California Children’s Services Coordination of Care
- Kern Regional Center Coordination of Care

- Kern County Public Health Department for new or existing public health issues such as Black Infant Health, preventative care and immunizations, and communicable and sexually transmitted disease
- Vision Services Plan for optometric diabetic screenings
- Kaiser Permanente Subcontract
- Program awareness of Mental Health benefit, including coordination with Kern County Public Health for Emergent Mental health services, including 9-8-8 hotline and Mental Evaluation Team (MET)and Medication Assisted Therapy (MAT)
- Hospitalist program expansion
- Low Income Housing through the Kern County Housing Authority and other partners
- Respite Services for our members and their care givers.
- Medically-Supportive Food/Meals/Medically Tailored Meals for members.
- Nursing Facility Transition/Diversion, Community Transition Services/Nursing Facility Transition to a Home and Personal Care & Homemaker Services for our older adult populations of focus

2023 Budget Documents

Senior Management will be presenting a PowerPoint summary of the 2023 Corporate Budget.

Also attached are the following documents relating to the 2023 Budget:

1) Consolidated Operating Budget
2) Operating Budget by Aid Category
3) Enrollment Assumptions
4) Revenue Assumptions
5) Medical Expense Assumptions
6) Administrative Expense Assumptions
7) Budgeted FTE by Department
8) Capital Budget for 2023
9) Preliminary 2022 Year-end and Projected 2023 TNE Calculation

Requested Action

Approve.

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2023 Corporate Budget

Board of Directors Meeting

December 15, 2022

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Presentation Overview

- KHS Corporate Projects and Strategic Path Overview (CEO)
- 2023 Corporate Budget and Assumptions (CFO)
- 2023 Corporate Project Consulting & Professional Services(CIO)
- Requested Finance Committee Action

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ACCREDITED NCQA HEALTH PLAN

BEHAVIORAL HEALTH

Quality Metrics

2023 Corporate Goals

Goal	Description
Implementation of new internal Behavioral Health Program	Development of internal Behavioral Health Department, Provider Network enhancements, expansion of Medication Assisted Treatments and Emergency Stabilization Services.
Quality and Health Equity Program	Health Equity Officer role, Care Management Programs and Strategies, Member Engagement and Communication.
Health Information Data Exchange and Security	System monitoring and logging, security audit and remediation.
Dual-Eligible Special Needs Plan (Medicare D-SNP)	Operational/Fiscal gap analysis, Implementation preparations, NCQA Accreditation gap analysis and readiness.
Department of Health Care Services (DHCS) Incentive Programs	Administration of CalAIM Incentive Program, Housing and Homelessness Incentive Program, and Student Behavioral Health Incentive Program.
Expansions to Telehealth Benefit	Implementation of permanent telehealth flexibilities based on DHCS' final policy design.

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory.

CalAIM Goals

- Implement a whole-person care approach and address social drivers of health.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation.
- Create a consistent, efficient, and seamless Medi-Cal system.

Population Health Management

Children and families | Adults | People with disabilities | Older Californians

Identifying Needs → Prevention → Wellness

Long-Term Services and Supports | Physical Health Care | Behavioral Health Care

Enrollee

Developmental and Intellectual Disabilities Services | Social Drivers of Health | Oral Health Care

Enhanced Care Management | Community Supports

People with serious mental illness/ substance use disorder | Medically complex | People who are justice involved | People experiencing homelessness or housing instability | Foster youth | People at risk of institutionalization

https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-Infographic.pdf

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2023 Corporate Budget & Assumptions

Robert Landis
Chief Financial Officer

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Budget Assumptions

	(Dollar Amounts in Thousands Except for PMPMs and Member Months)					
	Budgeted $ 2023	Projected $ 2022	Actual $ 2021	Budgeted PMPM 2023	Projected PMPM 2022	Actual PMPM 2021
Annual Member Months (1)	4,158,950	3,834,013	3,468,398			
Total Revenues (2)	1,601,496	1,342,884	1,330,200	385.07	350.26	383.52
Total Medical Costs (3)	1,370,414	1,128,897	1,134,546	329.51	294.44	327.11
Total Administrative Expenses (4)	84,391	63,603	54,547	20.29	16.59	15.73
Total MCO Tax	144,953	124,957	112,821	33.50	32.59	32.53
Net Profit/(Loss)	1,739	25,427	28,286	0.42	6.63	8.16
D-SNP Expenses	7,504	-	-	1.80	-	-
Health Home/CalAIM Grant Expenses	-	5,974	7,895	-	1.56	2.28
Net Profit/ (Loss) After D-SNP and Health Home/CalAIM Grant Expenses	(5,764)	19,454 (5)	20,390	(1.39)	5.07	5.88
Medical Loss Ratio Excluding MCO Tax D-SNP & Health Home/CalAIM Grants	92.98%	91.08%	92.24%			
Admin Ratio Excluding MCO Tax D-SNP & Health Home/CalAIM Grants	6.87%	6.37%	5.64%			

(1) See Attachment 3 in the 2023 Budget for Membership assumptions
(2) See Attachment 4 in the 2023 Budget for Revenue assumptions
(3) See Attachment 5 in the 2023 Budget for Utilization and Unit Cost assumptions
(4) See Attachment 6 in the 2023 Budget for Administrative assumptions
(5) Excludes $12.6 million of net favorable prior period adjustments

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Membership Assumptions

BUDGETED MEMBER MONTHS CY 2023	JAN'23	FEB'23	MAR'23	APR'23	MAY'23	JUN'23	JUL'23	AUG'23	SEP'23	OCT'23	NOV'23	DEC'23	CY 2023
19 & OVER	64,000	65,000	65,000	65,000	65,000	65,000	64,600	64,200	63,800	63,400	63,000	62,600	770,600
UNDER 19	145,000	148,400	148,800	149,200	149,600	150,000	149,500	149,000	148,500	148,000	147,500	147,000	1,780,500
SPDS	17,000	18,000	18,000	18,000	18,000	18,000	17,900	17,800	17,700	17,600	17,500	17,400	212,900
TOTAL OTHER	8,700	24,150	24,150	24,150	24,150	24,150	24,350	24,350	24,350	24,350	24,350	24,350	275,550
MEDI-CAL EXPANSION	91,000	93,000	93,000	93,000	93,000	93,000	92,400	91,800	91,200	90,600	90,000	89,400	1,101,400
-Expansion Dual	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	17,400
-Expansion Partial Dual	50	50	50	50	50	50	50	50	50	50	50	50	600
TOTAL MEDI-CAL	*327,200*	*350,050*	*350,450*	*350,850*	*351,250*	*351,650*	*350,250*	*348,650*	*347,050*	*345,450*	*343,850*	*342,250*	*4,158,950*
Kaiser Membership	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	168,000
TOTAL COMBINED	341,200	364,050	364,450	364,850	365,250	365,650	364,250	362,650	361,050	359,450	357,850	356,250	4,326,950

(1) Assumes additional 400 births each month for Child

(2) Assumes -2000 members reduction per month due to redeterminations beginning in July: Adult -400, Child -900, Expansion -600, Spd -100

(3) Assumes 1,000 Adults; 3,000 Children; 1,000 SPD's; 15,000 Duals; 2,000 Expansion members being transferred from Fee for Service to Managed Care starting in February

(4) Assumes 400 Long-Term Care Duals and 50 NonDual Members starting in February being transferred from Fee for Service to Managed Care then additional 200 Long-Term Care Duals in July

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Revenue Assumptions

	2023 BUDGET	EST. ANNUAL 2022	2021 ACTUAL
	$	$	$
REVENUE			
Capitation (excludes Prop 56 & GEMT)	942,680,028	829,971,589	726,504,349
Pharmacy Component of Capitation Revenue	-	-	118,022,231 (1)
LTC Dual/Non Dual Capitation	93,705,838	-	-
Maternity Kick Supplemental Payment	36,227,616	38,207,296	33,603,930
Behavioral Health Integration Program	-	4,569,085	6,645,789
Enhanced Care Management	25,475,578	22,988,032	-
Major Organ Transplant	6,615,222	6,130,022	-
CalAIM Incentive Program	30,606,291	17,973,215	4,868,691
Proposition 56 Supplemental Payments	79,782,687	69,962,512	68,061,590
Ground Emergency Medical Transportation (GEMT)	6,392,315	6,913,384	6,056,803
Total MCAL Revenue	1,221,485,574	996,715,136	963,763,383
Add-Ons (Directed Provider Payments)	228,984,127	220,023,715	243,729,690
MCO Tax Revenue	144,952,825	124,962,872	119,594,632
Interest	5,158,950	1,006,431	3,112,119
Reinsurance	914,969	175,997	-
TOTAL REVENUE	**1,601,496,445**	**1,342,884,151**	**1,330,199,824**

(1) Effective January 1, 2022 the Pharmacy Benefit was craved out from managed-care plans

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Revenue Assumptions (continued)

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Utilization and Unit Cost Assumptions

The below percentages were applied to paid claims incurred during the 6-month period January – June 2022 paid as of August 2022 to estimate 2023 medical expenses. Percentages are rounded to the nearest whole percentage.

	FAMILY & OTHER		SENIORS & PERSONS WITH DISABILITIES (SPD)		EXPANSION	
	Annualized Increase		Annualized Increase		Annualized Increase	
MEDICAL EXPENSES	Unit Cost	Utilization	Unit Cost	Utilization	Unit Cost	Utilization
Inpatient Hospital	3.00%	1.00%	4.00%	1.00%	3.00%	1.00%
Outpatient Facility	3.00%	1.00%	3.00%	1.00%	2.00%	3.00%
Emergency Room	3.00%	1.00%	3.00%	1.00%	1.00%	1.00%
Long Term Care/Hospice	3.00%	1.00%	3.00%	1.00%	3.00%	1.00%
Physician Primary Care	3.00%	1.00%	3.00%	1.00%	3.00%	1.00%
Urgent Care	3.00%	1.00%	3.00%	1.00%	3.00%	1.00%
Physician Specialty	3.00%	1.00%	3.00%	1.00%	3.00%	1.00%
Other Medical Professional and Medical Expenses	3.00%	1.00%	3.00%	1.00%	3.00%	1.00%

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Expense Assumptions

	2023 BUDGET	EST. ANNUAL 2022	2021 ACTUAL
	$	$	$
MEDICAL			
Inpatient Hospital	281,876,533	251,394,336	239,518,145
Outpatient Facility	122,276,102	106,982,989	91,571,151
Emergency Room Facility	68,934,910	60,238,341	54,752,776
Long-Term Care Facility - Long-Term	93,705,838	-	-
Primary Physician Services	53,023,513	46,289,209	41,047,521
Urgent Care	30,571,682	24,844,404	19,331,419
Physician Specialty	173,754,546	154,880,404	133,587,903
Provider Enhancement Expense - Prop 56	75,793,553	69,119,613	4,868,691
Add-Ons Directed Provider Payments	228,984,127	220,023,715	242,717,836
Pharmacy Services	-	-	110,173,753
Other Medical Expenses	241,492,846	195,124,218	196,976,803
TOTAL MEDICAL EXPENSES	**1,370,413,650**	**1,128,897,230**	**1,134,545,998**
ADMINISTRATIVE EXPENSES	**84,390,686**	**63,602,827**	**54,547,131**
MCO TAX EXPENSE	**144,952,825**	**124,956,603**	**112,821,118**
TOTAL EXPENSES	**1,599,757,161**	**1,317,456,660**	**1,301,914,247**

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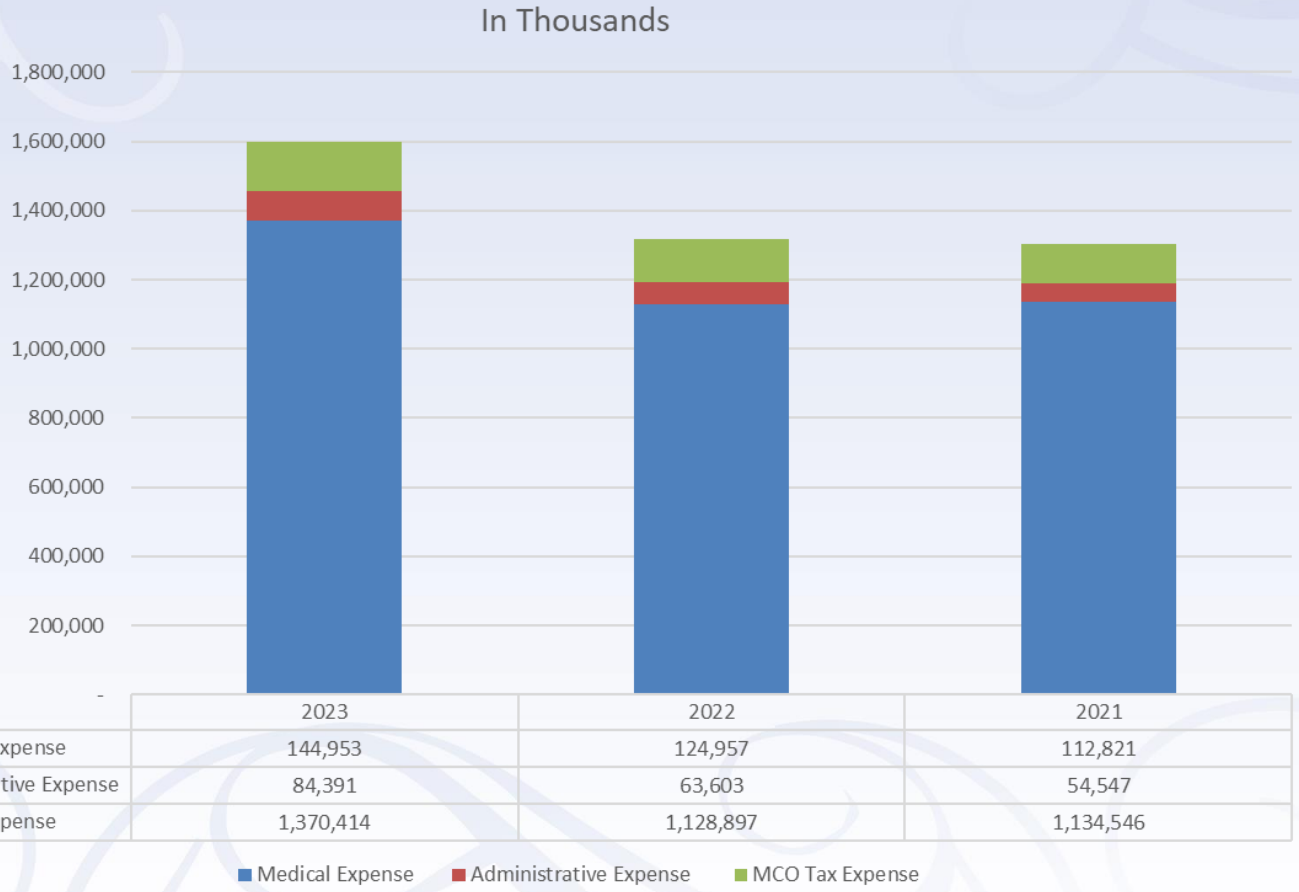
Expense Assumptions (continued)



	2023	2022	2021
MCO Tax Expense	144,953	124,957	112,821
Administrative Expense	84,391	63,603	54,547
Medical Expense	1,370,414	1,128,897	1,134,546

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Staffing (FTE) Summary

Department		Projected FTE's: 2022	Projected FTE's: 2023	Total Additional 2023 FTE's
Administrative FTE's				
110	EXECUTIVE	6	6	0
210	FINANCE	15	15	0
220	INFORMATION TECHNOLOGY	24	30	6
222	ENTERPRISE DEVELOPMENT	20	22	2
230	CLAIMS	61	62	1
240	PROJECT MANAGEMENT	10	12	2
320	PROVIDER NETWORK MANAGEMENT	27	27	0
330	MEMBER SERVICES	98	107	9
340	CORPORATE SERVICES	12	12	0
360	COMPLIANCE & REGULATORY AFFAIRS	8	11	3
420	MARKETING	4	6	2
510	HR	16	17	1
603	D-SNP/MEDICARE	0	3	3
Medical FTES:				
221	BUSINESS INTELLIGENCE	20	22	2
310	UTILIZATION MANAGEMENT	69	80	11
311	QI	21	21	0
312	HEALTH ED	20	21	1
313	PHARMACY	10	10	0
314	ENHANCED CARE MANAGEMENT	27	35	8
316	POPULATION HEALTH MANAGEMENT	40	43	3
317	COMMUNITY SUPPORT SERVICES	7	10	3
318	HHIP	1	1	0
319	IPP	2	2	0
410	MEMBER ENGAGEMENT	1	5	4
601	BEHAVIORAL HEALTH	2	5	3
602	HEALTH EQUITY	0	3	3
		521	**588**	**67**

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2023 Corporate Project Consulting & Professional Services

Richard M. Pruitt
Chief Information Officer

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General Overview

- Over the last few years, KHS started a transformation so that the convergence of the Health Plan, Clinician (Medical & Behavioral), Member/Patient, Social Services, and Community Supports are communicating/coordinated when rendering their respective services so that holistic care is being delivered.

- All of this is being accomplished by KHS through people (staff), processes, and systems as outlined by the State of California through the CalAIM initiatives (https://www.dhcs.ca.gov/calaim#initiatives).

- Each year, the organization augments the workforce by outsourcing with consultants, thus avoiding full-time employee hires, to accommodate the temporary resource demands of the organizational projects.

Sequence of Events

- Corporate Strategic Planning / Corporate Goals & Objectives
- Design the Annual Project Portfolio with Leadership
- Scope and Resource Planning for Annual Project Portfolio
- Executive Approval of Annual Project Portfolio
- Annual Budget Process for KHS
- Create Recommendation for the Board of Directors.

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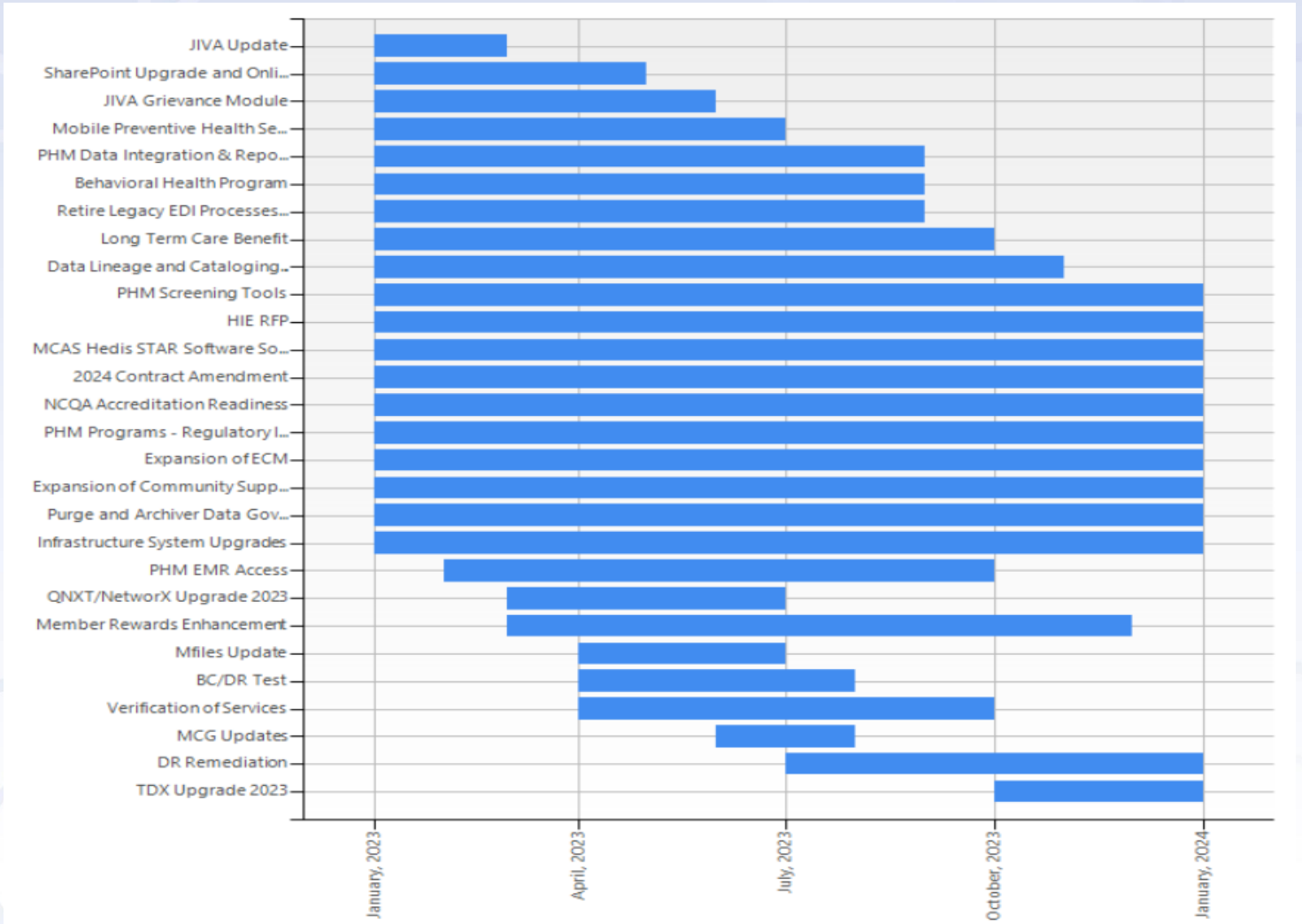
2023 Corporate Portfolio



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2023 Medicare DSNP

1.0 Medicare Strategy	2.0 Product Management	3.0 Member Sales & Marketing	4.0 Member Service Operations	5.0 Claims Operations	6.0 Provider Services	7.0 Medical Management	8.0 Pharmacy Services	9.0 Risk Adjustment & Quality	10.0 Business Oversight
1.1 Marketing Assessment	2.1 Market Research	3.1 MA Sales Management • Direct Sales Support • CMS Sales Support	4.1 Enrollment & Billing	5.1 Clearing- house Management	6.1 Provider Contract Maintenance	7.1 Medical Operations • Preservice • Medical Policies • Emergent/Urgent - Authorization assist	8.1 Drug formulary management	9.1 Risk Adjustment & Risk Accuracy	10.1 Compliance & Audit Support
1.2. Capability Maturity	2.2 Benefit Design & Pricing	3.2 Administer Commissions	4.2 Membership Maintenance	5.2 Claims Intake (EDI & Paper)	6.2 Provider Contract Development	7.2 In-Patient Utilization Management & Discharge Planning	8.2 Pharmacy Benefit Management	9.2 Encounters Submission	10.2 Operations & Process Oversight
1.3 Competitor Assessment	2.3 Supplemental Benefits	3.3 Broker/Agent Management	4.3 Membership Reconciliation	5.3 Authorization Processing	6.3 Provider Credentialing	7.3 Outpatient Care Management • Proactive CM • Reactive CM & care transitions • Behavioral Health	8.3 Clinical Protocols	9.3 Stars Initiative Analytics	10.3 Reporting & Data Management
1.4 Department of Insurance Due Diligence	2.3 Product Development	3.4 Marketing Materials Management	4.4 ID Cards and Member Material Fulfillment	5.4 Benefit Configuration	6.4 Provider Data Management	7.4 Post-acute Management	8.4 Specialty Drug Management	9.4 Stars Initiative Management	10.4 Performance Reporting & Analytics
1.5 Financial Alignment	2.4 MA Bid Creation & Submission	3.5 Market Products	4.5 Print fulfillment	5.5 Claims Adjudication	6.5 Provider Recruiting & Network Development	7.5 Model of Care Chronic Condition Program	8.5 Manage Pharmacy Directory	9.5 HEDIS Submissions	10.5 Risk Management
1.6 Corporate Strategic Alignment	2.5 CMS Application Process	3.6 Agent Customer Service & Self Service	4.6 Organization Determinations, Appeals & Grievances	5.6 Prepayment Editing	6.6 Service Provider Inquiries	7.6 Home & community-based services/partners (e.g., local and National)	8.6 Medication Therapy Management	9.6 CAHPS & HOS	10.6 Vendor Performance & Delegation Oversight
1.7 Enterprise Organizational Alignment		3.7 Shopping Experience	4.7 Call Center Management	5.7 Claims Payment	6.7 Manage Provider Directory	7.7 Wellness Programs	8.7 Pharmacy Customer Service & Self Service	9.10 Quality Improvement Program	10.7 Finance & Reconciliations
1.8 IT Strategic Alignment		3.8 Digital Marketing	4.8 IVR Management	5.8 Remittance Generation	6.8 Provider Performance Management	7.8 Provider Engagement (e.g., ACN, point of care collaboration)	8.8 Coverage Determinations, Appeals & Grievance	9.11 NCQA Measures	
1.9 Internal Comms & Change Management			4.9 Service Member Inquiries & Self Service	5.9 EOB Generation	6.9 Payment Integrity	7.9 Advanced Analytics	8.9 Pharmacy Reporting & Analytics		
			4.10 Medical Customer Service & Self Service		6.10 Provider Customer Service & Self Service	7.10 Population Health			

2023 Capital Budget

ITEM	CORPORATE PROJECTS	TYPE [1]	QTR	COST	2022	2021	2020	TOT. PRJ. [2]	CalAIM
1	Member Engagement System	B	3,4	$ 658,500				$ 658,500	Y
2	DSNP MCAS Star Software	N	3,4	$ 408,500				$ 408,500	Y
3	Population Health Management	N	1,2,3,4	$ 351,000				$ 351,000	Y
4	DSNP CRM System	B		$ 275,000				$ 275,000	Y
5	DSNP JIVA Medicare Module	N	3,4	$ 281,750				$ 281,750	Y
6	DSNP Risk Adjustment Software	N	3,4	$ 250,000				$ 250,000	Y
7	Data Lineage and Cataloging System	N	1,2	$ 181,012	$ 139,381			$ 320,393	N
	CORPORATE PROJECT SUBTOTAL			**$ 2,405,762**	**$ 3,664,556**	**$ 3,358,394**	**$ 5,362,940**	**$ 2,545,143**	
	BUILDING IMPROVEMENTS, OFFICE FURNITURE, & EQUIPMENT		QTR	COST	2022	2021	2020	PROJECT COST	
8	Office Furniture and Equipment	N	1,2,3,4	$ 560,000	$ 169,000	$ 88,250	$ 343,000	N/A	N
	OFFICE FURNITURE & EQUIPMENT SUBTOTAL			**$ 560,000**	**$ 169,000**	**$ 88,250**	**$ 343,000**	**N/A**	
	TECHNOLOGY		QTR	COST	2022 [3]	2021 [3]	2020 [3]		
9	Information Security (InfoSec) Software	N	1,2,3,4	$ 750,000	$ 50,051	$ 73,165	$ 69,791	N/A	N
10	Infrastructure Growth and Expansion	N	1,2,3,4	$ 582,000	$ 964,320	$ 197,743	$ 247,276	N/A	N
11	Employee Equipment	N	1,2,3,4	$ 290,000	$ 186,258	$ 167,168	$ 74,070	N/A	N
12	Core System Licensing [4]	N	3,4	$ 443,590	$ 624,264	$ 253,861	$ 417,275	N/A	N
	TECHNOLOGY SUBTOTAL			**$ 2,065,590**	**$ 1,824,893**	**$ 691,937**	**$ 808,412**	**N/A**	
	TOTAL 2023 CAPITAL ITEMS			**$ 5,031,352**	**$ 5,658,449**	**$ 4,138,581**	**$ 6,514,352**	**$ 2,545,143**	

(1) Type R is a Renewal or Replacement / Type N is New / Type B is Both

(2) Does not include ongoing maintenance and support that is expected not to exceed 10% of the total project cost during the initial five years

(3) Actual Expenditures

(4) Pending 2022 Invoice from Microsoft

2023 Resource Planning

PROJECTS		CATEGORY		TECHNICAL OPERATIONS			ENTERPRISE CONFIG			ENTERPRISE DEVELOPMENT				BUSINESS INTELLIGENCE				LABOR
ITEM	PROJECT NAME	BUDGET	TYPE	InfoSEC	System	Network	CONFIG (PAYMENT)	CONFIG (CLAIMS)	CONFIG (CLINICAL)	DB OPS	DB DEV	APP DEV	EDI DEV	BIA	PIA	DS	DA	TOTAL TECH HOURS
1	D-SNP Planning and Implementation Preparations	Expense	Regulatory		1,900		1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	23,304
2	PHM Programs - Regulatory Implementation	Expense	Regulatory		650				1,900		800	400		800	120	1,900	1,900	8,870
3	Expansion of ECM	Expense	Regulatory		372		216	216	1,384		1,500	300	552	444	80	180	180	5,853
4	NCQA Accreditation Readiness	Expense	Regulatory		560		280	280	728		560	560	560	608	528	560	560	5,836
5	2024 Contract Amendment	Expense	Regulatory					720	640		560	160	480				1,440	4,000
6	PHM EMR Access	IPP	Regulatory		240				120		800	250	800	40	60	800	200	3,310
7	Expansion of Community Support Services (CSS)	Expense	Regulatory		192		192	192	1,524					624	120		460	3,304
8	Behavioral Health Program	Expense	Regulatory		84				978		500	90	186	212	60	160	256	2,647
9	Retire Legacy EDI Processes/Systems	Expense	Risk		200					60	100	50	500	200	40	200	100	2,490
10	PHM Screening Tools	Capital	Regulatory		262				726		260	260	260	160	180	180	120	2,408
11	QNXT/NetworX Upgrade 2023	Expense	Risk		298		120	240	68	441	90	200	155	130	95	70	205	2,310
12	Infrastructure System Upgrades	Capital	Risk		640					1,900								2,120
13	ODS to EDW Migration	Expense	Risk		48					100	610	345		100	60	540	240	2,043
14	Purge and Archiver Data Governance Standards	Expense	Risk		412						960			140	180	140	140	1,972
15	Data Lineage and Cataloging (new) Governance Stand	Capital	Risk		412					360	360			140	180	140	140	1,732
16	PHM Data Integration & Reporting	IPP	Regulatory		180						300	180	120	176	120	336	240	1,652
17	DR Remediation	Expense	Risk		280					280	120	120	120	120	160	280	120	1,600
18	Long Term Care Benefit	Expense	Regulatory		96		112	128	408		220		220	128	100	60	60	1,532
19	Member Rewards Enhancement	Capital	Process Improvement		24				100		106		226		100	384	328	1,268
20	Verification of Services	Expense	Regulatory		196						224	408		124	60	80	60	1,152
21	BC/DR Test	Expense	Risk	106	178	94		80	80	80		80	80	80			80	1,104
22	MCAS Hedis STAR Software Solution	Capital	Risk		236						432				48	120	292	1,028
23	JIVA Grievance Module	Capital	DSNP						162		162	50	50		110	80	90	654
24	TDX Upgrade 2023	Expense	Risk		144					120		80			40	80	60	524
25	Claims Editing Software (CES) KB Updates	Expense	Regulatory		40			360		60							80	520
26	SharePoint Upgrade and Online Migration	Expense	Risk	24	120					80		20		88	70		80	482
27	Mobile Preventive Health Services Program	Expense	Medical Management				30							124	120	60	80	414
28	JIVA Update	Expense	Medical Management		120				120		80							320
29	Mfiles Update	Expense	Risk		60					68		64		12			44	248
30	MCG Updates	Expense	Regulatory		20				40									60
	Total (Hours)			**2,782**	**17,244**	**1,926**	**6,900**	**10,668**	**16,553**	**9,299**	**16,244**	**10,472**	**12,239**	**10,152**	**6,611**	**12,830**	**16,868**	**199,255**
	Resource Demand (Employee)			1.46	9.08	1.01	3.63	5.61	8.71	4.89	8.55	5.51	6.47	5.34	3.48	6.75	8.88	85
	Full-Time Employees			2.00	5.00	1.00	1.00	2.00	4.00	3.00	4.00	5.00	4.00	5.00	2.00	1.00	7.00	53
	Variance			0.54	(4.08)	(0.01)	(2.63)	(3.61)	(4.71)	(1.89)	(4.55)	(0.51)	(2.47)	(0.34)	(1.48)	(5.75)	(1.88)	32
	2023 CONSULTING REQUEST			**1.0**	**5.0**	**1.0**	**3.0**	**4.0**	**5.0**	**2.0**	**6.0**	**1.0**	**3.0**	**1.0**	**2.0**	**6.0**	**2.0**	**42.0**

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Benefits of Outsourcing

- Staffing Flexibility to Accommodate Temporary Project Load.
- Reduce Long Term Administrative Costs.
- Obtain Resources Not Easily Available Locally.
- Find Skilled Resources Needed for Specific Projects.
- Ensure Projects are Successful Through Adequate Staffing.

Historical Expenditures

AREA	PROJECTS	RESOURCES	REQUESTED	ACTUAL	VARIANCE
2020					
Management Information Systems	20	16	**$4,236,600**	$3,849,616	$386,984
2021					
Management Information Systems	28	13	**$3,561,948**	$3,164,567	$397,381

2022*	PROJECTS	RESOURCES	REQUESTED	ACTUAL	PROJECTED	VARIANCE
Management Information Systems	28	35	$9,178,190	$3,987,869	$5,827,772	$3,350,418
Project Management		5	$1,096,000	$465,540	$507,505	$588,495
DSNP		1	$95,000	$0	$81,648	$13,352
		TOTAL:	**$10,369,190**	$4,453,409	$6,416,925	$3,952,265

2023 (REQUEST)	PROJECTS	RESOURCES	REQUESTED	
Management Information Systems	30	29	$7,365,693	N/A
Project Management		5	$1,185,600	
DSNP		21	$6,515,185	
		TOTAL:	**$15,066,478**	

* Actual as of end of September and variance forecasted out to end of year.

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Professional Services Vendors

Item	Vendor	Avg. Price	Approach	LHPC	Onshore	Incumbent	Location	References	Financials
1	VENDOR 1	$80.32	5	5	Y	N	CA	3	N
2	VENDOR 2	$82.27	4	0	Y	N	NJ	4	Y
3	VENDOR 3	$87.18	5	5	Y	N	PA	3	Y
4	VENDOR 4	$91.10	5	0	Y	N	VA	3	Y
5	VENDOR 5	$93.00	4	5	Y	Y	MA	3	N
6	VENDOR 6	$98.36	5	5	Y	N	MD	3	Y
7	VENDOR 7	$102.27	4	5	Y	Y	WA	3	N
8	VENDOR 8	$108.18	4	0	Y	N	CA	3	Y
9	VENDOR 9	$113.18	5	5	Y	Y	PA	3	N
10	VENDOR 10	$118.64	4	0	Y	N	VA	3	Y
11	VENDOR 11	$118.95	5	5	Y	Y	MD	3	Y
12	VENDOR 12	$124.82	5	5	Y	Y	NY	4	Y

Requested Action

1) Recommend to KHS Board of Directors to approve 2023 Operating & Capital Budgets.

2) Recommend to KHS Board of Directors, as requested in the following agenda item, to authorize the CEO to approve contracts associated with the procurement of Professional Resources to various consulting companies in the amount not to exceed $15,066,478 in operating and capital expenses associated for labor needed to complete the 2023 corporate and department projects.

KERN HEALTH SYSTEMS
P & L BY MAJOR CATEGORY OF SERVICE
2023 BUDGET

	2023 BUDGET		EST ANNUAL 2022		DIFFERENCE	PMPM 2023 BUDGET	PMPM 2022 ANNUAL	PMPM DIFFERENCE	PMPM % DIFFERENCE
	$		$		$	4,158,950	3,834,013	324,937	8%
REVENUE									
Capitation (excludes Prop 56 & GEMT)	942,680,028		829,971,589	(3)	112,708,438	226.66	216.48	10.19	5%
LTC Dual/Non Dual Capitation	93,705,838	(4)	-		93,705,838	22.53	-	22.53	100%
Maternity Kick Supplemental Payment	36,227,616		38,207,296		(1,979,680)	8.71	9.97	(1.25)	-13%
Behavioral Health Integration Program	-	(7)	4,569,085		(4,569,085)	-	1.19	(1.19)	-100%
Enhanced Care Management	25,475,578		22,988,032		2,487,546	6.13	6.00	0.13	2%
Major Organ Transplant	6,615,222		6,130,022		485,200	1.59	1.60	(0.01)	-1%
CalAIM Incentive Program	30,606,291		17,973,215		12,633,076	7.36	4.69	2.67	57%
Proposition 56 Supplemental Payments	79,782,687		69,962,512		9,820,175	19.18	18.25	0.94	5%
Ground Emergency Medical Transportation (GEMT)									
Supplemental Payments	6,392,315		6,913,384		(521,070)	1.54	1.80	(0.27)	-15%
Total MCAL Revenue	1,221,485,574		996,715,136		224,770,438	293.70	259.97	33.73	13%
Add-Ons (Directed Provider Payments)	228,984,127		220,023,715		8,960,412	52.92	57.39	(4.47)	-8%
MCO Tax Revenue	144,952,825		124,962,872		19,989,953	33.50	32.59	0.91	3%
Interest	5,158,950		1,006,431		4,152,519	1.24	0.26	0.98	373%
Reinsurance	914,969		175,997		738,972	0.22	0.05	0.17	379%
TOTAL REVENUE	**1,601,496,445**		**1,342,884,151**		**258,612,294**	**385.07**	**350.26**	**34.82**	10%
MEDICAL									
Inpatient Hospital	281,876,533		251,394,336		30,482,197	67.78	65.57	2.21	3%
Outpatient Facility	122,276,102		106,982,989		15,293,113	29.40	27.90	1.50	5%
Emergency Room Facility	68,934,910		60,238,341		8,696,569	16.58	15.71	0.86	5%
Long-Term Care Facility - Long-Term	93,705,838	(4)	-		93,705,838	22.53	-	22.53	100%
Primary Physician Services	53,023,513		46,289,209		6,734,304	12.75	12.07	0.68	6%
Urgent Care	30,571,682		24,844,404		5,727,278	7.35	6.48	0.87	13%
Physician Specialty	173,754,546		154,880,404		18,874,142	41.78	40.40	1.38	3%
Behavioral Health Treatment and Mental Health	22,620,105		18,666,004		3,954,101	5.44	4.87	0.57	12%
Vision	4,252,839		3,872,353		380,486	1.02	1.01	0.01	1%
Other Medical Professional	22,607,969		18,000,368		4,607,600	5.44	4.69	0.74	16%
Enhanced Care Management	24,201,799		21,838,630		2,363,168	5.82	5.70	0.12	2%
Major Organ Transplant	6,284,461		5,823,521		460,940	1.51	1.52	(0.01)	-1%
DME	12,742,556		11,227,526		1,515,030	3.06	2.93	0.14	5%
Home Health and CBAS	12,024,455		10,031,679		1,992,776	2.89	2.62	0.27	10%
Other- Ambulance and Non-Emergent Transportation	19,687,593		17,037,921		2,649,672	4.73	4.44	0.29	7%
Other - LTC (Short-Term), SNF, Hospice	22,009,483		19,589,039		2,420,444	5.29	5.11	0.18	4%
Behavioral Health Integration Program	-	(7)	4,569,086		(4,569,086)	-	1.19	(1.19)	-100%
Pay for Performance Quality Incentive	6,238,425		5,751,020		487,405	1.50	1.50	(0.00)	0%
CalAIM Incentive Program	29,075,976		18,669,027		10,406,950	6.99	4.87	2.12	44%
Provider Enhancement Expense - Prop 56	75,793,553		69,119,613		6,673,940	18.22	18.03	0.20	1%
Provider Enhancement Expense - GEMT	6,072,699		5,759,007		313,691	1.46	1.50	(0.04)	-3%
Add-Ons Directed Provider Payments	228,984,127		220,023,715		8,960,412	52.92	57.39	(4.47)	-8%
Reinsurance Premium	914,969		690,122		224,847	0.22	0.18	0.04	22%
UM/QA Costs (including Utilization & Quality Review)	52,759,517	(5)	33,598,914		19,160,603	12.69	8.76	3.92	45%
Total Medical Costs	**1,370,413,650**	(8)	**1,128,897,230**		**241,516,420**	**329.51**	**294.44**	**35.07**	12%
GROSS PROFIT/(LOSS)	**231,082,795**		**213,986,921**		**17,095,875**	**55.56**	**55.81**	**(0.25)**	0%

ADMINISTRATIVE	**84,390,686**	**63,602,827**	**20,787,859**	**20.29**	**16.59**	**3.70**	22%
NET PROFIT/(LOSS) BEFORE MCO TAX	**146,692,109**	**150,384,093**	**(3,691,984)**	**35.27**	**39.22**	**(3.95)**	-10%
MCO TAX EXPENSE	**144,952,825**	**124,956,603**	**19,996,222**	**33.50**	**32.59**	**0.91**	3%
NET PROFIT/(LOSS) AFTER MCO TAX	**1,739,284**	**25,427,491**	**(23,688,207)**	**0.42**	**6.63**	**(6.21)**	-94%
D-SNP EXPENSES	**7,503,760** (6)	-					
HEALTH HOME PROGRAM/CAL AIM GRANT EXPENSES	-	**5,973,631**					
NET PROFIT/(LOSS) AFTER GRANT EXPENSE	**(5,764,476)**	**19,453,860** (1)(2)					
MEDICAL LOSS RATIO (EXCLUDING MCO TAX, GRANTS, DIRECTED PAYMENTS AND D-SNP)	92.98%	91.08%					
ADMIN RATIO (EXCLUDING MCO TAX, GRANTS, DIRECTED PAYMENTS AND D-SNP)	6.87%	6.37%					

(1) 2022 has been adjusted for approximately $12.6 million of net favorable prior period adjustments including retro capitation adjustments and IBNR and paid claims adjustments recognized as of September 2022.

(2) 2022 Annual is estimated using September Financials, the 2022 Budget, and other adjustments due to timing differences and availability of updated current information.

(3) 2022 Estimated Capitation revenue includes Behavioral Health Treatment (BHT) supplemental kick payments of approximately $18 mil. Starting January 1, 2023, the BHT supplemental payments will paid as part of the monthly capitation payments.

(4) Assumed in CY 2023 approximately 650 Long-Term Care Dual/Non-Dual members will be transferred from Fee for Service to Managed Care in addition to non-LTC aid code transitions. The impact is budgeted to be cost neutral.

(5) Includes new departments for Behaviorial Health , Member Engagement, Health Equity and significant increases for member incentives.

(6) Readiness preparation related to D-SNP/MediCare implementation with a scheduled go-live date of January 1, 2026.

(7) The Behavioral Health Integration (BHI) Incentive Program was a two year program scheduled through December 31, 2022.

(8) Includes $8.3 million of cost savings from Medical Management 2023 MLR Strategies.

KERN HEALTH SYSTEMS
P & L BY MAJOR CATEGORY OF SERVICE
2023 BUDGET

	ALL COAs		FAMILY & OTHER		SPD		EXPANSION	
		4,158,950	$	2,826,650	$	212,900	$	1,119,400
REVENUE								
Capitation	942,680,028	226.66	404,838,140	143.22	189,148,694	888.44	348,693,194	311.50
LTC Dual/Non Dual Capitation	93,705,838	22.53	48,019,080	16.99	32,454,658	152.44	13,232,100	11.82
Maternity Kick	36,227,616	8.71	33,389,786	11.81	-	-	2,837,830	2.54
Enhanced Care Management	25,475,578	6.13	8,055,361	2.85	6,086,811	28.59	11,333,406	10.12
Major Organ Transplant	6,615,222	1.59	1,849,363	0.65	1,935,261	9.09	2,830,598	2.53
CalAIM Incentive Program	30,606,291	7.36	13,385,047	4.74	6,535,815	30.70	10,685,428	9.55
Proposition 56 Supplemental Payments	79,782,687	19.18	51,086,695	18.07	6,335,767	29.76	22,360,225	19.98
GEMT	6,392,315	1.54	2,240,546	0.79	1,705,329	8.01	2,446,440	2.19
Total MCAL Revenue	1,221,485,574	293.70	562,864,017	199.13	244,202,336	1,147.03	414,419,221	370.22
Add-Ons (Directed Provider Payments)	228,984,127	52.92	102,523,426	36.27	41,153,974	193.30	85,306,726	76.21
MCO Tax Revenue	144,952,825	33.50	98,862,216	34.98	7,286,827	34.23	38,803,782	34.66
Interest	5,158,950	1.24	5,158,950	1.83	-	-	-	-
Reinsurance	914,969	0.22	621,863	0.22	46,838	0.22	246,268	0.22
TOTAL REVENUE	**1,601,496,445**	**385.07**	**770,030,473**	**272.42**	**292,689,975**	**1,374.78**	**538,775,997**	**481.31**
MEDICAL								
Inpatient Hospital	281,876,533	67.78	102,357,498	36.21	69,337,484	325.68	110,181,551	98.43
Outpatient Facility	122,276,102	29.40	44,263,662	15.66	25,479,644	119.68	52,532,796	46.93
Emergency Room Facility	68,934,910	16.58	39,206,952	13.87	7,103,688	33.37	22,624,270	20.21
Long-Term Care Facility - Long-Term	93,705,838	22.53	48,019,080	16.99	32,454,658	152.44	13,232,100	11.82
Primary Physician Services	53,023,513	12.75	36,017,151	12.74	3,680,699	17.29	13,325,663	11.90
Urgent Care	30,571,682	7.35	21,166,256	7.49	1,451,539	6.82	7,953,887	7.11
Physician Specialty	173,754,546	41.78	82,529,892	29.20	25,183,290	118.29	66,041,363	59.00
Behavioral Health Treatment and Mental Health	22,620,105	5.44	12,637,238	4.47	9,128,883	42.88	853,985	0.76
Vision	4,252,839	1.02	2,888,758	1.02	222,293	1.04	1,141,788	1.02
Other Medical Professional	22,607,969	5.44	9,863,979	3.49	3,555,302	16.70	9,188,688	8.21
Enhanced Care Management	24,201,799	5.82	7,652,592	2.71	5,782,470	27.16	10,766,736	9.62
Major Organ Transplant	6,284,461	1.51	1,756,895	0.62	1,838,498	8.64	2,689,068	2.40
DME	12,742,556	3.06	4,618,711	1.63	5,115,980	24.03	3,007,865	2.69
Home Health and CBAS	12,024,455	2.89	4,150,486	1.47	5,107,328	23.99	2,766,641	2.47
Other- Ambulance and Non-Emergent Transportation	19,687,593	4.73	10,413,984	3.68	3,867,306	18.16	5,406,303	4.83
Other - LTC (Short-Term), SNF, Hospice	22,009,483	5.29	4,349,624	1.54	11,429,074	53.68	6,230,785	5.57
Pay for Performance Quality Incentive	6,238,425	1.50	4,239,975	1.50	319,350	1.50	1,679,100	1.50
CalAIM Incentive Program	29,075,976	6.99	12,715,795	4.50	6,209,025	29.16	10,151,157	9.07
Provider Incentive Payments - Prop 56 & GEMT	81,866,252	19.68	50,660,878	17.92	7,639,042	35.88	23,566,332	21.05
Add Ons Directed Provider Payments	228,984,127	52.92	102,523,426	36.27	41,153,974	193.30	85,306,726	76.21
Reinsurance Premium	914,969	0.22	621,863	0.22	46,838	0.22	246,268	0.22
UM/QA Costs (including Utilization & Quality Review)	52,759,517	12.69	23,073,316	8.16	11,266,522	52.92	18,419,678	16.45
Total Medical Costs	**1,370,413,650**	**329.51**	**625,728,011**	**221.37**	**277,372,887**	**1,302.83**	**467,312,752**	**417.47**
GROSS PROFIT/(LOSS)	**231,082,795**	**55.56**	**144,302,461**	**51.05**	**15,317,088**	**71.94**	**71,463,245**	**63.84**
ADMINISTRATIVE	**84,390,686**	**20.29**	**38,887,467**	**13.76**	**16,871,589**	**79.25**	**28,631,629**	**25.58**
NET PROFIT/(LOSS) BEFORE MCO TAX	**146,692,109**	**35.27**	**105,414,994**	**37.29**	**(1,554,501)**	**(7.30)**	**42,831,616**	**38.26**
MCO TAX EXPENSE	**144,952,825**	**33.50**	**98,862,216**	**34.98**	**7,286,827**	**34.23**	**38,803,782**	**34.66**
NET PROFIT/(LOSS) AFTER MCO TAX	**1,739,284**	**0.42**	**6,552,778**	**2.32**	**(8,841,328)**	**(41.53)**	**4,027,834**	**3.60**
MEDICAL LOSS RATIO (EXCLUDING MCO TAX AND DIRECTED PROVIDER PAYMENTS)	92.98%		92.01%		96.71%		92.12%	
ADMIN RATIO (EXCLUDING MCO TAX AND DIRECTED PAYMENTS)	6.87%		6.84%		6.91%		6.90%	

Attachment 2

KERN HEALTH SYSTEMS
BUDGETED MEMBER MONTHS
CY 2023

MEDI-CAL	JAN'23	FEB'23	MAR'23	APR'23	MAY'23	JUN'23	JUL'23	AUG'23	SEP'23	OCT'23	NOV'23	DEC'23	CY 2023
19 & OVER	64,000	65,000	65,000	65,000	65,000	65,000	64,600	64,200	63,800	63,400	63,000	62,600	770,600
UNDER 19	145,000	148,400	148,800	149,200	149,600	150,000	149,500	149,000	148,500	148,000	147,500	147,000	1,780,500
SPDS	17,000	18,000	18,000	18,000	18,000	18,000	17,900	17,800	17,700	17,600	17,500	17,400	212,900
TOTAL OTHER	8,700	24,150	24,150	24,150	24,150	24,150	24,350	24,350	24,350	24,350	24,350	24,350	275,550
-Blind Disabled/Aged Dual (3)	*8,700*	*23,700*	*23,700*	*23,700*	*23,700*	*23,700*	*23,700*	*23,700*	*23,700*	*23,700*	*23,700*	*23,700*	*269,400*
-LTC Non Dual (4)	*0*	*50*	*50*	*50*	*50*	*50*	*50*	*50*	*50*	*50*	*50*	*50*	*550*
-LTC Dual (4)	*0*	*400*	*400*	*400*	*400*	*400*	*600*	*600*	*600*	*600*	*600*	*600*	*5,600*
MEDI-CAL EXPANSION	91,000	93,000	93,000	93,000	93,000	93,000	92,400	91,800	91,200	90,600	90,000	89,400	1,101,400
-Expansion Dual	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	1,450	17,400
-Expansion Partial Dual	50	50	50	50	50	50	50	50	50	50	50	50	600
TOTAL MEDI-CAL	*327,200*	*350,050*	*350,450*	*350,850*	*351,250*	*351,650*	*350,250*	*348,650*	*347,050*	*345,450*	*343,850*	*342,250*	*4,158,950*
Kaiser Membership	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	168,000
TOTAL COMBINED	341,200	364,050	364,450	364,850	365,250	365,650	364,250	362,650	361,050	359,450	357,850	356,250	4,326,950

(1) Assumes additional 400 births each month for Child
(2) Assumes -2000 members reduction per month due to redeterminations beginning in July: Adult -400, Child -900, Expansion -600, Spd -100
(3) Assumes 1,000 Adults; 3,000 Children; 1,000 SPD's; 15,000 Duals; 2,000 Expansion members being transferred from Fee for Service to Managed Care starting in February
(4) Assumes 400 Long-Term Care Duals and 50 NonDual Members starting in February being transferred from Fee for Service to Managed Care then

Attachment 3

KERN HEALTH SYSTEMS
MEDI-CAL
2023 REVENUE BUDGET

REVENUES		PMPM	$
Title XIX - Medicaid Adult/Child & Other		199.13	562,864,017
Title XIX - Medicaid Seniors & Persons w/Disabilities		1,147.03	244,202,336
Title XIX - Medicaid Expansion		370.22	414,419,221
SUBTOTAL PREMIUM REVENUE	(1-8)	293.70	1,221,485,574
Directed Payment Revenue	(9)	52.92	228,984,127
Title XIX - Medicaid - MCO Tax	(12)	33.50	144,952,825
TOTAL MEDICAID REVENUE		383.61	1,595,422,526
Interest Revenue	(10)	1.24	5,158,950
Reinsurance Recoveries	(11)	0.22	914,969
TOTAL REVENUES		**385.07**	**1,601,496,445**

REVENUE ASSUMPTIONS

1) PREMIUM REVENUE IS BASED ON DRAFT RATE INFORMATION FOR CY 2023 PROVIDED BY DHCS (JANUARY-DECEMBER 2023) ON SEPTEMBER 17, 2022. BASED ON ASSUMPTIONS, WE HAVE ACCOUNTED FOR ADJUSTMENTS TO BE INCLUDED IN THE FINAL RATES FOR NEW PROGRAM BENEFITS, TRENDS, AND RISK ADJUSTMENTS. PRELIMINARY DRAFT RATES FOR CY 2023 ARE EXPECTED TO BE ISSUED IN DECEMBER 2022.

2) PREMIUM REVENUE INCLUDES APPROXIMATELY $93.7 MILLION OF ADDITIONAL CAPITATION FOR THE LONG-TERM CARE DUAL/NON-DUAL MEMBER POPULATION BEING TRANSFERRED FROM FEE FOR SERVICE TO MANAGED CARE IN CY 2023. REVENUE AND EXPENSE ARE ASSUMED TO BE BUDGET NEUTRAL.

3) MATERNITY KICK REVENUE INCLUDED IN PREMIUM REVENUE INCLUDES A MONTHLY DELIVERY ASSUMPTION OF 400 DELIVERIES PER MONTH AND NEWBORNS ACCOUNT FOR A PORTION OF THE MONTHLY MEMBERSHIP INCREASE.

4) PROP 56 ADD-ON REVENUE IS BUDGETED WITH CY 2022 RATES AS PLACEHOLDER RATES AND ASSUMES NO SIGNIFICANT PROGRAM CHANGES FROM 2022. EXPENSE IS BUDGETED TO BE 95% OF REVENUE.

5) GEMT ADD-ON REVENUE IS BUDGETED USING CY 2022 RATES AND ASSUMES NO SIGNIFICANT PROGRAM CHANGES FROM 2022. EXPENSE IS BUDGETED TO BE 95% OF REVENUE.

6) ENHANCED CARE MANAGEMENT PROGRAM ADD-ON REVENUE INCLUDED IN PREMIUM REVENUE IS BUDGETED USING CY 2022 RATES. EXPENSE IS BUDGETED TO BE 95% OF REVENUE.

7) MAJOR ORGAN TRANSPLANT ADD-ON REVENUE INCLUDED IN PREMIUM REVENUE IS BUDGETED WITH CY 2022 RATE INFORMATION. EXPENSE IS BUDGETED TO BE 95% OF REVENUE.

8) CALAIM INCENTIVE PROGRAM REVENUE INCLUDED IN PREMIUM REVENUE IS BASED ON PROGRAM DOLLAR AMOUNTS EXPECTED TO BE PROVIDED BY DHCS. EXPENSE IS BUDGETED TO BE 95% OF REVENUE.

9) DIRECTED PAYMENT ADD-ON REVENUE INCLUDING PHDP, EPP, AND QIP IS BUDGETED USING CY 2021 RATES AS A PLACEHOLDER AS THESE RATES ARE THE MOST CURRENT AVAILABLE RATES PROVIDED BY DHCS. REVENUE AND EXPENSE ARE ASSUMED TO BE BUDGET NEUTRAL.

10) BUDGETED INTEREST REVENUE IS BASED ON THE RESULTS OF 2022 YTD EARNINGS THROUGH AUGUST AND INCREASED TO ACCOUNT FOR AN EXPECTED INCREASE IN CY 2023 INTEREST RATES. POTENTIAL UNKNOWN MARKET GAINS OR LOSSES ARE NOT INCLUDED.

11) FOR CY 2023, THE REINSURANCE DEDUCTIBLE IS EXPECTED TO INCREASE APPROXIMATELY 20% FROM THE 2022 RATES TO .22 PMPM. REINSURANCE RECOVERIES ARE ASSUMED AT 100% OF PREMIUM.

12) MCO TAX REVENUE IS BASED ON ESTIMATED PMPM RATES OF $33.50 WHICH IS ESTIMATED BASED ON THE CY2022 MCO TAX RATES. THE CURRENT MCO TAX PROGRAM IS SCHEDULED TO EXPIRE IN DECEMBER 2022 AND THE STATUS OF PROGRAM RENEWAL AND RATES AT THIS TIME IS UNKNOWN. REVENUE AND EXPENSE ARE ASSUMED TO BE BUDGET NEUTRAL.

Attachment 4

KERN HEALTH SYSTEMS
2023 BUDGET
UTILIZATION AND UNIT COST ASSUMPTIONS

FAMILY & OTHER	Annualized Increase	
	Unit Cost	Utilization
Inpatient Hospital	3.00%	1.00%
Outpatient Facility	3.00%	1.00%
Emergency Room	3.00%	1.00%
Long Term Care/Hospice	3.00%	1.00%
Urgent Care	3.00%	1.00%
Physician Primary Care	3.00%	1.00%
Physician Specialty	3.00%	1.00%
Other Medical Professional	3.00%	1.00%
Mental Health	3.00%	1.00%
Laboratory and Radiology	3.00%	1.00%
Home and Community Based Services	3.00%	1.00%
Other, Ambulance, and Non-Emergency Medical Transportation	3.00%	1.00%

SENIORS & PERSONS WITH DISABILITIES (SPD)	Annualized Increase	
	Unit Cost	Utilization
Inpatient Hospital	4.00%	1.00%
Outpatient Facility	3.00%	1.00%
Emergency Room	3.00%	1.00%
Long Term Care/Hospice	3.00%	1.00%
Urgent Care	3.00%	1.00%
Physician Primary Care	3.00%	1.00%
Physician Specialty	3.00%	1.00%
Other Medical Professional	3.00%	1.00%
Mental Health	3.00%	1.00%
Laboratory and Radiology	3.00%	1.00%
Home and Community Based Services	3.00%	1.00%
Other, Ambulance, and Non-Emergency Medical Transportation	3.00%	1.00%

EXPANSION	Annualized Increase	
	Unit Cost	Utilization
Inpatient Hospital	3.00%	1.00%
Outpatient Facility	2.00%	3.00%
Emergency Room	1.00%	1.00%
Long Term Care/Hospice	3.00%	1.00%
Urgent Care	3.00%	1.00%
Physician Primary Care	3.00%	1.00%
Physician Specialty	3.00%	1.00%
Other Medical Professional	3.00%	1.00%
Mental Health	3.00%	1.00%
Laboratory and Radiology	3.00%	1.00%
Home and Community Based Services	3.00%	3.00%
Other, Ambulance, and Non-Emergency Medical Transportation	3.00%	1.00%

Note 1: The above percentages were based on paid claims cost history for the 6 month period January 2022 through June 2022 paid as of August 2022. Percentages are rounded to the nearest whole percentage.

Note 2: The above percentages do not include any proposed 2023 Medical Management MLR Strategies which could result in utilization savings

Attachment 5

2023 ADMINISTRATIVE BUDGET ASSUMPTIONS

KERN HEALTH SYSTEMS MEDI-CAL ADMINISTRATIVE EXPENSES	2023 BUDGET		2022 ESTIMATED		DIFFERENCE	
Administrative:	PMPM	$	PMPM	$	PMPM	$
Compensation	11.59	48,218,491	10.20	39,108,465	1.39	9,110,025
Purchased Services	5.01	20,816,085	3.20	12,251,429	1.81	8,564,656
Supplies	0.49	2,045,056	0.34	1,289,093	0.16	755,963
Depreciation	1.88	7,799,394	1.82	6,969,109	0.06	830,285
Other Administrative Expenses	1.33	5,511,660	1.04	3,984,730	0.29	1,526,929
Total Administrative Expenses	20.29	$ 84,390,686	16.59	$ 63,602,827	3.70	$ 20,787,859
Member Months		4,158,950		3,834,013		324,937

COMPENSATION

COMPENSATION EXPENSE WAS BASED ON STAFFING LEVELS NEEDED FOR THE GRADUAL ENROLLMENT OF 4,158,950 MEMBER MONTHS AND FOR THE IMPLEMENTATION AND MANAGEMENT OF BENEFITS AND PROGRAMS REQUIRED UNDER CALAIM.

1.) THE 2023 BUDGETED COMPENSATION AMOUNT INCLUDES AN INCREASE OF APPROXIMATELY $3,600,000 FOR 29 NEW ADMINISTRATIVE STAFF POSITIONS NEEDED FOR REGULATORY PROJECTS, AND TO SUPPORT OPERATIONAL IMPROVEMENTS, MEMBERSHIP GROWTH AND NEW BENEFITS. APPROXIMATELY $3,100,000 OF THE PROJECTED INCREASE IS FOR A 4% AVERAGE MERIT ADJUSTMENT, PROMOTIONS, AND A $5,000 PER EMPLOYEE INFLATION STIPEND ON JULY 1, 2023 FOR ALL EMPLOYEES.
2.) THE 2023 EXPENSE INCLUDES AN INCREASE OF APPROXIMATELY $2,400,000 FROM ESTIMATED 2022 EXPENSE DUE TO ESTIMATED INCREASES IN PAYROLL TAXES AND BENEFIT RATES, INCLUDING CALPERS AND EMPLOYER RETIREMENT CONTRIBUTIONS.

PURCHASED SERVICES

3.) THE 2023 BUDGET INCLUDES AN EXPECTED INCREASE OF APPROXIMATELY $3,800,000 FOR OUTSIDE PROFESSIONAL SERVICES AND CONSULTING NEEDED TO COMPLETE 2023 APPROVED PROJECTS WHICH INCLUDE REGULATORY REQUIRED PROJECTS AND AN EXPECTED INCREASE OF APPROXIMATELY $2,000,000 FOR PROFESSIONAL RESOURCES NEEDED TO SUPPORT THE OPERATIONS OF ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORT SERVICES PROGRAMS.
4.) THE 2023 BUDGET INCLUDES APPROXIMATELY $2,200,000 FOR INCREASES IN ANNUAL SYSTEM MAINTENANCE EXPENSES INCLUDING PURCHASES OF NEW LICENSES AND INCREASES TO INFORMATION SECURITY SYSTEM EXPENSES.
5.) THE 2023 BUDGET INCLUDES AN EXPECTED INCREASE OF APPROXIMATELY $500,000 FOR OTHER PROFESSIONAL SERVICES EXPENSES INCLUDING INCREASES IN ADVERTISING AND PROMOTIONS, EQUIPMENT MAINTENANCE AND REPAIRS, LEGAL EXPENSES, AND CLAIM PROCESSING EXPENSES.

SUPPLIES

6.) THE 2023 BUDGETED EXPENSE FOR SUPPLIES INCLUDES AN INCREASE OF APPROXIMATELY $750,000 FOR SUCH OFFICE ITEMS AS LETTERHEAD, ENVELOPES, OFFICE EQUIPMENT PURCHASES, AND SUPPLIES RELATED TO MEMBER MAILINGS INCLUDING POSTAGE.

DEPRECIATION

7.) THE 2023 DEPRECIATION EXPENSE IS EXPECTED TO INCREASE APPROXIMATELY $800,000 DUE TO A FULL YEAR OF EXPENSE FOR CAPITALIZED ASSETS COMPLETED AND PUT INTO PRODUCTION IN 2022, INCLUDING NEW SOLAR PANELS.

OTHER ADMINISTRATIVE EXPENSES

8.) THE 2023 BUDGETED EXPENSE FOR OTHER ADMINISTRATIVE EXPENSES REFLECTS INCREASES OF APPROXIMATELY $500,000 IN RECRUITMENT EXPENSES AND TRAINING & DEVELOPMENT EXPENSE.
9.) THE 2023 BUDGET INCLUDES AN EXPECTED INCREASE OF APPROXIMATELY $1,000,000 FOR OTHER ADMINISTRATIVE EXPENSES INCLUDING INCREASES IN REGULATORY LICENSE FEES, EMPLOYEE TRAINING COSTS, UTILITIES AND MISCELLANEOUS OTHER EXPENSES.

ATTACHMENT 6

KERN HEALTH SYSTEMS

2023 BUDGETED FTE BY DEPARTMENT

	EXPECTED MEMBERSHIP		327,200	350,850	350,450	350,850	351,250	351,650	350,250	348,450	347,050	345,450	343,850	342,250	4,188,950	
CC	DEPARTMENT	PROJECTED DECEMBER 2022	JAN 2023	FEB 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023	JULY 2023	AUGUST 2023	SEPT 2023	OCT 2023	NOV 2023	DEC 2023	TOTAL 2023	TOTAL 2023 FTE ADDITIONS
ADMINISTRATIVE FTES:																
110	EXECUTIVE	6	-	-	-	-	-	-	-	-	-	-	-	-	6	-
210	FINANCE	15	-	-	-	-	-	-	-	-	-	-	-	-	15	-
220	INFORMATION TECHNOLOGY	24	6	-	-	-	-	-	-	-	-	-	-	-	30	6
222	ENTERPRISE DEVELOPMENT	20	2	-	-	-	-	-	-	-	-	-	-	-	22	2
230	CLAIMS	61	1	-	-	-	-	-	-	-	-	-	-	-	62	1
240	PROJECT MANAGEMENT	10	2	-	-	-	-	-	-	-	-	-	-	-	12	2
320	PROVIDER NETWORK MANAGEMENT	27	-	-	-	-	-	-	-	-	-	-	-	-	27	-
330	MEMBER SERVICES	98	9	-	-	-	-	-	-	-	-	-	-	-	107	9
340	CORPORATE SERVICES	12	-	-	-	-	-	-	-	-	-	-	-	-	12	-
360	COMPLIANCE & REGULATORY AFFAIRS	8	3	-	-	-	-	-	-	-	-	-	-	-	11	3
420	MARKETING	4	2	-	-	-	-	-	-	-	-	-	-	-	6	2
510	HR	16	1	-	-	-	-	-	-	-	-	-	-	-	17	1
682	D-SNP/MEDICARE	0	3	-	-	-	-	-	-	-	-	-	-	-	3	3
MEDICAL FTES:																
211	BUSINESS INTELLIGENCE	20	2	-	-	-	-	-	-	-	-	-	-	-	22	2
310	UTILIZATION MANAGEMENT	69	2	-	6	-	-	3	-	-	-	-	-	-	80	11
311	QI	21	-	-	-	-	-	-	-	-	-	-	-	-	21	-
312	HEALTH ED	20	1	-	-	-	-	-	-	-	-	-	-	-	21	1
313	PHARMACY	10	-	-	-	-	-	-	-	-	-	-	-	-	10	-
314	ENHANCED CARE MANAGEMENT	27	2	-	-	3	-	-	3	-	-	-	-	-	35	8
315	POPULATION HEALTH MANAGEMENT	40	3	-	-	-	-	-	-	-	-	-	-	-	43	3
317	COMMUNITY SUPPORT SERVICES	7	3	-	-	-	-	-	-	-	-	-	-	-	10	3
319	HHIP	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-
315	IPP	2	-	-	-	-	-	-	-	-	-	-	-	-	2	-
410	MEMBER ENGAGEMENT	1	4	-	-	-	-	-	-	-	-	-	-	-	5	4
691	BEHAVIORAL HEALTH	2	3	-	-	-	-	-	-	-	-	-	-	-	5	3
692	HEALTH EQUITY	0	3	-	-	-	-	-	-	-	-	-	-	-	3	3
	TOTAL	521	52	-	6	3	-	3	3	-	-	-	-	-	588	67

Attachment 7

KERN HEALTH SYSTEMS

ATTACHMENT 7

2023 New Employee Requests

Background:

Budget period 2023 is a continuation of the major transformation occurring with the Medi-Cal Managed Care Plans throughout California. The CalAIM initiatives will add several new benefits, expansion of membership, implementation of specific initiatives, and significant growth over the next three (3) years. To be successful in implementing the expanded regulatory requirements, KHS will have to expand in all functional areas and in some instances create new departments to be in regulatory compliance with DHCS. For 2023, the addition of full-time employees (FTEs) will be prioritized by focusing on strengthening regulatory compliance and implementation of CalAIM initiatives previously outlined in the 2023 corporate goals.

Described below is each department's additional FTE needs for 2023.

Process:

The KHS CEO and CFO met with each department to review all budgets and staffing requests. After the review was completed, **67 new FTEs** are deemed necessary positions required to meet the various departments demand resulting from:

- Expansion of DHCS programs, primarily from CalAIM initiatives, required over the next several years (D-SNP; NCQA Accreditation; Behavioral Health Program; Quality and Health Equity Program; Expansion of Telehealth Benefit)
- Increase in membership due to Medi-Cal eligibility membership being transferred from the State's Fee for Service Programs
- Increased focus on member Quality scores and overall regulatory compliance
- DHCS Incentive Programs (Incentive Payment Program, Housing and Homelessness Incentive Program, and Student Behavioral Health Improvement Program)
- Expanding health plans' role in data collection, compilation, formatting, presentation and filing requirements as mandated by DHCS and DMHC.

KERN HEALTH SYSTEMS

Department Specific Staffing Needs:

- **Information Technology (IT)**

  IT requires **6 FTEs** to manage the increased demand for more complex systems and population management as prescribed by DHCS with the CalAIM strategy. The CalAIM approach has placed a significant demand on the Clinical operations for initiatives such as PHM, ECM, CSS, MOT, and LTC, and so **2 FTEs** are required to provide support for the Enterprise Configuration team to complete the additional workload over the JIVA Medical Management System.

  Another significant requirement for CalAIM is member and provider engagement. Over the next two years, KHS will transform how it interacts with members and providers and **1 FTE** is required to support the call center, IVR campaigns, local and wide area networking, and internet connectivity. Historically for the last two years, this role has been filled by a consultant and the need to migrate from consulting to a permanent position will provide cost savings.

  As KHS grows, and adds 67 employees in 2023, **1 FTE** is needed to support the employee growth in end user support through the organizations help desk function. This role will be added to the existing three help desk analysts that exist today to work on initial support calls.

  Information Security is an essential function at KHS to safeguard and protect the company's digital asset. The Security Analyst at KHS has been with KHS for over seven years and is an active military reservist. Over the years, KHS has been able to provide coverage and **1 FTE** is required to provide continuous cyber security oversight to systems and the expansion of health information data exchanges with numerous provider groups and other third parties.

  Additionally, **1 FTE** is required to support the need for a new Quality Assurance (QA) program that will perform internal technical audits to ensure that all regulatory deliverables are reviewed for quality. This new role will institute and manage various routine and unplanned inspections for management to establish a quality assurance system.

KERN HEALTH SYSTEMS

- **Enterprise Development (ED)**

  ED requires a total of **2 FTEs** to keep up with overall growth and demand on Medi-Cal health plans from DHCS. This department is responsible for all data management for the company in the data warehouse; software system integrations; and third party (i.e., providers, supplemental benefits) data transformation and delivery. With CalAIM putting more demand on population health and data driven work approaches, this team has seen a significant increase in the data being managed by the plan and its partners. The ED department requires 2 FTEs for the Database Development and Operations team to manage and support the complex and growing database systems infrastructure needs for the organization.

- **Claims Adjudication and Processing**

  Claims requires **1 FTE** to meet the demand of growing regulatory implementations as well as the increase in claims volume. Claims volume will increase due to additional populations and benefit offerings required under Cal-Aim implementations.
  (Necessary to fulfill DHCS performance standards and service requirements in 2023)

- **Project Management (PM)**

  The PM department requires **2 FTEs** to keep up with the consistent need for new projects to meet the demands of more sophisticated, complex technical infrastructure, performance requirements from DHCS, DMHC and NCQA. The staff will be required to support the need for additional corporate projects to ensure that all regulatory deliverables are managed through the required related business and technical projects.

- **Member Services (MS)**

  The Member Services and grievance teams require **9 FTEs** to keep up with the growth in membership by approximately 15,000 members and the rising demand of incoming and outgoing customer service transactions. The Grievances & Appeals regulatory requirements as set forth by DHCS in APL 17-006 whereby all member dissatisfactions are considered grievances, has also increased in volume, administrative oversight, and reporting requirements. Furthermore, APL 21-004 requires Managed Care Plans to adopt additional grievance procedures that provide for the prompt and equitable resolution of discrimination related grievances.
  (Necessary to fulfill DHCS performance standards and service requirements in 2023)

KERN HEALTH SYSTEMS

- **Compliance and Regulatory Affairs (CRA)**

  The compliance and regulatory oversight needs to be fortified due to the financial and operational risk for the plan. CRA requires **3 FTEs** to support the increased number and complexity of regulatory requirements issued through All Plan Letters and other Directives, anticipated increases in Corrective Action Plan development and follow up related to upcoming Routine DHCS and DMHC Medical Audits, increased workload related to 2024 Contract Readiness Activities which includes the submission of approximately 150 deliverables in 2023 and resuming/expanding upon internal audits of operational areas from a contractual and DMHC/DHCS Audit perspective.
  (Necessary to fulfill DMHC and DHCS performance standards, filings, and service requirements in 2023)

- **Marketing**

  The Marketing department requires **2 FTEs** to enhance member, provider, employee, and corporate communications and to implement strategic approaches to maximize the continuity of coverage as normal eligibility and enrollment operations resume as per DHCS APL 22-004. Marketing will improve and expand communications by promoting KHS accomplishments and community benefits to our employees, providers and community, along with overseeing the development of messaging for member omnichannel communications. Marketing will lead vital Medi-Cal redetermination efforts in Kern County in collaboration with county, provider, and community partners.

- **Human Resources (HR)**

  HR requires **1 FTE** as an Instructional Designer in the Learning and Development ("L&D") area. With the addition of new departments, CalAIM requirements, a planned project to increase functionality and reporting in our current Learning Management System ("LMS"), the revision of all of our Compliance Courses to reflect updated laws and regulations, along with the integration of the LMS to provide resources for the Provider and Member portals, this position will enable the L&D Team to complete the 2023 anticipated project slate without extensive overtime or overburdening the existing team.

KERN HEALTH SYSTEMS

- **Dual Eligible Special Needs Population (D-SNP) and Medicare (New Department for 2023)**

  D-SNP requires **3 FTEs** to meet the new DHCS requirement to have a D-SNP operational by January 1, 2026. 1 FTE will serve as the Executive Director of Medicare and will be responsible for overall management, planning and setting of strategic objectives.1 FTE will serve as the Compliance Specialist and will be responsible to set up and implement the compliance monitoring program and oversight for the Medicare DSNP line of business by ensuring compliance with all applicable federal, state and county rules and regulations including but not limited to regulatory guidelines/policies/procedures. 1 FTE will serve as the D-SNP Quality RN and will be responsible for the solutioning/design and implementation of the KHS quality program, policies and procedures to ensure the Medicare D-SNP line of business meets or exceeds quality standards for HEDIS, Medicare 5-Star Quality, NCQA, CMS Quality measures and D-SNP Quality Measures. This team will be charged with leading the D-SNP roadmap for the organization.
  (Necessary to meet DHCS requirement in 2026)

- **Business Intelligence (BI)**

  BI requires **2 FTEs** to manage the increase in demand for more sophisticated analytics and reporting requirements on Medi-Cal health plans from DHCS, DMHC and NCQAA. This department is tasked with all reporting and analytics for the company. Much of the additional work in 2023 originates from the CalAIM strategy that is being implemented by KHS. Additionally, frequent audits, the consistent delivery of numerous APLs to the plan, and the new DSNP line of business will put even more demand on the BI department. The BI Department has not increased its FTE count over the last 2 years, but instead augmented with consultants. Since the demand for additional hours that will be persistent in future years, the Department requires 2 additional FTEs to support the growth in the workload

- **Utilization Management (UM)**

  UM requires **11 FTEs** to support the increased membership enrollment and volume of prior authorization requests to ensure compliance with DHCS requirements for decision timeliness. 7 FTEs will be Non-Clinical Intake coordinators (medical assistant level) and 2 will be Clinical Intake coordinators (RN level). Additionally, 2 new Clinical Intake coordinators (RN Level) will be needed for the new Long-Term Care (LTC) benefit in 2023 for oversight and census management with KHS physician involvement to ensure the care delivery setting is appropriate for the member's clinical and behavioral needs.
  (Necessary to fulfill DHCS performance standards, service requirements and new benefit in 2023)

KERN HEALTH SYSTEMS

- **Health Education (HE)**

  HE requires **1 FTE** to meet KHS' growing and diverse demands for health education program and services. The FTE will be a Health Education Assistant and will allow the department to continue to process referral requests for health education services from providers, members, internal KHS staff and community partners. This position will assist members with registering for KHS' health education services, provide technical assistance to members when accessing these services through KHS' virtual class platform, communicate member participation to the PCP and coordinate access to educational literature and resources. Health education services are not only required under KHS' contract with DHCS, but it is also a key component of prevention and wellness programs as part of KHS Population Health Management model of care and obtaining future NCQA accreditation.
  (CalAIM Expansion)

- **Enhanced Care Management (ECM)**

  ECM requires **8 FTEs** to assist with care management and outreach support to network ECM provider sites. As a key part of CalAIM, ECM is a Medi-Cal benefit available to select "Populations of Focus" that will address clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. In 2023, the ECM program will be adding 4 more sites/providers to the ECM network. As a result of this expansion, ECM requires 1 ECM Department Trainer for initial and ongoing training required for our ECM providers/sites, 1 ECM Nurse Auditor to support the quality audits required to be done for each site to ensure compliance with the ECM program requirements, 2 ECM Outreach Specialists to outreach to new members for enrollment and continued engagement into the program and 4 ECM Advocates for placement directly with ECM providers/sites, for continued member engagement and to serve as a liaison between the site and KHS.
  (CalAIM Expansion)

- **Population Health Management (PHM)**

  PHM requires **3 FTE** Licensed Vocational Nurse ("LVN") positions to support and fulfill the carve-in benefit responsibility for Long Term Care ("LTC") beginning January 1, 2023. The LVNs will provide care management and coordination to moderate and low risk level referrals. The LVNs will be assigned to approximately 200 referrals and conducting site visits in various facilities.
  (Necessary to fulfill DHCS performance standards and service requirements in 2023)

KERN HEALTH SYSTEMS

- **Community Support Services (CSS)**

  CCS requires **3 FTEs** to support additional services being offered effective January 1, 2023 such as Respite Care, Medically Tailored Meals, and Sobering Centers. Based on initial estimates, approximately 78,000 members will be considered eligible to receive these new services. Beginning July 1, 2023 additional services we be added including Nursing Facility Transition/Diversion, Community Transition Services/Nursing Facility Transition, Personal Care and Homemaker Services.
  (CalAIM Expansion)

- **Member Engagement (ME) - New Department for 2023**

  ME requires **4 FTEs** to encourage members to become more active and empowered in their health care, provide the right communication at the right time, create equity of access to health resources, and improve member health disparities. The FTEs will coordinate member engagement strategies for all KHS departments that serve members so that gaps are identified, successful strategies are shared, and member satisfaction and utilization are improved throughout the member's continuum of care.
  (Necessary to fulfill DHCS performance standards and service requirements in 2023)

- **Behavioral Health (BH) - New Department for 2023**

  BH requires **3 FTEs** as managed care plans have experienced a number of behavioral health focused services that transitioned under their scope of services. In 2018, the managed care plans assumed responsibility of Autistic Behavioral Therapy (ABA) and non-specialty mental health service delivery. Most recently, the plans are to collaborate with specialty mental health providers to incorporate a "No Wrong Door" structure which requires close engagement between providers in coordinating behavioral and mental health care for the member, regardless of initial screening or service entry point. Accordingly, with this increased focus on care integrations, the need to develop a department is essential.
  (Necessary to fulfill DHCS performance standards and service requirements in 2023)

- **Health Equity (HE) - New Department for 2023**

  CalAIM requires the implementation of a health equity program that will lead the health plan in the development of program services to address the specific inequities in care. This new department will initially require **3 FTEs** to take lead on these initiatives and ensure regulatory requirements are met. This team will also lead the member engagement initiatives to focus on addressing social determinants of health to specific ethnic groups and geographic disparities.
  (Necessary to fulfill DHCS performance standards and service requirements in 2023)

KERN HEALTH SYSTEMS
2023 CAPITAL BUDGET

ITEM	CORPORATE PROJECTS	TYPE	QTR	COST	NOTES	2022	2021	2020	TOT. PRJ. [2]	CalAIM
1	Member Engagement System	B	3,4	$ 658,500					$ 658,500	Y
2	DSNP MCAS Star Software	N	3,4	$ 408,500					$ 408,500	Y
3	Population Health Management	N	1,2,3,4	$ 351,000					$ 351,000	Y
4	DSNP CRM System	B		$ 275,000					$ 275,000	Y
5	DSNP JIVA Medicare Module	N	3,4	$ 281,750					$ 281,750	Y
6	DSNP Risk Adjustment Software	N	3,4	$ 250,000					$ 250,000	Y
7	Data Lineage and Cataloging System	N	1,2	$ 181,012		$ 139,381			$ 320,393	N
	CORPORATE PROJECT SUBTOTAL			**$ 2,405,762**		**$ 3,664,556**	**$ 3,358,394**	**$ 5,362,940**	**$ 2,545,143**	
	BUILDING IMPROVEMENTS, OFFICE FURNITURE, & EQUIPMENT		**QTR**	**COST**		**2022**	**2021**	**2020**	**ROJECT COST**	
8	Office Furniture and Equipment	N	1,2,3,4	$ 560,000		$ 169,000	$ 88,250	$ 343,000	N/A	N
	OFFICE FURNITURE & EQUIPMENT SUBTOTAL			**$ 560,000**		**$ 169,000**	**$ 88,250**	**$ 343,000**	**N/A**	
	TECHNOLOGY		**QTR**	**COST**		**2022 [3]**	**2021 [3]**	**2020 [3]**		
9	Information Security (InfoSec) Software	N	1,2,3,4	$ 750,000		$ 50,051	$ 73,165	$ 69,791	N/A	N
10	Infrastructure Growth and Expansion	N	1,2,3,4	$ 582,000		$ 964,320	$ 197,743	$ 247,276	N/A	N
11	Employee Equipment	N	1,2,3,4	$ 290,000		$ 186,258	$ 167,168	$ 74,070	N/A	N
12	Core System Licensing [4]	N	3,4	$ 443,590		$ 624,264	$ 253,861	$ 417,275	N/A	N
	TECHNOLOGY SUBTOTAL			**$ 2,065,590**		**$ 1,824,893**	**$ 691,937**	**$ 808,412**	**N/A**	
	TOTAL 2023 CAPITAL ITEMS			**$ 5,031,352**		**$ 5,658,449**	**$ 4,138,581**	**$ 6,514,352**	**$ 2,545,143**	

(1) Type R is a Renewal or Replacement / Type N is New / Type B is Both
(2) Does not include ongoing maintenance and support that is expected not to exceed 10% of the total project cost during the initial five years
(3) Actual Expenditures
(4) Pending 2022 Invoice from Microsoft

2023 Capital Summary

Corporate Projects

1. ***Member Engagement System***
   Member engagement is the ongoing interaction between a member and an organization in exchange for meaningful value. Kern Health Systems (KHS) has procured and built several systems over the years to facilitate the organizations member engagement. These systems include the customer service phone calls (cold calls); social media; member website portal; mobile phone application; texting software; automated phone calls (robocalls); online and mobile health risk assessment applications; member rewards; and a Patient Access API (Interoperability). As per policy, KHS reviews major systems after two contract renewals, and the KHS member and provider portal are due to be bid out again in 2023. The incumbent vendor for the portals has been acquired and has outlined a new roadmap for their platform. This project will review all the member engagement systems that exist within KHS and potentially consolidate into a new core member engagement platform.
   (Budgetary Impact: $658,500.)

2. ***DSNP Managed Care Accountability Sets (***MCAS***) Star System***
   Medicare uses a Star Rating System to measure how well Medicare Advantage and Part D plans perform. Medicare scores plan performance in several categories, including quality of care and customer service. Ratings range from one to five stars, with five being the highest and one being the lowest. The Star Ratings system helps Medicare consumers compare the quality of Medicare health and drug plans being offered so they are empowered to make the best health plan selection. The Star Ratings system financially rewards higher-performing plans. As part of the DSNP Line of Business KHS will need to procure a system to manage the plan's Star rating using the collective KHS data set.
   (Budgetary Impact: $408,500.)

3. ***Population Health Management Screening Tools***
   Population Health Management screening tools and health surveys are used by health plans to engage with members and providers. Member satisfaction surveys are required and necessary to keep in touch with the needs of our membership, increasing the effectiveness and efficiency of each visit, and improving patient outcomes. The Health Plan is expected to use surveys from various medians such as provider and member portals, phone, apps, and point of service methods. Additionally, CalAIM requires plans to address Social Determinants of Health that is best captured by direct member applications and tools. This project will expand the

current health surveys tools and system integration needed to accommodate the additional CalAIM requirement in 2023.
(Budgetary Impact: $351,000.)

4. ***DSNP Customer Relationship Management (CRM) System***
As part of the DSNP Line of Business (LOB), KHS will need to procure a Customer Relationship Module system that allows the plan to store customer and prospect contact information, identify sales opportunities, and manage marketing campaigns all in one central location. The CRM will store all customer information about every interaction for anyone at the company who might need it for reporting and analytics. KHS will need to market and engage potential members for the DSNP Medicare product. This will require KHS to procure a CRM system to perform the complexity of calculating return on investment (ROI); allow for planning; and implement marketing campaigns.
(Budgetary Impact: $275,000.)

5. ***DSNP JIVA Medicare Module***
KHS leverages the ZeOmega JIVA software as the core medical management system. This system stores all clinical information and provides the many operational workflows in a single location for medical management to function. As part of the DSNP LOB, KHS will review and may procure the ZeOmega JIVA Medicare Module in 2023 as part of the comprehensive review of the systems for the DSNP LOB.
(Budgetary Impact: $281,750.)

6. ***DSNP Risk Adjustment Software***
Risk Adjustment is a statistical technique that calculates a relative risk score which can be accumulated to compare health risks of a population and of individuals. This process often uses the Hierarchical Condition Category to estimate future health care costs for patients. As part of the DSNP Line of Business, KHS will need to ensure that Dual eligible members are being properly evaluated and that they receive the appropriate diagnosis, risk code, treatment, and outcomes for their specific set of conditions and disease states. KHS will need to gain insights into provider performance and capabilities, as well as the current health condition of this population for evaluation and consideration for developing care programs. This project will review and procure a system or vendor that will perform these functions for the health plan.
(Budgetary Impact: $250,000.)

2023 Capital Summary

7. ***Data Lineage and Cataloging System***
As KHS has grown in members, utilization, and new programs, so has the amount of data that KHS manages. Examples of these data sets include Electronic Medical Records, laboratory results, vision encounters, pharmacy data, and claims. The data is stored in the Enterprise Data Warehouse (EDW) and normalized for the business to perform analytics and reporting. To ensure that strong organizational data governance occurs, a data lineage software tool is required. Today, KHS uses manual processes and audit reporting to facilitate this aspect of data governance and will replace the manual system with a commercial enterprise data lineage system. Data lineage software will provide KHS with tools that dynamically source data origins, how it is transformed, and reduce data errors for analytics and reporting.
(Budgetary Impact: $181,012.)

Office Furniture

8. ***Office Furniture and Equipment***
Corporate Services is responsible for maintaining appropriate office furniture to accommodate current and future staffing levels and improving efficiencies in mail processing throughout the company. The furniture makeup includes items such as chairs, desks, credenzas, standing desks, cubicle furniture, and office configuration. In 2023, KHS will be centralizing much of its printing fulfillment into the Corporate Services Department to create a more efficient mail processing system that will automate most mail processing tasks. Equipment needed includes a paper folder/inserter, postage machine, an industrial capacity printer, and the associated software.
(Budgetary Impact: $560,000.)

Technology

9. ***Information Security (InfoSec) Solutions***
KHS is responsible for safeguarding the Personal Healthcare Information (PHI) of its members. On an annual basis, KHS solicits a third-party audit of its Information Security system and strategy. Two recommendations from the prior audit were that KHS improve its manual Security Information Event Management (SIEM) and to deidentify PHI in non-production environments known as data masking. This capital expenditure will provide KHS with the procurement, installation, and configuration of a software based SIEM tool and Data Masking software solution to continue to protect the organizations data assets.
(Budgetary Impact: $750,000.)

2023 Capital Summary

10. Infrastructure Growth and Expansion

Annually, KHS reviews data center equipment (i.e., Servers, memory, disks, etc.) for replacement and growth based on prior year growth trends; manufacturers life cycle and support; normal wear and tear; utilization performance; and potential new systems that will be installed. Based on this review, this capital expenditure will provide the procurement of additional data center hardware for the 2023 calendar year to meet the organization's demands.
(Budgetary Impact: $582,000.)

11. Employee Equipment

Each year KHS procures various types of desktop equipment for employees. This equipment can be attributed to a change in role, new employee hires, or aged equipment that is no longer supported. For 2023, KHS is proposing to hire 67 new employees which require new operation set-ups. Also on the schedule is the replacement of forty-nine (49) outdated laptops. The average costs per employee and laptop replacement is $2,500 per desktop environment and this includes the desktop computer, dual monitors, cisco telephone and associated hardware.
(Budgetary Impact: $290,000.)

12. Core System Licensing

Annually, KHS is contractually obligated to audit various operational systems for licensure. The operational systems in this category are the core member and claims processing system (Cognizant QNXT); the clinical management system (ZeOmega JIVA); and the employee desktop and data center server software (Microsoft). The licensure models are either users based (per employee) or member based (Medi-Cal membership). These audits are normally based on a "True-up" process where KHS pays for new licenses in use at the end of the calendar year based on the license model.
(Budgetary Impact: $443,590.)

KERN HEALTH SYSTEMS
TANGIBLE NET EQUITY (TNE) REVIEW
2023 BUDGET

	12/31/2021 ACTUAL $	12/31/2022 ESTIMATED $	12/31/2023 BUDGET $
CAPITAL RESERVE	$ 247,476,323	$ 280,090,057	$ 274,325,581
CALCULATION OF MINIMUM TANGIBLE NET EQUITY (TNE) AMOUNT (1)	$ 51,387,565	$ 51,470,471	$ 60,909,984
CAPITAL RESERVE AS % OF TNE	481.59%	544.18%	450.38%
CURRENT BOARD APPROVED TNE TARGET RANGE	500% - 600%	500% - 600%	500% - 600%

(1) AMOUNT BASED ON DMHC'S CALCULATION FOR MINIMUM TNE USING ANNUAL HEALTHCARE EXPENSES

Attachment 9

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Richard M. Pruitt, Chief Information Officer

Date: December 15, 2022

Re: Project Consulting Professional Services

Background

Over the last few years, KHS started a transformation so that the convergence of the Health Plan, Clinician (Medical & Behavioral), Member/Patient, Social Services, and Community Supports are communicating/coordinated when rendering their respective services so that holistic care is being delivered.

All of this is being accomplished by KHS through people (staff), processes, and systems as outlined by the State of California through the CalAIM initiatives (https://www.dhcs.ca.gov/calaim#initiatives).

Each year, the organization augments the workforce by outsourcing with consultants, thus avoiding full-time employee hires, to accommodate the temporary resource demands of the organizational projects.

Requested Action

Recommend to the Board of Directors to authorize the CEO to approve contracts associated with the procurement of Professional Resources to various consulting companies in the amount not to exceed $15,066,478 in operating and capital expenses associated for labor needed to complete the 2023 corporate and department projects.

KERN HEALTH SYSTEMS

To: **KHS Board of Directors**

From: **Alan Avery, COO**

Date: **December 15, 2022**

Re: **Agreement with Kern County Department of Human Services**

Background

During the Public Health Emergency, the annual eligibility redetermination (renewal) process required by the Centers for Medicare and Medicare Services and Kern County Department of Human Services (KCDHS) for Medi-Cal beneficiaries was suspended. That suspension is anticipated to be withdrawn with the elimination of the Public Health Emergency sometime during the first quarter of 2023. With that elimination, KCDHS will be required to implement the redetermination process for all Medi-Cal participants.

KHS management has reached out to KCDHS to help in coordinating the redetermination of Medi-Cal beneficiaries as this will be a huge undertaking. The first phase of that coordination includes finalizing an Agreement between KHS & KCDHS to share ongoing beneficiary demographic change information. KHS will develop an extensive member outreach communication campaign to members requesting they update their contact information with KCDHS and/or KHS. KCDHS reports that approximately 70% of the beneficiaries require manual intervention for their renewal, primarily due to incorrect contact information or missing documentation. Demographic data changes will then be shared between the two entities.

The second phase of the redetermination coordination will involve KCDHS embedding dedicated Human Services Technicians (HSTs) within the KHS offices to assist KHS members to resolve redetermination eligibility issues. KCDHS has agreed to provide 3-5 HSTs beginning February 1, 2023. KHS will provide office space and technology assistance for the dedicated HST staff. KHS has also agreed to provide reimbursement of KCDHS personnel costs of the agreed upon number of HST staff, not to exceed $85,000 per employee with the total costs to be paid by KHS not to exceed $425,000 per year with a maximum total not to exceed $850,000 over the two-year term of the agreement.

Requested Action

Recommend to the Board of Directors to authorize the CEO to sign the Medi-Cal Outreach, Enrollment and Renewal Assistant Agreement with KCDHS for an amount not to exceed $425,000 per year with a maximum total not to exceed $850,000 over the two-year term of the agreement.

KERN HEALTH SYSTEMS

TO: **KHS Board of Directors**

FROM: **Emily Duran, Chief Executive Officer**

DATE: **December 15, 2022**

RE: **COVID-19 Vaccination Incentive Program Summary**

Background

The Department of Health Care Services (DHCS) allocated up to $250 million to incentivize COVID-19 vaccinations for Medi-Cal managed care plans for COVID-19 vaccinations received September 1, 2021 through February 28, 2022. This voluntary incentive program was targeted to increase COVID-19 vaccinations in general with a focus on four targeted member populations:

*Members who are homebound and unable to travel to vaccination sites
*Members who are 50-64 with multiple chronic conditions
*Members who self-identify as persons of color
*Youth 12-25 years of age

Kern Health Systems (KHS) developed an aggressive COVID-19 vaccination plan and received approval from DHCS to encourage expansion of vaccination sites, increase member outreach and education, expand provider engagement and member acceptance, and increase the vaccination rates. The attached report highlights the success of the KHS vaccination plan including the use of pop-up clinics, community efforts, increased media campaigns, implementation of reservation specialists and direct member financial incentives.

In summary, KHS member vaccination rates increased from 41.7% who were fully vaccinated in September 2021 to 55.4% as of February 2022 which equates to over 41,000 additional members being vaccinated.

The report provides additional details of the results of the program and closes out the KHS Vaccination Plan.

Requested Action

Receive and File.

KERN HEALTH SYSTEMS
COVID-19 VACCINATION
INCENTIVE PROGRAM

Report Prepared
for
KHS Board of Directors

December 15, 2022

Emily Duran, CEO, Kern Health Systems
Emily.Duran@khs-net.com

Table of Contents

Background

The department of Healthcare Services (DHCS) allocated up to $250,000,000 to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery system from September 2021 to the end of February 2022. This incentive program was a voluntary program that focused on increasing COVID-19 vaccination rates among the Medi-Cal population, especially for populations that experienced disproportionate challenges in the initial phases of the vaccine distribution. The populations that encountered this disparity were homebound members; members between 50 and 64 years of age with chronic health issues; persons of color; and youth ages 12 through 25. To increase the vaccination rates among Kern Health Systems' (KHS) members, KHS quickly developed and launched a robust and intense COVID-19 Vaccination Plan. This plan not only aimed to increase the vaccination rates, it also encouraged the expansion of vaccination sites and increased outreach and education.

COVID-19 Pop-Up Clinics

KHS provided support to many pop-up clinics throughout the county in collaboration with other organizations. KHS also held two COVID-19 Vaccination events at the Buck Owens office in conjunction with the Latino COVID Taskforce and Kern Medical.

Vaccination Clinics supported by KHS included:

- **Cal State University of Bakersfield -** KHS and Kern Medical provided on-campus vaccination clinics once a week for 6 months for students and the public.
- **Kern County Latino-COVID 19 Taskforce -** provided vaccination events throughout Kern County along with education and mental health service and help lines through June 2022.
- **No Sister Left Behind –** provided vaccination clinics at the MLK Park Gym in January/March 2022 with education to our African American Community.
- **California Farmworker Foundation** - provided 22 vaccination clinics at worksites/communities in northern and southern Kern to over 20,000 Kern County farmworkers and 20 employers including direct education through early March 2022.
- **Delano Union School District –** held vaccine events at school sites once a month for the 2021-2022 school year where they successfully vaccinated 400-500 individuals.
- **Other Vaccination Clinics -** KHS providers held various vaccination clinics and organized targeted pop-up clinics in areas of Kern that were more likely to be unvaccinated such as Delano, Wasco, Taft, Southeast Bakersfield, and East Kern.

COVID-19 Community Efforts Supported by KHS

KHS is invested in community efforts around increasing the health and wellbeing of our members. As such, KHS partnered with various community partners and groups ranging from Kern County Supervisor Leticia Perez, the African American Chamber of Commerce and local churches through the African American Collaborative. KHS worked closely with the Vision y Compromiso, family resource centers, and community health workers to disseminate information. KHS is proud to have contributed to the COVID-19 vaccination rate increase by way of providing support to the Kern Behavioral Health & Recovery Services, Kern County Public Health Department's Black Infant Health Program, and Central California Asthma Collaborative

KHS Media & Staffing Efforts

In addition to the groundwork KHS laid to increase vaccination rates, KHS launched a robust media campaign. Efforts included a GET Bus Fall Pocket Map, targeted digital messaging on mobile devices and social media platforms, billboards in targeted locations, public service announcements, and television ads in collaboration with the Latino COVID Taskforce, Dignity Health, Kern Public Health, and No Sister Left Behind.

KHS also conducted direct member outreach efforts that included direct member mailings to all KHS eligible member households and robocall campaigns that provided members information about the COVID-19 Vaccine Direct Member Incentive Program, ways to schedule a vaccination appointment, and transportation assistance.

In addition, KHS hired Member Services Reservation Specialists who performed direct member outreach to assist members with scheduling vaccination appointments using the MyTurn portal, locating a walk-in vaccination site, providing assistance with transportation to and from vaccination appointments, and transferred members to a doctor who would speak to them about concerns with the vaccine.

Direct Member Incentive

The Department of Health Care Services (DHCS) provided a direct member incentive reimbursement offer for up to $50.00 (fifty-dollars) to each fully vaccinated plan member to incentivize members to get vaccinated. KHS' COVID-19 Vaccine Direct Member Incentive Program provided this incentive to members beginning September 1, 2021. Members who received the Moderna or Pfizer COVID-19 Vaccinations, were mailed a $25.00 (twenty-five dollars) gift card for each dose of the vaccine totaling $50 when fully vaccinated. For members who received the Johnson & Johnson vaccines, members were sent a $50.00 (fifty-dollars) gift card. Though the DHCS reimbursement offer ended on February 28, 2022, KHS extended the offer through the end of March 2022 to all eligible members 5 years and older. KHS continues to incentivize high risk members to get vaccinated or boosted.

Provider Incentive Program

KHS developed a Provider Incentive Program that rewarded network providers with specified measures of improvement in vaccination rates.

Results & Outcomes

Kern County's vaccination rates in September 2021 were 39%. By February of 2022, vaccination rates were up to 62%. The results of these efforts are a reflection of community collaboration and partnerships Kern Health Systems aims to continue and build. Kern Health Systems is dedicatedly serving our members by increasing accessibility to health care services by designing, launching, and implementing programs that are robust in launch, active in nature, and provide positive outcomes for our members and their wellbeing, especially those who are encountering disparate health inequities.

Below are the results depicting 86% (eighty-six percent) participating providers who met all three measurement baselines and received maximum incentive payout.

VIP Provider Results	
Provider Type	**Number of Participating Providers**
Primary Care Physicians	**19**
Safety Net Providers	**3**
Specialist	**11**
Pharmacies	**16**

Table 1: Describes VIP Provider Results Depicting 86% meeting measurement baselines

Below are Kern Health Systems Member Vaccination Results

KHS Member Vaccination Results	
September 2021	**41.7% KHS members fully vaccinated**
February 2022	**55.4% KHS members fully vaccinated**
Vaccinated between Sep '21 – Feb '22	**41,297 KHS Members**
Direct Member Incentive	**$2,600,000**

Table 2 Describes Vaccination Results by Percentage and Incentives Received.

Pre & Post COVID-19 Vaccination Efforts

Below are the results of pre and post vaccination rates of Kern Health System Members by ethnicity. The results below indicate how impactful and beneficial the COVID-19 vaccination incentive program was to our members in Kern. These results are also indicative of the level of service delivery and streamlined effort Kern Health Systems commits to its members.

Ethnicity	% of Members	Pre Vaccination Rate	Post Vaccination Rate	Vaccination Rate Increase %
HISPANIC	61.45%	44.2%	59.6%	34.7%
CAUCASIAN	17.75%	31.4%	41.4%	31.8%
NO VALID DATA	9.34%	41.5%	52.1%	25.4%
AFRICAN AMERICAN	6.14%	26.6%	42.3%	59.1%
UNKNOWN	0.88%	53.2%	64.9%	21.9%
ASIAN INDIAN	1.66%	73.2%	83.0%	13.4%
FILIPINO	1.36%	72.7%	83.0%	14.1%
ASIAN/PACIFIC	0.63%	56.0%	66.9%	19.5%
ALASKAN/AMER INDIAN	0.23%	32.3%	43.0%	33.1%
CAMBODIAN	0.09%	51.4%	62.2%	21.1%
VIETNAMESE	0.21%	79.2%	86.4%	9.0%
CHINESE	0.09%	74.8%	81.7%	9.3%
SAMOAN	0.02%	33.3%	45.8%	37.5%
LAOTIAN	0.03%	50.0%	64.9%	29.7%
KOREAN	0.07%	78.6%	83.1%	5.8%
HAWAIIAN	0.02%	51.4%	59.5%	15.8%
GUAMANIAN	0.01%	20.0%	40.0%	100.0%
JAPANESE	0.01%	50.0%	61.5%	23.1%
Grand Total		**41.7%**	**55.4%**	**32.9%**

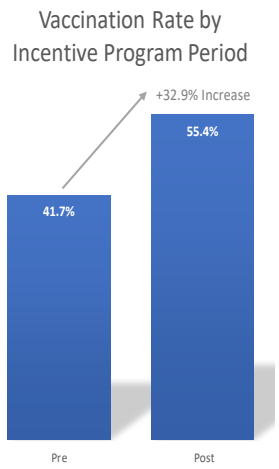


Table 3 Describes Vaccination Rate of KHS Members by Ethnicity over Incentive Program Time Period.

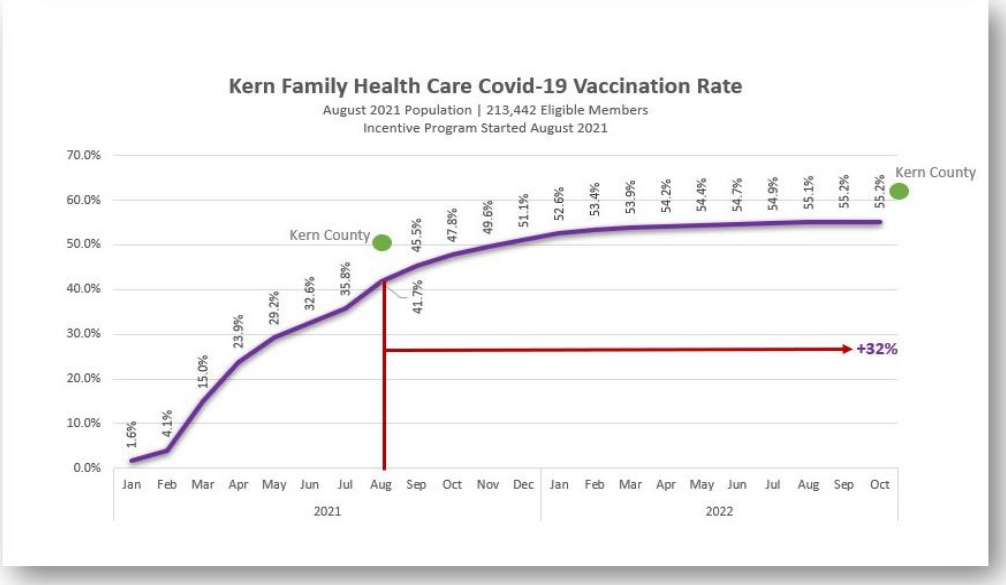


Table 4 Describes Kern County Vaccination Rate Over Time

To: KHS Board of Directors

From: Deborah Murr, MHA, BS-HCM, RN Chief Health Services Officer

Date: December 15, 2022

Re: Quality Improvement Program Documents

Background

All Medi-Cal Managed Care Plan Quality Improvement (QI) Programs are defined by three documents:

- The Quality Improvement Program Description,
- The Quality Improvement Program Evaluation, and
- The Quality Improvement Program Work Plan

These documents are updated annually and presented to the Physician Advisory Committee, QI-UM Committee, and the Board of Directors for review, input and approval. Opportunities identified in the previous year's QI Program Evaluation are considered in development of the following year's QI Program Description and Work Plan.

Discussion

2021 QI Program Evaluation (Attachment A)

The QI Program Evaluation reflects the outcomes for the primary QI program activities. Outcomes oftentimes drive changes to the QI Program Description or the next year. The QI Program Evaluation is performed annually. It is a reflection of the outcomes for the primary program objectives and activities. Outcomes from the annual program evaluations may drive changes to the QI Program Description for the next year. For example, results of the HEDIS/MCAS measures may influence Process Improvement Projects (PIPs) and/or Improvement Plans (IPs). Regulatory and contractual changes with DHCS may also provide input into the director for the following year's QI Work Plan.

2022 QI Program Description (Attachment B)

The QI Program Description provides an overview of KHS's QI Program objectives and program functions. The scope of the program is defined and describes how the program is integrated throughout all departments in the organization. The QI Program Description defines the lines of authority, with the CMO having primary responsibility and reporting up to the CEO and Board of Directors. The program description describes the role of KHS's Board (pg. 4) as well as the CMO and the associated committees (QI-UM Committee, Physician Advisor Committee, Pharmacy & Therapeutics Committee, the Public Policy/Community Advisory Committee and the Grievance Review Team). The structure of each of these committees is also defined.

2022 QI Program Work Plan (Attachment C)

The QI Program Work Plan identifies the primary activities that will occur throughout the current year. The activities may be ongoing, recurring ones, or they may be special projects or improvement plans. Outcomes of the Work Plan are key to the program evaluation.

Requested Action

Review and approve the 2021 QI Program Evaluation, 2022 QI Program Description, and the 2022 QI Program Work Plan.

Quality Improvement Program 2022

Board of Directors Meeting
December 15, 2022

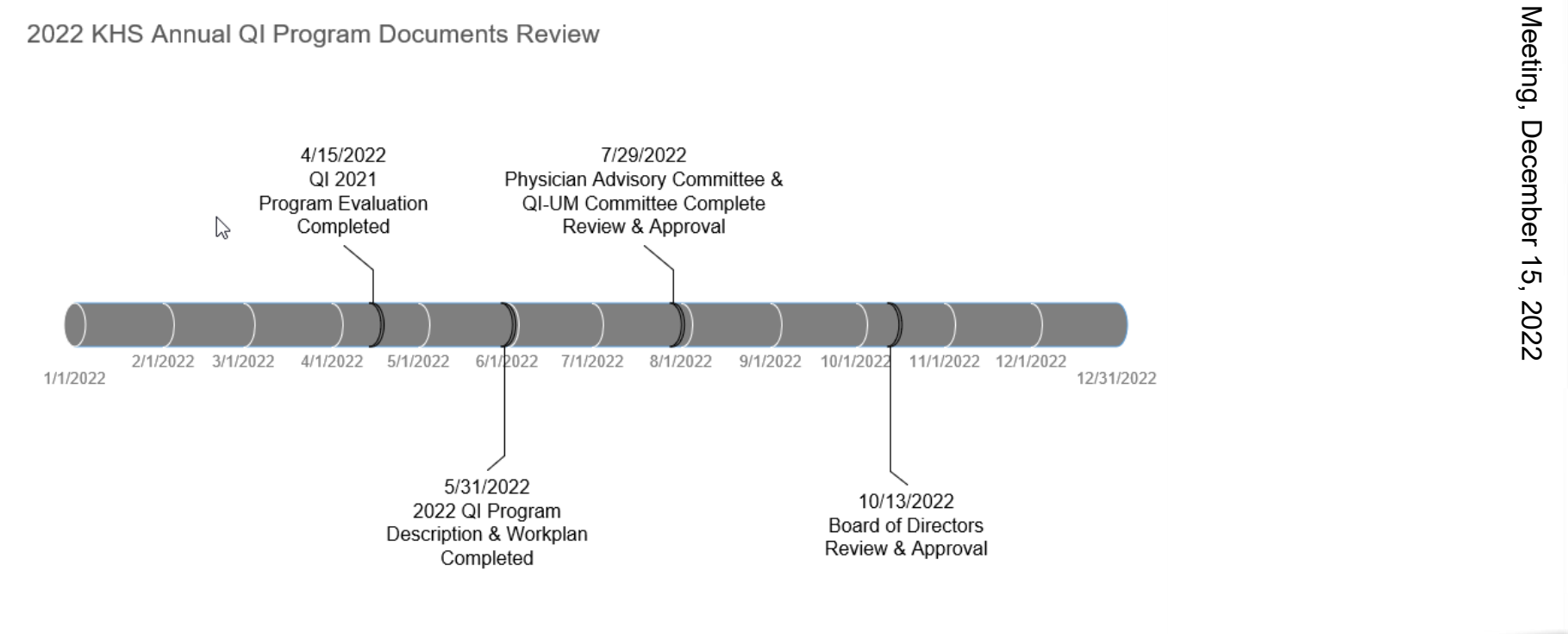
KERN HEALTH SYSTEMS

Agenda

- Annual Documents Development & Review Timeline
- Primary Impacts of COVID
- 2021 Quality Improvement Program Evaluation
- 2022 Quality Improvement Program Description
- 2022 Quality Improvement Workplan
- Program Direction for 2023

KERN HEALTH SYSTEMS

Quality Improvement Program: Annual Documents Development & Review Timeline



KERN HEALTH SYSTEMS

Quality Improvement Program - Primary Impacts of COVID

- Conducted Provider Site & Medical Record Review Virtually
  - Plan implemented to complete backlog of reviews by June 30, 2022
  - New DHCS Site Review Requirements delayed to July 1, 2022
- Though increased from 2021, volume of medical records retrieved for MCAS/HEDIS audit lower than non-pandemic times
- Fewer members seeking preventive health services when COVID spikes occurred

KERN HEALTH SYSTEMS

Quality Improvement 2021 Program Evaluation – MCAS Results MY2021

- Managed Care Accountability Set (MCAS)

Met MPL

✓ 5 Measures met MPL for MY 2021 compared to only 1 measure for MY2020

Improved

✓ 9 of 15 measures had improved compliance rates compared to MY2020

KERN HEALTH SYSTEMS

Quality Improvement 2021 Program Evaluation – Key Actions Completed

COVID Vaccination & Back to Care Promotion	MCAS Committee Implemented	Quarterly Quality meetings with network providers	3 Member Engagement & Rewards campaigns
6 Performance improvement projects in Children's & Woman's Health Domains •2 Mobile mammography events - results supported recommendation to expand mobile preventive health services	Enhanced process for RN and MD Review of QOC Grievances	Provider-level trending reports & outcome reports for MCAS initiatives	Gaps in Care visibility for member-facing, KHS departments
Gaps in Care visibility for members in Member Portal	Provider education & support for coding MCAS measures	KHS access to EMR systems for MCAS annual audit	Potential Quality of Care process enhanced for increased Medical Director-level Review for all PQIs

KERN HEALTH SYSTEMS

Quality Improvement
2022 Program Description

Overview:

- Defines QI Program goals, objectives & functions
- Defines program scope & integration throughout organization
- Defines lines of authority
- Identifies primary program activities

Key Changes for 2022

- Member Engagement & Rewards Program – 3 Campaigns Scheduled
- SWOT Action Plan focused on Children's Health Domain for MCAS measures
- COVID Vaccination Promotion
- Quarterly meetings for MCAS improvement collaboration with network providers
- Organizational Quality Incentives Project focused on actions to support MCAS measures compliance for MY2022

KERN HEALTH SYSTEMS

Approaches to Achieving MCAS Compliance

MEMBER

PROVIDER

DATA

KERN HEALTH SYSTEMS

Quality Improvement
2022 Workplan

The 2022 Workplan:

1. Identifies program's primary activities throughout current year

- Example: MCAS quality measures monitoring, access to care monitoring, grievance investigation involving quality of care.

2. Outlines: QI Work Activity, Special Projects and Performance Improvement Plans

3. Provides feedback for the 2022 QI Program Evaluation Results

- Identifies areas for improvement
- Validates and reinforces initiatives leading to favorable outcomes

KERN HEALTH SYSTEMS

Program Direction for 2023

Key strategies for 2023 for the QI Program

1. Complete readiness review & action plan for:
   - National Committee for Quality Assurance - Health Plan & Health Equity Accreditation
   - D-SNP Medicare certification
2. Re-structure Quality Improvement-Utilization Management Committee to align with DHCS Comprehensive Quality Strategy Plan
3. Implement Mobile Preventive Health Services Program
4. Incorporate Health Equity into QI metrics to address health disparities
5. Implement Provider Innovation Initiative to support provider practice behaviors that maximize our members' health and wellness

KERN HEALTH SYSTEMS

Requested Action

Requesting Board approval for the 2021 QI Program Evaluation, 2022 QI Program Description, and 2022 QI Program Work Plan

KERN HEALTH SYSTEMS

For questions, please contact:

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(661) 664-5141

KERN HEALTH SYSTEMS

Kern Health Systems
Quality Improvement Program Evaluation
Reporting Period: January 1, 2021 – December 31, 2021

1. QI ACTIVITIES

According to the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-017 (effective 12/26/2019), Quality and Performance Improvement Requirements, all Medi-Cal managed care health plans are contractually required to report annual performance measurements results selected by DHCS, participate in a consumer satisfaction survey when indicated by DHCS and conduct ongoing quality performance improvement projects (PIPs).

MANAGED CARE ACCOUNTABILITY SET (MCAS):

The 2021 edition of the Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of health care and services. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA), a private, not-for-profit organization dedicated to improving health care quality, since 1990.

All Medi-Cal managed care health plans must submit annual outcome measurement scores for the required Managed Care Accountability Set (MCAS) performance measures. MCAS measures are selected by DHCS and typically include a combination of HEDIS and Medicaid's Adult and Child Health Care Quality Measures.

The previous calendar year is the standard measurement year for MCAS data. Therefore, the MCAS Report Year (RY) 2021 results shown in this report reflect Measurement Year (MY) 2020 data. MCAS RY 2021 results can be found in Appendix A. DHCS has adopted a performance improvement tool known as the Plan Do Study Act (PDSA) to test change through rapid-cycle improvement when a Managed Care Plan (MCP) performs below the Minimum Performance Level (MPL) of the 50th percentile. The MPL is set by DHCS and the percentile benchmarks are provided by NCQA in their annual Quality Compass Report. The number of required PDSAs is determined by DHCS based on the MCP's overall performance in that MY. MCPs that fail to meet MPLs are subject to sanctions and may also be subject to Corrective Action Plans (CAPs).

The COVID-19 virus pandemic has continued throughout 2021. KHS worked from home for all of 2021 for safety reasons. Visits by KHS staff to provider offices did not occur in 2021 for the protection of KHS staff, providers, and members. This continued to impact the collection of medical records that would have normally been retrieved as part of the process for measuring compliance outcomes of MCAS for MY2020/RY2021. That factor, but more importantly, the reduced volume of members going to their PCP for preventive health services continued to reflect in significantly lower than normal compliance rates for the MCAS measures. Outside of the pandemic, KHS would likely would have seen significantly higher compliance rates for the MCAS measures.

KHS was compliant with 1 out of 19 MCAS Measures (see **Appendix A**).

The one measure met was:

- PPC-Post: Timely post-partum care, PPC-Post.

4 measures were within 5% of compliance:

- IMA-2: Immunizations for Adolescents (met MPL)
- AMP-B: Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing
- BCS: Breast Cancer Screening
- CHL: Chlamydia Screening in Women Ages 16 – 24

4 out of the 19 measures showed improvement from the previous year:

- CDC-H9: HbA1c Poor Control (>9.0%)
- CBP: Controlling High Blood Pressure <140/90 mm Hg
- AMR: Asthma Medication Ratio
- BCS: Breast Cancer Screening

Factors impacting compliance with MCAS measures included:

- Change of the MPL benchmark from the 25th percentile to the 50th percentile beginning with MY 2019. We have not been able to meet the new benchmark for most measures.
- Reduced volume of preventive health services delivered due to safety concerns from the COVID-19 pandemic.

DHCS advised the Medi-Cal managed care plans (MCPs) that sanctions and corrective action plans for MY2020 MCAS results will not be applied. DHCS required KHS to conduct a new Strengths-Weaknesses-Opportunities-Threats (SWOT) project from September 2021 through May 2022 with a focus on improving measures in the Children's Health Domain.

A copy of the SWOT Analysis and initial SWOT Action Plan (SAP) can be found in Appendix B. The analysis and SAP were initiated in the 4th quarter of 2021 and will continue through May of 2022.

CONSUMER STATISFACTION SURVEYS:

Per MMCD APL 19-017, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both adults and children is administered every two years by the External Quality Review Organization (EQRO) contracted by DHCS for each MCP. The survey was administered in Measurement Year (MY) 2020 and results were provided in 2021 by DHCS. DHCS provided the sample of member information for contracted health plans to the EQRO. The CAHPS survey summary results are as follows:

The standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Surveys was designed to support members in assessing the performance of health plans and choosing the plans that best meet their needs. Health plans can also use the survey results to identify their strengths and weaknesses and target areas for improvement.

Results for each enrollee population are provided for the core survey composite measure questions and rating questions. There are four categories under **Composite Measures**: *Getting Needed care, Getting Care Quickly, How Well Doctors Communicate and Health Plan Information and Customer Service*. The **Rating questions** are categorized into *Rating of personal doctor, Rating of specialist, Rating of all health care and Rating of health plan*. The summary-level results calculated from CAHPS Health Plan Survey data are for Adult and Child health plan enrollee populations.

KSH Adult CAHPS Scores: For MY2020 Adult CAHPS survey, out of the four composite measures, *'How Well Doctors Communicate,'* scored highest with 70% of respondents indicating that their doctors always communicated well. *'Getting Needed care'* scored the lowest with 46% satisfaction. The specific question that scored low in this category is *'Got appointment with specialist as soon as needed'*. For the Rating category, *Specialist Seen Most Often* and *Rating of Personal Doctor* had the highest score at 79%. Rating of *All Health Care* scored lowest with

73.99%. Compared to MY2018 most of the categories showed improvement except *Rating of health of plan* which decreased by 2.23% and *Getting care needed* which decreased by 0.64%.

Adult Survey Categories	Higest Scored Item	Oppurtunity for Improvement (Lowest Scored item)
Composite Measures	How Well Doctors Communicate-70%	Getting Needed care-46%
Rating Category	Specialist Seen Most Often and Rating of Personal Doctor -79%	Rating of All Health care-73.99%

KHS Child CAHPS Score: For MY2020 Child Survey, the only statistically valid measure out of all the **Composite Measure** categories was '*How Well Doctors Communicate*' which scored 68% satisfaction. Remaining categories were not applicable (NA) because the measure had less than 100 responses. Under **Rating category**, *Rating of All Healthcare* scored highest with 88% satisfaction. *Rating of Personal Doctors* scored lowest with an 85% satisfaction score. In the Child **Rating Category**, *Rating of All Health Care* and *Rating of Health Plan* increased compared to the past two years. *Rating of Personal Doctor* decreased by 2.25% compared to MY2018, indicating this is one of the areas with opportunity for improvement.

Child Survey Categories	Higest Scored Item	Oppurtunity for Improvement (Lowest Scored item)
Composite Measures	How Well Doctors Communicate-70% (The only statistically vaild measure)	NA- Remaining all categories were not applicable
Rating Category	Rating of All Health care- 88%	Rating of Personal Doctor -85%

A detailed summary of KHS' MY2020 CAHPS survey is provided in **Appendix B** and the results are planned for presentation to the MCAS Committee in Q1 of 2022.

PROCESS IMPROVEMENT PROJECTS (PIPs):

Performance Improvement Projects (PIPs) are a key federal protocol used by DHCS for the External Quality Review (EQR) of MCPs. DHCS has identified two categories for the two PIPs MCPs are required to conduct. The first is Child and Adolescent Health and the second is Health Equity. Each PIP occurs over approximately 18 months. MCPs must design PIPs to systematically improve these areas. The PIPs are designed to enhance quality and outcomes of health care for Medi-Cal members.

KHS's PIPs started in 2020 and will be completed at the end of 2022. The two active PIPs during 2021 included:

1. Child-Adolescent Health Domain PIP: Improving Asthma Medication Ratio Compliance in Children 5-11 & Adolescents 12-21 years of age, and

2. Health Disparity PIP: Improving the Health and Wellness of Low-Income Children and Adolescents, Ages 3 to 21, Through Well-Care Visits.

Each PIP utilizes a rapid cycle improvement model. The core component of the model includes testing changes on a small-scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation that informs the project theory and practice during the improvement project.

Both PIPs identified completed 2 of the 4 modules and both modules were accepted by DHCS. Module 1 focused on outlining the framework for each project and Module 2 identified the quality improvement activities that have a potential impact to the SMART Aim (defining the population and PIP process). Modules 3 and 4 will be completed in 2022. Module 3 focuses on testing the interventions and Module 4 is a conclusive summary of the project.

2. FACILITY SITE REVIEWS AND COLLABORATION

Kern Health Systems (KHS) QI nurses who are DHCS-certified site reviewers perform a facility site review on all contracted primary care providers (PCP). This includes Internal Medicine, General and Family Practice, OB/GYN and Pediatricians serving in PCP capacity in free-standing offices, IPAs, or Clinics.

Personnel performing the site review are trained by a DHCS certified Master Trainer nurse on the required criteria for site compliance. All contracting plans within a county have equal responsibility for the coordination and consolidation of provider site reviews. Site review responsibilities are shared equally by all plans within the county. KHS has a Memorandum of Understanding (MOU) with Health Net, and both plans share site review information.

The purpose of conducting site reviews is to ensure that all contracted PCP sites used by managed care plans for delivery of services to plan members have sufficient capacity to: 1. provide appropriate primary health care services; 2. carry out processes that support continuity and coordination of care; 3. maintain patient safety standards and practices; and 4. operate in compliance with all applicable federal, state, and local laws and regulations.

Due to the COVID-19 pandemic, DHCS allowed an alternative mode of conducting on-site, site and medical record reviews via virtual review. This alternate to complete the reviews virtually was used for all of 2021. This direction was provided in APL 20-11, Governor's Executive Order N-55-20 In Response to Covid-19. DHCS has advised that they will accept full site and medical record

reviews done virtually during the COVID-19 pandemic and Public Health Emergency.

A new All Plan Letter, 20-006, Site Reviews: Facility Site Review and Medical Record, was scheduled to take effect July 1, 2020. This was also delayed until 6 months after the PHE has ended.

In the fall of 2021, one of our existing Certified Site Reviewers (CSR) achieved DHCS certification as a Master Trainer. Filling that role allowed us to have another QI RN complete DHCS certification as a CSR.

Due to the COVID-19 pandemic and the impact of not being able to conduct in person site and medical records reviews, a backlog of reviews accrued. A backlog evolved for the majority, if not all, MCPs. In the fall of 2021, DHCS required all MCPs to submit plans and goals to eliminate the backlogs resulting from the pandemic. KHS has targeted having our backlog of site and medical record reviews cleared by the end of the 2nd quarter in 2022.

3. MONITORING AND FOCUS REVIEWS

All PCP sites are monitored between each regularly scheduled full scope site review survey. Methods for conducting this review may include site visits but may also include methodologies other than site visits. Monitoring sites between audits includes the use of both internal systems and external sources of information. Evaluation of the nine critical elements is monitored on all sites between full scope site surveys. The nine critical elements are as follows:

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

The focused review is a "targeted" audit of one or more specific site or medical record review survey areas and is not substituted for the full scope survey. Focused reviews are used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. The nine critical elements are always reviewed. Additional areas of monitoring may include but are not limited to:

• Diabetes Care Monitoring	• KRC Monitoring
• Asthma Care Monitoring	• Referral Process Monitoring
• Prenatal Care Monitoring	• SBIRT/Alcohol Misuse Screening and Counseling (AMSC) services Alcohol Misuse Screening and Counseling (AMSC) services
• Initial Health Assessment (IHA)	• Tobacco use
• IHEBA aka Staying Healthy Assessment	• Other preventive care services
• California Children's Service (CCS)	

KHS' QI Department uses a system for management and documentation of Site and Medical Record Reviews. This system is being used by many other MCPs.

4. DHCS Ad Hoc Facility Site Review Audit

On December 7 – 9, 2021 DHCS' Medical Monitoring Unit conducted an ad hoc, monitoring audit for a sample of KHS' PCP providers. The audit was completed primarily in person and consisted of a periodic site and medical record review. One provider was reviewed virtually. Findings for critical elements were corrected within the required 10 business days. Corrective Action Plans for non-critical element findings were completed within 30 days of notification of the findings. The audit was closed with no further action required.

QI PROGRAM OVERVIEW

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
General				
Oversight of all delegated QI functions for the following services: • Kaiser • VSP	Met	8/31/2021	QI delegation audit for Kaiser for the lookback period of April 1, 2019 through March 31, 2021 will be completed and any findings will have a corrective action plan completed.	Audit conducted on June 28, 2021. No findings identified. Complete copy of audit results available in **Appendix C** VSP audit is planned for 2022.
QI Policies and Procedures	Met	Ongoing	1. QI Policies and Procedures are updated every 3 years as well as reviewed periodically to comply with any new regulatory requirements. 2. Each policy and procedure are reviewed against the DHCS contract and regulatory requirements and revised as needed to ensure compliance. 3. Two policies were updated during the second quarter of 2021. 2.70-I Potential Inappropriate Care (PIC) and 20.50-I Medi-Cal Managed Care QI and Performance Improvement Program	Complete for 2021
Audits				

QI Program Evaluation 2021

Attachment A

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Site review (SR) timeliness audit	Met	12/31/2021	Site Review Timeliness – A spreadsheet of reviews due and reviews completed was obtained through our SR system. Most reviews were not timely due to the stay at home orders for the pandemic. This prevented us from going onsite to complete the reviews. A virtual process for completing reviews was used for all of 2021. Below is a table summarizing the reviews that were due in 2021 and the number completed. The number completed within timeliness standards and those that were not completed timely are also included. Priority was given to the full site and medical record reviews. For that reason, interim reviews did not occur. A plan to clear the backlog of untimely reviews was initiated in September of 2021 and is targeted for completion by the end of Q2 2022.	Partially Complete for 2021

Type of Review	Total Number of Reviews Due	Number of Reviews Completed	Number of Reviews Completed & Met Timeliness Stds	Number of Reviews Not Completed
Initial full site reviews	12	12	12	0
Initial medical record reviews	9	9	9	0
Periodic full site reviews	32	32	0	20
Periodic medical record reviews	22	22	0	20
Interim reviews	7	0	0	7
Total – All reviews	**75**	**75**	**31**	**40**

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Staying Healthy Assessment	Met	12/1/2021	416 positive Staying Healthy Assessments (SHAs) were identified through and MCAS chart review. These were forwarded to Health Education for follow up member outreach and education.	Complete for 2021
30-day readmission	Met	Ongoing	The QI department continues to look for opportunities for improvement in members who are readmitted within 30 days of discharge. There were 200 re-admissions evaluated for quality of care (QOC) concerns in 2021. 50 cases were selected each quarter and the standard investigation and provider follow up was completed to focus on any QOC issues related to the member's re-admission.	Complete for 2021
Notifications (Death, General)	Met	Ongoing	UM nurses refer those death notifications in which there is a suspected quality of care concern. In 2021, there were a total of 7 referrals submitted. Each of these was investigated using the standard process and provider follow up to focus on any QOC issues related to the member's death.	Complete for 2021
Potential Inappropriate Care	Met	Ongoing	In August of 2021, a clinical auditing process was developed for monitoring of PQI reviews to ensure compliance with KHS policies and procedures and appropriate clinical assessment and documentation. Beginning in Q2, the QI Manager began conducting quarterly audits of a sample of PQI cases completed by each QI nurse who reviews PQIs. For audit results that did not achieve a passing score of 90%, the QI Manager followed the corresponding action plan and addressed the areas of deficiency with the assigned QI nurse to remedy the deficiencies within 5 business days of shared audit findings. The corrections were reflected on the next audit.	Complete for 2021

QI Program Evaluation
2021

Attachment A

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Grievances	Met	Ongoing	All grievances classified as a potential inappropriate care concern are referred to the QI Department. These referrals are investigated according to our Potential Inappropriate Care policy and procedure (2.70-I) and all cases with an actual or potential quality of care concern are reviewed by a KHS medical director to complete their review, render a final determination of the risk level, and identify follow up actions needed. Quality of care issues may result in tracking and trending or a corrective action plan. This information is shared with the Chief Medical Officer during the re-credentialing process. The Physician Advisory Committee is utilized for consultation and advisement as needed. The bulk of PIC referrals are from member Grievances. In 2021, QI received 759 PIC referrals from the Grievance team which represents 9.1% of all Grievances received.	Complete for 2021
Resources				
• Director of Quality Improvement	Not Met	Ongoing	A Director of QI is currently in place.	Complete for 2021
• QI Clinical Manager	Met	Ongoing	The original QI manager hired in Q1 of 2021 resigned within 2 months of starting. A new manager was hired in May of 2021 and is in place.	Complete for 2021
• QI Operations Supervisor	Met	Ongoing	An Operations Supervisor was in place for 2021	Completed for 2021
• QI RN II	Met	12/31/21	One QI RN I achieved her DHCS Master Trainer certification and was promoted to a QI RN II. This was a planned promotion.	Complete for 2021

QI Program Evaluation
2021

Attachment A

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
• QI RN I	Met	12/31/2021	During 2021 3 QI RNs resigned. The 3 positions underwent active recruitment into 2022.	Partially Complete for 2021
• QI Coordinator	Met	Ongoing	QI Coordinator currently in place	Complete for 2021
• QI Assistant	Met	12/31/2021	The QI Assistant transferred to another department at KHS. The position was changed to a Senior QI Coordinator with certified medical assistant credentials and filled in November of 2021.	Complete for 2021
• Senior Operational Analyst	Met	12/31/2021	The staff member for this position was promoted to a Senior QI Operational Analyst. This was planned promotion.	Complete for 2021
• QI Program Manager	Met	12/31/2021	This is a new position that was approved to provide primary, project management support for the annual MCAS audit and rate submission along with program management for other key projects and programs within the QI Department. This position was filled in the 1st quarter of 2021	Complete for 2021
• Senior Support Clerk	Met	12/31/2021	QI Senior Support Clerk currently in place	Complete for 2021
QI Projects				
Member Education Material	Met	12/31/2021	The HEDIS team, acting on provider request, obtained educational material for providers on the following topics: • Human papillomavirus (HPV) • Diet and Exercise for children • Avoidance of antibiotics for acute bronchitis • Language Line Access flyers • BMI Wheels • Provided links to the CLEA Waivers	Partially Completed for 2021

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			• Nutrition Booklets • Immunization Growth Charts Due to the pandemic, distribution of these educational materials did not occur in 2021. KHS' public website was leveraged to upload both member and provider materials with a focus on resources and tips to consider in light of the COVID-19 pandemic.	
Member Engagement and Rewards Program	Met	12/31/2021	A new program was implemented in the first Quarter of 2021. The program includes outreach to members with MCAS measure gaps in care to educate them on the importance of receiving the preventive care services and inform them of rewards they can earn by doing so. At total of 2 campaigns were completed in 2021. One in June/July and the second in October. <u>Results of before and 3 months after the June campaign</u> was completed identified increased levels of compliance for the following measures: • Timely Prenatal Visits • Child & Adolescent Well-Care Visits • Infant Well-Care Visits 2 measures demonstrated insignificant improvements: • Timely Post-Partum Visits • Initial Health Assessments. <u>Results of before and 3 months after the October campaign</u> was completed identified increased levels of compliance for the following measures: • Adolescent Well Care Visits	Complete for 2021

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>

Child Well Care Visits (3-6 y.o.)
Infant Well Care Visits (0-15 mos.)
Timely Post-Partum Visit

1 measure demonstrated insignificant improvement:

Timely Prenatal Visit

The outcomes for both campaigns demonstrated value for continuing the program and to recommend expansion with additional MCAS measures
<table>
<tr><th>Measure</th><th>Total Eligible Members</th><th>Members Who Achieved Reward</th><th>Reward $$ Paid</th></tr>
<tr><td>AWC – Adolescent Wellness Visit</td><td>9,293</td><td>9,239</td><td>$263,385</td></tr>
<tr><td>IHA – Initial Health Assessment</td><td>5,967</td><td>5,928</td><td>$72,815</td></tr>
<tr><td>PPC – Timely Post-partum Care</td><td>3,130</td><td>2,802</td><td>$98,313</td></tr>
<tr><td>PPC – Timely Prenatal Care</td><td>3,087</td><td>3,047</td><td>$99,928</td></tr>
<tr><td>W15 – Well Baby 0-15 mos</td><td>8,983</td><td>8,472</td><td>$133,994</td></tr>
<tr><td>W34 – Well Child 3-6 yo</td><td>7,344</td><td>7,265</td><td>$160,615</td></tr>
<tr><td>W30 – Well Baby 0-30 mos</td><td>8,003</td><td>6,792</td><td>$99,244</td></tr>
<tr><td>WCV – Child/Adol Well Care Visit</td><td>20,843</td><td>20,665</td><td>$357,349</td></tr>
<tr><td>Totals</td><td>66,650</td><td>64,210</td><td>$1,285,643</td></tr>
</table>
</td><td></td></tr>
<tr><td colspan="5">Committees</td></tr>
<tr><td>Quality Improvement/Utilization Management Committee (QI/UMC)</td><td>Met</td><td>Quarterly - ongoing</td><td colspan="2">1. Reports to the Board of Directors and retains oversight of the QI Program with direction from the Chief Medical Officer (CMO).
2. The QI_UM Committee disseminates the quality improvement process to participating groups and physicians, practitioner/providers, subcommittees, and internal KHS functional areas with oversight by the Chief Medical Officer.</td><td>Complete for 2021</td></tr>
</table>

QI Program Evaluation
2021

Attachment A

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>3. Committee also performs oversight of UM activities conducted by KHS to maintain high quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.
4. Eight (8) of the ten (10) positions are filled; four (4) QI/UMC meetings were held in the reporting period with attendance as follows:
<table>
<tr><th>QI/UM Committee Members</th><th>Attended</th></tr>
<tr><td>CMO</td><td>4 meetings</td></tr>
<tr><td>Family Practitioner</td><td>3 meetings</td></tr>
<tr><td>Family Practitioner</td><td>Open Position</td></tr>
<tr><td>1st Specialist (ENT)</td><td>4 meetings</td></tr>
<tr><td>2nd Specialist (OB-GYN)</td><td>4 meetings</td></tr>
<tr><td>FQHC Provider</td><td>2 meetings</td></tr>
<tr><td>Pharmacy Provider</td><td>3 meetings</td></tr>
<tr><td>Public Health Department</td><td>2 meetings</td></tr>
<tr><td>Home Health/Hospice Provider</td><td>Open Position</td></tr>
<tr><td>DME Provider</td><td>4 meetings</td></tr>
</table></td><td></td></tr>
<tr><td></td><td>Met</td><td>12/31/2021</td><td>1. Practitioner attendance and participation in the QI/UM Committee or subcommittees is required.
2. The participating practitioners represent a broad spectrum of specialties and participate in clinical QI and UM activities, guideline development, peer review committees and clinically related task forces.
3. Participation in committee meetings represented a quorum of members and was relevant to the QI activities undertaken by KHS.</td><td>Complete for 2021</td></tr>
</table>

Attachment A

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
	Met	12/31/2021	1. Practitioner participation and attendance for this reporting period continue to result in meaningful discussion and input from the committee members. 2. Participating practitioners involved in the QI Program serve as a communication representation for the practitioner community. 3. Committee members provide input and support toward educating participating providers about the principles of QI, and specific quality activities.	Complete for 2021
Physician Advisory Committee (PAC)	Met	12/31/2021	1. Serves as advisor to the Board of Directors on health care issues, peer review, provider discipline, and credentialing/recredentialing decisions. 2. This committee meets monthly and is responsible for reviewing practitioner/provider grievances and/or appeals, practitioner/provider quality issues, and other peer review matters as directed by the KHS Medical Director. 3. The PAC has a total of ten (10) voting committee positions. There were nine (9) active voting members in 2021.	Complete for 2021
	Met	12/31/2021	Ten (10) PAC meetings were held during the reporting period with attendance as follows: **Physician Advisory Committee Members** / **Attended** CMO — 10 meetings Pediatrician — 9 meetings Clinical Psychologist — Open Position Eye Specialist — 9 meetings OB/GYN Provider — 9 meetings	Complete for 2021

QI Program Evaluation
2021

Attachment A

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td><table><tr><td>Pain Medicine Provider</td><td>10 meetings</td></tr><tr><td>Family Practitioner</td><td>Open Position</td></tr><tr><td>Internal Medicine Provider</td><td>10 meetings</td></tr></table></td><td></td></tr>
<tr><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met</td><td>12/31/2021</td><td>1. Serves to objectively appraise, evaluate, and select pharmaceutical products for formulary addition or deletion.
2. This is an ongoing process to ensure the optimal use of therapeutic agents.
3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost.
4. Medications are evaluated on their clinical use and develop policies for managing drug use and administration.
5. Coordination with DHCS and the new, Medi-Cal Rx Pharmacy Benefit Management organization, Magellan, occurred in support of transition on January 1, 2022</td><td>Complete for 2021</td></tr>
<tr><td></td><td>Met</td><td>12/31/2020</td><td>Four (4) P&T meetings were held during the reporting period with attendance as follows:<table><tr><th>Pharmacy & Therapeutics Committee Members</th><th>Attended</th></tr><tr><td>CMO</td><td>4 meetings</td></tr><tr><td>Retail Pharmacy/Independent</td><td>4 meetings</td></tr><tr><td>Pediatrician</td><td>2 meetings</td></tr><tr><td>Retail Pharmacy/Chain</td><td>3 meetings</td></tr><tr><td>Board Member/Rx Representative</td><td>4 meetings</td></tr></table></td><td>Complete for 2021</td></tr>
</table>

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			Pharmacy/Specialty Practice: 1 meeting Pharmacy/Geriatric Specialist: Open Position Internal Medicine: 1 meeting General Practice/Geriatrics: 4 meetings KHS Pharmacy Director/Alternate Chairperson: 4 meetings	
Public Policy/Community Advisory Committee (PP/CAC)	Met	12/31/2021	1. PP/CAC provides a mechanism or structured input from KHS members and community representatives regarding how KHS operations impact the delivery of care. 2. The PP/CAC is supported by the Board of Directors to provide input in the development of public policy activities for KHS. 3. The committee meets every Quarter throughout the year and provides recommendations and reports findings to the Board of Directors.	Complete for 2021
	Met	12/31/2021	PP/CAC has fourteen (14) committee positions. All fourteen (14) positions were filled; Four (4) PP/CAC meetings were held in the reporting period with attendance as follows:	Complete for 2021

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Chair</td><td>4</td></tr>
<tr><td>KFHC Member</td><td>4</td></tr>
<tr><td>KFHC Member</td><td>4</td></tr>
<tr><td>KFHC Member</td><td>4</td></tr>
<tr><td>KFHC Member</td><td>4</td></tr>
<tr><td>KFHC Member</td><td>3</td></tr>
<tr><td>KFHC Member</td><td>3</td></tr>
<tr><td>KFHC Member</td><td>3</td></tr>
<tr><td>1 Member of KHS Boards of Directors</td><td>4</td></tr>
<tr><td>1 Participating Health Care Provider</td><td>4</td></tr>
<tr><td>Community Representative</td><td>4</td></tr>
<tr><td>Community Representative</td><td>4</td></tr>
<tr><td>Kern County Department of Human Services</td><td>4</td></tr>
<tr><td>Kern County Department of Public Health</td><td>3</td></tr>
</table>
</td><td></td></tr>
<tr><td>MCAS Committee</td><td>Met</td><td>12/31/21</td><td>1. Met six (6) times to evaluate status of compliance with MCAS measures to identify strengths and opportunities, and
2. Establish a strategic action plan to address opportunities for improvement with MCAS measures.</td><td>Complete for 2021</td></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><th>Committee Member Title</th><th>MCAS Committee Members</th><th># Meetings Attended</th></tr>
<tr><td>Chief Health Services Officer (Executive Sponsor)</td><td>Deborah Murr</td><td>6 meetings</td></tr>
<tr><td>Chief Medical Officer (Primary Clinical Advisor)</td><td>Martha Tasinga</td><td>3 meetings</td></tr>
</table>
</td><td></td></tr>
</table>

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			Director of Quality Improvement (Chair) — Jane Daughenbaugh — 6 meetings Manager of Quality Improvement — Kailey Collier or Nancy Sharif — 4 meetings QI MCAS Lead RN — Stephanie Kelly — 5 meetings Director of CM/PHM — Mike Pitts/Abbie Romo — 5 meetings Director of Business Intelligence — Cesar Delgado — 5 meetings Director of Compliance — Carmen Dobry or Jane MacAdam — 5 meetings Director of Health Education and Cultural & Linguistics Services — Isabel Silva — 6 meetings Director of Marketing and Public Relations — Louie Iturriria — 6 meetings Director of Member Services — Nate Scott — 5 meetings Director of Pharmacy — Bruce Wearda — 3 meetings Director of Utilization Management — Shannon Miller or Hadassah Perez — 5 meetings	
Regulatory Compliance				
DHCS audit	Met	9/13/21 – 9/24/21	DHCS conducted a virtual audit in September. Results of the audit are anticipated in the first quarter of 2022. Formal corrective actions for any findings will be developed and completed when the findings are received. In the interim,	Complete for 2021

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			each department involved in the audit initiated remediation/quality improvement actions based on verbal feedback received from DHCS during the virtual interviews.	
DMHC Audit	Pending	8/10/21 – 8/12/21	A follow-up review (Survey) by the Department of Managed Healthcare was conducted in August 2021 of outstanding deficiencies identified in the July 10, 2020 audit. 12 of 13 outstanding deficiencies were corrected. The remaining deficiency related to the language included in our letters when denying or modifying a request for a prescription drug is no longer an issue due to the transition of the prescription drug coverage to Medi-Cal Rx effective January 1, 2022.	Complete for 2021
Managed Care Accountability Set (MCAS) RY2020 Audit	Partially Met	7/2021	On 7/14/2021 we received our Medi-Cal Managed Care, HEDIS® MY2020 Compliance Audit™ Final Report. All elements of the HEDIS 2020 audit were complete and approved by HSAG and NCQA accepted our submission. KHS was compliant in meeting the minimum performance level (MPL) for 3 out of 18 MCAS Measures. • IMA-2: Immunizations for Adolescents • PPC-Pre: Timeliness of Prenatal Care • PPC-Post: Timeliness of Postpartum Care KHS was not compliant with the remaining 15 measures. Factors impacting compliance with MCAS measures: o DHCS changed the minimum performance level (MPL) from the 25th percentile to the 50th percentile in 2019 o COVID-19 reduced the volume of medical records retrieved due to safe distancing orders	Complete for 2021

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			Due to the pandemic, DHCS is not imposing sanctions or corrective action plans for MCAS RY2020 results.	
Performance Improvement Projects (PIPs), Plan-Do-Study-Act (PDSA) Projects, and Quality Improvement Project (QIP)				
Disparities in Well Child Visits (PIP)	New	12/31/2022	This PIP is focused on improving the health and well-being of children, ages 3 to 6 years, by aligning the Well Child Visit with industry standards of care and evidence-based practices. It was selected due to the importance of this preventive health measure for children to receive an annual well care visit. At the end of June 2020, DHCS informed the MCPs that the current cycle of PIPs was being halted due to the COVID-19 public health emergency as well as the transition of the External Quality Review Organization (EQRO) contract. In October of 2020, DHCS advised MCPs that a new cycle of PIPs would begin in November. KHS opted to retain the previous PIP topic for well child visits and that was accepted by DHCS. The new PIP will continue until the end of 2022.	Complete for 2021. Continuing until end of 2022
Child/Adolescent Health Asthma Medication Ratio (PIP)	New	12/31/2022	This PIP focuses on improving the health of members, ages 5-21 years, identified as having persistent asthma and who had a ratio of controller medication to total asthma medications of 0.5 or greater during the measurement year. It was selected based on MY 2020 MCAS results not meeting the MPL. At the end of June 2020, DHCS informed the MCPs that the current cycle of PIPs was being halted due to the COVID-19 public health emergency as well as the transition of the External Quality Review Organization (EQRO) contract. In October of 2020, DHCS advised MCPs that a new cycle of PIPs would begin in October. KHS opted to retain the previous PIP topic for well child visits and that was accepted by DHCS. The new PIP will continue the end of 2022.	Complete for 2021. Continuing until end of 2022

QI Program Evaluation
2021

Attachment A

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Increasing rate of Breast Cancer Screening for Women through Mobile Mammography PDSA by 5%	New	May 31, 2022	Complete at least 1 mobile mammography events in rural areas of Kern County to increase accessibility of screening to those who may not otherwise be able to obtain the service. Results of the first event supported moving forward with more mobile mammography events in 2022.	Complete for 2021
Increase the rate of infants aged 0 to 15 months in receiving 6 well care visits within that age timeframe by 5%	New	May 31, 2022	Complete at least one member outreach campaign inclusive of well care visits for infants 0 – 15 months old using the Member Engagement and Rewards Program (MERP) and partnering with Clinica Sierra Vista (CSV). Results of the event held in October support continuing with additional campaigns in 2022.	Complete for 2021
COVID QIP to support KHS members with information about COVID and the vaccine.	New	March 2022	Initiate a Quality Improvement project focused on educating members about COVID-19 and encouraging them to receive the vaccinations. The strategies focused on the following domains of healthcare: Behavioral Health, Chronic Disease, and Women's health. Strategies include partnering with Kern Behavioral Health and Recovery Services, Black Infant Health Program, Latino COVID-19 Task Force and CA State University Bakersfield.	Complete for 2021
Site Reviews				
• Initial	Met	12/31/2020	3 Initial Medical Record Reviews were due and completed and 9 Initial Full Site Reviews were due and completed. All CAPS and required follow-up visits were completed and closed.	Partially Completed for 2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			It should be noted that due to the stay-at-home, social distancing orders related to the pandemic in March of 2020, on site reviews were stopped. Around May, KHS initiated conducting virtual site and medical record reviews to the extent possible. The ability to conduct reviews virtually was dependent upon the provider's ability to participate. The pandemic caused many provider offices to close or to experience staffing shortages.	
• Periodic	Met	12/31/2020	23 Periodic Medical Record Reviews were due and 9 were completed. 26 Full Site Reviews were due and 11 were completed. PARS were reviewed and completed if needed. All CAPS and required follow-up visits were completed and closed. It should be noted that due to the stay-at-home, social distancing orders related to the pandemic in March of 2020, on site reviews were stopped. Around May, KHS initiated conducting virtual site and medical record reviews to the extent possible. The ability to conduct reviews virtually was dependent upon the provider's ability to participate. The pandemic caused many provider offices to close or to experience staffing shortages.	Partially Completed for 2020
• Focused	Met	12/31/2020	40 interim reviews were due, and none were completed. A decision was made not to do these reviews due to the challenges resulting from the pandemic for stay-at-home, social distancing orders. Providers were severely impacted by	Partially Completed for 2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			the pandemic causing many offices to close or to experience severe staffing shortages.	

Appendix A

Measurement Year 2020/Report Year 2021
MCAS Results

MY2020 MCAS Rate Tracking Report
Hybrid Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2020 HPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
CCS	Cervical Cancer Screening	54.01	61.31	72.68	56.20	-7.30	-2.19
CIS-10	Childhood Immunization Status	22.87	37.47	52.07	29.93	-14.60	N/A
CDC-H9*	HbA1c Poor Control (>9.0%)	50.85	37.47	27.98	57.91	-13.38	7.06
CBP	Controlling High Blood Pressure <140/90 mm Hg	52.07	61.8	72.75	38.93	-9.73	13.14
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	33.09	36.86	50.85	41.36	-3.77	-8.27
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	70.07	89.05	95.86	84.18	-18.98	-14.11
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	77.62	76.4	84.18	81.02	1.22	-3.40
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	63.50	80.5	90.77	66.42	-17.00	N/A
WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	52.80	71.55	85.16	NA	-18.75	N/A
WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	51.09	66.79	81.02	NA	-15.70	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

QI Program Evaluation
2021

Attachment A

Administrative Measures Held to MPL							
Measure		Current MY2020 Rate	MY2020 MPL	MY2020 HPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
AMM -Acute	Antidepressant Medication Management – Acute Phase Treatment	48.05	53.57	64.29	50.24	-5.52	-2.19
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	31.77	38.18	49.37	32.64	-6.41	-0.87
APM–B	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing	50.00	54.42	69.66	NA	-4.42	N/A
APM–C	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Cholesterol Testing	16.67	37.08	58.40	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	56.34	NA	-18.76	N/A
AMR	AsthmaMedication Ratio	54.39	62.43	73.38	48.78	-8.04	5.61
BCS	Breast Cancer Screening	54.50	58.82	69.22	57.29	-4.32	-2.79
CHL	Chlamydia Screening in Women Ages 16 – 24	54.02	58.44	71.42	55.29	-4.42	-1.27
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	92.31	82.09	87.91	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

Appendix B

KHS' MY2020 CAHPS Survey Summary

CAHPS Detailed
Summary Report - 1(

Appendix C
2021 Quality Improvement Delegation Audit – Kaiser Permanente

Department
Summary Report- Qu

Attachment B

KERN HEALTH SYSTEMS
Quality Improvement Program Description
2022

I. **Mission:** In a commitment to the community of Kern County and the members of Kern Health Systems (KHS), the Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of those being served. KHS' Quality Improvement Department manages the Program and oversees activities undertaken by KHS to achieve improved health of the covered population. All contracting providers of KHS will participate in the Quality Improvement (QI) program.

II. **Purpose:** Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative managing the medical and mild to moderate behavioral health care for Medi-Cal enrollees in Kern County. Specialty mental health care and substance use disorder benefits are carved out from KHS' Medi-Cal plan and covered by Kern County Behavioral Health and Recovery Services pursuant to a contract between the County and the State. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serve as the governing body for KHS.

KHS recognizes that a strong QI Program must be the foundation for a successful Managed Care Plan (MCP). In the basic program design and structure, KHS QI systems and processes have been developed and implemented to improve, monitor, and evaluate the quality and safety of care and service provided by contracting providers for all aspects of health care delivery consistent with standards and laws.

The KHS Quality Improvement Program Description is a written description of the overall scope and responsibilities of the QI Program. The QI Program actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members. This is accomplished through the development and maintenance of an interactive health care system that includes the following elements:

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
2. A process and structure for quality improvement with contracting providers. This includes identification of quality of care problems and a corrective action process for resolution for all provider entities.
3. Oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).
5. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

III. **Goals and Objectives:** KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. An

evaluation of program objectives and progress is performed by the QI Department on an annual basis with modifications as directed by the KHS Board of Directors. Results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QI Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.
4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers in an effort to seek solutions to problems that will lead to improved health care delivery systems.
5. Providing monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information, including
    - Over and underutilization data,
    - Grievances,
    - Potential and actual quality of care issues,
    - Accessibility of health care services,
    - Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services,
    - Pharmacy services, and
    - Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance with State and Federal requirements.
7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
10. Reviewing concerns regarding quality of care issues for members that are identified from grievances, the Public Policy/Community Advisory Committee (PP/CAC), or any other internal, provider, or other community resource.
11. Identifying and meeting external federal and state regulatory requirements for licensure.
12. Continuously monitoring internal processes in an effort to improve and enhance services to members and contracting providers.
13. Performing an annual assessment and evaluation of the effectiveness of the QI Program and its activities to determine
    a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care,
    b. The quality of service provided to members, and
    c. Modifications needed to the QI Program.

Results of the annual evaluation are presented to the QI/UM Committee and Board of Directors.

IV. Scope: The KHS QI Program applies to all programs, services, facilities, and individuals that have direct or indirect influence over the delivery of health care to KHS members. This may range from choice of contracted provider to the provision and a commitment to activities that improve clinical quality of care (including behavioral health), promotion of safe clinical practices and enhancement of services to members throughout the organization. The scope of the QI Program includes the following elements:

1. The QI Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
   a. KHS will not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
   b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QI Program reflects the population served and applies equally to covered medical and behavioral health services. With increased membership, the majority of KHS'membership has shifted from children (45%) to adults (55%). 52% of the membership falls into the adult age group up to age 64 years and approximately 3% fall into the age of 65 years or older. Gender distribution has between moved to an even distribution with 50% female members and 50% male members. The main ethnicity of our members is reported as Hispanic at 63% followed by Whites at 17% and African Americans at 6.4%.

2. The QI Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings.

3. The QI Program assessment activities encompass all diagnostic and therapeutic activities, and outcomes affecting members, including primary care and specialty practitioners, vision providers, behavioral health care providers, pharmaceutical services, preventive services, prenatal care, and family planning services in all applicable care settings, including emergency, inpatient, outpatient, and home health.

4. The QI Program evaluates quality of service, including the availability of practitioners, accessibility of services, coordination, and continuity of care. Member input is obtained through member participation on the Public Policy/Community Advisory Committee (PP/CAC), grievances, and member satisfaction surveys.

5. The QI Program activities are integrated internally across appropriate KHS departments. This occurs through multi-departmental representation on the QI/UM Committee.

6. Mental health care is covered jointly by KHS and Kern County Department of Health. It is arranged and covered, in part, by Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

Application of the Quality Improvement Program occurs with all procedures, care, services, facilities, and individuals with direct or indirect influence over the delivery of health care to members.

Quality Improvement Integration: the QI Program includes quality improvement, utilization management, risk management, credentialing, member's rights and responsibilities, and preventive health & health education.

V. Authority: Lines of authority originate with the Board of Directors and extend to contracting providers.

1. **The KHS Board of Directors:** The Board of Directors serves as the governing body for KHS. The Board of Directors assigns the responsibility to lead, direct and monitor the activities of the QI a program to the QI/UM Committee. The QI/UM Committee is responsible for the ongoing development, implementation, and evaluation of the QI program. All the activities described in this document are conducted under the auspices of the QI/UM Committee. The KHS Board of Directors are directly involved with the QI process in the following ways:

    a. Approve and support the QI Program direction, effectiveness evaluation, and resource allocation. Support takes the form of establishing policies needed to implement the program.
    b. Receive and review periodic summary reports on quality of care and service and make decisions regarding corrective action when appropriate for their level of intervention.
    c. Receive, review, and make final decisions on issues involving provider credentialing and recredentialing recommendations from the Physician Advisory Committee (PAC).
    d. Receive input from the Public Policy/Community Advisory Committee (PP/CAC).
    e. Receive reports representing actions taken and improvements made by the QI/UM Committee, at a minimum, on a quarterly basis.
    f. Evaluate and approve the annual QI Program Description.
    g. Evaluate and approve the annual QI Program Work Plan, providing feedback as appropriate.
    h. Evaluate and approve the annual QI Program Evaluation.
    i. Monitor the following activities delegated to the KHS Chief Medical Officer (CMO):
        i. Oversight of the QI Program
        ii. Chairperson of the QI/UM Committee
        iii. Chairperson of associated subcommittees
        iv. Supervision of Health Services staff
        v. Oversight and coordination of continuity of care activities for members
        vi. Proactive incorporation of quality outcomes into operational policies and procedures
        vii. Oversight of all committee reporting activities to link information

The Board of Directors delegates responsibility for monitoring the quality of health care delivered to members to the CMO and the QI/UM Committee with administrative processes and direction for the overall QI Program initiated through the CMO.

2. **Chief Medical Officer (CMO):** The CMO reports to the Chief Executive Officer (CEO) and the KHS Board of Directors and, as Chairperson of the QI/UM Committee and Subcommittees, provides direction for internal and external QI Program functions, and supervision of KHS staff including:

   a. Application of the QI Program by KHS staff and contracting providers
   b. Participation in provider quality activities, as necessary
   c. Monitoring and oversight of provider QI programs, activities, and processes
   d. Oversight of KHS delegated credentialing and recredentialing activities
   e. Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care
   f. Final authority and oversight of KHS non-delegated credentialing and recredentialing activities
   g. Monitoring and oversight of any delegated UM activities
   h. Supervision of Health Services staff involved in the QI Program, including: the Chief Health Services Officer (CHSO), Director of Quality Improvement, Director of Health Education and Cultural & Linguistics Services, Case Management Director, UM Director, Pharmacy Director, and other related staff
   i. Supervision of all Quality Improvement Activities performed by the QI Department
   j. Monitoring covered medical and behavioral health care provided to ensure they meet industry and community standards for acceptable medical care
   k. Actively participating in the functioning of the plan grievance procedures
   l. Resolving grievances related to medical quality of care

   KHS may have designee performing the functions of the CMO when the CMO position is not filled.

4. **QI/UM Committee (QI/UMC):** The QI/UMC reports to the Board of Directors and retains oversight of the QI Program with direction from the CMO. The QI/UM Committee develops and enforces the quality improvement process with respect to contracting providers, subcommittees and internal KHS functional areas with oversight by the CMO. This committee also performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services.

5. **Subcommittees:** The following subcommittees, chaired by the CMO, or designee, report to the QI/UMC:

a. **Physician Advisory Committee (PAC):** This committee is composed of contracting PCPs and Specialists and is charged with addressing provider issues.

Performs peer review, addresses quality of care issues and recommends provider discipline and Corrective Action Plans.

Performs credentialing functions for providers who either directly contract with KHS or for those submitted for approval of participation with KHS, including monitoring processes, development of pharmacologic guidelines and other related functions.

Develops clinical practice guidelines for acute, chronic, behavioral health or preventive clinical activities with recommendations for dissemination, promotion, and subsequent monitoring. Performs review of new technologies and new applications of existing technologies for consideration as KHS benefits.

6. Other Committees: The following committees, although independent from the QI/UM Committee, submit regular reports to the QI/UMC:

a. **Drug Utilization Review (DUR) Committee:** The Pharmacy & Therapeutics Committee has provided ovsight of medication prescribing practices by contracting providers, usage patterns by members and assistance with study design and clinical guidelines development. This committee will cease to exist after the transition of the pharmacy benefit to MCRx. The DUR Committee will continue.

b. **Public Policy/Community Advisory Committee (PP/CAC):** The PP/CAC reviews and comments on operational issues that could impact member quality of care, including access, cultural and linguistic services, and Member Services.

c. **Managed Care and Accountability Set (MCAS) Committee:** develops a tiered, multi-pronged approach to improve on all health care quality measures identified by the CA Department of Health Care Services (DHCS). These measures are typically focused on preventive health care and chronic condition management needs for Medi-Cal members. The committee monitors the status of KHS' performance with these measures and modifies strategies and interventions accordingly.

d. **Grievance Review Committee (GRC)**: provides input towards satisfactory resolution of member grievances and determines any necessary follow-up with Provider Network Management, Quality Improvement, Pharmacy and/or Utilization Management.

VI. Committee and Subcommittee Responsibilities: Described below are the basic responsibilities of each Committee and Subcommittee. Further details can be found in individual committee policies.

1. **QI/UM Committee (QI/UMC):**

a. **Role** – The QI/UM Committee directs the continuous monitoring of all aspects of covered health care (including Utilization Management) administered to members, with oversight by the CMO or their designee. Committee findings and recommendations for policy decisions are reported through the CMO to the Board of Directors on a quarterly basis or more often if indicated.

   i. **Objectives** – The QI/UM Committee provides review, oversight, and evaluation of delegated and non-delegated QI activities, including accessibility of health care services and care rendered, continuity and coordination of care, utilization management, credentialing and recredentialing, facility and medical record compliance with established standards, member satisfaction, quality and safety of services provided, safety of clinical care and adequacy of treatment. Grievance information, peer review and utilization data are used to identify and track problems and implement corrective actions. The QI/UM Committee monitors member/provider interaction at all levels, throughout the entire range of care, from the member's initial enrollment to final outcome.

      Objectives include review, evaluation and monitoring of UM activities, including: quality and timeliness of UM decisions, referrals, pre-authorizations, concurrent and retrospective review; approvals, modifications, and denials, evaluating potential under and over utilization, and the provision of emergency services.

   ii. **Program Descriptions**– the QI/UM Committee is responsible for the annual review, update and approval of the QI and UM Program Descriptions, including policies, procedures, and activities. The Committee provides direction for development of the annual Work Plans and makes recommendations for improvements to the Board of Directors, as needed.

   iii. **Studies** – The review and approval of proposed studies is the responsibility of the QI/UM Committee, with subsequent review of audit results, corrective action, and reassessment. A yearly comprehensive plan of studies to be performed is developed by the CMO, CHSO, Director of Quality Improvement, and the QI/UM Committee, including studies that address the health care and demographics of members.

b. **Function -** The following elements define the functions of the QI/UM Committee in monitoring and oversight for quality of care administered to members:

   i. Identify methods to increase the quality of health care and service for members
   ii. Design and accomplish QI Program objectives, goals, and strategies
   iii. Recommend policy direction

iv. Review and evaluate results of QI activities at least annually and revise as necessary
v. Institute needed quality improvement actions and ensure follow-up
vi. Develop and assign responsibility for achieving goals
vii. Monitor quality improvement, including compliance with MCAS preventive health and chronic condition management measures
viii. Monitor clinical safety
ix. Prioritize quality problems
x. Oversee the identification of trends and patterns of care
xi. Monitor grievances and appeals for quality issues
xii. Develop and monitor Corrective Action Plan (CAP) performance
xiii. Report progress in attaining goals to the Board of Directors
xiv. Assess the direction of health education resources
xv. Ensure incorporation of findings based on member and provider input/issues into KHS policies and procedures
xvi. Provide oversight for the KHS UM Program
xvii. Provide oversight for KHS credentialing
xviii. Provide oversight of the Health Education Department
xix. Assist in the development of clinical practice and preventive care health guidelines

The following elements define the functions of the QI/UM Committee in monitoring and oversight of utilization management related to QI:

i. Develop special studies based on data obtained from UM reports to review areas of concern and to identify utilization and/or quality problems that affect outcomes of care.
ii. Review over and underutilization practices retrospectively utilizing any or all of the following data: bed-day utilization, physician referral patterns, member and provider satisfaction surveys, readmission reports, length of stay and referral and treatment authorizations. Action plans are developed including standards, timelines, interventions, and evaluations.
iii. Evaluate results of member and provider satisfaction surveys that relate to satisfaction with the UM process and report results to the QI/UM Committee. Identified sources of dissatisfaction require CAPs and are monitored through the QI/UMC.
iv. Identify potential quality issues and report them to the QI Department for investigation
v. Annually review and approve the KHS Health Education program, new and/or revisions to existing policies, and criteria to be utilized in the provision of Health Education services for members.
vi. Identify potential quality issues with subsequent reporting to the QI/UMC.

c. **Structure –** the QI/UMC provides oversight for the QI and UM Programs and is composed of:

i. 1 KHS CMO or designee (Chairperson)
ii. 2 Participating Primary Care Physicians

iii. 2 Participating Specialty Physicians
iv. 1 Federally Qualified Health Center (FQHC) Provider
v. 1 Pharmacy Provider
vi. 1 Kern County Public Health Officer or Representative
vii. 1 Home Health/Hospice Provider
viii. 1 DME Provider

The QI/UM Committee is responsible for periodic assessment and review of subcommittee activities and recommendations for changes, with subsequent reporting to the Board of Directors at least quarterly.

d. **Meetings -** The QI/UM Committee meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. Issues needing immediate assistance that arise prior to the next scheduled meeting are reviewed by the CMO and reported back to the QI/UM Committee, when applicable.

2. Physician Advisory Committee (PAC):

a. **Role –** The PAC serves as advisor to the Board of Directors on health care issues, peer review, provider discipline and credentialing/ recredentialing decisions. This committee is responsible for reviewing provider grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS CMO or designee.

The QI/UM Committee has delegated credentialing and recredentialing functions for KHS to the PAC. The PAC is responsible for reviewing individual providers for denial or approval of participation with KHS.

The PAC is charged with the assessment of standards of health care as applied to members and providers; assist with development of indicators for studies; and regularly review guidelines that are promulgated to contracting providers and members. This committee consists of a variety of practitioners in order to represent the appropriate level of knowledge to adequately assess and adopt healthcare standards. The committee obtains an external independent review and opinion when necessary to assist with a decision regarding preventive care guidelines, disease management or coverage of a new technology as a covered benefit for members.

The PAC reviews and comments upon pertinent KHS standards and guidelines with updates, as needed. The PAC evaluates improvements in practice patterns of contracting providers and the development of local care standards. Development of educational programs includes input from the PAC. The PAC reviews and comments on other issues as requested by the Board of Directors.

b. **Function –** The functions of the PAC are as follows:

i. Serve as the committee for clinical quality review of contracting providers.

ii. Evaluate, assess, and make decisions regarding contracting provider issues, grievances and clinical quality of care issues referred by the KHS CMO or designee and develop and recommend actions plans as required.
iii. Review provider qualifications, including adverse findings and recommend to the Board of Directors approval or denial of participation with KHS on initial credentialing and every three years in conjunction with recredentialing. Report Board action regarding credentialing/recredentialing to the QI/UM Committee at least quarterly.
iv. Review contracting providers referred by the KHS CMO or designee due to grievance and/or complaint trend review, other quality indicators or other information related to contracting provider quality of care or qualifications.
v. Review, analyze and recommend any changes to the KHS Credentialing and Recredentialing program policies and procedures on an annual basis or as deemed necessary.
vi. Monitor any delegated credentialing/recredentialing process, facility review and outcomes for all providers.
vii. Develop, review, and distribute preventive care guidelines for members, including infants, children, adults, elderly, and perinatal patients.
viii. Base preventive care and disease management guidelines on scientific evidence or appropriately established authority.
ix. Develop, review, and distribute disease management and behavioral health guidelines for selected diagnosis and treatments administered to members.
x. Periodically review and update preventive care and clinical practice guidelines as presented by the CMO.
xi. Review and assess new medical technologies and new applications of existing technologies for potential addition as covered benefits for members.
xii. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers.
xiii. Assess industry and technology trends with updates to KHS standards as indicated.

c. **Structure** – the PAC is structured to provide oversight of quality of care concerns, delegated credentialing activities and the overall credentialing program to monitor compliance with KHS requirements. Contracting providers with medically related grievances that cannot be resolved at the administrative level may address problems to the PAC.

Recommendations and activities of the PAC are reported to the QI/UM Committee and Board of Directors on a regular basis. The committee is composed of:

i. KHS CMO (Chairperson)
ii. 1 Family Practice Providers
iii. 1 Pediatrician

iv. 1 Obstetrician/Gynecologist
v. 1 Eye Specialist
vi. 1 Pain Medicine Provider
vii. 1 Clinical Psychologist
viii. 1 Internal Medicine Provider

The PAC consists of a variety of practitioners to represent a broad level of knowledge to adequately assess and adopt healthcare standards.

d. **Meetings –** The PAC meets at least quarterly or more frequently if necessary.

3. 1. Drug Utilization Review Committee (DUR):

a. **Role –** the P&T Committee monitors the KHS Formulary, oversees medication prescribing practices by contracting providers, assesses usage patterns by members and assists with study design and clinical guidelines development. This committee will cease to exist after the transition of the pharmacy benefit to Medi-Cal Rx. The DUR Committee will continue.

b. **Function –** the functions of the DUR Committee are as follows:

i. Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs; Retrospective reviews focused on:
- Early fill/completion factor
- Duplication of therapy
- Therapeutic duplications
- SUPPORT ACT: concurrent therapy with opioids

ii. Provide recommendations regarding protocols and procedures for the use of non-formulary medications.
iii. Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers.
iv. Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions.
v. Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling.
vi. Participate in the DHCS' DUR Board and other DHCS organized pharmacy meetings.
vii. Complete DHCS annual report to CMS as it pertains to KHS.

c. **Structure –** The QI/UM Committee has delegated the responsibility of oversight of pharmaceutical activities related to members to the DUR Committee. The committee reports all activities to the QI/UM Committee quarterly or more frequently depending on the severity of the issue. The committee is composed of:

i. 1 KHS CMO (Chairperson)
ii. 1 KHS Director of Pharmacy (Alternate Chairperson)
iii. 1 KHS Board Member/Rx Representative
iv. 1 Retail/Independent Pharmacist
v. 1 Retail/Chain Pharmacist
vi. 1 Geriatric Pharmacist
vii. 1 General Practice Provider
viii. 1 Pediatrician
ix. 1 Internal Medicine Provider
x. 1 Obstetrician/Gynecologist
xi. 1 Provider at Large

d. **Meetings –** The DUR Committee meets quarterly with additional meetings as necessary.

4. Public Policy/Community Advisory Committee (PP/CAC):

a. **Role –** The Kern Family Health Care (KFHC) Public Policy/Community Advisory Committee (PP/CAC) provides participation of members in the establishment of public policy of KFHC. Public policy means acts performed by a plan 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.[1]

b. **Function –** The functions of the PP/CAC are as follows:

i. Culturally appropriate service or program design;
ii. Priorities for health education and outreach program;
iii. Member satisfaction survey results;
iv. Findings of health education and cultural and linguistic Population Needs Assessment;
v. Plan marketing materials and campaigns;
vi. Communication of needs for provider network development and assessment;
vii. Community resources and information;
viii. Periodically review the KHS grievance processes;
ix. Report program data related to Case Management and Disease Management;
x. Review changes in policy or procedure that affects public policy;
xi. Advise on educational and operational issues affecting members who speak a primary language other than English;
xii. Advise on cultural and linguistic issues.

c. **Structure** – The PP/CAC is delegated by the KHS Board of Directors to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors through the Quality Improvement/Utilization Management Committee.

[1] Knox Keene § 1369; Rule § 1300.69(b) (2)

Appointed members include:

i. 1 Ex-officio Non-Voting Member: KHS Director of Marketing and Public Affairs (Chairperson)
ii. 1 Member of the KHS Board of Directors
iii. 7 KFHC Members (minimum to ensure at least 51% of committee members are plan enrollees)
iv. 1 Participating Health Care Provider
v. 1 Kern County Department of Human Services Representative
vi. Kern County Department of Public Health Representative
vii. 2 Community Representatives

d. **Meetings -** The PP/CAC meets at least quarterly with additional meetings as necessary.

5. Managed Care Accountability Set (MCAS) Committee

1. Role – The purpose of the Kern Health Systems (KHS) Managed Care and Accountability Set (MCAS) Committee is to provide direction and oversight of KHS' level of compliance with the MCAS measures. It also 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).

2. Function – functions of the MCAS Committee include:

i. Regularly evaluate the status of compliance with each MCAS measure designated by DHCS using reports and other data to identify strengths and opportunities.
ii. Establish an organization-wide strategic action plan to address opportunities with MCAS measures.
iii. Evaluate outcomes of the strategic action plan and modify the strategy and actions as appropriate.
iv. Assure that all departments who influence member and provider compliance with MCAS measures actively participate in development and implementation of strategic planning and interventions.
v. Ensure that adequate policies and procedures exist and are up to date to support KHS' compliance with MCAS measures.
vi. The Executive Sponsor and Chairperson provide an annual update to KHS' Quality Improvment-Utilization Management Committee (QI-UMC) summarizing our strategies and level of compliance with MCAS measures. Outstanding issues from the Committee may be advanced to KHS' QI-UMC as needed.

3. Structure – The MCAS Committee includes the following KHS staff

i. Chief Medical Officer

ii. Chief Health Services Officer
iii. Administrative Director, Health Homes Program
iv. Director of Business Intelligence
v. Director of Case (CM) & Disease Management (DM)
vi. Director of Compliance & Regulatory Affairs
vii. Director of Health Education and Cultural and Linguistics Services
viii. Director of Marketing and Public Relations
ix. Director of Member Services
x. Director of Pharmacy
xi. Director of QI
xii. Director of UM
xiii. Provider Relations Manager
xiv. QI Manager
xv. QI MCAS Lead Registered Nurse (RN)

4. Meetings – The Committee meets at least every quarter and more frequently as needed.

6. Grievance Review Committee (GRC)

a. Role – The GRT provides input towards satisfactory resolution of member grievances and determines any necessary follow-up with Provider Network Management, Quality Improvement, Pharmacy and/or Utilization Management.

b. Function - functions of the GRC are as follows:

i. Ensure that KHS policies and procedures are applied in a fair and equitable manner.
ii. Hear grievances in a timely manner and recommend action to resolve the grievance as appropriate within the required timeframe.
iii. Review and evaluate KHS practices and procedures that consistently produce dissatisfaction, and recommend, when appropriate, modification to such practices and procedures.

c. Structure – Appointed members include:
i. 1 KHS CMO (Chairperson) or designee
ii. 1 KHS Director of Marketing and Member Services or designee
iii. 1 KHS Director of Provider Network Management or designee
iv. 1 KHS Chief Operations Officer or designee
v. 1 KHS Grievance Coordinator (Staff)
vi. 1 KHS Director of Compliance and Regulatory Affairs or designee
vii. 1 KHS Director of Quality Improvement or designee
viii. 1 KHS Chief of Health Services Officer or designee
ix. 1 KHS Pharmacy Director or designee

d. **Meetings** - The GRC meets on a weekly basis.

The Director of Member Services provides performance reports at least quarterly to the QI/UM Committee.

VII. Personnel: Reporting relationships, qualifications and position responsibilities are defined as follows:

1. **Chief Executive Officer (CEO)** – appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include: KHS direction, organization and operation; developing strategies for each department including the QI Program; Human Resources direction and position appointments; fiscal efficiency; public relations; governmental and community liaison, and contract approval. The CEO directly supervises the Chief Financial Officer (CFO), CMO, Compliance Department, and the Director of Marketing and Member Services. The PAC reports to the CEO and contributes information regarding provider issues. The CEO interacts with the CMO regarding ongoing QI Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

2. **Chief Medical Officer (CMO)** – The KHS CMO must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the QI Program.

   The CMO reports to the CEO and communicates directly with the Board of Directors as necessary. The CMO supervises the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Health Education and Disease Management. The CMO also supervises all QI activities performed by the Quality Improvement Department. The CMO devotes the majority of their time to quality improvement activities. The duties of the position include: providing direction for all medical aspects of KHS, preparation, implementation and oversight of the QI Program, medical services management, resolution of medical disputes and grievances; and medical oversight on provider selection, provider coordination, and peer review. Principal accountabilities include: developing and implementing medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality. These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).

   The CMO is responsible for providing direction to the QI/UM Committee and associated committees including PAC and Drug Utilization Review (DUR) Committee. As Chairperson of the QI/UM Committee and associated committees, the CMO provides assistance with study development and

coordination of the QI Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Director of Provider Network Management with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.

The CMO is also responsible for oversight of the development and ongoing revision of the Provider Policy and Procedure Manual related to health care services. The CMO executes, maintains, and updates a yearly QI Program for KHS and an annual summary of the QI Program activities to be presented to the Board of Directors. Resolution of medical disputes and grievances is also the responsibility of the CMO. The CMO and staff work with the appropriate departments to develop culturally and linguistically appropriate member and provider materials that identify benefits, services, and quality expectations of KHS. The CMO provides continuous assessment of monitoring activities, direction for member, provider education, and coordination of information across all levels of the QI Program and among KHS functional areas and staff.

3. **Chief Health Services Officer (CHSO)** - The CHSO position requires a valid Registered Nurse license to practice within the State of California and is experienced in managed care plan administrative and clinical operations. Under direction from the Chief Medical Officer (CMO), this position is responsible for overseeing the activities of the Health Services Department in support of the company's strategic plan; establishing the strategic vision, and the attendant policies and procedures, initiatives, and functions. The Health Services Department includes: Utilization Management, Case and Disease Management, Health Education, and Quality Improvement.

   The Chief Health Services Officer provides direct clinical support to the Directors of the Health Services department for both operational and strategic management. The position is responsible for overseeing the development of quality improvement strategies for the enterprise and clinical program development for population-based clinical quality measures. In addition, the position is responsible for directing the development of the clinical quality plan and the integration of quality into the overall business process to ensure that all activities are relevant and meeting the needs of the population served.
   Other responsibilities include:

   - Evaluates industry best practices, medical research, and other resources to develop clinical programs and tools which facilitate and support quality, cost-effective care.
   - Provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of results of data analysis.
   - Meets regularly with Finance Department to review trends in medical costs and to determine areas of focus;
   - Reviews analyses of activities, costs, operations and forecast data to determine departmental progress towards stated goals and objectives;

- Administer and ensure compliance with the National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan;
- Ensures adherence to all contract and regulatory requirements;
- Develops short- and long-term objectives and monitors processes and procedures to ensure consistency and compliance;
- Develops and implements process and program redesigns.

3. **Director of Quality Improvement** - The Director must possess a valid Registered Nurse (RN) license issued by the State of California and completion of a master's degree in Nursing (MSN) or other healthcare field from an accredited college or university. A minimum of five years of experience in a managed health care organization and a minimum of 3 years staff and program management experience. The Director of Quality Improvement has knowledge of managed care systems in a Knox-Keene licensed health plan, applicable standards and laws pertaining to quality improvement programs for the DHCS, NCQA and HEDIS data collection and analysis, study design methods, and appropriate quality tools and applications.

   The Director of Quality Improvement dedicates 100% of his/her time to the Quality Improvement Department and reports to the Chief of Health Services Officer. The Director of Quality Improvement is responsible for the oversight and direction of the KHS Quality Improvement staff. He/She assists the CMO in developing, coordinating, and maintaining the QI Program and its related activities to oversee the quality process and monitor for health care improvement. Activities include the ongoing assessment of contracted/network provider compliance with KHS requirements and standards, including: medical record assessments, accessibility and availability studies, monitoring provider trends and report submissions, and oversight of facility inspections. The Director of Quality Improvement monitors the review and resolution of medically related grievances with the CMO and evaluates the effectiveness of QI systems.

4. **Quality Improvement Manager** – The Quality Improvement Manager possesses a master's degree in health or business administration or bachelor's or Associates Degree in Nursing and five (5) years of experience in the direct patient care setting or operations management, or teaching adult learners, **and** one (1) year of experience in health care Quality Improvement, Utilization Management, or Process Improvement, and two (2) years of management experience.

   Under the direction of the Director of QI, the QI Manager conducts oversight and management of state and regulatory and contractual compliance for the QI program. This includes managing the HEDIS and Managed Care Accountability Set (MCAS) audit and initiatives to improve health outcomes related to those measures. They also manage quality improvement initiatives for Performance Improvement Projects (PIPs), Improvement Plans (IPs), Facility Site Reviews (FSRs), delegation audits, and other external quality reviews. The manager

applies clinical knowledge and analytical skills to manage and oversee day-to-day operations of the QI team.

5. **Quality Improvement RN Supervisor – T**he QI Supervisor is a new position in 2022 and replaces the previous QI Operations Supervisor position which was non-clinical. This position reports to the QI Manager. This position is a licensed, CA registered nurse with at least Five (5) years of experience in the direct patient care setting, one (1) year of experience in health care Quality Improvement, and two (2) years of management and operations management, experience.

   The QI RN Supervisor is responsible for overseeing the day-to-day operations and activities for designated clinical and non-clinical staff within the QI Department, including oversight of all clinical Grievances, Potential Quality Issues (PQIs), Performance Improvement Projects (PIPs), and any other relevant clinical or non-clinical activities. The QI Supervisor works closely with the QI Senior Analyst and Trainer and QI Manager for coordination of training and orientation of new staff in QI processes and procedures.

7. **QI Program Staffing** – the QI Director and Manager oversee a QI Program staff consisting of the following:

   a. **QI Registered Nurses** – The QI nurses possess a valid California Registered Nursing license and three years registered nurse experience in an acute health care setting preferably in emergency, critical and/or general medical-surgical care. The QI nurses assist in the implementation of the QI Program and Work Plan through the quality monitoring process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of responsibilities for the QI Program development and implementation. Additionally, the QI nurses teach contracting providers DHCS MMCD standards and KHS policies and procedures to assist them in maintaining compliance.

   b. **Quality Improvement Program Manager** - The QI Program Manager possesses a bachelor's degree or higher in Healthcare, Business, Data Science, Project Management or related field. They have at least 2 years' experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years' experience in project management work.

      Under the direction of the Director of Quality Improvement, the QI Program Manager manages, plans, coordinates, and monitors Quality Improvement Special Programs including but not limited to:
      - Annual Managed Care Accountability Set (MCAS) audit and measurement results submission,
      - QI Department Strategic Goals and Projects, and Special Programs (such as member incentives and engagement, DHCS-required project improvement plans, site reviews, etc.).

   c. **Senior QI Operations Analyst**: The Senior QI Operations Analyst reports to the QI Director and has a master's degree in Business, Statistics, Mathematics, or other related field with academic demonstration of

analytical skills from an accredited school or equivalent AND three (3) years' working experience with a Managed Care Organization (MCO) or similar type organization.

d. This position provides primary oversight, management and validation of data and reports submission for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QI Department, vendors and internal KHS Department such as IT. They provide similar management and support for other department audits. They are responsible for providing operational department support for department processes, projects, or other assignments and provide data and reports for ongoing activities such as performance improvement projects.

e. **Senior Quality Improvement Coordinator -** The QI Senior QI Coordinator reports to the QI RN Supervisor. He/she is a high school graduate and is licensed/certified in CA as either a certified medical assistant (CMA) or licensed vocational nurse (LVN) with either five (5) years of experience for a CMA or two (2) years experience for a LVN in a physician's office.

The Senior QI Coordinator assists in department functions related to data collection, data entry, report preparation, record maintenance, and collaboration with other departments, regulatory and contracted agencies. This position will work extensively with MCAS methodology, data collection and intervention development and implementation. The QI Coordinator will be a liaison between the health plan and the provider network for record retrieval and post-MCAS interventions. They also assist with medical record requests for any QI activity.

f. **QI Coordinator** – The QI Coordinator is a graduate from a licensed Medical Assistant training institution with 4 years' experience in a provider office setting. The QI Coordinator manages the MCAS annual audit process including but not limited to producing and validating the chase list, producing fax lists, collecting data, and reporting essential elements of the MCAS annual audit process.

g. **QI Senior Support Clerk** – The QI Senior Support Clerk reports to the QI RN Supervisor and has a high school diploma or equivalent, two years experience in the field health care, and at least one year data entry experience. He/she assists in the department functions related to data collection, data entry, report preparation, and record maintenance, and assists with other projects as needed.

VIII. Program Information – KHS utilizes information provided through the Information Technology (IT), Operations and Provider Network Management departments. Information includes but is not limited to claims, UM data, case management and care coordination data, encounter and enrollment data, and grievance and appeal information. The KHS QI Department identifies data sources, develops studies and provides statistical analysis of results.

IX. Work Plan – The annual QI Work Plan is designed to target specific QI activities, projects, and tasks to be completed during the coming year and monitoring and

investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QI Program, including accomplishments and impact on members. Evaluation and planning the QI Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

1. The Work Plan is developed by the Quality Improvement Manager on an annual basis and is presented to the PAC, QI/UMC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
2. The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care and the quality of service provided to members.
3. After review and approval of quality study results including action plans initiated by the QI/UMC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS' Provider bulletins to contracting providers.
4. The activities in the QI Work Plan are annually evaluated for effectiveness.
5. QI Work Plan responsibilities are assigned to appropriate individuals.

X. QI Activities – Covered health care provided to members is evaluated through a variety of activities designed to identify areas for corrective action and assess improvement.

1. **Quality Studies** – Studies are conducted across the spectrum of health care as described below.

   a. **Primary Care Physician (PCP) and Specialist Access Studies** – KHS performs physician access studies per KHS Policy 4.30, Accessibility Standards. Reporting of access compliance activities is the responsibility of the Provider Network Management Manager and is reported annually.

      i. **PCP and Specialist Appointment Availability** – KHS 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

ii. **PCP After-Hours Access** – KHS contracts with an after-hours triage service to facilitate after-hours member access to care. The Director of UM reviews monthly reports for timeliness, triage response and availability of contracting providers. Results of the access studies are shared with contracting providers, QI/UM Committee, Board of Directors and DHCS.

2. **Managed Care Accountability Set (MCAS)** – KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by DHCS. The measures are a combination of ones selected by DHCS from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO to validate that the data collection, data used and calculations meet the specifications assigned by DHCS.

   DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50th percentile based on outcomes published in the latest edition of NCQA's Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan's (MCP) compliance. When a MCP does not meet the 50th percentile or better for a measure we are held accountable to, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2022. Results for the 2022 measures will be calculated and submitted in report year (RY) 2023,

#	**MEASURE** Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	**MEASURE ACRONYM**	**MEASURE TYPE METHODOLOGY**	**HELD TO MPL?**
1	Breast Cancer Screening	BCS	Administrative	Yes
2	Cervical Cancer Screening	CCS	Hybrid/Admin**	Yes
3	Child and Adolescent Well-Care Visits	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10	CIS-10	Hybrid/Admin**	Yes
5	Chlamydia Screening in Women	CHL	Administrative	Yes-i
6	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
7	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
8	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid/Admin**	Yes
9	Controlling High Blood Pressure	CBP	Hybrid/Admin**	Yes
10	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid	Yes
11	Lead Screening in Children	LSC	Hybrid/Admin**	Yes
12	Prenatal and Postpartum Care: Postpartum Care	PPC-Pst	Hybrid/Admin**	Yes
13	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-Pre	Hybrid/Admin**	Yes
14	Well-Child Visits in the First 30 Months of Life – 0to 15 Months – Six or More Well-Child Visits	W30-2+	Hybrid/Admin**	Yes
16	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
17	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
18	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
19	Asthma Medication Ratio ii	AMR	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Colorectal Cancer Screening*	COL	Hybrid/Admin**	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
22	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
23	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
24	Topical Fluoride for Children	TFL-CH	Administrative	No
25	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No
26	Developmental Screening in the First Three Years of Life	DEV	Administrative	No
27	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
28	Follow-Up After Emergency Department Visit for Mental Illness	FUM	Administrative	No
29	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	Administrative	No
30	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
31	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
32	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
33	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
34	Pharmacotherapy for Opioid Use Disorder	POD	Administrative	No
35	Plan All-Cause Readmissions	PCR ii	Administrative	No
36	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No
37	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No
38	Prenatal Immunization Status	PRS-E	ECDS	No
39	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No

i. MCPs held to the MPL on the total rate only
ii. Stratified by Seniors and Persons with Disabilities (SPDs)

* Measures must be stratified by race/ethnicity. DHCS to provide further direction.
** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or that is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required.

The MCAS measure results since MY2019 were significantly impacted by the COVID-19 pandemic. Primary factors impacting KHS' compliance with the MCAS measures included:

- Stay at home orders for public safety
- Provider staffing resource challenges
- Provider office closures

As the pandemic continues, we are focusing on supporting members to return to their PCPs to receive routine and preventive health services. This support is occurring through the MERP program and expansion of rewards available to members for receiving needed preventive health services. New measures included in this year's rewards program are:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Testing
- Blood Lead Testing (for infants up to 2 yrs.).

Revisions to the provider Pay-for-Performance Program are in place for this year to increase providers successfully closing member gaps in care.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis and Action Plan DHCS advised the MCPs that financial penalties would not be imposed for RY2021 non-compliant MCAS measures. However, a SWOT Analysis and Action Plan was initiated last year due to KHS not meeting the required MCAS measures for MY2020. This was a requirement of KHS by DHCS. The SWOT plan will be completed by the end of May 2022. It started with an analysis of KHS' strengths, weaknesses, and opportunities to support development of an action plan to improve compliance with the measures. The SWOT emphasis is on the children's and women's domains of healthcare and includes the following three strategies.

Strategy 1: Increase awareness of low performing providers' MCAS rates in real time to allow for more timely interventions in 2021-2022.

Strategy 2: Leverage existing relationships with Community Based Organizations (CBOs) and Kern County Public Health Department (KCPHD) to identify shared activities to promote children's health services in Kern County.

Strategy 3: Increase access to children's preventative health services available to members in rural Kern County.

Plan, Do, Study, Act (PDSA) Projects
As a result of KHS' MY2020 MCAS scores, the QI Department is performing two PDSA's required by DHCS. PDSAs are Rapid-Cycle Improvement Projects. Our first PDSA is focused on the Breast Cancer Screening (BCS) measure in the Women's Health Domain. The second PDSA is utilization of robocalls via the Member Engagement and Rewards Program (MERP) campaign for the W30 measure with a focus on W15 (0-15 months). We are partnering with Clinica Sierra Vista (CSV) for the W30 PDSA. The plan anticipates completion of the PDSAs by mid-May.

3. **COVID Quality Improvement Plan (QIP)**
All MCPs are required by DHCS to develop a COVID QIP regardless of MCAS compliance. This was initiated in September of 2021. 3 strategies were developed for KHS to support our members with information about COVID and the vaccine. The strategies focused on the following domains of healthcare:

Behavioral Health, Chronic Disease, and Women's health. The plan anticipates completion of the QIP by the end of March.

4. **Performance Improvement Projects (PIPs)** – KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 18-month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project. For 2020-2022, the following two (2) PIPs were approved by DHCS for KHS:
   - The first PIP is targeted on a health disparity as outlined in DHCS' Health Equity PIP Topic Proposal Form and is called, Disparities in Well Child Visits, Improving the Health and Wellness of Low-Income Children and Adolescents, Ages 3 to 21, Through Well-Care Visits. This PIP is focused on improving the health and well-being of children, ages 8 to 10 years, by aligning the Well Child Visit with industry standards of care and evidence-based practices.
   - The second PIP is focused on improving the health of members, ages 5-21 years with persistent asthma and who have a ratio of controller medication to total asthma medications of 0.5 or greater. It will focus on improvement opportunities for two member programs:
     - Asthma Mitigation Project (AMP)
     - Asthma Preventive Health Program

5. **Potential Inappropriate Care (PIC) Issues/Potential Quality of Care Issue (PQI)** - This is a possible adverse deviation from expected clinician performance, clinical care, or outcome of care. PICs are investigated to determine if an actual quality issue or opportunity for improvement exists. Based on definition changes by DHCS, we are changing this term to Potential Quality of Care Issues (PQI). To ensure any grievance received/identified is evaluated for Quality of Care (QOC) issues, KHS has added an additional QI RN FTE dedicated to screening all grievances for a possible PQI. When a possible PQI is identified with a grievance, the QI RN summarizes their review and refers the grievance to the KHS' QI medical director for review, final determination of classification of the grievance as a QOC, and direction on any additional actions needed.

6. **Member Services -** The Director of Member Services presents reports regarding customer service performance and grievances monthly to the CEO, CMO and Chief Operations Officer. At least quarterly, reports are presented to the QI/UM Committee for review and recommendations.

7. **Prioritization of Identified Issues** – Action is taken on all issues identified to have a direct or indirect impact on the health and clinical safety of members. These issues are reviewed by appropriate Health Services staff, including the CMO, and prioritized according to the severity of impact, in terms of severity and urgency, to the member.

8. **Corrective Actions** – Corrective Action Plans (CAP) are designed to eliminate deficiencies, implement appropriate actions, and enhance future outcomes when an issue is identified. CAPs are issued in accordance with *KHS Policy and Procedure 2.70-I Potential Quality of Care Issues (PQI)*. All access compliance activities are reported to the Deputy Director of Provider Network who prepares

an activity report and presents all information to the CEO, CMO, Chief Operations Officer, Chief Network Administration Officer, and QI/UM Committee.

9. **Quality Indicators** – Ongoing review of indicators is performed to assess progress and determine potential problem areas. Clinical indicators are monitored and revised as necessary by the QI/UM Committee and PAC. Clinical practice guidelines are developed by the DUR Committee and PAC based on scientific evidence. Appropriate medical practitioners are involved in review and adoption of guidelines. The PAC re-evaluates guidelines every two years with updates as needed.

   KHS targets significant chronic conditions and develops educational programs for members and practitioners. Members are informed about available programs through individual letters, member newsletters and through KHS Member Services. Providers are informed of available programs through KHS provider bulletins and the KHS Provider Manual. Tracking reports and provider reports are reviewed and studies performed to assess performance. KHS assesses the quality of covered health care provided to members utilizing quality indicators developed for a series of required studies. Among these indicators are the MCAS measures developed by NCQA and CMS. MCAS reports are produced annually as well as throughout the year and have been incorporated into QI assessments and evaluations.

8. **Clinical Practice and Preventive Health Guidelines** – Clinical Practice Guidelines are developed using current published literature, current practice standards and expert opinions. They are directed toward specific medical problems commonly found with members. The PAC reviews and approves all Clinical Practice Guidelines and/or Preventive Health Guidelines prior to presentation to QI/UM Committee. The QI/UM Committee is responsible for adopting and disseminating Clinical Practice Guidelines for acute, chronic, and behavioral health care services. Guidelines are reviewed every two years and updated if necessary.

9. **Trended Adverse Event/Sentinel Events** Utilization Management is responsible for coordinating and conducting prospective, concurrent, and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care/continuum of care, and continued inpatient stay, as appropriate.

   The QI Department reviews a sampling of hospital re-admissions that occurred within 30 days of the first hospital discharge each quarter to identify and follow-up on potential inappropriate care issues.

   Any issue that warrants further investigation of potential inappropriate care is forwarded from the Utilization Management Department, Member Services Department, or any other KHS Department, to the QI Department for determination whether a PQI issue exists and follow up corrective action based on the severity level of PQI identified. These referrals may include member deaths, delay in service or treatment, or other opportunities for care improvement.

   Grievances with a PQI identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues

are reviewed by KHS' CMO or their designee to determine the severity level and follow up actions needed. All cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include tracking and trending a provider for additional PQIs and/or request(s) for a corrective action plan (CAP) for issues or concerns identified during review. The CMO or their designee may present select cases to the PAC for review and direction as needed.

a. **Member Safety** – KHS continuously monitors patient safety for members and develops appropriate interventions as follows:

   i. **Drug Utilization Review** – KHS performs drug utilization reviews to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care.

   ii. **Facility Site and Medical Record Review** – Facility site and medical record reviews are performed before a provider is awarded participation privileges and every three years thereafter. As part of the facility review, KHS QI Nurses review for the following potential safety issues:

   - Medication storage practices to ensure that oral and injectable medications, and "like labeled" medications, are stored separately to avoid confusion.
   - The physical environment is safe for all patients, personnel, and visitors.
   - Medical equipment is properly maintained.
   - Professional personnel have current licenses and certifications.
   - Infection control procedures are properly followed.
   - Medical record review includes an assessment for patient safety issues and sentinel events.
   - Bloodborne pathogens and regulated wastes are handled according to established laws.

   DHCS distributed a new All Plan Letter (APL), APL 20-006, for Site and Medical Record Reviews that was scheduled to take effect July 1, 2020. Due to the COVID-19 pandemic, DHCS has delayed implementation of this new APL until July 1, 2022. Policies and procedures have been updated to align with the new APL and education for KHS staff and KHS' provider network will be provided in advance of implementation.

   iii. **Coordination of Care Studies** – KHS performs Coordination of Care Studies to reduce the number of acute inpatient stays that

were followed by an acute readmission for any diagnosis within 30 days.

iv. **Grievance Satisfaction Data** – KHS reviews Member grievances and satisfaction study results as methods for identifying patient safety issues.

v. **Interventions** – KHS initiates interventions appropriate to identified issues. Such interventions are based on evaluation of processes and could include distribution of safety literature to members, education of contracting providers, streamlining of processes, development of guidelines, and/or promotion of safe practices for members and providers.

b. **Fraud, Waste, and Abuse (FWA)** – The Quality Improvement Department provides support to KHS' Fraud, Waste, and Abuse program in the following ways:

i. **PQI Referrals** – In the course of screening and investigating PIC referrals, the QI Department consistently evaluates for any possible FWA concerns. All FWA concerns are referred to KHS' Compliance Department for further evaluation and follow up.

ii. **FWA Investigations** – The QI Department clinical staff may provide clinical review support to the Compliance Department for FWA referrals being screened or investigated.

iii. **FWA Committee –** The Director of QI or their designee is an active member of KHS' FWA Committee to provide relevant input and suggestions for topics and issues presented.

10. **Member Information on QI Program Activities** – A description of QI activities are available to members upon request. Members are notified of their availability through the Member Handbook. The KHS QI Program Description and Work Plan are available to contracting providers upon request.

XI. KHS Providers: KHS contracts with physicians and other types of health care providers. The Provider Network Management Department conducts a quarterly assessment of the adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff.

XII. Annual Evaluation of the KHS Quality Improvement Program: On an annual basis, KHS evaluates the effectiveness and progress of the QI Program and Work Plan, and updates the program as needed. The CMO, with assistance from the Director of Quality Improvement, Pharmacy Director, Director of Health Education and Cultural & Linguistics Services, Director of Marketing, Director of Member Services and Deputy Director of Provider Network, documents a yearly summary of all completed and ongoing QI Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

The report includes pertinent results from QI Program studies, member access to care surveys, physician credentialing and facility review compliance, member satisfaction surveys, and other significant activities affecting medical and behavioral health care provided to members. The report demonstrates the overall effectiveness of the QI Program. Performance measures are trended over time to determine service, safety, and clinical care issues, and then analyzed to verify improvements. The CMO presents the results to the QI/UM Committee for comment, suggested program adjustments and revision of procedures or guidelines, as necessary. Also included is a Work Plan for the coming year. The Work Plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

The yearly QI Program summary and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the coming year, and approval of changes in the QI Program. The Board of Directors is responsible for the direction of the QI Program and actively evaluates the annual plan to determine areas for improvement. Board of Director Comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of QI activities and progress toward meeting QI goals is available to members and contracting providers upon request by contacting KHS Member Services.

XIII. Integration of Study Outcomes with KHS Operational Policies and Procedures: KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

XIV. Confidentiality: All members, participating staff and guests of the QI/UM Committee and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

XV. Members Right to Confidentiality: KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. The QI/UM Committee reviews practices regarding the collection, use and disclosure of medical information.

XVI. Conflict of Interest: All committee members are required to sign a conflict of interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

XVII. Provider Participation:

1. **Provider Information** – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.
2. **Provider Cooperation** – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

XVIII. Provider and Hospital Contracts: Participating provider and hospital contracts contain language that designates access for KHS to perform monitoring activities and require compliance with KHS QI Program activities, standards, and review system.

1. Provider contracts include provisions for the following:
    1. An agreement to participate in the KHS QI Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.
    2. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.
    3. Cooperation with the KHS QI Program including access to applicable records and information.
    4. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.
2. Physician contracts include provisions for the following:
    a. An agreement to participate in the KHS QI Program including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.
    b. An agreement to provide access to facilities and records as necessary for audits or inspections to ascertain compliance with KHS requirements.
    c. Cooperation with the KHS QI Program, including access to applicable records and information.
3. Hospital contracts include provisions for the following:
    a. An agreement to participate in the KHS QI Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.
    b. Development of an ongoing QI Program to address the quality of care provided by the hospital including CAPs for identified quality issues.

c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

d. Cooperation with the KHS QI Program, including access to applicable records and information.

XIX. On-Site Medical Records: Member medical records are not kept on site. Paper documents supporting UM, Grievance and Quality Improvement processes are securely shredded following use.

XX. **Delegation:** KHS delegates quality improvement activities as follows:

1. In collaboration with other Kern County Health Plans – delegation for Site Reviews as described in APL 20-006, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.
2. Kaiser Permanente – delegation of QI and UM processes with oversight through the QI/UM committee.
3. VSP – delegation of QI and UM processes with oversight through the QI/UM committee.

XXI. Assessment and Monitoring: To monitor that contracting providers have the capacity and capability to perform required functions, KHS has a pre-contractual and post-contractual assessment and monitoring system. Details of the activities with standards, tools and processes are found in specific policies and include:

Pre-contractual Assessment of Providers – All providers desiring to contract with KHS must, prior to contracting with KHS, complete a document that includes the following sections:

1. Health Care Delivery Systems, including clinical safety, access/waiting, referral tracking, medical records, and health education.
2. Credentialing information.

XXII. Quality and Safety of Clinical Care – KHS evaluates the effect of activities implemented to improve patient safety. Safety measures are monitored by the QI Department in collaboration with other KHS departments, including:

1. **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.
2. **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
3. **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

XXIII. Enforcement/Compliance: The Director of Quality Improvement is responsible for monitoring and oversight of the QI Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in

policies. Compliance activities not under the oversight of QI are the responsibility of the Compliance Department.

XXIV. Medical Reviews and Audits by Regulatory Agencies - KHS' Director of Compliance & Regulatory Affairs, in collaboration with the CHSO and the Director of Quality Improvement manages KHS medical reviews and medical audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI Program. CAPs for medical matters are approved and monitored by the QI/UM Committee.

_____

KHS Board of Directors (Chair) Date

_____

Chief Executive Officer Date

_____

Chairman QI/UM COMMITTEE Date

Attachment C

Kern Health Systems
2022 Quality Improvement Program Work plan

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
I. QUALITY MANAGEMENT AND IMPROVEMENTS					
A. Annual Review/Approval of QI Program (QIP) Documents					
1. Approval QI Evaluation	Approval of 2021 QI Program Evaluation	9/2/2022	Chief Medical Officer (CMO) / QI Director	None	Board of Directors Meeting Agenda August 2022
2. Review/Update and Approval of QI Program Description	Approval of 2022 QI Program Description	9/2/2022	Chief Medical Officer (CMO) / QI Director	None	Board of Directors Meeting Agenda August 2022
3. Review/Update and Approval of QI Work Plan	Approval of 2022 QI Work Plan	9/2/2022	Chief Medical Officer (CMO) / QI Director	None	Board of Directors Meeting Agenda August 2022
B. Clinical - Focused Studies					
1. State Required				None	
a. Asthma Medication Ration PIP - Improving Asthma Medication Ratio Compliance in Children 5-21 years of age	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with the Asthma Disease Management Program and Asthma Mitigation Project to increase correct medication usage by asthmatic members	12/31/2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing through 2022 with final submission to DHCS at year end
b. Improving the Health and Well Being of low income children, ages 3- 21 years, through Well Child Visits (WCV)	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with increasing the number of children ages 3 - 21 years old with completing an annual well care visit.	12/31/2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing through 2022 with final submission to DHCS at year end
c. PDSA for increasing compliance rate for Breast Cancer Screening	PDSA focused improving the MCAS rate for the Breast Cancer Screening (BCS) by 5% by offering mobile mammograms in a targeted, rural area of Kern County	5/31/2022	Chief Medical Officer (CMO) / QI Director	None	On track for completion by end of May 2022
d. PDSA for increasing compliance rate for infant wellness visits	PDSA focused on improving Clinica Sierra Vista's MCAS compliance rates for infant wellness visits in the First 30 Months of Life (W30) measure, ages 0-15 months of life, by 2.5%	5/31/2022	Chief Medical Officer (CMO) / QI Director	None	On track for completion by end of May 2022
e. COVID-19 Quality Improvement Plan	Conduct a COVID Quality Improvement Plan to support members during the pandemic with education and vaccination promotion. This was initiated in September of 2021. 3 strategies will be completed to support members with information about COVID and the vaccine. Focused on these domains of healthcare: Behavioral Health, Chronic Disease, and Women's health.	3/31/2022	Chief Medical Officer (CMO) / QI Director	None	Completed in March 2022 with acceptance of plan and results by DHCS
C. MCAS Quality Measurements Monitoring & Support					
1. MCAS Audit and Rate Submission MY2021/RY2022	Report to State via NCQA and EQRO Auditor, HSAG	1/31/2022	Director of QI/Director of Business Intelligence/Director of Claims/Director of IT/Chief Network Administration Officer	None	Completed
2 Configure MCAS/HEDIS software for new measures (Cotiviti) MY2021/RY2022	Vendor, Cotiviti, to have all new measure configured, tested and changes approved by NCQA	3/31/2022	QI Director/ IT Director	None	Completed
3 Configure KHS data and reports for new measures	KHS to modify data receipt, storage and reports to meet new DHCS MCAS specifications	3/31/2022	QI Director/ IT Director	None	Completed
4. Educate KHS Staff on MY2022 measures	KHS to educate internal staff on new requirements for MCAS	3/31/2022	Chief Medical Officer (CMO)/ QI Director	None	Completed
5. Educate providers on MY2022 measures	KHS to educate providers on new requirements for MCAS	3/31/2022	Chief Medical Officer (CMO)/ QI Director/ PNM Director	None	Completed

KERN HEALTH SYSTEMS
2022 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
MCAS Compliance Rates for MY2022 - Breast Cancer Screening (BCS) - Cervical Cancer Screening (CCS_ - Child and Adolescent Well-Care Visits (WCV) - Childhood Immunization Status: Combination 10 (CIS-10) - Chlamydia Screening in Women (CHL) - Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9) - Controlling High Blood Pressure (CBP) - Immunizations for Adolescents: Combination 2 (IMA-2) - Prenatal and Postpartum Care: Postpartum Care (PPC-Pst and PPC-Pre) - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents (WCC-BMI) - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition (WCC-N)	Report final rate annually to QI/UM Committee and Board of Directors (BOD)/DHCS	10/31/2022	Chief Medical Officer (CMO) / QI Director	None	In Progress
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity (WCC-PA) - Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months and Ages 15 - 30 Months (W30) - Ambulatory Care: Emergency Department (ED) Visits (ABM-ED) - Antidepressant Medication Management: Acute and Continuation Phase Treatments (AMM-Acute and AMM-Cont) - Asthma Medication Ratio (AMR) - Concurrent Use of Opioids and Benzodiazepines (COB) - Contraceptive Care - All Women: Long Acting Reversible Contraception (LARC) (CCW-LARC) - Contraceptive Care - All Women: Most or Moderately Effective Contraception (CCW-MMEC)	Report final rate annually to QI/UM Committee and Board of Directors (BOD)/DHCS	10/31/2022	Chief Medical Officer (CMO) / QI Director	None	In Progress
- Contraceptive Care - Postpartum Women: LARC - 3 Days and 60 Days (CCP-LARC3 and CCP-LARC60) - Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days and 60 Days (CCP-MMEC3 and CCP-MMEC60) - Developmental Screening in the First Three Years of Life (DEV) - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - Follow-Up After Emergency Department Visit for Mental Illness (FUM) - Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase (ADD-C&M)	Report final rate annually to QI/UM Committee and Board of Directors (BOD)/DHCS	10/31/2022	Chief Medical Officer (CMO) / QI Director	None	In Progress

KERN HEALTH SYSTEMS
2022 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
- Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase (ADD-Init) - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Plan All-Cause Readmissions (PCR) - Screening for Depression and Follow-Up Plan (CDF) - Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Report final rate annually to QI/UM Committee and Board of Directors (BOD)/DHCS	10/31/2022	Chief Medical Officer (CMO) / QI Director	None	In Progress
D. Other On-going Monitoring					
1. 30 day re-admissions	In annual QI Plan Evaluation for 2021 reported to QI/UMC & BOD in 2022	Annually	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
2. Potential Quality of Care Issues (PQI)	In annual QI Plan Evaluation for 2021 reported to QI/UMC & BOD in 2022	Annually	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
3. Facility Site Reviews (FSR)	Provider review of physical offices to ensure DHCS site safety and other requirements are met.	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI	Low	Ongoing 2022 - Due to COVID-19 Pandemic, reviews are being done virtually when possible. DHCS assessing plan to address reviews for providers not completed during the pandemic after PHE.
a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly		Low	
b. IHEBA - Staying Healthy Assessment	Physician Site Monitoring / Quarterly reporting	Quarterly		Low	
c. Initial Health Assessment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly		Low	
d. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly		Low	
e. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		Low	
f. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		Low	
g. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		Low	
4. 2022 Facility Site Review - DHCS New APL 20-006	Implementation of new DHCS requirements for Site & Medical Record Reviews that take effect July 1, 2022.	July 1, 2022	QI Director / Chief Network Administration Officer	None	On track for completion by July 1, 2022.
a. Implement Form Changes	Identify and implement process for documenting each type of FSR using the new forms finalized by DHCS			None	
b. Implement Reporting Changes	Identify changes to existing FSR reports and new reports needed based on the new, finalized FSR guidelines from DHCS			None	
c. Educate Staff on New Forms & Requirements	Develop and deliver educational information for KHS staff on the changes to the forms and FSR requirements			None	
d. Educate Providers on New Requirements	Develop and deliver educational information for network providers on the new FSR requirements by DHCS			None	
5. Resolve FSR Backlog	Complete Site & Medical Record Reviews that were delayed due to the pandemic. Includes quarterly status report to DHCS of progress.	June 30, 2022	Chief Medical Officer (CMO) / QI Director	None	
E. Safety of Clinical Care					
1. Autoclave	Credentialing/Recredentialing/As necessary	12/31/2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
2. Bio-hazardous waste	Credentialing/Recredentialing/As necessary	12/31/2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
3. Infection Control	Credentialing/Recredentialing/As necessary	12/31/2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
4. Facility Site Review (FSR) DHS Database	FSR database of completed site reviews	12/31/2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
5. Focused Reviews - Critical Elements	Physician Site Monitoring / Quarterly Reporting to QI/UMC	Quarterly	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
F. Availability					
1. Primary Care Practitioners				None	

KERN HEALTH SYSTEMS
2022 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
2. Specialty Practitioners					
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
b. Geographic Standard	Measure and Report	Annually	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
G. Access					
1. Primary Care Appointments					
a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
e. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
2. Telephone access to Member Services					
a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
3. Mental Health Appointment	Quarterly MOU Meetings/Grievances	As necessary	Director of UM; Director of CM	None	Ongoing 2022
a. Life-threatening Emergency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
c. Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
d. Routine office visit Standard (visit within 10 working days)	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
e. Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	None	Ongoing 2022
- Caller reaches non-recorded voice					
- Abandonment rate					
H. Encounters, Complaints, Grievances and Appeals Data Analysis	Report aggregate data quarterly to QI/UM Committee	Quarterly	Director of Member Services	None	Ongoing 2022
I. CAHPS Survey	State administered survey every 2 years - Next survey will be administered for 2022 in Q1 of 2023	N/A	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	Will be conducted by HSAG Q1 2023
1. Member data provided to EQRO to conduct CAHPS survey in 2021	Provide member data per EQRO specifications	Will be conducted in Q1 2023 for 2022	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	Will be conducted in Q1 2023 for 2022
2. Results reported to QI/UMC	Report to QI/UMC	Results anticipated 2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	2023
3. Results reported to practitioners and providers	Report to Physician Advisory Committee	Results anticipated 2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	2023
J. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2022
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
2. PCP & Mental Health	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
3. Specialist	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022
K. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes ongoing reporting of Grievances, QI Program, Evaluation and Work plan	12/31/2022	QI Director	None	Ongoing 2022
L. Annual Review of QI Policies and Procedures	Submit to QI/UMC and DHCS	Annually and as necessary	Chief Medical Officer (CMO) / QI Director/Director Compliance	None	Ongoing 2022
M. QI/UM Committee					
1. Reports and agenda items	Gathered from pertinent departments	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	Ongoing 2022
2. Minutes	Attached to next meetings agenda and sent to Board of Directors	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	Ongoing 2022
3. Form 700 (Statement of Economic Interests)	Send to all committee members yearly	Initial / Yearly December	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	Ongoing 2022
4. PO's and Check Requests	Fill out for each member attending meeting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	Ongoing 2022

KERN HEALTH SYSTEMS
2022 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
N. MCAS Member Engagement & Incentive Program	Conduct at least 3 campaigns using Interactive Voice Recognition, Text messaging and Mailers to contact members with Gaps in Care related to the MCAS measures. Outreach is focused on providing health education or reminders about preventive health measures and incentivizing them with a reward for closing a care gap.	12/31/2022	Chief Health Services Officer/QI Director/Health Education Director	None	Ongoing 2022
O. MCAS Committee	Multi-department committee focused on providing strategic direction and oversight of KHS' level of compliance with the MCAS measures. Committee meets at least quarterly	12/31/2022	Chief Health Services Officer/QI Director	None	Ongoing
1. Strengths, Weaknesses, Opportunities and Threats (SWOT) Action Plan for Children's Domain of MCAS measures	Develop and complete SWOT analysis and action plan to improve MCAS measures in the children's health domain. Progress reports to and collaboration with DHCS are required.	9/1/2022	Chief Health Services Officer/QI Director	None	Ongoing
2. Update and disseminate MCAS Provider Guide and MCAS Coding Card for MY2022 MCAS Measures	Update the KHS MCAS Provider Guide to reflect measures for MY2022. The guide provides a definition and specifications for each measure, diagnosis and service codes as applicable and tips for achieving compliance. The guide is made available to all KHS providers accountable to meet these measures. The coding card lists the most commonly used service and diagnosis codes for documenting completion of MCAS measures.	3/31/2022	Director of Quality Improvement/Provider Network Management/Provider Relations Manager	None	Completed
II. UTILIZATION MANAGEMENT - See UM Work Plan					
A. Annual Review/Approval of UM Program Documents by KHS QI/UMC and Board of Directors.	Program Description 2022	10/1/2022	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	
	Program Evaluation 2021	10/1/2022	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	
III. CREDENTIALING AND RECREDENTIALING					
A. Initial Credentialing Site Visit & Medical Record	Site and Medical Record Reviews done to validate new provider's compliance with DHCS regulatory requirements. Both reviews must be passed before a provider can be added to the KHS Provider Network.	Ongoing	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	Ongoing 2022
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/Compliance/MS for any opportunities for improvement identified. QI Department performs review of readmissions within 30 days of discharge and member deaths notifications for potential inappropriate	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	Ongoing 2022
1. Hospitals	Tracking grievances, PIC referrals, Deaths Notifications with potential Quality issues, and a sampling of readmissions within 30 days of discharge for possible quality issues related to readmission	Ongoing	Chief Network Administration Officer	None	Ongoing 2022
2. SNF's	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer	None	Ongoing 2022
3. Home Health Agencies	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer	None	Ongoing 2022
4. Free-Standing Surgery Centers	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer	None	Ongoing 2022
5. Impatient MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer	None	Ongoing 2022
6. Residential MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer	None	Ongoing 2022
7. Ambulatory MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer	None	Ongoing 2022

KERN HEALTH SYSTEMS
2022 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
C. Ongoing Monitoring of Sanctions and Complaints	Ongoing; time sensitive; sanctions; grievance process	Ongoing	Chief Network Administration Officer/Compliance	None	Ongoing 2022
D. Credentialing / Recredentialing File Audit	Ongoing KHS/Compliance random audits	Ongoing	Chief Network Administration Officer	None	Ongoing 2022
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is TJC accredited	Annually / as necessary	Chief Network Administration Officer	None	Ongoing 2022
F. Annual Review of Credentialing/Recredentialing Policies and Proc	Ongoing	Annually / as necessary	Chief Network Administration Officer	None	Ongoing 2022
IV. MEMBER RIGHTS AND RESPONSIBILITIES					
A. Statement of Members' Rights and Responsibilities	Review, annually / revise as necessary	Annually / as necessary	Director of Member Services	None	Ongoing 2022
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services	None	Ongoing 2022
C. Complaints and Appeals	Aggregate/analyze/report to QI/UM Committee Quarterly	Quarterly	Director of Member Services	None	Ongoing 2022
D. Grievance Report (HFP)	Report number and types of benefit grievances for previous calendar year - geographic region, ethnicity, gender and primary language	Quarterly	Director of Member Services	None	Ongoing 2022
				None	Ongoing 2022
				None	Ongoing 2022
E. Annual Analysis of Privacy and Confidentiality Policies	Review annually / Revise as needed	Ongoing	Director Compliance	None	Ongoing 2022
F. Delegation of Members' Rights and Responsibilities Activities	Non-delegated. Grievance committee	N/A	Grievance Committee	None	Ongoing 2022
G. Annual Review of Member Rights Policies and Procedures	Non-delegated	N/A	Grievance Committee	None	Ongoing 2022
VI. MEDICAL RECORDS					
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2022	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI	None	Ongoing 2022
B. Distribution of Standards to New Providers	Ongoing / as necessary	Ongoing	Director of Provider Network Management	None	Ongoing 2022
C. Audit of Medical Records Documentation	Refer to Credentialing/Recredentialing	Ongoing	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI / Director of Provider Network Management	None	Ongoing 2022
D. Annual Review of Policies and Procedures	Annually and as necessary	Ongoing	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2022

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Deborah Murr, MHA, BS-HCM, RN Chief Health Services Officer

Date: December 15, 2022

Re: Utilization Management Program Documents

Background

All Medi-Cal Managed Care Plan Utilization Management (UM) Programs are defined by the following documents:

- The Utilization Management Program Description, and
- The Utilization Management Program Evaluation

These documents are updated annually and presented to the Physician Advisory Committee, QI-UM Committee, and the Board of Directors for review, input and approval as defined under our contract with the Department of Health Care Services (DHCS). Opportunities identified in the previous year's Program Evaluation are considered in development of the following year's Program Description.

Discussion

2021 UM Program Evaluation (Attachment A)

The UM Program Evaluation is performed annually to review the effectiveness of the UM Program on how well it has deployed its resources to improve the quality and safety of clinical care and decision making. Where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Description.

2022 UM Program Description (Attachment B)

The purpose of the Utilization Management (UM) Program is to provide an overview of the comprehensive health care and applicable processes and resources in place deployed in assisting our membership in achieving the optimum level of health in a high quality, cost-effective manner.

The scope of the program is defined and describes how the program is integrated throughout all the departments in the organization. The UM Program Description defines the lines of authority, defines UM staffing structure and responsibilities, benefits and available services to provide patient centered care, and the methodology of the UM decision making processes. The UM Program Description outlines the regulatory requirements under our contract with DHCS.

Requested Action

Review and approve the 2021 UM Program Evaluation and 2022 UM Program Description.

2021 Utilization Management (UM) Program Evaluation and 2022 Utilization Management Program Description 2023 Utilization Management Planned Program Description

December 15, 2022

Deborah Murr, MHA, BS-HCM, RN
Chief Health Services Officer

Agenda

- Overview/Purpose
- 2021 UM Program Evaluation
- 2022 UM Program Description
- 2023 Planned UM Program Description

KERN HEALTH SYSTEMS

Overview

DHCS contract requirement

- Title 22 CCR 53860 Quality of Care
- Health and Safety Code 1363.50 Utilization Management
- DHCS/DMHC audits

- Annual review mandated
  - QI/UM Committee
  - KHS Governing body

KERN HEALTH SYSTEMS

2021 UM Program Evaluation

- Evaluate effectiveness of UM Program annually
- Pandemic influences

	3Q/2021	4Q/2021	1Q/2022	2Q/2022	3Q/2022
Total Referrals	59334	56514	63975	63681	67654

	3Q/21	4Q/21	1Q/22	2Q/22	3Q/22
Admissions	4505	3911	4066	4468	4027
Days	16405	15674	14376	16556	15004

- Identify opportunities for improvements and change management
- Changes incorporated into the subsequent annual UM Program Description based on goal achievement or barriers

KERN HEALTH SYSTEMS

2021 UM Program Evaluation Results

Goals Met

- Delegated Oversight Audits
  - Kaiser
  - Vision Service Plan (VSP) quarterly
  - Health Dialog quarterly operations
- Quarterly internal process auditing
- Medical Loss Ratio <93%
- Clinical Training/Evaluation-IRR
- Annual review decision-making guidelines
  - MCG (evidence-based integration)
- DHCS Reporting Submission
- Committee meeting cadence
  - QI/UM
  - Physician Advisory Committee (PAC)
  - Pharmacy & Therapeutics (P&T)
  - Community Advisory/Public Policy (CAC/PP)

Goals Not Met

- Policy updates-*partially*
- UM Key Performance Indicators
  - Turnaround times (Urgent/Routine <70% Q4)
  - Notifications (Member <90% Q3/Q4)
- Inpatient
  - COVID impact
  - Transitions/Length of stay >4.0

KERN HEALTH SYSTEMS

2022 UM Program Description

Purpose

- Overview of the comprehensive health care and applicable processes and resources
- Develops, implements, continuously updates, and improves the UM program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services
- Scope of the program is defined and integrated throughout all the departments in the organization

KERN HEALTH SYSTEMS

2022 UM Program Description Contents

- Regulatory requirements
  - Major Organ Transplant
  - Long Term Care benefit 2023
- UM processes
  - Behavioral and Substance Use Disorder
- Delegation oversight
  - Kaiser
- Authority and Roles/Responsibility
  - Board/Executives/Committees/Departmental
- Training
- Special programs
- Coordination/Collaboration with Community Entities

KERN HEALTH SYSTEMS

2023 Planned UM Program Description

- KHS Regulatory Oversight
  - DMHC Audit 1/17/2023
  - DHCS Audit TBD
- Delegated UM processes
  - Kaiser membership
- Project Collaboration/Implementation
  - Long Term Care
  - NCQA
  - Medicare Advantage Duals
- Process and efficiency improvement
  - Prior authorization
  - Medical Loss Ratio
- Department alignment

KERN HEALTH SYSTEMS

Requested Action

Requesting Board approval for the 2021 UM Program Evaluation and 2022 UM Program Description

Questions

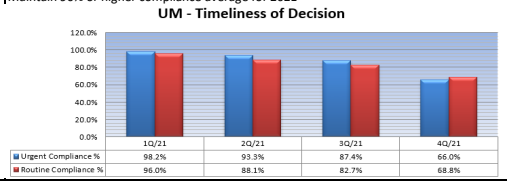
Contact
Deborah Murr, MHA, BS-HCM, RN
Chief Health Services Officer
661-664-5141
deborah.murr@khs-net.com

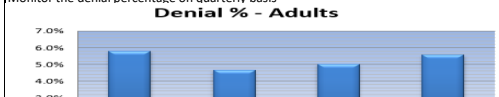
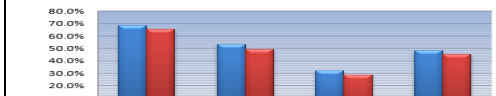
Attachment A

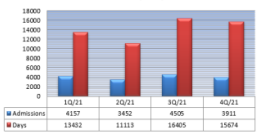
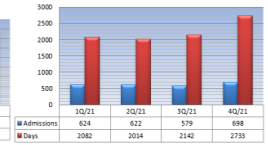
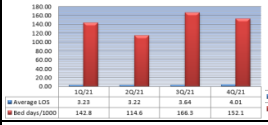
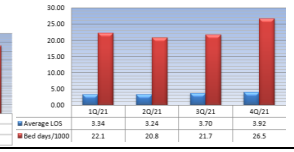
2021 Utilization Management Program Evaluation

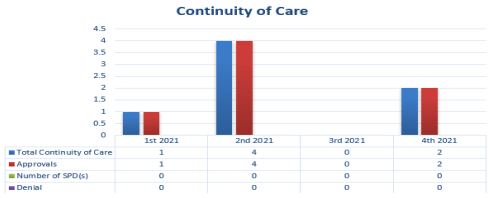
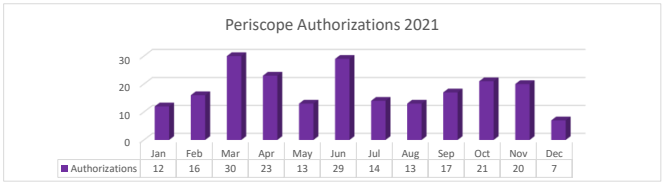
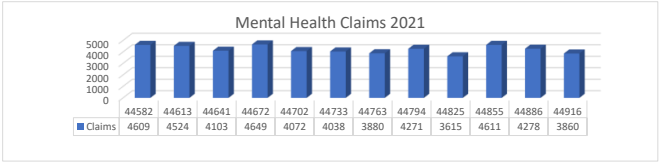
Executive Summary : Kern Health Systems (KHS) Utilization Management (UM) Program is designed to manage the use of limited resources to maximize the effectiveness of the care provided to Kern Health Systems members. It is designed to promote equitable, safe and consistent UM decision- making and coordination of care. The Medi-Cal (MCAL) beneficiary eligible residents have chosen Kern Family Health Care as their managed care plan due to the exceptional quality of care and service provided to the members. Ensuring KHS members are provided high quality, cost effective care in an appropriate setting while maintaining compliance with the Department of Health Care Services and the Department of Managed Health Care are goals that are foremost for the Utilization Management Department. The UM Program includes prior authorization, concurrent review, retrospective review and case management components, depending upon the type of service and the identified member's clinical condition. Systems have been established to facilitate the monitoring of the referral process and the evaluation of those processes in collaboration with KHS delegates and the Chief Medical Officer and /or their designee(s), to promote timely services for members. Conducting an annual evaluation of the effectiveness of the UM Program allows an organization to determine how well it has deployed its resources in the recent past to improve the quality and safety of clinical care and the quality of service provided to its membership. Where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Descriptions. KHS experienced continued membership growth during 2020. In addition to growth and due to impact from the COVID-19 public health emergency came increasing medical complexity of member health needs and coordination of care. The Statement of Work completed in 2020 is as follows:

Required By	Goals	Metrics	Target Completion Date	Action Steps and Monitoring	Results
UM	⍰ Update UM Program Description ⍰ Completion of 2021 Annual UM Program Evaluation ⍰ Development and implementation of 2021 UM Program Description	Met/Not Met	Year End 2021	1. Review and revise the annual UM Program Description and Complete prior year UM Program Evaluation 2. Obtain approval of the 2021 UM Program Description and UM Program Evaluation from the Board of Directors and QI/UM Committee 3. Evaluate the adequacy of resources and program performance to identify any changes needed	Goal Met : All program documents reviewed and approved.
UM	Oversight of all delegated UM functions provided by the following delegates: Kaiser Foundation Health Plan, VSP, Health Dialog	Met/Not Met	Year End 2021	1. Evaluate the effectiveness of the delegated UM functions for policy adherence to verify compliance with state, federal, and NCQA Standards 2. Submit outcomes of delegated oversight monitoring to appropriate UM and Quality Committees	Goal Met: 1. Annual delegated oversight audit of Kaiser deferred in 2020 due to public health emergency impacts. Audit (desk level) conducted 2021. Regular monitoring of received reports conducted as well as quarterly JOM to allow for regular oversight. 2. Continued quarterly review of delegated services and UM reports by VSP, Health Dialog. Ad hoc reviews completed as needed. 3. Reports included to relevant Committees and QI/UM Committee.
UM	Continued remote workforce support	Met/Not Met	Year End 2021	Continued ongoing technical support for UM remote staff in order to retain skilled workforce.	Goal Met: 1. KHS technical teams expanded and enhanced remote workforce systems. This allowed for majority of UM staff to transition to remote workforce as necessitated by the public health emergency in 2021 without any interruptions to service.
UM	Update UM Training Programs	Met/Not Met	Year End 2021	Review and revise UM training materials for relevant areas and roles within UM. Strengthen onboarding materials and schedules to ensure successful onboarding for clinical and non-clinical staff.	Goal Met: Training materials updated and changes to training program made as part of process improvement outcomes and feedback on training from new staff. Central repository developed on the UM Sharepoint site to facilitate easy access for all staff and ensure updating. Next Steps: 1. Continue to revise training materials and develop job aids for various processes in UM. 2. Conduct regular refresher and targeted training to all staff
UM	Complete review of UM criteria and/or policies used for authorization requests to ensure compliance with regulatory requirements	Met/Not Met	Year End 2021	1. Complete policy revisions needed due to updated DHCS/DMHC or other regulatory guidance and APLs. 2. Complete review of UM guidelines and criteria by PAC and QI/UM Committees to ensure compliance with regulatory requirements and evidenced based medicine.	Goal Met: 1. KHS Internal Criteria reviewed and criteria retired as appropriate. 2. MCG Clinical Guideline version updated to current edition content 3. Policy revisions completed or in process as needed to comply with regulatory changes and APLs.
UM	Demonstrate Interrater Reliability	Met/Not Met	Year End 2021	MCG Interrater Reliability testing completed with all UM Clinical staff successfully passing with score of 85% or better supporting consistent application of medical necessity guidelines used in the decision making process.	Goal Met-All clinical staff rendering medical decisions completed both Spring and Fall 2021 IRR evaluations.
UM	Quarterly State Reports Timely Submission	Met/Not Met	Year End 2021	Successfully submit all necessary UM reporting to DHCS within defined timeframes	Goal Met

DHCS	Quality Improvement/Utilization Management Committee (QI/UMC)	Met/Not Met	Year End 2021	1. Reports to the Board of Directors and retains oversight of the UM Program with direction from the Chief Medical Officer or their designee. 2. The QI/UMC promulgates the quality improvement process to participating groups and physicians, practitioner/providers, subcommittees, and internal KHS functional areas with oversight by the Chief Medical Officer. 3. Committee also performs oversight of UM activities conducted by KHS to maintain high quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. 4.Practitioner attendance and participation in the QI/UM Committee or subcommittees is required. 5. The participating practitioners represents a broad spectrum of specialties and participate in clinical QI and UM activities, guideline development, peer review committees and clinically related task forces. 6. The extent of participation must be relevant to the QI activities undertaken by KHS.	Goal Met 4 QI/UM Committee meetings were held in 2021
DHCS	Physician Advisory Committee (PAC)	Met/Not Met	Year End 2021	1. Serves as advisor to the Board of Directors on health care issues, peer review, provider discipline, criteria and policy recommendations and development, and credentialing/recredentialing decisions. 2. This committee meets on a monthly basis and is responsible for reviewing practitioner/provider grievances and/or appeals, practitioner/provider quality issues, clinical criteria and guidelines, and other peer review matters as directed by the KHS Medical Director. 3. The PAC has a total of ten (10) voting committee positions	Goal Met-meetings held as required. Current vacancies include: (2) general/family practitioner; (1) Non invasive specialist; (1) practitioner at large
DHCS	Pharmacy and Therapeutics Committee (P&T)	Met/Not Met	Year End 2021	1. Serves to objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion. 2. This is an ongoing process to ensure the optimal use of therapeutic agents. 3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost. 4. Medications are evaluated on their clinical use and develop policies for managing drug use and administration.	Goal Met-meetings held as required. Current vacancies include: (1) retail chain pharmacist; (1) general practice medical director
DHCS	Public Policy/Community Advisory Committee (PP/CAC)	Met/Not Met	Year End 2021	1. Provides a mechanism or structured input from KHS members and community representatives regarding how KHS operations impact the delivery of care. 2. The PP/CAC is supported by the Board of Directors to provide input in the development of public policy activities for KHS. 3. The committee meets every four months and provides recommendations and reports findings to the Board of Directors. 4. Maintains required (51%) Member participation levels	Goal Met
UM	Utilization Management Policy & Procedure Review, Revision/Development, and Implementation	Met/Not Met	Year End 2021	1. UM Policies and Procedures are reviewed at least annually and updated at a minimum every 2-3 years. Revisions are performed periodically in order to comply with any new regulatory requirements. 2. Each policy and procedure is reviewed against the DMHC requirements as well as DHCS contract and regulatory requirements and are revised as needed to ensure compliance. 3. A review of UM policies and procedures are performed as well as the creation of new policies in direct relation to the addition of the new or revised benefits, and others to meet the reporting and medical identification requirements set forth by the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) in various APLs and regulatory guidance.	Goal Partially Met: 1. Policies and procedures reviewed and updated based on various APLs and regulatory guidance from DHCS and DMHC. 2. Not all policies and procedures were reviewed during 2021 due to large volume of regulatory and state guidance as it related to public health emergency. Next Steps: Complete review of all UM Policies and Procedures in 2022
UM	Monitoring UM Decision Turn-Around Times, Volume, and Denial Rates	Met/Not Met	Year End 2021	1. Timeliness of UM Decisions are monitored on a daily basis through activity reports produced the UM Auditor through the Business Intelligence reporting program, Business Objects. 2. The UM Management staff is able to identify the number of referrals each Clinical Intake Coordinator are required to complete within the state mandated turnaround times. 3. A formal timeliness report is provided by the Director of Utilization Management on a quarterly basis to the QI/UM Committee including both decision timeliness and notification timeliness. 4. Monitoring of referral volumes and denial rates done on a monthly basis.	See below
UM	Timeliness of Decisions	Met/Not Met	Year End 2021	Maintain 90% or higher compliance average for 2021  	Goal not met: < 90% compliance rate for Q4 2021. Compliance decreased in the 3rd and 4th quarter with the increase of membership. Process and staffing changes to address compliance.

UM	Referral Notification Compliance	Met/Not Met	Year End 2021	Maintain 90% or higher compliance average for 2021 **UM - Referral Notification Compliance**  120.0% 100.0% 80.0% 60.0% 40.0% 20.0% 0.0% 1Q/21 2Q/21 3Q/21 4Q/21 Member Notification 95.0% 95.0% 83.0% 89.0% Provider Notification 100.0% 100.0% 100.0% 100.0% Criteria Included 97.0% 94.0% 97.0% 94.0% MD Signature Included 98.0% 100.0% 99.0% 100.0%	Goal Not Met for member notification Q3/Q4 2021
UM	Referral Count Monitoring	Met/Not Met	Year End 2021	Monitor the referral volume received on quarterly basis **Total Referrals Received**  61000 60000 59000 58000 57000 56000 55000 54000 1Q/2021 2Q/2021 3Q/2021 4Q/2021 Total Referrals 57157 60105 59334 56514	Goal Met
UM	Denial Percentage Monitoring	Met/Not Met	Year End 2021	Monitor the denial percentage on quarterly basis **Denial % - Adults**  7.0% 6.0% 5.0% 4.0% 3.0% 2.0% 1.0% 0.0% 1Q/21 2Q/21 3Q/21 4Q/21 Denial % 5.8% 4.7% 5.0% 5.6% **Denial % - PEDS**  80.0% 70.0% 60.0% 50.0% 40.0% 30.0% 20.0% 10.0% 0.0% 1Q/21 2Q/21 3Q/21 4Q/21 Denial 68.1% 53.3% 31.9% 48.0% CCS Denial 65.5% 49.3% 28.8% 45.3%	Goal Met-high denial rate in correlation to CCS coordination of benefits.
UM	Monitoring of After Hours call and nurse triage line services by Health Dialog	Met/Not Met	Year End 2021	1. Provide oversight and monitoring of the after-hours call, medical triage, eligibility information provided by Health Dialog by monitoring call reports, as well as monthly and quarterly summary reports to identify trends. 2. Determine next steps due to any identified trends or patterns to ensure PCP access and/or address needs for member education and/or support 3. Quarterly JOC for report and strategic oversight/planning	Goal Met Reports regularly reviewed. Additional systems put in place to support transfer by Health Dialog nurse of a member to a KHS provider for members with concern for COVID-19 symptoms or questions.

UM	Monitor Inpatient Utilization	Met/Not Met	Year End 2021	Closely monitor inpatient utilization trends using various reports and monitoring tools to identify trends and interventions needed. **Hospital Census - Adults Admission/Days**  1Q/21 2Q/21 3Q/21 4Q/21 Admissions 4157 3452 4505 3911 Days 13432 11113 16405 15674 **Daily Census - PEDS-Admission/Days**  1Q/21 2Q/21 3Q/21 4Q/21 Admissions 624 622 579 698 Days 2082 2014 2142 2733 **Hospital Census - Adult Avg LOS/Bed Days**  1Q/21 2Q/21 3Q/21 4Q/21 Average LOS 3.23 3.22 3.64 4.01 Bed days/1000 142.8 114.6 166.3 152.1 **Daily Census - PEDS-Avg LOS/Bed Days**  1Q/21 2Q/21 3Q/21 4Q/21 Average LOS 3.34 3.24 3.70 3.92 Bed days/1000 22.1 20.8 21.7 26.5	Goal Met
UM	Monitoring under-utilization	Met/Not Met	Year End 2021	1. The UM department mails correspondence notifications to both the practitioners and members of any carved-out services that are provided outside of KHS benefit coverage for Coordination of care. 2. Referrals for various educational programs, including smoking cessation, obesity, prenatal care, asthma, high blood pressure and diabetes are forwarded to QI/Health Education to assist UM in promoting the member's health through education and facilitating services with community based programs and other contracted service providers. 4. The Prior Authorization (PA) lists' goal is to facilitate timely access of services to members while eliminating barriers to the provider and enhance the provider experience. 5. PA information is communicated to the providers via a monthly update on the KHS internet site and provider portal. Various departments review trends to determine which services can be included for inclusion in a future PA listing. 6. Audits are conducted to review for under utilization of services that no longer require prior authorization to identify aberrant provider behavior or performed focused reviews on outlier activity and communicate with providers how to become more aligned with the positive trending. 7. Auth fulfillment reports are reviewed to determine the % of authorizations that are unused-outpatient and non consult data.	Goal Met Additionally due to impact from pandemic, authorizations were extended for up to 12 months to allow for utilization without need for additional submission.
UM	Monitoring over-utilization	Met/Not Met	Year End 2021	1. Triage provided by Health Dialog for KFHC member's to receive services in the emergency room and urgent care center are reviewed retrospectively for appropriateness of the triage. On a monthly basis, the Case Management social worker receives a report that identifies members with multiple ER and/or UC usage for review and follow-up. 2. This helps to identify PCP access issues, members needing guidance on medical services, needs for disease management, and inappropriate behavior of members seeking controlled drugs. 3. Monitoring speciality services and procedure utilization as well as tertiary care utilization. 6. KHS contracts with a consultant who performs in home evaluations to determine the appropriate equipment and recommend additional functional devices as needed to improve member's mobility and independence. 7. The admission and continued stay of KHS members in an acute or rehabilitation facility are concurrently reviewed for the severity of illness and the intensity of service. Levels of Care are monitored closely to ensure the member receives care in the appropriate setting for promotion of wellbeing and recovery. 8. Analysis of Primary Care and Specialty physician referral trends are reviewed to determine if requests are appropriate and if aberrancies noted, staff will initiate appropriate through coordination with Provider Relations Department. 9. Providers area contacted directly to begin dialogue and request clarifications to referral requests and provide additional education through criteria and policy and procedure review to increase compliance and reduce unnecessary referral requests and processing. 10. Overutilization or suspicion of fraud, waste, abuse are reported to KHS compliance and furhter investigation.	Goal Met New report developed to compare utilization between same speciality providers that are also normalized for utilization per member to provide comparisons. Collaborative process for provider education and dialogue developed between UM, PNM, and Claims teams
UM	CCS Collaboration	Met/Not Met	Year End 2021	Ongoing supportive and collaborative partnership with county CCS. KHS worked with CCS to identify transportation duplication among KHS membership. CCS has provided a direct liasion for an integrative approach for managing the bifurcated benefits based on diagnosis to reduce/eliminate duplication and or delay in services. KHS continues to collaborate with CCS on successful transitions of members aging out of CCS and into full KHS management of previous CCS eligible conditions through education via providers, conferences, and other modes of communication. Quartelry JOC with CCS for report and strategic oversight/planning	Goal Partially Met due to cancellations from CCS

UM	COPD Program	Met/Not Met	Year End 2021	Continue to develop and enroll members into the COPD management program which includes four components: (1) assess and monitor disease; (2) reduce risk factors; (3) manage stable COPD; (4) manage exacerbations. Strategic Goals include: • Improve health status and quality of life • Improve overall quality of care in the management of members with COPD • Prevent disease progression • Decrease ER/urgent care utilization • Decrease hospitalizations/readmissions and length of stay • Decrease overall COPD related costs by 10%	Goal Met Continue to expand program by Identifying methods to improve member enrollment and participation in program, develop robust program monitoring tool. Additnoally, program will expand to become part of the Population Health Management program in 2022-2023.
UM	Medical Loss Ratio (MLR)	Met/Not Met	Year End 2021	Continued efforts that support maintaining MLR of < 93% across all COA by identifying areas for UM focus. Revising Key Performance Indicator (KPI) Metrics for areas of focus to provide clear information on performance and to include utilization and financial impact. Monitor for over-utilization concerns and impact to MLR Develop new programs to postively reduce MLR in 2022	Goal Met: MLR Year to date was 92.2%.
UM	Increase KHS program referrals for members by UM staff	Met/Not Met	Year End 2021	Identify members who would benefit from referrals to internal KHS programs or services such as DM, CM, HHP, HE and other services like WPC and HFI, making the initial referral to the appropriate areas if member is not already connected. By connecting members to appropriate services, UM would help support them in managing their health. Ensure UM enhancements to allow internal referrals are tracked within Jiva or other reportable platform. Include screening and appropriate member referral as part of the clinical staff auditing. Goal: Increasing connection of appropriate members to these programs supports goal of decreasing MLR and improving members health and social determinents.	Goal Met Reports established to monitor UM staff referrals for members to various programs. Activities created within Medical Management System (JIVA) to facilitate referrals between departments and programs.
UM	Continuity of Care	Met/Not Met	Year End 2021		Goal Met for coordination of care requests to promote continuity of care.
UM	Periscope Group	Met/Not Met	Year End 2021		Goal Met for cost savings for overutilization/inappropriate utilization
UM	Mental Health Claims	Met/Not Met	Year End 2021		Goal Met for coordination of services

UM	ABA Services	Met/Not Met	Year End 2021

SEVERITY	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
MILD	23	23	31	26	33	37	23	16	22	17	14	0	265
MODERATE	34	35	40	35	20	41	23	22	27	20	23	1	321
SEVERE	9	8	12	3	17	7	5	4	9	2	3	0	79
Approved FBA	64	69	68	57	52	86	68	60	64	62	69	92	811
Approved Treatment	63	69	73	63	55	83	71	68	67	54	61	101	828
PENDING DX	29	28	22	31	12	54	69	65	41	15	21	100	487

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
AGE 7 OR LESS	72	59	78	68	57	100	88	75	74	37	43	67	818
AGE 8 OR GREATER	23	35	27	27	24	39	32	32	23	17	18	34	331
TOTAL	95	94	105	95	81	139	120	107	97	54	61	101	1149
% < 7	75.79%	62.77%	74.29%	71.58%	70.37%	71.94%	73.33%	70.09%	76.29%	68.52%	70.49%	66.34%	71.19%
% > 8	24.21%	37.23%	25.71%	28.42%	29.63%	28.06%	26.67%	29.91%	23.71%	31.48%	29.51%	33.66%	28.81%

Goal Met for coordination of services

UM	Audits (Denied, Modified, and Delayed)	Met/Not Met	Q2-Q4 Year End 2021

Month 2021	July	August	September
Total Referrals Processed	18,613	19,287	18,824
Total Referrals Denied	1,239	1,256	1,192
Percent of Denials	7%	7%	6%
Percent of Audit	10%	10%	10%
Number of Referrals in Audit (Not Included: Search and Serve, or Mental Health Referrals)	124	108	106

Month 2021	July	August	September
Total Referrals Processed	18,613	19,287	18,824
Total Referrals Modified	327	323	350
Percent of Modifies	2%	2%	2%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10%	10%	10%
Number of Referrals in Audit	33	34	35

Month 2021	July	August	September
Total Referrals Processed	18,613	19,287	18,824
Total Referrals Delayed	70	39	64
Percent of Delays	<1%	<1%	<1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10 referrals	10 referrals	10 referrals
Number of Referrals in Audit	10	10	10

Month 2021	October	November	December
Total Referrals Processed	18,915	17,748	17,318
Total Referrals Denied	1,233	1,067	595
Percent of Denials	7%	6%	3%
Percent of Audit	10%	10%	10%
Number of Referrals in Audit (Not Included: Search and Serve, or Mental Health Referrals)	105	89	47

Month 2021	October	November	December
Total Referrals Processed	18,915	17,748	17,318
Total Referrals Modified	338	247	149
Percent of Modifies	2%	2%	1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10%	10%	10%
Number of Referrals in Audit	33	25	15

Month 2021	October	November	December
Total Referrals Processed	18,915	17,748	17,318
Total Referrals Delayed	57	5	9
Percent of Delays	<1%	<1%	<1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10 referral	5 referral	9 referral
Number of Referrals in Audit	10	5	9

Goal Met for completing quarterly audits for QI-UM committee

Attachment B

KERN FAMILY HEALTH CARE
UTILIZATION MANAGEMENT
2022 PROGRAM DESCRIPTION

Introduction

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative for the arrangement of medical, social, and behavioral health care for Medi-Cal enrollees in Kern County. KHS is a public agency formed under Section 14087.38 of the California Welfare and Institutions Code. KHS began full operations on September 1, 1996, under the Kern County Board of Supervisors. KHS serves more than 304,000 Medi-Cal participants in Kern County. Medi-Cal is a jointly funded, Federal-State health insurance program for certain low-income beneficiaries. KHS is committed to the mission of improving the health of members with an emphasis on prevention and access to quality healthcare services. KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to elevate the health status of all community members.

The purpose of the Utilization Management (UM) Program is to provide members with comprehensive health care and health education, within available resources, and to achieve the optimum level of quality health care in a cost-effective manner. Coordination with various internal departments such as Case Management, Pharmacy, Disease Management, Health Homes Program, and Health Education, and partnering with our contracted and community entities assists KHS with the provision of a holistic and patient centered approach to providing health care to our membership. Success of the UM Program begins with positive patient-practitioner relationships and depends, not on the portioning of services, but on the management and delivery of medically necessary, cost-effective health care designed to achieve optimal health status.

To ensure efficacy, efficiency and continuity in this program, policies and procedures have been developed to define major functions and accountabilities. All activities described in the UM Program are conducted with oversight by the Quality Improvement/Utilization Management (QI/UM) Committee.

Most requests for routine non-emergent medical care (unless otherwise specified) are authorized prospectively by the UM department for Kern Family Health Care (KFHC) members. Prior authorization is required for specific identified services for that care to be reimbursed by Kern Health Systems (KHS). Authorization may also be obtained verbally from the KHS Chief Medical Officer or their designee(s) or a UM Nurse or Clinical Intake Coordinator.

Exceptions to the requirement for prior authorizations include but are not limited to:

- Primary Care Provider Services,
- Specific OB/GYN services, including midwifes and free-standing birth center facility
- Abortion Services,
- Dialysis,
- Hospice Care,
- Transportation (verification of visit location required),
- Sexually Transmitted Disease treatments,
- HIV Services,
- Family Planning Services,
- Mental Health evaluation,
- Maternity Care,
- Vision,
- Sensitive Services, both child and adult
- Emergent/Urgent Care, and other procedures as identified.

The UM department nursing staff function primarily as Clinical Intake Coordinators evaluating utilization of services, while providing ongoing monitoring of patient care for quality and continuity in collaboration with the QI department. Authority to accomplish this is delegated to UM department staff by the KHS Chief Medical Officer, or designee (Medical Director or another Executive). Essential to this process and success is strong support and understanding of the UM Program by the KHS Chief Medical Officer, Medical Director(s), and Board of Directors. The KHS Utilization Management Program Description is a written description of the overall scope and responsibilities of the UM Program. The UM clinical team actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety and/or outcomes of covered health care services delivered by all contracting providers rendering services to members. This is done through the development and maintenance of an interactive health care system that includes the following elements:

- The development and implementation of a structure for the assessment, measurement and problem resolution of the medical, behavioral health, social, and vision needs of the members;
- To provide the process and structure for monitoring contracted providers referral patterns;
- To provide oversight and direction for processes affecting the delivery of covered health care to members, either directly or indirectly;
- To ensure that members have access to covered health care in accordance with state legal standards;
- To monitor and improve the quality and safety of clinical care for covered services for members.

Overview

Purpose

The UM Program is comprised of various systems and processes which interface with other departments and administrative systems in the delivery of quality and value enhanced care. The link between UM and other clinical and administrative systems must be collaborative in order to deliver quality care and effective resource management.

- Provide the coordination of medically necessary services to all KFHC eligible members as defined by contractual obligations under the Department of Health Care Services, Department of Managed Care, and the regulations outlined in our Knox-Keene license in the State of California; and KHS Policies and Procedures;
- Monitor appropriateness of medical care and related services delivered to KFHC members;
- Provide systematic monitoring of the delivery of medical care and related services in a timely, effective, efficient manner consistent with the delivery of high quality and value enhanced care;
- Continually monitor, evaluate and optimize health care resource utilization and medical outcomes;
- Monitor utilization practice patterns of practitioners and provider organizations;
- Identify the need for Population Health Management programs including Complex Case Management, Disease Management, and Health Education through the referral/authorization review process;
- Foster Transitional Care to enhance the continuum of care;
- Develop programs that address specific needs of the KHS population;
- Educate members, practitioners, and provider organizations of objectives for providing high quality and value enhanced managed health care; and
- Identify potential quality of care issues and refer to QI department for further evaluation.

Objectives

The annual KHS UM Program develops, implements, continuously updates and improves the UM program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services.

The UM program includes:

- Qualified clinical staff responsible for the UM Program;
- Separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management concerns;

- Provision for a second opinion from a qualified health professional is provided at no cost to the Member; and
- Established criteria for approving, modifying, deferring, denying, or terminating requested services.

The KHS UM Program utilizes nationally recognized evaluation criteria and standards in making decisions to approve, modify, defer, deny or terminate services. The KHS UM Program will also review and present internally generated and other outside criterions to the Physician Advisory Committee (PAC) and the QI/UM Committee for direction in the development and/or adoption of specific criteria to be utilized by the KHS UM staff.

When making medical necessity decisions, UM staff obtains relevant clinical information to finalize UM decisions. Clinical information is provided to the Chief Medical Officer or their designee to support the decision-making process. Examples of clinical information include the following but is not limited to:

- History and physicals
- Office and ancillary service notes
- Treatment plans and Progress notes
- Health Risk Assessments
- Psychosocial history
- Risk Stratification
- Diagnostic results, such as laboratory or radiology results
- Specialty Consultation records, including photographs, operative, and pathology reports
- Pharmacy profiles
- Telehealth communications
- Behavioral Health/Mental Health records
- Information regarding benefits and any changes as required under the Department of Healthcare Services (DHCS) contract and Department of Managed Healthcare (DMHC) Knox-Keene Licensure

The review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may be modified to a given instance. The relevant circumstances, described below, are discussed with the physician/practitioner reviewer and requesting physician in order to render an appropriate decision:

- Age
- Sex
- Comorbidities
- Complications
- Home environment, as appropriate
- Progress toward accomplishing treatment goals

- Family support
- Previous treatment regimens
- Psychosocial situation and needs
- Benefit structure including coverage for post-acute or home care services when needed
- Delivery system capabilities and limitations
- Local hospitals' ability to provide all recommended services within the estimated length of stay

The KHS UM Program verifies that its pre-authorization, concurrent, and retrospective review procedures meet the following minimum requirements:

- Qualified health care professionals supervise review decisions, and a qualified physician will make the determination to deny any services based on medical necessity;
- Annual competency evaluation (at a minimum) for all clinical staff assigned to medical necessity determinations;
- Maintain a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, consistently applied, regularly reviewed and updated as needed;
- Reasons for decisions are clearly documented and communicated to the provider and member.

The KHS UM Program utilizes several approved sources to determine benefit coverage and to make decisions based on medical necessity. Many decisions are outlined in state regulatory guidelines and law. In addition, clinical guidelines are available as a guide for medical-necessity decisions. Medical judgment and decision making is individualized based on the member's condition.

The hierarchy for the consistent application of medical necessity criteria used in the decision-making process is as follows:

A. Medi-Cal guidelines-DHCS/DMHC
B. MCG (Milliman Care Guidelines)
C. Up to Date
D. Professional Society Organizations, i.e.,
    a. American Academy of Pediatrics
    b. American Academy of Orthopaedic Surgeons
    c. American College of Cardiology

Regulations and guidelines include but not limited to:

- California Code of Regulations Title 22
- California Code of Regulations Title 28
- California Code of Regulations Title 42
- California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16
- Medi-Cal /Medicare Guidelines

- MCG Health LLC
- UpToDate
- DHCS/DMHC Guidelines
- All Plan Letters (APL)
- Policy and Procedure Letters (PPL)
- Professional Society Guidelines.

Scope

KHS UM Program provides comprehensive health care services. The scope of covered services defined by the UM Program includes:

- Prior authorizations/referral management
- Concurrent review
- Retrospective review
- Continuity of Care
- Denial/Notice of Action
- Appeals and Grievance
- Claims and Disputes
- Utilization data management
- Recommendations for policy decisions
- Guidance of studies and improvement activities
- Population Health Management programs including Complex Case Management, Disease Management, and Health Education
- Transitional Care
- Primary and Specialty Care
- Maternity Care
- Gender Dysphoria
- Acupuncture
- Chiropractic
- Dental Anesthesia
- Genetics
- Tertiary referral coordination
- Major Organ Transplants (Kidney only for 2021, will expand to all major organs as of 1/1/2022)
- Social Services (i.e., tracking of appropriate usage of services, mental health service assistance, social services assistance)
- Behavioral/Mental Health
- Autism Spectrum Disorder/Behavioral Intervention Services
- Community Based Adult Services (CBAS)

- Recuperative Care (DHCS approved KHS benefit enhancement, will transition to ILOS benefit 1/1/2022)
- Rehabilitation Services
- Occupational and Physical Therapy Services
- Speech and Language Therapy Services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Cardiac Rehabilitation
- Pulmonary Rehabilitation (DHCS approved KHS benefit enhancement)
- External (Out-of-Network) referrals (including post stabilization care requests)
- Emergency service management
- Discharge planning
- Skilled Nursing Facility (SNF) and limited Long-Term Care (LTC) benefit
- Ancillary service management
- Medical Transportation (emergent/non-emergent)
- Home Health
- Supplemental Shift Nursing Services
- Hospice Services
- Palliative Care
- Pain Management Services
- Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
- Medication Therapy Management in coordination with Pharmacy Department
- Prescription Drug Program in coordination with the Director of Pharmacy
- Specialty Medication in coordination with Pharmacy Department
- After Hours Nurse Triage Services

The UM Program addresses the technical, professional, and clinical aspects of patient care. These include but are not limited to:

- Indication for services (medical necessity)
- Fraud, waste, and abuse monitoring
- Efficient ordering practices
- Appropriate level(s) of hospital care
- Appropriate and efficient use of resources
- Effective coordination and communication
- Reduction in the duplication of services
- Timeliness and access to care
- Identification of potential quality of care issues
- Clinical staff training for quality and accuracy
- Valid data management to include the following data sources:
  - Claims and encounter submission
  - Medical Records
  - Medical Utilization data

- Pharmacy Utilization data
- Predictive Modeler data

Mental Health Services

KHS responsibilities are limited to mild to moderate mental health conditions rendered in the outpatient setting. Psychotropic drug therapy remains carved out and provided under the Fee for Service MCAL payment structure by the County Mental Health Plan. Referrals for mental health services may be generated by the practitioner, KHS Social Workers, KHS' 24-hour contracted advice and triage nurses, school systems, employers, family, or the member.

Members needing immediate crisis intervention may self-refer to the Emergency Room or to the Kern County Behavioral and Recovery Services' Crisis Stabilization Unit. This information is provided to the members through the member handbook, and periodically, through the member newsletter. Mental Health Services for Medi-Cal participants are a covered benefit as described under the Kern Health Systems Health Plan in the contract with the Department of Health Care Services (DHCS).

KHS administers the mental health benefit as well as coordinating the benefit with the Kern Behavioral Health and Recovery Services (KBHRS) through a Memorandum of Understanding (MOU) and other contracted provider groups for their covered services. Quality issues are assessed through review of member grievances, member satisfaction study results, interactions with members, and quarterly meetings with KBHRS. KHS UM staff is available to assist KBHRS with complex cases and facilitate coordination and continuity of care between providers when transitioning between mild to moderate and extreme and pervasive mental health conditions.

Members who meet medical necessity criteria for medical conditions may receive Voluntary Inpatient Detoxification (VID) services in a general acute care hospital. VID services are carved-out (non-capitated) of the managed care contract and covered through the Medi-Cal Fee for Service program. Inpatient detoxification must be the primary reason for the member's voluntary inpatient admission.

KHS complies with Mental Health Parity requirements as required by Title 42, CFR, §438.930. The policies and procedures are consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

Behavioral Health Therapy (BHT) and Behavioral Intervention Services (BIS)

Autism Spectrum Disorder (ASD) encompasses several conditions that were previously diagnosed separately: autistic disorder, pervasive development disorder not otherwise specified (PDD-NOS) and Asperger syndrome. Primary Care Providers or other specialists can submit a prior authorization request for the comprehensive diagnostic evaluation by a psychiatrist, psychologist, or neurologist. Upon completion of the comprehensive diagnostic evaluation that results in a diagnosis of a qualifying ASD or another condition that would benefit from ABA services, ABA services will be reviewed in the usual manner as any other medical or behavioral service request to KFHC. KHS is responsible for coverage of the BHT benefit which includes non-ASD diagnosis and provides provisions for Continuity of Care for members.

Recuperative Care

The purpose of Recuperative Care is to reduce the costs of unnecessary hospital utilization and repeated costly emergency room visits for homeless individuals and other individuals who are hard to place post discharge. This DHCS approved Plan enhanced benefit will transition to an Community Support Services (CSS) formerly In Lieu of Services (ILOS) benefit as of January 1, 2022.

Recuperative Care includes post-hospitalization services to individuals who are at risk of homelessness or lack a physical address at the time of discharge from an acute care, inpatient facility. Typically, patients will stay in Recuperative Care from fourteen (14) to sixty (60) days is dependent on individual recovery and personal needs. This model is based on the following parameters:

- Intensive Case Management
- Substance Use Disorder
- Resource linkage
- Self-care and independent living

Transitional Care Program

The Transitional Care Model (TCM) is an evidence-based solution to these challenges. The TCM has consistently demonstrated improved quality and cost outcomes for high-risk, cognitively intact and impaired older adults when compared to standardized care: reductions in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs.

- *Avoidance of hospital readmissions for primary and complicating conditions***.** TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are re-hospitalized, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.

- *Improvements in health outcomes after hospital discharge.* Patients who received TCM have reported improvements in physical health, functional status and quality of life.
- *Enhancement in patient and family caregiver experience with care.* Overall patient satisfaction is increased among patients receiving TCM. In ongoing studies, TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

Collaborative care is the cornerstone of the TCM model. Collaborating partner's staff will form the interdisciplinary clinic that provides biopsychosocial and diagnostic screenings and evaluations, medication management, care management, treatment planning and intervention services, as well as general medical services for the identified population. The main goals of integration include:

- Foster cross-system partnerships;
- Quality and value-based system of care;
- Create robust inpatient discharge coordination and develop cross-system transfer of care protocols;
- Expand strategies and educational opportunities;
- Improve patient experience and quality outcomes; and
- Implement model of care that is sustainable and cost effective.

Major Organ Transplant

Effective January 1, 2022, the Plan will expand coverage to cover all major organ transplants, in addition to the current benefit of kidney transplant services. The UM Nurse and Clinical Intake Coordinator will work closely with the Major Organ Transplant Program team to ensure these vulnerable members are connected to this care coordination program to help assist and support them in navigating this complex process.

Long Term Care

Effective January 1, 2023, KHS will be administering the Medi-Cal Long Term Benefit for qualifying members. Long term care may be required due to physical or mental conditions that need continuous skilled nursing services; for Medi-Cal managed care, the LTC benefit for these services includes room and board and other covered services medically necessary for care. Kern Health Systems ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities may include, a. Skilled Nursing Facilities b. Sub-acute Facilities (pediatric and adult), and c. Intermediate Care Facilities. A member in need of long-term care is identified by his/her physician, health care clinician, acute care attending physician, case managers or discharge planners. To support appropriate utilization management, case management and service coordination to maintain the member at the LTC level of care, KHS follows specific protocols and standards for determining levels of care and authorizing services that are consistent with policies established by the Federal Centers for Medicare and Medicaid Services (CMS) and

in accordance with: a. 22 CCR § 51335 Title 22. Social Security Division 3. Health Care Services Subdivision 1. California Medical Assistance Program (Refs & Annos) Chapter 3. Health Care Services Article 4. Scope and Duration of Benefits § 51335. Skilled Nursing Facility Services.

Collaboration of Services

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to KHS members.

Continuity of Care is provided upon enrollment for those members with established relationships with Primary Care Providers, Specialists, and ancillary providers to promote uninterrupted services that may have been initiated prior to the member's enrollment with KHS. KHS is also required to provide beneficiaries with continuity of care from a non-participating provider or from a terminated provider, subject to certain conditions. The beneficiaries must be given the option to continue treatment for up to 12 months.

KHS must provide continuity of care with an out-of-network provider when KHS is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider); the provider is willing to accept the higher of the KHS's contract rates or Medi-Cal Fee for Service rates; and the provider meets KHS's applicable professional standards and has no disqualifying quality of care issues.

Collaboration with other outside agencies such as Kern Regional Center, Department of Public Health, Department of Mental Health, Homeless Coalition and Housing Authority, Department of Aging and Health and Human Services, California Children Services, Denti-Cal, and other internal KHS departments and coordination of services for the KFHC membership is an important aspect of the UM process. The UM Nurse and Clinical Intake Coordinator assist the members in obtaining carved-out services and when necessary, coordinate and provide services not covered by the carved-out practitioner/provider.

The UM Nurse and Clinical Intake Coordinator coordinates Mental Health services with Kern Behavioral Health and Recovery Services through a Memorandum of Understanding pursuant to a contract between the County and the State. This coordination is essential in order to provide members with a seamless transition between mental health services beyond the scope of KHS responsibility to manage mild to moderate symptomatology and the more severe diagnosis under the responsibility of the County System of Care.

In addition, KHS UM staff also coordinates Autism Spectrum Disorder (ASD) and Behavioral Intervention services with Kern Regional Center (KRC) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical and supportive services as they transition between the systems of care.

The UM Nurse and Clinical Intake Coordinator also coordinates Specialty children's services with California Children's Services (CCS) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical services as they transition between the systems of care.

Regularly scheduled quarterly (or more often if deemed necessary) Joint Operations Meetings are held with Mental Health, CCS, and Regional Center partners to promote coordination, quality, and timely decisions regarding member's identified needs.

The UM Nurse and Clinical Intake Coordinator also identifies members who are eligible and could benefit from KHS internal programs such as Health Homes Program, Complex Case Management, Disease Management, and Transitional Care programs in order to link them to additional supportive services to improve member health outcomes. Member health education and disease management is an important component in member Case Management. Improvement of the member's health is a collaborative effort between the member, and the member's practitioner, KHS Health Education, Disease management, UM Nurse and Clinical Intake Coordinator, and numerous community partnerships.

Authority and Responsibility

KHS Board of Directors

The Board of Directors for KHS assigns the responsibility to lead, direct, and monitor the activities of the UM and QI Programs to the QI/UM Committee. The QI/UM Committee is responsible for the ongoing development, implementation, and evaluation of the UM and QI Programs. All the activities described in this document are conducted under the oversight of the QI/UM Committee.

Structure

- 1 Board Chair
- 1 Rural PCP Representative
- 1 Urban PCP Representative
- 1 Safety Net Provider Representative
- 1 Hospital Representative
- 1 Pharmacist Representative
- 2 1st District Community Representative
- 2 2nd District Community Representative
- 2 3rd District Community Representative
- 2 4th District Community Representatives
- 2 5th District Community Representatives

The Board is directly involved with the UM process in the following ways:

- Approve and support the UM Program direction, evaluate effectiveness and resource allocation. Support takes the form of establishing policies needed to implement the plan;
- Appoint individual and/or departments within the KHS organization to provide oversight of the UM Program;
- Approve policies and procedures needed to maintain the UM Program;
- Receive and review periodic summary reports on quality and safety of clinical care and quality of service, and make decisions regarding corrective actions that require the Board's level of intervention;
- Receive, review, and make final decisions on issues involving provider credentialing and recredentialing recommendations from the Physician Advisory Committee (PAC) and Pharmacy and Therapeutics Committee (P&T);
- Receive reports representing actions taken and improvements made by the QI/UMC, at a minimum on a quarterly basis;
- Evaluate and approve the UM Program Description and UM Program Evaluation annually, providing recommendations as appropriate and track findings.
- Monitor the following activities delegated to the KHS Chief Medical Officer or designee:
    - Oversight of the UM Program
    - Chairperson of the QI/UM Committee
    - Chairperson of associated subcommittees (PAC, P&T, Public Policy)
    - Supervision of Health Services staff to include UM, QI, Pharmacy, Health Homes (HHP), Health Ed, Case Management, and Disease Management;
    - Oversight and coordination of Continuity of Care activities for members;
    - Proactive incorporation of quality outcomes into operational policies and procedures;
    - Oversight of all committee reporting activities to link information.

The Board of Directors delegate's responsibility for monitoring the quality of health care delivered to members to the Chief Medical Officer or designee, and the QI/UMC with administrative processes and direction for the overall UM Program initiated through the Chief Medical Officer.

Chief Medical Officer (CMO) Responsibilities:

The Chief Medical Officer reports to the Chief Executive Officer (CEO) and the KHS Board of Directors and, as Chairperson of the QI/UMC and Subcommittees provide direction for internal and external UM Program functions, and supervision of the KHS staff including:

- Application of the UM Program, by KHS staff and contracting providers;
- Participation in provider quality activities, as necessary;
- Monitoring and oversight of provider QI and UM programs, activities and processes including policies;

- Oversight of KHS delegated credentialing and recredentialing activities;
- Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care;
- Final authority and oversight of KHS non-delegated credentialing and recredentialing activities;
- Monitoring and oversight of any delegated UM activities;
- Supervision of Health Services staff involved in the UM Program, including Chief Health Services Officer, Director of Pharmacy, Medical Directors, Physician Advisors, and Director of Utilization Management;
- Supervision of all Utilization Management activities performed by the UM Department;
- Monitoring that covered medical care provided meets industry and community standards for acceptable medical care;
- Contributor in the development of medical criteria for necessity determinations;
- Actively participating in the functioning of the plan grievance and appeals procedures;
- Review and resolution of grievances related to medical quality of care.

Medical Director (s):

The Medical Director (s) support the Chief Medical Officer with projects as assigned and serves the role of Chief Medical Officer in the CMO's absence or when the CMO's position is not filled. The Medical Director (s) provide oversight for the following including:

- Serve as a member of the following committees of the KHS Board of Directors: Physician Advisory Committee; Grievance; Pharmacy & Therapeutics Committee;
- Quality Improvement and Utilization Management Committees (Serve as Chairperson of these committees as delegated by CMO). Attend committee meetings as scheduled.
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS;
- Represents KHS in the medical community and in general community public relations;
- Participates in the implementation of the KHS Credentialing Program;
- Direct responsibility for prior authorization review and medical necessity determinations based on application of evidence based medical criteria and MCAL established guidelines;
- Identify fraud, waste, and abuse through multi-disciplinary internal staff participation;
- Obtains support of the medical community for QI, UM, DM, HE, HHP, and CM programs;
- Supports, communicates, and collaborates with KHS Clinical Intake Coordinators and UM Nurses in order to resolve case management and referral issues;

- Implements the Disease Management, Health Education, Case Management, Health Homes, and Quality Improvement Program(s).
- Directly communicates with primary care physicians and other referring physicians in order to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines;

Program Structure

Committees

Quality Improvement/Utilization Management (QI/UM) Committee

The QI/UM Committee (QI/UMC) reports to the Board of Directors and retains oversight of the UM Program with direction from the CMO or designee. The QI/UM Committee performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. This committee also develops and enforces the quality improvement process with respect to contracting providers, subcommittees and internal KHS functional areas with oversight by the CMO.

Key Responsibilities

- Assure that practitioner/provider organizations participate in specific QI/UM activities as assigned;
- Oversee the effectiveness of UM activities within KHS (internal and external);
- Review, investigate and make recommendations to the appropriate individual or department regarding utilization issues affecting member care; or, in the case of review of individual practitioners/provider organizations performance, refer such review/investigation to the CMO /Physician Advisory Committee (PAC) Corrective Action Plans (CAP);
- Promote communication of UM activities across KHS and to practitioner/provider organizations;
- Maintain processes to promote confidentiality of the UM Program information as well as avoidance of conflict of interest on the part of practitioner reviewers;
- Identify methods to increase the quality of health care and service for members;
- Design and accomplish UM Program objectives, goals and strategies;
- Recommend policy direction;
- Review and evaluate results of UM activities at least annually and revise as necessary;
- Institute needed actions and ensured follow-up;
- Develop and assign responsibility for achieving goals;
- Monitor clinical safety;

- Ensuring access to quality care;
- Oversee the identification of trends and patterns of care;
- Monitor results of site reviews to ensure patient safety
- Monitor grievances and appeals for clinical issues;
- Develop and monitor Corrective Action Plan (CAP) performance;
- Report progress in attaining goals to the Board of Directors;
- Ensure incorporation of findings based on member and provider input/issues into KHS policies and procedures;
- Provide oversight for the KHS UM Program;
- Provide oversight for KHS credentialing;
- Assist in the development of clinical practice guidelines.

Structure

1	KHS Chief Medical Officer (Chairperson), or designee
2	Participating Primary Care Physician-Family Practitioner and Pediatrician
2	Participating Specialty Physicians-OB/GYN (OPEN) and ENT
1	Participating Home Health/Hospice Representative
1	Kern County Public Health Officer or designee
1	Participating FQHC Provider
2	Other Participating Ancillary Representatives-Durable Medical Equipment and Independent Pharmacy
1	Participating Hospital Representative
1	OPEN

The QI/UMC is responsible for periodic assessment and review of subcommittee activities and recommendations for changes, with subsequent reporting to the Board of Directors at least quarterly.

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. Issues needing immediate assistance that arise prior to the next scheduled meeting are reviewed by the CMO and reported back to the QI/UM Committee when applicable.

Physician Advisory Committee (PAC)

Key Responsibilities

- Serve as advisor to the Board of Directors on health care issues, peer review and provider discipline. Review and comment on Credentialing/Recredentialing Policies and Procedures;

- Review and comment on other issues such as grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee or as requested by the Board of Directors;
- Perform assigned functions under the Credentialing policies and procedures, the QI program, the UM program, the complaint/grievance process, and the practitioner/provider organizations appeal process;
- Serve as the committee for clinical quality review of contracting providers;
- Evaluate, assess, and make decisions regarding contracting provider issues, grievances and clinical quality of care issues referred by the KHS CMO or designee and develop and recommend actions plans as required;
- Review provider qualifications, including adverse findings and recommend to the Board of Directors approval or denial of participation with initial credentialing and every three years in conjunction with recredentialing. When indicated, the time frame form credentialing/recredentialing may be shortened. Report Board action regarding credentialing/recredentialing to the QI/UMC at least quarterly;
- Review contracting providers referred by the KHS CMO or designee due to grievance and/or complaint trend review, other quality indicators or other information related to contracting provider quality of care or qualifications;
- Review, analyze and recommend any changes to the KHS Credentialing and Recredentialing program policies and procedures on an annual basis or as deemed necessary;
- Monitor any delegated credentialing/recredentialing process, facility review and outcomes for all delegated actions related to providers;
- Review and distribute preventive care guidelines for members, including infants, children, adults, elderly, Seniors and Persons with Disabilities, and perinatal patients;
- Base preventive care and disease management guidelines on scientific evidence or appropriately established authority;
- Develop, review and distribute disease management and behavioral health guidelines for selected diagnosis and treatments administered to members;
- Periodically review and update preventive care and clinical practice guidelines as presented by the CMO or designee;
- Review and assess new medical technologies and new applications of existing technologies for potential addition as covered benefits for members;
- Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers;
- Develop internally criteria utilized through application of evidence-based benchmarks; and
- Assess industry and technology trends with updates to KHS standards as indicated.

The QI/UMC has delegated credentialing and recredentialing functions for KHS to the PAC. The PAC is responsible for reviewing individual providers for denial or approval of participation with KHS.

The PAC is charged with the assessment of standards of health care as applied to members and providers; assist with development of indicators for studies; and regularly review guidelines that are promulgated to contracting providers and members. This committee consists of a variety of practitioners in order to represent the appropriate level of knowledge to adequately assess and adopt healthcare standards. The committee obtains an external independent review and opinion when necessary to assist with a decision regarding preventive care guidelines, disease management or coverage of a new technology as a covered benefit for members.

The PAC reviews and comments upon pertinent KHS standards and guidelines with updates as needed. The PAC evaluates improvements in practice patterns of contracting providers and the development of local care standards. Development of educational programs includes input from the PAC. The PAC also reviews and comments on other issues as requested by the Board of Directors.

Structure

1	KHS Chief Medical Officer (Chairperson) or designee
2	General/Family Practitioners-PCP-(1) OPEN
1	General Internist
1	Pediatrician
1	Obstetrician/Gynecologist
1	Non-invasive Specialist-Clinical Psychologist
1	Invasive Specialist-Pain Medicine
1	Practitioner at Large-Ophthalmology
1	OPEN

The PAC consists of a variety of practitioners to represent a broad level of knowledge to adequately assess and adopt healthcare standards.

Meeting Schedule

The PAC meets monthly or more frequently if necessary.

Reporting Relationship

The PAC reports recommendations to the QI/UM Committee quarterly. The QI/UM Committee reports PAC recommendations to the Board of Directors quarterly through the Chief Medical Officer or their designee.

Pharmacy and Therapeutics Committee (P&T)

Key Responsibilities

- Objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion. This is an ongoing process to ensure the optimal use of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use and cost;
- Evaluate the clinical use of medications and develop policies for managing drug use and administration;
- Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
- Provide recommendations regarding protocols and procedures for the use of non-formulary medications;
- Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
- Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions;
- Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling;
- Review elements and format of the Formulary;
- Review parameters of prescribing practices for frequency of refills and the number of refills that may be dispensed at one time;
- Make recommendations to the QI/UM Committee for prescribing parameters;
- Review quality of care issues that arise pertaining to the prescribing and dispensing of medications;
- Report to the QI/UM Committee situations that may indicate substandard quality of care.

Membership

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Pharmacy (Alternate Chairperson)
1	KHS Board Member/Rx Representative
1	Retail/Independent Pharmacy
1	Retail Chain Pharmacy
1	Pharmacy/Specialty Practice-OPEN
1	Pharmacy/Geriatric Specialist
1	Pediatrician
1	Internal Medicine
1	General Practice /Cardiologist
1	General Practice/Geriatrics-OPEN
1	OB/GYN Practitioner

Meeting Schedule

The P&T meets quarterly with additional meetings as necessary

Reporting Relationship

Reports to the QI/UM Committee quarterly

Public Policy/Community Advisory Committee (PP/CAC)

The PP/CAC provides a mechanism for structured input from members regarding how KHS operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages.

The functions of the PP/CAC are as follows:

- Culturally appropriate service or program design;
- Priorities for health education and outreach program;
- Member satisfaction survey results;

- Findings of health education and cultural and linguistic Group Needs Assessment;
- Plan marketing materials and campaigns;
- Communication of needs for provider network development and assessment;
- Community resources and information;
- Periodically review the KHS grievance processes;
- Report program data related to Case Management and Disease Management
- Review changes in policy or procedure that affects public policy;
- Advise on educational and operational issues affecting members who speak a primary language other than English;
- Advise on cultural and linguistic issues.

The PP/CAC is delegated by the Board of Directors to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors.

Appointed members include:

1	Ex-officio Non-Voting Member: KHS Director of Marketing and Public Affairs (Chairperson)
3	KHS Members
2	KHS Members-OPEN
2	Community Representatives
2	Participating Health Care Practitioner-OPEN
1	Kern County Department of Public Health Representative
1	Kern County Department of Human Services

The PP/CAC meets at least quarterly with additional meetings as necessary.

Grievance Review Team (GRT)

The GRT provides input towards satisfactory resolution of member grievances and appeals and determines any necessary follow-up with Provider Relations, Quality Improvement, Pharmacy and/or Utilization Management/Health Services.

Key Responsibilities

- Ensure that KHS' policies and procedures are applied in a fair and equitable manner;
- Hear submitted grievances in a timely manner and recommend action to resolve the grievance as appropriate within the stipulated timeframe;
- Review and evaluate KHS' practices and procedures that consistently produce dissatisfaction, and recommend, when appropriate, modification to such practices and procedures;
- Participate in the Independent Medical Review process as warranted;
- Provide detailed explanation for decisions to both member and provider;
- Participate in the State Fair Hearing process as warranted to resolve grievances;
- Provide prompt and accurate information to the member detailing the resolution outcome of the grievance.

Structure

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Compliance and Regulatory Affairs
1	KHS Director of Provider Relations
1	KHS Chief Operations Officer
1	KHS Grievance Coordinator (Staff)
1	KHS Quality Improvement
1	KHS Director of Pharmacy
1	KHS Chief Health Services Officer, or designee
1	KHS Director of Member Services

Meeting Schedule Grievance Review Team meets on a weekly basis or sooner if necessary.

Program Staff Responsibilities

Chief Executive Officer (CEO)

Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability.

The CEO directly supervises the Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Information Officer (CIO), Chief Network Administration Officer (CNAO), Chief Human Resources Officer (CHRO), and the Senior Director of Governmental Relations and Strategic Development. The PAC reports to the CEO and contributes information regarding provider issues. The CEO interacts with the Chief Medical Officer regarding ongoing QI/UM Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action. Responsibilities include:

- Lead KHS mission, vision and direction, organization and operation;
- Developing strategies for each department including the QI Program; Human Resources direction and position appointments;
- Fiscal efficiency;
- Public relations;
- Governmental and Community liaison;
- Contract approval.

Chief Medical Officer (CMO)

The Chief Medical Officer must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the UM Program.

As Chairperson of the QI/UM Committee and associated committees, the CMO provides assistance with study development and coordination of the UM Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Chief Network Administration Officer with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members. Responsibilities include, but are not limited to:

- Provide direction for all medical aspects of KHS, preparation, implementation and oversight of the UM Program, medical services management, resolution of medical disputes and grievances;
- Medical oversight on provider selection, provider coordination, and peer review;
- Principal accountabilities include development and implementation of medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct;

- Assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality.
- Ensure that medical decisions are rendered by qualified medical personnel;
- Are not influenced by fiscal or administrative management considerations;
- Ensure that the medical care provided meets the current standards for acceptable care;
- Ensure that medical protocols and rules of conduct for practitioner or plan medical personnel are followed;

These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).

Medical Director

The Medical Director will provide clinical leadership and guidance in the development and measurement of the strategic approach to quality, performance improvement, and patient satisfaction, and safety. As determined by the plan Chief Medical Officer, the Medical Director assists in short- and long-range program planning, total quality management (quality improvement) and external relationships, as well as develops and implements systems and procedures for all medical components of health plan operations.

In collaboration with the Chief Medical Officer and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the Chief Medical Officer and Quality Improvement Committee. Additionally, he or she represents the health plan on various committees and routinely reports to the Board of Directors on credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets. Responsibilities include, but are not limited to:

- Develop and implements medical policy;
- Resolve grievances related to medical quality of care and service;
- Actively participate in the functioning of KHS' grievance procedures and implementation of the plan Quality Improvement Program;
- Provide direction and oversight to administration of the QI, UM, and Credentialing Programs;
- Detect and correct inadequate practitioners/provider organizations performance within responsibility level
- Supports the CMO with projects as assigned;
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS

- Responsible for monitoring and controlling the appropriate utilization of health care services in order to achieve high quality outcomes in the most cost-effective manner
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS
- Responsible for monitoring and controlling the appropriate utilization of health care services to achieve high quality outcomes in the most cost-effective manner
- Directly communicates with primary care physicians and other referring physicians in order to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines; and
- Supports, communicates, and collaborates with KHS case managers in order to resolve case management and referral issues.

Chief Health Services Officer (CHSO)

Under direction of the Chief Medical Officer (CMO) this position is responsible for overseeing the activities of the Health Services Department in support of the company's strategic plan; establishing the strategic vision, and the attendant policies and procedures, initiatives, and functions. The Health Services Department includes Utilization Management, Population Health and Case Management, Health Education, and Quality Improvement.

Position requires a licensure to practice as a Registered Nurse in the State of California. Qualifications for the Chief Health Services Officer include two years of management level experience in utilization management in managed care environment AND one year of experience as a utilization review or medical (physical medicine) nurse OR four years of experience as a utilization review or medical (physical medicine) nurse AND two years of supervisory experience; OR any equivalent combination of experience. A Bachelor's degree in Nursing is desirable.

The Chief Health Services Officer provides direct clinical support to the Directors of the Health Services department for both operational and strategic management. The position is responsible for overseeing the development of quality improvement strategies for the enterprise and clinical program development for population-based clinical quality measures. In addition, the position is responsible for directing the development of the clinical quality plan and the integration of quality into the overall business process to ensure that all activities are relevant and meeting the needs of the population served. Responsibilities include, but are not limited to:

- Evaluates industry best practices, medical research, and other resources to develop clinical programs and tools which facilitate and support quality, cost-effective care.
- Develops and implements an annual plan detailing the strategies, programs, and tools to be implemented.
- Assures compliance with QI and UM work plans, and when necessary, assures compliance with NCQA standards.

- Provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of results of data analysis.
- Tracks Health Services Program performance and results.
- Works with both internal and external customers to promote understanding of health services activities and objectives and to prioritize projects according to corporate goals, monitoring of case management activity and accuracy of decision making is reported to the executive team.
- Ongoing development and monitoring of activities related to identification and tracking of members needing disease management, case management, behavioral health or autism services, tracking of inpatient members including authorizations of level of care, appropriateness of admissions to non-par facilities and timely transfer to participating facilities are critical to the effectiveness of the UM program.
- Establish, initiate, evaluate, assess, and coordinate processes in all areas of Health Services;
- Oversees all activities of department and aids the CMO and appropriate corporate staff in formulating and administering organizational and departmental initiatives;
- Meets regularly with Finance Department to review trends in medical costs and to determine areas of focus;
- Reviews analyses of activities, costs, operations and forecast data to determine departmental progress towards stated goals and objectives;
- Administer and ensure compliance with the National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan;
- Participate in, attend and plan/coordinate staff, departmental, committee, sub-committee, community, State and other activities, meetings and seminars;
- Participate in provider education and contracting as necessary;
- Leads and participates in cross functional teams which design and implement new case management programs and quality interventions to improve health outcomes;
- Leads teams of clinicians charged with promoting effective use of resources.
- Ensures adherence to all contract and regulatory requirements;
- Develops short- and long-term objectives and monitors processes and procedures to ensure consistency and compliance;
- Manages budget and special projects; and
- Develops and implements process and program redesigns.

Director of Utilization Management

Under the direction of the Chief Health Services Officer, the Director of Utilization Management will oversee and participate in activities related to Utilization Management (UM) for the organization and membership by monitoring, assessing and improving performance in ambulatory and inpatient health care delivery or health care related services. The UM Director will assist in the implementation of the KHS Utilization Management Program Plan and Evaluation and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report

writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

The Director of UM provides direct clinical support to the UM Nurse and Clinical Intake Coordinators, Health Services Manager, Health Services Program Administrator, Senior Operational Analyst, and the UM Clinical Inpatient and Outpatient Nurse Supervisor(s), ensuring that the appropriate level of member care is being provided through referral processing.

This position is responsible for collaborative oversight of the Utilization Management functions for KHS. The UM Director will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. This position will assist in ensuring compliance with Medi-Cal contractual stipulations for Utilization programs. In collaboration with the Chief Health Services Officer, will make an effective contribution to KHS's business planning and fiscal processes and will remain clear about departmental objectives and resource requirements. In addition, this position will reinforce a shared sense of purpose throughout the organization and serve as a mentoring role that strongly encourages the growth of team members. Ensuring professional development goals are incorporated into team members' annual performance objectives, and regular reviews progress towards attaining them is paramount to this role. Responsibilities include, but are not limited to:

- Maintains delegated responsibility in coordination with the Chief Health Services Officer for activities within the Utilization Management departments;
- Shares in direction and supervision for ongoing and new projects for the UM program with the Chief Health Services Officer;
- Oversees quality of care investigations and reporting;
- Works closely with the Director of Case Management to facilitate needs for members identified as High Risk or requiring coordination of services;
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges;
- Ensure coordination of medically necessary services within the plan and with community;
- Coordinates UM activities and data collection between KHS departments and KHS contracted providers;
- Assists with interviews, selects, trains, develops and evaluates subordinate staff; provides input to HR regarding disciplinary issues, as necessary;
- Serves as resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee and other committees, as appropriate;
- Works in a coordinated effort with the UM Health Services Manager and Health Services Program Administrator to ensure the smooth and efficient operations of the outpatient processes;
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards; Coordinates and conducts in-depth chart analysis, data collection, and report preparation;

- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review;
- In coordination with the UM Auditor, perform periodic audits of the Clinical Intake Coordinators and Social Workers of outpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit; and
- Implements and facilitate internal audit studies and work groups for continuous improvement within the organization.

UM Clinical Manager

Under direction of the Director of Utilization Management, this position manages, leads, acts as a subject matter expert, and provides guidance on unit functions and departmental operations, including regarding clinical health outcomes related to population health management, clinical data management and retrieval, reporting standards and State policy and procedure implementation. Develops implements and evaluates clinical programs related to Health Services initiatives. Manages, supervises, mentors and trains assigned staff. Responsibilities include, but are not limited to:

- Direct activities of the Utilization Management staff.
- Oversee staff performance with regard to prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination, and other clinical and medical management programs. These responsibilities extend to behavioral health care services.
- Ensure effective daily operation of the Utilization Management Department utilizing all applicable statutory provisions, contracts and established policies and administrative procedures.
- Maintain optimal staffing patterns based on contractual obligations and current Utilization Management budget.
- Comply with all policies and procedures for personnel requisitions, interviews, and employment. Maintain accurate position control and organizational chats of assigned departments.
- Prepare reports and conduct analysis of operations / services as required by departmental, corporate, regulatory, and State requirements.
- Work collaboratively with BI and Pharmacy Departments on identifying required data for reporting.
- Assist in preparation, coordination, and follow up of Utilization Management audits, such as readiness review and DHCS site visits, pertaining to the Utilization Management Department.
- Partner with community agencies and contracted vendors to develop and maintain collaborative contact to assure members have access to the appropriate resources and to avoid duplication of efforts

- Act as a liaison with outside entities, including but not limited to physicians, hospital, health care vendors. social services agencies, member advocates, county and other care entities.
- Participate in coordination of internal and external Provider and Member directed communication regarding issues impacting Utilization Management coordination and delivery, such as medication management, use of generic medications, etc.
- Establish performance and productivity requirements and communicate expectations to management team.
- Work collaboratively with Supervisor in identification of individual and / or group deficiencies in scheduled Performances Reviews.
- Establish action plan for assessment and resolution of identified issues.
- Oversee the collaborative efforts of the Supervisors to ensure that all new and existing staff are oriented to organizational and department policies and procedures.
- Ensure that credentials of all licensed staff are verified in accordance with licensing agency initially and prior to expiration date. Maintain current and accurate files of such licensure and ongoing education status.
- Ensure that staff meets minimal skill and clinical knowledge requirements to be successful in assigned role.
- Participate in current process review and development of new and / or revised work processes, policies and procedures relating to Utilization Management responsibilities.
- Provide input into the development of educational material and programs necessary to meet business objectives, members' needs, contractual and regulatory guidelines, and staff professional development.
- Comply with Corporate, Federal, and State confidentiality standards to ensure the appropriate protection of member identifiable health information
- Develop and maintain department budget.

Health Services Manager

The Health Services Manager reports to the Chief Health Services Officer and is responsible for the daily management, evaluation and operations of the health services administrative processes, provide supervisory support to Utilization Management (UM) staff and assist with defining and creation of reports in collaboration with the UM Senior Auditor/Analyst, UM Senior Analyst/Trainer, and Senior Health Services Program Administrator.
This position will work with the administrative support staff to promote the delivery of quality health care to Kern Health System (KHS) members through comprehensive case management, compliance with KHS policies and procedures, and maintenance of a positive and safe work environment leading to maximum departmental efficiency, accuracy, and quality.
Responsibilities include, but are not limited to:

- Supervise the functions and activities of the clerical support staff;
- Monitors and reports production and quality of work by clinical and clerical staff;
- Works with clerical staff to achieve production, timeliness, and quality of work;

- Participate with Inter-departmental process improvement teams and planned quality management;
- Assist with development and formalization of departmental budget;
- Assist with development and updating of UM criteria, guidelines, and policies;
- Responsible for payroll activities, including approval of timecards, for all clerical hourly staff in the UM;
- Monitor UM processes for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes;
- Train staff, as appropriate, regarding use of the Medical Management systems as it relates to the UM and Pharmacy processes;
- Generates reports for CMO and Chief Health Services Officer to support business decisions;
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental analyst(s) and Senior Health Services Program Administrator;
- Works in collaboration with the Senior Health Services Program Administrator to develop and facilitate new program processes and guidelines under the supervision of the Chief Health Services Officer.

UM Outpatient Clinical Supervisor

The UM Outpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Outpatient Medical, Behavioral, Mental Health, and Social Services within the UM Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient and productive operations within the UM Department, as directed by the Chief Health Services Officer. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills;
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes;
- Participation on inter-departmental process improvement teams and KHS quality management;
- Monitor UM nursing staff referral and documentation for accuracy and appropriateness;
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines;

- Supervise the appropriate case management in compliance with UM guidelines and KHS Policies and Procedures;
- Monitors and reports production and quality of work by outpatient clinical staff;
- Works with staff to achieve production, timeliness, accuracy, and quality of work;
- Summarize and prepare necessary production reports for management;
- Perform periodically scheduled audits of outpatient clinical decisions for appropriateness and accuracy of documentation;
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards;
- Ensure coordination of medically necessary services within the plan and with community;
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions;
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

UM Inpatient Clinical Supervisor

The UM Inpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Inpatient Medical, Mental, Behavioral, and Social Services within the UM Department. The UM Inpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient and productive operations within the UM Department, as directed by the Chief Health Services Officer. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills;
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes;
- Participation on inter-departmental process improvement teams and KHS quality management;
- Monitor UM nursing staff referral and documentation for accuracy and appropriateness;
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines;
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policies and Procedures;
- Monitors and reports production and quality of work by inpatient clinical staff;

- Reviews decisions regarding hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership as related to coordination of services upon discharge;
- Assists with coordinating discharge planning activities with facility discharge planners;
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan i.e., CCS, Mental Health, Long Term Care, State Waiver Programs.
- Works closely with the Transitional Care team to facilitate needs for members identified as High Risk or requiring coordination of services;
- Identify members who may quality for the Health Homes Program;
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges;
- In coordination with the UM Clinical Auditor, perform periodic audits of the UM Nurse RN and Social Workers of inpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit;
- Works with staff to achieve production, timeliness, accuracy, and quality of work;
- Summarize and prepare necessary production reports for management;
- Perform periodically scheduled audits of inpatient clinical decisions for appropriateness and accuracy of documentation;
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards;
- Ensure coordination of medically necessary services within the plan and with community;
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions;
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

UM Nurse and Clinical Intake Coordinators (RN /LVN)

Under the direction of the Kern Health Systems (KHS) Director of Utilization Management, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The UM Nurse and Clinical Intake Coordinators are supported by a non-clinical team for administrative duties and coordination. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent, and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload on a monthly basis. Responsibilities include, but are not limited to:

- Promote coordination and continuity of care and quality improvement in both the inpatient and ambulatory care setting;

- Evaluate the appropriateness of care using established criteria and KHS' benefit guidelines;
- Support KHS developed programs through member identification for participation; i.e., Diabetic Clinic, Health Home, Complex Case Management, Respite, Palliative, Transitional Care, Health Home, and Social Worker interventions;
- Review and approve specialty and ancillary service referrals using established criteria for purposes of pre-authorization of payment;
- Review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership;
- Coordinates discharge planning activities with facility discharge planners;
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan i.e., CCS, Long Term Care, State Waiver Programs;
- Participates in UM and QI data and statistical gathering, collation, and reporting; and
- Audits for over and underutilization are performed to identify any potential fraud, waste, and abuse. If FWA is suspected, the information is reported to Compliance within five (5) working days and the audit findings are then subsequently reported quarterly to QI/UM Committee

Clinical Auditor/Trainer (RN)

Under the direction of the Director of Utilization Management, the UM Clinical Auditor and Trainer RN is responsible for reviewing Utilization Management (UM) policy and guidelines to ensure staff compliance with policies. Responsibilities include ensuring coordination of services not only within inpatient and outpatient groups, but also between the groups and community. Perform audits on various project reports, Notice of Action notifications, and referrals for compliance. Responsible for reporting findings to management for review and possible corrective action. Provide recommendation for process improvement and assist with action plans for making those corrections. The Clinical Auditor and Trainer RN will work in a coordinated effort with UM Clinical Supervisor(s), Manager of Health Services, and Business Analyst to ensure smooth, efficient, and productive operations within the UM Department as directed by the Director of Utilization Management. This position will work closely with the Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Train other UM clinical licensed staff as appropriate regarding use of the all platforms and core adjudication system as it relates to the UM process;
- Develop and implement staff training for new and existing employees along with internal findings;
- Responsible for written and verbal communication with contract providers and internal KHS staff to promote timely coordination of care and dissemination of KHS policies and procedures;

- Assist the UM clinical staff in the review of claims and disputes for the accuracy and appropriateness of billed charges;
- In coordination with the UM Senior Auditor/Analyst, perform spot audits of performance of UM Clinical Intake Coordinators and Social Workers and summarize and report the results of the audit to UM Management for process improvement;
- Perform periodic spot audits of inpatient and outpatient clinical decisions for appropriateness and accuracy of documentation;
- Assists in data collection and compilation, of various committee and quarterly reports; and
- Summarize and prepare necessary production reports for management.

Claims and Disputes Review Nurse (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Medical Claims Review RN will be responsible for retroactive review of medical service claims and disputes for payment and medical necessity following accurate contract and non-contract guidelines for both Inpatient and Outpatient services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Responsibilities include, but are not limited to:

- Reports, track and documents all claims, and disputes review activity in appropriate programs such as QNXT, as well as specially developed internal logs for tracking and trending purposes;
- Perform retro review and approval of specialty and ancillary services referrals using established criteria for purposes of payment;
- Perform retro review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership;
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan i.e., CCS, Long Term Care, State Waiver Programs.

Long Term Care Nurse Reviewer (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Long-Term Care Nurse reviewer performs a comprehensive assessment and ongoing reassessments for members referred for long term care (LTC) placement. The assessment process evaluates benefit and medical necessity application of criteria to assure that the member is placed in a health care facility that provides the level of care most appropriate to the member's medical needs. Considerations for placement include:

- Self-determined directive of the member/care giver for the placement,
- Geographical location of placement to maintain members in the community of their choice,
- The unique medical and psychosocial needs of the member,

- Exhaustion of community options/settings to safely maintain the member's health.

Essential Functions:

- Conducts remote and or onsite assessments of member (s) for comprehensive health re-assessments regarding clinical, behavioral and ADL requirements.
- Communicates with LTC Staff and attending health care providers involved in care of the member to coordinate TAR service requests by obtaining complete and accurate information as needed.
- Collects information concerning ongoing eligibility.
- Coordinates with Care Management team and provides updates regarding member health status.
- Participates in collaboration as necessary in member case management and ICT conferences
- Adheres to all HIPPA standards and confidentiality requirements.

Social Worker (MSW)/Licensed Clinical Social Worker (LCSW)

The Master of Social Worker or Licensed Clinical Social Worker primary duties are to identify and assist members that are displaying a complex variety of social and or emotional needs and usage of services reflective of abuse, lack of compliance to medical or pharmaceutical instructions, or self-destructive habits. The MSW or LSCW coordinates with these members and the member's PCP to provide better medical management and to track and gauge the effectiveness of that effort. Responsibilities include, but are not limited to:

- Responsible for the promotion of coordination, continuity of care and quality improvement in both the inpatient and ambulatory care settings;
- Assists the members with psychosocial and discharge planning needs as well as community resources;
- Performs reviews available reports for frequent usages of services and inappropriate usage of services by members;
- Identifies environmental impediments to client or patient progress through both personal or telephonic interviews and review of medical records;
- Investigates suspected child/elder abuse or neglect cases and notify authorized protective agencies when necessary.
- Refers member to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, or education.
- Advocates for members to resolve crises and demonstrate proficiency in de-escalation and interventional techniques

- Provides assistance and education to members as appropriate and in coordination with disease management, works to improve member participation in regular testing and screening along with follow-up visits to their PCP;
- Works collaboratively with the Care Management team to assist with identified social issues;
- Provide guidance and recommendations for the Behavioral and Mental Health Benefits (mild to moderate), including Autism Spectrum Disorders and Behavioral intervention.

Senior Health Services Program Administrator

The Senior Health Program Administrator is responsible for oversight, coordination, planning, management, execution, and finalization of Business-related programs that require Business resources. The Senior Health Program Administrator will be required to conduct program analysis, comprehend technical requirements, define plans for execution, coordinate technical resources assigned to tasks or programs, create program tracking reports, and accurately report to all levels of management on a program(s) status. This position requires the ability to maintain an interdependent relationship with providers, staff and members by providing administrative support on sponsored projects. Responsibilities include, but are not limited to:

- Consult with medical, business, and community groups to discuss service problems, respond to community needs, coordinate activities and plans, and promote programs;
- In a liaison role, assist in the design, review and testing of system generated processes used within KHS;
- Perform complex analytics in support of the overall achievement of strategic goals set out by the Board of Directors and Chief Executive Officer;
- Works closely with the Business Intelligence (BI) Department as needed to ensure proper processing of internal data processing technology, government regulations, health insurance changes and financing options;
- Interviews department personnel, research existing procedures and requirements in sufficient detail to yield statistics concerning volumes, timing, personnel requirements and representative transactions; analyzes and documents study findings; coordinate the system design between all users and data processing; designates controls and audit trails; writes program specifications; conducts user education
- Review and analyze facility activities and data to aid planning and cash and risk management and to improve service utilization;
- Act as a program management resource for Health Services on projects as assigned and may have to establish objectives and evaluative or operational criteria;
- Evaluate KHS Health Services preparedness recommend/suggest change in integrated health care delivery systems, such as work restructuring, technological innovations, and shifts in the focus of care;
- Participate in the preparation of business plans, analyses, financial projections, and programmatic and operational reports; work with internal teams to develop and

implement strategic initiatives for any issues that may require root cause analysis evaluation(s);
- Demonstrate an analytical aptitude to learn and understand business segment processes, including understanding issues of data integrity, security and confidentiality according to the Health Insurance Portability and Accountability Act (HIPAA).

Senior Operational Analyst

This position is responsible for providing an advanced role in the analysis of health care information as it relates to multiple disciplines for functional departments within the organization. The Senior Operational Analyst (OA) position is a resource with an ability in providing experience within integrated reporting, data analytics, process improvement, departmental metrics, and data integrity based on the collection, association, review, and the interpretation of data and operational processes. The OA will provide the skills necessary for report writing and presentation and performs detailed business analytics that contribute to and support the company's dashboard reporting efforts.

The Senior Operational Analyst is responsible for eliciting and projecting the actual needs of stakeholders, not simply their expressed desires, through an experienced methodical analytic process and seasoned ability to expose data reporting requirements. The position plays a central and critical role in aligning the needs of multiple business units with capabilities delivered by Information Technology and other operational departments and will lead or facilitate complex analytical discussions between all groups.
Some of the key fundamental goals and objectives of the incumbent include but are not limited to:

- Providing professional skills to mentor and assist team members in the most complicated analytics and report writing;
- Identify and address operational issues as to why a certain behavior or outcomes are exhibited in a department's data metrics;
- Function as the Departmental Subject Matter Expert (SME) for project requirement definition and communication;
- Ability to analyze and answer difficult operational questions under the direction of the Chief Medical Officer to provide validity as to why a certain measured artifact exists in data and brings meaningful context with a clear presentation to all levels of management.

Senior Analyst/Trainer

The purpose of this position is to provide support to the UM Management team for report generation, data collection for providing to the UM Clinical Auditor for review. Based on feedback from the UM Auditor, management, and clinical staff, assist in training criteria for staff improvement along with providing one-on-one training to improve staff efficiencies. Responsibilities include, but are not limited to:

- Performs utilization management activities related to data collection, data review and report preparation per KHS Utilization Management Program;
- Assists in the reporting of DHCS and DMHC required reports and Utilization Management's quality studies in order to meet State contractual requirements.
- Develop and implement staff training for new and existing employees along with internal findings as it relates to the duties of Utilization Management.

Senior Auditor/Analyst

This position provides the vital link between inpatient and outpatient as it relates to case managing members moving from hospital to home care. This position will ensure that processes are in place and followed in support of all members seeking care. This is a proactive audit of UM processes as they are in motion to catch and prevent errors. This position will link the social worker, case managers and medical directors in direct support of members under case management. Responsibilities include, but are not limited to:

- Performs audit of staff referral processing as it relates to compliance, accuracy, and performance levels;
- Reviews available reports and data to analyze the accuracy of staff performance as it relates to timeliness of referral processing, accuracy of data entry and appropriateness of decisions;
- Prepares State mandated report requirements as scheduled by the DHCS for management review and approvals;
- Reviews post-activity audit findings to UM Management to ensure compliance and to review where further training opportunity exist.

Director of Pharmacy

Qualifications for the Pharmacy Director include possession of a California State Board of Pharmacy registered pharmacy license, two years of health plan related pharmacy experience at a supervisory level or four years of pharmacy practice in a similar setting as a hospital or group purchasing organization. This position reports to the Chief Medical Officer (CMO).

KHS performs drug utilization reviews (DUR) to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care. Responsibilities include, but are not limited to:

- Participates and serves as the Chairperson on the Pharmacy & Therapeutics Committee;
- Offers direction for the Committee for continued development of the Formulary;
- Assists providers and members with issues concerning pharmaceuticals;

- Review of Treatment Authorization Request (TAR) for approval or denial;
- Encodes TAR information in Pharmacy Benefit Manager desktop system;
- Develops and maintains printed Formulary for providers;
- Contributes information on Formulary for provider newsletters;
- Accountability for maintaining drug expenditure within an established pharmacy budget;
- Coordination for opioid prescriptions and safeguards to prevent overutilization;
- Creation of clinically efficacious and cost-effective management programs;
- Development, implementation, and monitoring of clinical strategies to improve quality of care for members as well as provide clinical consultative services to contracting providers and KHS staff as necessary to support clinical programs;
- Oversight of clinical programs with supervision of the Pharmaceutical Program prior authorization process enabling open lines of communication with pharmacy providers on issues related to the KHS Formulary, pharmacy policies and procedures;
- Oversight and management of all clinically related activities with the KHS Pharmacy benefits staff.

Pharmacist

This position is responsible for executing the adherence of the Formulary and associated activities regarding pharmaceuticals for a Knox-Keene licensed health maintenance organization (HMO). Development and maintenance of protocols for disease state management that involves pharmaceuticals while serving as a liaison with pharmaceutical vendor representatives and other vendor representatives regarding pharmaceutical issues is critical to ensure appropriate medication decision making.

Pharmacy Technician

Support the KHS Director of Pharmacy in pharmacy activities related to the review, authorization, and TAR preparation under the direction of the Director of Pharmacy. The Pharmacy Technician assists the Director of Pharmacy and, as necessary, communicates follow-up to members, perform data entry, record keeping, data collection, filing, chart audits, collaboration with other departments at KHS and interaction with regulatory and contracted agencies. The Pharmacy Technician has a current CA Technician license or Certified Pharmacy Technician certificate with at least three years of pharmacy technician experience.

Components of the UM Program

Regulatory Components

The referral and authorization process conforms 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; 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
- 2020 DHCS Contract Exhibit
- DHCS MMCD Letters
- DHCS APL
- DMHC PPL
- Centers for Medicare and Medicaid Services (CMS) Federal Regulations
- Knox-Keene License

UM Department Orientation/Onboarding

Upon completion of the company orientation provided by Human Resources, all new employees assigned to UM for initial department orientation. For clerical level staff, the UM Senior Analyst/ Trainer will begin the training process dependent on the role the employee is moving into. For clinical staff (nurses) the UM Clinical Auditor/Trainer works collaboratively with the Outpatient and Inpatient Clinical Supervisor(s) to complete the orientation process which include introductions to policy and procedures, guidelines and information pertaining to the role of Clinical Intake Coordinator or UM Nurse. Initial training on referral or inpatient processing is cooperative and slowly migrated to allow the new employee autonomy into their role based on their level of understanding and competence demonstrated for the process.

Ongoing Training

KHS provides and encourages ongoing staff training. Areas of opportunity includes seminars, conferences, workshops, training by KHS Learning and Development department, and specialty specific training by contracted practitioners and provider organizations. The role of Senior Analyst /Trainer and UM Clinical Auditor/Trainer receives direction on the training needs of specific staff members from the UM Department leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

The Clinical Intake Coordinators and UM Nurse staff utilize established criteria for referral review and determination. Quarterly random audits are conducted to ensure compliance of the referral process and inter-rater reliability and are reported to UM Management for process improvement and staff education. Results of the findings are presented to the CMO and reported to the QI/UM Committee.
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. The Director of UM selects specific topics for completion by the UM clinical staff. The IRR training module records the completion for each user, along with the test results. KHS UM Management staff evaluates competency utilizing the MCG IRR training module for necessary remediation and education. Successful completion is required as a fulfillment of the clinical staff outlined job duties.

Referral Management

Referral management is designed to determine medical necessity utilizing established criteria based on an assessment of the member's clinical condition, diagnosis and requested treatment plan. Each case is evaluated individually, and sound medical criteria applied as appropriate. Contract providers are obligated to refer members to KHS network providers, and/or providers approved through the Utilization Management Letter of Agreement process, unless medical necessity or emergency dictates otherwise. Physician requested Out of Area/Out of Network referrals are processed through Provider Relations Department with Letters of Agreement (LOA) for financial reimbursement methodology. KHS utilizes a member centric medical management documentation platform, JIVA system by ZeOmega, to house all clinical information for each member. All health services departments with the exception of Pharmacy, have been implemented on the new platform in 2019.

Pre-authorization

Except for specific OB/GYN, Abortion Services, treatment for Sexually Transmitted Disease, HIV services, Sensitive services, Family Planning Services, Maternity Care, Transportation, Vision, Emergent/Urgent care, and Mental Health, PCP services from a KHS contract PCP, and services listed outside of the Prior Authorization List, most non-urgent specialty care must be pre-authorized by KHS in accordance with KHS referral policy and procedures. Requests for services are submitted either by fax or electronic online submission to KHS for review and processing.

For those services requiring pre-authorization, only KHS UM Clinical Staff and/or KHS Chief Medical Officer or designee(s), including the Physician Advisory Panel staff, may give authorization for payment by KHS. Denials, delays/extended delay, modifications, and terminations are performed in accordance with the Knox Keene license and DHCS contract. KHS utilizes both internal MD staff as well as contracted vendor(s), Advanced Medical Review (AMR), for medical necessity reviews as additional guidance and evidence based scholarly references to ensure appropriate medical decision making.

Analytics are completed at various times throughout the year when new information is received from Medi-Cal, and internally, at least quarterly, to reevaluate the appropriateness for prior authorization requirements.

Over and underutilization systemically is viewed through two objective methods both of which provide for further scrutiny to reveal where over or under-utilization occurs by service type or provider performance.

On a macro level, Kern Health Systems reports monthly utilization and cost metrics for all major service groups (pharmacy, professional, outpatient services, hospitalization, ER visits) by aid category, to determine if performance meets expectation. Target performance or expectation comes from the DHCS approved utilization and unit cost values for each service group, extracted

from data submitted to DHCS and approved as part of the annual rate development process. Aberrancies are investigated to determine the underlying reason for variations. Material differences (above or below expectation) are investigated to determine the root cause. Patterns, unrelated to natural acuity trends such as seasonality (e.g., flu season) are tracked and investigated for medical treatment appropriateness.

On a micro level, quarterly, KHS compares for both PCP and Specialists practice patterns for similar diagnosis (within the same specialty) to identify behavior inconsistent with their colleagues. Differences in practice patterns for similar diagnosis for same provider type are measured for:

- Over or under patient visits (churning)
- Over or under dx testing
- Over or under outside referrals

Providers deemed outliers are investigated to determine the reason(s) for their behavior. Where it is not justified, providers will be appropriately reported, educated, and monitored to assure their practice patterns are brought in line with their colleagues and remain consistent with expectation.

Concurrent Review

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a hospital admission in order to justify the continued level of care. The concurrent review process is conducted by California licensed Registered Nurses by review of the member's medial record, reviewing the hospital's case management notes, dialoguing with the attending physician and other members of the health care team, and speaking with the patient and/or family or significant other, as needed.

Hospitalizations are concurrently reviewed for appropriate length of stay and discussed during scheduled rounding meetings with the KHS CMO (or designee) if medical necessity cannot be established. Concurrent reviews are performed collaboratively with KHS contracted hospitalist groups and/or providers and KHS RN staff to determine medical necessity of admission, length of stay, and post discharge dispositions.

Through the hospitalist program, the UM Nurse can authorize referral requests for member discharge planning and coordination of services for post-acute care. UM Nurse and/or the UM Social Worker will assess member's post hospital continuing care needs and will collaborate with the provider organization's discharge planning staff to plan for appropriate post-acute services pertinent to the member's recovery such as SNF, Acute Rehabilitation, DME, Home Health, specialist follow-up visits, community resources, and any other services identified. Recuperative Care and Transitional Care Clinics are designed to address potentially avoidable

readmission, recidivism, and improve health through member empowerment and early intervention.

Retrospective Review

For those services requiring prior authorization, retrospective review for payment of claims is initiated when no prior authorization was obtained by the practitioner or provider organization. Retrospective review is also initiated for services performed by a non-contracted provider or when no authorization was obtained before completion of the service. Members, practitioners, and provider organizations are notified by mail/online of the UM/ claims decision.

Utilization Management Decision Timeframes

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member's condition. KHS remains compliant with the defined timelines under the DHCS contract. When the member faces an imminent and serious threat to his or her health, including, but not limited to, potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests from provider, shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to render a decision.

Medical Necessity Review Criteria

During the review/case management process, KHS UM department staff uses criteria to assist in the clinical appropriateness determination. The criteria used include, but are not limited to:

A. **Medi-Cal guidelines**-DHCS/DMHC provide ongoing updates
B. **MCG (Milliman Care Guidelines)**-updated annually by the vendor
C. **Up to Date**- Evidence-based physician-authored clinical decision support resource which clinicians utilize to determine point-of-care decisions, including a collection of medical and patient information, access to Lexi-comp drug monographs and drug-to-drug, drug-to-herb and herb-to-herb interactions information, and a number of medical calculators.
D. **Professional Society Organizations**, i.e.,
    a. American Academy of Pediatrics
    b. American Academy of Orthopaedic Surgeons
    c. American College of Cardiology

Clinical Practice Guidelines are developed using current published literature, current practice standards and expert opinions. They are directed toward specific medical problems commonly found with members. The PAC reviews and approves all Clinical Practice Guidelines and/or Preventive Health Guidelines prior to presentation to QI/UMC. The QI/UMC is responsible for

adopting and disseminating Clinical Practice Guidelines for acute, chronic, and behavioral health care services. Guidelines are reviewed annually and updated if necessary. All criteria are available to the public upon request.

Review criteria are communicated to practitioners when KHS UM modify, delay, or deny referrals for services requested. The practitioners are notified during their office In-service/onboarding by the Provider Relations department and through KHS practitioner newsletters/bulletins of the availability of KHS referral criteria.

The KHS Chief Medical Officer or their designee(s) are responsible for ensuring medical decisions are rendered by qualified medical personnel and that the medical care provided meets the standards for acceptable medical care, as well as ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

KHS maintains the organizational and administrative capacity to provide services to our members. All medical decisions are rendered by the qualified Chief Medical Officer, or Medical Director(s), unhindered by fiscal and administrative management considerations. In addition, any decision based on medical necessity or otherwise, shall be reviewed by a different Medical Director, or Physician Reviewer, who did not take part in any prior decision-making processes.

Second Opinions

Members have a right to a second opinion by a qualified medical professional. A request for second opinion is reviewed to determine whether KHS has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed within the plan to obtain second opinion. When an appropriate, qualified physician is not available within the plan, an out of area/out of network referral with LOA is authorized.

Independent Medical Review

Medi-Cal members can request independent medical review (IMR) on denied appeals involving medical necessity, including requests related to experimental/investigational services and receipt of out of Plan Emergency Department services. The DMHC administers the IMR program in the State of California at no cost to the member in compliance with applicable statutory requirements and accreditation standards. The IMR decision is binding on KHS.

Depending on the complexity of certain medical condition, KHS may require additional expertise in determining medical necessity for certain diagnosis and related procedures. Utilizing a nationally recognized and comprehensive review solution as a supplement to these difficult cases will provide the KHS CMO and Medical Directors with comprehensive medical recommendations utilizing case-specific patient information and history and industry standard guidelines including treatment protocols supported by current scientific evidence-based medicine

to promote quality health care. Each review will be assigned to the IMR Reviewer who will be in an appropriate specialty or who will possess specific knowledge appropriate to the request of the treating provider. The IMR Physician Advisors will be specifically trained in Medicare/Medicaid rules and regulations based upon California state guidelines and remain well versed in the ongoing regulatory landscape to ensure up to date legislative rulings are current in the review process.

All services will be performed based on specific turnaround times which are calculated from the time the request and all related materials are received by the IMR reviewer. Submission of requests via a secure portal are completed by the KHS Clinical Intake Coordinator (CIC) on behalf of the CMO or designee at their direction only. It is the responsibility of the submitting CIC to track the progress of the review to ensure receipt based on the recommended turnaround timeline. The designated turnaround times will align with all DHCS timelines for medical decision making as outlined in KHS contract.

Denial Process

All recommended denials are reviewed by the CMO or designee(s), with the exception of administrative denials that are not based on medical necessity and performed by the UM RN Clinical Intake Coordinators/UM Nurse. Services denied, delayed/extended delay, terminated, or modified based on medical necessity may be eligible for an Independent Medical Review. The referring practitioner, provider and member are notified of the denial through a Notice of Action (NOA) letter, translated in both English and Spanish with non-discrimination clauses and tagline notations.

When a physician requests a health care service that is subject to prior authorization and the request has been reviewed, denied, delayed, or modified as a result of UM review, the member and provider are provided a written communication that includes the following required elements:

- A clear and concise explanation of the reasons for the Plan's decision;
- A description of the utilization review criteria used, and the clinical reasons for
- the decision regarding medical necessity;
- Information as to how the member may file a grievance or appeal with the Plan and, in
- case of Medi- Cal members, information, and explanation on how to request an
- administrative hearing in compliance with Title 22 of the California Code of Regulations;
- Notice of availability of language assistance services;
- Written notice to physicians or other health care providers of a denial, delay, or
- modification of a request, including the name and telephone number of the health
- care professional responsible for the decision. The telephone number is a direct
- number or an extension that allows the physician or health care provider easy access
- to the professional responsible for the UM decision. UM staff and physicians are
- available during normal business hours to assist members and physicians with UM

- concerns;
- Written Notice to the physician and member includes information on
- Independent Medical Review.

Denial notices are issued in accordance with applicable regulations and accreditation standards. The Department of Health Care Services and Department of Managed Health Care provide direction to and oversight of the process of issuing written notification of non-coverage to KHS members.

Appeal Process

KFHC members are notified in writing of his/her right to appeal through the Member Grievance Process within the Notice of Action letter correspondence. The notice includes member's right to request a State Fair Hearing, member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend, or other spokesperson, the name, address, and phone number of KHS, toll free number for obtaining information on legal service organizations for representation, and the right to request an Independent Medical Review.

Practitioners/providers may submit a written appeal for referrals that have been denied on the member behalf with a member's consent. KHS has established a fast, fair and cost-effective appeal resolution mechanism to process and resolve practitioner/provider prior auth appeals. A practitioner or provider appeal is defined as "A contracted, or non-contracted practitioner's or providers written notice to KHS seeking resolution of a denial-of-service referral request." The appeal must contain the practitioner/provider's name, tax identification number, contact information, and a clear explanation of the issue and the practitioner/provider's position thereon." Additional medical information pertinent to the appeal should be included at that time. All appeals must be submitted to KHS within 60 calendar days of the date of KHS action, or in the case of inaction, 365 calendar days after the time for action has expired.

All KHS members have the right to ask for an expedited decision on prior authorization or concurrent requests for health care services and supplies, and/or expedited review of decisions to terminate health care services. When a member's life, health, or ability to regain maximum function could be jeopardized using standard utilization review time frames, or when a provider familiar with the member's clinical situation states that the need for review is urgent, the appeal is expedited.

Telemedicine/Telehealth

Telemedicine and other remote monitoring capability are a growing trend in the evaluation of a member's health. Telemedicine allows for HIPAA compliant medical information to be 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 virtual/telephonic communication modalities technology. No additional prior authorization is required for telemedicine, only the service is subject to those contained in the Prior

Authorization list 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. This allows KHS additional options to serve members in both local and rural areas to improve primary care and specialty access and reduce wait times.

Emergency Services

KHS complies with all applicable requirements of Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Health and Safety Code Section 1371.4.
KHS shall reimburse providers for emergency services and care provided to members, until the care results in stabilization of the member. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention may be expected to result in any of the following:

- An imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- A delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.

KHS strives to strengthen our collaborations with community entities in order to reduce costs, improve the patient experience, and improve the health of the populations we serve. Strategies are reviewed annually to determine the best approach to reducing inappropriate ER utilization. These include:

- Broaden access to Primary Care Services
- Focus/enroll high utilizers into Case management programs
- Target members with behavioral health problems

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization

KHS does not require prior authorization for emergency services. Post-service claims review (for out of plan emergency care) considers whether the member's decision to Present to the Emergency Department was reasonable under the circumstance.

Post-stabilization

KHS requires review and authorization for all out of plan post-stabilization care, and follows all statutory requirements and accreditation standards in making post-stabilization care authorization decisions.

Completion of Covered Services

KHS, at the request of a member, provides for the completion of covered services by a terminated provider or by a nonparticipating provider. The completion of the covered service shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services to include:

- Acute Condition
- Chronic Condition
- Pregnancy
- Terminal Illness
- Care of a Newborn (between birth and 36 months of age)
- Performance of a surgery or other procedure authorized by the plan as part of a course of treatment
- Applied Behavioral Analysis
- Mental Health Condition

The plan may require a non-participating provider, whose services are continued, to agree in writing to the same contractual terms and conditions that are imposed upon providers under current contract.

Standing Referrals

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. 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. Members are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity. A standing referral may be limited by number of visits and/or length of time. 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 will negotiate letters of agreement for services not available within the network.

Delegation of Utilization Management Functions

KHS has the discretion to delegate, and the responsibility to oversee, UM functions performed by either Kaiser Foundations Health Plan in support of the KHS UM goals and objectives. KHS also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KHS retains accountabilities for all delegated Utilization Management activities conducted for members and ensures that delegated UM processes are designed to meet member service and access needs.

On an annual basis, KHS performs a comprehensive assessment of the delegated UM activities to include a UM file review. The entity's annual evaluation of delegated UM functions and

assessment summaries of activities are presented to KHS Medical leadership for review and approval.

Should there be any concerns regarding failure of a delegated entity to carry out delegated activities, KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

UM Delegation to Affiliated Providers

When UM activities are delegated to contract affiliated providers, KHS retains responsibility and oversight of the delegated functions. The delegation is subject to an executed delegation agreement in which UM activities are clearly defined, including:

- Reporting requirements for the delegated entity;
- Reporting requirements for KHS to the delegated entity;
- Evaluation process of the delegated entity's responsibilities;
- KHS Approval of the delegated entity's UM program and processes;
- Mechanisms for evaluating the delegated entity's program reports;
- The delegated entity’s ability to collect performance data necessary to assess member experience and clinical experience, as applicable;
- KHS right to revoke and terminate a delegation agreement.

Delegation of UM Activities

KHS has delegation oversight activities/processes for pre-delegation evaluation, delegation oversight activities, and regular reporting used to monitor delegates according to the standards established by KHS, licensing and regulatory bodies. KHS may delegate Utilization Management (UM) and Pharmacy functions/activities to entities with established Quality Improvement and Utilization Management programs and policies consistent with licensure and regulatory requirements.

KHS remains accountable for and has appropriate structures and mechanisms to oversee delegated activities even if it delegates all or part of these activities. KHS tracks and processes all KHS member’s UM activity internally with the exception of Kaiser assigned MCAL members whose UM functions are delegated as part of a two-way agreement under contractual requirement with DHCS. Joint Operations meetings are conducted quarterly in addition to an annual delegation audit to ensure compliance with DHCS regulatory requirements.

KHS contracts with a third-party vendor to provide 24/7, weekend and holiday triage services for all KHS members. The vendor provides not only triage services but also supports a member-initiated Health Library to promote education on a varying number of topics. Reports are

generated monthly to monitor their activities as well as identify member patterns during execution of after hour services. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

Vision Care is delegated to a 3rd party vendor and capitated for all vision services. Reports are generated monthly to monitor their activities as well as identify utilization patterns. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

KHS contracts with a vendor, Health Dialog, to perform 24-hour Nurse Advice and triage call center activity and provides summary reports detailing the utilization of services at scheduled intervals. The report is reviewed for trending of ER and Urgent Care usage based on total usage compared against deferment back to the PCP and Home/Self Help care. Monthly touchpoints are scheduled to address any issues or trends identified. Actions plans are developed if utilization patterns raise concerns for escalation. Health Dialog provides a Health Audio Library for member self-service of specific health topics or acute/chronic condition education.

All delegated entities are required to support and adhere to the same regulatory reporting and access standards as KHS. KHS has the responsibility to the Delegated or Subcontractor's agreement to revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or KHS determine that the Subcontractor has not performed satisfactorily.

Complete delegated oversight audits are conducted at least annually, and more often if warranted, to ensure all aspects of KHS's contract are performed to the standards outlined by DHCS and DMHC.

Appropriate Utilization Oversight and Monitoring

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. The UM department sends correspondence notifying the practitioners and members of the carved-out services and a reminder to see their primary care provider for all other health care services not addressed by the carved-out specialty care provider for gaps in care closure.
- Over-utilization of services is monitored through several functions. Reports are reviewed to analyze unfulfilled authorizations or gaps in care to determine interventions directed to ameliorate any identified adverse trends.
- At least quarterly, the Chief Health Services Officer meets quarterly with the CMO, Medical Directors, and Health Service's leadership team to review utilization trends.

- Audits for over and underutilization are performed to identify any potential fraud, waste, and abuse. If suspected, the information is reported to Compliance within five (5) working days and the audit findings are then subsequently reported quarterly to QI/UM Committee
- Utilization across all UM functions are evaluated to determine if fraud, waste, abuse, or quality concerns warrant investigation. Suspected or identified fraud, waste, and abuse is reported to the Compliance department within five (5) days for investigation to determine if additional actions are required, and subsequently reported quarterly to QI/UM Committee

Request for prior authorization or the continuations of previously authorized services are tracked for duplication and appropriateness of continued use. Coordination of the member's health care as part of the targeted case management process serves to determine the medical necessity of diagnostic and treatment services recommended but may be covered services through Kern County Public Health, Kern Regional Center, Kern Behavioral and Recovery Service, California Children Services (CCS), or various community programs and resources.

Resource Management

Resource Management activities focus on the prudent and clinically appropriate allocation of resources for the provision of health care services. These activities are not subject to direct regulation under the Knox-Keene Act. The UM Program monitors and provides oversight of coordinated performance related to Utilization/Resource Management across the continuum to include:

- Drug Utilization
- Laboratory Utilization
- Product Utilization
- Radiology Utilization
- Surgical Utilization

Medical Loss Ratio

Medical Loss Ratio (MLR) is a metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues. KHS has placed major emphasis on the reduction of MLR to monitor and manage utilization within the health plan. Areas of focus include achieving an overall Key Performance Indicators (KPI) metrics Goal of <92% across all lines of business-SPD, Family/Other, and Expansion. Dashboards have been created for transparency of all identified KP.

Evaluation of New Medical Technologies

KHS evaluates a variety of web-based interactive applications for future consideration of medical technologies adoption. KHS MIS department develops and implements new

technologies as they emerge to provide efficient methods of tracking member activity and report generation. UM clinical staff have direct access to various websites for review and reference for discussions on innovative methods not currently in use by KHS that may be implemented in the delivery of healthcare to KHS members. New technologies are vetted with MCAL guidelines for coverage, then forwarded to the PAC and QI/UM committees before board approval.

The following information is gathered, documented, and considered for determination:

- Proposed procedure/treatment/medication device
- Length of time the treating practitioner has been performing the procedure/treatment
- Number of cases the practitioner has performed
- Privileging or certification requirements to perform this procedure
- Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated
- Identification of other treatment modalities available
- Consideration as to whether Medicare/Medi-Cal approves the service/procedure
- Whether the medication/procedure is FDA approved
- Literature search findings
- Input from network Specialist

The CMO, or designee, or the Director of Pharmacy, consults specialists, market colleagues, the Physicians Advisory Committee (PAC) and/or the Pharmacy and Therapeutics Committee (P&T) as needed to assist in making coverage determinations and/or recommendations.

Medical Reviews and Audits by Regulatory Agencies

KHS' Director of Compliance and Regulatory Affairs, in collaboration with the CMO, Chief Health Services Officer, and other Clinical leadership, provides direct oversight to all KHS medical audits and other inquiries by our regulatory agencies, DHCS and DMHC. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

Integration of Study Outcomes with KHS Operational Policies and Procedures

KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed, and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

Provider and Member Satisfaction

Satisfaction Surveys are conducted annually by the KHS Member Services and Provider Relations Department. Results are shared with the Executive leadership and other KHS departments. Any unsatisfactory areas of the UM process are re-evaluated by the KHS Chief Medical Officer or designee, Chief Health Services Officer, and the Director of Utilization Management to develop and implement strategies to ameliorate deficiencies.

KHS participates in the Consumer Assessment of Health Plan Survey (CAHPS) Member Satisfaction Survey and utilizes these results in the assessment of member experience with the UM program. Analysis of grievance and appeal data related to UM is also monitored as a part of the member experience review.

KHS contracts with physicians and other types of health care providers. Provider Relations conducts assessments of the network adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff and includes other information related to disability accommodations and hours of operation. The Provider Directory is 274 compliant with DHCS requirements and is available to members in printed or electronic versions.

Statement of Conflict of Interest

UM decision-making is based on established criteria, appropriateness of care and service, and existence of coverage. KHS does not provide financial incentive for practitioners or other individuals conducting utilization review for denials of services or coverage. All committee members are required to sign a conflict-of-interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to UM Physicians and staff on the Kaiser Permanente Intranet compliance site. Ongoing mandatory education is required annually for all staff.

Confidentiality

To ensure member and practitioner information is held in strict confidence, to safeguard the information received, and to protect against defacement, tampering or use by unauthorized persons or for unauthorized purposes, all member specific information, documents, reports, committee minutes and proceedings are protected from inadvertent release and discovery.

All staff members sign a confidentiality statement as a condition of employment. All documentation and information received are confidential and distributed only on a need-to- know basis.

Access to this information is restricted to a need-to-know basis. The proceedings and records of the continuous review of the quality of care, performance of medical personnel, utilization of services and facilities and costs are subject to confidential treatment under Health and Safety Code 1370 and Section 1157 of the California Evidence Code.

The UM department handles all patient identifiable information used in clinical review, care, and service in a privileged and proprietary manner. The QI/UM Committee develops and implements confidentiality policies and procedures and reviews practices regarding the collection, use, and disclosure of medical information. KHS retains oversight for provider confidentiality procedures.

KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process.

All members, participating KHS staff and guests of the QI/UMC and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hiring. The confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Annual Program Evaluation

On an annual basis, KHS evaluates and revises as necessary, the UM Program Description and Evaluation. The Chief Medical Officer, in collaboration with the Chief Health Services Officer, documents a yearly summary of all completed and ongoing UM Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms. A written evaluation of the UM Program is prepared and reported to the QI/UM Committee and Board of Directors annually.

UM Program Integration with KHS Quality Management Program

The UM Program is an integral part of the KHS Quality Management Program. UM incorporates quality, risk, safety processes and initiatives into the review process for the identification of incidents, patterns, and trends. Identified potential anomalies are escalated to the Quality Department in a timely manner. Utilization reports, including over- and under-utilization trends, display metrics across regional service areas, and medical center level. Performance data is collected and analyzed to identify improvement opportunities, ensure consistency, increase health equity, and decrease variation in practice and care delivery. Results of monitoring and analysis are integrated into the KHS Quality Program through reports to the appropriate KHS Committee.

The Board of Directors is responsible for the direction of the UM Program and actively evaluates the annual plan to determine areas for improvement. Board of Director comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of UM activities and progress toward meeting UM goals is available to members and contracting providers upon request.

_____

KHS Board of Directors (Chair/Designee) Date

_____

Chief Executive Officer Date

_____

Chief Medical Officer Date

_____

Chief Health Services Officer Date

_____

Director of Utilization Management Date

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robin Dow-Morales, Director of Claims

Date: December 15, 2022

Re: Optum Renewal, Claims Editing Software

Background

The Kern Health Systems ("KHS") contract with the Department of Health Care Services ("DHCS") requires health plans to use industry standard claims editing software to ensure the accuracy of claims submissions from billing providers. KHS issued a Request for Quote ("RFQ") for a Claims Editing Software ("CES") in October of 2017 to replace McKesson Claimcheck software that reached its end of life. CES allows KHS to edit claim errors automatically for clinical coding and billing using a set of industry rules to prevent provider payments with incorrect code combinations. CES also contributes to the Auto Adjudication of claims which reduces manual processing by staff. This is the first renewal.

Discussion

Optum will provide KHS with the Claims Editing Software for a five (5) year term with support.

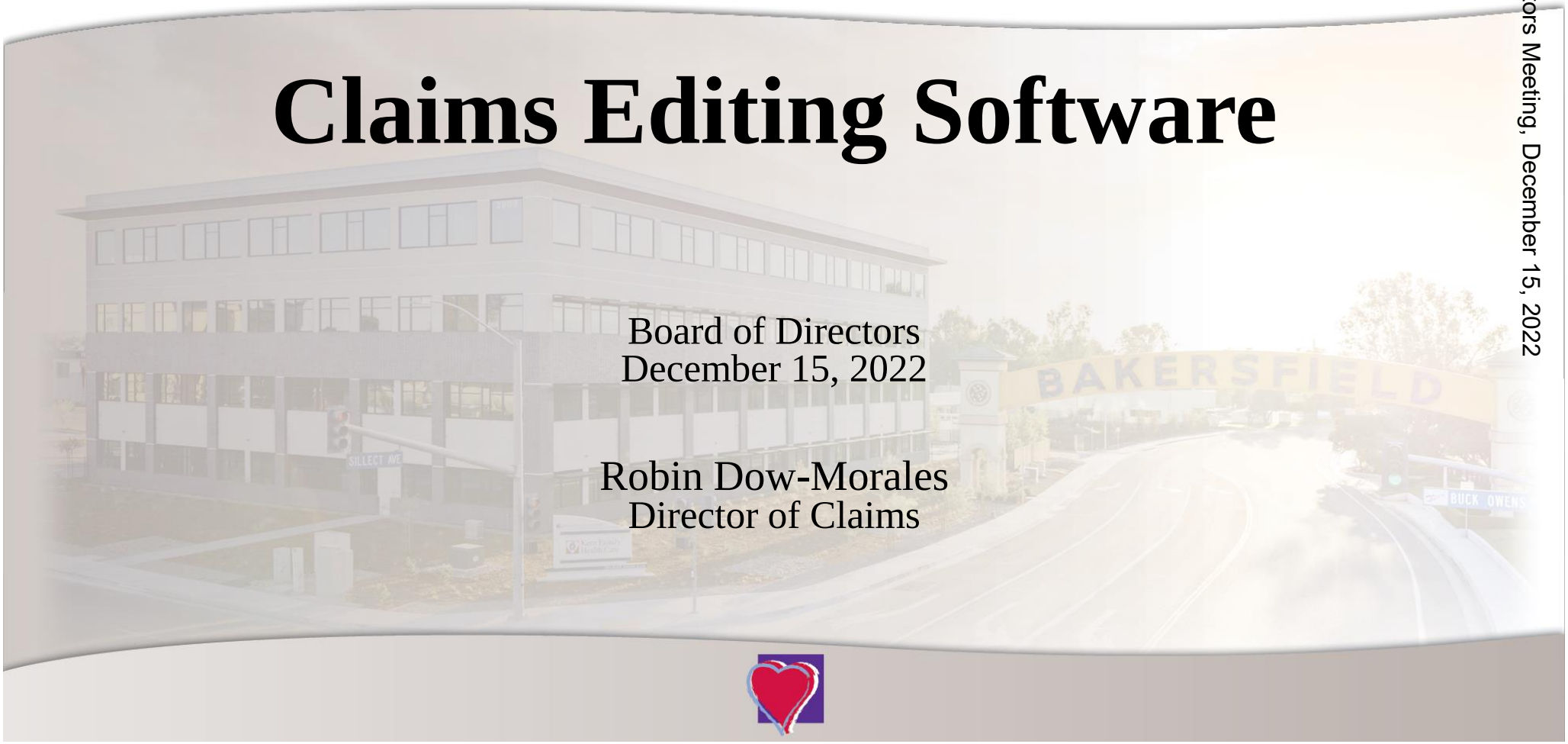
Financial Impact

Cost for the five-year term not to exceed $3,845,563 per five years.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

Claims Editing Software



Board of Directors
December 15, 2022

Robin Dow-Morales
Director of Claims

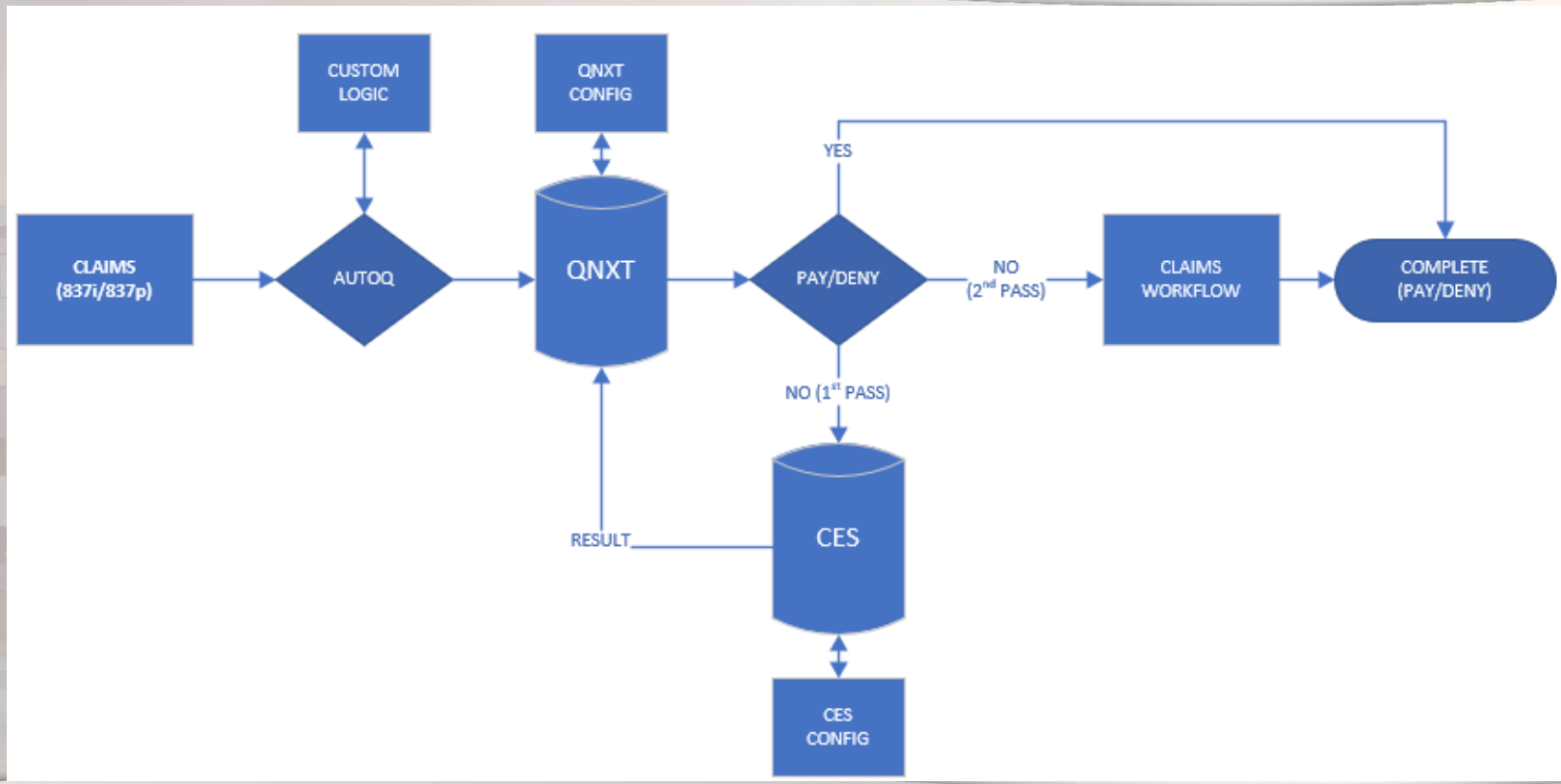
Agenda

- Agenda
- Background
- System Function/Design
- Effectiveness
- Evaluation
- Board Request

Background

- KHS uses the Optum Claims Edit System (CES) in tandem with the QNXT claims processing system to review providers claims prior to adjudication.
- Allows KHS to edit claim errors automatically for clinical coding and billing using an expansive set of industry rules to prevent improper provider payment when incorrect code combinations are identified.
- Contributes to the Auto Adjudication that KHS leverages to reduce manual processing by staff
- Per DHCS Contract, the plan is required to edit claims based on Medi-Cal, CCI, and standard coding requirements.

System Design/Function



Effectiveness

Claim Edit Software | CES Impact Quantification Analysis
January 2018 through November 2022

KERN HEALTH SYSTEMS

Business Intelligence

	Total Claims	Claims with CES Edits	% of Claims with CES Edits	Claims with CES Edits AA	Claims with CES Edits AA Rate	Claims Processer per Day	Working Days per Year	Claims Processer per Year	Amount of Staff to Process
2018	2,563,668	594,793	23%	329,345	55%	100	252	25,200	13.07
2019	3,034,771	971,122	32%	661,143	68%	100	252	25,200	26.24
2020	2,978,154	912,392	31%	621,365	68%	100	253	25,300	24.56
2021	3,368,694	1,086,767	32%	832,959	77%	100	249	24,900	33.45
2022	3,315,308	1,153,801	35%	887,125	77%	100	222	22,200	39.96

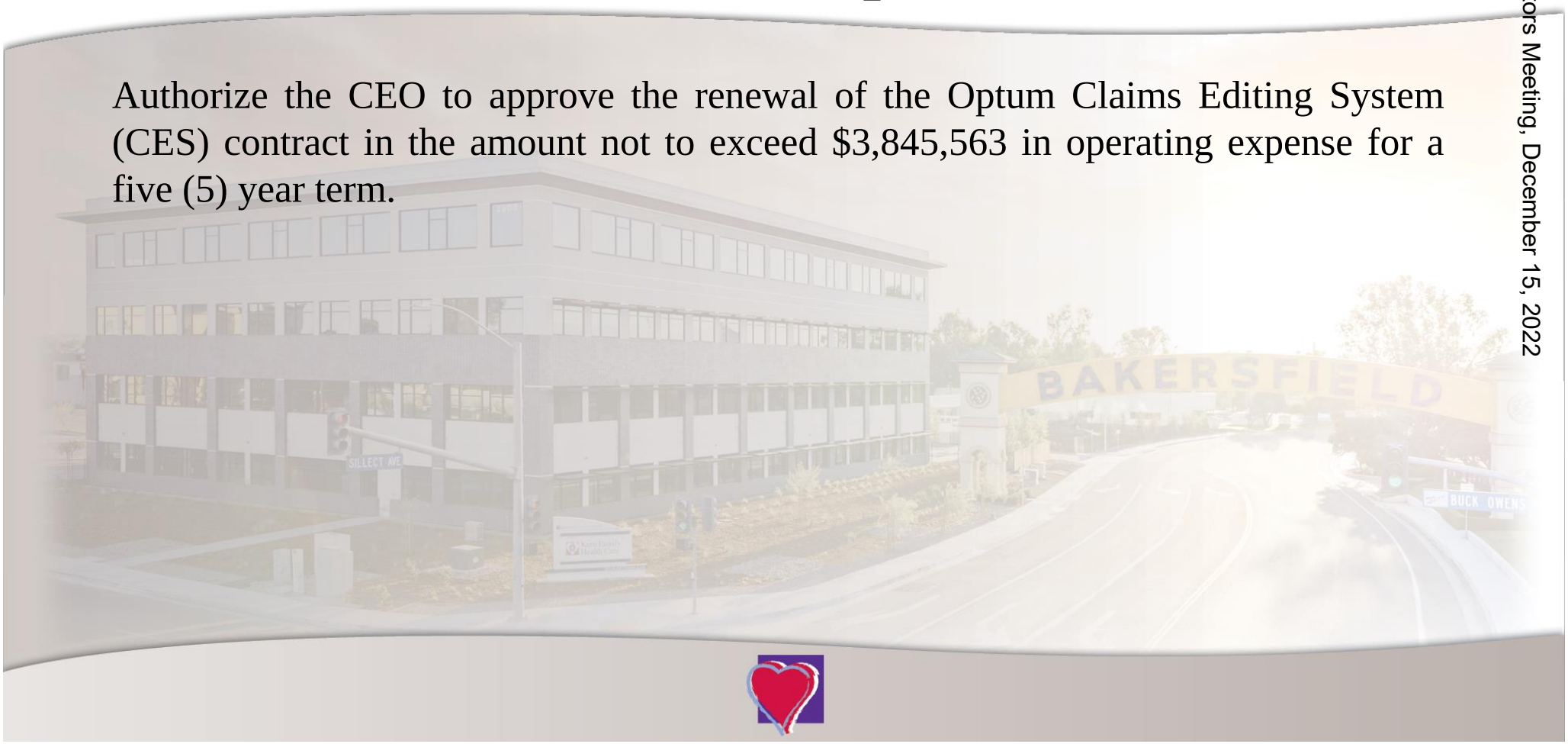
Run Date: 11/15/2022

Evaluation

- First renewal of the Optum CES contract after the initial five-year term.
- Complex system that would require significant effort and time to replace to ensure accurate auditing.
- Tool provides significant plan savings by reducing manual claims processing by thirty (30) full-time employees in 2022. ($3M in salaries and benefits).
- Contract cost for the first 5 years was $3,171,821. Contract request for the next 5 years is $3,845,563. The $673,742 difference is mainly due from a significant increase in membership over the last 5 years along with a 3% annual rate increase that is consistent with the initial 5 year term.

Board Request

Authorize the CEO to approve the renewal of the Optum Claims Editing System (CES) contract in the amount not to exceed $3,845,563 in operating expense for a five (5) year term.



Questions

For additional information, please contact:

Robin Dow-Morales
Director of Claims
661-617-2598
Robin.dow-morales@khs-net.com

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: CL Department Head: Robin Dow-Morales

Vendor Name: OptumInsight, Inc. Contact name & e-mail: Chris Bentley, chris.bentley@optum.com

What services will this vendor provide to KHS? Optum will provide KHS with Claims Editing Software for a five (5) year term with support.

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☐ New agreement ☒ Continuation of Agreement ☐ Addendum ☒ Amendment No. 2 ☐ Retroactive Agreement	Background: Optum to provide Claims Editing Software that has the ability to identify Medicare, Medicaid and Medi-Cal edits. It also has the flexibility to allow KHS to select specific rules based on business needs and contracts. Software identifies services that should be bundled, MUE edits, and limits/maximums. Optum to provide support for the use of the CES as well as training. Brief Explanation: Optum will provide KHS with Claims Editing Software for a five (5) year term.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification: ____

☒ Sole source – no competitive process can be performed.

Brief reason for sole source: KHS currently holds an ongoing contract with vendor.

☐ Conflict of Interest Form is required for this Contract

☐ HIPAA Business Associate Agreement is required for this Contract

Fiscal Impact

KHS Governing Board previously approved this expense in KHS' FY 2022 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☒ NO	☐ YES
Capital project	☒ NO	☐ YES

Project type: ____

Budgeted Cost Center 225 GL# 5400

Form updated 10/13/22

Maximum cost of this agreement not to exceed: $3,845,563.00 per five years

Notes: ____

Contract Terms and Conditions

Effective date: 12/22/2022 Termination date: 12/21/2027

Explain extension provisions, termination conditions and required notice: ____

Approvals

Compliance DMHC/DHCS Review:

Director of Compliance and Regulatory Affairs

Date

Legal Review:

Approved by Legal Scott Koller

Legal Counsel

per email dated 12/26/17

Date

Contract Owner:

Department Head

Date

Purchasing:

~~Director of Procurement and Facilities~~ Senior Contracts Coordinator

11/29/22

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

11/30/22

Date

Recommended by the Executive Committee:

Chief Operating Officer

12-1-2022

Date

IT Approval:

Chief Information Officer or IT Director

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

KHS Board Chairman

Date

Form updated 10/13/22

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Richard Pruitt, Chief Information Officer

Date: December 15, 2022

Re: Nutanix Software Support and Maintenance Renewal

Background

KHS leverages the Nutanix manufacturer of hardware and software as its Hyper-Converged Infrastructure (HCI) for the company servers and storage. The HCI infrastructure supports the end-user desktop, core processing systems, various applications, and database technology within KHS.

Discussion

KHS continuously reviews data center equipment for replacement and growth based on the manufacturers life cycle and support; normal wear and tear; utilization performance; and when procuring new systems to be installed. Based on this review, KHS will continue to leverage the Nutanix HCI infrastructure to support its production systems. This expenditure will support the data center renewal of hardware and software for a three-year term (2023-2025).

Fiscal Impact

Cost for three (3) years term not to exceed $1,328,560.25 in budgeted expenses

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

9700 Stockdale Highway, Bakersfield, CA 93311-3617
(661) 664-5000 • Fax (661) 664-5151
www.kernhealthsystems.com

Nutanix Support Renewal

Board of Directors
December 15, 2022

Richard Pruitt
Chief Information Officer

Agenda

- Background
- Procurement Process
- Vendor Selection
- Management Recommendation
- Board Request

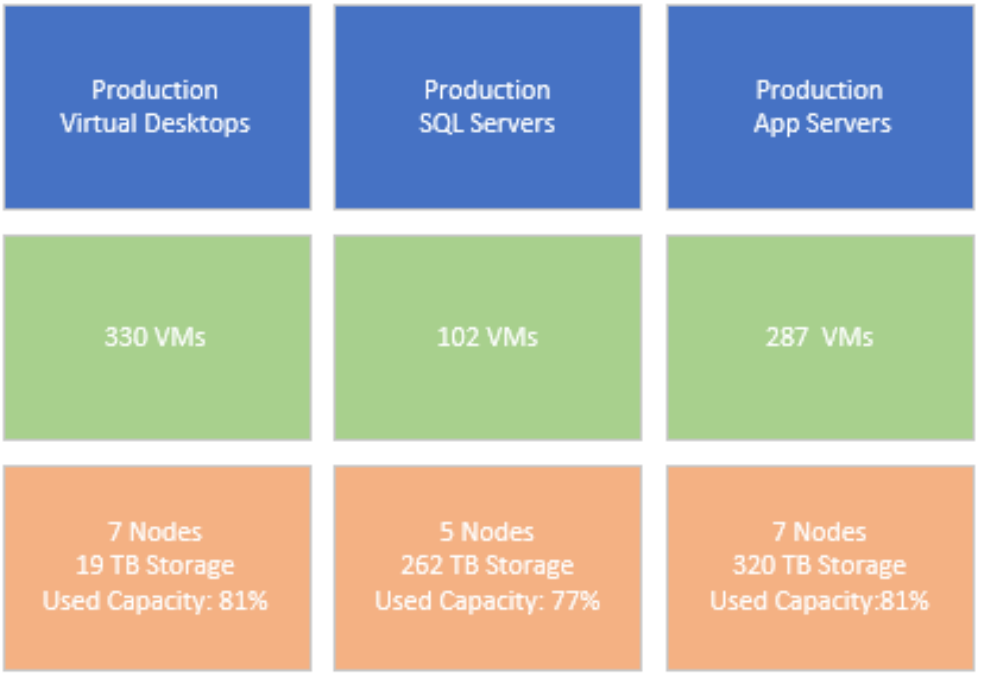
Background

KHS leverages the Nutanix manufacturer of hardware and software as its Hyper-Converged Infrastructure (HCI) for the company servers and storage. The HCI infrastructure supports the end-user desktop, core processing systems, various application and database technology within KHS.

KHS continuously reviews data center equipment for replacement and growth based on the manufacturers life cycle and support; normal wear and tear; utilization performance; and when procuring new systems to be installed. Based on this review, this expenditure will support the data center renewal of hardware and software for a three-year term (2023-2025).

Nutanix Renewal Usage

- Production Systems Supported by Renewal:
- Total Servers: 719
- Total Storage: 601 TB
- Total Nodes: 19
- Supported Production Systems:
  - Production Virtual Desktops
  - Production SQL Servers (All KHS Production Data)
  - Production Application Servers (All KHS Production Systems)



Procurement Process

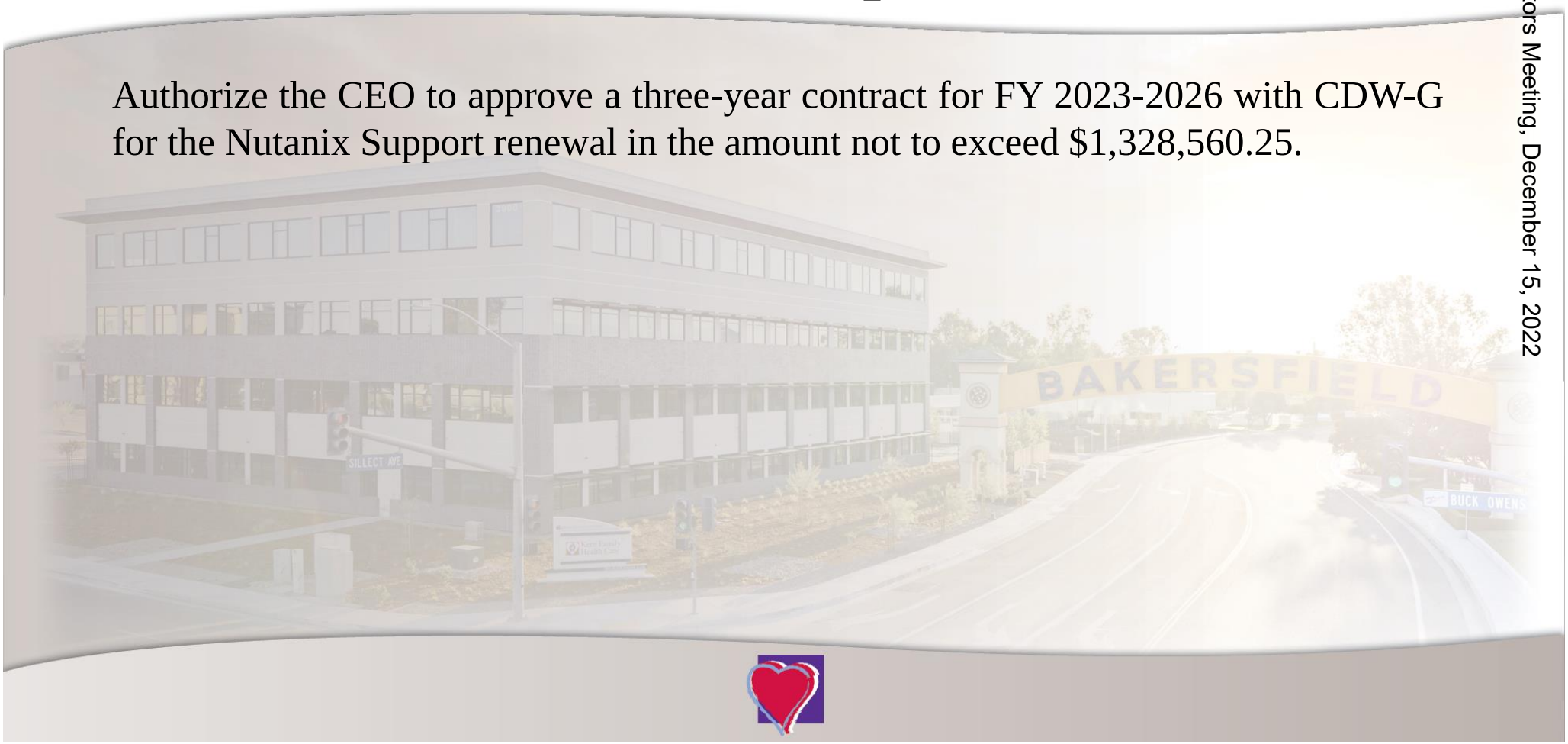
- Reviewed and Defined Licensing Needs
- Created and Published RFQ
- Reviewed and Selected Vendor
- Create Recommendation and Presentation for Board

Vendor Recommendation

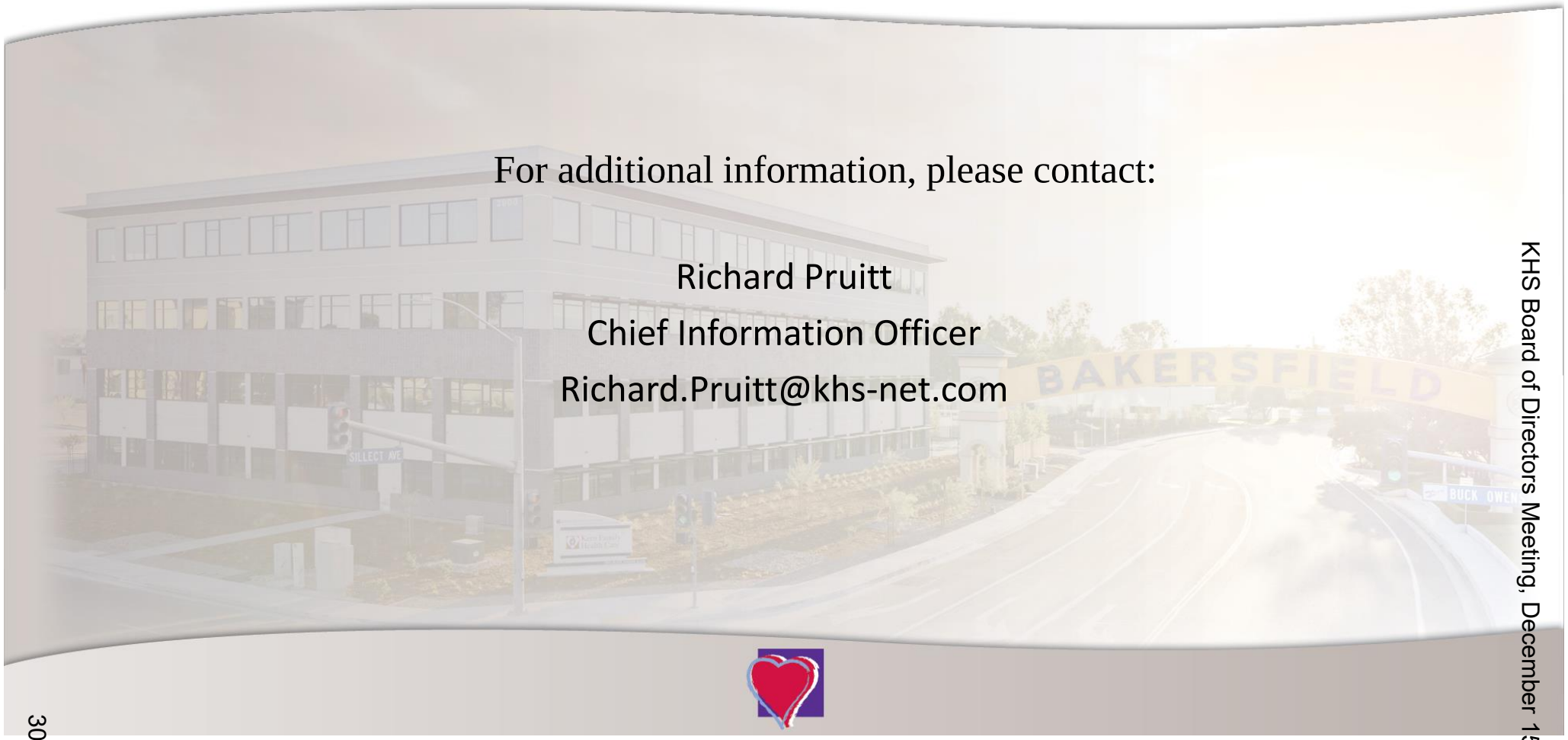
Vendor	Vendor 1	Vendor 2	Vendor 3
Price	$ 1,328,560.25	$ 1,376,336.82	$ 1,337,936.89
Shipping	$ -	$ -	$ -
Tax	$ -	$ -	$ -
Total Cost	**$ 1,328,560.25**	**$ 1,376,336.82**	**$ 1,337,936.89**

Board Request

Authorize the CEO to approve a three-year contract for FY 2023-2026 with CDW-G for the Nutanix Support renewal in the amount not to exceed $1,328,560.25.



Questions



For additional information, please contact:

Richard Pruitt

Chief Information Officer

Richard.Pruitt@khs-net.com

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: IT Department Head: Richard M. Pruitt

Vendor Name: CDW-G Contact name & e-mail: Tom Latzke, tomlat@cdw.com

What services will this vendor provide to KHS? CDW-G will provide KHS with software support and maintenance for our current Nutanix Hardware Platform for a three (3) year term.

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☒ New agreement ☐ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background: KHS leverages the Nutanix manufacturer of hardware and software as its Hyper-Converged Infrastructure (HCI) for the company servers and storage. The HCI infrastructure supports the end-user desktop, core processing systems, various application and database technology within KHS. Brief Explanation: CDW-G will provide KHS with software support and maintenance for our current Nutanix Hardware Platform for a three (3) year term.
☒ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to Fifty Thousand Dollars or more if not budgeted ($50,000.00) and One Hundred Thousand Dollars or more if budgeted ($100,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over Fifty Thousand Dollars or more if not budgeted ($50,000.00) and One Hundred Thousand Dollars or more if budgeted ($100,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Fifty Thousand Dollars ($50,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)* Brief vendor selection justification: Vendor provided with the lowest pricing	
☐ Sole source – no competitive process can be performed. Brief reason for sole source: ____	
☐ Conflict of Interest Form is required for this Contract	
☐ HIPAA Business Associate Agreement is required for this Contract	

Fiscal Impact		
KHS Governing Board previously approved this expense in KHS' FY 2023 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☒ NO	☐ YES
Capital project	☒ NO	☐ YES
Project type: ____		
Budgeted Cost Center 225 GL# 5403		

Form updated 11/21/19

Maximum cost of this agreement not to exceed: $1,328,560.25 per three years

Notes: ___

Contract Terms and Conditions

Effective date: 1/23/2023 Termination date: 1/22/2026

Explain extension provisions, termination conditions and required notice: _____

Approvals

Compliance DMHC/DHCS Review:

Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

Date

Contract Owner:

Department Head

Date

Purchasing:

Director of Procurement and Facilities

10/26/22

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

10/27/22

Date

Recommended by the Executive Committee:

Chief Operating Officer

10-27-2022

Date

IT Approval:

Chief Information Officer or IT Director

10/27/2022

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Board of Directors approval is required on all contracts over $50,000 if not budgeted and $100,000 if budgeted.

KHS Board Chairman

Date

Form updated 11/21/19

To: KHS Board of Directors

From: Jeremy McGuire, Sr. Director of Government Relations & Strategic Development

Date: December 15, 2022

Re: 2022 State Legislative and Budget Summary

Background

The 2022 State Legislative session ended on September 30th as this was the deadline for the Governor to sign or veto bills. Throughout the legislative cycle KHS staff worked to monitor, analyze, and provide feedback on pending bills. Staff tracked 72 bills with potential impact to the plan, and 30 of those passed the legislature and were signed by the Governor. Of those 30, there are 15 bills with notable impact to KHS. Many of the other bills that passed were amended to have minimal impact to KHS. Additionally, the State Budget was finalized in July and included several material changes.

The accompanying presentation provides a review of the 2022 State Legislative Session and State Budget outcomes which impact KHS.

Requested Action

Receive and File.

Kern Family Health Care™
The Friendly Face
Of Kern Health Systems

2022 State Legislative and Budget Summary

December 15, 2022

2022 Legislative Session At-a-Glance

- The 2022 State Legislative session ended on 9/30/22 as this was the deadline for the Governor to sign or veto bills. Bills are effective 1/1/23 unless otherwise noted.

- 72 Bills were being tracked. Of those, 30 passed the legislature and were signed by the Governor. Of those, 15 are notably impactful to KHS.

- The State Budget was finalized in July. KHS staff met to review the impacts and plan for implementation.

- Worked internally and with Trade Associations to monitor, analyze, and advocate on relevant bills and the budget throughout the year.

- Internal workgroups reviewed impactful items for implementation implications.

2022-2023 State Budget

The following noteworthy items were included in the State Budget:

- **Medi-Cal for undocumented immigrants** – Expands Medi-Cal coverage to the remaining cohort of adults between ages 26-49 regardless of immigration status, beginning no later than January 2024. There are an estimated 700,000 individuals Statewide who would transition into full Medi-Cal coverage under this initiative.

- **Equity and Practice Transformation Payments** – Would allocate $700 million statewide over 5 years in incentive payments to providers with the goal of advancing equity; addressing gaps in preventive, maternity, and behavioral health care measures; reducing COVID-19 driven disparities; supporting upstream interventions to address social drivers of health and improving early childhood outcomes; and preparing practices to accept risk-based contracts and move towards value-based care. It is anticipated this funding would be administered by the Managed Care Plans.

- **Telehealth** – DHCS developed a telehealth flexibilities policy which will be implemented at the end of the Public Health Emergency. This includes the continuance of payment parity for video and audio-only telehealth at the equivalent in-person rates. It also maintains FQHC and RHC originating site flexibilities which allows providers and patients to conduct services outside the physical clinic setting. And it allows for telehealth to be included in the calculation of the Plan's Network Adequacy process.

2022-2023 State Budget

- **Public Health Emergency Unwinding** - Includes additional County workload costs related to Medi-Cal redeterminations. Also funds enrollment navigators and an outreach campaign.

- **CalAIM** – Partially delays the Long-Term Care carve-in to 7/1/23, specifically for certain intermediate care facilities. Also includes additional new enrollees which will be mandatorily enrolled into Managed Care on 1/1/23.

- **Office of Health Care Affordability** – Would create a new State office charged with increasing the transparency of pricing, developing specific cost targets for different sectors of the health care industry, and imposing financial consequences for entities failing to meet these targets.

- **…And More…**

- **General next steps**: DHCS/DMHC workgroups and policy development, followed by regulatory/policy guidance.

State Legislation

- **AB 2724 – Kaiser Direct Contracting with DHCS**
  - By 2024, authorizes DHCS to enter a direct contract with Kaiser in areas specified by DHCS which are also regions in which Kaiser already provides commercial coverage (including Kern County).
  - Continues existing continuity of care enrollment and family linkage rules.
  - Also allows for the enrollment of Duals, Foster Youth, and the Default Assignment Process. This language is not specific in the legislation.
  - **Next steps:** Advocating for DHCS to release and discuss a 2024 transition plan. DHCS acknowledged they are working on one. Many details to work out regarding default assignment and the other new populations.

State Legislation

- **SB 1473 – COVID-19 Therapeutics**
  - Update to last year's SB 510 related to coverage of COVID testing and vaccines both in and out of network.
  - Requires health plan coverage, without cost-sharing or utilization management, of therapeutics for COVID-19 approved or granted emergency use authorization by the FDA for COVID-19.
  - Requires for an out-of-network provider, the health plan to reimburse an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic in which the therapeutic was delivered.
  - Requires health plans to cover COVID-19 therapeutics delivered by out of network providers six months following the end of the federal public health emergency.
  - Includes an urgency clause which makes the bill effective immediately upon signature by the Governor. SB 1473 is current law as of September 26, 2022.
- **Next steps:** Anticipate updates to the All-Plan Letter which outlines COVID coverage requirements.

State Legislation

- **SB 987 – Cancer Care**
  - Requires MCPs to make a good faith effort to contract with at least one NCI-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center for provision of services to any eligible enrollee diagnosed with a complex cancer diagnosis.
  - MCPs must allow enrollees diagnosed with a complex cancer diagnosis to request a referral to receive services through an in-network cancer center.
  - If the MCP is unsuccessful in its good-faith contracting efforts, it shall allow an enrollee to request a referral to receive services through an Out-Of-Network cancer center if the MCP and cancer center agree upon a rate.
  - A Medi-Cal managed care plan shall notify all enrollees of their right to request a referral to access care through an NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center, if they are diagnosed with a complex cancer diagnosis.
  - **Next steps:** Effective 1/1/23, so expecting DHCS guidance. Updated member handbook language was shared by DHCS in late November.

State Legislation

- **SB 923 – Cultural Competency Training**
  - No later than 3/1/25, Requires all health plan staff who are in direct contact with enrollees in the delivery of services to complete evidence-based cultural competency training for providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI).
  - DMHC/DHCS will work to develop/approve the curriculum. Also, DMHC/DHCS oversight process for completion of the curriculum and monitoring of any related grievances.
  - Within six months after DMHC and DHCS issue guidance, and not later than March 1, 2025, requires plans to include information in the plan's provider directory and call center that identifies which in-network providers offer gender-affirming services.
  - By 3/1/24, develop a quality standard for patient experience to measure cultural competency related to the TGI community.
  - **Next steps:** Workgroup recommendations on training curriculum must be developed by March 1, 2024.

State Legislation

- **SB 1207 – Maternal Mental Health Programs**
  - By July 1, 2023, requires health plans to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Requires the program to include quality measures to encourage screening, diagnosis, treatment, and referral.
  - Requires that the program guidelines be provided to relevant medical providers, including all contracting obstetric providers.
  - A prior 2018 bill (AB 2193) required Plans create a maternal mental health program by 2019, this bill resets that date again to 2023. DMHC previously required from Plans an attestation that they would develop programs consistent with AB 2193.
- **Next steps:** Expect guidance from DMHC and DHCS regarding specific requirements.

State Legislation

- **SB 1019 – Mental Health Outreach and Education**
  - By January 1, 2025, MCPs are to conduct annual outreach and education for its enrollees regarding covered mental health benefits.
  - Outreach Plan will be reviewed and approved by DHCS. To be informed by Population Needs Assessment and Utilization Data.
  - Also requires outreach and education to PCPs regarding coverage of mental health benefits.
  - DHCS will assess enrollee experience with Mental Health benefits every 3 years and publish public-facing plan-specific reports.
- **Next steps:** DHCS stakeholder engagement in 2023 or 2024 to inform subsequent guidance regarding specific elements or requirements for MCP outreach and education.

State Legislation – Quick Look

- **AB 1929 – Violence Prevention** – Adds violence prevention services as a covered Medi-Cal benefit. Assumed that what is mentioned under the Community Health Workers benefit will meet these requirements.
- **AB 2697 – CHW Services** – Requires MCPs to conduct outreach and education to enrollees and providers related to CHW services. DHCS to seek stakeholder input.
- **SB 966 – FQHC and RHC visits** – Upon Federal approval, would permanently extend the ability for FQHCs and RHCs to bill for services rendered by an associate clinical social worker (ACSW) or an associate marriage and family therapist (AMFT) under supervision of a licensed behavioral health provider. This was a flexibility granted temporarily under the Public Health Emergency.
- **SB 858 – DMHC Penalties** – Beginning 1/1/28, updates and increases the penalty amounts that can be levied by DMHC. Requires the amounts to be updated every 5 years, based on average premium costs. Adds factors DMHC must consider when assessing penalties, similar to DHCS.
- **SB 225 – Timely Access** – Clean-up bill from SB 221 related to mental health follow-up appointments. Specifies DMHC has authority to take disciplinary action for non-compliance with timely access requirements. Allows DMHC to set timely access standards.

State Legislation – Quick Look

- **AB 32 – Telehealth** – Amends certain provisions of DHCS' telehealth policy to allow additional flexibilities. DHCS' proposal prohibited establishing new patients via audio-only telehealth, but this bill allows for exceptions based on "sensitive services" and patient's inability to access video. DHCS policy also requires providers to offer video telehealth in addition to audio-only. This bill allows exceptions in areas without access to broadband internet.
- **AB 2242 – Transition from Temporary Holds or Conservatorship** – Creates a stakeholder process to define a care coordination plan to use when discharging members under temporary hold or conservatorship. Does include the Medi-Cal Plans in the stakeholder process. Assumed to mostly impact County Behavioral Health, but there was language about the appropriate party (including Plans) contacting members for coordination of follow-up care.
- **AB 2581 – Mental Health Provider Credentialing** – Requires MCPs to assess and verify the qualifications of Mental Health/Substance Use Disorder provider within 60-days of receiving a completed application. Requires MCP to notify the provider within 7 days of receiving the application.
- **SB 1419 – Interoperability** – Codifies the federal interoperability rules, effective 1/1/24. (includes payer-to-payer and leaves open to future APIs such as Prior Auth).

Next Steps

- Bills impacting KHS will result in further guidance by DHCS and/or DMHC.
- KHS will continue to work with Trade Associations and DHCS/DMHC in developing draft policies where relevant.
- Final policies are shared with plans via contract amendment and/or “All-Plan Letters” that outline specific requirements and timelines.
- Material changes to KHS policy or budget will be independently raised to the Board of Directors as needed.
- Preparations for the upcoming 2023 Legislative Session and State Budget Cycle.

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
December 15, 2022

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 11/02/2022				
Community Health Centers of America		733 3rd Street McFarland CA 93250	Change of Ownership Existing Provider: Manbir Singh MD	12/1/2022
David H. Bonilla dba: Best Non-Emergency Medical Transport Service, Inc.		5001 California Ave Ste 107 Bakersfield CA 93309		12/1/2022
James' Mercy Southwest Pharmacy Inc dba: Hina's Mercy Southwest Pharmacy		500 Old River Road Ste. 125 Bakersfield CA 93311		12/1/2022
Lamont Healthcare Inc. dba: Valley Pharmacy		10400 Main Street Ste D Lamont CA 93241		12/1/2022
PAC 12/07/2022				
24Hr HomeCare LLC dba: 24 Hour Home Care	Recuperative Care (Medical Respite)	200 N Pacific Coast Hwy Ste. 300 El Segunda CA 90245		1/1/2023
Alaidandrew Corporation DBA: Valley Convalescent Hospital	SNF	1205 8th Street Bakersfield CA 93304		1/1/2023
Bakersfield Healthcare & Wellness Centre LLC dba: The Rehabilitation Center of Bakersfield	SNF	2211 Mt Vernon Ave. Bakersfield CA 93306		1/1/2023
Bakersfield Rehabilitation Hospital LLC dba: Bakersfield Rehabilitation Hospital	Rehab Hospital	4400 Kircaldy Drive Bakersfield CA 93306		1/1/2023
Cardiac RMS LLC	IDTF/Assistive Device DME	125 High Rock Ave Saratoga Springs NY 12866		1/1/2023
County of Kern dba: Kern Behavioral Health & Recover Services Location Name: Bakersfield Recovery Station	Sobering Center (CSS)	312 Kentucky Street Bakersfield CA 93305		1/1/2023
Deirdre Washington dba: Washington & Associates	Pain Management	5329 Office Center Court Ste. 110 Bakersfield CA 93309		1/1/2023
GA Food Services of Pinellas LLC	Medical Tailored Meals (CSS)	12200 32nd Court North St. Petersburg, FL 33716		1/1/2023

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
December 15, 2022

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
Kern Valley Healthcare District dba: Kern Valley Healthcare District D/P SNF	SNF	6412 Laurel Avenue Lake Isabella CA 93240		1/1/2023
George Quan dba: Kiddo Educational Services	Behavioral Health	4900 California Avenue Ste. 200B Bakersfield CA 93309		1/1/2023
Modify Health LLC	Medical Tailored Meals (CSS)	190 Bluegrass Valley Pkwy Alpharetta GA 30005		1/1/2023
Parkview Julian LLC dba: Parkview Julian Healthcare Center	SNF	1801 Julian Ave. Bakersfield CA 93304		1/1/2023
Personrx Incorporated dba: Ming & H Drugs	Pharmacy/DME	1717 Ming Ave. Bakersfield CA 93304		**Retro-Eff 12/1/2022**
Purfoods LLC dba: Mom's Meals	Medical Tailored Meals (CSS)	310 SE Corporate Woods Dr. Ankeny IA 50021		1/1/2023
Rajan Goyal MD Inc	Pulmonary Disease	5531 Business Park S. Bakersfield CA 93309		1/1/2023
SD Healthcare Consulting LLC	Recuperative Care (Medical Respite)	2201 Parkgate Street Bakersfield CA 93311		1/1/2023
Shafter Nursing Rehab LLC dba: Shafter Nursing Care	SNF	140 E Tulare Ave Shafter CA 93263		1/1/2023

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
December 15, 2022

Legal Name DBA	Specialty	Address	Comments	Term Effective Date
Guardian Angel Home Care, Inc.	Home Health	5001 E Commerce Ctr Dr Ste 240 Bakersfield CA	Change in Ownership	11/20/2022
Janardhan Grandhe, MD A Med Corp dba: Central Valley Pain Management	Pain Management	6401 Truxtun Avenue Ste. B Bakersfield CA	KHS Termed No Cause Contract (USAO)	11/11/2022
Kidney Center A Medical Group Inc (Carolyn Wong MD)	Nephrology	3838 San Dimas Street Ste. A100 Bakersfield CA	Retirement	9/30/2022
Save Mart Supermarkets	Pharmacy	9600 Hageman Road Bakersfield CA	Closed	9/30/2022
Scott R. Boynton, DPM	Wound Care	3012 Sillect Avenue Ste. B Bakersfield CA	Moved out of State	11/9/2022

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: December 15, 2022

Re: September 2022 Financial Results

The September results reflect a $3,211,068 Net Increase in Net Position which is a $3,450,110 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $1.1 million favorable variance primarily due to:

   A) $4.0 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $1.3 million favorable variance in Premium-Hospital Directed Payments primarily due to higher-than-expected budgeted membership offset against amounts included in 2D below.

   C) $4.6 million unfavorable variance in Rate Adjustment -Hospital Directed Payments due to receiving updated rates from DHCS in September 2022 for the period July 1, 2020-December 31, 2020, which is offset against amounts included in 2E below.

2) Total Medical Costs reflect a $2.0 million favorable variance primarily due to:

   A) $1.0 million unfavorable variance in Physician Services primarily due to higher-than-expected utilization of Referral Specialty Services over the last several months by Family and SPD members.

   B) $1.0 million favorable variance in Emergency Room primarily due to lower-than-expected utilization over the last several months.

   C) $2.2 million unfavorable variance in Inpatient primarily due to higher-than-expected utilization over the last several months by Family and SPD members.

   D) $1.3 million unfavorable variance in Hospital Directed Payments primarily due to higher-than-expected budgeted membership offset against amounts included in 1B above.

   E) $4.1 million favorable variance in Hospital Directed Payment Adjustment due to receiving updated rates from DHCS in September 2022 for the period July 1, 2020-December 31, 2020, which is offset against amounts included in 1C above.

   F) $.8 million favorable IBNR, Incentive, Paid Claims Adjustment primarily from lower-than-expected P4P payouts relating to the prior year.

The September Medical Loss Ratio is 89.0% which is favorable to the 92.9% budgeted amount. The September Administrative Expense Ratio is 6.5% which is favorable to the 6.9% budgeted amount.

The results for the 9 months ended September 30, 2022 reflects a Net Increase in Net Position of $31,031,094. This is a $34,010,417 favorable variance to the budget and includes approximately $12.6 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 88.7% which is favorable to the 92.8% budgeted amount. The year-to-date Administrative Expense Ratio is 6.4% which is favorable to the 7.1% budgeted amount.

Kern Health Systems
Financial Packet
September 2022

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF SEPTEMBER 30, 2022

ASSETS	SEPTEMBER 2022	AUGUST 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 142,667,501	$ 134,523,073	$ 8,144,428
Short-Term Investments	236,155,812	215,869,792	20,286,020
Premiums Receivable - Net	107,091,819	109,684,845	(2,593,026)
Premiums Receivable - Hospital Direct Payments	358,506,643	396,775,284	(38,268,641)
Interest Receivable	252,634	92,007	160,627
Provider Advance Payment	2,777,176	2,986,954	(209,778)
Other Receivables	322,166	289,002	33,164
Prepaid Expenses & Other Current Assets	3,335,933	3,666,291	(330,358)
Total Current Assets	$ 851,109,684	$ 863,887,248	$ (12,777,564)
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,323,130	1,371,186	(48,056)
Computer Hardware and Software - Net	18,855,103	19,119,241	(264,138)
Building and Building Improvements - Net	33,943,525	34,019,634	(76,109)
Capital Projects in Progress	6,066,787	5,954,066	112,721
Total Capital Assets	$ 64,279,251	$ 64,554,833	$ (275,582)
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,604,652	1,623,201	(18,549)
Total Long Term Assets	$ 1,904,652	$ 1,923,201	$ (18,549)
DEFERRED OUTFLOWS OF RESOURCES	$ 4,731,067	$ 4,731,067	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 922,024,654	$ 935,096,349	$ (13,071,695)
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 4,858,302	$ 4,659,585	198,717
Accrued Other Operating Expenses	2,465,066	1,990,876	474,190
Accrued Taxes and Licenses	32,495,339	21,611,880	10,883,459
Claims Payable (Reported)	21,227,073	15,291,586	5,935,487
IBNR - Inpatient Claims	53,360,793	47,880,532	5,480,261
IBNR - Physician Claims	19,207,025	18,053,928	1,153,097
IBNR - Accrued Other Medical	24,584,524	24,241,114	343,410
Risk Pool and Withholds Payable	4,727,132	6,503,576	(1,776,444)
Statutory Allowance for Claims Processing Expense	2,509,938	2,509,938	-
Other Liabilities	113,519,424	114,343,380	(823,956)
Accrued Hospital Directed Payments	358,324,300	396,775,284	(38,450,984)
Total Current Liabilities	$ 637,278,916	$ 653,861,679	$ (16,582,763)
NONCURRENT LIABILITIES:			
Net Pension Liability	900,000	600,000	300,000
TOTAL NONCURRENT LIABILITIES	$ 900,000	$ 600,000	$ 300,000
DEFERRED INFLOWS OF RESOURCES	$ 5,338,319	$ 5,338,319	$ -
NET POSITION:			
Net Position - Beg. of Year	247,476,325	247,476,325	-
Increase (Decrease) in Net Position - Current Year	31,031,094	27,820,026	3,211,068
Total Net Position	$ 278,507,419	$ 275,296,351	$ 3,211,068
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 922,024,654	$ 935,096,349	$ (13,071,695)

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED SEPTEMBER 30, 2022

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
206,544	207,100	(556)	Family Members	1,830,864	1,817,100	13,764
92,424	83,830	8,594	Expansion Members	791,148	735,870	55,278
17,289	16,330	959	SPD Members	150,134	143,370	6,764
9,663	7,740	1,923	Other Members	84,107	69,660	14,447
14,126	13,000	1,126	Kaiser Members	121,693	117,000	4,693
340,046	328,000	12,046	Total Members - MCAL	2,977,946	2,883,000	94,946
			REVENUES			
37,957,277	36,480,346	1,476,931	Title XIX - Medicaid - Family and Other	334,350,043	321,608,180	12,741,863
31,275,148	29,197,301	2,077,847	Title XIX - Medicaid - Expansion Members	272,718,273	256,325,041	16,393,232
15,760,220	15,301,788	458,432	Title XIX - Medicaid - SPD Members	136,478,439	134,342,763	2,135,676
10,883,460	10,850,379	33,081	Premium - MCO Tax	92,014,704	91,716,915	297,789
18,857,014	17,605,832	1,251,182	Premium - Hospital Directed Payments	163,452,673	154,861,070	8,591,603
353,347	84,613	268,734	Investment Earnings And Other Income	(193,569)	743,088	(936,657)
-	56,700	(56,700)	Reinsurance Recoveries	-	497,880	(497,880)
(4,606,563)	-	(4,606,563)	Rate Adjustments - Hospital Directed Payments	22,544,963	-	22,544,963
203,911	-	203,911	Rate/Income Adjustments	(1,726,541)	-	(1,726,541)
110,683,814	109,576,959	1,106,855	TOTAL REVENUES	1,019,638,985	960,094,937	59,544,048
			EXPENSES			
			Medical Costs:			
18,622,853	17,632,262	(990,591)	Physician Services	167,691,287	154,817,365	(12,873,922)
5,024,917	5,926,418	901,501	Other Professional Services	45,879,154	52,509,592	6,630,438
4,773,821	5,738,181	964,360	Emergency Room	42,063,554	50,384,434	8,320,880
22,797,560	20,611,293	(2,186,267)	Inpatient	188,753,846	180,965,414	(7,788,432)
142,533	56,700	(85,833)	Reinsurance Expense	418,844	497,880	79,036
9,352,210	8,762,220	(589,990)	Outpatient Hospital	80,353,699	76,932,212	(3,421,487)
15,744,662	16,160,821	416,159	Other Medical	145,155,663	142,170,833	(2,984,830)
490,964	472,500	(18,464)	Pay for Performance Quality Incentive	4,280,127	4,149,000	(131,127)
18,857,014	17,605,832	(1,251,182)	Hospital Directed Payments	163,452,673	154,861,070	(8,591,603)
(4,064,727)	-	4,064,727	Hospital Directed Payment Adjustment	22,878,119	-	(22,878,119)
9,821	-	(9,821)	Non-Claims Expense Adjustment	(628,170)	-	628,170
(789,121)	-	789,121	IBNR, Incentive, Paid Claims Adjustment	(16,146,287)	-	16,146,287
90,962,507	92,966,226	2,003,719	Total Medical Costs	844,152,509	817,287,799	(26,864,710)
19,721,307	16,610,733	3,110,574	GROSS MARGIN	175,486,476	142,807,138	32,679,338
			Administrative:			
3,213,222	3,369,438	156,216	Compensation	28,057,715	30,399,946	2,342,231
997,356	1,108,544	111,188	Purchased Services	8,605,075	9,976,898	1,371,823
85,530	212,108	126,578	Supplies	818,313	1,908,968	1,090,655
583,673	526,572	(57,101)	Depreciation	5,229,746	4,739,148	(490,598)
298,240	366,066	67,826	Other Administrative Expenses	2,907,310	3,294,591	387,281
420,793	-	(420,793)	Administrative Expense Adjustment	2,105,161	-	(2,105,161)
5,598,814	5,582,728	(16,086)	Total Administrative Expenses	47,723,320	50,319,550	2,596,230
96,561,321	98,548,954	1,987,633	TOTAL EXPENSES	891,875,829	867,607,349	(24,268,480)
14,122,493	11,028,005	3,094,488	OPERATING INCOME (LOSS) BEFORE TAX	127,763,156	92,487,588	35,275,568
10,883,459	10,850,379	(33,080)	MCO TAX	92,008,435	91,716,915	(291,520)
3,239,034	177,626	3,061,408	OPERATING INCOME (LOSS) NET OF TAX	35,754,721	770,673	34,984,048
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
4,416	(333,334)	337,750	Provider Grants/CalAIM Initiative Grant	(4,091,014)	(2,999,998)	(1,091,016)
(32,382)	(83,334)	50,952	Health Home	(632,613)	(749,998)	117,385
(27,966)	(416,668)	388,702	TOTAL NONOPERATING REVENUE (EXPENSE)	(4,723,627)	(3,749,996)	(973,631)
3,211,068	(239,042)	3,450,110	NET INCREASE (DECREASE) IN NET POSITION	31,031,094	(2,979,323)	34,010,417
89.0%	92.9%	3.9%	MEDICAL LOSS RATIO	88.7%	92.8%	4.1%
6.5%	6.9%	0.3%	ADMINISTRATIVE EXPENSE RATIO	6.4%	7.1%	0.6%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED SEPTEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
206,544	207,100	(556)	Family Members	1,830,864	1,817,100	13,764
92,424	83,830	8,594	Expansion Members	791,148	735,870	55,278
17,289	16,330	959	SPD Members	150,134	143,370	6,764
9,663	7,740	1,923	Other Members	84,107	69,660	14,447
14,126	13,000	1,126	Kaiser Members	121,693	117,000	4,693
340,046	328,000	12,046	Total Members - MCAL	2,977,946	2,883,000	94,946
			REVENUES			
175.56	169.80	5.76	Title XIX - Medicaid - Family and Other	174.60	170.46	4.14
338.39	348.29	(9.90)	Title XIX - Medicaid - Expansion Members	344.71	348.33	(3.62)
911.57	937.04	(25.46)	Title XIX - Medicaid - SPD Members	909.04	937.04	(27.99)
33.39	34.45	(1.05)	Premium - MCO Tax	32.22	33.16	(0.94)
57.86	55.89	1.97	Premium - Hospital Directed Payments	57.23	55.99	1.24
1.08	0.27	0.82	Investment Earnings And Other Income	(0.07)	0.27	(0.34)
0.00	0.18	(0.18)	Reinsurance Recoveries	0.00	0.18	(0.18)
(14.13)	0.00	(14.13)	Rate Adjustments - Hospital Directed Payments	7.89	0.00	7.89
0.63	0.00	0.63	Rate/Income Adjustments	(0.60)	0.00	(0.60)
339.60	347.86	(8.26)	TOTAL REVENUES	356.98	347.11	9.88
			EXPENSES			
			Medical Costs:			
57.14	55.98	(1.16)	Physician Services	58.71	55.97	(2.74)
15.42	18.81	3.40	Other Professional Services	16.06	18.98	2.92
14.65	18.22	3.57	Emergency Room	14.73	18.22	3.49
69.95	65.43	(4.52)	Inpatient	66.08	65.42	(0.66)
0.44	0.18	(0.26)	Reinsurance Expense	0.15	0.18	0.03
28.69	27.82	(0.88)	Outpatient Hospital	28.13	27.81	(0.32)
48.31	51.30	3.00	Other Medical	50.82	51.40	0.58
1.51	1.50	(0.01)	Pay for Performance Quality Incentive	1.50	1.50	0.00
57.86	55.89	(1.97)	Hospital Directed Payments	57.23	55.99	(1.24)
(12.47)	0.00	12.47	Hospital Directed Payment Adjustment	8.01	0.00	(8.01)
0.03	0.00	(0.03)	Non-Claims Expense Adjustment	(0.22)	0.00	0.22
(2.42)	0.00	2.42	IBNR, Incentive, Paid Claims Adjustment	(5.65)	0.00	5.65
279.09	295.13	16.04	Total Medical Costs	295.55	295.48	(0.07)
60.51	52.73	7.78	GROSS MARGIN	61.44	51.63	9.81
			Administrative:			
9.86	10.70	0.84	Compensation	9.82	10.99	1.17
3.06	3.52	0.46	Purchased Services	3.01	3.61	0.59
0.26	0.67	0.41	Supplies	0.29	0.69	0.40
1.79	1.67	(0.12)	Depreciation	1.83	1.71	(0.12)
0.92	1.16	0.25	Other Administrative Expenses	1.02	1.19	0.17
1.29	0.00	(1.29)	Administrative Expense Adjustment	0.74	0.00	(0.74)
17.18	17.72	0.54	Total Administrative Expenses	16.71	18.19	1.48
296.27	312.85	16.58	TOTAL EXPENSES	312.25	313.67	1.41
43.33	35.01	8.32	OPERATING INCOME (LOSS) BEFORE TAX	44.73	33.44	11.29
33.39	34.45	1.05	MCO TAX	32.21	33.16	0.95
9.94	0.56	9.37	OPERATING INCOME (LOSS) NET OF TAX	12.52	0.28	12.24
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
0.01	(1.06)	1.07	Reserve Fund Projects/Community Grants	(1.43)	(1.08)	(0.35)
(0.10)	(0.26)	0.17	Health Home	(0.22)	(0.27)	0.05
(0.09)	(1.32)	1.24	TOTAL NONOPERATING REVENUE (EXPENSE)	(1.65)	(1.36)	(0.30)
9.85	(0.76)	10.61	NET INCREASE (DECREASE) IN NET POSITION	10.86	(1.08)	11.94
89.0%	92.9%	3.9%	MEDICAL LOSS RATIO	88.7%	92.8%	4.1%
6.5%	6.9%	0.3%	ADMINISTRATIVE EXPENSE RATIO	6.4%	7.1%	0.6%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH SEPTEMBER 30, 2022	SEPTEMBER 2021	OCTOBER 2021	NOVEMBER 2021	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022
ENROLLMENT							
Members - MCAL	294,672	295,865	296,989	298,205	309,342	310,281	312,490
REVENUES							
Title XIX - Medicaid - Family and Other	35,961,464	37,040,845	37,111,335	36,899,197	37,009,614	37,126,546	36,539,594
Title XIX - Medicaid - Expansion Members	29,932,046	30,140,656	31,001,586	30,241,720	29,968,453	29,945,915	29,350,530
Title XIX - Medicaid - SPD Members	16,075,172	16,206,131	16,254,790	16,506,513	14,953,594	14,858,906	14,791,754
Premium - MCO Tax	10,136,079	10,229,218	10,229,533	10,273,393	9,899,314	9,894,054	9,893,826
Premium - Hospital Directed Payments	16,554,814	16,726,476	16,753,272	16,836,470	17,606,870	17,654,496	17,949,134
Investment Earnings And Other Income	(59,079)	131,645	157,659	(694,967)	329,573	86,457	(1,241,065)
Rate Adjustments - Hospital Directed Payments	5,709	4,491	8,691	(3,586)	230,177	24,013	26,907,309
Rate/Income Adjustments	122,473	52,871	66,815	5,625	957,475	977,794	493,268
TOTAL REVENUES	108,728,678	110,532,333	111,583,681	110,064,365	110,955,070	110,568,181	134,684,350
EXPENSES							
Medical Costs:							
Physician Services	17,895,535	17,549,058	17,258,969	17,972,930	17,538,030	19,319,317	19,919,152
Other Professional Services	4,347,759	4,846,005	4,829,415	4,344,076	5,041,033	4,902,710	5,254,779
Emergency Room	3,735,609	4,506,067	4,818,883	4,391,622	5,209,937	5,098,972	5,150,400
Inpatient	20,303,427	23,207,054	21,256,426	17,137,562	20,610,105	20,031,970	20,232,342
Reinsurance Expense	84,384	85,133	86,151	86,147	53,660	53,896	57,686
Outpatient Hospital	7,529,697	7,080,379	7,793,785	6,083,159	8,214,215	8,223,126	8,686,122
Other Medical	10,572,454	10,784,127	12,549,269	11,502,354	17,263,621	17,534,988	15,788,879
Pharmacy	9,913,574	10,236,384	10,196,195	10,620,178	-	-	-
Pay for Performance Quality Incentive	-	-	-	1,420,000	464,013	465,422	465,421
Hospital Directed Payments	16,554,814	16,726,476	16,753,272	16,836,470	17,606,870	17,654,496	17,949,134
Hospital Directed Payment Adjustment	(132,637)	4,491	8,691	(3,586)	230,177	24,013	26,678,156
Non-Claims Expense Adjustment	20,737	8,907	24,857	(44,256)	43,538	4,118	572,469
IBNR, Incentive, Paid Claims Adjustment	14,595	(924,120)	(1,378,922)	(1,022,824)	627	(1,010,781)	(3,987,493)
Total Medical Costs	90,839,948	94,109,961	94,196,991	89,323,832	92,275,826	92,302,247	116,767,047
GROSS MARGIN	17,888,730	16,422,372	17,386,690	20,740,533	18,679,244	18,265,934	17,917,303
Administrative:							
Compensation	2,791,543	2,746,218	2,775,542	2,592,690	3,116,842	2,847,002	3,108,703
Purchased Services	968,021	991,178	1,095,098	1,355,474	846,917	877,498	1,098,614
Supplies	(17,330)	58,257	188,536	164,659	191,908	(8,268)	103,207
Depreciation	427,804	424,376	716,552	746,072	571,126	571,126	571,126
Other Administrative Expenses	443,524	348,575	276,718	605,706	389,918	259,997	346,089
Administrative Expense Adjustment	3,540	300	77,569	(194,326)	(1,904)	(44,283)	31,776
Total Administrative Expenses	4,617,102	4,568,904	5,130,015	5,270,275	5,114,807	4,503,072	5,259,515
TOTAL EXPENSES	95,457,050	98,678,865	99,327,006	94,594,107	97,390,633	96,805,319	122,026,562
OPERATING INCOME (LOSS) BEFORE TAX	13,271,628	11,853,468	12,256,675	15,470,258	13,564,437	13,762,862	12,657,788
MCO TAX	9,894,054	9,894,054	9,894,054	9,895,157	9,894,054	9,894,054	9,893,826
OPERATING INCOME (LOSS) NET OF TAX	3,377,574	1,959,414	2,362,621	5,575,101	3,670,383	3,868,808	2,763,962
TOTAL NONOPERATING REVENUE (EXPENSE)	(2,438,918)	(1,027,231)	(1,516,642)	(175,210)	(400,389)	(986,700)	(1,001,012)
NET INCREASE (DECREASE) IN NET POSITION	938,656	932,183	845,979	5,399,891	3,269,994	2,882,108	1,762,950
MEDICAL LOSS RATIO	90.7%	92.6%	91.5%	87.4%	89.4%	89.9%	90.2%
ADMINISTRATIVE EXPENSE RATIO	5.6%	5.5%	6.1%	6.4%	6.1%	5.4%	6.6%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH SEPTEMBER 30, 2022	APRIL 2022	MAY 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	314,691	315,663	319,333	323,572	324,961	325,920	4,041,984
REVENUES							
Title XIX - Medicaid - Family and Other	36,762,722	35,766,911	37,731,384	37,514,641	37,941,354	37,957,277	481,362,884
Title XIX - Medicaid - Expansion Members	29,812,384	29,600,713	30,533,210	30,993,375	31,238,545	31,275,148	394,034,281
Title XIX - Medicaid - SPD Members	14,924,745	14,887,158	15,402,431	15,833,803	15,065,828	15,760,220	201,521,045
Premium - MCO Tax	9,894,054	9,872,493	9,910,584	10,883,460	10,883,459	10,883,460	132,882,927
Premium - Hospital Directed Payments	17,905,917	17,928,276	18,280,365	18,674,627	18,595,974	18,857,014	230,323,705
Investment Earnings And Other Income	(326,288)	357,517	(633,952)	1,002,315	(121,473)	353,347	(658,311)
Rate Adjustments - Hospital Directed Payments	3,898	(23,892)	5,129	9,235	(4,343)	(4,606,563)	22,560,268
Rate/Income Adjustments	59,935	(4,649,731)	(364,397)	350,036	245,168	203,911	(1,478,757)
TOTAL REVENUES	109,037,367	103,739,445	110,864,754	115,261,492	113,844,512	110,683,814	1,460,548,042
EXPENSES							
Medical Costs:							
Physician Services	18,291,501	17,895,843	18,921,901	18,984,281	18,198,409	18,622,853	238,367,779
Other Professional Services	5,361,545	4,835,075	5,112,961	5,137,341	5,208,793	5,024,917	64,246,409
Emergency Room	5,098,584	4,139,529	3,167,228	4,764,039	4,661,044	4,773,821	59,515,735
Inpatient	20,364,608	21,395,635	19,551,774	22,935,749	20,834,103	22,797,560	270,658,315
Reinsurance Expense	56,409	56,248	57,216	(33,668)	(25,136)	142,533	760,659
Outpatient Hospital	8,458,833	8,281,163	9,196,013	10,013,268	9,928,749	9,352,210	108,840,719
Other Medical	16,341,907	16,301,024	15,522,071	15,416,935	15,241,576	15,744,662	190,563,867
Pharmacy	-	-	-	-	-	-	40,966,331
Pay for Performance Quality Incentive	472,037	473,494	478,060	485,358	485,358	490,964	5,700,127
Hospital Directed Payments	17,905,917	17,928,276	18,280,365	18,674,627	18,595,974	18,857,014	230,323,705
Hospital Directed Payment Adjustment	3,898	(3,419)	5,129	9,235	(4,343)	(4,064,727)	22,755,078
Non-Claims Expense Adjustment	62,025	(1,371,999)	29,799	17,040	5,019	9,821	(617,925)
IBNR, Incentive, Paid Claims Adjustment	(2,812,496)	(3,724,314)	(4,072,490)	(238,100)	487,881	(789,121)	(19,457,558)
Total Medical Costs	89,604,768	86,206,555	86,250,027	96,166,105	93,617,427	90,962,507	1,212,623,241
GROSS MARGIN	19,432,599	17,532,890	24,614,727	19,095,387	20,227,085	19,721,307	247,924,801
Administrative:							
Compensation	3,075,151	3,259,102	2,980,813	3,307,910	3,148,970	3,213,222	38,963,708
Purchased Services	783,960	927,532	850,526	1,078,360	1,144,312	997,356	13,014,846
Supplies	41,533	145,499	66,970	74,368	117,566	85,530	1,212,435
Depreciation	570,835	575,899	626,073	576,074	583,814	583,673	7,544,550
Other Administrative Expenses	252,930	300,845	329,335	414,331	315,625	298,240	4,581,833
Administrative Expense Adjustment	164,256	(2,834)	811,890	425,467	300,000	420,793	1,992,244
Total Administrative Expenses	4,888,665	5,206,043	5,665,607	5,876,510	5,610,287	5,598,814	67,309,616
TOTAL EXPENSES	94,493,433	91,412,598	91,915,634	102,042,615	99,227,714	96,561,321	1,279,932,857
OPERATING INCOME (LOSS) BEFORE TAX	14,543,934	12,326,847	18,949,120	13,218,877	14,616,798	14,122,493	180,615,185
MCO TAX	9,894,054	9,888,018	9,894,051	10,883,459	10,883,460	10,883,459	131,585,754
OPERATING INCOME (LOSS) NET OF TAX	4,649,880	2,438,829	9,055,069	2,335,418	3,733,338	3,239,034	49,029,431
TOTAL NONOPERATING REVENUE (EXPENSE)	(1,110,153)	744,870	(1,996,822)	(3,380)	57,925	(27,966)	(9,881,628)
NET INCREASE (DECREASE) IN NET POSITION	3,539,727	3,183,699	7,058,247	2,332,038	3,791,263	3,211,068	39,147,803
MEDICAL LOSS RATIO	88.3%	89.9%	82.2%	90.4%	88.9%	89.0%	89.3%
ADMINISTRATIVE EXPENSE RATIO	6.0%	6.9%	6.9%	6.9%	6.6%	6.5%	6.3%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH SEPTEMBER 30, 2022	SEPTEMBER 2021	OCTOBER 2021	NOVEMBER 2021	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022
ENROLLMENT							
Members - MCAL	294,672	295,865	296,989	298,205	309,342	310,281	312,490
REVENUES							
Title XIX - Medicaid - Family and Other	179.43	183.53	183.31	181.56	177.17	177.17	173.28
Title XIX - Medicaid - Expansion Members	383.93	383.57	393.96	382.19	357.24	355.03	344.90
Title XIX - Medicaid - SPD Members	1,017.48	1,018.29	1,026.19	1,042.14	903.21	907.36	895.60
Premium - MCO Tax	34.40	34.57	34.44	34.45	32.00	31.89	31.66
Premium - Hospital Directed Payments	56.18	56.53	56.41	56.46	56.92	56.90	57.44
Investment Earnings And Other Income	(0.20)	0.44	0.53	(2.33)	1.07	0.28	(3.97)
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	0.02	0.02	0.03	(0.01)	0.74	0.08	86.11
Rate/Income Adjustments	0.42	0.18	0.22	0.02	3.10	3.15	1.58
TOTAL REVENUES	368.98	373.59	375.72	369.09	358.68	356.35	431.00
EXPENSES							
Medical Costs:							
Physician Services	60.73	59.31	58.11	60.27	56.69	62.26	63.74
Other Professional Services	14.75	16.38	16.26	14.57	16.30	15.80	16.82
Emergency Room	12.68	15.23	16.23	14.73	16.84	16.43	16.48
Inpatient	68.90	78.44	71.57	57.47	66.63	64.56	64.75
Reinsurance Expense	0.29	0.29	0.29	0.29	0.17	0.17	0.18
Outpatient Hospital	25.55	23.93	26.24	20.40	26.55	26.50	27.80
Other Medical	35.88	36.45	42.25	38.57	55.81	56.51	50.53
Pharmacy	33.64	34.60	34.33	35.61	0.00	0.00	0.00
Pay for Performance Quality Incentive	0.00	0.00	0.00	4.76	1.50	1.50	1.49
Hospital Directed Payments	56.18	56.53	56.41	56.46	56.92	56.90	57.44
Hospital Directed Payment Adjustment	(0.45)	0.02	0.03	(0.01)	0.74	0.08	85.37
Non-Claims Expense Adjustment	0.07	0.03	0.08	(0.15)	0.14	0.01	1.83
IBNR, Incentive, Paid Claims Adjustment	0.05	(3.12)	(4.64)	(3.43)	0.00	(3.26)	(12.76)
Total Medical Costs	308.27	318.08	317.17	299.54	298.30	297.48	373.67
GROSS MARGIN	60.71	55.51	58.54	69.55	60.38	58.87	57.34
Administrative:							
Compensation	9.47	9.28	9.35	8.69	10.08	9.18	9.95
Purchased Services	3.29	3.35	3.69	4.55	2.74	2.83	3.52
Supplies	(0.06)	0.20	0.63	0.55	0.62	(0.03)	0.33
Depreciation	1.45	1.43	2.41	2.50	1.85	1.84	1.83
Other Administrative Expenses	1.51	1.18	0.93	2.03	1.26	0.84	1.11
Administrative Expense Adjustment	0.01	0.00	0.26	(0.65)	(0.01)	(0.14)	0.10
Total Administrative Expenses	15.67	15.44	17.27	17.67	16.53	14.51	16.83
TOTAL EXPENSES	323.94	333.53	334.45	317.21	314.83	311.99	390.50
OPERATING INCOME (LOSS) BEFORE TAX	45.04	40.06	41.27	51.88	43.85	44.36	40.51
MCO TAX	33.58	33.44	33.31	33.18	31.98	31.89	31.66
OPERATING INCOME (LOSS) NET OF TAX	11.46	6.62	7.96	18.70	11.87	12.47	8.84
TOTAL NONOPERATING REVENUE (EXPENSE)	(8.28)	(3.47)	(5.11)	(0.59)	(1.29)	(3.18)	(3.20)
NET INCREASE (DECREASE) IN NET POSITION	3.19	3.15	2.85	18.11	10.57	9.29	5.64
MEDICAL LOSS RATIO	90.7%	92.6%	91.5%	87.4%	89.4%	89.9%	90.2%
ADMINISTRATIVE EXPENSE RATIO	5.6%	5.5%	6.1%	6.4%	6.1%	5.4%	6.6%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH SEPTEMBER 30, 2022	APRIL 2022	MAY 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	314,691	315,663	319,333	323,572	324,961	325,920	4,041,984
REVENUES							
Title XIX - Medicaid - Family and Other	173.44	168.25	176.65	173.99	175.92	175.56	176.76
Title XIX - Medicaid - Expansion Members	345.21	341.10	343.27	340.07	338.95	338.39	356.47
Title XIX - Medicaid - SPD Members	912.10	913.04	917.14	941.54	880.12	911.57	944.29
Premium - MCO Tax	31.44	31.28	31.04	33.64	33.49	33.39	32.88
Premium - Hospital Directed Payments	56.90	56.80	57.25	57.71	57.23	57.86	56.98
Investment Earnings And Other Income	(1.04)	1.13	(1.99)	3.10	(0.37)	1.08	(0.16)
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	0.01	(0.08)	0.02	0.03	(0.01)	(14.13)	5.58
Rate/Income Adjustments	0.19	(14.73)	(1.14)	1.08	0.75	0.63	(0.37)
TOTAL REVENUES	346.49	328.64	347.18	356.22	350.33	339.60	361.34
EXPENSES							
Medical Costs:							
Physician Services	58.13	56.69	59.25	58.67	56.00	57.14	58.97
Other Professional Services	17.04	15.32	16.01	15.88	16.03	15.42	15.89
Emergency Room	16.20	13.11	9.92	14.72	14.34	14.65	14.72
Inpatient	64.71	67.78	61.23	70.88	64.11	69.95	66.96
Reinsurance Expense	0.18	0.18	0.18	(0.10)	(0.08)	0.44	0.19
Outpatient Hospital	26.88	26.23	28.80	30.95	30.55	28.69	26.93
Other Medical	51.93	51.64	48.61	47.65	46.90	48.31	47.15
Pharmacy	0.00	0.00	0.00	0.00	0.00	0.00	10.14
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.49	1.51	1.41
Hospital Directed Payments	56.90	56.80	57.25	57.71	57.23	57.86	56.98
Hospital Directed Payment Adjustment	0.01	(0.01)	0.02	0.03	(0.01)	(12.47)	5.63
Non-Claims Expense Adjustment	0.20	(4.35)	0.09	0.05	0.02	0.03	(0.15)
IBNR, Incentive, Paid Claims Adjustment	(8.94)	(11.80)	(12.75)	(0.74)	1.50	(2.42)	(4.81)
Total Medical Costs	284.74	273.10	270.09	297.20	288.09	279.09	300.01
GROSS MARGIN	61.75	55.54	77.08	59.01	62.24	60.51	61.34
Administrative:							
Compensation	9.77	10.32	9.33	10.22	9.69	9.86	9.64
Purchased Services	2.49	2.94	2.66	3.33	3.52	3.06	3.22
Supplies	0.13	0.46	0.21	0.23	0.36	0.26	0.30
Depreciation	1.81	1.82	1.96	1.78	1.80	1.79	1.87
Other Administrative Expenses	0.80	0.95	1.03	1.28	0.97	0.92	1.13
Administrative Expense Adjustment	0.52	(0.01)	2.54	1.31	0.92	1.29	0.49
Total Administrative Expenses	15.53	16.49	17.74	18.16	17.26	17.18	16.65
TOTAL EXPENSES	300.27	289.59	287.84	315.36	305.35	296.27	316.66
OPERATING INCOME (LOSS) BEFORE TAX	46.22	39.05	59.34	40.85	44.98	43.33	44.68
MCO TAX	31.44	31.32	30.98	33.64	33.49	33.39	32.55
OPERATING INCOME (LOSS) NET OF TAX	14.78	7.73	28.36	7.22	11.49	9.94	12.13
TOTAL NONOPERATING REVENUE (EXPENSE)	(3.53)	2.36	(6.25)	(0.01)	0.18	(0.09)	(2.44)
NET INCREASE (DECREASE) IN NET POSITION	11.25	10.09	22.10	7.21	11.67	9.85	9.69
MEDICAL LOSS RATIO	88.3%	89.9%	82.2%	90.4%	88.9%	89.0%	89.3%
ADMINISTRATIVE EXPENSE RATIO	6.0%	6.9%	6.9%	6.9%	6.6%	6.5%	6.3%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED SEPTEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
27,964,412	27,294,992	669,420	Premium - Medi-Cal	246,568,130	240,285,886	6,282,244
3,704,403	2,764,572	939,831	Premium - Maternity Kick	25,459,293	24,881,151	578,142
541,408	475,450	65,958	Premium - Enhanced Care Management	4,719,802	4,208,526	511,276
143,459	133,272	10,187	Premium - Major Organ Transplant	1,254,476	1,176,120	78,356
786,750	502,208	284,542	Premium - Cal AIM	7,176,338	4,410,475	2,765,863
791,280	775,537	15,743	Premium - BHT Kick	6,923,807	6,810,893	112,914
3,537,141	4,110,301	(573,160)	Premium - Provider Enhancement	34,776,790	36,105,685	(1,328,895)
212,766	207,727	5,039	Premium - Ground Emergency Medical Transportation	1,877,625	1,826,811	50,814
145,874	105,564	40,310	Premium - Behavorial Health Integration Program	2,554,888	927,076	1,627,812
-	-	-	Premium - Vaccine Incentive	885,814	-	885,814
-	-	-	Premium - Student Behavioral Health Incentive	364,822	-	364,822
-	-	-	Premium - Housing and Homelessness Incentive	652,683	-	652,683
129,784	110,722	19,062	Other	1,135,575	975,556	160,019
37,957,277	36,480,346	1,476,931	Total Title XIX - Medicaid - Family & Other	334,350,043	321,608,180	12,741,863
			Title XIX - Medicaid - Expansion Members			
27,678,514	25,416,139	2,262,375	Premium - Medi-Cal	236,941,877	223,084,484	13,857,393
194,969	234,964	(39,995)	Premium - Maternity Kick	3,749,395	2,114,676	1,634,719
991,672	852,007	139,665	Premium - Enhanced Care Management	8,480,419	7,476,743	1,003,676
236,313	212,795	23,518	Premium - Major Organ Transplant	2,023,580	1,867,369	156,211
338,928	466,917	(127,989)	Premium - Cal AIM	2,966,011	4,098,651	(1,132,640)
-	-	-	Premium - BHT Kick	12,659	-	12,659
1,502,756	1,674,520	(171,764)	Premium - Provider Enhancement	14,495,003	14,699,140	(204,137)
232,598	212,006	20,592	Premium - Ground Emergency Medical Transportation	1,992,376	1,861,015	131,361
63,041	98,145	(35,104)	Premium - Behavorial Health Integration Program	1,042,319	861,531	180,788
-	-	0	Premium - Vaccine Incentive	291,013	-	291,013
-	-	-	Premium - Student Behavioral Health Incentive	148,933	-	148,933
-	-	-	Premium - Housing and Homelessness Incentive	263,528	-	263,528
36,357	29,808	6,549	Other	311,160	261,432	49,728
31,275,148	29,197,301	2,077,847	Total Title XIX - Medicaid - Expansion Members	272,718,273	256,325,041	16,393,232
			Title XIX - Medicaid - SPD Members			
13,809,689	12,978,268	831,422	Premium - Medi-Cal	118,486,337	113,943,307	4,543,031
505,700	466,875	38,825	Premium - Enhanced Care Management	4,338,876	4,098,951	239,925
157,327	148,440	8,887	Premium - Major Organ Transplant	1,349,855	1,303,236	46,619
63,673	238,436	(174,763)	Premium - Cal AIM	561,811	2,093,359	(1,531,548)
608,032	788,597	(180,565)	Premium - BHT Kick	5,853,108	6,923,525	(1,070,417)
449,546	485,064	(35,518)	Premium - Provider Enhancement	4,222,390	4,258,640	(36,250)
154,386	145,990	8,396	Premium - Ground Emergency Medical Transportation	1,324,622	1,281,726	42,896
11,867	50,119	(38,252)	Premium - Behavorial Health Integration Program	200,506	440,020	(239,514)
-	-	-	Premium - Vaccine Incentive	61,893	-	61,893
-	-	-	Premium - Student Behavioral Health Incentive	27,982	-	27,982
-	-	-	Premium - Housing and Homelessness Incentive	51,059	-	51,059
15,760,220	15,301,788	458,432	Total Title XIX - Medicaid - SPD Members	136,478,439	134,342,763	2,135,676

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED SEPTEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
3,859,118	4,053,899	194,781	Primary Care Physician Services	33,972,955	35,596,880	1,623,925
13,253,634	11,906,522	(1,347,112)	Referral Specialty Services	115,119,502	104,540,430	(10,579,072)
1,501,101	1,662,841	161,740	Urgent Care & After Hours Advise	18,516,930	14,598,155	(3,918,775)
9,000	9,000	-	Hospital Admitting Team	81,900	81,900	-
18,622,853	17,632,262	(990,591)	TOTAL PHYSICIAN SERVICES	167,691,287	154,817,365	(12,873,922)
			OTHER PROFESSIONAL SERVICES			
327,811	331,025	3,214	Vision Service Capitation	2,828,225	2,906,715	78,490
1,890,140	2,154,063	263,923	Medical Departments - UM Allocation *	16,839,246	19,386,561	2,547,315
1,282,862	1,564,134	281,272	Behavior Health Treatment	12,099,901	13,734,420	1,634,519
180,406	156,954	(23,452)	Mental Health Services	1,339,712	1,378,144	38,432
1,343,698	1,720,242	376,544	Other Professional Services	12,772,070	15,103,753	2,331,683
5,024,917	5,926,418	901,501	TOTAL OTHER PROFESSIONAL SERVICES	45,879,154	52,509,592	6,630,438
4,773,821	5,738,181	964,360	EMERGENCY ROOM	42,063,554	50,384,434	8,320,880
22,797,560	20,611,293	(2,186,267)	INPATIENT HOSPITAL	188,753,846	180,965,414	(7,788,432)
142,533	56,700	(85,833)	REINSURANCE EXPENSE PREMIUM	418,844	497,880	79,036
9,352,210	8,762,220	(589,990)	OUTPATIENT HOSPITAL SERVICES	80,353,699	76,932,212	(3,421,487)
			OTHER MEDICAL			
1,597,466	1,649,882	52,416	Ambulance and NEMT	12,025,244	14,486,837	2,461,593
739,073	711,257	(27,816)	Home Health Services & CBAS	7,870,890	6,245,053	(1,625,837)
1,076,096	1,106,708	30,612	Utilization and Quality Review Expenses	6,877,428	9,960,372	3,082,944
1,573,989	1,486,357	(87,632)	Long Term/SNF/Hospice	15,072,909	13,049,836	(2,023,073)
5,228,484	5,985,413	756,929	Provider Enhancement Expense - Prop. 56	50,934,834	52,554,788	1,619,954
520,821	537,437	16,616	Provider Enhancement Expense - GEMT	4,126,184	4,721,080	594,896
825	-	(825)	Vaccine Incentive Program Expense	3,172,868	-	(3,172,868)
220,783	253,828	33,045	Behaviorial Health Integration Program	3,797,714	2,228,628	(1,569,086)
1,936,841	1,794,332	(142,509)	Enhanced Care Management	16,662,142	15,784,216	(877,926)
510,244	494,909	(15,335)	Major Organ Transplant	4,396,516	4,344,554	(51,962)
1,352,580	1,207,561	(145,019)	Cal AIM Incentive Programs	11,826,431	10,602,485	(1,223,946)
987,460	933,137	(54,323)	DME/Rebates	8,392,503	8,192,984	(199,519)
15,744,662	16,160,821	416,159	TOTAL OTHER MEDICAL	145,155,663	142,170,833	(2,984,830)
490,964	472,500	(18,464)	PAY FOR PERFORMANCE QUALITY INCENTIVE	4,280,127	4,149,000	(131,127)
18,857,014	17,605,832	(1,251,182)	HOSPITAL DIRECTED PAYMENTS	163,452,673	154,861,070	(8,591,603)
(4,064,727)	-	4,064,727	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	22,878,119	-	(22,878,119)
9,821	-	(9,821)	NON-CLAIMS EXPENSE ADJUSTMENT	(628,170)	-	628,170
(789,121)	-	789,121	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(16,146,287)	-	16,146,287
90,962,507	92,966,226	2,003,719	Total Medical Costs	844,152,509	817,287,799	(26,864,710)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED SEPTEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
11.84	12.87	1.03	Primary Care Physician Services	11.89	12.87	0.98
40.67	37.80	(2.87)	Referral Specialty Services	40.30	37.79	(2.51)
4.61	5.28	0.67	Urgent Care & After Hours Advise	6.48	5.28	(1.21)
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
57.14	55.98	(1.16)	TOTAL PHYSICIAN SERVICES	58.71	55.97	(2.74)
			OTHER PROFESSIONAL SERVICES			
1.01	1.05	0.05	Vision Service Capitation	0.99	1.05	0.06
5.80	6.84	1.04	Medical Departments - UM Allocation *	5.90	7.01	1.11
3.94	4.97	1.03	Behavior Health Treatment	4.24	4.97	0.73
0.55	0.50	(0.06)	Mental Health Services	0.47	0.50	0.03
4.12	5.46	1.34	Other Professional Services	4.47	5.46	0.99
15.42	18.81	3.40	TOTAL OTHER PROFESSIONAL SERVICES	16.06	18.98	2.92
14.65	18.22	3.57	EMERGENCY ROOM	14.73	18.22	3.49
69.95	65.43	(4.52)	INPATIENT HOSPITAL	66.08	65.42	(0.66)
0.44	0.18	(0.26)	REINSURANCE EXPENSE PREMIUM	0.15	0.18	0.03
28.69	27.82	(0.88)	OUTPATIENT HOSPITAL SERVICES	28.13	27.81	(0.32)
			OTHER MEDICAL			
4.90	5.24	0.34	Ambulance and NEMT	4.21	5.24	1.03
2.27	2.26	(0.01)	Home Health Services & CBAS	2.76	2.26	(0.50)
3.30	3.51	0.21	Utilization and Quality Review Expenses	2.41	3.60	1.19
4.83	4.72	(0.11)	Long Term/SNF/Hospice	5.28	4.72	(0.56)
16.04	19.00	2.96	Provider Enhancement Expense - Prop. 56	17.83	19.00	1.17
1.60	1.71	0.11	Provider Enhancement Expense - GEMT	1.44	1.71	0.26
0.00	0.00	(0.00)	Vaccine Incentive Program Expense	1.11	0.00	(1.11)
0.68	0.81	0.13	Behaviorial Health Integration Program	1.33	0.81	(0.52)
5.94	5.70	(0.25)	Enhanced Care Management	5.83	5.71	(0.13)
1.57	1.57	0.01	Major Organ Transplant	1.54	1.57	0.03
4.15	3.83	(0.32)	Cal AIM Incentive Programs	4.14	3.83	(0.31)
3.03	2.96	(0.07)	DME	2.94	2.96	0.02
48.31	51.30	3.00	TOTAL OTHER MEDICAL	50.82	51.40	0.58
1.51	1.50	(0.01)	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	0.00
57.86	55.89	(1.97)	HOSPITAL DIRECTED PAYMENTS	57.23	55.99	(1.24)
(12.47)	0.00	12.47	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	8.01	0.00	(8.01)
0.03	0.00	(0.03)	NON-CLAIMS EXPENSE ADJUSTMENT	(0.22)	0.00	0.22
(2.42)	0.00	2.42	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(5.65)	0.00	5.65
279.09	295.13	16.04	Total Medical Costs	295.55	295.48	(0.07)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH SEPTEMBER 30, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022
PHYSICIAN SERVICES					
Primary Care Physician Services	3,472,901	3,950,940	3,869,340	4,216,012	3,710,885
Referral Specialty Services	11,390,029	12,825,148	13,133,782	12,603,720	12,666,671
Urgent Care & After Hours Advise	2,665,800	2,534,829	2,906,730	1,462,769	1,508,987
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300
TOTAL PHYSICIAN SERVICES	17,538,030	19,319,317	19,919,152	18,291,501	17,895,843
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	298,113	299,421	320,479	313,381	312,490
Medical Departments - UM Allocation *	1,874,290	1,814,144	1,930,871	1,799,307	1,920,750
Behavior Health Treatment	1,143,733	984,520	1,425,684	1,406,426	1,172,372
Mental Health Services	385,915	151,598	138,742	134,047	69,233
Other Professional Services	1,338,982	1,653,027	1,439,003	1,708,384	1,360,230
TOTAL OTHER PROFESSIONAL SERVICES	5,041,033	4,902,710	5,254,779	5,361,545	4,835,075
EMERGENCY ROOM	5,209,937	5,098,972	5,150,400	5,098,584	4,139,529
INPATIENT HOSPITAL	20,610,105	20,031,970	20,232,342	20,364,608	21,395,635
REINSURANCE EXPENSE PREMIUM	53,660	53,896	57,686	56,409	56,248
OUTPATIENT HOSPITAL SERVICES	8,214,215	8,223,126	8,686,122	8,458,833	8,281,163
OTHER MEDICAL					
Ambulance and NEMT	1,321,069	1,293,500	1,339,544	1,466,846	1,405,832
Home Health Services & CBAS	733,519	813,833	841,676	781,545	1,039,980
Utilization and Quality Review Expenses	767,373	755,405	504,541	724,744	1,037,565
Long Term/SNF/Hospice	1,585,601	1,669,982	1,938,253	1,975,528	1,770,701
Provider Enhancement Expense - Prop. 56	5,806,204	5,819,707	5,888,710	5,878,051	5,871,736
Provider Enhancement Expense - GEMT	463,070	463,069	300,851	354,994	480,313
Vaccine Incentive Program Expense	1,143,595	1,628,354	173,216	136,387	739
Behaviorial Health Integration Program	824,339	824,339	824,339	225,048	216,518
Enhanced Care Management	2,023,406	1,561,486	1,821,649	1,818,393	1,820,636
Major Organ Transplant	472,866	473,613	496,178	480,362	480,654
Cal AIM Incentive Programs	1,241,196	1,257,731	1,089,466	1,285,346	1,268,891
DME	881,383	973,969	570,456	1,214,663	907,459
TOTAL OTHER MEDICAL	17,263,621	17,534,988	15,788,879	16,341,907	16,301,024
PAY FOR PERFORMANCE QUALITY INCENTIVE	464,013	465,422	465,421	472,037	473,494
HOSPITAL DIRECTED PAYMENTS	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	230,177	24,013	26,678,156	3,898	(3,419)
NON-CLAIMS EXPENSE ADJUSTMENT	43,538	4,118	572,469	62,025	(1,371,999)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	627	(1,010,781)	(3,987,493)	(2,812,496)	(3,724,314)
Total Medical Costs	92,275,826	92,302,247	116,767,047	89,604,769	86,206,555

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH SEPTEMBER 30, 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES					
Primary Care Physician Services	3,643,312	3,951,533	3,298,914	3,859,118	33,972,955
Referral Specialty Services	14,157,633	12,653,874	12,435,011	13,253,634	115,119,502
Urgent Care & After Hours Advise	1,111,956	2,369,574	2,455,184	1,501,101	18,516,930
Hospital Admitting Team	9,000	9,300	9,300	9,000	81,900
TOTAL PHYSICIAN SERVICES	18,921,901	18,984,281	18,198,409	18,622,853	167,691,287
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	317,864	315,663	323,003	327,811	2,828,225
Medical Departments - UM Allocation *	1,835,227	1,913,288	1,861,229	1,890,140	16,839,246
Behavior Health Treatment	1,493,794	1,392,248	1,798,262	1,282,862	12,099,901
Mental Health Services	98,672	112,742	68,357	180,406	1,339,712
Other Professional Services	1,367,404	1,403,400	1,157,942	1,343,698	12,772,070
TOTAL OTHER PROFESSIONAL SERVICES	5,112,961	5,137,341	5,208,793	5,024,917	45,879,154
EMERGENCY ROOM	3,167,228	4,764,039	4,661,044	4,773,821	42,063,554
INPATIENT HOSPITAL	19,551,774	22,935,749	20,834,103	22,797,560	188,753,846
REINSURANCE EXPENSE PREMIUM	57,216	(33,668)	(25,136)	142,533	418,844
OUTPATIENT HOSPITAL SERVICES	9,196,013	10,013,268	9,928,749	9,352,210	80,353,699
OTHER MEDICAL					
Ambulance and NEMT	825,707	1,358,335	1,416,945	1,597,466	12,025,244
Home Health Services & CBAS	1,056,675	1,083,945	780,644	739,073	7,870,890
Utilization and Quality Review Expenses	642,907	696,258	672,539	1,076,096	6,877,428
Long Term/SNF/Hospice	1,113,446	1,750,512	1,694,897	1,573,989	15,072,909
Provider Enhancement Expense - Prop. 56	6,032,156	5,197,617	5,212,169	5,228,484	50,934,834
Provider Enhancement Expense - GEMT	494,051	503,001	546,014	520,821	4,126,184
Vaccine Incentive Program Expense	85,682	2,148	1,922	825	3,172,868
Behaviorial Health Integration Program	220,783	220,782	220,783	220,783	3,797,714
Enhanced Care Management	1,866,858	1,907,842	1,905,031	1,936,841	16,662,142
Major Organ Transplant	492,226	504,463	485,910	510,244	4,396,516
Cal AIM Incentive Programs	1,807,413	1,195,617	1,328,191	1,352,580	11,826,431
DME	884,167	996,415	976,531	987,460	8,392,503
TOTAL OTHER MEDICAL	15,522,071	15,416,935	15,241,576	15,744,662	145,155,663
PAY FOR PERFORMANCE QUALITY INCENTIVE	478,060	485,358	485,358	490,964	4,280,127
HOSPITAL DIRECTED PAYMENTS	18,280,365	18,674,627	18,595,974	18,857,014	163,452,673
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	5,129	9,235	(4,343)	(4,064,727)	22,878,119
NON-CLAIMS EXPENSE ADJUSTMENT	29,799	17,040	5,019	9,821	(628,170)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(4,072,490)	(238,100)	487,881	(789,121)	(16,146,287)
Total Medical Costs	86,250,027	96,166,105	93,617,427	90,962,508	844,152,509

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH SEPTEMBER 30, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022
PHYSICIAN SERVICES					
Primary Care Physician Services	11.23	12.73	12.38	13.40	11.76
Referral Specialty Services	36.82	41.33	42.03	40.05	40.13
Urgent Care & After Hours Advise	8.62	8.17	9.30	4.65	4.78
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	56.69	62.26	63.74	58.13	56.69
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	0.96	0.96	1.03	1.00	0.99
Medical Departments - UM Allocation *	6.06	5.85	6.18	5.72	6.08
Behavior Health Treatment	3.70	3.17	4.56	4.47	3.71
Mental Health Services	1.25	0.49	0.44	0.43	0.22
Other Professional Services	4.33	5.33	4.60	5.43	4.31
TOTAL OTHER PROFESSIONAL SERVICES	16.30	15.80	16.82	17.04	15.32
EMERGENCY ROOM	16.84	16.43	16.48	16.20	13.11
INPATIENT HOSPITAL	66.63	64.56	64.75	64.71	67.78
REINSURANCE EXPENSE PREMIUM	0.17	0.17	0.18	0.18	0.18
OUTPATIENT HOSPITAL SERVICES	26.55	26.50	27.80	26.88	26.23
OTHER MEDICAL					
Ambulance and NEMT	4.27	4.17	4.29	4.66	4.45
Home Health Services & CBAS	2.37	2.62	2.69	2.48	3.29
Utilization and Quality Review Expenses	2.48	2.43	1.61	2.30	3.29
Long Term/SNF/Hospice	5.13	5.38	6.20	6.28	5.61
Provider Enhancement Expense - Prop. 56	18.77	18.76	18.84	18.68	18.60
Provider Enhancement Expense - GEMT	1.50	1.49	0.96	1.13	1.52
Vaccine Incentive Program Expense	3.70	5.25	0.55	0.43	0.00
Behaviorial Health Integration Program	2.66	2.66	2.64	0.72	0.69
Enhanced Care Management	6.54	5.03	5.83	5.78	5.77
Major Organ Transplant	1.53	1.53	1.59	1.53	1.52
Cal AIM Incentive Programs	4.01	4.05	3.49	4.08	4.02
DME	2.85	3.14	1.83	3.86	2.87
TOTAL OTHER MEDICAL	55.81	56.51	50.53	51.93	51.64
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	1.49	1.50	1.50
HOSPITAL DIRECTED PAYMENTS	56.92	56.90	57.44	56.90	56.80
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.74	0.08	85.37	0.01	(0.01)
NON-CLAIMS EXPENSE ADJUSTMENT	0.14	0.01	1.83	0.20	(4.35)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(3.26)	(12.76)	(8.94)	(11.80)
Total Medical Costs	298.30	297.48	373.67	284.74	273.10

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH SEPTEMBER 30, 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES					
Primary Care Physician Services	11.41	12.21	10.15	11.84	11.89
Referral Specialty Services	44.34	39.11	38.27	40.67	40.30
Urgent Care & After Hours Advise	3.48	7.32	7.56	4.61	6.48
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	59.25	58.67	56.00	57.14	58.71
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	1.00	0.98	0.99	1.01	0.99
Medical Departments - UM Allocation *	5.75	5.91	5.73	5.72	5.90
Behavior Health Treatment	4.68	4.30	5.53	3.94	4.24
Mental Health Services	0.31	0.35	0.21	0.55	0.47
Other Professional Services	4.28	4.34	3.56	4.12	4.47
TOTAL OTHER PROFESSIONAL SERVICES	16.01	15.88	16.03	15.34	16.06
EMERGENCY ROOM	9.92	14.72	14.34	14.65	14.73
INPATIENT HOSPITAL	61.23	70.88	64.11	69.95	66.08
REINSURANCE EXPENSE PREMIUM	0.18	(0.10)	(0.08)	0.44	0.15
OUTPATIENT HOSPITAL SERVICES	28.80	30.95	30.55	28.69	28.13
OTHER MEDICAL					
Ambulance and NEMT	2.59	4.20	4.36	4.90	4.21
Home Health Services & CBAS	3.31	3.35	2.40	2.27	2.76
Utilization and Quality Review Expenses	2.01	2.15	2.07	3.30	2.41
Long Term/SNF/Hospice	3.49	5.41	5.22	4.83	5.28
Provider Enhancement Expense - Prop. 56	18.89	16.06	16.04	16.04	17.83
Provider Enhancement Expense - GEMT	1.55	1.55	1.68	1.60	1.44
Vaccine Incentive Program Expense	0.27	0.01	0.01	0.00	1.11
Behaviorial Health Integration Program	0.69	0.68	0.68	0.68	1.33
Enhanced Care Management	5.85	5.90	5.86	5.94	5.83
Major Organ Transplant	1.54	1.56	1.50	1.57	1.54
Cal AIM Incentive Programs	5.66	3.70	4.09	4.15	4.14
DME	2.77	3.08	3.01	3.03	2.94
TOTAL OTHER MEDICAL	48.61	47.65	46.90	48.31	50.82
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	1.49	1.51	1.50
HOSPITAL DIRECTED PAYMENTS	57.25	57.71	57.23	57.86	57.23
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.02	0.03	(0.01)	(12.47)	8.01
NON-CLAIMS EXPENSE ADJUSTMENT	0.09	0.05	0.02	0.03	(0.22)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(12.75)	(0.74)	1.50	(2.42)	(5.65)
Total Medical Costs	270.09	297.20	288.09	279.02	295.55

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED SEPTEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
480,177	459,798	(20,379)	110 - Executive	4,019,294	4,213,181	193,887
205,332	234,469	29,137	210 - Accounting	1,903,142	2,110,221	207,079
379,477	359,967	(19,510)	220 - Management Information Systems	3,154,167	3,239,702	85,535
35,696	54,298	18,602	221 - Business Intelligence	312,325	488,682	176,357
262,856	383,664	120,808	222 - Enterprise Development	2,531,169	3,452,976	921,807
415,178	533,193	118,015	225 - Infrastructure	4,336,384	4,798,737	462,353
474,159	615,321	141,162	230 - Claims	5,109,744	5,537,889	428,145
252,716	187,947	(64,769)	240 - Project Management	1,442,885	1,691,523	248,638
169,157	180,989	11,832	310 - Health Services - Utilization Management	1,347,845	1,628,901	281,056
317	14,039	13,722	311 - Health Services - Quality Improvement	2,981	126,351	123,370
(2,865)	513	3,378	312 - Health Services - Education	1,042	4,617	3,575
43,043	50,828	7,785	313- Pharmacy	322,815	457,452	134,637
18,382	2,308	(16,074)	314 - Enhanced Care Management	108,173	20,772	(87,401)
55,570	74,558	18,988	316 -Population Health Management	538,067	671,022	132,955
25	333	308	317 - Community Based Services	293	2,997	2,704
-	-	-	318 - Housing & Homeless Incentive Program	-	-	-
313,213	359,942	46,729	320 - Provider Network Management	2,784,805	3,239,478	454,673
715,313	871,663	156,350	330 - Member Services	6,129,090	7,844,967	1,715,877
836,837	721,857	(114,980)	340 - Corporate Services	7,047,353	6,496,713	(550,640)
86,380	97,177	10,797	360 - Audit & Investigative Services	712,069	874,593	162,524
23,027	92,450	69,423	410 - Advertising Media	466,451	832,050	365,599
75,839	76,696	857	420 - Sales/Marketing/Public Relations	584,680	690,264	105,584
338,192	303,042	(35,150)	510 - Human Resourses	2,763,385	2,727,378	(36,007)
420,793	(92,324)	(513,117)	Administrative Expense Adjustment	2,105,161	(830,916)	(2,936,077)
5,598,814	5,582,728	(16,086)	Total Administrative Expenses	47,723,320	50,319,550	2,596,230

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED SEPTEMBER 30, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022
110 - Executive	424,308	403,286	429,743	446,418	470,648
210 - Accounting	233,241	178,928	252,864	163,976	225,728
220 - Management Information Systems (MIS)	335,777	238,917	337,588	352,426	352,473
221 - Business Intelligence	13,042	65,687	31,834	45,508	45,708
222 - Enterprise Development	307,654	250,898	286,566	265,813	303,353
225 - Infrastructure	473,799	427,685	536,529	343,776	562,405
230 - Claims	582,040	548,583	591,767	559,648	590,588
240 - Project Management	171,917	152,433	174,210	123,662	152,467
310 - Health Services - Utilization Management	139,536	126,622	128,165	132,502	154,797
311 - Health Services - Quality Improvement	277	15,545	(90)	186	(15,257)
312 - Health Services - Education	-	180	2,174	310	89
313- Pharmacy	39,824	36,716	38,879	36,385	35,680
314 - Enhanced Care Management	3,281	241	19	12,005	22,519
316 -Population Health Management	65,121	62,696	63,150	64,161	66,172
317 - Community Based Services	-	24	22	17	5
318 - Housing & Homeless Incentive Program	-	-	-	-	9,346
320 - Provider Network Management	327,923	326,761	325,559	269,804	308,858
330 - Member Services	754,477	623,424	700,611	644,994	694,732
340 - Corporate Services	786,930	685,514	778,083	735,005	751,597
360 - Audit & Investigative Services	69,757	69,895	71,016	82,269	83,957
410 - Advertising Media	11,825	27,353	55,984	38,254	34,202
420 - Sales/Marketing/Public Relations	66,531	51,460	70,326	65,913	62,815
510 - Human Resourses	309,451	254,507	352,740	341,377	295,995
Total Department Expenses	5,116,711	4,547,355	5,227,739	4,724,409	5,208,877
ADMINISTRATIVE EXPENSE ADJUSTMENT	(1,904)	(44,283)	31,776	164,256	(2,834)
Total Administrative Expenses	5,114,807	4,503,072	5,259,515	4,888,665	5,206,043

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED SEPTEMBER 30, 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	YEAR TO DATE 2022
110 - Executive	353,073	504,491	507,150	480,177	4,019,294
210 - Accounting	222,884	202,574	217,615	205,332	1,903,142
220 - Management Information Systems (MIS)	336,194	449,253	372,062	379,477	3,154,167
221 - Business Intelligence	16,186	42,730	15,934	35,696	312,325
222 - Enterprise Development	291,350	256,153	306,526	262,856	2,531,169
225 - Infrastructure	524,493	450,547	601,972	415,178	4,336,384
230 - Claims	529,776	654,284	578,899	474,159	5,109,744
240 - Project Management	105,055	152,605	157,820	252,716	1,442,885
310 - Health Services - Utilization Management	166,719	167,284	163,063	169,157	1,347,845
311 - Health Services - Quality Improvement	178	1,002	823	317	2,981
312 - Health Services - Education	222	895	37	(2,865)	1,042
313- Pharmacy	34,727	33,787	23,774	43,043	322,815
314 - Enhanced Care Management	12,559	16,919	22,248	18,382	108,173
316 -Population Health Management	55,430	54,747	51,020	55,570	538,067
317 - Community Based Services	36	7	157	25	293
318 - Housing & Homeless Incentive Program	(9,346)	42	(42)	-	-
320 - Provider Network Management	305,807	307,080	299,800	313,213	2,784,805
330 - Member Services	635,012	682,669	677,858	715,313	6,129,090
340 - Corporate Services	842,924	814,888	815,575	836,837	7,047,353
360 - Audit & Investigative Services	69,158	91,281	88,356	86,380	712,069
410 - Advertising Media	52,260	169,122	54,424	23,027	466,451
420 - Sales/Marketing/Public Relations	72,927	58,511	60,358	75,839	584,680
510 - Human Resourses	236,093	340,172	294,858	338,192	2,763,385
Total Department Expenses	4,853,717	5,451,043	5,310,287	5,178,021	45,618,159
ADMINISTRATIVE EXPENSE ADJUSTMENT	811,890	425,467	300,000	420,793	2,105,161
Total Administrative Expenses	5,665,607	5,876,510	5,610,287	5,598,814	47,723,320

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF SEPTEMBER 30, 2022

ASSETS	SEPTEMBER 2022	AUGUST 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,142,022	$ 1,142,022	-
Interest Receivable	3,869	1,400	2,469
TOTAL CURRENT ASSETS	$ 1,145,891	$ 1,143,422	$ 2,469
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,136,102	1,136,102	-
Increase (Decrease) in Net Position - Current Year	9,789	7,320	2,469
Total Net Position	$ 1,145,891	$ 1,143,422	$ 2,469
TOTAL LIABILITIES AND NET POSITION	$ 1,145,891	$ 1,143,422	$ 2,469

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED SEPTEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
2,469	-	2,469	Interest	6,887	-	6,887
-	-	-	Other Investment Income	2,902	-	2,902
2,469	-	2,469	TOTAL REVENUES	9,789	-	9,789
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
2,469	-	2,469	GROSS MARGIN	9,789	-	9,789
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
2,469	-	2,469	OPERATING INCOME (LOSS)	9,789	-	9,789
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
2,469	-	2,469	NET INCREASE (DECREASE) IN NET POSITION	9,789	-	9,789
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
0%	0%	0%	ADMINISTRATIVE EXPENSE RATIO	0%	0%	0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2022 MEMBER MONTHS	JAN'22	FEB'22	MAR'22	APR'22	MAY'22	JUN'22	JULY'22	AUG'22	SEPT'22
ADULT AND FAMILY										
ADULT	***560,633***	60,708	60,882	61,379	61,726	61,739	62,276	63,581	64,006	64,336
CHILD	***1,270,231***	139,223	139,605	140,344	141,029	141,356	141,902	142,505	142,059	142,208
SUB-TOTAL ADULT & FAMILY	***1,830,864***	***199,931***	***200,487***	***201,723***	***202,755***	***203,095***	***204,178***	***206,086***	***206,065***	***206,544***
OTHER MEMBERS										
PARTIAL DUALS - FAMILY	***7,384***	824	801	811	796	815	837	842	814	844
PARTIAL DUALS - CHILD	***0***	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	***56***	4	13	6	5	5	5	6	6	6
FULL DUALS (SPD)										
SPD FULL DUALS	***76,667***	8,138	8,257	8,336	8,411	8,662	8,572	8,684	8,794	8,813
SUBTOTAL OTHER MEMBERS	***84,107***	***8,966***	***9,071***	***9,153***	***9,212***	***9,482***	***9,414***	***9,532***	***9,614***	***9,663***
TOTAL FAMILY & OTHER	***1,914,971***	***208,897***	***209,558***	***210,876***	***211,967***	***212,577***	***213,592***	***215,618***	***215,679***	***216,207***
SPD										
SPD (AGED AND DISABLED)	***150,134***	16,556	16,376	16,516	16,363	16,305	16,794	16,817	17,118	17,289
MEDI-CAL EXPANSION										
ACA Expansion Adult-Citizen	**779,059**	82,803	83,199	83,828	85,037	85,412	87,526	89,680	90,672	90,902
ACA Expansion Duals	**12,089**	1,086	1,148	1,270	1,324	1,369	1,421	1,457	1,492	1,522
SUB-TOTAL MED-CAL EXPANSION	***791,148***	***83,889***	***84,347***	***85,098***	***86,361***	***86,781***	***88,947***	***91,137***	***92,164***	***92,424***
TOTAL KAISER	***121,693***	***12,787***	***13,032***	***13,253***	***13,407***	***13,552***	***13,722***	***13,842***	***13,972***	***14,126***
TOTAL MEDI-CAL MEMBERS	***2,977,946***	***322,129***	***323,313***	***325,743***	***328,098***	***329,215***	***333,055***	***337,414***	***338,933***	***340,046***

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: December 15, 2022

Re: October 2022 Financial Results

The October results reflect a $3,987,926 Net Increase in Net Position which is a $4,203,119 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $5.3 million favorable variance primarily due to:

   A) $4.0 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $1.3 million favorable variance in Premium-Hospital Directed Payments primarily due to higher-than-expected budgeted membership offset against amounts included in 2C below.

2) Total Medical Costs reflect a $1.5 million unfavorable variance primarily due to:

   A) $1.0 million favorable variance in Emergency Room primarily due to lower-than-expected utilization over the last several months.

   B) $1.7 million unfavorable variance in Inpatient primarily due to higher-than-expected utilization over the last several months by Family and SPD members.

   C) $1.3 million unfavorable variance in Hospital Directed Payments primarily due to higher-than-expected budgeted membership offset against amounts included in 1B above.

   D) $.4 million favorable variance primarily from IBNR Adjustments relating to the prior year.

The October Medical Loss Ratio is 88.7% which is favorable to the 92.9% budgeted amount. The October Administrative Expense Ratio is 6.6% which is favorable to the 6.8% budgeted amount.

The results for the 10 months ended October 31, 2022 reflects a Net Increase in Net Position of $35,019,020. This is a $38,213,536 favorable variance to the budget and includes approximately $13.1 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 88.7% which is favorable to the 92.8% budgeted amount. The year-to-date Administrative Expense Ratio is 6.5% which is favorable to the 7.0% budgeted amount.

Kern Health Systems
Financial Packet
October 2022

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF OCTOBER 31, 2022

ASSETS	OCTOBER 2022	SEPTEMBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 155,712,819	$ 142,667,501	$ 13,045,318
Short-Term Investments	216,266,372	236,155,812	(19,889,440)
Premiums Receivable - Net	106,316,288	107,091,819	(775,531)
Premiums Receivable - Hospital Direct Payments	377,478,453	358,506,643	18,971,810
Interest Receivable	84,010	252,634	(168,624)
Provider Advance Payment	2,599,965	2,777,176	(177,211)
Other Receivables	1,973,160	322,166	1,650,994
Prepaid Expenses & Other Current Assets	3,011,430	3,335,933	(324,503)
Total Current Assets	$ 863,442,497	$ 851,109,684	$ 12,332,813
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,307,117	1,323,130	(16,013)
Computer Hardware and Software - Net	18,555,056	18,855,103	(300,047)
Building and Building Improvements - Net	33,867,417	33,943,525	(76,108)
Capital Projects in Progress	6,353,893	6,066,787	287,106
Total Capital Assets	$ 64,174,189	$ 64,279,251	$ (105,062)
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,604,652	1,604,652	-
Total Long Term Assets	$ 1,904,652	$ 1,904,652	$ -
DEFERRED OUTFLOWS OF RESOURCES	$ 4,731,067	$ 4,731,067	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 934,252,405	$ 922,024,654	$ 12,227,751
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 5,183,589	$ 4,858,302	325,287
Accrued Other Operating Expenses	2,332,830	2,465,066	(132,236)
Accrued Taxes and Licenses	10,728,420	32,495,339	(21,766,919)
Claims Payable (Reported)	25,138,610	21,227,073	3,911,537
IBNR - Inpatient Claims	55,619,619	53,360,793	2,258,826
IBNR - Physician Claims	19,630,283	19,207,025	423,258
IBNR - Accrued Other Medical	24,071,362	24,584,524	(513,162)
Risk Pool and Withholds Payable	5,220,812	4,727,132	493,680
Statutory Allowance for Claims Processing Expense	2,509,938	2,509,938	-
Other Liabilities	117,487,167	113,519,424	3,967,743
Accrued Hospital Directed Payments	377,296,111	358,324,300	18,971,811
Total Current Liabilities	$ 645,218,741	$ 637,278,916	$ 7,939,825
NONCURRENT LIABILITIES:			
Net Pension Liability	1,200,000	900,000	300,000
TOTAL NONCURRENT LIABILITIES	$ 1,200,000	$ 900,000	$ 300,000
DEFERRED INFLOWS OF RESOURCES	$ 5,338,319	$ 5,338,319	$ -
NET POSITION:			
Net Position - Beg. of Year	247,476,325	247,476,325	-
Increase (Decrease) in Net Position - Current Year	35,019,020	31,031,094	3,987,926
Total Net Position	$ 282,495,345	$ 278,507,419	$ 3,987,926
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 934,252,405	$ 922,024,654	$ 12,227,751

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED OCTOBER 31, 2022

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
207,776	208,400	(624)	Family Members	2,038,640	2,025,500	13,140
94,305	84,430	9,875	Expansion Members	885,453	820,300	65,153
17,179	16,430	749	SPD Members	167,313	159,800	7,513
9,861	7,740	2,121	Other Members	93,968	77,400	16,568
14,281	13,000	1,281	Kaiser Members	135,974	130,000	5,974
343,402	330,000	13,402	Total Members - MCAL	3,321,348	3,213,000	108,348
			REVENUES			
37,949,223	36,666,872	1,282,351	Title XIX - Medicaid - Family and Other	372,299,266	358,275,052	14,024,214
31,549,369	29,405,387	2,143,982	Title XIX - Medicaid - Expansion Members	304,267,642	285,730,428	18,537,214
15,913,345	15,395,491	517,854	Title XIX - Medicaid - SPD Members	152,391,784	149,738,254	2,653,530
10,883,459	10,916,540	(33,081)	Premium - MCO Tax	102,898,163	102,633,455	264,708
18,961,885	17,711,807	1,250,078	Premium - Hospital Directed Payments	182,414,558	172,572,877	9,841,681
179,268	85,125	94,143	Investment Earnings And Other Income	(14,301)	828,213	(842,514)
-	57,060	(57,060)	Reinsurance Recoveries	-	554,940	(554,940)
9,926	-	9,926	Rate Adjustments - Hospital Directed Payments	22,554,889	-	22,554,889
124,448	-	124,448	Rate/Income Adjustments	(1,602,093)	-	(1,602,093)
115,570,923	110,238,282	5,332,641	TOTAL REVENUES	1,135,209,908	1,070,333,219	64,876,689
			EXPENSES			
			Medical Costs:			
18,169,774	17,746,255	(423,519)	Physician Services	185,861,061	172,563,620	(13,297,441)
5,041,998	5,950,303	908,305	Other Professional Services	50,921,152	58,459,895	7,538,743
4,790,820	5,775,041	984,221	Emergency Room	46,854,374	56,159,475	9,305,101
22,462,437	20,745,728	(1,716,709)	Inpatient	211,216,283	201,711,142	(9,505,141)
58,493	57,060	(1,433)	Reinsurance Expense	477,337	554,940	77,603
9,319,855	8,819,325	(500,530)	Outpatient Hospital	89,673,554	85,751,537	(3,922,017)
16,418,094	16,256,520	(161,574)	Other Medical	161,573,757	158,427,353	(3,146,404)
493,681	475,500	(18,181)	Pay for Performance Quality Incentive	4,773,808	4,624,500	(149,308)
18,961,885	17,711,807	(1,250,078)	Hospital Directed Payments	182,414,558	172,572,877	(9,841,681)
9,926	-	(9,926)	Hospital Directed Payment Adjustment	22,888,045	-	(22,888,045)
(248,768)	-	248,768	Non-Claims Expense Adjustment	(876,938)	-	876,938
(435,695)	-	435,695	IBNR, Incentive, Paid Claims Adjustment	(16,581,982)	-	16,581,982
95,042,500	93,537,540	(1,504,960)	Total Medical Costs	939,195,009	910,825,339	(28,369,670)
20,528,423	16,700,742	3,827,681	GROSS MARGIN	196,014,899	159,507,880	36,507,019
			Administrative:			
3,387,496	3,369,438	(18,058)	Compensation	31,445,211	33,769,384	2,324,173
1,009,393	1,108,544	99,151	Purchased Services	9,614,468	11,085,442	1,470,974
66,157	212,108	145,951	Supplies	884,470	2,121,076	1,236,606
584,905	526,572	(58,333)	Depreciation	5,814,651	5,265,720	(548,931)
304,229	366,066	61,837	Other Administrative Expenses	3,211,539	3,660,657	449,118
299,429	-	(299,429)	Administrative Expense Adjustment	2,404,590	-	(2,404,590)
5,651,609	5,582,728	(68,881)	Total Administrative Expenses	53,374,929	55,902,278	2,527,349
100,694,109	99,120,267	(1,573,842)	TOTAL EXPENSES	992,569,938	966,727,617	(25,842,321)
14,876,814	11,118,015	3,758,799	OPERATING INCOME (LOSS) BEFORE TAX	142,639,970	103,605,603	39,034,367
10,883,460	10,916,540	33,080	MCO TAX	102,891,895	102,633,455	(258,440)
3,993,354	201,475	3,791,879	OPERATING INCOME (LOSS) NET OF TAX	39,748,075	972,148	38,775,927
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
(4,416)	(333,334)	328,918	Provider Grants/CalAIM Initiative Grant	(4,095,430)	(3,333,332)	(762,098)
(1,012)	(83,334)	82,322	Health Home	(633,625)	(833,332)	199,707
(5,428)	(416,668)	411,240	TOTAL NONOPERATING REVENUE (EXPENSE)	(4,729,055)	(4,166,664)	(562,391)
3,987,926	(215,193)	4,203,119	NET INCREASE (DECREASE) IN NET POSITION	35,019,020	(3,194,516)	38,213,536
88.7%	92.9%	4.2%	MEDICAL LOSS RATIO	88.7%	92.8%	4.1%
6.6%	6.8%	0.2%	ADMINISTRATIVE EXPENSE RATIO	6.5%	7.0%	0.6%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED OCTOBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
207,776	208,400	(624)	Family Members	2,038,640	2,025,500	13,140
94,305	84,430	9,875	Expansion Members	885,453	820,300	65,153
17,179	16,430	749	SPD Members	167,313	159,800	7,513
9,861	7,740	2,121	Other Members	93,968	77,400	16,568
14,281	13,000	1,281	Kaiser Members	135,974	130,000	5,974
343,402	330,000	13,402	Total Members - MCAL	3,321,348	3,213,000	108,348
			REVENUES			
174.37	169.64	4.73	Title XIX - Medicaid - Family and Other	174.57	170.37	4.20
334.55	348.28	(13.74)	Title XIX - Medicaid - Expansion Members	343.63	348.32	(4.69)
926.33	937.04	(10.71)	Title XIX - Medicaid - SPD Members	910.82	937.04	(26.22)
33.07	34.44	(1.37)	Premium - MCO Tax	32.30	33.29	(0.99)
57.61	55.87	1.74	Premium - Hospital Directed Payments	57.27	55.98	1.29
0.54	0.27	0.28	Investment Earnings And Other Income	(0.00)	0.27	(0.27)
0.00	0.18	(0.18)	Reinsurance Recoveries	0.00	0.18	(0.18)
0.03	0.00	0.03	Rate Adjustments - Hospital Directed Payments	7.08	0.00	7.08
0.38	0.00	0.38	Rate/Income Adjustments	(0.50)	0.00	(0.50)
351.15	347.75	3.40	TOTAL REVENUES	356.38	347.17	9.21
			EXPENSES			
			Medical Costs:			
55.21	55.98	0.77	Physician Services	58.35	55.97	(2.38)
15.32	18.77	3.45	Other Professional Services	15.99	18.96	2.98
14.56	18.22	3.66	Emergency Room	14.71	18.22	3.51
68.25	65.44	(2.81)	Inpatient	66.31	65.43	(0.88)
0.18	0.18	0.00	Reinsurance Expense	0.15	0.18	0.03
28.32	27.82	(0.50)	Outpatient Hospital	28.15	27.81	(0.34)
49.88	51.28	1.40	Other Medical	50.72	51.39	0.66
1.50	1.50	0.00	Pay for Performance Quality Incentive	1.50	1.50	0.00
57.61	55.87	(1.74)	Hospital Directed Payments	57.27	55.98	(1.29)
0.03	0.00	(0.03)	Hospital Directed Payment Adjustment	7.19	0.00	(7.19)
(0.76)	0.00	0.76	Non-Claims Expense Adjustment	(0.28)	0.00	0.28
(1.32)	0.00	1.32	IBNR, Incentive, Paid Claims Adjustment	(5.21)	0.00	5.21
288.78	295.07	6.29	Total Medical Costs	294.85	295.43	0.59
62.37	52.68	9.69	GROSS MARGIN	61.54	51.74	9.80
			Administrative:			
10.29	10.63	0.34	Compensation	9.87	10.95	1.08
3.07	3.50	0.43	Purchased Services	3.02	3.60	0.58
0.20	0.67	0.47	Supplies	0.28	0.69	0.41
1.78	1.66	(0.12)	Depreciation	1.83	1.71	(0.12)
0.92	1.15	0.23	Other Administrative Expenses	1.01	1.19	0.18
0.91	0.00	(0.91)	Administrative Expense Adjustment	0.75	0.00	(0.75)
17.17	17.61	0.44	Total Administrative Expenses	16.76	18.13	1.38
305.95	312.68	6.73	TOTAL EXPENSES	311.60	313.57	1.96
45.20	35.07	10.13	OPERATING INCOME (LOSS) BEFORE TAX	44.78	33.61	11.17
33.07	34.44	1.37	MCO TAX	32.30	33.29	0.99
12.13	0.64	11.50	OPERATING INCOME (LOSS) NET OF TAX	12.48	0.32	12.16
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
(0.01)	(1.05)	1.04	Reserve Fund Projects/Community Grants	(1.29)	(1.08)	(0.20)
(0.00)	(0.26)	0.26	Health Home	(0.20)	(0.27)	0.07
(0.02)	(1.31)	1.30	TOTAL NONOPERATING REVENUE (EXPENSE)	(1.48)	(1.35)	(0.13)
12.12	(0.68)	12.80	NET INCREASE (DECREASE) IN NET POSITION	10.99	(1.04)	12.03
88.7%	92.9%	4.2%	MEDICAL LOSS RATIO	88.7%	92.8%	4.1%
6.6%	6.8%	0.2%	ADMINISTRATIVE EXPENSE RATIO	6.5%	7.0%	0.6%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH OCTOBER 31, 2022	OCTOBER 2021	NOVEMBER 2021	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022
ENROLLMENT							
Members - MCAL	295,865	296,989	298,205	309,342	310,281	312,490	314,691
REVENUES							
Title XIX - Medicaid - Family and Other	37,040,845	37,111,335	36,899,197	37,009,614	37,126,546	36,539,594	36,762,722
Title XIX - Medicaid - Expansion Members	30,140,656	31,001,586	30,241,720	29,968,453	29,945,915	29,350,530	29,812,384
Title XIX - Medicaid - SPD Members	16,206,131	16,254,790	16,506,513	14,953,594	14,858,906	14,791,754	14,924,745
Premium - MCO Tax	10,229,218	10,229,533	10,273,393	9,899,314	9,894,054	9,893,826	9,894,054
Premium - Hospital Directed Payments	16,726,476	16,753,272	16,836,470	17,606,870	17,654,496	17,949,134	17,905,917
Investment Earnings And Other Income	131,645	157,659	(694,967)	329,573	86,457	(1,241,065)	(326,288)
Rate Adjustments - Hospital Directed Payments	4,491	8,691	(3,586)	230,177	24,013	26,907,309	3,898
Rate/Income Adjustments	52,871	66,815	5,625	957,475	977,794	493,268	59,935
TOTAL REVENUES	110,532,333	111,583,681	110,064,365	110,955,070	110,568,181	134,684,350	109,037,367
EXPENSES							
Medical Costs:							
Physician Services	17,549,058	17,258,969	17,972,930	17,538,030	19,319,317	19,919,152	18,291,501
Other Professional Services	4,846,005	4,829,415	4,344,076	5,041,033	4,902,710	5,254,779	5,361,545
Emergency Room	4,506,067	4,818,883	4,391,622	5,209,937	5,098,972	5,150,400	5,098,584
Inpatient	23,207,054	21,256,426	17,137,562	20,610,105	20,031,970	20,232,342	20,364,608
Reinsurance Expense	85,133	86,151	86,147	53,660	53,896	57,686	56,409
Outpatient Hospital	7,080,379	7,793,785	6,083,159	8,214,215	8,223,126	8,686,122	8,458,833
Other Medical	10,784,127	12,549,269	11,502,354	17,263,621	17,534,988	15,788,879	16,341,907
Pharmacy	10,236,384	10,196,195	10,620,178	-	-	-	-
Pay for Performance Quality Incentive	-	-	1,420,000	464,013	465,422	465,421	472,037
Hospital Directed Payments	16,726,476	16,753,272	16,836,470	17,606,870	17,654,496	17,949,134	17,905,917
Hospital Directed Payment Adjustment	4,491	8,691	(3,586)	230,177	24,013	26,678,156	3,898
Non-Claims Expense Adjustment	8,907	24,857	(44,256)	43,538	4,118	572,469	62,025
IBNR, Incentive, Paid Claims Adjustment	(924,120)	(1,378,922)	(1,022,824)	627	(1,010,781)	(3,987,493)	(2,812,496)
Total Medical Costs	94,109,961	94,196,991	89,323,832	92,275,826	92,302,247	116,767,047	89,604,768
GROSS MARGIN	16,422,372	17,386,690	20,740,533	18,679,244	18,265,934	17,917,303	19,432,599
Administrative:							
Compensation	2,746,218	2,775,542	2,592,690	3,116,842	2,847,002	3,108,703	3,075,151
Purchased Services	991,178	1,095,098	1,355,474	846,917	877,498	1,098,614	783,960
Supplies	58,257	188,536	164,659	191,908	(8,268)	103,207	41,533
Depreciation	424,376	716,552	746,072	571,126	571,126	571,126	570,835
Other Administrative Expenses	348,575	276,718	605,706	389,918	259,997	346,089	252,930
Administrative Expense Adjustment	300	77,569	(194,326)	(1,904)	(44,283)	31,776	164,256
Total Administrative Expenses	4,568,904	5,130,015	5,270,275	5,114,807	4,503,072	5,259,515	4,888,665
TOTAL EXPENSES	98,678,865	99,327,006	94,594,107	97,390,633	96,805,319	122,026,562	94,493,433
OPERATING INCOME (LOSS) BEFORE TAX	11,853,468	12,256,675	15,470,258	13,564,437	13,762,862	12,657,788	14,543,934
MCO TAX	9,894,054	9,894,054	9,895,157	9,894,054	9,894,054	9,893,826	9,894,054
OPERATING INCOME (LOSS) NET OF TAX	1,959,414	2,362,621	5,575,101	3,670,383	3,868,808	2,763,962	4,649,880
TOTAL NONOPERATING REVENUE (EXPENSE)	(1,027,231)	(1,516,642)	(175,210)	(400,389)	(986,700)	(1,001,012)	(1,110,153)
NET INCREASE (DECREASE) IN NET POSITION	932,183	845,979	5,399,891	3,269,994	2,882,108	1,762,950	3,539,727
MEDICAL LOSS RATIO	92.6%	91.5%	87.4%	89.4%	89.9%	90.2%	88.3%
ADMINISTRATIVE EXPENSE RATIO	5.5%	6.1%	6.4%	6.1%	5.4%	6.6%	6.0%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH OCTOBER 31, 2022	MAY 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	315,663	319,333	323,572	324,961	325,920	329,121	4,076,433
REVENUES							
Title XIX - Medicaid - Family and Other	35,766,911	37,731,384	37,514,641	37,941,354	37,957,277	37,949,223	483,350,643
Title XIX - Medicaid - Expansion Members	29,600,713	30,533,210	30,993,375	31,238,545	31,275,148	31,549,369	395,651,604
Title XIX - Medicaid - SPD Members	14,887,158	15,402,431	15,833,803	15,065,828	15,760,220	15,913,345	201,359,218
Premium - MCO Tax	9,872,493	9,910,584	10,883,460	10,883,459	10,883,460	10,883,459	133,630,307
Premium - Hospital Directed Payments	17,928,276	18,280,365	18,674,627	18,595,974	18,857,014	18,961,885	232,730,776
Investment Earnings And Other Income	357,517	(633,952)	1,002,315	(121,473)	353,347	179,268	(419,964)
Rate Adjustments - Hospital Directed Payments	(23,892)	5,129	9,235	(4,343)	(4,606,563)	9,926	22,564,485
Rate/Income Adjustments	(4,649,731)	(364,397)	350,036	245,168	203,911	124,448	(1,476,782)
TOTAL REVENUES	103,739,445	110,864,754	115,261,492	113,844,512	110,683,814	115,570,923	1,467,390,287
EXPENSES							
Medical Costs:							
Physician Services	17,895,843	18,921,901	18,984,281	18,198,409	18,622,853	18,169,774	238,642,018
Other Professional Services	4,835,075	5,112,961	5,137,341	5,208,793	5,024,917	5,041,998	64,940,648
Emergency Room	4,139,529	3,167,228	4,764,039	4,661,044	4,773,821	4,790,820	60,570,946
Inpatient	21,395,635	19,551,774	22,935,749	20,834,103	22,797,560	22,462,437	272,817,325
Reinsurance Expense	56,248	57,216	(33,668)	(25,136)	142,533	58,493	734,768
Outpatient Hospital	8,281,163	9,196,013	10,013,268	9,928,749	9,352,210	9,319,855	110,630,877
Other Medical	16,301,024	15,522,071	15,416,935	15,241,576	15,744,662	16,418,094	196,409,507
Pharmacy	-	-	-	-	-	-	31,052,757
Pay for Performance Quality Incentive	473,494	478,060	485,358	485,358	490,964	493,681	6,193,808
Hospital Directed Payments	17,928,276	18,280,365	18,674,627	18,595,974	18,857,014	18,961,885	232,730,776
Hospital Directed Payment Adjustment	(3,419)	5,129	9,235	(4,343)	(4,064,727)	9,926	22,897,641
Non-Claims Expense Adjustment	(1,371,999)	29,799	17,040	5,019	9,821	(248,768)	(887,430)
IBNR, Incentive, Paid Claims Adjustment	(3,724,314)	(4,072,490)	(238,100)	487,881	(789,121)	(435,695)	(19,907,848)
Total Medical Costs	86,206,555	86,250,027	96,166,105	93,617,427	90,962,507	95,042,500	1,216,825,793
GROSS MARGIN	17,532,890	24,614,727	19,095,387	20,227,085	19,721,307	20,528,423	250,564,494
Administrative:							
Compensation	3,259,102	2,980,813	3,307,910	3,148,970	3,213,222	3,387,496	39,559,661
Purchased Services	927,532	850,526	1,078,360	1,144,312	997,356	1,009,393	13,056,218
Supplies	145,499	66,970	74,368	117,566	85,530	66,157	1,295,922
Depreciation	575,899	626,073	576,074	583,814	583,673	584,905	7,701,651
Other Administrative Expenses	300,845	329,335	414,331	315,625	298,240	304,229	4,442,538
Administrative Expense Adjustment	(2,834)	811,890	425,467	300,000	420,793	299,429	2,288,133
Total Administrative Expenses	5,206,043	5,665,607	5,876,510	5,610,287	5,598,814	5,651,609	68,344,123
TOTAL EXPENSES	91,412,598	91,915,634	102,042,615	99,227,714	96,561,321	100,694,109	1,285,169,916
OPERATING INCOME (LOSS) BEFORE TAX	12,326,847	18,949,120	13,218,877	14,616,798	14,122,493	14,876,814	182,220,371
MCO TAX	9,888,018	9,894,051	10,883,459	10,883,460	10,883,459	10,883,460	132,575,160
OPERATING INCOME (LOSS) NET OF TAX	2,438,829	9,055,069	2,335,418	3,733,338	3,239,034	3,993,354	49,645,211
TOTAL NONOPERATING REVENUE (EXPENSE)	744,870	(1,996,822)	(3,380)	57,925	(27,966)	(5,428)	(7,448,138)
NET INCREASE (DECREASE) IN NET POSITION	3,183,699	7,058,247	2,332,038	3,791,263	3,211,068	3,987,926	42,197,073
MEDICAL LOSS RATIO	89.9%	82.2%	90.4%	88.9%	89.0%	88.7%	89.1%
ADMINISTRATIVE EXPENSE RATIO	6.9%	6.9%	6.9%	6.6%	6.5%	6.6%	6.3%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH OCTOBER 31, 2022	OCTOBER 2021	NOVEMBER 2021	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022
ENROLLMENT							
Members - MCAL	295,865	296,989	298,205	309,342	310,281	312,490	314,691
REVENUES							
Title XIX - Medicaid - Family and Other	183.53	183.31	181.56	177.17	177.17	173.28	173.44
Title XIX - Medicaid - Expansion Members	383.57	393.96	382.19	357.24	355.03	344.90	345.21
Title XIX - Medicaid - SPD Members	1,018.29	1,026.19	1,042.14	903.21	907.36	895.60	912.10
Premium - MCO Tax	34.57	34.44	34.45	32.00	31.89	31.66	31.44
Premium - Hospital Directed Payments	56.53	56.41	56.46	56.92	56.90	57.44	56.90
Investment Earnings And Other Income	0.44	0.53	(2.33)	1.07	0.28	(3.97)	(1.04)
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	0.02	0.03	(0.01)	0.74	0.08	86.11	0.01
Rate/Income Adjustments	0.18	0.22	0.02	3.10	3.15	1.58	0.19
TOTAL REVENUES	373.59	375.72	369.09	358.68	356.35	431.00	346.49
EXPENSES							
Medical Costs:							
Physician Services	59.31	58.11	60.27	56.69	62.26	63.74	58.13
Other Professional Services	16.38	16.26	14.57	16.30	15.80	16.82	17.04
Emergency Room	15.23	16.23	14.73	16.84	16.43	16.48	16.20
Inpatient	78.44	71.57	57.47	66.63	64.56	64.75	64.71
Reinsurance Expense	0.29	0.29	0.29	0.17	0.17	0.18	0.18
Outpatient Hospital	23.93	26.24	20.40	26.55	26.50	27.80	26.88
Other Medical	36.45	42.25	38.57	55.81	56.51	50.53	51.93
Pharmacy	34.60	34.33	35.61	0.00	0.00	0.00	0.00
Pay for Performance Quality Incentive	0.00	0.00	4.76	1.50	1.50	1.49	1.50
Hospital Directed Payments	56.53	56.41	56.46	56.92	56.90	57.44	56.90
Hospital Directed Payment Adjustment	0.02	0.03	(0.01)	0.74	0.08	85.37	0.01
Non-Claims Expense Adjustment	0.03	0.08	(0.15)	0.14	0.01	1.83	0.20
IBNR, Incentive, Paid Claims Adjustment	(3.12)	(4.64)	(3.43)	0.00	(3.26)	(12.76)	(8.94)
Total Medical Costs	318.08	317.17	299.54	298.30	297.48	373.67	284.74
GROSS MARGIN	55.51	58.54	69.55	60.38	58.87	57.34	61.75
Administrative:							
Compensation	9.28	9.35	8.69	10.08	9.18	9.95	9.77
Purchased Services	3.35	3.69	4.55	2.74	2.83	3.52	2.49
Supplies	0.20	0.63	0.55	0.62	(0.03)	0.33	0.13
Depreciation	1.43	2.41	2.50	1.85	1.84	1.83	1.81
Other Administrative Expenses	1.18	0.93	2.03	1.26	0.84	1.11	0.80
Administrative Expense Adjustment	0.00	0.26	(0.65)	(0.01)	(0.14)	0.10	0.52
Total Administrative Expenses	15.44	17.27	17.67	16.53	14.51	16.83	15.53
TOTAL EXPENSES	333.53	334.45	317.21	314.83	311.99	390.50	300.27
OPERATING INCOME (LOSS) BEFORE TAX	40.06	41.27	51.88	43.85	44.36	40.51	46.22
MCO TAX	33.44	33.31	33.18	31.98	31.89	31.66	31.44
OPERATING INCOME (LOSS) NET OF TAX	6.62	7.96	18.70	11.87	12.47	8.84	14.78
TOTAL NONOPERATING REVENUE (EXPENSE)	(3.47)	(5.11)	(0.59)	(1.29)	(3.18)	(3.20)	(3.53)
NET INCREASE (DECREASE) IN NET POSITION	3.15	2.85	18.11	10.57	9.29	5.64	11.25
MEDICAL LOSS RATIO	92.6%	91.5%	87.4%	89.4%	89.9%	90.2%	88.3%
ADMINISTRATIVE EXPENSE RATIO	5.5%	6.1%	6.4%	6.1%	5.4%	6.6%	6.0%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH OCTOBER 31, 2022	MAY 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	315,663	319,333	323,572	324,961	325,920	325,920	4,073,232
REVENUES							
Title XIX - Medicaid - Family and Other	168.25	176.65	173.99	175.92	175.56	174.37	176.41
Title XIX - Medicaid - Expansion Members	341.10	343.27	340.07	338.95	338.39	334.55	352.71
Title XIX - Medicaid - SPD Members	913.04	917.14	941.54	880.12	911.57	926.33	937.37
Premium - MCO Tax	31.28	31.04	33.64	33.49	33.39	33.39	32.78
Premium - Hospital Directed Payments	56.80	57.25	57.71	57.23	57.86	58.18	57.09
Investment Earnings And Other Income	1.13	(1.99)	3.10	(0.37)	1.08	0.55	(0.10)
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	(0.08)	0.02	0.03	(0.01)	(14.13)	0.03	5.54
Rate/Income Adjustments	(14.73)	(1.14)	1.08	0.75	0.63	0.38	(0.36)
TOTAL REVENUES	328.64	347.18	356.22	350.33	339.60	354.60	359.97
EXPENSES							
Medical Costs:							
Physician Services	56.69	59.25	58.67	56.00	57.14	55.75	58.54
Other Professional Services	15.32	16.01	15.88	16.03	15.42	15.47	15.93
Emergency Room	13.11	9.92	14.72	14.34	14.65	14.70	14.86
Inpatient	67.78	61.23	70.88	64.11	69.95	68.92	66.93
Reinsurance Expense	0.18	0.18	(0.10)	(0.08)	0.44	0.18	0.18
Outpatient Hospital	26.23	28.80	30.95	30.55	28.69	28.60	27.14
Other Medical	51.64	48.61	47.65	46.90	48.31	50.37	48.18
Pharmacy	0.00	0.00	0.00	0.00	0.00	0.00	7.62
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.49	1.51	1.51	1.52
Hospital Directed Payments	56.80	57.25	57.71	57.23	57.86	58.18	57.09
Hospital Directed Payment Adjustment	(0.01)	0.02	0.03	(0.01)	(12.47)	0.03	5.62
Non-Claims Expense Adjustment	(4.35)	0.09	0.05	0.02	0.03	(0.76)	(0.22)
IBNR, Incentive, Paid Claims Adjustment	(11.80)	(12.75)	(0.74)	1.50	(2.42)	(1.34)	(4.88)
Total Medical Costs	273.10	270.09	297.20	288.09	279.09	291.61	298.50
GROSS MARGIN	55.54	77.08	59.01	62.24	60.51	62.99	61.47
Administrative:							
Compensation	10.32	9.33	10.22	9.69	9.86	10.39	9.70
Purchased Services	2.94	2.66	3.33	3.52	3.06	3.10	3.20
Supplies	0.46	0.21	0.23	0.36	0.26	0.20	0.32
Depreciation	1.82	1.96	1.78	1.80	1.79	1.79	1.89
Other Administrative Expenses	0.95	1.03	1.28	0.97	0.92	0.93	1.09
Administrative Expense Adjustment	(0.01)	2.54	1.31	0.92	1.29	0.92	0.56
Total Administrative Expenses	16.49	17.74	18.16	17.26	17.18	17.34	16.77
TOTAL EXPENSES	289.59	287.84	315.36	305.35	296.27	308.95	315.27
OPERATING INCOME (LOSS) BEFORE TAX	39.05	59.34	40.85	44.98	43.33	45.65	44.70
MCO TAX	31.32	30.98	33.64	33.49	33.39	33.39	32.52
OPERATING INCOME (LOSS) NET OF TAX	7.73	28.36	7.22	11.49	9.94	12.25	12.18
TOTAL NONOPERATING REVENUE (EXPENSE)	2.36	(6.25)	(0.01)	0.18	(0.09)	(0.02)	(1.83)
NET INCREASE (DECREASE) IN NET POSITION	10.09	22.10	7.21	11.67	9.85	12.24	10.35
MEDICAL LOSS RATIO	89.9%	82.2%	90.4%	88.9%	89.0%	88.7%	89.1%
ADMINISTRATIVE EXPENSE RATIO	6.9%	6.9%	6.9%	6.6%	6.5%	6.6%	6.3%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED OCTOBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
28,151,380	27,444,148	707,232	Premium - Medi-Cal	274,719,510	267,730,035	6,989,475
3,359,457	2,764,572	594,885	Premium - Maternity Kick	28,818,750	27,645,723	1,173,027
544,604	477,409	67,195	Premium - Enhanced Care Management	5,264,406	4,685,935	578,471
144,468	133,920	10,548	Premium - Major Organ Transplant	1,398,944	1,310,040	88,904
787,931	505,247	282,684	Premium - Cal AIM	7,964,269	4,915,722	3,048,547
839,147	780,230	58,917	Premium - BHT Kick	7,762,954	7,591,123	171,831
3,681,127	4,134,940	(453,813)	Premium - Provider Enhancement	38,457,917	40,240,625	(1,782,708)
214,287	208,914	5,373	Premium - Ground Emergency Medical Transportation	2,091,912	2,035,725	56,187
150,927	106,202	44,725	Premium - Behavorial Health Integration Program	2,705,815	1,033,278	1,672,537
(70,806)	-	(70,806)	Premium - Vaccine Incentive	815,008	-	815,008
-	-	-	Premium - Student Behavioral Health Incentive	364,822	-	364,822
-	-	-	Premium - Housing and Homelessness Incentive	652,683	-	652,683
146,701	111,288	35,413	Other	1,282,276	1,086,844	195,432
37,949,223	36,666,872	1,282,351	Total Title XIX - Medicaid - Family & Other	372,299,266	358,275,052	14,024,214
			Title XIX - Medicaid - Expansion Members			
27,753,005	25,598,749	2,154,256	Premium - Medi-Cal	264,694,882	248,683,233	16,011,649
397,436	234,964	162,472	Premium - Maternity Kick	4,146,831	2,349,640	1,797,191
994,910	858,179	136,731	Premium - Enhanced Care Management	9,475,329	8,334,922	1,140,407
236,927	214,336	22,591	Premium - Major Organ Transplant	2,260,507	2,081,705	178,802
337,922	470,258	(132,336)	Premium - Cal AIM	3,303,933	4,568,909	(1,264,976)
-	-	-	Premium - BHT Kick	12,659	-	12,659
1,526,447	1,686,505	(160,058)	Premium - Provider Enhancement	16,021,450	16,385,645	(364,195)
233,179	213,523	19,656	Premium - Ground Emergency Medical Transportation	2,225,555	2,074,538	151,017
58,174	98,848	(40,674)	Premium - Behavorial Health Integration Program	1,100,493	960,379	140,114
(31,561)	-	(31,561)	Premium - Vaccine Incentive	259,452	-	259,452
-	-	-	Premium - Student Behavioral Health Incentive	148,933	-	148,933
-	-	-	Premium - Housing and Homelessness Incentive	263,528	-	263,528
42,930	30,024	12,906	Other	354,090	291,456	62,634
31,549,369	29,405,387	2,143,982	Total Title XIX - Medicaid - Expansion Members	304,267,642	285,730,428	18,537,214
			Title XIX - Medicaid - SPD Members			
13,891,984	13,057,743	834,242	Premium - Medi-Cal	132,378,321	127,001,049	5,377,273
508,844	469,734	39,110	Premium - Enhanced Care Management	4,847,720	4,568,685	279,035
158,265	149,349	8,916	Premium - Major Organ Transplant	1,508,120	1,452,585	55,535
63,497	239,896	(176,399)	Premium - Cal AIM	625,308	2,333,255	(1,707,947)
678,596	793,426	(114,830)	Premium - BHT Kick	6,531,704	7,716,951	(1,185,247)
452,016	488,034	(36,018)	Premium - Provider Enhancement	4,674,406	4,746,674	(72,268)
155,305	146,884	8,421	Premium - Ground Emergency Medical Transportation	1,479,927	1,428,610	51,317
11,684	50,426	(38,742)	Premium - Behavorial Health Integration Program	212,190	490,446	(278,256)
(6,846)	-	(6,846)	Premium - Vaccine Incentive	55,047	-	55,047
-	-	-	Premium - Student Behavioral Health Incentive	27,982	-	27,982
-	-	-	Premium - Housing and Homelessness Incentive	51,059	-	51,059
15,913,345	15,395,491	517,854	Total Title XIX - Medicaid - SPD Members	152,391,784	149,738,254	2,653,530

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED OCTOBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
3,539,808	4,079,659	539,851	Primary Care Physician Services	37,512,763	39,676,538	2,163,775
12,805,568	11,984,058	(821,510)	Referral Specialty Services	127,925,070	116,524,488	(11,400,582)
1,815,098	1,673,238	(141,860)	Urgent Care & After Hours Advise	20,332,028	16,271,394	(4,060,634)
9,300	9,300	-	Hospital Admitting Team	91,200	91,200	-
18,169,774	17,746,255	(423,519)	TOTAL PHYSICIAN SERVICES	185,861,061	172,563,620	(13,297,441)
			OTHER PROFESSIONAL SERVICES			
326,350	333,127	6,777	Vision Service Capitation	3,154,575	3,239,842	85,267
1,939,399	2,154,063	214,664	Medical Departments - UM Allocation *	18,778,645	21,540,624	2,761,979
1,345,602	1,573,656	228,054	Behavior Health Treatment	13,445,503	15,308,076	1,862,573
152,793	157,953	5,160	Mental Health Services	1,492,505	1,536,097	43,592
1,277,854	1,731,504	453,650	Other Professional Services	14,049,924	16,835,256	2,785,332
5,041,998	5,950,303	908,305	TOTAL OTHER PROFESSIONAL SERVICES	50,921,152	58,459,895	7,538,743
4,790,820	5,775,041	984,221	EMERGENCY ROOM	46,854,374	56,159,475	9,305,101
22,462,437	20,745,728	(1,716,709)	INPATIENT HOSPITAL	211,216,283	201,711,142	(9,505,141)
58,493	57,060	(1,433)	REINSURANCE EXPENSE PREMIUM	477,337	554,940	77,603
9,319,855	8,819,325	(500,530)	OUTPATIENT HOSPITAL SERVICES	89,673,554	85,751,537	(3,922,017)
			OTHER MEDICAL			
1,521,656	1,660,387	138,731	Ambulance and NEMT	13,546,900	16,147,224	2,600,324
777,227	715,760	(61,467)	Home Health Services & CBAS	8,648,117	6,960,813	(1,687,304)
1,003,496	1,106,708	103,212	Utilization and Quality Review Expenses	7,880,924	11,067,080	3,186,156
1,516,247	1,495,867	(20,380)	Long Term/SNF/Hospice	16,589,156	14,545,703	(2,043,453)
5,256,673	6,023,503	766,830	Provider Enhancement Expense - Prop. 56	56,191,507	58,578,291	2,386,784
492,730	540,856	48,126	Provider Enhancement Expense - GEMT	4,618,914	5,261,936	643,022
(3,500)	-	3,500	Vaccine Incentive Program Expense	3,169,368	-	(3,169,368)
220,784	255,476	34,692	Behaviorial Health Integration Program	4,018,498	2,484,104	(1,534,394)
1,945,941	1,805,322	(140,619)	Enhanced Care Management	18,608,083	17,589,538	(1,018,545)
512,675	498,168	(14,507)	Major Organ Transplant	4,909,191	4,842,722	(66,469)
2,135,655	1,215,402	(920,253)	Cal AIM Incentive Programs	13,962,086	11,817,887	(2,144,199)
1,038,510	939,072	(99,438)	DME/Rebates	9,431,013	9,132,056	(298,957)
16,418,094	16,256,520	(161,574)	TOTAL OTHER MEDICAL	161,573,757	158,427,353	(3,146,404)
493,681	475,500	(18,181)	PAY FOR PERFORMANCE QUALITY INCENTIVE	4,773,808	4,624,500	(149,308)
18,961,885	17,711,807	(1,250,078)	HOSPITAL DIRECTED PAYMENTS	182,414,558	172,572,877	(9,841,681)
9,926	-	(9,926)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	22,888,045	-	(22,888,045)
(248,768)	-	248,768	NON-CLAIMS EXPENSE ADJUSTMENT	(876,938)	-	876,938
(435,695)	-	435,695	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(16,581,982)	-	16,581,982
95,042,500	93,537,540	(1,504,960)	Total Medical Costs	939,195,009	910,825,339	(28,369,670)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED OCTOBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
10.76	12.87	2.11	Primary Care Physician Services	11.78	12.87	1.09
38.91	37.80	(1.10)	Referral Specialty Services	40.16	37.80	(2.36)
5.51	5.28	(0.24)	Urgent Care & After Hours Advise	6.38	5.28	(1.11)
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
55.21	55.98	0.77	TOTAL PHYSICIAN SERVICES	58.35	55.97	(2.38)
			OTHER PROFESSIONAL SERVICES			
0.99	1.05	0.06	Vision Service Capitation	0.99	1.05	0.06
5.89	6.80	0.90	Medical Departments - UM Allocation *	5.90	6.99	1.09
4.09	4.96	0.88	Behavior Health Treatment	4.22	4.97	0.74
0.46	0.50	0.03	Mental Health Services	0.47	0.50	0.03
3.88	5.46	1.58	Other Professional Services	4.41	5.46	1.05
15.32	18.77	3.45	TOTAL OTHER PROFESSIONAL SERVICES	15.99	18.96	2.98
14.56	18.22	3.66	EMERGENCY ROOM	14.71	18.22	3.51
68.25	65.44	(2.81)	INPATIENT HOSPITAL	66.31	65.43	(0.88)
0.18	0.18	0.00	REINSURANCE EXPENSE PREMIUM	0.15	0.18	0.03
28.32	27.82	(0.50)	OUTPATIENT HOSPITAL SERVICES	28.15	27.81	(0.34)
			OTHER MEDICAL			
4.62	5.24	0.61	Ambulance and NEMT	4.25	5.24	0.98
2.36	2.26	(0.10)	Home Health Services & CBAS	2.71	2.26	(0.46)
3.05	3.49	0.44	Utilization and Quality Review Expenses	2.47	3.59	1.12
4.61	4.72	0.11	Long Term/SNF/Hospice	5.21	4.72	(0.49)
15.97	19.00	3.03	Provider Enhancement Expense - Prop. 56	17.64	19.00	1.36
1.50	1.71	0.21	Provider Enhancement Expense - GEMT	1.45	1.71	0.26
(0.01)	0.00	0.01	Vaccine Incentive Program Expense	0.99	0.00	(0.99)
0.67	0.81	0.14	Behaviorial Health Integration Program	1.26	0.81	(0.46)
5.91	5.70	(0.22)	Enhanced Care Management	5.84	5.71	(0.14)
1.56	1.57	0.01	Major Organ Transplant	1.54	1.57	0.03
6.49	3.83	(2.65)	Cal AIM Incentive Programs	4.38	3.83	(0.55)
3.16	2.96	(0.19)	DME	2.96	2.96	0.00
49.88	51.28	1.40	TOTAL OTHER MEDICAL	50.72	51.39	0.66
1.50	1.50	0.00	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	0.00
57.61	55.87	(1.74)	HOSPITAL DIRECTED PAYMENTS	57.27	55.98	(1.29)
0.03	0.00	(0.03)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	7.19	0.00	(7.19)
(0.76)	0.00	0.76	NON-CLAIMS EXPENSE ADJUSTMENT	(0.28)	0.00	0.28
(1.32)	0.00	1.32	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(5.21)	0.00	5.21
288.78	295.07	6.29	Total Medical Costs	294.85	295.43	0.59

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH OCTOBER 31, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	3,472,901	3,950,940	3,869,340	4,216,012	3,710,885	3,643,312
Referral Specialty Services	11,390,029	12,825,148	13,133,782	12,603,720	12,666,671	14,157,633
Urgent Care & After Hours Advise	2,665,800	2,534,829	2,906,730	1,462,769	1,508,987	1,111,956
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300	9,000
TOTAL PHYSICIAN SERVICES	17,538,030	19,319,317	19,919,152	18,291,501	17,895,843	18,921,901
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	298,113	299,421	320,479	313,381	312,490	317,864
Medical Departments - UM Allocation *	1,874,290	1,814,144	1,930,871	1,799,307	1,920,750	1,835,227
Behavior Health Treatment	1,143,733	984,520	1,425,684	1,406,426	1,172,372	1,493,794
Mental Health Services	385,915	151,598	138,742	134,047	69,233	98,672
Other Professional Services	1,338,982	1,653,027	1,439,003	1,708,384	1,360,230	1,367,404
TOTAL OTHER PROFESSIONAL SERVICES	5,041,033	4,902,710	5,254,779	5,361,545	4,835,075	5,112,961
EMERGENCY ROOM	5,209,937	5,098,972	5,150,400	5,098,584	4,139,529	3,167,228
INPATIENT HOSPITAL	20,610,105	20,031,970	20,232,342	20,364,608	21,395,635	19,551,774
REINSURANCE EXPENSE PREMIUM	53,660	53,896	57,686	56,409	56,248	57,216
OUTPATIENT HOSPITAL SERVICES	8,214,215	8,223,126	8,686,122	8,458,833	8,281,163	9,196,013
OTHER MEDICAL						
Ambulance and NEMT	1,321,069	1,293,500	1,339,544	1,466,846	1,405,832	825,707
Home Health Services & CBAS	733,519	813,833	841,676	781,545	1,039,980	1,056,675
Utilization and Quality Review Expenses	767,373	755,405	504,541	724,744	1,037,565	642,907
Long Term/SNF/Hospice	1,585,601	1,669,982	1,938,253	1,975,528	1,770,701	1,113,446
Provider Enhancement Expense - Prop. 56	5,806,204	5,819,707	5,888,710	5,878,051	5,871,736	6,032,156
Provider Enhancement Expense - GEMT	463,070	463,069	300,851	354,994	480,313	494,051
Vaccine Incentive Program Expense	1,143,595	1,628,354	173,216	136,387	739	85,682
Behaviorial Health Integration Program	824,339	824,339	824,339	225,048	216,518	220,783
Enhanced Care Management	2,023,406	1,561,486	1,821,649	1,818,393	1,820,636	1,866,858
Major Organ Transplant	472,866	473,613	496,178	480,362	480,654	492,226
Cal AIM Incentive Programs	1,241,196	1,257,731	1,089,466	1,285,346	1,268,891	1,807,413
DME	881,383	973,969	570,456	1,214,663	907,459	884,167
TOTAL OTHER MEDICAL	17,263,621	17,534,988	15,788,879	16,341,907	16,301,024	15,522,071
PAY FOR PERFORMANCE QUALITY INCENTIVE	464,013	465,422	465,421	472,037	473,494	478,060
HOSPITAL DIRECTED PAYMENTS	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276	18,280,365
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	230,177	24,013	26,678,156	3,898	(3,419)	5,129
NON-CLAIMS EXPENSE ADJUSTMENT	43,538	4,118	572,469	62,025	(1,371,999)	29,799
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	627	(1,010,781)	(3,987,493)	(2,812,496)	(3,724,314)	(4,072,490)
Total Medical Costs	92,275,826	92,302,247	116,767,047	89,604,769	86,206,555	86,250,027

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH OCTOBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES					
Primary Care Physician Services	3,951,533	3,298,914	3,859,118	3,539,808	37,512,763
Referral Specialty Services	12,653,874	12,435,011	13,253,634	12,805,568	127,925,070
Urgent Care & After Hours Advise	2,369,574	2,455,184	1,501,101	1,815,098	20,332,028
Hospital Admitting Team	9,300	9,300	9,000	9,300	91,200
TOTAL PHYSICIAN SERVICES	18,984,281	18,198,409	18,622,853	18,169,774	185,861,061
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	315,663	323,003	327,811	326,350	3,154,575
Medical Departments - UM Allocation *	1,913,288	1,861,229	1,890,140	1,939,399	18,778,645
Behavior Health Treatment	1,392,248	1,798,262	1,282,862	1,345,602	13,445,503
Mental Health Services	112,742	68,357	180,406	152,793	1,492,505
Other Professional Services	1,403,400	1,157,942	1,343,698	1,277,854	14,049,924
TOTAL OTHER PROFESSIONAL SERVICES	5,137,341	5,208,793	5,024,917	5,041,998	50,921,152
EMERGENCY ROOM	4,764,039	4,661,044	4,773,821	4,790,820	46,854,374
INPATIENT HOSPITAL	22,935,749	20,834,103	22,797,560	22,462,437	211,216,283
REINSURANCE EXPENSE PREMIUM	(33,668)	(25,136)	142,533	58,493	477,337
OUTPATIENT HOSPITAL SERVICES	10,013,268	9,928,749	9,352,210	9,319,855	89,673,554
OTHER MEDICAL					
Ambulance and NEMT	1,358,335	1,416,945	1,597,466	1,521,656	13,546,900
Home Health Services & CBAS	1,083,945	780,644	739,073	777,227	8,648,117
Utilization and Quality Review Expenses	696,258	672,539	1,076,096	1,003,496	7,880,924
Long Term/SNF/Hospice	1,750,512	1,694,897	1,573,989	1,516,247	16,589,156
Provider Enhancement Expense - Prop. 56	5,197,617	5,212,169	5,228,484	5,256,673	56,191,507
Provider Enhancement Expense - GEMT	503,001	546,014	520,821	492,730	4,618,914
Vaccine Incentive Program Expense	2,148	1,922	825	(3,500)	3,169,368
Behaviorial Health Integration Program	220,782	220,783	220,783	220,784	4,018,498
Enhanced Care Management	1,907,842	1,905,031	1,936,841	1,945,941	18,608,083
Major Organ Transplant	504,463	485,910	510,244	512,675	4,909,191
Cal AIM Incentive Programs	1,195,617	1,328,191	1,352,580	2,135,655	13,962,086
DME	996,415	976,531	987,460	1,038,510	9,431,013
TOTAL OTHER MEDICAL	15,416,935	15,241,576	15,744,662	16,418,094	161,573,757
PAY FOR PERFORMANCE QUALITY INCENTIVE	485,358	485,358	490,964	493,681	4,773,808
HOSPITAL DIRECTED PAYMENTS	18,674,627	18,595,974	18,857,014	18,961,885	182,414,558
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	9,235	(4,343)	(4,064,727)	9,926	22,888,045
NON-CLAIMS EXPENSE ADJUSTMENT	17,040	5,019	9,821	(248,768)	(876,938)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(238,100)	487,881	(789,121)	(435,695)	(16,581,982)
Total Medical Costs	96,166,105	93,617,427	90,962,508	95,042,500	939,195,009

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH OCTOBER 31, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	11.23	12.73	12.38	13.40	11.76	11.41
Referral Specialty Services	36.82	41.33	42.03	40.05	40.13	44.34
Urgent Care & After Hours Advise	8.62	8.17	9.30	4.65	4.78	3.48
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	56.69	62.26	63.74	58.13	56.69	59.25
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	0.96	0.96	1.03	1.00	0.99	1.00
Medical Departments - UM Allocation *	6.06	5.85	6.18	5.72	6.08	5.75
Behavior Health Treatment	3.70	3.17	4.56	4.47	3.71	4.68
Mental Health Services	1.25	0.49	0.44	0.43	0.22	0.31
Other Professional Services	4.33	5.33	4.60	5.43	4.31	4.28
TOTAL OTHER PROFESSIONAL SERVICES	16.30	15.80	16.82	17.04	15.32	16.01
EMERGENCY ROOM	16.84	16.43	16.48	16.20	13.11	9.92
INPATIENT HOSPITAL	66.63	64.56	64.75	64.71	67.78	61.23
REINSURANCE EXPENSE PREMIUM	0.17	0.17	0.18	0.18	0.18	0.18
OUTPATIENT HOSPITAL SERVICES	26.55	26.50	27.80	26.88	26.23	28.80
OTHER MEDICAL						
Ambulance and NEMT	4.27	4.17	4.29	4.66	4.45	2.59
Home Health Services & CBAS	2.37	2.62	2.69	2.48	3.29	3.31
Utilization and Quality Review Expenses	2.48	2.43	1.61	2.30	3.29	2.01
Long Term/SNF/Hospice	5.13	5.38	6.20	6.28	5.61	3.49
Provider Enhancement Expense - Prop. 56	18.77	18.76	18.84	18.68	18.60	18.89
Provider Enhancement Expense - GEMT	1.50	1.49	0.96	1.13	1.52	1.55
Vaccine Incentive Program Expense	3.70	5.25	0.55	0.43	0.00	0.27
Behaviorial Health Integration Program	2.66	2.66	2.64	0.72	0.69	0.69
Enhanced Care Management	6.54	5.03	5.83	5.78	5.77	5.85
Major Organ Transplant	1.53	1.53	1.59	1.53	1.52	1.54
Cal AIM Incentive Programs	4.01	4.05	3.49	4.08	4.02	5.66
DME	2.85	3.14	1.83	3.86	2.87	2.77
TOTAL OTHER MEDICAL	55.81	56.51	50.53	51.93	51.64	48.61
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	1.49	1.50	1.50	1.50
HOSPITAL DIRECTED PAYMENTS	56.92	56.90	57.44	56.90	56.80	57.25
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.74	0.08	85.37	0.01	(0.01)	0.02
NON-CLAIMS EXPENSE ADJUSTMENT	0.14	0.01	1.83	0.20	(4.35)	0.09
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(3.26)	(12.76)	(8.94)	(11.80)	(12.75)
Total Medical Costs	298.30	297.48	373.67	284.74	273.10	270.09

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH OCTOBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES					
Primary Care Physician Services	12.21	10.15	11.84	0.87	11.78
Referral Specialty Services	39.11	38.27	40.67	3.14	40.16
Urgent Care & After Hours Advise	7.32	7.56	4.61	0.45	6.38
Hospital Admitting Team	0.03	0.03	0.03	0.00	0.03
TOTAL PHYSICIAN SERVICES	58.67	56.00	57.14	4.46	58.35
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	0.98	0.99	1.01	0.08	0.99
Medical Departments - UM Allocation *	5.91	5.73	5.72	0.47	5.90
Behavior Health Treatment	4.30	5.53	3.94	0.33	4.22
Mental Health Services	0.35	0.21	0.55	0.04	0.47
Other Professional Services	4.34	3.56	4.12	0.31	4.41
TOTAL OTHER PROFESSIONAL SERVICES	15.88	16.03	15.34	1.23	15.99
EMERGENCY ROOM	14.72	14.34	14.65	1.18	14.71
INPATIENT HOSPITAL	70.88	64.11	69.95	5.51	66.31
REINSURANCE EXPENSE PREMIUM	(0.10)	(0.08)	0.44	0.01	0.15
OUTPATIENT HOSPITAL SERVICES	30.95	30.55	28.69	2.29	28.15
OTHER MEDICAL					
Ambulance and NEMT	4.20	4.36	4.90	0.37	4.25
Home Health Services & CBAS	3.35	2.40	2.27	0.19	2.71
Utilization and Quality Review Expenses	2.15	2.07	3.30	0.25	2.47
Long Term/SNF/Hospice	5.41	5.22	4.83	0.37	5.21
Provider Enhancement Expense - Prop. 56	16.06	16.04	16.04	1.29	17.64
Provider Enhancement Expense - GEMT	1.55	1.68	1.60	0.12	1.45
Vaccine Incentive Program Expense	0.01	0.01	0.00	(0.00)	0.99
Behaviorial Health Integration Program	0.68	0.68	0.68	0.05	1.26
Enhanced Care Management	5.90	5.86	5.94	0.48	5.84
Major Organ Transplant	1.56	1.50	1.57	0.13	1.54
Cal AIM Incentive Programs	3.70	4.09	4.15	0.52	4.38
DME	3.08	3.01	3.03	0.25	2.96
TOTAL OTHER MEDICAL	47.65	46.90	48.31	4.03	50.72
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.49	1.51	0.12	1.50
HOSPITAL DIRECTED PAYMENTS	57.71	57.23	57.86	4.65	57.27
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.03	(0.01)	(12.47)	0.00	7.19
NON-CLAIMS EXPENSE ADJUSTMENT	0.05	0.02	0.03	(0.06)	(0.28)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(0.74)	1.50	(2.42)	(0.11)	(5.21)
Total Medical Costs	297.20	288.09	279.02	23.32	294.85

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED OCTOBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
415,725	459,798	44,073	110 - Executive	4,435,019	4,672,979	237,960
194,777	234,469	39,692	210 - Accounting	2,097,919	2,344,690	246,771
401,399	359,967	(41,432)	220 - Management Information Systems	3,555,566	3,599,669	44,103
42,115	54,298	12,183	221 - Business Intelligence	354,440	542,980	188,540
324,056	383,664	59,608	222 - Enterprise Development	2,855,225	3,836,640	981,415
490,604	533,193	42,589	225 - Infrastructure	4,826,988	5,331,930	504,942
598,883	615,321	16,438	230 - Claims	5,708,627	6,153,210	444,583
169,021	187,947	18,926	240 - Project Management	1,611,906	1,879,470	267,564
185,718	180,989	(4,729)	310 - Health Services - Utilization Management	1,533,563	1,809,890	276,327
(1,702)	14,039	15,741	311 - Health Services - Quality Improvement	1,279	140,390	139,111
130	513	383	312 - Health Services - Education	1,172	5,130	3,958
35,057	50,828	15,771	313- Pharmacy	357,872	508,280	150,408
452	2,308	1,856	314 - Enhanced Care Management	108,625	23,080	(85,545)
57,087	74,558	17,471	316 -Population Health Management	595,154	745,580	150,426
156	333	177	317 - Community Based Services	449	3,330	2,881
6	-	(6)	318 - Housing & Homeless Incentive Program	6	-	(6)
324,920	359,942	35,022	320 - Provider Network Management	3,109,725	3,599,420	489,695
789,492	871,663	82,171	330 - Member Services	6,918,582	8,716,630	1,798,048
741,929	721,857	(20,072)	340 - Corporate Services	7,789,282	7,218,570	(570,712)
117,460	97,177	(20,283)	360 - Audit & Investigative Services	829,529	971,770	142,241
43,549	92,450	48,901	410 - Advertising Media	510,000	924,500	414,500
137,183	76,696	(60,487)	420 - Sales/Marketing/Public Relations	721,863	766,960	45,097
284,163	303,042	18,879	510 - Human Resourses	3,047,548	3,030,420	(17,128)
299,429	(92,324)	(391,753)	Administrative Expense Adjustment	2,404,590	(923,240)	(3,327,830)
5,651,609	5,582,728	(68,881)	Total Administrative Expenses	53,374,929	55,902,278	2,527,349

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED OCTOBER 31, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
110 - Executive	424,308	403,286	429,743	446,418	470,648	353,073
210 - Accounting	233,241	178,928	252,864	163,976	225,728	222,884
220 - Management Information Systems (MIS)	335,777	238,917	337,588	352,426	352,473	336,194
221 - Business Intelligence	13,042	65,687	31,834	45,508	45,708	16,186
222 - Enterprise Development	307,654	250,898	286,566	265,813	303,353	291,350
225 - Infrastructure	473,799	427,685	536,529	343,776	562,405	524,493
230 - Claims	582,040	548,583	591,767	559,648	590,588	529,776
240 - Project Management	171,917	152,433	174,210	123,662	152,467	105,055
310 - Health Services - Utilization Management	139,536	126,622	128,165	132,502	154,797	166,719
311 - Health Services - Quality Improvement	277	15,545	(90)	186	(15,257)	178
312 - Health Services - Education	-	180	2,174	310	89	222
313- Pharmacy	39,824	36,716	38,879	36,385	35,680	34,727
314 - Enhanced Care Management	3,281	241	19	12,005	22,519	12,559
316 -Population Health Management	65,121	62,696	63,150	64,161	66,172	55,430
317 - Community Based Services	-	24	22	17	5	36
318 - Housing & Homeless Incentive Program	-	-	-	-	9,346	(9,346)
320 - Provider Network Management	327,923	326,761	325,559	269,804	308,858	305,807
330 - Member Services	754,477	623,424	700,611	644,994	694,732	635,012
340 - Corporate Services	786,930	685,514	778,083	735,005	751,597	842,924
360 - Audit & Investigative Services	69,757	69,895	71,016	82,269	83,957	69,158
410 - Advertising Media	11,825	27,353	55,984	38,254	34,202	52,260
420 - Sales/Marketing/Public Relations	66,531	51,460	70,326	65,913	62,815	72,927
510 - Human Resourses	309,451	254,507	352,740	341,377	295,995	236,093
Total Department Expenses	5,116,711	4,547,355	5,227,739	4,724,409	5,208,877	4,853,717
ADMINISTRATIVE EXPENSE ADJUSTMENT	(1,904)	(44,283)	31,776	164,256	(2,834)	811,890
Total Administrative Expenses	5,114,807	4,503,072	5,259,515	4,888,665	5,206,043	5,665,607

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED OCTOBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	YEAR TO DATE 2022
110 - Executive	504,491	507,150	480,177	415,725	4,435,019
210 - Accounting	202,574	217,615	205,332	194,777	2,097,919
220 - Management Information Systems (MIS)	449,253	372,062	379,477	401,399	3,555,566
221 - Business Intelligence	42,730	15,934	35,696	42,115	354,440
222 - Enterprise Development	256,153	306,526	262,856	324,056	2,855,225
225 - Infrastructure	450,547	601,972	415,178	490,604	4,826,988
230 - Claims	654,284	578,899	474,159	598,883	5,708,627
240 - Project Management	152,605	157,820	252,716	169,021	1,611,906
310 - Health Services - Utilization Management	167,284	163,063	169,157	185,718	1,533,563
311 - Health Services - Quality Improvement	1,002	823	317	(1,702)	1,279
312 - Health Services - Education	895	37	(2,865)	130	1,172
313- Pharmacy	33,787	23,774	43,043	35,057	357,872
314 - Enhanced Care Management	16,919	22,248	18,382	452	108,625
316 -Population Health Management	54,747	51,020	55,570	57,087	595,154
317 - Community Based Services	7	157	25	156	449
318 - Housing & Homeless Incentive Program	42	(42)	-	6	6
320 - Provider Network Management	307,080	299,800	313,213	324,920	3,109,725
330 - Member Services	682,669	677,858	715,313	789,492	6,918,582
340 - Corporate Services	814,888	815,575	836,837	741,929	7,789,282
360 - Audit & Investigative Services	91,281	88,356	86,380	117,460	829,529
410 - Advertising Media	169,122	54,424	23,027	43,549	510,000
420 - Sales/Marketing/Public Relations	58,511	60,358	75,839	137,183	721,863
510 - Human Resourses	340,172	294,858	338,192	284,163	3,047,548
Total Department Expenses	5,451,043	5,310,287	5,178,021	5,352,180	50,970,339
ADMINISTRATIVE EXPENSE ADJUSTMENT	425,467	300,000	420,793	299,429	2,404,590
Total Administrative Expenses	5,876,510	5,610,287	5,598,814	5,651,609	53,374,929

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF OCTOBER 31, 2022

ASSETS	OCTOBER 2022	SEPTEMBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,145,891	$ 1,142,022	3,869
Interest Receivable	1,200	3,869	(2,669)
TOTAL CURRENT ASSETS	$ 1,147,091	$ 1,145,891	$ 1,200

LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -

NET POSITION:			
Net Position- Beg. of Year	1,136,102	1,136,102	-
Increase (Decrease) in Net Position - Current Year	10,989	9,789	1,200
Total Net Position	$ 1,147,091	$ 1,145,891	$ 1,200
TOTAL LIABILITIES AND NET POSITION	$ 1,147,091	$ 1,145,891	$ 1,200

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED OCTOBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
1,200	-	1,200	Interest	8,087	-	8,087
-	-	-	Other Investment Income	2,902	-	2,902
1,200	-	1,200	TOTAL REVENUES	10,989	-	10,989
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
1,200	-	1,200	GROSS MARGIN	10,989	-	10,989
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
1,200	-	1,200	OPERATING INCOME (LOSS)	10,989	-	10,989
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
1,200	-	1,200	NET INCREASE (DECREASE) IN NET POSITION	10,989	-	10,989
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
0%	0%	0%	ADMINISTRATIVE EXPENSE RATIO	0%	0%	0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2022 MEMBER MONTHS	JAN'22	FEB'22	MAR'22	APR'22	MAY'22	JUN'22	JULY'22	AUG'22	SEPT'22	OCT'22
ADULT AND FAMILY											
ADULT	***625,885***	60,708	60,882	61,379	61,726	61,739	62,276	63,581	64,006	64,336	65,252
CHILD	***1,412,755***	139,223	139,605	140,344	141,029	141,356	141,902	142,505	142,059	142,208	142,524
SUB-TOTAL ADULT & FAMILY	***2,038,640***	***199,931***	***200,487***	***201,723***	***202,755***	***203,095***	***204,178***	***206,086***	***206,065***	***206,544***	***207,776***
OTHER MEMBERS											
PARTIAL DUALS - FAMILY	***8,212***	824	801	811	796	815	837	842	814	844	828
PARTIAL DUALS - CHILD	***0***	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	***62***	4	13	6	5	5	5	6	6	6	6
FULL DUALS (SPD)											
SPD FULL DUALS	***85,694***	8,138	8,257	8,336	8,411	8,662	8,572	8,684	8,794	8,813	9,027
SUBTOTAL OTHER MEMBERS	***93,968***	***8,966***	***9,071***	***9,153***	***9,212***	***9,482***	***9,414***	***9,532***	***9,614***	***9,663***	***9,861***
TOTAL FAMILY & OTHER	***2,132,608***	***208,897***	***209,558***	***210,876***	***211,967***	***212,577***	***213,592***	***215,618***	***215,679***	***216,207***	***217,637***
SPD											
SPD (AGED AND DISABLED)	***167,313***	16,556	16,376	16,516	16,363	16,305	16,794	16,817	17,118	17,289	17,179
MEDI-CAL EXPANSION											
ACA Expansion Adult-Citizen	**871,717**	82,803	83,199	83,828	85,037	85,412	87,526	89,680	90,672	90,902	92,658
ACA Expansion Duals	**13,736**	1,086	1,148	1,270	1,324	1,369	1,421	1,457	1,492	1,522	1,647
SUB-TOTAL MED-CAL EXPANSION	***885,453***	***83,889***	***84,347***	***85,098***	***86,361***	***86,781***	***88,947***	***91,137***	***92,164***	***92,424***	***94,305***
TOTAL KAISER	***135,974***	***12,787***	***13,032***	***13,253***	***13,407***	***13,552***	***13,722***	***13,842***	***13,972***	***14,126***	***14,281***
TOTAL MEDI-CAL MEMBERS	***3,321,348***	***322,129***	***323,313***	***325,743***	***328,098***	***329,215***	***333,055***	***337,414***	***338,933***	***340,046***	***343,402***

KERN·HEALTH SYSTEMS

September AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	529,097.70	4,572,366.60	SEPT. 2022 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4982	NGC US, LLC	437,291.36	2,452,917.28	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T5155	A-C ELECTRIC COMPANY ****	227,572.50	229,186.50	SOLAR PROJECT DEPOSIT	CAPITAL PROJECT
T2686	ALLIANT INSURANCE SERVICES INC. ****	214,936.27	894,688.79	2022 -2023 INSURANCE PREMIUM - SPECIAL LIABILITY INSURANCE PROGRAM (SLIP)	ADMINISTRATION
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC ****	205,000.00	290,000.00	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI/HE
T1408	DELL MARKETING L.P.	116,522.79	1,083,326.85	HARDWARE- (49) DELL LATITUDE BASE AND (50) DELL DOCKS	MIS INFRASTRUCTURE
T1071	CLINICA SIERRA VISTA	105,231.26	1,879,828.04	JUN. & JUL. 2022 HEALTH HOMES GRANT	COMMUNITY GRANTS
T4391	OMNI FAMILY HEALTH	87,922.45	1,368,061.63	2021-2022 PROVIDER GRANT PROGRAM-JAN.	COMMUNITY GRANTS
T2458	HEALTHCARE FINANCIAL, INC ****	75,502.99	189,502.99	JUL. 2022 PROFESSIONAL SERVICES	ADMINISTRATION
T4350	COMPUTER ENTERPRISE	59,008.20	2,676,990.41	JUL. & AUG. 2022 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS

KERN·HEALTH SYSTEMS

September AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5447	PROSPHIRE, LLC	58,140.00	189,620.00	JUL. & AUG.. 2022 PROFESSIONAL SERVICES	CAPITAL PROJECT
T2167	PG&E	55,973.50	290,067.03	SEPT. 2022 USAGE / UTILITIES	CORPORATE SERVICES
T3449	CDW GOVERNMENT ****	54,941.08	178,852.48	(168) DELL DOCKS, PRINTER LABELS, (15) ADOBE LICENSES & (2) UBIQUITI LICENSES	MIS INFRASTRUCTURE
T5509	NGUYEN CAO LUU-TRONG ****	53,587.50	59,437.50	AUG 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	51,937.50	362,955.00	AUG. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5466	ZIPARI, INC	43,123.28	264,245.12	AUG. 2022 JIVA MEMBER PORTAL	MIS INFRASTRUCTURE
T5337	CAZADOR CONSULTING GROUP INC	41,537.77	296,436.51	AUG. & SEPT. 2022 TEMPORARY HELP - (8) MS; (2) IT; (1) CS	VARIOUS
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	41,209.97	359,456.44	SEPT. 2022 EMPLOYEE HEALTH BENEFITS	VARIOUS
T1183	MILLIMAN USA ****	40,217.25	70,066.75	JUL. 2022 PROFESSIONAL SERVICES	FINANCE

KERN·HEALTH SYSTEMS

September AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T2584	UNITED STATES POSTAL SVC. - HASLER	40,000.00	280,000.00	POSTAGE METER PREFUND	CORPORATE SERVICES
T4737	TEKSYSTEMS, INC	39,811.34	340,876.12	JUN., JUL. & AUG. 2022 PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T5421	PREMIER ACCESS INSURANCE COMPANY	38,995.95	342,926.80	SEPT. 2022 EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T5333	CENTRAL CALIFORNIA ASTHMA COLLABORATIVE	37,017.63	148,193.39	DEC. 2021 & JUN. 2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4502	MORGAN CONSULTING RESOURCES, INC. ****	35,840.00	35,840.00	RECRUITMENT FEES - DIRECTOR OF POPULATION HEALTH MANAGEMENT	HUMAN RESOURCES
T5546	BITWISE TECHNOLOGY CONSULTING, LLC ****	27,793.23	27,793.23	JUL. & AUG. 2022 OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	26,960.99	249,302.33	AUG. 2022 EDI CLAIM PROCESSING	CLAIMS
T4424	GUROCK SOFTWARE GmbH ****	26,565.00	26,565.00	TESTRAIL SOFTWARE RENEWAL	MIS INFRASTRUCTURE
T4733	UNITED STAFFING ASSOCIATES	25,498.08	536,406.08	AUG. 2022 TEMPORARY HELP - (8) MS; (1) HE	VARIOUS
T4452	WELLS FARGO	23,728.44	205,429.39	SEPT. - ACH MISC CREDIT CARD PURCHASES	VARIOUS
T4460	PAYSPAN, INC	22,715.35	173,095.16	AUG. 2022 ELECTRONIC CLAIMS/PAYMENTS	FINANCE

KERN·HEALTH SYSTEMS

September AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T3011	OFFICE ALLY, INC.	21,806.30	189,191.23	AUG. 2022 EDI CLAIMS PROCESSING	CLAIMS
T4237	FLUIDEDGE CONSULTING, INC.	21,280.00	507,802.10	AUG. 2022 CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T5490	WORKSITE LABS, INC	20,300.00	31,620.00	AUG. 2022 ONSITE COVID-19 TESTING	HUMAN RESOURCES
T4585	DELANO UNION SCHOOL DISTRICT ****	20,000.00	70,000.00	SCHOOL WELLNESS GRANT - 1ST INSTALLMENT	HEALTH EDUCATION
		2,927,065.68			
	TOTAL VENDORS OVER $20,000	2,927,065.68			
	TOTAL VENDORS UNDER $20,000	586,135.59			
	TOTAL VENDOR EXPENSES- SEPTEMBER	**$ 3,513,201.27**			

Note:
****New vendors over $20,000 for the month of September

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	4,572,366.60	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE INC.	2,676,990.41	PROFESSIONAL SERVICES / CONSULTING SERVICES	VARIOUS
T4982	NGC US, LLC	2,452,917.28	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T1071	CLINICA SIERRA VISTA	1,879,828.04	2022 HEALTH HOMES GRANT & PROVIDER CARE QUALITY GRANT PROGRAM	COMMUNITY GRANTS
T4391	OMNI FAMILY HEALTH	1,368,061.63	2022 HEALTH HOMES GRANT & PROVIDER CARE QUALITY GRANT PROGRAM	COMMUNITY GRANTS
T2704	MCG HEALTH LLC	1,214,288.28	HEALTH CARE MANAGEMENT & SOFTWARE LICENSE 8/5/2022 -08/04/2023	UTILIZATION MANAGEMENT
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	1,131,436.65	PROFESSIONAL SERVICES & ANNUAL LICENSING	VARIOUS
T1408	DELL MARKETING L.P.	1,083,326.85	HARDWARE & COMPUTER EQUIPMENT & LICENSE FEES	MIS INFRASTRUCTURE
T2686	ALLIANT INSURANCE SERVICES INC.	894,688.79	2022 -2023 INSURANCE PREMIUMS	ADMINISTRATION
T5111	ENTISYS 360	850,833.77	ACROPOLIS ANNUAL LICENSE 2022	MIS INFRASTRUCTURE
T4483	INFUSION AND CLINICAL SERVICES, INC	640,212.76	HEALTH HOMES GRANT	COMMUNITY GRANT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T3130	OPTUMINSIGHT, INC	542,030.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T4733	UNITED STAFFING ASSOCIATES	536,406.08	TEMPORARY HELP	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC.	507,802.10	CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T1180	LANGUAGE LINE SERVICES INC.	500,815.74	INTERPRETATION SERVICES	MEMBER SERVICES
T1845	DEPARTMENT OF MANAGED HEALTH CARE	471,317.70	2022-2023 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	362,955.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	359,456.44	VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T4165	SHI INTERNATIONAL CO.	354,929.12	NETWORK SWITCHES WITH SUPPORT	MIS INFRASTRUCTURE
T5421	PREMIER ACCESS INSURANCE COMPANY	342,926.80	EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T4737	TEKSYSTEMS, INC.	340,876.12	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T5022	SVAM INTERNATIONAL INC	329,366.00	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5337	CAZADOR CONSULTING GROUP INC	296,436.51	TEMPORARY HELP	VARIOUS
T2167	PG&E	290,067.03	USAGE / UTILITIES	CORPORATE SERVICES
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	290,000.00	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI
T4699	ZEOMEGA, INC.	288,312.46	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T2584	UNITED STATES POSTAL SVC. - HASLER	280,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T4193	STRIA LLC	275,736.02	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T5466	ZIPARI, INC	264,245.12	2022 JIVA MEMBER PORTAL	MIS INFRASTRUCTURE
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	249,302.33	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T5005	CRAYON SOFTWARE EXPERTS LLC	233,512.45	ANNUAL SOFTWARE LICENSE AND ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T4657	DAPONDE SIMPSON ROWE PC	230,586.31	LEGAL FEES	VARIOUS
T5155	A-C ELECTRIC COMPANY ****	229,186.50	CARPOOL SOLAR PROJECT DEPOSIT	CAPITAL
T2726	DST PHARMACY SOLUTIONS, INC.	208,431.51	PHARMACY CLAIMS	PHARMACY

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4452	WELLS FARGO	205,429.39	ACH- MISC CREDIT CARD PURCHASES	VARIOUS
T5319	CITIUSTECH INC.	197,913.00	FAST+ ANNUAL MAINTENANCE & SUPPORT	MIS INFRASTRUCTURE
T4353	TWE SOLUTIONS, INC	193,536.80	INTERNAL AUDIT SOFTWARE	MIS INFRASTRUCTURE
T5447	PROSPHIRE, LLC	189,620.00	CONSULTING - CLINICAL ADMINISTRATOR STAFF AUGMENTATION	UTILIZATION MANAGEMENT
T2458	HEALTHCARE FINANCIAL, INC	189,502.99	PROFESSIONAL SERVICES	ADMINISTRATION
T3011	OFFICE ALLY, INC	189,191.23	EDI CLAIM PROCESSING	CLAIMS
T3449	CDW GOVERNMENT	178,852.48	HEADSETS, CABLES & ADOBE LICENSES	MIS INFRASTRUCTURE
T1861	CERIDIAN HCM, INC.	173,342.55	MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4460	PAYSPAN, INC	173,095.16	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T5145	CCS ENGINEERING FRESNO INC.	166,986.41	JANITORIAL & ADDITIONAL DAY PORTER	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2469	DST HEALTH SOLUTIONS, LLC.	156,427.30	ANNUAL ACG LICENSE & SUPPORT	BUSINESS INTELLEGENCE
T5322	MANINDER KHALSA	154,030.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5479	TRANSFORMING LOCAL COMMUNITIES, INC	150,508.69	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4707	SHAFTER PEDIATRICS	150,000.00	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5333	CENTRAL CALIFORNIA ASTHMA COLLABORATIVE	148,193.39	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	138,017.53	2022 ANNUAL DUE ASSESSMENT	VARIOUS
T4582	HEALTHX, INC.	124,728.00	MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5435	TEGRIA SERVICES GROUP - US, INC.	114,500.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5360	SYNERGY PHARMACY SOLUTIONS INC.	108,900.00	2021 KOMOTO ASTHMA PROGRAM	POPULATION HEALTH MANAGEMENT
T1005	COLONIAL LIFE & ACCIDENT	107,552.57	LIFE INSURANCE PREMIUM	VARIOUS
T2961	SOLUTION BENCH, LLC	104,061.95	2022/2023 ANNUAL M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1128	HALL LETTER SHOP	102,489.25	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS	VARIOUS
T4038	POLYCLINIC MEDICAL CENTER, INC	102,089.73	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5300	CENTRAL VALLEY OCCUPATION MEDICAL GROUP, INC	101,140.00	COVID-19 TESTING	HUMAN RESOURCES
T5292	ALL'S WELL HEALTH CARE SERVICES	99,938.31	TEMPORARY HELP	VARIOUS
T2918	STINSONS	99,775.75	2022 OFFICE SUPPLIES	VARIOUS
T3001	MERCER	97,500.00	PROFESSIONAL SERVICES	HUMAN RESOURCES
T5486	ALLIED GENERAL CONTRACTORS, INC	92,425.76	BUILDING IMPROVEMENTS	CORPORATE SERVICES
WT/ACH	USPS	90,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES
T2933	SIERRA PRINTERS, INC	88,087.73	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T4686	CENTRIC HEALTH	86,939.92	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5529	FINDHELP	83,000.00	COMMUNITY SUPPORT REFERRAL SYSTEM IMPLEMENTATION	CAPITAL PROJECT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4963	LINKEDIN CORPORATION	81,729.00	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T4217	CONTEXT 4 HEALTHCARE, INC	75,142.83	AMA ROYALTY FEE & CPT RENEWAL	MIS INFRASTRUCTURE
T1272	COFFEY COMMUNICATIONS INC.	73,645.40	MEMBER NEWSLETTER/WEBSITE IMPLEMENTATION	HEALTH EDUCATION/MEDIA & ADVERTISING
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	73,600.00	2022 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4503	VISION SERVICE PLAN	73,185.20	EMPLOYEE HEALTH BENEFITS	VARIOUS
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	72,786.25	CONSULTING SERVICES	ADMINISTRATION
T1022	UNUM LIFE INSURANCE CO.	71,690.26	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T1183	MILLIMAN USA	70,066.75	CY2020/2021 TNE & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T4052	RAHUL SHARMA	70,000.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4585	DELANO UNION SCHOOL DISTRICT	70,000.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T5121	TPX COMMUNICATIONS	67,775.83	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T5185	HOUSING AUTHORITY COUNTY OF KERN	67,600.00	2021 HOUSING AUTHORITY GRANT	POPULATION HEALTH MANAGEMENT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5275	CREATIVE FINANCIAL STAFFING, LLC.	67,409.92	RECRUITMENT FEES	HUMAN RESOURCES
T2413	TREK IMAGING INC	61,394.72	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T5509	NGUYEN CAO LUU-TRONG ****	59,437.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5377	TELEHEALTHDOCS MEDICAL GROUP	59,047.43	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	58,841.86	EDI CLAIM PROCESSING	CLAIMS
T5109	RAND EMPLOYMENT SOLUTIONS	57,634.76	TEMPORARY HELP	VARIOUS
T5376	KCHCC	55,700.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T1195	KOMOTO PHARMACY, INC	54,500.00	COVID-19 POP UP CLINIC	PROVIDER NETWORK MANAGEMENT
T5329	RELAY NETWORK, LLC	53,333.36	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T4688	VANGUARD MEDICAL CORPORATION	51,500.00	2021-2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5132	TIME WARNER CABLE LLC	51,023.05	INTERNET SERVICES	MIS INFRASTRUCTURE
T5426	UNIVERSAL HEALTHCARE SERVICES, INC	50,000.00	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5367	ADVENTIST HEALTH DELANO	49,697.20	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	49,500.00	2021 AUDIT FEES	FINANCE
T2969	AMERICAN BUSINESS MACHINES INC	49,400.15	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T5487	MR2 SOLUTIONS, INC	49,400.00	2022/2023 VIRTUAL CHIEF INFORMATION SECURITY OFFICER	MIS INFRASTRUCTURE
T5420	PAYPRO ADMINISTRATORS	49,351.12	FSA EMPLOYEE BENEFIT	VARIOUS
T4792	KP LLC	48,521.84	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PHARMACY/PROVIDER RELATIONS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	47,728.42	ONSITE SECURITY	CORPORATE SERVICES
T3986	JACQUELYN S. JANS	47,242.25	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T4182	THE LAMAR COMPANIES	45,063.00	OUTDOOR ADVERTISEMENT - BILLBOARDS	ADVERTISING
T5396	NYMI INC	44,745.00	15 WEARABLES/ SOFTWARE/MAINTENANCE FOR TRACING DEVICES	CORPORATE SERVICES
T5215	RICHARD GARCIA	42,600.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5340	GARTNER INC	42,391.67	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	MIS ADMINISTRATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4607	AGILITY RECOVERY SOLUTIONS INC.	41,657.00	PROFESSIONAL SERVICES	ADMINISTRATION
T4785	COMMGAP	41,187.50	INTERPRETATION SERVICES	HEALTH EDUCATION
T2941	KERN PRINT SERVICES INC.	41,161.91	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T4059	KERN VALLEY HEALTHCARE DISTRICT	40,461.90	2022 PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T2441	LAURA J. BREZINSKI	40,300.00	MARKETING MATERIALS	MARKETING
T5408	MARY HARRIS	38,325.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5107	CITRIX SYSTEMS, INC.	38,250.00	ANNUAL SERVICE RENEWAL	MIS INFRASTRUCTURE
T2446	AT&T MOBILITY	37,890.00	CELLULAR PHONE/INTERNET USAGE	MIS INFRASTRUCTURE
T5286	BROOKLYNNS BOX INC.	37,750.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5389	ADAKC	37,453.97	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4484	JACOBSON SOLUTIONS	36,891.09	TEMPORARY HELP	UTILIZATION MANAGEMENT-UM

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T3515	DOUG HAYWARD	36,565.85	CONSULTING SERVICES	ADMINISTRATION
T4605	KERNVILLE UNION SCHOOL DISTRICT	36,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T5398	GOLDEN EMPIRE GLEANERS	35,979.59	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4502	MORGAN CONSULTING RESOURCES, INC. ****	35,840.00	RECRUITMENT FEES - DIRECTOR OF POPULATION HEALTH MANAGEMENT	HUMAN RESOURCES
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	35,833.34	COMMUNITY SPONSORSHIP	ADMINISTRATION
T5455	HC2 STRATEGIES, INC	34,639.00	CALAIM ROUNDTABLE SUPPORT	COMMUNITY SUPPORT SERVICES
T3092	LINKS FOR LIFE, INC.	33,100.00	COMMUNITY RESOURCES GRANT PROGRAM	COMMUNITY GRANT
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO. INC.	32,742.86	2022 BUILDING MAINTENANCE	CORPORATE SERVICE
T5401	KERN MEDICAL SUPPLY, LLC	32,303.30	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5490	WORKSITE LABS, INC	31,620.00	EMPLOYEE ON-SITE COVID TESTING	HUMAN RESOURCES
T4563	SPH ANALYTICS	31,046.40	2021/2022 PROVIDER SATISFACTION SURVEYS	MEMBER SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5325	WADE A MCNAIR	30,000.00	LEADERSHIP ACADEMY TRAINING	HUMAN RESOURCES
T2509	USPS	29,467.33	FUND MAILING PERMIT #88	CORPORATE SERVICES
T1097	NCQA	29,247.00	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	QUALITY IMPROVEMENT
T4944	CENTRAL VALLEY FARMWORKER FOUNDATION	28,600.50	COVID EDUCATION OUTREACH SPECIALIST	PROVIDER NETWORK MANAGEMENT
T5387	NAVIA BENEFITS SOLUTIONS, INC.	28,207.23	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T4496	VOX NETWORK SOLUTIONS, INC	28,013.43	TELSTRAT LICENSES & ANNUAL HOSTING	MIS INFRASTRUCTURE
T4514	A.J. KLEIN, INC. T.DENATALE, B. GOLDNER	27,853.82	LEGAL FEES	ADMINISTRATION
T5546	BITWISE TECHNOLOGY CONSULTING, LLC ****	27,793.23	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	27,530.00	ADVERTISEMENT - MEDIA	MARKETING
T5494	LDP ASSOCIATES, INC	27,300.00	2022/2023 DISASTER RECOVERY & PC COOLING MAINT.	VARIOUS
T4424	GUROCK SOFTWARE GmbH ****	26,565.00	TESTRAIL SOFTWARE RENEWAL	MIS INFRASTRUCTURE
T5488	SALUSKY LAW GROUP	25,417.00	LEGAL FEES	ADMINISTRATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4663	DEVELOPMENT DIMENSIONS INTERNATIONAL, INC	25,000.00	2021-2023 LEADERSHIP LICENSE	HUMAN RESOURCES
T4466	SMOOTH MOVE USA	23,866.24	OFF SITE STORAGE	CORPORATE SERVICES
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC.	23,612.50	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T4731	LOGMEIN USA, INC.	23,137.81	INTERNET SERVICES	MIS INFRASTRUCTURE
T5201	JAC SERVICES, INC	23,135.00	AC MAINTENANCE & SERVICE	CORPORATE SERVICES
T5480	PRESS GANEY ASSOCIATES LLC	22,500.00	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T4611	LAMONT SCHOOL DISTRICT	22,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T4993	LEGALSHIELD	21,508.45	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION
T4216	NEXSTAR BROADCASTING INC	20,650.00	ADVERTISEMENT - MEDIA	MARKETING
T5520	BG HEALTHCARE CONSULTING, INC ****	20,475.00	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	20,355.22	EMPLOYEE PREMIUM	ADMINISTRATION
T1347	ADVANCED DATA STORAGE	20,288.44	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T5161	INTEGRATED HEALTHCARE ASSOCIATION	20,142.92	CONSULTING SERVICES	PROVIDER NETWORK MANAGEMENT
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT	20,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
		34,469,774.39		
	TOTAL VENDORS OVER $20,000	34,469,774.39		
	TOTAL VENDORS UNDER $20,000	1,504,329.63		
	TOTAL VENDOR EXPENSES-YTD	**35,974,104.02**		

Note:
****New vendors over $20,000 for the month of September

KERN·HEALTH SYSTEMS

October AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4391	OMNI FAMILY HEALTH	1,633,456.23	3,001,517.86	MAR, APR, MAY 2022 PROVIDER GRANT PROGRAM, & OCT 2021 - FEB 2022 SUPPLEMENTAL PGP 2021-2022	COMMUNITY GRANTS
T4350	COMPUTER ENTERPRISE	637,830.41	3,314,820.82	JUL. AUG. & SEPT. 2022 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T1045	KAISER FOUNDATION HEALTH - HMO	526,175.57	5,098,542.17	OCT. 2022 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4982	NGC US, LLC	300,000.00	2,752,917.28	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T1408	DELL MARKETING L.P.	175,560.43	1,258,887.28	HARDWARE- (16) OPTIPLEX, (1000) MONITORS, (49) DELL LATITUDE AND (102) DELL DOCKS	MIS INFRASTRUCTURE
T2686	ALLIANT INSURANCE SERVICES INC.	175,525.00	1,070,213.79	2022 -2023 INSURANCE PREMIUMS - EXCESS COMMERCIAL LIABILITY	ADMINISTRATION
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	143,249.69	1,274,686.34	SEPT. 2022 PROFESSIONAL SERVICES & EDI CLAIM PROCESSING	VARIOUS
T1180	LANGUAGE LINE ****	142,792.68	570,082.10	AUG. & SEPT. 2022 INTERPRETATION SERVICES	MEMBER SERVICES
T4699	ZEOMEGA ****	66,890.19	355,202.65	AUG. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4237	FLUIDEDGE CONSULTING, INC.	62,280.00	570,082.10	AUG. & SEPT. 2022 CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T4737	TEKSYSTEMS, INC	56,761.23	397,637.35	AUG., SEPT., & OCT. 2022 PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	52,987.50	415,942.50	SEPT. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5509	NGUYEN CAO LUU-TRONG	47,850.00	107,287.50	SEPT. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2458	HEALTHCARE FINANCIAL, INC	47,186.92	236,689.91	AUG. 2022 PROFESSIONAL SERVICES	ADMINISTRATION

KERN·HEALTH SYSTEMS

October AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5018	FIRESTONE GRILL - BAKERSFIELD ****	46,599.64	46,599.64	EMPLOYEE SERVICE AWARDS 2022	MARKETING
T5275	CREATIVE FINANCIAL STAFFING, LLC ****	46,056.40	113,466.32	PLACEMENT FEES	HUMAN RESOURCES
T1861	CERIDIAN HCM, INC.	45,370.51	218,713.06	AUG., SEPT. & OCT 2022 MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T1183	MILLIMAN USA	45,334.25	115,401.00	AUG. 2022 PROFESSIONAL SERVICES	FINANCE
T4688	VANGUARD MEDICAL CORPORATION ****	43,500.00	95,000.00	AUG. 2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4934	APPLE INC. ****	42,534.59	50,202.17	(49) IPHONES, POWER ADAPTERS AND LIGHTNING CABLES	MIS INFRASTRUCTURE
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	41,863.31	401,319.75	OCT. 2022 EMPLOYEE HEALTH BENEFITS	VARIOUS
T5479	TRANSFORMING LOCAL COMMUNITIES, INC ****	40,454.74	190,963.43	AUG. 2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5313	HEALTH LITERACY INNOVATIONS, LLC ****	40,125.00	57,630.00	HLA 1 YR LICENSE RENEWAL	MIS INFRASTRUCTURE
T5421	PREMIER ACCESS INSURANCE COMPANY	39,795.81	382,722.61	OCT. 2022 EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T5447	PROSPHIRE, LLC	38,000.00	22,762.00	SEPT. 2022 PROFESSIONAL SERVICES	CAPITAL PROJECT
T2167	PG&E	37,981.08	328,048.11	SEPT. 2022 USAGE / UTILITIES	CORPORATE SERVICES
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	37,303.70	327,303.70	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI
T5467	MOSS ADAMS LLP ****	36,997.00	36,997.00	2022 CLAIMS AUDIT TOOL	CLAIMS

KERN·HEALTH SYSTEMS

October AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5022	SVAM INTERNATIONAL INC ****	35,144.00	364,510.00	AUG. 2022 PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T5574	CARMAX AUTO SUPERSTORES, INC ****	31,952.35	31,952.35	2022 EQUINOX COMPANY VEHICLE	CORPORATE SERVICES
T5546	BITWISE TECHNOLOGY CONSULTING, LLC	31,938.69	59,731.92	SEPT. 2022 OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T4484	JACOBSON SOLUTIONS ****	31,318.52	68,209.61	SEPT. & OCT. 2022 TEMPORARY HELP (3) UM	VARIOUS
T4733	UNITED STAFFING ASSOCIATES	30,519.46	566,925.54	SEPT. 2022 TEMPORARY HELP - (11) MS; (1) HE	VARIOUS
T4452	WELLS FARGO	29,237.71	234,667.10	OCT - ACH MISC CREDIT CARD PURCHASES	VARIOUS
T4417	KAISER FOUNDATION HEALTH PLAN - OR ****	25,893.22	25,893.22	NOV. 2021 - OCT 2022 EMPLOYEE HEALTH BENEFITS PREMIUM	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	25,600.47	274,902.80	SEPT. 2022 EDI CLAIM PROCESSING	CLAIMS
T5387	NAVIA BENEFITS SOLUTIONS, INC ****	24,516.98	52,724.21	AUG. 2021-OCT. 2021 FSA DISBURSEMENTS	HUMAN RESOURCES
T4460	PAYSPAN, INC	22,296.21	195,391.37	SEPT. 2022 ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T4657	DAPONDE SIMPSON ROWE PC	21,358.00	251,944.31	AUG. & SEPT. 2022 LEGAL FEES	VARIOUS
T5319	CITIUSTECH INC. ****	21,249.00	219,162.00	Q3 2022 FAST MAINTENANCE AND SUPPORT	MIS INFRASTRUCTURE
		4,981,486.49			
	TOTAL VENDORS OVER $20,000	4,981,486.49			
	TOTAL VENDORS UNDER $20,000	502,044.84			
	TOTAL VENDOR EXPENSES- OCTOBER	**$ 5,483,531.33**			

Note:
****New vendors over $20,000 for the month of October

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	5,098,542.17	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE INC.	3,314,820.82	PROFESSIONAL SERVICES / CONSULTING SERVICES	VARIOUS
T4391	OMNI FAMILY HEALTH	3,001,517.86	HEALTH HOMES GRANT	COMMUNITY GRANTS
T4982	NGC US, LLC	2,752,917.28	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T1071	CLINICA SIERRA VISTA	1,880,379.13	2022 HEALTH HOMES GRANT & PROVIDER CARE QUALITY GRANT PROGRAM	COMMUNITY GRANTS
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	1,274,686.34	PROFESSIONAL SERVICES & ANNUAL LICENSING	VARIOUS
T1408	DELL MARKETING L.P.	1,258,887.28	HARDWARE & COMPUTER EQUIPMENT & LICENSE FEES	MIS INFRASTRUCTURE
T2704	MCG HEALTH LLC	1,214,288.28	HEALTH CARE MANAGEMENT & SOFTWARE LICENSE 8/5/2022 -08/04/2023	UTILIZATION MANAGEMENT
T2686	ALLIANT INSURANCE SERVICES INC.	1,070,213.79	2022 -2023 INSURANCE PREMIUMS	ADMINISTRATION
T5111	ENTISYS 360	850,833.77	ACROPOLIS ANNUAL LICENSE 2022	MIS INFRASTRUCTURE
T4483	INFUSION AND CLINICAL SERVICES, INC	650,148.66	HEALTH HOMES GRANT	COMMUNITY GRANT
T1180	LANGUAGE LINE SERVICES INC.	643,608.42	INTERPRETATION SERVICES	MEMBER SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4237	FLUIDEDGE CONSULTING, INC.	570,082.10	CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T4733	UNITED STAFFING ASSOCIATES	566,925.54	TEMPORARY HELP	VARIOUS
T3130	OPTUMINSIGHT, INC	542,030.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T1845	DEPARTMENT OF MANAGED HEALTH CARE	471,317.70	2022-2023 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	415,942.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	401,319.75	VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T4737	TEKSYSTEMS, INC.	397,637.35	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T5421	PREMIER ACCESS INSURANCE COMPANY	382,722.61	EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T4165	SHI INTERNATIONAL CO.	368,751.07	NETWORK SWITCHES WITH SUPPORT	MIS INFRASTRUCTURE
T5022	SVAM INTERNATIONAL INC	364,510.00	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T4699	ZEOMEGA, INC.	355,202.65	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T2167	PG&E	328,048.11	USAGE / UTILITIES	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	327,303.70	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI
T5337	CAZADOR CONSULTING GROUP INC	309,972.03	TEMPORARY HELP	VARIOUS
T4193	STRIA LLC	285,379.86	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T2584	UNITED STATES POSTAL SVC. - HASLER	280,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	274,902.80	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T5466	ZIPARI, INC	264,245.12	2022 JIVA MEMBER PORTAL	MIS INFRASTRUCTURE
T4657	DAPONDE SIMPSON ROWE PC	251,944.31	LEGAL FEES	VARIOUS
T4452	WELLS FARGO	234,667.10	ACH- MISC CREDIT CARD PURCHASES	VARIOUS
T2458	HEALTHCARE FINANCIAL, INC	236,689.91	PROFESSIONAL SERVICES	ADMINISTRATION
T5005	CRAYON SOFTWARE EXPERTS LLC	233,512.45	ANNUAL SOFTWARE LICENSE AND ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T5155	A-C ELECTRIC COMPANY	229,186.50	CARPOOL SOLAR PROJECT DEPOSIT	CAPITAL
T5447	PROSPHIRE, LLC	227,620.00	CONSULTING - CLINICAL ADMINISTRATOR STAFF AUGMENTATION	UTILIZATION MANAGEMENT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5319	CITIUSTECH INC.	219,162.00	FAST+ ANNUAL MAINTENANCE & SUPPORT	MIS INFRASTRUCTURE
T1861	CERIDIAN HCM, INC.	218,713.06	MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T2726	DST PHARMACY SOLUTIONS, INC.	218,002.98	PHARMACY CLAIMS	PHARMACY
T3011	OFFICE ALLY, INC	207,210.81	EDI CLAIM PROCESSING	CLAIMS
T4460	PAYSPAN, INC	195,391.37	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T4353	TWE SOLUTIONS, INC	193,536.80	INTERNAL AUDIT SOFTWARE	MIS INFRASTRUCTURE
T5479	TRANSFORMING LOCAL COMMUNITIES, INC	190,963.43	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T3449	CDW GOVERNMENT	187,430.52	HEADSETS, CABLES & ADOBE LICENSES	MIS INFRASTRUCTURE
T5145	CCS ENGINEERING FRESNO INC.	183,131.41	JANITORIAL & ADDITIONAL DAY PORTER	CORPORATE SERVICES
T2469	DST HEALTH SOLUTIONS, LLC.	156,427.30	ANNUAL ACG LICENSE & SUPPORT	BUSINESS INTELLEGENCE
T5322	MANINDER KHALSA	154,030.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4707	SHAFTER PEDIATRICS	150,000.00	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5333	CENTRAL CALIFORNIA ASTHMA COLLABORATIVE	149,250.71	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	138,110.50	2022 ANNUAL DUE ASSESSMENT	VARIOUS
T5435	TEGRIA SERVICES GROUP - US, INC.	132,000.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4582	HEALTHX, INC.	124,728.00	MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T1005	COLONIAL LIFE & ACCIDENT	118,995.81	LIFE INSURANCE PREMIUM	VARIOUS
T1128	HALL LETTER SHOP	118,463.41	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS	VARIOUS
T1183	MILLIMAN USA	115,401.00	CY2020/2021 TNE & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T5275	CREATIVE FINANCIAL STAFFING, LLC.	113,466.32	RECRUITMENT FEES	HUMAN RESOURCES
T5360	SYNERGY PHARMACY SOLUTIONS INC.	108,900.00	2021 KOMOTO ASTHMA PROGRAM	POPULATION HEALTH MANAGEMENT
T5509	NGUYEN CAO LUU-TRONG	107,287.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5300	CENTRAL VALLEY OCCUPATION MEDICAL GROUP, INC	105,960.00	COVID-19 TESTING	HUMAN RESOURCES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2961	SOLUTION BENCH, LLC	104,061.95	2022/2023 ANNUAL M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE
T5292	ALL'S WELL HEALTH CARE SERVICES	102,776.46	TEMPORARY HELP	VARIOUS
T4038	POLYCLINIC MEDICAL CENTER, INC	102,089.73	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T2918	STINSONS	99,775.75	2022 OFFICE SUPPLIES	VARIOUS
T3001	MERCER	97,500.00	PROFESSIONAL SERVICES	HUMAN RESOURCES
T4688	VANGUARD MEDICAL CORPORATION	95,000.00	2021-2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5486	ALLIED GENERAL CONTRACTORS, INC	92,425.76	BUILDING IMPROVEMENTS	CORPORATE SERVICES
WT/ACH	USPS	90,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES
T2933	SIERRA PRINTERS, INC	88,568.50	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T4686	CENTRIC HEALTH	86,939.92	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5529	FINDHELP	83,000.00	COMMUNITY SUPPORT REFERRAL SYSTEM IMPLEMENTATION	CAPITAL PROJECT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	82,257.50	CONSULTING SERVICES	ADMINISTRATION
T4503	VISION SERVICE PLAN	81,812.92	EMPLOYEE HEALTH BENEFITS	VARIOUS
T4963	LINKEDIN CORPORATION	81,729.00	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T1022	UNUM LIFE INSURANCE CO.	80,513.06	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T1272	COFFEY COMMUNICATIONS INC.	78,941.32	MEMBER NEWSLETTER/WEBSITE IMPLEMENTATION	HEALTH EDUCATION/MEDIA & ADVERTISING
T5121	TPX COMMUNICATIONS	77,116.51	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T4217	CONTEXT 4 HEALTHCARE, INC	75,142.83	AMA ROYALTY FEE & CPT RENEWAL	MIS INFRASTRUCTURE
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	73,600.00	2022 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4052	RAHUL SHARMA	70,000.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4585	DELANO UNION SCHOOL DISTRICT	70,000.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T2413	TREK IMAGING INC	69,907.44	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4484	JACOBSON SOLUTIONS	68,209.61	TEMPORARY HELP	UTILIZATION MANAGEMENT-UM
T5185	HOUSING AUTHORITY COUNTY OF KERN	67,600.00	2021 HOUSING AUTHORITY GRANT	POPULATION HEALTH MANAGEMENT
T5329	RELAY NETWORK, LLC	66,666.70	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	64,761.18	EDI CLAIM PROCESSING	CLAIMS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	62,197.68	ONSITE SECURITY	CORPORATE SERVICES
T5109	RAND EMPLOYMENT SOLUTIONS	59,760.38	TEMPORARY HELP	VARIOUS
T5546	BITWISE TECHNOLOGY CONSULTING, LLC	59,731.92	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T5377	TELEHEALTHDOCS MEDICAL GROUP	59,047.43	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5313	HEALTH LITERACY INNOVATIONS, LLC	57,630.00	LITERACY ADVISOR ANNUAL SOFTWARE LICENSE	MIS INFRASTRUCTURE
T5376	KCHCC	55,700.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T5132	TIME WARNER CABLE LLC	55,025.27	INTERNET SERVICES	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1195	KOMOTO PHARMACY, INC	54,500.00	COVID-19 POP UP CLINIC	PROVIDER NETWORK MANAGEMENT
T2969	AMERICAN BUSINESS MACHINES INC	53,260.74	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T5387	NAVIA BENEFITS SOLUTIONS, INC.	52,724.21	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T3986	JACQUELYN S. JANS	52,492.25	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T5396	NYMI INC	51,520.00	WEARABLES/ SOFTWARE/MAINTENANCE FOR TRACING DEVICES	CORPORATE SERVICES
T5420	PAYPRO ADMINISTRATORS	51,136.12	FSA EMPLOYEE BENEFIT	VARIOUS
T4792	KP LLC	50,556.54	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PHARMACY/PROVIDER RELATIONS
T4934	APPLE INC. ****	50,202.17	EQUPMENT - CELL PHONES	VARIOUS
T5426	UNIVERSAL HEALTHCARE SERVICES, INC	50,000.00	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5367	ADVENTIST HEALTH DELANO	49,697.20	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	49,500.00	2021 AUDIT FEES	FINANCE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5487	MR2 SOLUTIONS, INC	49,400.00	2022/2023 VIRTUAL CHIEF INFORMATION SECURITY OFFICER	MIS INFRASTRUCTURE
T4182	THE LAMAR COMPANIES	47,935.00	OUTDOOR ADVERTISEMENT - BILLBOARDS	ADVERTISING
T5215	RICHARD GARCIA	46,837.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5018	FIRESTONE GRILL - BAKERSFIELD ****	46,599.64	EMPLOYEE SERVICE AWARDS 2022	MARKETING
T4059	KERN VALLEY HEALTHCARE DISTRICT	44,714.80	2022 PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T2441	LAURA J. BREZINSKI	44,350.00	MARKETING MATERIALS	MARKETING
T5340	GARTNER INC	42,391.67	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	MIS ADMINISTRATION
T2446	AT&T MOBILITY	42,136.04	CELLULAR PHONE/INTERNET USAGE	MIS INFRASTRUCTURE
T2941	KERN PRINT SERVICES INC.	41,783.65	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T4607	AGILITY RECOVERY SOLUTIONS INC.	41,657.00	PROFESSIONAL SERVICES	ADMINISTRATION
T4785	COMMGAP	41,187.50	INTERPRETATION SERVICES	HEALTH EDUCATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5455	HC2 STRATEGIES, INC	38,770.00	CALAIM ROUNDTABLE SUPPORT	COMMUNITY SUPPORT SERVICES
T5408	MARY HARRIS	38,325.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5107	CITRIX SYSTEMS, INC.	38,250.00	ANNUAL SERVICE RENEWAL	MIS INFRASTRUCTURE
T5286	BROOKLYNNS BOX INC.	37,750.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5389	ADAKC	37,453.97	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5467	MOSS ADAMS LLP ****	36,997.00	2022 CLAIMS AUDIT TOOL ANNUAL SUPPORT	CLAIMS
T3515	DOUG HAYWARD	36,565.85	CONSULTING SERVICES	ADMINISTRATION
T5398	GOLDEN EMPIRE GLEANERS	36,372.59	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4605	KERNVILLE UNION SCHOOL DISTRICT	36,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T4502	MORGAN CONSULTING RESOURCES, INC.	35,840.00	RECRUITMENT FEES - DIRECTOR OF POPULATION HEALTH MANAGEMENT	HUMAN RESOURCES
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	35,833.34	COMMUNITY SPONSORSHIP	ADMINISTRATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC.	33,162.50	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T3092	LINKS FOR LIFE, INC.	33,100.00	COMMUNITY RESOURCES GRANT PROGRAM	COMMUNITY GRANT
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO. INC.	32,742.86	2022 BUILDING MAINTENANCE	CORPORATE SERVICE
T5401	KERN MEDICAL SUPPLY, LLC	32,303.30	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5574	CARMAX AUTO SUPERSTORES, INC ****	31,952.35	2022 EQUINOX COMPANY VEHICLE	CORPORATE SERVICES
T5490	WORKSITE LABS, INC	31,620.00	EMPLOYEE ON-SITE COVID TESTING	HUMAN RESOURCES
T4563	SPH ANALYTICS	31,046.40	2021/2022 PROVIDER SATISFACTION SURVEYS	MEMBER SERVICES
T5325	WADE A MCNAIR	30,000.00	LEADERSHIP ACADEMY TRAINING	HUMAN RESOURCES
T2509	USPS	29,467.33	FUND MAILING PERMIT #88	CORPORATE SERVICES
T1097	NCQA	29,247.00	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	QUALITY IMPROVEMENT
T4514	A.J. KLEIN, INC. T.DENATALE, B. GOLDNER	28,843.82	LEGAL FEES	ADMINISTRATION
T4944	CENTRAL VALLEY FARMWORKER FOUNDATION	28,600.50	COVID EDUCATION OUTREACH SPECIALIST	PROVIDER NETWORK MANAGEMENT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4496	VOX NETWORK SOLUTIONS, INC	28,211.79	TELSTRAT LICENSES & ANNUAL HOSTING	MIS INFRASTRUCTURE
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	27,530.00	ADVERTISEMENT - MEDIA	MARKETING
T5494	LDP ASSOCIATES, INC	27,300.00	2022/2023 DISASTER RECOVERY & PC COOLING MAINT.	VARIOUS
T4424	GUROCK SOFTWARE GmbH	26,565.00	TESTRAIL RENEWAL	MIS INFRASTRUCTURE
T4417	KAISER FOUNDATION HEALTH PLAN - OR ****	25,893.22	2021-2022 EMPLOYEE HEALTH BENEFITS PREMIUM	VARIOUS
T5488	SALUSKY LAW GROUP	25,417.00	LEGAL FEES	ADMINISTRATION
T4663	DEVELOPMENT DIMENSIONS INTERNATIONAL, INC	25,000.00	2021-2023 LEADERSHIP LICENSE	HUMAN RESOURCES
T4993	LEGALSHIELD	24,023.40	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION
T4466	SMOOTH MOVE USA	23,866.24	OFF SITE STORAGE	CORPORATE SERVICES
T4731	LOGMEIN USA, INC.	23,137.81	INTERNET SERVICES	MIS INFRASTRUCTURE
T5201	JAC SERVICES, INC	23,135.00	AC MAINTENANCE & SERVICE	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1347	ADVANCED DATA STORAGE	22,872.28	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	22,536.74	EMPLOYEE PREMIUM	ADMINISTRATION
T5480	PRESS GANEY ASSOCIATES LLC	22,500.00	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T4611	LAMONT SCHOOL DISTRICT	22,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T4228	THE SSI GROUP, LLC	21,686.80	EDI CLAIM PROCESSING	CLAIMS
T5366	CONCUR TECHNOLOGIES, INC	20,693.35	2021 - 2022 SAP PROFESSIONAL SERVICES	FINANCE
T4216	NEXSTAR BROADCASTING INC	20,650.00	ADVERTISEMENT - MEDIA	MARKETING
T5520	BG HEALTHCARE CONSULTING, INC	20,475.00	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T5161	INTEGRATED HEALTHCARE ASSOCIATION	20,142.92	CONSULTING SERVICES	PROVIDER NETWORK MANAGEMENT
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT	20,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
		39,825,271.60		
	TOTAL VENDORS OVER $20,000	39,825,271.60		
	TOTAL VENDORS UNDER $20,000	984,305.33		
	TOTAL VENDOR EXPENSES-YTD	**40,809,576.93**		

Note:
****New vendors over $20,000 for the month of October

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
January							
FluidEdge	$50,000.00	Yes	PNM	Emily Duran	Interim Program Manager for ECM and PNM dept. (Katie Sykes)	1/3/2022	3/31/2022
CEI	$93,555.00	Yes	PM	LaVonne Banks	Project Manager/Scrum Master professional resources (Mark Stepko)	1/3/2022	4/30/2022
HD Dynamics	$53,760.00	Yes	PNM	Emily Duran	Support and consulting hours for CRM for HHP	1/3/2022	12/31/2022
Symplr	$35,700.00	Yes	IT	Richard Pruitt	Annual support for Cactus SaaS & DEA licenses	1/6/2022	1/5/2023
Mercer	$95,000.00	Yes	HR	Anita Martin	Compensation study for 75 KHS jobs	1/20/2022	12/31/2022
KP	$35,000.00	Yes	HE	Isabel Silva	Prenatal, postpartum, and COVID guides insert mailing	1/2/2022	12/31/2022
Lamar	$37,336.00	Yes	MRK	Louie Iturriria	5 Billboard Advertisement	1/24/2022	1/23/2023
Jacquelyn Jans	$63,000.00	Yes	MRK	Louie Iturriria	Marketing and corporate image consultant	1/2/2022	12/31/2022
Poppyrock	$99,600.00	Yes	MRK	Louie Iturriria	Graphic design for KHS/KFHC members and provider	1/2/2022	12/31/2023
February							
Gartner	$42,391.67	Yes	IT	Richard Pruitt	Individual Access Advisor license	2/1/2022	1/31/2023
MKB Landscaping	$30,800.00	Yes	CS	Alonso Hurtado	Weekly landscaping services	2/10/2022	2/9/2023
Dell	$56,799.22	Yes	IT	Richard Pruitt	Dell laptops (18), Docking Stations (18), and monitors (36)	2/9/2022	2/8/2026
Coffey Communications	$70,000.00	Yes	HE	Isabel Silva	Provider Directory Print agreement	2/15/2022	2/14/2023
ZeOmega	$57,818.70	Yes	IT	Richard Pruitt	Member portal implementation	2/9/2022	12/31/2022
March							
Wade McNair	$30,000.00	Yes	HR	Anita Martin	Leadership Academy Training for new and experienced leaders	3/1/2022	6/17/2022
Ceridian	$34,170.00	Yes	HR	Anita Martin	configurations	3/10/2022	3/9/2023
HC2	$54,756.00	Yes	PNM	Emily Duran	Needs assessment for CalAIM initiatives	3/10/2022	3/9/2023
April							
TWE Solutions	$91,450.00	Yes	IT	Richard Pruitt	1,355 Cortex XDR Pro licenses and 100 Annual Forensics licenses	4/29/2022	4/29/2023
Citrix	$38,250.00	Yes	IT	Richard Pruitt	403 Citrix ADC Premium Edition and Desktop licenses	4/2/2022	4/1/2023
SSI Group, LLC	$56,000.00	Yes	Claims	Robin Dow-Morales	EDI claims and electronic transactions	4/4/2022	4/3/2024
FluidEdge	$67,200.00	Yes	PNM	Emily Duran	Interim Program Manager, Katie Sykes	4/2/2022	6/30/2022
Dell	$53,328.33	Yes	IT	Richard Pruitt	25 Dell 5420 Laptops and 25 Docking stations	4/21/2022	4/20/2026
Cognizant	$54,000.00	Yes	IT	Richard Pruitt	Claims Integrity Implementation for Zelis	4/21/2022	3/20/2025
Coffey Communications	$89,360.00	Yes	MRK	Louie Iturriria	KHS Digital platform agreement	4/1/2022	3/31/2023
May							
Dell	$98,096.46	Yes	IT	Richard Pruitt	Dell 5520 Latitude, Qnty 49	5/18/2022	5/17/2026
Cognizant	$99,999.00	Yes	IT	Richard Pruitt	Nutanix Xi Leap Cloud annual renewal	5/27/2022	5/26/2023
MR2	$44,400.00	Yes	IT	Richard Pruitt	vCISO (Virtual Chief Information Security) Services	5/26/2022	5/25/2023

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
June							
Milliman	$99,900.00	Yes	ACCT	Veronica Barker	D-SNP (Base, Level and Gap Analysis)	6/1/2022	5/31/2023
HMA	$99,000.00	Yes	ACCT	Veronica Barker	Actuarial Services (RDT, SDR's & Rate Analysis)	6/1/2022	5/31/2023
LDPq	$40,365.00	Yes	CS	Alonso Hurtado	Support and maintenance for 3 APC InRow cooling units (1st floor)	6/4/2022	6/3/2025
Presidio	$50,550.00	Yes	IT	Richard Pruitt	Exchange Online Migration	6/14/2022	6/13/2023
Presidio	$57,174.00	Yes	IT	Richard Pruitt	SSRS Dashboard Discovery & Power BI implementation	6/14/2022	6/13/2023
TWE Solutions	$99,946.40	Yes	IT	Richard Pruitt	24x7 Managed Security services	6/14/2022	6/13/2023
Context4 Healthcare	$75,142.83	Yes	IT	Richard Pruitt	ICD-10 and CPT codes through AMA co-termed w/HCPCS codes	6/27/2022	6/27/2023
LDP	$41,535.00	Yes	CS	Alonso Hurtado	Support & maint. for 3 APC cooling units	6/4/2022	6/3/2025
JLL/Technologies	$38,752.00	Yes	CS	Alonso Hurtado	Cubicle resource scheduling app	6/28/2022	6/27/2023
July							
Spectrum	$61,164.00	Yes	IT	Richard Pruitt	1Gbps of Internet access	7/17/2022	7/16/2025
AT&T	$63,576.00	Yes	IT	Richard Pruitt	1Gbps of Internet access for KHS building	7/13/2022	7/12/2025
Rest and Reassure, LLC	$72,000.00	Yes	IT	Richard Pruitt	Consulting services for Cal-Aim & PHM dept requirements	7/15/2022	12/31/2022
Solution Bench	$76,461.95	Yes	IT	Richard Pruitt	M-files subscription base licenses & 2 add-on modules	7/23/2022	7/22/2027
CDW-G	$41,811.41	Yes	IT	Richard Pruitt	Juniper switches support & maint.	7/1/2022	6/30/2023
FluidEdge	$67,200.00	Yes	PNM	Amisha Pannu	PNM consultant, Katie Sykes	7/1/2022	9/30/2022
BG Healthcare Consulting	$30,000.00	Yes	PHM	Deborah Murr	Consulting services to audit KHS policies	7/13/2022	12/31/2022
August							
Octopai	$64,800.00	Yes	IT	Richard Pruitt	Data Lineage System	8/10/2022	8/9/2023
Cotiviti	$80,750.00	Yes	PHM	Deborah Murr	HRA outreach of SPD members	8/1/2022	7/31/2023
Dell	$98,099.72	Yes	IT	Richard Pruitt	(49) 5520 laptops	8/30/2022	8/29/2026
September							
CCS	$193,740.00	Yes	CS	Alonso Hurtado	Janitorial Services for KHS building	9/6/2022	9/5/2023
Spectrum	$84,480.00	Yes	IT	Richard Pruitt	Cloud Connect to Azure	9/24/2022	9/23/2024
The Periscope Group	$98,880.00	Yes	UM	Deb Murr	In-home assessment visits to members	9/5/2022	9/4/2023
JMD Solutions	$144,000.00	Yes	IT	Richard Pruitt	Kern Medical Data Extration and Transformation	9/26/2022	1/31/2023
TriZetto	$95,000.00	Yes	CL	Robin Dow-Morales	Electronic claims processing	9/6/2022	9/5/2025
October							
HMA	$99,150.00	Yes	COMP	Jane MacAdam	One (1) Senior Consultant to assist withing KHS Complinace Dept	10/5/2022	5/30/2023
Catalyst Solutions	$90,720.00	Yes	IT	Richard Pruitt	D-SNP Advisor/ Program Manager	10/11/2022	12/31/2022
FluidEdge	$96,200.00	Yes	COMP	Jane MacAdam	Consulting services	10/4/2022	12/31/2022

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
Dell	$99,856.63	Yes	IT	Richard Pruitt	Additional (47) Dell Latitude 5530 Laptops	10/27/2022	10/26/2026
Optum	$61,177.00	Yes	IT	Richard Pruitt	Payment system	10/1/2022	4/30/2024
Secure-Centric	$191,889.68	Yes	IT	Richard Pruitt	Rubrik brick	10/20/2022	10/19/2023

2022 TECHNOLOGY CONSULTING RESOURCES																		
ITEM	PROJECT	CAP/EXP	BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	YTD	TOTAL	REMAINING BALANCE
#	Project Name																	
1	*Community Based Organization Referral System*	*CAP*	$370,080	$15,440	$30,360	$20,160	$20,160	$0	$0	$0	$0	$0					$86,120	$283,960
2	*Medical Management/Fraud, Waste, and Abuse Programs*	*CAP*	$500,000	$21,120	$35,798	$25,066	$17,472	$0	$0	$0	$0	$0					$99,456	$400,544
3	*Claims Workflow Conversion (QNXT)*	*CAP*	$472,800		$8,826	$51,501	$57,335	$40,726	$37,318	$45,317	$38,701	$18,094					$297,818	$174,982
4	*Data Linage System*	*CAP*	$184,800	$17,472	$0	$19,320	$0	$0	$37,789	$0	$0	$0					$74,581	$110,219
5	*Analytic Software (Power BI) Migration*	*CAP*	$124,800						$36,691	$17,472	$0	$0					$54,163	$70,637
6	*Communication Software Replacement*	*CAP*	$121,800					$17,600	$0	$23,920	$0	$0					$41,520	$80,280
8	*Staff Augmentation*	*EXP*	$7,393,315	$410,586	$359,294	$356,945	$344,059	$373,337	$342,030	$312,222	$392,822	$442,916					$3,334,211	$4,059,104
	Totals:	**Totals**	**$9,167,595**	**$464,618**	**$434,278**	**$472,992**	**$439,026**	**$431,663**	**$453,828**	**$398,931**	**$431,523**	**$461,010**	**$0**	**$0**	**$0**	**$3,987,869**	**$5,179,726**	

Updated 11/7/22

KERN HEALTH SYSTEMS

TO: **KHS Board of Directors**

FROM: **Alan Avery, COO**

DATE: **December 15, 2022**

RE: **3rd Quarter 2022 Operations Report**

The Kern Health Systems Operational Departments continued to meet and, in many cases, exceed all regulatory and health plan performance goals during the 3rd Quarter of 2022. I think it is safe to say from an operational performance perspective, the lingering effects of the COVID-19 pandemic are behind us. The workforce is settling into the new work model, with a group of permanent workers returning to the building, a group of permanent workers performing admirably remotely, and a third group of hybrid workers alternating weeks in the building. We are continuing to study the operational performance of the hybrid workforce, with an expected completion of the study in the 2nd Quarter of 2023.

Claims

Incoming provider claim receipts for the 3rd Quarter of 2022 continued to follow the trend of the previous two quarters by increasing over 100,000 claims from the 3rd Quarter of 2021. This increase is attributed to significant new member growth, lack of member redeterminations, and members once again seeking healthcare services post COVID-19 pandemic. Even though claim receipts continue to increase, we are not concerned with this increased volume, as 99% of claims continue to be submitted electronically, with only 1% of claims received on paper. These paper claims are forwarded to a local partner (Stria) who scans and converts them into an electronic file format, allowing them to load electronically into the KHS claims workflow. Once loaded into the claims workflow, the QNXT core system processes them automatically. We identified a slight decrease in auto adjudication – claims received and processed without any manual intervention. Auto adjudication fell slightly due to delays in configuration associated with the Department of Health Care Services (DHCS) fiscal year updates, and a few provider agreements. Those updates have been made and auto adjudication in October is back on track.

The Claims Department has implemented the Claims Provider Call Center where providers can contact Claims staff with questions and concerns. Previously, providers would call the Member Services Department, leave a message, and Claims staff would return the call. Provider calls are now routed directly to Claims Department staff. The staff managing these calls are seasoned Claims Processors III who can resolve most calls immediately or with minimal delay. During the 3rd Quarter of 2022 the Claims Provider Call Center received 7,705 calls.

Member Services

Member and Provider call volume into the Member Services Department remained consistent with the prior quarter, at 66,000 calls. The top five reasons members call Member Services remained in line with prior quarters: (1) New Member questions, (2) Changing PCP, (3) Making demographic changes, (4) ID Card replacement and (5) Checking referral status. Outbound phone activity experienced a 10% increase, primarily attributed to new member growth and gaps-in-care wellness calls including asthma, cancer screenings, initial health assessments, pre-natal, and well-baby calls. With the opening of the building in July, Member Services Representatives interacted face-to-face with 204 members in the office during the 3rd Quarter of 2022. We continue to successfully manage phone activity by encouraging members to obtain their own personal account on the KHS Member Portal, powered by the Zipari/HealthX platform. Currently 54,361 members have online accounts, allowing them to perform all the top five reasons they would normally call the Member Services Department.

Provider Network Management

On a quarterly basis, the Provider Network Management Department monitors network growth, capacity, and accessibility.

In the 3rd Quarter of 2022 the Plan's network of Primary Care Providers (PCP) experienced a slight decrease of 7 providers, while the network of Core Specialty providers increased by 47. Our complete contracted provider network was 2,527 providers as of the 3rd Quarter of 2022.

The Provider Network Management Department monitors network capacity/adequacy via a Full-Time Equivalency (FTE) provider to member ratio, based on regulatory requirements. For PCPs, the regulatory standard is one FTE PCP for every 2,000 members; as of the 3rd Quarter of 2022, the Plan maintains a network of one FTE PCP for every 1,759 members, meeting the requirement. The Plan is also required to maintain a network of one FTE physician for every 1,200 members; as of the 2nd Quarter of 2022, the Plan maintains a network of one FTE Physician for every 507 members, meeting the requirement. Even as our membership continues to grow, the Plan's network continues to meet all regulatory capacity/adequacy requirements. The Plan's Provider Network Management Department maintains ongoing recruitment and contracting efforts to promote network growth and ensure access to care for Plan members. On a quarterly basis, the Provider Network Management Department conducts an appointment availability survey. Per Plan policy and regulatory requirements, PCPs are required to offer a non-urgent appointment within 10 days of request; the results of the survey found an average wait of 4.3 days for this appointment type, meeting the requirement. Specialist providers are required to offer a non-urgent appointment within 15 days of request; the results of the survey found an average wait of 12.2 days for this appointment type, meeting the requirement.

Human Resources

During the 3rd Quarter of 2022, the Human Resources Department participated in multiple recruiting activities, including the San Joaquin Valley College (SJVC) career fair, the Bakersfield College Career Expo, and the Kern County Job Fest. Human Resources is also building partnerships with the Bakersfield Adult School, and working with Bakersfield College and California State University Bakersfield (CSUB) to develop collaborative intern programs. During the 3rd Quarter of 2022 the Human Resources team held the annual Employee Benefits Fair and subsequent Open Enrollment. Employee turnover is 8.97% year to date.

Grievance Report

The volume of formal grievances during the 3rd Quarter of 2022 increased by 216 grievances, for a total of 1,181 formal grievances. In addition to the continued increase of discrimination grievances, a new grievance type required by the DHCS, there was significant volume shifts in Potential Inappropriate Care and Medical Necessity grievances.

The DHCS requires health plans to forward copies of all member grievances within 10 days to the DHS Office of Civil Rights when members allege discrimination based on any characteristic protected by federal or state nondiscrimination laws. Characteristics protected by federal or state nondiscrimination laws includes sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental ability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, or health status. The Plan received 73 grievances classified as discrimination during the 3rd Quarter of 2022 and reported these timely to DHS Office of Civil Rights.

Medical Necessity Grievances/Appeals had a slight increase over the 2nd Quarter of 2022, primarily attributed to the overall increase in provider referrals during the quarter.

The significant increase in Potential Inappropriate Care (PIC) grievances can be directly attributed to the recommendations made by the DHCS auditors during their recent audit. Their recommendation was related to our classification process of PIC grievances which require clinical review oversight. All grievances are now being reviewed by the Quality Improvement nurses to ensure we avoid future regulatory recommendations.

Quality-of-Service grievances saw a sizeable decrease in volume during the 3rd Quarter of 2022. This category includes issues associated with provider professionalism, courtesy, and attitude of the office staff.

Exempt Grievances increased by 11% during the quarter. Exempt grievances are primarily simple service-related complaints, usually when the member does not want to file a formal complaint. They can be easily resolved the same day without significant research or follow up; these include such things as PCP changes or complaints about the physical nature of the office or staff.

Given the continued growth of member grievances, I reached out to my peer Chief Operating Officers at the other Local Health Plans of California and all confirmed they have experienced significant growth in their grievance submissions as well.

Part two of the Grievance Report required by the regulators is the disposition of the formal grievances. All the formal grievances are now being sent to the Quality Improvement Department for review of Potential Inappropriate Care issues. Following their review of the 1,181 grievances received, 492 of the decisions by the plan were upheld, 120 required further review, 413 were overturned and ruled in favor of the member, and 156 cases are still under review. The Quality Improvement Department has not identified any trends that need to be addressed. The primary reason for overturning the original decision occurs when we receive additional supporting documentation from the member or the provider.

Lastly, to fully understand the dynamics and relativity of the grievance volume, the Plan calculates the number of grievances received in relation to the number of medical visits and Plan enrollment. During the 3rd Quarter of 2022, there was over 980,000 medical visits provided to over 340,000 members, many of whom are new to managed care. KHS received 0.83 grievances per 1,000 members, below the average of the other Local Health Plan which average between 1.00 – 3.99 per month.

Transportation Update

Transportation activity during the 3rd Quarter of 2022 continued to grow with overall ridership increasing by over 15,000 rides during the quarter. The ride share programs (GET OnDemand and Uber) continue to reflect robust activity with an increase of 29% over the 2nd Quarter of 2022. All other transportation options had minor changes. Overall, the use of transportation services continues to inch closer to the pre-COVID activity but is still 20% below the average use.

KERN HEALTH SYSTEMS

3rd Quarter 2022 Operational Report

Alan Avery
Chief Operating Officer

3rd Quarter 2022 Claims Department Indicators

Activity	Goal	3rd Quarter 2022	Status	2nd Quarter 2022	1st Quarter 2022	4th Quarter 2021	3rd Quarter 2021
Claims Received		**982,337**		954,234	913,452	853,656	881,263
Electronic	95%	**99%**		98%	98%	98%	98%
Paper	5%	**1%**		2%	2%	2%	2%
Claims Processed within 30 days	90%	**99%**		99%	99%	99%	99%
Claims Processed within 45 days	95%	**99%**		99%	99%	99%	99%
Claims Processed within 90 days	99%	**100%**		100%	99%	99%	100%
Claims Inventory: Under 30 days	96%	**99%**		99%	99%	99%	99%
31-45 days	<3%	**<1%**		1%	<1%	<1%	1%
Over 45 days	<1%	**<1%**		<1%	<1%	1%	1%
Auto Adjudication	85%	**85%**		87%	88%	87%	87%
Audited Claims with Errors	<3%	**2%**		2%	1%	2%	1%
Claims Disputes	<5%	**1%**		1%	1%	1%	1%

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3rd Quarter 2022 Member Service Indicators

Activity	Goal	3rd Quarter 2022	Status	2nd Quarter 2022	1st Quarter 2022	4th Quarter 2021	3rd Quarter 2021
Incoming Calls		**66,020**		66,410	70,459	63,724	69,132
Abandonment Rate	<5%	**1.00%**		1.00%	3.39%	1.14%	3%
Avg. Answer Speed	<2:00	**:09**		:05	:23	:13	:40
Average Talk Time	<8:00	**7:34**		7:22	7:10	8:00	8:19
Top Reasons for Member Calls	Trend	**1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals**		1. New Member 2. PCP Change 3. Demo 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demo 4. Referrals 5. ID Card	1. New Member 2. PCP Change 3. Referrals 4. Demo 5. ID Card	1. New Member 2. Referrals 3. Demo 4. ID Card 5. PCP Change
Outbound Calls	Trend	**85,326**		77,818	89,784	79,894	69,826
# of Walk Ins	Trend	**204**		0	0	0	0
Member Portal Accounts-Q/Total	4%	**4058 54,361 (15.93%)**		3163 50,303 (15.09%)	3640 47,937 (14.70%)	2605 44,301 (14.23%)	2842 41,697 (14.18%)

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3rd Quarter Provider Network Indicators

Activity	Goal	3rd Quarter 2022	Status	2nd Quarter 2022	1st Quarter 2022	4th Quarter 2021	3rd Quarter 2021
Provider Counts							
# of PCP		434		441	441	425	423
% Growth		(1.81%)		0%	3.76%	2.84%	[3.64%]
# of Specialist		495		448	442	444	422
% Growth		10.49%		1.34%	[.45%]	5.21%	[.94%]
FTE PCP Ratio	1:2000	1:1759		1:1938	1:1893	1:1819	1:1837
FTE Physician Ratio	1:1200	1:507		1:704	1:685	1:671	1:680
PCP	< 10 days	4.3 days		6.5 days	4.1 days	2.5 days	4.2 days
Specialty	< 15 days	12.2 days		9.5 days	11.4 days	6.3 days	6 days

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3rd Quarter Human Resources Indicators

Activity	Approved	3rd Quarter 2022	Status	2nd Quarter 2022	1st Quarter 2022	4th Quarter 2021	3rd Quarter 2021
Staffing Count	521	**480**		478	459	431	425
Employee Turnover	12%	**8.97%**		8.8%	6.32%	10.83%	10.38%
Turnover Reasons	Voluntary Involuntary Retired Deceased	**61%** **16%** **23%** **0%**		65% 10% 25% 0%	85.7% 0% 14.3% 0%	60.87% 23.91% 8.70% 6.52%	66.67 23.24 3.03 6.06

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3rd Quarter 2022 Grievance Report

Category	3rd Quarter 2022	Status	Issue	2nd Quarter 2022	1st Quarter 2022	4th Quarter 2021	3rd Quarter 2021
Access to Care	132		Appointment Availability	117	169	131	148
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	346		Questioning denial of service	259	138	266	329
Other Issues	30		Miscellaneous	20	41	36	18
Potential Inappropriate Care	514		Questioning services provided. All cases forwarded to Quality Dept.	415	479	256	164
Quality of Service	86		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	120	125	55	53
Discrimination (New Category)	73		Alleging discrimination based on the protected characteristics	34	15		
Total Formal Grievances	1181			965	967	744	712
Exempt	2328		Exempt Grievances	2087	1404	1431	1520
Total Grievances (Formal & Exempt)	3509			3052	2371	2175	2232

KHS Grievances per 1,000 members - .83/month. LHPC Average 1.0 – 3.99/month

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Additional Insights-Formal Grievance Detail

Issue	3rd Quarter 2022	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	55	31	0	11	13
Coverage Dispute	0	0	0	0	0
Specialist Access	77	26	0	19	32
Medical Necessity	346	140	0	140	66
Other Issues	30	22	0	3	5
Potential Inappropriate Care	514	164	120	230	0
Quality of Service	86	55	0	10	21
Discrimination	73	54	0	0	19
Total	**1181**	**492**	**120**	**413**	**156**

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3rd Quarter 2022 Transportation Update

Operational Statistics	3rd Quarter 2022	2nd Quarter 2022	1st Quarter 2022	4th Quarter 2021	3rd Quarter 2021
ALC Calls	**93,642**	80,404	63,118	63,425	67,680
One Way Rides Scheduled	**101,117**	86,068	70,936	78,330	75,066
NMT	**63,341**	48,968	38,685	39,898	37,936
Bus Passes Distributed	1096	878	749	1047	1065
GET Van Share	5099	3720	5258	5248	8253
Ride Share Rides	57,146	44,370	32,678	32,315	28,618
No Shows	5883	4958	3866	4320	5103
NEMT	**37,776**	37,100	32,251	38,162	37,129
Van Rides Scheduled	37,077	36,625	31,815	37,632	36,546
Gurney Rides Scheduled	699	475	436	530	583
Member Reimbursement	**2365**	2975	1361	1785	2496
ALC Admin Expense	**$512,637.00**	$548,696.30	$387,173.70	$423,776.90	$415,333.25

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To: KHS Board of Directors

From: Martha Tasinga M.D, MPH, MBA, Chief Medical Officer

Date: December 15, 2022

Re: CMO BOARD REPORT

Medical Cost and Utilization Trend Analyses: (Attachment A)

Physician Services: *(*PCPs, Specialists, Hospitalist, Other Professional and Urgent Care):

The trend for the professional visits per member per month for all AID codes is stable at or below forecasted levels. The cost of professional services for the SPDs continue to be above projections but has leveled off since August 2022. The professional services utilization for the other Aid codes has been stable. As we look at the diagnosis driving utilization of professional services, we see that 44.14/1000 are for routine visits without complaint which is what we want to see. The number one diagnosis for outpatient utilization of professional services is hypertension at 14.57/1000. Chronic kidney disease and diabetes continue to be the other 2 diagnosis that are driving outpatient utilization of professional services. With the implementation of population health programs for the common chronic conditions we are hoping to see this trend continuing. We prefer that the members use the outpatient services to stabilize their chronic conditions instead of waiting until things are so bad that they need ER or inpatient care.

Inpatient Services

The overall PMPM, cost per bed-day, bed-days incurred and average length of stay in the acute hospital for all aide codes had been at or below budget for aid codes. The number of admits for the SPDs is higher than projected but the fact that the other metrics for measuring acute care utilization are favorable, our total PMPM for all AID codes is at or below budget. The most frequent diagnosis for admission for all AID codes combine are related to pregnancy and childbirth. The most frequent admission diagnosis for the SPDs is sepsis.

Most admissions continue to be at KM followed closely by BMH **(Attachment B).**

Hospital Outpatient

The utilization of hospital outpatient is at or below budget for all Aid Codes. The observation stays in the acute hospitals are considered and counted as outpatient hospital services for reporting. In 2022, we implemented programs to support our members in the community, so they do not need to go to the acute hospital for observation. We are hopeful that these programs and new ones continue to have a positive impact on the utilizations of observation level of care.

Emergency Room (ER)

The PMPM cost and number of ER visits have been at or below budget for all Aid code since the beginning of the Pandemic. The most frequent diagnosis for the ER for all AID codes in October 2022 is upper respiratory infections including Influenza,

Most of the ER visits continue to be occurring at BMH **(Attachment D).**

Obstetric Metrics: (Attachment C)

Most of our deliveries are occurring at BMH. The report shows a drop in deliveries. This is due to delay in claims. Usually, it takes up do 45 days to get a claim after a delivery. Most of our deliveries continue to be at BMH. When we look at our concurrent inpatient data, we see that the number of deliveries is stable at around 400 deliveries a month. The C/Section rate of 20% continue to be below the State goal of **22.8%**, and below a public health target of 23.9% set by the Centers for Disease Control and Prevention in its Healthy People 2020 goals.

Managed Care Accountability Set (MCAS)

This is a set of performances measures that DHCS selects for annual reporting by Medi- Cal managed care health plans (MCPs). The new Managed Care Accountability Set (MCAS) prescribes a set of 39 quality measures, with 16 measures subject to a 50% Minimum Performance Level (MPL) benchmark. Each measurement count requires a patient encounter specific to service(s), that when performed, will indicate the measurement was met for that patient. All KHS members identified as having the medical condition associated with the measurement represent the denominator. When members receive service(s), it is recorded as "compliant" becoming part of the numerator. The level of achievement is shown as the percentage (%) of members who have received required (service(s). The minimum target performance percentage (MPL) is established by DHCS each year and they might also add or remove required measures every year. As a result of these changes, Medi-Cal health plans and providers are under increased pressure to coordinate their quality programming and metrics.

I have not included any data in this month's report because 12/31/22 is the anchor date for measuring year 2022. At the next Board meeting we will bring a detail report of our MCAS performance and strategy for 2023 measuring year.

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Governed Reporting System

Kern Health Systems

KHS Medical Management Performance Dashboard (Critical Performance Measurements)

KERN HEALTH SYSTEMS

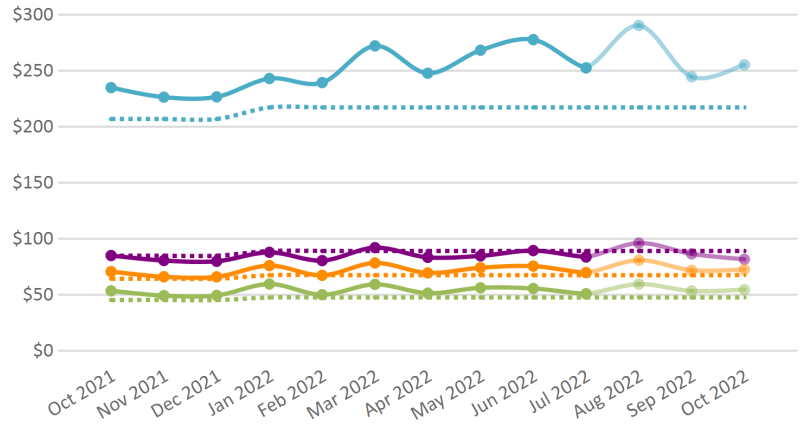
Governed Reporting System

Physician Services

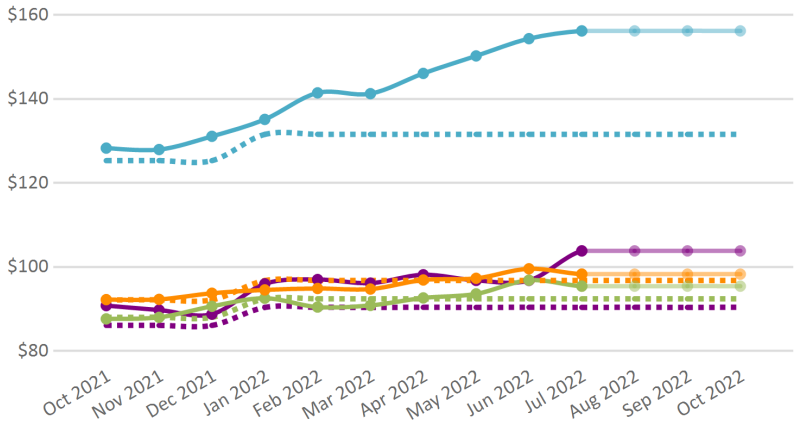
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

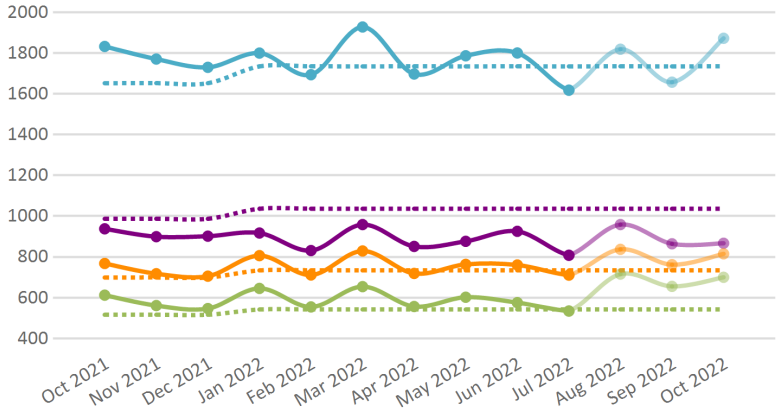
Professional Services Incurred by Aid Group PMPM



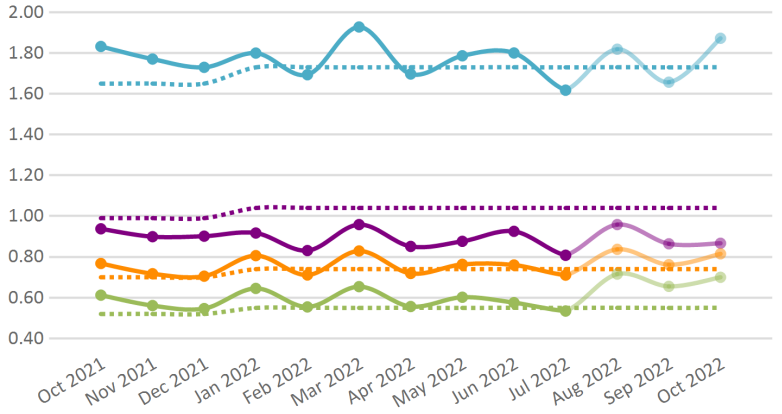
Cost per Professional Service Visit by Aid Group



Professional Service Visits per 1,000 per Month by Aid Group



Professional Service Visits per Member per Month by Aid Group



KERN HEALTH SYSTEMS

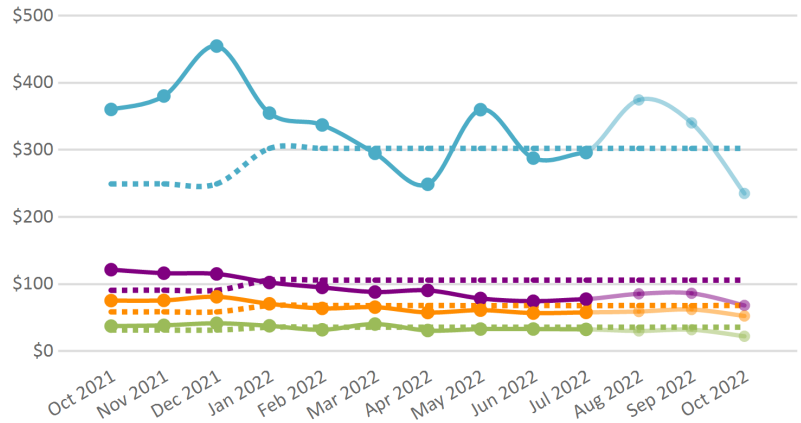
Governed Reporting System

Inpatient

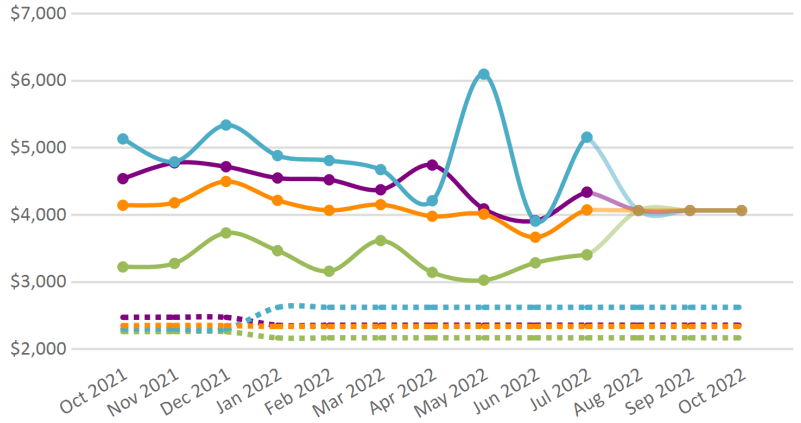
(Includes: Inpatient Hospital Claims)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

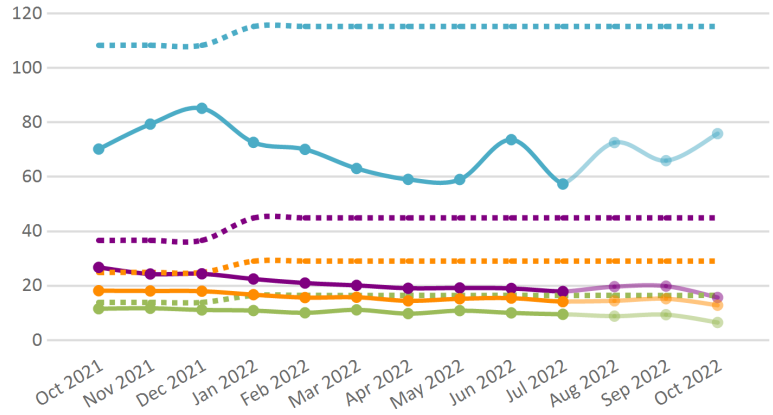
Inpatient Services Incurred by Aid Group PMPM



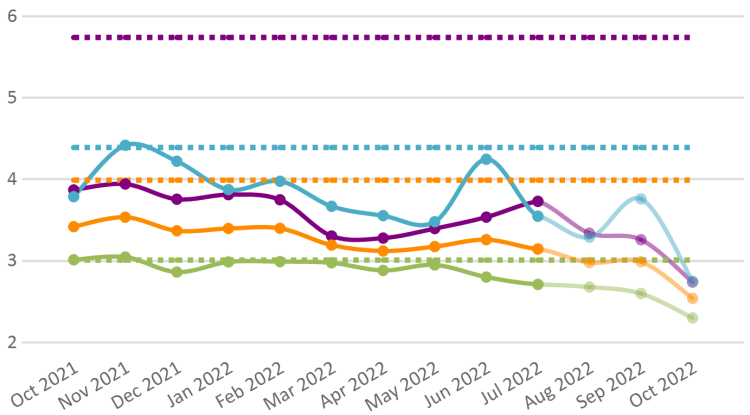
Cost Per Bed Day by Aid Group



Incurred Bed Days per 1,000 per Month by Aid Group



Average Length of Stay in Days by Aid Group

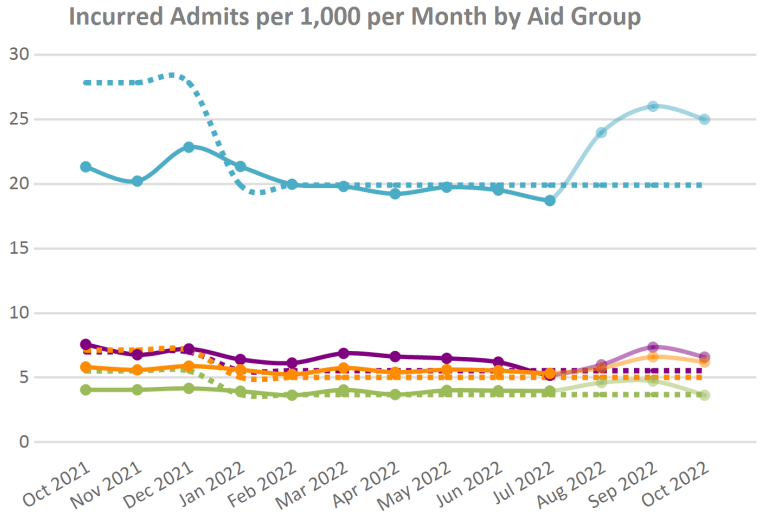


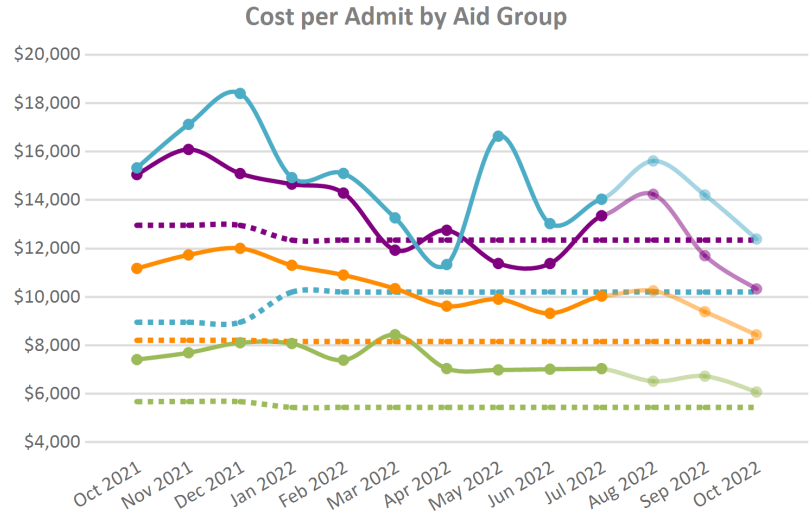
KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient

(Includes: Inpatient Hospital Claims)





KERN HEALTH SYSTEMS

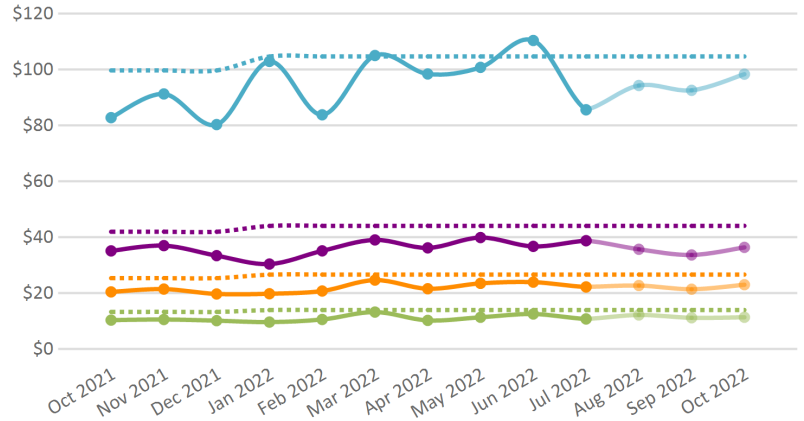
Governed Reporting System

Outpatient Hospital

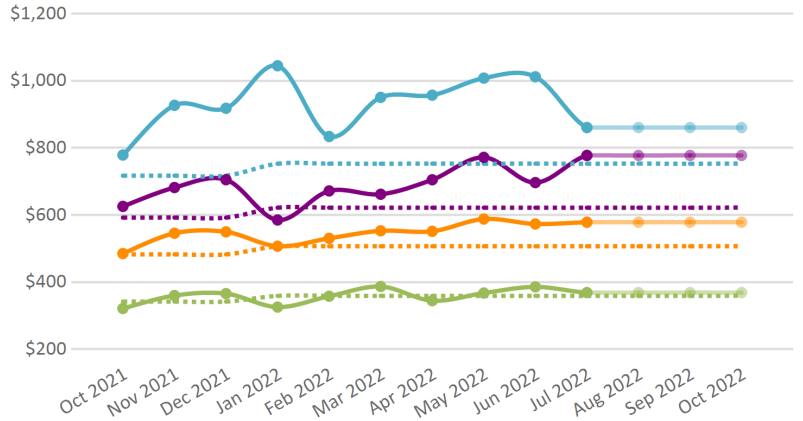
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

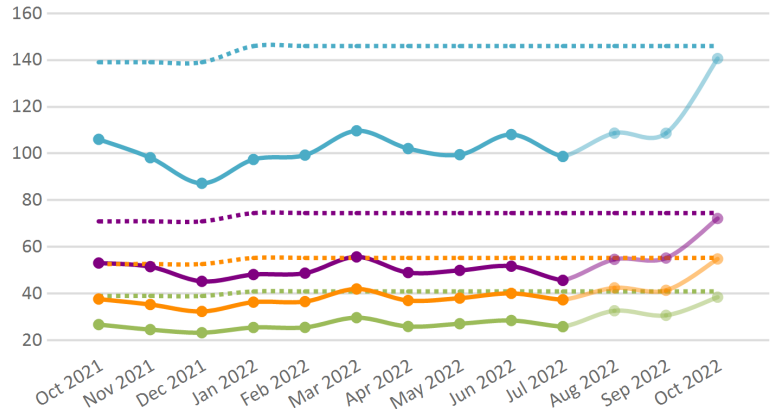
Outpatient Services Incurred by Aid Group PMPM



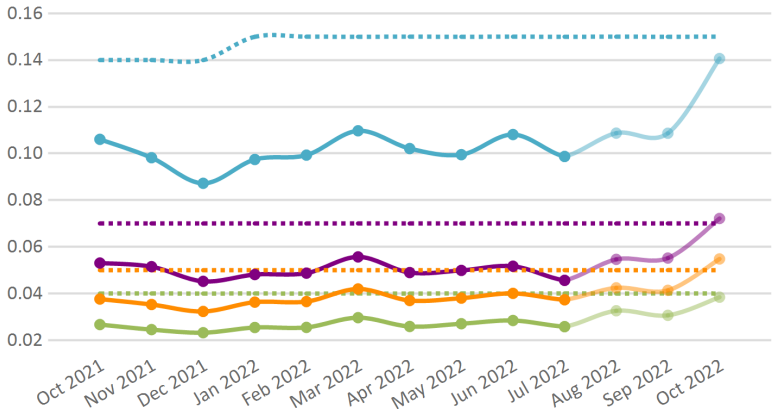
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



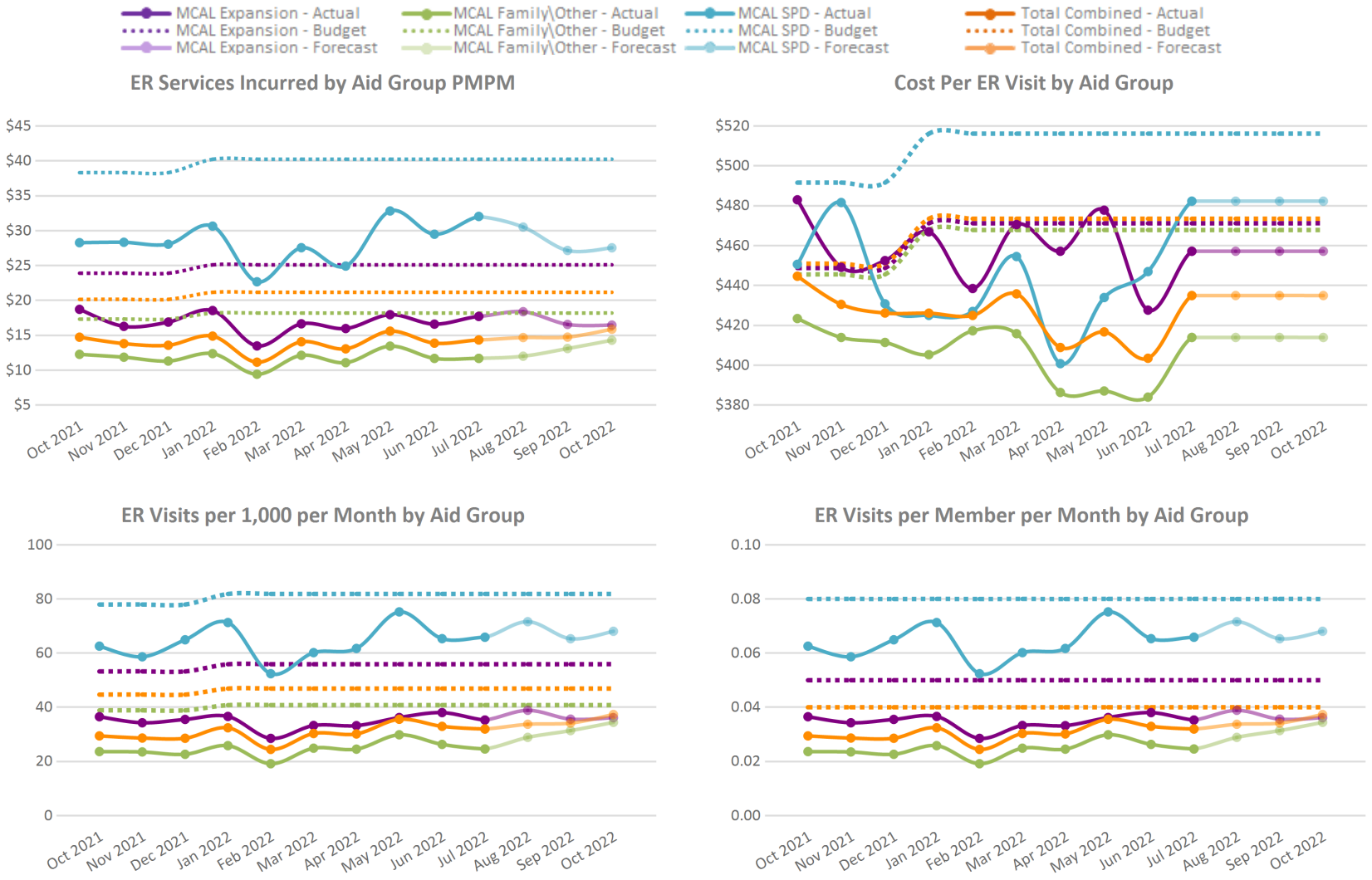
Outpatient Visits per Member per Month by Aid Group



KERN HEALTH SYSTEMS

Governed Reporting System

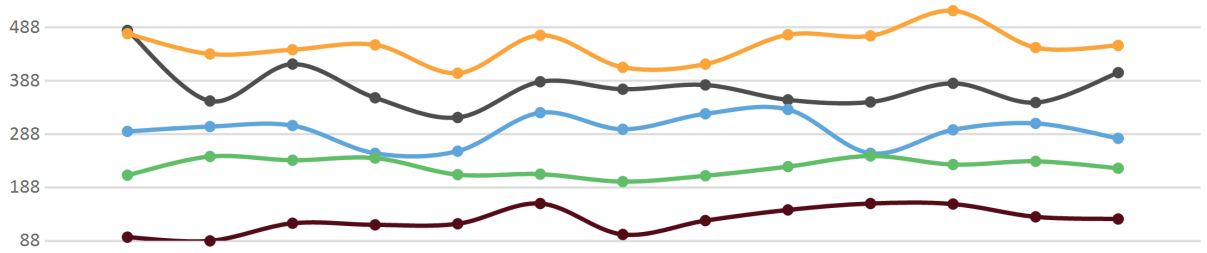
Emergency Room



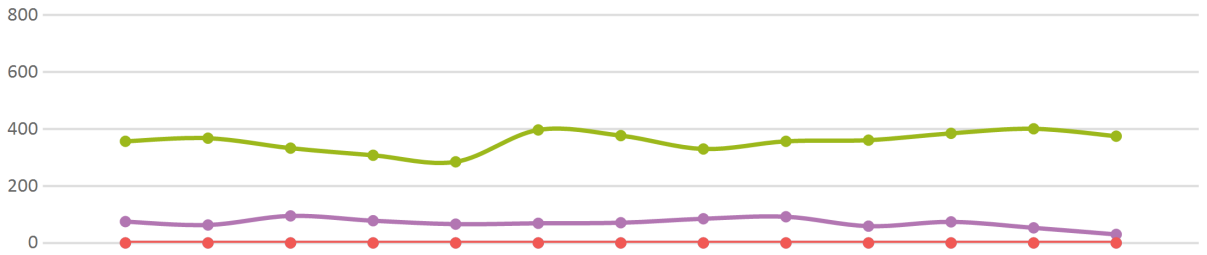
KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient Admits by Hospital

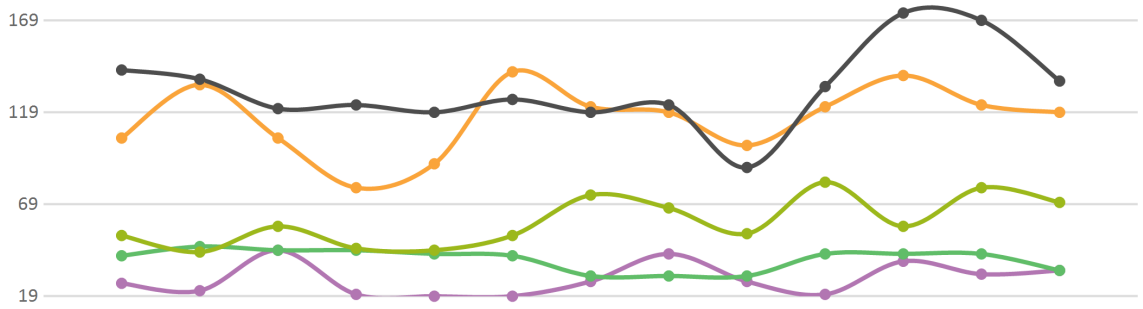


	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
KERN MEDICAL	476	438	446	455	402	473	413	419	474	472	519	450	454
BAKERSFIELD MEMORIAL	482	350	419	356	319	386	372	380	352	348	383	347	403
ADVENTIST HEALTH	293	302	304	252	256	328	297	326	334	252	296	308	280
MERCY HOSPITAL	211	246	239	243	212	213	199	210	227	247	231	237	224
GOOD SAMARITAN HOSPITAL	95	88	121	118	120	158	100	126	146	158	157	133	129

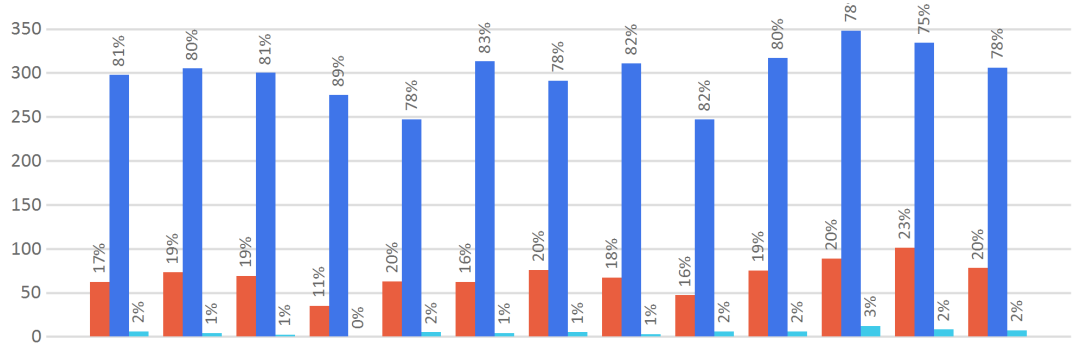


	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
DELANO REGIONAL HOSPITAL	75	63	95	78	66	69	71	85	92	59	74	53	30
OUT OF AREA	357	368	333	308	285	397	377	330	357	361	385	401	375
BAKERSFIELD HEART HOSP	34	49	39	33	38	37	22	37	42	34	44	31	34

Obstetrics Metrics



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
BAKERSFIELD MEMORIAL	142	137	121	123	119	126	119	123	89	133	173	169	136
KERN MEDICAL	105	134	105	78	91	141	122	119	101	122	139	123	119
OTHER	52	43	57	45	44	52	74	67	53	81	57	78	70
MERCY HOSPITAL	41	46	44	44	42	41	30	30	30	42	42	42	33
DELANO REGIONAL HOSPITAL	26	22	44	20	19	19	27	42	27	20	38	31	33

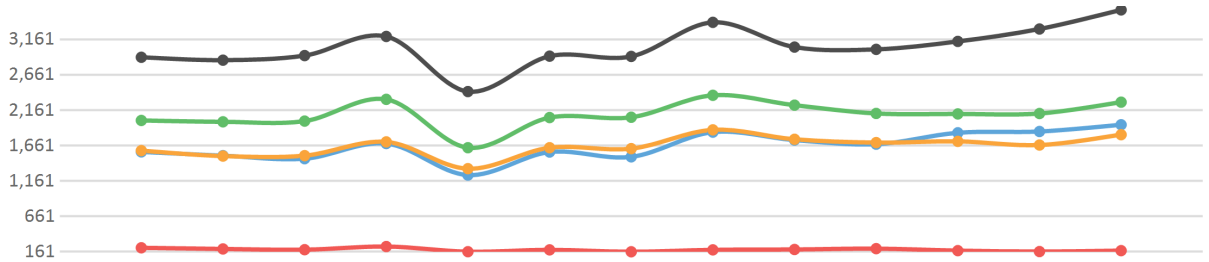


	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
VAGINAL DELIVERY	298	305	300	275	247	313	291	311	247	317	348	334	306
C-SECTION DELIVERY	62	73	69	35	63	62	76	67	47	75	89	101	78
PREVIOUS C-SECTION DELIVERY	6	4	2	0	5	4	5	3	6	6	12	8	7

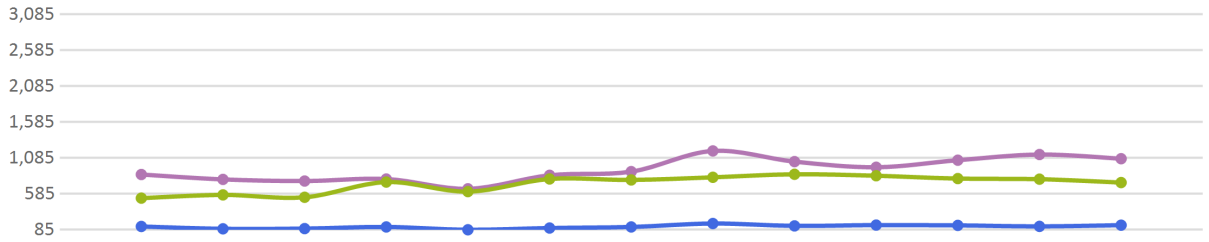
KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Visits by Hospital



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
BAKERSFIELD MEMORIAL	2,907	2,866	2,931	3,201	2,423	2,923	2,919	3,400	3,051	3,019	3,131	3,306	3,576
MERCY HOSPITAL	2,015	1,996	2,006	2,313	1,630	2,056	2,060	2,370	2,231	2,114	2,107	2,113	2,273
KERN MEDICAL	1,589	1,512	1,518	1,712	1,334	1,630	1,617	1,882	1,749	1,702	1,720	1,668	1,814
ADVENTIST HEALTH	1,571	1,518	1,475	1,689	1,244	1,569	1,501	1,850	1,738	1,680	1,841	1,859	1,954
BAKERSFIELD HEART HOSP	217	201	190	235	162	188	161	188	193	205	177	164	177



	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
DELANO REGIONAL HOSPITAL	854	786	763	791	655	843	894	1,182	1,033	955	1,053	1,132	1,074
OUT OF AREA	525	570	537	749	616	792	778	815	857	837	797	789	742
KERN VALLEY HEALTHCARE	131	98	101	124	85	109	124	172	139	150	146	132	149

KERN HEALTH SYSTEMS

CHIEF EXECUTIVE OFFICER'S REPORT

DECEMBER 15, 2022

BOARD OF DIRECTORS MEETING

COMPLINACE AND REGULATORY ACTIVITIES

The December 2022 Compliance and Regulatory Affairs Report highlights current KHS oversight activities with details included under ***Attachment A*** of this report.

KHS STRATEGIC PLAN UPDATE

On October 13, 2022, the Kern Health Systems Board of Directors engaged in a strategic planning session which identified the key priority areas for the organization. The strategic plan will provide a roadmap for 2023-2025. Included under ***Attachment B*** of this report is a high-level summary of the priority areas. At the February 2023 Board of Directors meeting, a final strategic plan that will include action items, deliverables, and timelines will be presented for final approval.

COVID-19 PUBLIC HEALTH EMERGENCY EXTENSION

KHS continues to monitor the federal Department of Health and Human Services (HHS) Public Health Emergency (PHE) declaration related to COVID-19. On October 15, 2022, HHS extended the PHE for an additional 90-days through mid-January. HHS has committed to giving a 60-day notice before ending the PHE to allow for unwinding of preparations. KHS continues to prepare for the ending of the administrative flexibilities permitted by the PHE such as supporting Medi-Cal redetermination process to be located at our facility and the expansion of telehealth services.

PROGRAM DEVELOPMENT ACTIVITIES

STATE PROGRAM DEVELOPMENT

CalAIM

The KHS team continues to implement CalAIM projects according to the 2022 Corporate Goals and Project Portfolio. Below is the latest information from the Department of Health Care Services (DHCS) related to those initiatives which will be newly effective on 1/1/23:

> ***Population Health Management (PHM)*** – DHCS shared a draft All-Plan Letter (APL) in early November for review and feedback. We are expecting to receive a new Policy Guide in mid-December to reflect updated transitional care requirements. DHCS is also

working to retire and/or modify existing APLs related to required member screenings to align with the broader PHM policies.

Long Term Care (LTC) – KHS received utilization and authorization data for the incoming LTC members. Staff are reviewing this information to assist in the transition and coordination of care for these members. The State sent 60-day notices to transitioning members in late October and 30-day notices were sent in late November.

Mandatory Managed Care Enrollment (MMCE) Phase 2 – DHCS is requiring additional populations be mandatorily enrolled into Managed Care Plans effective 1/1/23. There are over 29,000 members transitioning in Kern County, with KHS likely to receive the vast majority. Over 2/3^{rds} of these members are dually enrolled in both Medicare and Medi-Cal. The Plan is analyzing State-provided utilization and authorization data for the transitioning members. The State also sent 60-day notices to members in late October and 30-day notices were sent in late November.

Screening and Transition Tools – The State has developed standardized screening and transition tools to be used by KHS and County Behavioral Health. The goal of these tools is to direct members to the correct system of care based on their needs. KHS recently received a draft APL from DHCS outlining the requirements and usage of the tools.

Concurrently, staff are participating in policy development discussions for future CalAIM transitions in 2023 and beyond. This includes discussions with DHCS on future ECM Populations of Focus, additional LTC populations, NCQA accreditation requirements, and Medicare D-SNP preparations.

Doula Services
Doula Services are still scheduled to become effective on 1/1/23. The State is making progress in defining the benefit requirements. DHCS has stated they intend to share a draft APL with Plans in early December. This will provide critical guidance about the Doula benefit, provider requirements, payment and billing information, etc. KHS Staff are ready to proceed upon receipt of the final guidance.

Student Youth Behavioral Health Initiative (SBHIP) –

Background: The State Budget for 2021-2022 included $13.2 million over three years in incentive funding to build infrastructure, partnerships, and capacity for school behavioral health services in Kern County. In collaboration, KHS and HealthNet convened several stakeholders in Kern County including local education and behavioral health agencies, to collectively identify specific school districts, student populations, and interventions to build infrastructure and support behavioral services on or near campuses. KHS and HealthNet engaged a consultant to complete a county wide needs assessment to collect both qualitative and quantitative data to identify the existing gaps and opportunities within the county education system. Nine school districts in total agreed to participate and include Arvin Union, Bakersfield City, Edison Elementary, Kern High, Lost Hills Union Elementary, Kernville Union, McFarland Union, Pond

Union, and Kern County Superintendent of Schools Special Education and Alternative Education Program.

Update: Nine needs assessments, each detailing the school districts' identified gaps, are now complete and recommendations for aligning the corresponding targeted interventions under the SBHIP program have been selected. The interventions selected across all nine school districts include implementation of Behavioral Health and Wellness Programs, Substance Use Disorder Programs, Family and Parent Support Services, and building stronger partnerships between the schools, managed care plans and county behavioral health to increase access to Medi-Cal services. The consultant, along with KHS and Health Net leadership, have initiated the design and content of the project plan with specific milestones in preparation for submission to Department of Health Care Services (DHCS) before December 31, 2022. Upon DHCS's approval in early 2023, infrastructure builds can begin based on the selected targeted interventions, thereby initiating the receipt of the allocated incentive dollars over the next two years until the program sunsets in December 2024.

Incentive Payment Program (IPP):
Background: The CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of Enhanced Care Management (ECM) and Community Supports (CS) by incentivizing managed care plans (MCPs), in accordance with 42 CFR Section 438.6(b), to drive MCP delivery system investment in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports. In January, KHS submitted a gap assessment report to DHCS identifying the gaps in services for ECM and Community Supports in Kern County. Based on the gap assessment report, KHS has been approved for $14.2 million dollars in incentive funds to expansion our ECM and CS programs. We are also supporting some of the current ECM and CS programs with delivery system infrastructure upgrades. All projects have milestones that the provider must meet to earn the incentive funds. The IPP program time frame is January 1, 2022 to December 31, 2023.
Update: The Incentive Payment Program funds will be distributed to KHS in two payments. KHS received payment 1 in April 2022 in the amount of $7,136.106 and payment 2 is tentative scheduled for June 2023 for the remaining amount of $ 7,136,106. We have funded 8 new ECM programs and 5 new CS programs that will be implemented starting as early as 4th quarter of 2022.

Housing and Homelessness Incentive Program (HHIP) –
Background: As a part of the State's overarching home and community-based services (HCBS) spending plan, the California Department of Health Care Services (DHCS) launched the Housing and Homelessness Incentive Program (HHIP) from January 1, 2022, to December 31, 2023. HHIP aims to prevent and reduce homelessness and housing instability & insecurity by

addressing social determinants of health while improving health outcomes and accessibility to whole-person care for those who are a part of the Medi-Cal population and simultaneously experiencing or at risk of being homeless. HHIP is a voluntary incentive program that will allow Medi-Cal Managed Care Plans (MCPs) to earn incentive funds by collaborating with providers and community-based organizations to build capacity & infrastructure to streamline a continuity of housing and homelessness services. All projects have milestones approved by DHCS, and the provider must meet to earn the incentive funds.
Update: KHS is partnering with agencies to advance health equity and accessibility to one of our most vulnerable populations and will pass through over $19 million towards housing and homelessness initiatives in all of Kern County. KHS released a Request for Applications and received over twenty project proposals related to the areas identified in the Investment Plan. A review of these project proposals were assessed for impact, alignment of measures & milestones, and sustainability to address the housing and homeless crisis in Kern County. Kern Health Systems continues to work with the contracted entities comprised of 13 network providers and community-based organizations to support 19 housing and homelessness service delivery projects. These projects range from Street Medicine, Mental & Behavioral Health Support Services, Prevention & Diversion, Non-Congregate Shelters & Expanding Emergency Shelters for Youth, Adults, and Families, and Permanent Housing for Youth, Adults, and Families. These projects demonstrated a commitment to address inequities and disparities in homeless populations and achieve equitable provision of wrap-around services for those who are disproportionately impacted by homelessness, are at risk of homelessness, experiencing housing instability, and/or recidivated to homelessness – particularly for marginalized communities, at-risk youth, older adults, veterans and their families who do not qualify for veteran's health care services, people with disabilities, and individuals who identify as LGBTQ+. The HHIP project agreements will be fully executed in Q4 of 2022 with targeted services identified in the Investment Plan implemented in 2023.

LEGISLATIVE SUMMARY UPDATE
With the conclusion of the State Legislative and Budget cycle, staff has prepared a separate presentation providing an overview of the items impactful to KHS.

KHS DECEMBER 2022 ENROLLMENT:

Medi-Cal Enrollment

As of December 1, 2022, Medi-Cal enrollment is 221,115, which represents an increase of 0.3% from November enrollment.

Seniors and Persons with Disabilities (SPDs)

As of December 1, 2022, SPD enrollment is 16,989, which represents an increase of 0.3% from November enrollment.

Expanded Eligible Enrollment

As of December 1, 2022, Expansion enrollment is 95,462, which represents an increase of 1.4% from November enrollment.

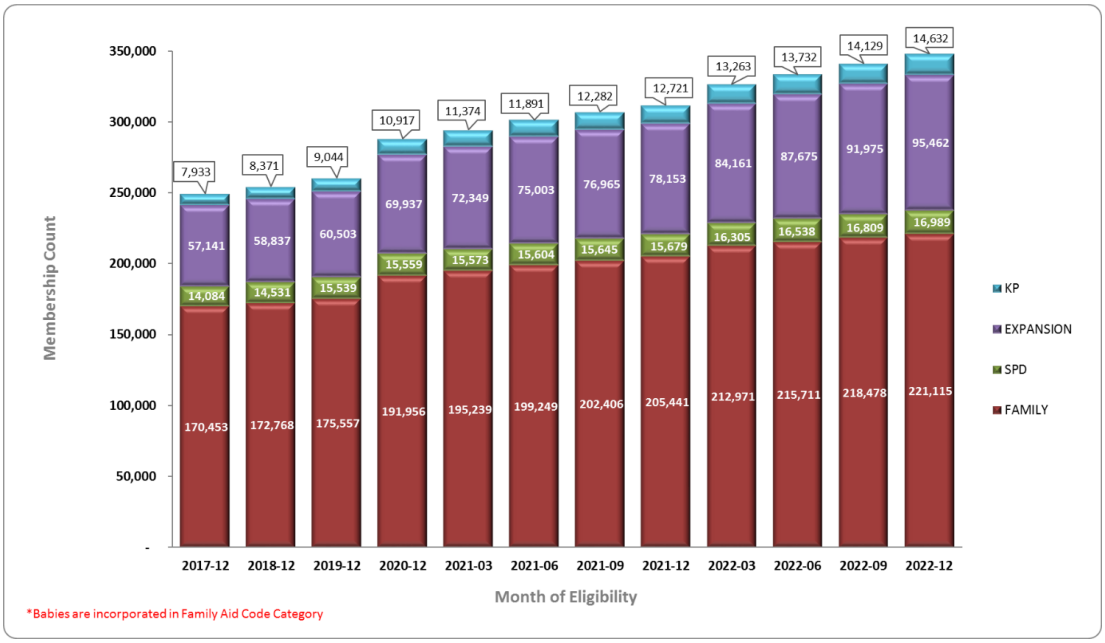
Kaiser Permanente (KP)

As of December 1, 2022, Kaiser enrollment is 14,632, which represents an increase of 1.4% from November enrollment.

Total KHS Medi-Cal Managed Care Enrollment

As of December 1, 2022, total Medi-Cal enrollment is 348,198, which represents an increase of 0.6% from November enrollment.

Membership as of Month of Eligibility	FAMILY	SPD	EXPANSION	KP	BABIES	Member Total
2017-12	170,006	14,084	57,141	7,933	447	249,611
2018-12	172,290	14,531	58,837	8,371	478	254,507
2019-12	175,128	15,539	60,503	9,044	429	260,643
2020-12	191,549	15,559	69,937	10,917	407	288,369
2021-03	194,853	15,573	72,349	11,374	386	294,535
2021-06	198,853	15,604	75,003	11,891	396	301,747
2021-09	201,890	15,645	76,965	12,282	516	307,298
2021-12	204,992	15,679	78,153	12,721	449	311,994
2022-03	212,546	16,305	84,161	13,263	425	326,700
2022-06	215,246	16,538	87,675	13,732	465	333,656
2022-09	217,951	16,809	91,975	14,129	527	341,391
2022-12	220,697	16,989	95,462	14,632	418	348,198



DHS Medi-Cal Renewal Partnership:

Background: The U.S. Department of Health & Human Services' public health emergency order remains in place. As a result, the Department of Health Care Services continues to freeze Medi-Cal redeterminations. Thus, the Kern County Department of Human Services' suspension of their "automated discontinuance process" for Medi-Cal Redeterminations continues. The automated discontinuance process was in place locally prior to the public health emergency order when Medi-Cal beneficiaries did not complete the Annual Eligibility Redetermination process. However, Kern DHS continues working new Medi-Cal applications, reenrollments, successful renewals, additions, etc. (anything with a positive outcome).

In preparation for the PHE to end, the State, County, KHS and other stakeholders are working together to ensure continuity of coverage once the complete Medi-Cal redetermination process resumes. Since more than half of Medi-Cal enrollees complete their annual renewal through the manual mailing process, it is important Kern DHS has updated contact information of Medi-Cal enrollees. As such, Kern DHS is educating local residents about the importance of sharing updated contact information such as mailing addresses, phone numbers, email addresses, etc. KHS is supporting their efforts by educating our health plan members about this through printed materials (flyers and posters), website, social media and robocalls and intend to share demographic updates via a data exchange with Kern DHS.

Update:

Included in this board meeting agenda is the final agreement between KHS and Kern County DHS for Human Services Technicians that will be located at the KHS office. DHS staff will place these individuals on-site as early as February 2023. This will support Kern DHS in hiring staff to process updates from KHS and complete the renewal process. Kern DHS will notify KHS which members must complete the manual mailing renewal process and provide timelines and due dates. KHS will communicate the importance of this process to members and share the information with staff, contracted providers, and local enrollment entities. KHS will continue to work with the local Medi-Cal enrollment entities to support the correct completion of the renewal applications which Kern DHS will review and use to determine eligibility. We have begun the data sharing with Kern DHS as well. KHS Leadership is meeting with DHS Leadership regularly. KHS also kicked off our member texting campaign to support Kern DHS efforts.

KHS MARTKETING AND PUBLIC REALTIONS

KHS Media Clip
Click on the title or "Read More" to view the complete article.
Sons of the American Revolution presents flag certificate to Kern Family Health Care in honor of veterans
By 23ABC News

Sons of the American Revolution is a nonprofit organization dedicated to teaching youth about patriotism and American history that began in San Francisco in 1889.

Read More

Kern's sprawling land mass shows need for smaller-scale community health centers | News | bakersfield.com

By The Bakersfield Californian

Emily Duran, the CEO of Kern Family Health Care, noted the location opened Thursday has 86,000 residents within a 5-mile radius who qualify for care under KHS, the county's largest health plan geared toward low-income residents. Omni Family Health is KHS' largest provider, she noted during her remarks.

Read More

Community Events

KHS will share sponsorship in the following events in December and January:

- KHS donated $10,000 to the Kern Partnership for Children & Families Holiday Cottage (the nonprofit organization for the Kern County Department of Human Services). This charity event has been happening for 35 years to grant Christmas wishes for local foster children. Our donation will fill the wishes for 200 children.
- KHS donated $2,500 to "HolidayLights" benefiting the California Living Museum.
- KHS donated $2,500 to Cirugía Sin Fronteras Medical Nonprofit Foundation to sponsor their "5th Annual Sharing the Hope Virtual Community Wellness Health Fair".
- KHS donated $2,500 to the Bakersfield City School District Foundation to sponsor their "26th Annual Teddy Bear Picnic".
- KHS donated $2,500 to the United Farm Workers to sponsor their "60th Anniversary".
- KHS donated $2,500 to "Christmas with the Cranktones" benefiting the Kern County Cancer Foundation.
- KHS donated $1,000 to the United Way of Kern County to sponsor their "Circle of Friends Celebration".
- KHS donated $1,000 to Clinica Sierra Vista to sponsor the holiday luncheon for their Patient Access to Care Program employees.
- KHS donated $1,000 to Del Oro High School KHSD to sponsor their "Holiday Hygiene Kit Drive".
- KHS donated $3,500 to the Kern County Cancer Foundation to sponsor their "Pediatric Cancer Holiday Party".
- KHS donated $1,000 to the Bakersfield-Kern Regional Homeless Collaborative to sponsor the "2nd Annual Homeless Memorial Vigil".
- KHS donated $1,500 to Houchin Community Blood Bank for their January promotion "Resolve to Get Fit and Save Lives!" The goals are to encourage blood donations and promote exercise and good health.
- KHS donated $1,000 to the "33rd Annual 5K/10K FOG Run" benefiting the Probation Auxiliary County of Kern.
- KHS donated $1,500 to the "Thin Mint 5K and Trefoil Trot" benefiting the Girls Scouts of Central California South.
- KHS donated $850 to the "The Annual Rev. Dr. Martin Luther King, Jr. Community Awards Breakfast" benefiting the SCLC of Kern County Inc. & Dr. Martin Luther King Jr. Committee.
- KHS donated $500 to the "The Race Against Trafficking 5K Run/Walk" benefiting the Kern County Family Justice Center Foundation.

Employee Video Newsletter

KHS' Video Employee Newsletter can be seen by clicking the following link:
https://vimeo.com/779339349

Member Newsletter

KFHC's Member Newsletter can be viewed by clicking the following link:
Kern Family Health Care | Family Health | Winter 2022 (flippublication.com)

KERN HEALTH SYSTEMS

Compliance and Regulatory Affairs

Board of Directors Meeting

Jane MacAdam
Director of Compliance & Regulatory Affairs
December 15, 2022
Attachment A

STATE REGULATORY AFFAIRS

All Plan Letters and Regulatory Guidance released since the October 2022 Kern Health Systems Board of Directors' meeting:

The Department of Health Care Services (DHCS) released three revised All Plan Letters (APL) and six new APLs during this time period.

- APL 20-022 COVID-19 Vaccine Administration (Issued 12/28/2020 and Revised 10/06/2022)

  This APL provides Plans with information and guidance regarding COVID-19 vaccine coverage and administration in the Medi-Cal program.

- APL21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Issued 10/18/2021 and Attachments Revised 10/14/2022)

  This APL's attachments were updated and includes information on the Mandatory Managed Care Enrollment (MMCE) Requirement and Major Organ Transplant (MOT) Requirements.

- APL 22-018 Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Issued 09/28/2022 and Revised 10/25/2022)

  The APL was revised from the previous month's version and provides the requirements to Plans on the Skilled Nursing Facility Long Term Care (LTC) Benefit Standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of beneficiaries to managed care.

Continued…

STATE REGULATORY AFFAIRS (continued)

- APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review (Issued 9/22/2022)

  The APL and Attachments inform Plans of updates to the DHCS Primary Care Provider site review process, which includes Facility Site Review and Medical Record Review policies. Plans were expected to implement all updated tool requirements effective July 1, 2022.

- APL 22-019 Proposition 56 Value-Based Payment Program Directed Payments (Supersedes APL 20-014) (Issued 10/10/2022)

  The APL provides Medi-Cal Plans with guidance on value-based directed payments, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), to Network Providers for qualifying services tied to performance on designated health care quality measures in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.

- APL22-020 Community-Based Adult Services Emergency Remote Services (Supersedes APL 20-007) (Issued 10/21/2022 and revised 11/02/2022)

  The APL and attachment are to provide Plans with policy guidance regarding the end of CBAS Temporary Alternative Services effective September 30, 2022, and implementation of Community-Based Adult Services Emergency Remote Services authorized under CalAIM.

STATE REGULATORY AFFAIRS (continued)

- APL22-021 Proposition 56 Behavioral Health Integration Incentive Program (Issued 10/26/2022)

  The APL is to provide Medi-Cal Plans with guidance on the Behavioral Health Integration Incentive Program, funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), for achievement of specified milestones and measures tied to BHI.

- APL 22-022 Abortion Services (Supersedes APL 15-020) (Issued 10/28/2022)

  The APL is to provide Medi-Cal Plans with information regarding their responsibility to provide Members with timely access to abortion services.

- APL 22-023 Street Medicine Provider: Definitions and Participation in Managed Care (Issued 11/08/2022)

  The APL is to provide guidance to Medi-Cal Plans on opportunities to utilize street medicine providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.

STATE REGULATORY AFFAIRS (continued)

The Department of Managed Health Care (DMHC) released seven All Plan Letters (APL) during this time period.

- APL 22-019 - Health Plan Coverage of Monkeypox Testing, Vaccinations, and Therapeutics (Issued 10/6/2022)

  This APL reminds health plans of their obligation to cover testing, vaccinations, and therapeutics for Monkeypox.

- APL 22-020 - Notice of Rate Changes for Independent Medical Reviews (Issued 10/10/2022

  Effective January 1, 2023, Maximus will implement a 25% rate increase to complete IMRs assigned by the Department.

- APL 22-021 - Quarterly Grievance Reports (Issued 10/11/2022)

  This APL reminds Plans to comply with the quarterly grievance data reporting requirements as outlined in the California Code of Regulations.

STATE REGULATORY AFFAIRS (continued)

- APL 22-024 - New and Amended Annual Network Report Forms for Reporting Year 2023, Resulting from SB 221 and AB 457 (Issued 10/27/2022)

  The APL and its' attachments provide information regarding the new and amended report forms for the reporting year 2023 Annual Network Report submission, based on recent changes to the law resulting from Senate Bill (SB) 221 and Assembly Bill (AB) 457.

- APL 22-025 - Health Plan Requirements to File Annual Antifraud Report (Issued 11/1/2022)

  This APL reminds Plans of their continuing obligation to comply with the annual antifraud reporting requirements under the Knox-Keene Health Care Service Act of 1975.

- APL 22-026 - Implementation of TA Regulation Amendments (Issued 11/4/2022)

  This APL is regarding the Implementation Filing Requirements Related to the Amendments to the Timely Access and Network Reporting Statutes and Regulation related to the amendments of the Timely Access and Network Reporting Statutes and Regulation.

- APL 22-027 - Timely Access to Emergent and Urgent Services When an Enrollee is Outside of California (Issued 11/7/2022)

  This APL reminds Plans of their responsibility to provide timely access to medically necessary basic health care services for the Plans' enrollees, even when those enrollees happen to be outside of California when they need the services.

STATE REGULATORY AFFAIRS (continued)

APL22-015 Enforcement Actions: Administrative and Monetary Sanctions (Issued 08/24/2022)

As mentioned in last month's Board presentation, DHCS issued an updated APL regarding Enforcement Actions. In an effort to provide some additional visibility into the most significant updates, a high-level overview is provided below:

- Expanded language for which Enforcement Action may be taken
- Specifies DHCS may impose sanctions with a corrective action plan, instead of a corrective action plan, and/or for failure to meet corrective action plan requirements
- Clarifies that each member impacted constitutes a separate sanctionable violation
- Increases Sanction Amounts:
  - Up to $25,000 for first violation (previously $5,000)
  - Up to $50,000 for the second violation (previously $10,000)
  - Up to $100,000 for each subsequent violation (previously $25,000)
- Advises sanction amounts may be separately and independently assessed for each day the plan fails to correct an identified deficiency.
- Provides additional detail regarding:
  - Temporary suspension orders, including requirement the termination of MCP Personnel or subcontractors in given circumstances
  - Temporary management

REGULATORY ENFORCEMENT ACTIONS

DMHC issued a notice of Enforcement Action against Kern Health Systems (KHS) on November 7, 2023 for failure to expedite response to the Department's request for information (Cal. Code Regs., tit. 28, § 1300.68, subd. (h).)

- The Department requested information from KHS regarding a complaint filed by the Enrollee with the Department, requiring a response within two days (due 03/13/2019).
- KHS failed to respond by the required due date and provided the response six days late (03/19/2019) after follow up from the Department.
- KHS provided a response to the Department on 11/23/2022 and agreed to settle the matter with a penalty assessed in the amount of $7,500.
- Actions to ensure compliance with this regulation (and others regarding the processing of complaints received through DMHC) include, but are not limited to:
    - The Director of Compliance responsible for the handling of these types of complaints in 2019 is no longer an employee of KHS.
    - The Compliance Department currently has a Compliance Analyst (and backup) dedicated to respond to the Department's inquiries of this nature timely.
    - A log is maintained within Compliance to track the timeliness of responses.
    - The current Director of Compliance provides oversight regarding the process.
    - To date in 2022, 39 requests have been received from DMHC, for which all responses have been timely.

2024 Operational Contract Readiness

Deliverable due dates and status:

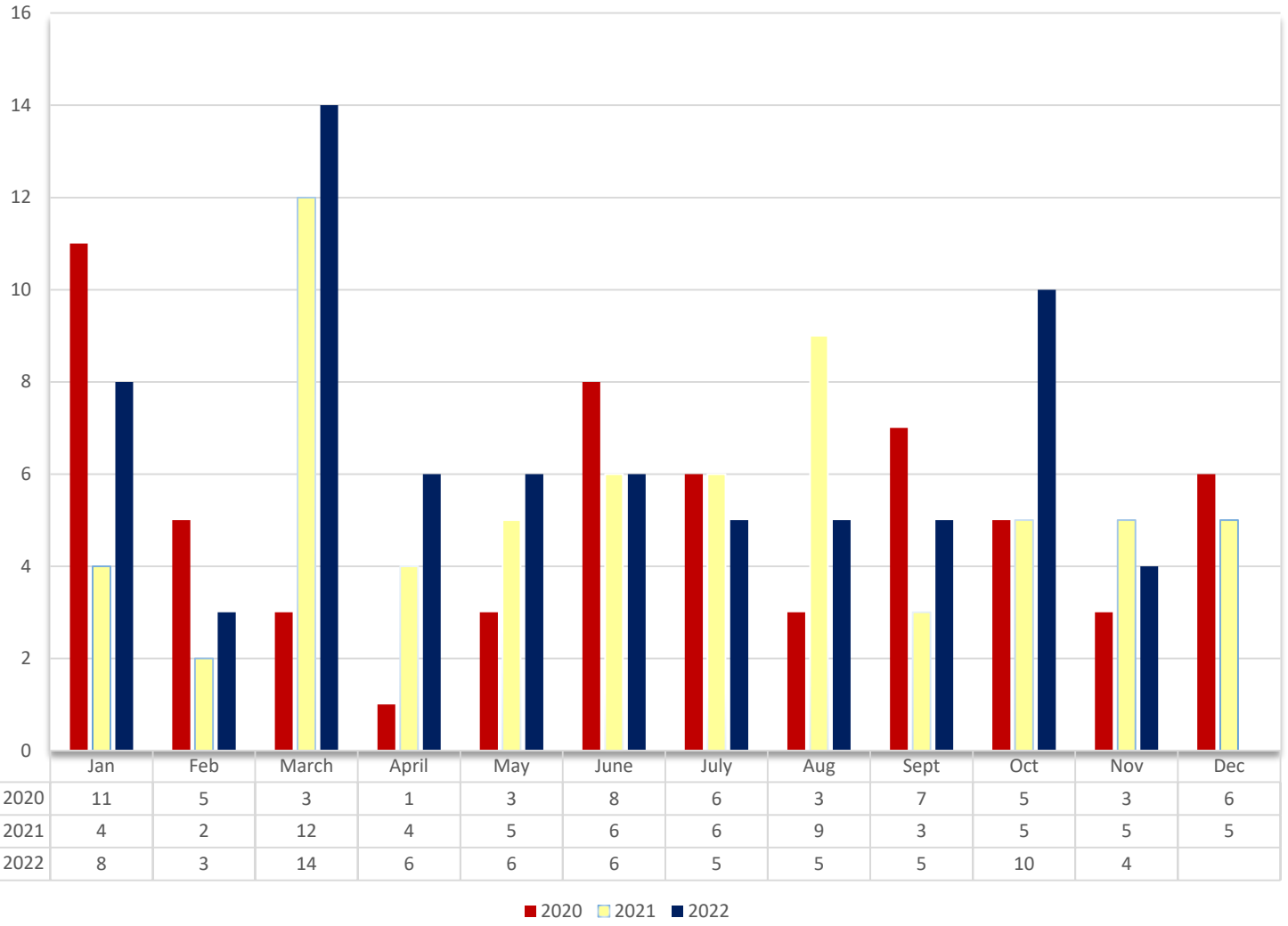
- All deliverables provided for 2024 Operational Readiness have been approved by DHCS.
- KHS is on track to submit the next set of deliverables due by 12/19/2022

2024 Contract - Operational Readiness					
DHCS Deliverable Due Date	# of Deliverables Due	Current Status			Comments
		Approved	In Review	Additional Information Requested	
8/12/2022	20	20	0	0	Initial Submissions Timely
9/12/2022	27	27	0	0	Initial Submissions Timely
10/3/2022	14	14	0	0	Initial Submissions Timely
12/19/2022	43				
1/9/2023	21				
3/1/2023	1				
4/24/2023	56				
5/22/2023	43				
7/10/2023	5				
8/1/2023	1				
More information will be provided in spring 2023	4				
non-standard (align with beginning of phase Phase 2	1				
Blanks	2				
Total	**238**	**61**	**0**	**0**	

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

Number of Regulatory All Plan Letters and Guidance Letters Received by the Plan



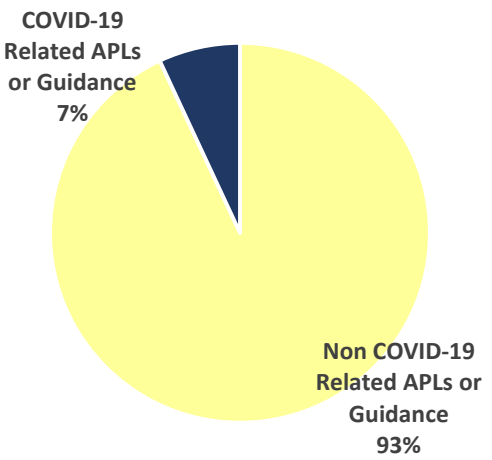
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2020	11	5	3	1	3	8	6	3	7	5	3	6
2021	4	2	12	4	5	6	6	9	3	5	5	5
2022	8	3	14	6	6	6	5	5	5	10	4	

Continued...

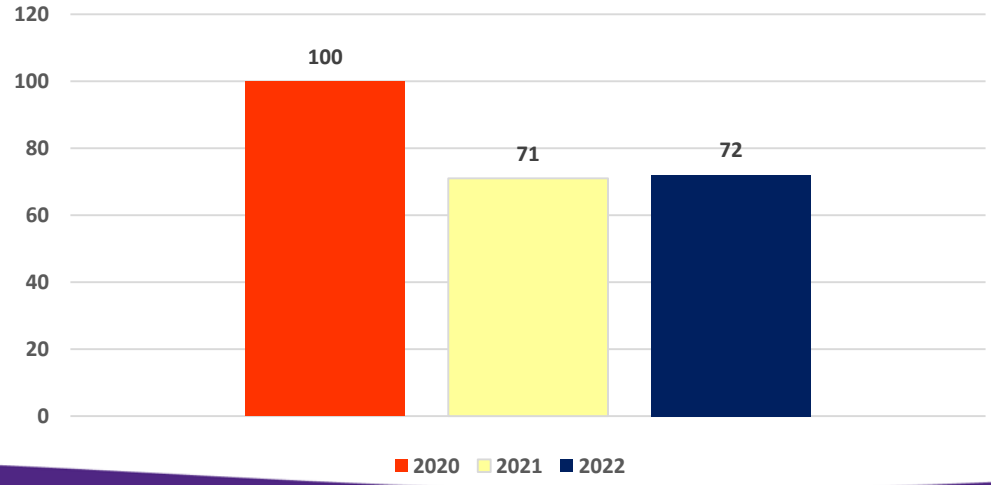
COVID-19 Impact 2022

Regulatory All Plan Letters and Guidance

Percentage of COVID-19 vs. Non-COVID-19 Related APLs or Guidance for 2022



Comparison of All Plan Letters and Guidance Letters Received by the Plan for Years 2020, 2021, & 2022



KERN HEALTH SYSTEMS

Number of Regulatory Reports & Filings Submissions to Government Agencies October and November 2022

Regulatory Agency	October 2022		November 2022	
	Ad Hoc	Standard	Ad Hoc	Standard
DHCS	23	23	17	18
DMHC	0	14	0	9

Regulatory Audits

Department of Managed Health Care (DMHC)

2020 DMHC Non-Routine Survey:

- The Plan is waiting for the DMHC to provide the Final Report and/or feedback regarding our response to the Preliminary Audit Report of the Non-Routine Survey:
  - Preliminary Report received 08/15/2022
  - KHS Response and Corrective Action Plan submitted 09/28/2022

DMHC Routine Medical Survey – January 2023:

- KHS is scheduled for a DMHC Routine Medical Survey in January of 2023
- The Survey Period is 09/1/2020 through 08/31/2022.
- KHS submitted over 1,000 documents for the pre-audit deliverables
- Additionally, KHS has submitted over 700 detailed verification study requests (samples of grievances, call inquires, potential quality issues, etc.) in very short turn-around timeframes required by DMHC.
- It has been extra challenging with the overlap of due dates for both the DMHC and DHCS Audit activity.

Regulatory Audits (continued)

Department of Health Care Services (DHCS)

2021 Medical Audit – September 2021

The DHCS conducted a Routine Medical Survey of Kern Health Systems from September 13, 2021 through September 24, 2021. The survey period was from August 1, 2019 through July 31, 2021.

- DHCS continues to review the KHS Corrective Action Plan submitted 03/11/2022 and additional supporting documentation has been provided.
- Compliance continues to monitor the elements of the Corrective Action Plan with future deliverable dates and meet with key stakeholders.
- DHCS is asking follow up questions related to the Corrective Action Plans taken during the 2022 Audit currently underway.

Regulatory Audits (continued)

Department of Health Care Services (DHCS)

2022 DHCS Routine Medical Survey – November 2022:

- DHCS provided KHS a notice of a routine survey for 2022 on 08/30/2022
- The survey period is 11/01/2021 – 10/31/2022
- Pre-Audit deliverables included over 1,000 documents submitted the week of 10/17/2022
- The DHCS request for samples (verification studies) involved providing detailed screen prints, letters, case documentation, etc. for over 350 sample cases (Care Management, Potential Quality Issues, Grievances, Prior Authorizations, Claims, etc.) due within 9 business days.
- KHS has also responded to over 120 follow up requests for additional information, in extremely short turn-around timeframes required by DHCS (often 24 hours)
- The interview portion of the Audit began the week of 11/28/2022 and continues through 12/09/2022

KERN HEALTH SYSTEMS

Compliance Department
Fraud, Waste, & Abuse Activity
October and November 2022

The Compliance Department maintains communications with State and Federal agencies and cooperates with their related investigations and requests for information.

State Medi-Cal Program Integrity Unit, US Department of Justice, and the Kern County Deputy Attorney's Office Requests for Information for the months of October 2022 and November 2022

Providers:

The Plan received three (3) requests for information from the State Medi-Cal Program Integrity Unit - related to potential provider fraud, waste, or abuse during this time period.

Members:

The Plan received zero (0) requests for information from the State Medi-Cal Program Integrity Unit related to Plan Members during this time period.

The Plan is not provided with an outcome in relation to the information requests by the two regulatory agencies.

Continued…

Fraud, Waste & Abuse
Allegations Reported to the Plan
October and November 2022

The Plan investigates and reports information and evidence of alleged fraud, waste, & abuse cases to appropriate state and federal officials.

Information compiled during an investigation is forwarded to the appropriate state and federal agencies as required.

Members:

During months of October 2022 and November 2022, the Compliance Department received fourteen (14) allegations of fraud, waste, or abuse involving Plan Members.

Providers:

During months of October 2022 and November 2022, the Compliance Department received nine (9) allegations of Provider fraud.

The Plan continues to investigate the allegations and required reporting to DHCS has been submitted timely in all cases.

KERN HEALTH SYSTEMS

Compliance Department
HIPAA Breach Activity
October and November 2022

Summary of Potential Protected Health Information ("PHI") Disclosures for the months of October and November 2022:

The Plan is dedicated to ensuring the privacy and security of the PHI and personally identifiable information ("PII") that may be created, received, maintained, transmitted, used or disclosed in relation to the Plan's members. The Plan strictly complies with the standards and requirements of Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH").

In October and November 2022, the Compliance Department investigated and reviewed nine (9) allegations of privacy concerns. All nine were closed as non-breaches.

KERN HEALTH SYSTEMS

For more information

Jane MacAdam, Director of Compliance

Jane.macadam@khs-net.com

(661) 664-5016

KERN HEALTH SYSTEMS

Attachment B

2023-2025 STRATEGIC PLAN SUMMARY (DRAFT)

Goals	Strategies	Expected Outcomes
Quality and Equity Deliver exceptional quality outcomes and health equity for KHS members	• Increase overall quality with a drive toward achieving Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps. • Meet National Committee for Quality Assurance (NCQA) standards and work toward accreditation. • Further maturity of the organization's Health Equity programs under the direction of the Chief Equity Officer.	• Increase in MCAS average performance scores and achievement of MPL for accountable measures. • Achievement of Medi-Cal NCQA Health Plan and Health Equity Accreditation by January 2026. • Reduction in disparities across targeted populations. • Increased Provider accountability in providing quality and equitable care and access. • Improved data sharing between KHS and Provider Network.
Workforce Develop initiatives for the recruitment and retention of both internal and external workforce needed to fulfill KHS' mission	• Identify Provider Network needs and gaps to inform target areas and approaches. • Strengthen and expand the KHS provider network through innovative and effective recruitment and retention programs. • Identify business needs and gaps in current workforce to inform target areas and approaches. • Meet the growing operational demands of the organization by creating recruitment and retention programs for internal staffing and leadership needs.	• Provider Network Plan which considers expanding membership and new benefits/products. • Provider Network that is adequate to meet the needs of our members while delivering high quality and equitable care. • Staffing Plan which supports the upcoming operational changes (CalAIM, NCQA, D-SNP, etc.) • Create an effective employee engagement program • Maintain or reduce staff turnover.

CalAIM Continue to develop, implement, and grow the programs and policies included under DHCS' CalAIM initiative	• Continued growth and maturity of existing CalAIM programs – Population Health Management, Enhanced Care Management, Community Supports, and Long-Term Care. • Strengthen Existing and Establish New Community Partnerships to Support CalAIM. • Ongoing collaboration between KHS staff and the Department of Health Care Services (DHCS) on the development and implementation of future CalAIM initiatives.	• Effective and efficient program operations in the areas of PHM, ECM, CSS, and LTC. • Data-driven operational oversight of programs. • Capable and adequate network of providers, with improved data sharing capabilities. • Improve member engagement, health outcomes, and satisfaction in CalAIM programs. • Meet regulatory deadlines for the implementation of the remaining CalAIM roadmap.
Medicare Duals Special Needs Plan (D-SNP) Develop and implement a competitive D-SNP product in alignment with State and Federal requirements	• Development of the long-term D-SNP strategy and implementation roadmap. • Analysis of the appropriate market factors to maximize the competitiveness of the product. • Design and implementation of an efficient Medicare D-SNP offering with competitive advantages, leveraging KHS innovation and new business/new product development capabilities.	• Clear vision, strategy, and tactical plan for D-SNP implementation. • Development and implementation of extensive staffing, operational, fiscal, and systems changes necessary to implement the Medicare D-SNP product. • Successfully launch an attractive and viable D-SNP product effective January 2026. • Improve coordination of services for members who receive both Medicare and Medi-Cal coverage (Duals).
Behavioral Health Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions	• Development and maturity of an internal Behavioral Health Department. • Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS). • Communication and coordination with County Behavioral Health regarding DHCS requirements. • Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment services.	• Improved member coordination and outcomes. • Provider network composition which adequately meets the needs of our members and regulators. • Enhanced coordination between KHS and the County system of Mental/Behavioral Healthcare. • Increase in screening, referrals, care coordination and access to Substance Use Disorder treatments and a reduction in associated negative health outcomes.

Member Engagement Increase member engagement in their health care	• Identify and implement innovative and effective offerings designed to engage members more in their health care. • Work with internal staff and external partners to develop strategies that ensure continuity of coverage for our members. • Leverage convenient technology to enhance the effectiveness of engagement and suit members' needs.	• Centralized policies and procedures for the execution of Member Engagement campaigns. • Improved health outcomes and quality care for engaged populations. • Reduction in Medi-Cal coverage loss related to redetermination administrative barriers. • Increase in member satisfaction and better patient experience.
KHS Foundation Explore the opportunity for KHS to create a non-profit foundation to further its mission in the community	• Conduct exploratory analysis of the necessary major components needed for the creation of a KHS non-profit foundation.	• Understanding of the requirements, structure, and financing mechanisms of a non-profit Foundation. • Feasibility analysis and recommendation to the Board of Directors.

SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, October 7, 2022

8:00 A.M.

COMMITTEE RECONVENED

Members: Martinez, Deats, Garcia, McGlew, Watson
ROLL CALL: 3 Present; 2 Absent – Deats, Garcia

NOTE: The vote is displayed in bold below each item. For example, Rhoades-Deats denotes Director Rhoades made the motion and Director Deats seconds the motion.

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

COMMITTEE ACTION SHOWN IN CAPS

1) Finance Committee Resolution to Allow Virtual Committee Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) - APPROVED
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

3) 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 (Government Code Section 54954.2(a)(2))
NO ONE HEARD

CA-4) Minutes for Kern Health Systems Finance Committee meeting on August 5, 2022- APPROVED
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

5) Proposed revisions to Policy 100.12-I, Contracting Policy for Administrative Contracts (Fiscal Impact: None) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew: 3 Ayes; 2 Absent – Deats, Garcia

6) Proposed Agreement with Mihalik Group, for NCQA Accreditation Consulting Services, from January 1, 2023, through December 31, 2023 (Fiscal Impact: $243,720; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

7) Proposed Agreement with Change Healthcare, for Electronic Claims Clearing House Services, from October 20, 2022, through October 19, 2025, in an amount not to exceed $0.18 Per Claim Fee (Fiscal Impact: $310,000 estimated annually; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

8) Proposed Agreement with ZeOmega, Inc., for Medical Management Platform, from November 1, 2022, through October 31, 2027 (Fiscal Impact: $3,918,001; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

9) Proposed Agreement with Health Dialog, for 24/7 Nurse Triage Services for KHS members, from November 2, 2022, through November 1, 2025 (Fiscal Impact: $1,495,200 estimated; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

10) Report on Kern Health Systems financial statements for July 2022 and August 2022 (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

11) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for July 2022 and August 2022 and IT Technology Consulting Resources for the period ended July 31, 2022 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Martinez: 3 Ayes; 2 Absent – Deats, Garcia

ADJOURN TO FRIDAY, DECEMBER 9, 2022 AT 8:00 A.M.
McGlew