KERN HEALTH SYSTEMS

REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, October 14, 2021
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, October 14, 2021

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: McGlew, Judd, Stewart, Deats, Bowers, Flores, Garcia, Hoffmann, Jones, Martinez, Melendez, Nilon, Patel, Patrick, Rhoades, Watson

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 August 12, 2021 (Fiscal Impact: None) –
APPROVE

CA-6) Report on the Chief Executive Officer Search Committee progress (Fiscal Impact: None) –
RECEIVE AND FILE

CA-7) Report on Kern Health Systems 2021 Corporate Goals for 3rd Quarter and 2022 Corporate Goals Update (Fiscal Impact: None) –
RECEIVE AND FILE

8) Report on COVID-19 Kern Health Systems Member Vaccine Plan (Fiscal Impact: None) –
RECEIVE AND FILE

9) Report on Kern Health Systems 2020 Utilization Management (UM) Program Evaluation and the 2021 UM Program Description (Fiscal Impact: None) –
APPROVE

10) Report on Kern Health Systems Quality Improvement (QI) 2020 Program Evaluation, 2021 QI Program Description and, the 2021 QI Program Work Plan (Fiscal Impact: None) –
APPROVE

CA-11) Report on Managed Care Accountability Set (MCAS) Strategies (Fiscal Impact: None) –
RECEIVE AND FILE

CA-12) Proposed renewal and binding of employee benefit plans for medical, vision, dental, life insurance, short-term and long-term disability, and long-term care effective January 1, 2022 (Fiscal Impact: $6,520,000 Estimated; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-13) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

14) Report on Kern Health Systems financial statements for July 2021 and August 2021 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-15) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for July 2021 and August 2021 and IT Technology Consulting Resources for the period ended June 30, 2021 (Fiscal Impact: None) –
RECEIVE AND FILE

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

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

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

CA-19) Proposed modifications to Kern Health Systems Formulary (Fiscal Impact: None) – APPROVE

CA-20) Miscellaneous Documents – RECEIVE AND FILE

A) Minutes for Kern Health Systems Finance Committee meeting on August 6, 2021

ADJOURN TO DECEMBER 16, 2021 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: Douglas Hayward, CEO

Date: October 14, 2021

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 October 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 OCTOBER 2021

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 October 1, 2021, and shall be effective until the earlier of October 30, 2021, 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 _____, seconded by _____, was duly and regularly adopted by the Board of Directors of Kern Health Systems at an official meeting thereof

on the ____th day of October, 2021, 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, August 12, 2021

8:00 A.M.

BOARD RECONVENED

Directors: McGlew, Judd, Stewart, Deats, Bowers, Flores, Garcia, Hoffmann, Jones, Martinez, Melendez, Nilon, Patel, Patrick, Rhoades, Watson
ROLL CALL: 14 Present; 2 Absent – Hoffmann, Patrick

NOTE: The vote is displayed in bold below each item. For example, Rhoades-Deats denotes Director Rhoades 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

ADJOURN TO CLOSED SESSION
Rhoades

CLOSED SESSION

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

8:15 A.M.

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 1 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING AUGUST 2021** 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 JUDD ABSTANED FROM VOTING ON IMBASCIANI, KAHLON, KAUR, LAWANDY, MAI, MITCHELL, NACHTIGALL; DIRECTOR STEWART ABSTAINED FROM VOTING ON GRAHAM, WELDEN, ZARAZUA; DIRECTOR GARCIA ABSTAINED FROM VOTING ON KANKAR

Item No. 1 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING AUIGUST 2021** 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 MCGLEW ABSTAINED FROM VOTING ON BATDORF, LOPEZ; DIRECTOR JUDD ABSTAINED FROM VOTING ON GALINDO, PELAEZ, PETERSEN, GAJJAR, GHANDFOROUSH, MITCHELL, RATHORE, SALAM; DIRECTOR STEWART ABSTAINED FROM VOTING ON GARBELL

PUBLIC PRESENTATIONS

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NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

3) 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))

DIRECTOR JUDD REPORTED ON THE STATE MANDATED VACCINATION POLICY AND STATED THAT HOSPITAL EMPLOYEES ARE REQUIRED TO BE VACCINATED BY SEPT 30TH; WHICH MAY CAUSE AN EXODUS OF WORKFORCE, THAT MAY AFFECT AVAILABILTY OF SERVICES. DIRECTOR JUDD ALSO REPORTED THAT UNVACCINATED VISTORS ARE NOT ALLOWED INTO THE HOSPITALS AND IS EXPECTING MORE CLARIFICATION FROM THE STATE

CA-4) Minutes for Kern Health Systems Board of Directors regular meeting on June 10, 2021 (Fiscal Impact: None) – APPROVED
Nilon-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

5) Report on the Chief Executive Officer Search Committee progress (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Patel: 14 Ayes; 2 Absent – Hoffmann, Patrick

6) Report from the Milliman actuary firm regarding capital reserves (Fiscal Impact: None) – CRAIG B. KEIZUR, MILLIMAN, HEARD; APPROVED
Rhoades-Melendez: 14 Ayes; 2 Absent – Hoffmann, Patrick

7) Proposed Kern Health Systems 2021 Grant Allocation Program (Fiscal Impact: None) – RECEIVED AND FILED
Flores-Jones: 14 Ayes; 2 Absent – Hoffmann, Patrick

CA-8) Proposed revisions to Policy 10.01-I, Clinical and Public Advisory Committee Appointment (Fiscal Impact: None) – APPROVED POLICY REVISIONS
Nilon-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

CA-9) Report on Kern Health Systems 2021 Corporate Goals for 2nd Quarter (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

CA-10) Report on Kern Health Systems investment portfolio for the second quarter ending June 30, 2021 (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

CA-11) Proposed Agreement with Commercial Cleaning Systems, Inc., for janitorial services for 2900 Buck Owens Blvd., from September 6, 2021 through September 5, 2022 (Fiscal Impact: $192,000; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Nilon-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

CA-12) 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-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

13) Report on Kern Health Systems financial statements for May 2021 and June 2021 (Fiscal Impact: None) – RECEIVED AND FILED
Rhoades-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

CA-14) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for May 2021 and June 2021 and IT Technology Consulting Resources for the period ended June 30, 2021 (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

15) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) – RECEIVED AND FILED
Melendez-Patel: 14 Ayes; 2 Absent – Hoffmann, Patrick

16) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Patel-Judd: 14 Ayes; 2 Absent – Hoffmann, Patrick

NOTE – DIRECTOR PATEL LEFT THE DAIS AT 10:00 AM AND DID NOT RETURN

17) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Rhoades-Flores: 13 Ayes; 3 Absent – Hoffmann, Patel, Patrick

18) Discussion on Reinstituting Onsite Only Board of Directors Meetings (Fiscal Impact: None) – RECEIVED AND FILED
Rhoades-Flores: 13 Ayes; 3 Absent – Hoffmann, Patel, Patrick

CA-19) Miscellaneous Documents – RECEIVED AND FILED
Nilon-Deats: 14 Ayes; 2 Absent – Hoffmann, Patrick

A) Minutes for Kern Health Systems Finance Committee meeting on June 4, 2021

ADJOURN TO THURSDAY, OCTOBER 14, 2021 AT 8:00 A.M.
Deats

/s/ Cindy Stewart, Secretary
Kern Health Systems Board of Directors

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Tim McGlew, Chairman

Date: October 14, 2021

Re: CEO Search Committee Progress Report

Background

At the June Board of Directors Meeting, the Board established a Search Committee to undertake locating qualified CEO candidates from which to select our current CEO's replacement when he retires mid-year 2022.

The Board authorized the Search Committee to locate and engage a professional recruiting agency to aid in the search. Witt/ Kieffer was selected and notified they were awarded the contract.

Mark Andrew, of Witt/Kieffer held an initial meeting with Search Committee members on September 9th to get their input on the selection process and desired characteristics and qualifications they would like to see in a new CEO. This information will help Witt/Kieffer to create a Company / Position Profile used for informing prospective candidates about the CEO position, Kern Health Systems and the Bakersfield community.

Witt/Kieffer is expected to identify qualified candidates over the next 45 to 60 days with interviews to begin shortly after the holidays.

Requested Action

Receive and File .

To: KHS Board of Directors

From: Douglas Hayward, CEO

Date: October 14, 2021

Re: Update on 2021 Corporate Goals and KHS Strategic Planning Timeline Adjustment

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Background

2021 Corporate Goals

Historically, Management has updated the Board quarterly on the status of the Strategic Plan. As previously reported to the Board, the re-initiation of CalAIM in January has necessitated a reconsideration of the Strategic Planning timeline. Thus, KHS is using the 2021 Corporate Goals as the topline direction for the organization. With Q3 coming to an end, Management is providing an update on the status of these goals. Items with new updates to report are noted in blue font, while previously reported items are in green font. Overall, KHS is on track with items that were due to complete in the third quarter.

Strategic Planning Timeline Update

Given the upcoming retirement of KHS' current CEO and the anticipated timing of hiring a new CEO, Management is updating the timeline for the creation of the 2023-2025 Strategic Plan. To allow for guidance and participation from the incoming CEO, the process would be scheduled to begin in Q2 2022. The new timeline below will be incorporated into KHS' 2022 Corporate Goals and Objectives:

Deliverables:

- ***Q3 2022 KHS Board to receive overview of the process to be undertaken culminating with a new three-year Strategic Plan***

- ***Q3 2022, Board members will receive background information and questionnaire in preparation for upcoming Board of Directors strategic planning retreat.***

- ***Q3 2022 Board to participate in a one-day strategic planning retreat to be held onsite at Kern Health Systems***

- ***Q4 2022 from information and feedback obtained during the retreat, a draft version of the 2023 -2025 Three Year Strategic Plan will be sent to Board members for comment.***

- ***Q4 2022 Board to adopt the 2023 -2025 Three Year Strategic Plan***

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

Corporate Performance Goals for 2021

Background

No one could have predicted a pandemic nor its impact on our way of life and work. To minimize its toll on the public's health, the Governor issued a Statewide order for all residents to 'stay at home' resulting in an economic downturn from layoffs, furloughs and business interruptions.

Deficit estimates are projected to be between $30-50 billion which means that there could be significant cuts to services and programs across the State. To put that in perspective, during the recession in 2008, the deficit was approximately $20 billion. It will take all of us to be sure we're staying focused on our core mission of serving those most vulnerable during the potentially tumultuous days ahead.

The Governor recently shared his revised Fiscal Year 2020-21 proposed budget showing what a significant negative impact COVID-19 has and will continue to have on the State's economy. The final budget agreement is expected to include revenue reductions to the Medi-Cal program. The significance will vary depending on the health plan. However, it is expected to include both a retro rate reduction of 1.5% and future (2021) reduction of an additional 3%. This will have a material impact to KHS revenue in 2021 and will weigh on staffing, projects, contracting and equipment decisions for the 2021 budget.

The following must be kept in mind when developing your department goals and budgets:

1. **Staffing:** Our employees are what makes us who we are at KHS. As we navigate through the difficult days ahead, as much as possible, our existing employees will not be directly impacted by the new realities of the State budget. We fully intend to keep all current employees without layoffs or furloughs. However, new 2021 budget positions will require the department to demonstrate a clear return on investment (ROI). There are times when it will be the best decision to invest in more staff if a particular project will result in large cost savings. It's important that we be the best steward of our existing resources.

2. **New Projects, Programs or Activities:** As a leader of your department, you're truly the experts in your field. You will need to guide the organization on programs *that are nice-to-haves but not essential*. Department heads are expected to discuss with their Executive leader their recommendations for programs, projects or activities that could potentially be

placed on-hold for 2021. As with staffing, new projects, programs and activities not mandated by government regulation or policy will need to show a return on investment through savings or efficiency.

3. **Provider Payment:** Year over year, the State pays Medi-Cal health plans based on historical cost information they receive from us. The goal is to assure the reimbursement rates health plans receive will cover the anticipated health services cost adjusted for trends in utilization or unanticipated medical cost expenses health plans incur from time to time. When benefits are added, or omitted rates will be adjusted accordingly as well. For the health plan's benefit, this practice should yield "actuarily sound" rates and enough reimbursement to cover medical cost for the insured Medi-Cal population for year in which the rate applies. On the rare occasion (such as the one occurring now) the State will make arbitrary decisions that negatively impacts reimbursement. The retro rate reduction of 1.5% and anticipated 2021 rate reduction of another 3% are two examples of this and will likely result in the amount of money we pay providers in 2021 to be more than what we get reimbursed from the State during that same period. Cash reserves become incredibly important because it allows us to continue to pay Hospitals and Providers even when we're underpaid or delays occur in receiving reimbursement from the State.

As we navigate these uncertain times, it is likely COVID -19 will remain paramount in the minds of the State, Providers, Members and our community. The 2021 Corporate goals will consider both the pandemic and its impact to our way of doing business and obligation to our members. In addition, the goals will recognize the specific requirements the State and Federal government will impose on health plans in 2021 such as Interoperability and Long-Term Care at Home. Finally, it will be necessary to carry over from 2020 certain programs partially or never launched due to the pandemic. These programs have been rescheduled for continued development and implementation in 2021.

Goal 1– Behavioral Health Integration Program

The Department of Health Care Services (DHCS) offered grant funding to incentivize Medi-Cal Managed Care Health Plans (MCPs) to promote behavioral health integration (BHI) at the primary care level. The Program objectives were:

- To improve physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated and coordinated care delivery for the whole patient.
- To increase network integration for providers at all levels of integration, focused on new target populations or health disparities, and improve provider's level of integration or impact.
- To create and integrated model that can be replicated by MCPs throughout their network.

DHCS identified six options MCPs could follow for achieving the desired outcome:

- Basic Behavioral Health Integration
- Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment
- Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses
- Diabetes Screening and Treatment for People with Serious Mental Illness
- Improving Follow-Up after Hospitalization for Mental Illness
- Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis

Kern Health Systems was awarded five grants for three providers totaling $11,000,000 from DHCS to implement behavioral health integration programs over a two-year period. The awards were based on proposals received from participating network providers interested in developing integrated physical and behavioral health focused initiatives. Grants were given to: Good Samaritan Hospital (2), Adventist Health (2) and Premier Valley Medical Group.

Deliverables

- ***Determine BHI readiness for each grantee by 1st Quarter, 2021*** – *Readiness review for each grantee was completed per their individual program design. Regular contact between organizations occurred beginning late 2020 to ensure successful implementation.*

- ***Create BHI grant agreement for each grantee by 1st Quarter, 2021*** – *Grant agreements and MOUs were developed and approved by DHCS as required. This included specific program readiness and project milestones for achievement tied to the grant funding.*

- ***Contract with each grantee by 1st Quarter, 2021*** *- Grant agreements have been executed for Good Sam Hospital (2 programs), Premier Valley Medical Group, and Adventist Health Tehachapi Valley (2 programs).*

- ***Execute start date of each BHI program initiatives by 1st Quarter, 2021*** *– All programs are currently operational as of April 2021. Below is a summary of the programs:*

  Premier *- Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses. Program started 1/1/2021.*

  Good Sam Hospital *- Improving Follow-up after Hospitalization for Mental Illness. Program started 1/1/2021.*

  Good Sam Hospital *- Basic Behavioral Health Integration – Wasco Rural Health Center. Program started 4/1/2021.*

  Adventist Health Tehachapi Valley *- Diabetes Screening and Treatment for People with Serious Mental Illness. Program started 4/1/2021.*

  Adventist Health Tehachapi Valley *- Improving Follow-up after Emergency Department Visit for Behavioral Health Diagnosis. Program started 4/1/2021.*

- ***Continue to monitor grantees performance against predetermined objectives throughout the 2-year grant cycle starting following initiation of each grantee's program by 2nd Quarter, 2021.*** *Grantee performance monitoring underway, Q2 results as follows:*

  Premier *- Medication Management for Beneficiaries with Co-occurring Chronic Medical and Behavioral Diagnoses. Data for Q2: Universal Urgent Care Patient Screening for 568 patients, 223 patients served, 98 patients enrolled in treatment for depression, 121 patients enrolled in treatment for anxiety, 77 patients enrolled in treatment for SUD, 59 patients active with psychiatrist.*

  Good Sam Hospital *- Improving Follow-up after Hospitalization for Mental Illness. Data for Q2: 190 patients screened, 100 patients received medication delivery aid, exceeding goals for connecting patients with outreach specialists.*

  Good Sam Hospital *- Basic Behavioral Health Integration – Wasco Rural Health Center. Data for Q2: 31 patients accepted treatment, 18 patients positive for depression, 17 patients positive for anxiety, 1 active with psychiatrist.*

Adventist Health Tehachapi Valley *- Diabetes Screening and Treatment for People with Serious Mental Illness. Onboarded new navigator staff and began conducting case conferences, conducted community outreach. 47 patients contacted within 7 days for follow-up.*

Adventist Health Tehachapi Valley *- Improving Follow-up after Emergency Department Visit for Behavioral Health Diagnosis. Data for Q2: 63 patients contacted within 15 days of discharge to develop treatment plans.*

- *PNM continues to monitor the provider's performance towards their milestones outlined for the BHI projects. PNM has submitted to DHCS the Plan's PY1-Quarter 2 Milestone report for the provider's BHI projects.*

Goal 2 Expansion of KHS's Alternative Payment Model (Phase V)

In 2020, KHS expanded its alternative reimbursement program with the implementation of the Chronic Obstructive Pulmonary Disease (COPD) APM Program. COVID-19 impeded the COPD Program's progress preventing KHS from achieving the Program's expected outcomes which will be measured when clinical practice returns to more normal schedules. The APM Program will continue in 2021 with new applications yet to be determined.

Deliverables:

- ***Identify and develop provider specific proposals for another appropriate specialty care practice or special needs program by 1st Quarter, 2021*** *– Provider Network Management has worked with the Health Services and Business Intelligence team to identify potential proposals for 2021. Opportunities identified include Transition of Care Programs with Premier Valley Medical Group and Golden State Hospitalists, COPD program with Nephrology Medical Group of Bakersfield, and an Oncology APM program.*

- ***For selected providers, initiate provider contract revisions to change or enhance compensation arrangements by 2nd Quarter, 2021 -*** *KHS staff have finalized a new TOC program agreement with Golden State Hospitalist Group, (Dr. Sharma). This new TOC started in mid-August. The Transition of Care Program with Premier Valley Medical Group and the COPD program with Nephrology Medical Group of Bakersfield have also already initiated.*

- ***Determine impact to KHS internal operations by beginning of 3rd Quarter, 2021*** *KHS staff continue to work on all programs which are part of our Population Health Management Program. Provider Network Management is working with providers to set up standardized data exchanges and setting up the dashboard to monitor outcomes.*

- ***Design data tracking and reporting of specialty care to determine achievement of the desired outcome and / or ROI by the 3rd Quarter, 2021 -*** *KHS staff continue to monitor the COPD and TOC programs. Provider Network Management is working with the MIS departments to create automated reports and dashboards to track the outcomes of the programs. Current enrollment in these programs is as follows: COPD – 355 members, Premier TOC –13 members.*

- ***Following implementation, begin monitoring to determine if targeted outcomes are achieved by 4th Quarter, 2021***

Goal 3 – Expansion of Kern Health System's Health Home Program (Cont.)

Kern Health Systems recognizes several thousand members will benefit from receiving their medical services through a patient centered medical home. To date, Kern Health Systems has established six health homes programs located at various provider sites throughout Kern County.

Despite launching six provider site-based health home programs countywide, there remains significant unmet need in Kern County for these programs. In 2020, it was expected this gap would be significantly reduced with the addition of 2 new external sites and the launch of a new model called the Distributed Health Home Program whereby eligible PCP physicians with a significant number of HHP qualified members assigned to their practice may become part of a "decentralized network". The network will be supported with six broad service areas in the effort to achieve the HHP goal to address these medically complex cases:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Serves
- Referral to Community and Social Supports

While member's PCP will provide the clinical treatment, KHS will serve as manager and coordinator for these broader services in the DHHP. This HHP "without walls" enables members to continue to receive care from their PCP along with these enhanced services. The DHHP will follow the same DHCS guidelines and reporting requirements of our other HHPs.

COVID -19 delayed implementation of some of our 2020 HHP sites with the Governor's stay at home order. Although some progress was made in 2020 pre-pandemic, not enough work could be done to consider it successful.

Besides the DHHP rollout delay, KHS expected Clinica Sierra Vista (CSV) to begin their long awaited HHP program in 2020. Due to CSV's leadership change, their HHP launch was delayed and will need to be reintroduced in 2021.

Deliverable:

- ***Select remaining interested PCPs with a significant number of HHP qualified members by 1st Quarter. 2021.*** – *Staff conducted analytics and identified two additional providers who would qualify for the distributive model: Westside Taft Clinic and Dr. William Bichai.*

- ***Modify new PCP participants contract to include role, function and responsibilities as a PCP under the DHHP concept by 2nd Quarter, 2021.*** *Contract amendments have been fully executed for West Side Taft Clinic and Dr. William Bichai to reflect the responsibilities of the DHHP program. The KHS configuration requirements have been completed to ensure the payments are compensated as agreed.*

- ***Modify new PCP participants practice setting to meet DHHP requirements beginning 2nd Quarter, 2021.*** *The KHS Distributive Model Care team worked with the identified PCPs to ensure readiness for the DHHP requirements.*

- ***Conduct new PCP participants and staff training program under the DHHP beginning 3rd Quarter, 2021.*** *Training for staff and PCP participants has been completed and will be continued as need depending on hiring of new staff.*

- ***Launch expanded DHHP with new participants beginning by end of 3rd Quarter, 2021.*** *Both of the DHHP PCP sites launched their programs early. Westside Taft Clinic began in January 2021 and is currently serving 47 members. Dr. Bichai's office began in April 2021 and is currently serving 66 members.*

- ***Launch CSV's HHP site by 2nd Quarter, 2021.*** – *CSV's Greenfield location began seeing Health Homes Program members in early March. They're currently serving 155 members.*

Goal 4 – Kern Health Systems 2021 to 2023 Three Year Strategic Plan

In 2017 Pacific Health Consulting Group assisted Kern Health Systems in developing a 3-year Strategic Plan. Over the past 3 years, Kern Health Systems has implemented the strategies and tasks around five major goals:

- Delivery System and Payment Reform
- Primary Care and Specialty Care Access
- Premier Health Plan of Choice for MCAL in Kern County
- Health Plan Sustainability and Diversification
- Technology Optimization to Improve Constituency Service

With outside assistance, Kern Health Systems will again undertake a new Strategic Planning session in early 2021. The Strategic Plan serves as a management tool to ensure KHS remains committed to its mission, working toward achieving desired goals, addressing new challenges and identifying new opportunities.

The overarching themes of this session should revolve around the changing healthcare environment (particularly CalAIM) and its impact to Kern Health Systems. The Board of Directors along with Executive staff will need to evaluate:

- Mission and Vision Statement
- External Environment and Competitive Market Conditions
- Internal review (strengths, weakness)
- Opportunities and Choices (including challenges to success)

From this evaluation, the Board will develop Goals and Strategies to position KHS for future success.

Deliverable:

- ***Board to adopt a new three-year strategic plan for the period 2021 -2023 by the end of 1st Quarter, 2021*** *– As previously reported to the Board, the re-initiation of CalAIM in January has necessitated a reconsideration of the Strategic Planning timeline. KHS is moving forward in 2021 with these Corporate Goals as the topline direction for the organization. During the June board meeting the discussion of the 2022 Corporate Goals included an updated requested timeline for Strategic Planning into 2022.*

KERN HEALTH SYSTEMS

Goal – 5 Interoperability and Patient Access

CMS and the State of California have regulated the Interoperability and Patient Access Rule (CMS-9115-F) to *"deliver on the Administration's promise to put patients first, giving them access to their health information when they need it most and in a way they can best use it."* The goal is to break down information silos for patients leading to better care and improved outcomes. This secure data link between 3rd parties, payors, providers, and patients and is intended to improve care coordination and reduce cost through data exchange and technological innovations.

Deliverables:

- ***Establish new technology systems and processes to facilitate data exchanges with members and providers by the end 1st Quarter 2021.*** - *The new technology system has been purchased, installed, and configured, and the team continues to test the system to present the data in a meaningful manner for the Q2 goal.*
- ***Create Provider and Member Portal applications to present data in a meaningful manner to providers and members by the end of 2nd Quarter 2021*** *The portal application is at 95% completion and will be finalized in late August. The Interoperability data will be accessible for members to present to any clinical engagement for continuity of care.*
- ***Research and identify 3rd party applications to use data in a manner that will benefit a Medi-Cal population by end of 2nd Quarter 2021.*** *There are a limited number of third-party applications that are being developed in the market, and KHS did a significant amount of research on various tools. KHS did find one vendor that is in the process of registering their application with KHS for member Interoperability data utilization.*
- ***Engage and inform members and providers on new methods of data access and tools by end of 3rd Quarter 2021*** *The plan is engaging 3rd party providers to create access points for members; developed a website for members to directly access data; and is upgrading the member mobile application to promote more member interactions.*
- ***Establish audit and reconciliation processes to manage data exchange effectiveness with reporting and analytics by end of 4th Quarter 2021.***
- ***Create Payer to Payer data exchanges to collect external data sources to consolidate and deliver other payor data by end of 1st Quarter 2022.***

Goal 6 – Prescription Drug Benefit Carved Out from Managed Care Plans

Beginning 2021, with few exceptions, the Medi-Cal prescription drug benefit will be administered by the State in partnership with Magellan Medicaid Administration. For managed care health plans, this will mean a diminished role in the administration and distribution of the pharmacy benefit. However, under certain circumstances and in specific situations, managed care plans (MCP) will continue to administer the Medi-Cal pharmacy benefit. Transitioning to this new arrangement began in 2020 and will continue to a smaller extent in 2021. The transition to the new arrangement with realignments in place is expected to be finished by the end of 1st quarter, 2021. Though the claims processing/payment and authorization for outpatient drugs will fall to the State, the MCPs are expected to continue their case management, DUR, MTM, and other related activities. Quality measures that involve administrative pharmacy data will also be activities the plans will be required to meet.

Deliverables: *Recently DHCS announced the Medi-Cal Rx transition will resume with an effective date of 1/1/22. The transition had been on hold since February. DHCS has re-engaged with Health Plans and other stakeholders to work toward this transition date. Much of the transition work has been completed internally and is being resumed as needed. The deliverables due dates below have been updated accordingly. This item is also already included in the 2022 Corporate Goals.*

- ***Create Data Exchange and integration to current system application beginning in 3rd Quarter, 2020.*** *Efforts were started in 2020 and ongoing testing has been conducted throughout the postponement. Some reports, data, etc. are not able to be fully integrated until after the transition. Some minor modifications are being made now through the transition as needed.*

- ***Incorporate Operational readiness for Member Services, Provider Network Management, Health Services, Claims Adjudication, and Business Intelligence by 4th Quarter, 2020.*** *Training, Bulletins, and materials were undertaken in 4th Quarter 2020 and have continued throughout 2021 as DHCS/Magellan shared them. More robust training efforts are being conducted now. DHCS is scheduling Provider training for the plans.*

- ***Transition Pharmacy Operations for outpatient pharmacy processing only beginning 1st Quarter, 2021.*** *This will now occur beginning 1/1/22.*

- ***Complete 180-day transition for TAR drugs or grandfathering medications by 2nd Quarter, 2021.*** *This will now occur through Q2 2022.*

- ***Continue to perform run out activities for outpatient pharmacy through 1st Quarter, 2021.*** *This will now occur through Q2 2022.*

- ***Complete Member and Provider transition for outpatient pharmacy from KHS to Magellan by beginning of 1st Quarter, 2021.*** *This will now occur beginning 1/1/22.*

- ***Transition department to providing ongoing support to members and providers for pharmacy prescription benefits remaining the responsibility of KHS (ongoing).***

Goal 7 - Back to Care for Members

COVID 19 put a sudden halt to members receiving routine non-emergent care in a variety of areas including:

- Child immunizations, screenings and well visits
- Adult screenings and annual physicals
- High risk patients with chronic medical conditions on medication
- Special needs patients such as Health Home Programs, Chronic Pulmonary Clinic, Prediabetic Prevention Programs, etc.
- Patients who've delayed or deferred elective procedures or elective surgeries

Travel restrictions and government orders to suspend elective care for a time resulted in pent up demand for medical care. With these restrictions lifted, KHS will need to examine members falling into these categories to prioritize who may need assistance to restart or continue their care. A plan will be developed to assist members and providers on when and how members should reengage in their care. Technology will be used to contact members to remind them to resume their care or where appropriate, augment their care by offering telehealth consults for those who remain at home.

With the elimination of Prop 56 supplemental payments and expected performance shortfall in the 2020 P4P incentive program, a new incentive program will be part of the "Back to Care Program" to encourage patients to return to their doctor.

Deliverables

- ***Identify membership qualifying for participation from one or more of these groups beginning of 1st Quarter, 2021*** *– The Back to Care program includes a number of initiatives which may apply to some or all of KHS' enrollees and some or all of KHS' provider network. As appropriate, the various initiatives included creation of reports and data to target the desired population. Additionally, KHS staff who have contact with members are reviewing a member's gaps in care when conducting telephone conversations.*

- ***Prioritize members for intervention beginning 1st Quarter, 2021*** *– The Back to Care Program included a comprehensive approach to reach both the member and provider community. This included different interventions both broad and targeted. The targeted campaigns prioritized the areas of child immunizations, adult screenings, and high risk/special needs members.*

- ***Develop the Back to Care Communication Program to encourage providers and members to reengage in their health care by 1st Quarter, 2021*** *– There was a comprehensive communication and media campaign completed as part of this effort. Primary Care and Specialty Providers were notified about the opportunity to participate in provider incentive payments. Also, the "We're Here For You" member marketing campaign ran from February to May and included television, billboards, radio, print, and digital advertisements.*

- ***Under appropriate circumstances create a provider incentive program to aid in achieving desired outcomes by 2nd Quarter, 2021 -*** *KHS created two "back to care" provider incentive programs. These payments were made for services rendered between 9/1/20 and 12/31/20. All reporting was due to KHS by 2/28/21. Payments were issued beginning in May 2021. The Specialist program paid out $3.67 million and the PCP program paid out $1.5 million.*

- ***Under appropriate circumstances create a patient incentive program to aid in achieving desired outcomes by 2nd Quarter, 2021 -*** *KHS launched its first member rewards and engagement program in the 4th Quarter of 2020 and concluded in March 2021. The program leveraged Interactive Voice Recognition calls (IVR, aka Robocalls), text messaging, mailed letters/materials and live phone calls to encourage members to follow through with specific preventive health or condition management services. This outreach included information about gift cards that could be earned for receiving certain services. The gift cards ranged from $10-$30 and were paid for wellness visits (baby, child, youth), prenatal/postpartum visits, and new member initial health assessments. The first campaign included a payout total of $561,438.79.*

  The second campaign kicked off on June 16th and robocalls were completed for non-compliant members at that time. This campaign added additional member incentives for:
  - *Babies who complete 6 well baby visits between 0-15 months are eligible to receive a $10 gift card per visit. In addition, babies between 15-30 months who complete 2 well baby visits are eligible to receive a $10 gift card per visit. Total potential incentive is $80.*

- *Members who are between 3 and 21 years of age and complete a yearly wellness exam are eligible to receive a $15 gift card.*

- ***Determine ways to use technology to improve member and /or provider communication and with KHS staff by 2nd Quarter, 2021 -*** *Gaps in Care dashboard has been implemented on the member and provider portal as well as for KHS staff to have visibility into the various gaps in members preventative health. This provides one source of truth for a member's care gaps and triggers discussions and recommendations for completion. In addition, a member can reference their gaps in care rewards, pregnancy information page, and submit a prenatal visit reward form.*

  Health Services, Member services, and MIS are reviewing a potential pilot with Rite Aid/Health Dialog to implement kiosks that facilitate the collection of social determinants of health (SDoH) information and health risk/initial health assessment. This would also include an aligned member incentive for completion.

  Mobile mammography clinic was facilitated by KHS Quality Improvement staff to schedule 32 members to have mammograms performed at the Taft Westside Clinic who otherwise would need to travel to Bakersfield for care.

- ***Incorporate Telehealth Services (where appropriate) to expand access to care by 2nd Quarter, 2021 -*** *KHS implemented telehealth services according to the DHCS guidance on telehealth flexibility for services rendered to KHS members for most eligible benefits including behavioral health, home health, physical therapy, and autism therapy. KHS is allowing both synchronous, interactive audio and telecommunications systems and asynchronous store and forward telecommunications systems, thereby allowing both virtual and telephonic communication. In addition, internal auditing reports have been created to validate the utilization patterns of providers, types of services rendered, and will potentially remain after PHE.*

  Provider Network Management and the Clinical team are working on a contract with ConferMED for EConsult capability and Valley Children's Hospital for potential services for pediatric populations.

  KHS recently awarded grant funding to a provider to purchase a mobile telehealth clinic Vehicle (MTCV). It is an ADA compliant van conversion, with all the necessary equipment for a patient telehealth consultation. The MTCV will be equipped similarly to a consultation room along with a monitor, camera, microphone, speakers, and broadband

capability. This vehicle will drive to various Kern County communities including outlying areas such as Delano, McFarland, Lamont, Arvin, and Lost Hills to provide services. They will also partner with Boys and Girls Clubs in Kern County to provide mental health services to their adolescent population. The MTCV represents an additional resource to those who would not otherwise have easy access to medical care for necessary treatments and chronic disease management. The provider will set up a weekly schedule of the areas the MTCV will be set up, so KHS may share that information to our members.

- ***Develop tracking instrument and report to measure the Program's effectiveness in timely reengagement of patients by 4th Quarter, 2021.***

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, Chief Network Administration Officer

Date: October 14, 2021

Re: COVID 19 Vaccination Incentive Program

Background

Kern Health Systems embarked on an aggressive COVID-19 Vaccination Incentive Program that aligns with the Department of Health Care Service's initiative to materially increase vaccines among California's Medi-Cal population. This program focuses on identifying unvaccinated beneficiaries, educating them as to the vaccine's importance, increasing access to COVID-19 vaccination sites and providing incentives to encourage becoming vaccinated.

Starting September 1, 2021 through February 28, 2022, KHS will be offering an incentive to members who get fully vaccinated. Providers that are willing to enhance their efforts in getting their assigned members vaccination and become a vaccination site, are also being incentivized.

Provider Incentive

Incentives have been offered to our Safety Net Providers, PCPs, high volume Specialist and pharmacies. To assist the providers with member outreach, KHS has added a COVID-19 dashboard to the KHS Provider Portal which reports in detail the members who are unvaccinated or partially vaccinated. Using the State's vaccine registration file, the portal information is updated to provide the latest vaccine status of their assigned members. Incentives are paid when each assigned member becomes fully vaccinated.

Member Incentive

KHS will be offering an incentive to our members who become fully vaccinated against COVID-19. KHS will pay $50 to members receiving full vaccinations. A team of KHE staff are performing outreach calls to inform our members of vaccination sites and pop-up clinic events.

COVID-19 Pop-up Clinic Sites

Several mobile vaccination clinics are being held and will continue to be organized to focus on geographical areas with the highest number of unvaccinated or partially vaccinated members. Since KHS tracks unvaccinated members, cross checking their residents with mobile location sites will allow us to outreach to members letting them know of the time and date the mobile clinic will be in their location.

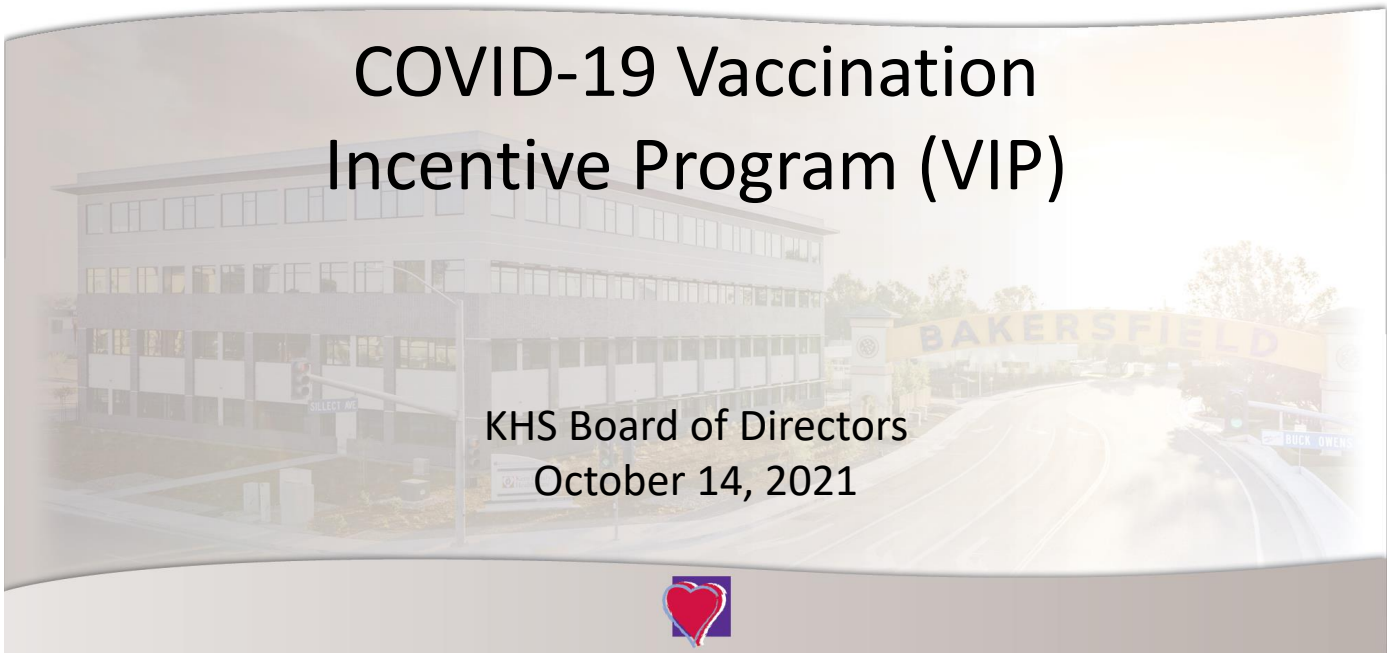
Community Based Efforts

KHS has also partnered with several community organizations and initiatives that are focusing on education and access to COVID 19 vaccinations in our county. A focused COVID-19 vaccination media campaign will commence October 18, 2021.

A presentation will provide more detail to the overall COVID-19 vaccination efforts. It is the hope that these strategies will meet the challenge of increasing the number of vaccinated KHS members and the community at large.

Requested Action

Receive and File.



COVID-19 Vaccination Incentive Program (VIP)

KHS Board of Directors
October 14, 2021

Background

The Department of Health Care Services (DHCS) is allocating up to $350 million to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery (MCP) system for the service period of September 1, 2021 through February 28, 2022.

This is a voluntary incentive program that focuses on increasing COVID-19 vaccination rates among the Medi-Cal population. DHCS provided a very short timeframe to develop and implement a plan.

DHCS identified populations of focus served by MCPs, who have been disproportionately challenged in the initial phases of vaccine distribution. These include members who:

- Are homebound and unable to travel to vaccination sites;
- Are 50-64 years of age with multiple chronic diseases;
- Self-identify as persons of color; and
- Youth 12-25 years of age

Kern Health Systems quickly developed a fairly aggressive COVID-19 vaccination plan to encourage expansion of vaccination sites, increase outreach and education to our members and communities, and increase the vaccination rates amongst our membership.

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KHS Vaccination Goal

Gap closure from baseline to a target defined as the percent of members (12 years of age and older) who received at least one dose of a COVID-19 vaccine on or before the outcome ascertainment date in the county.
On September 24, after program was initiated, DHCS issued a change to this key measure, that will result in a higher % vaccination target.
Kern County fully vaccinated rate = **39.26%** as of Aug. 31, 2021.

Kern Health Systems						
Total Qualified Membership	214,541					
Vaccinated	67,816					
Unvaccinated	146,725					
Baseline rate	**31.61%**	(does not inc. partial vaccination)				
Measurement Periods | Vaccination Performance			Cumulative			
			% of baseline	targeted members	total	Vaccination Rate
	October 31, 2021		10%	6,782	74,598	34.8%
	January 2, 2022		20%	13,563	81,379	37.9%
	February 28, 2022		30%	20,345	88,161	**41.1%**

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Provider Incentive Program Structure

KHS will issue payment for outcome measures upon approving the achievement of the specified goals outlined:

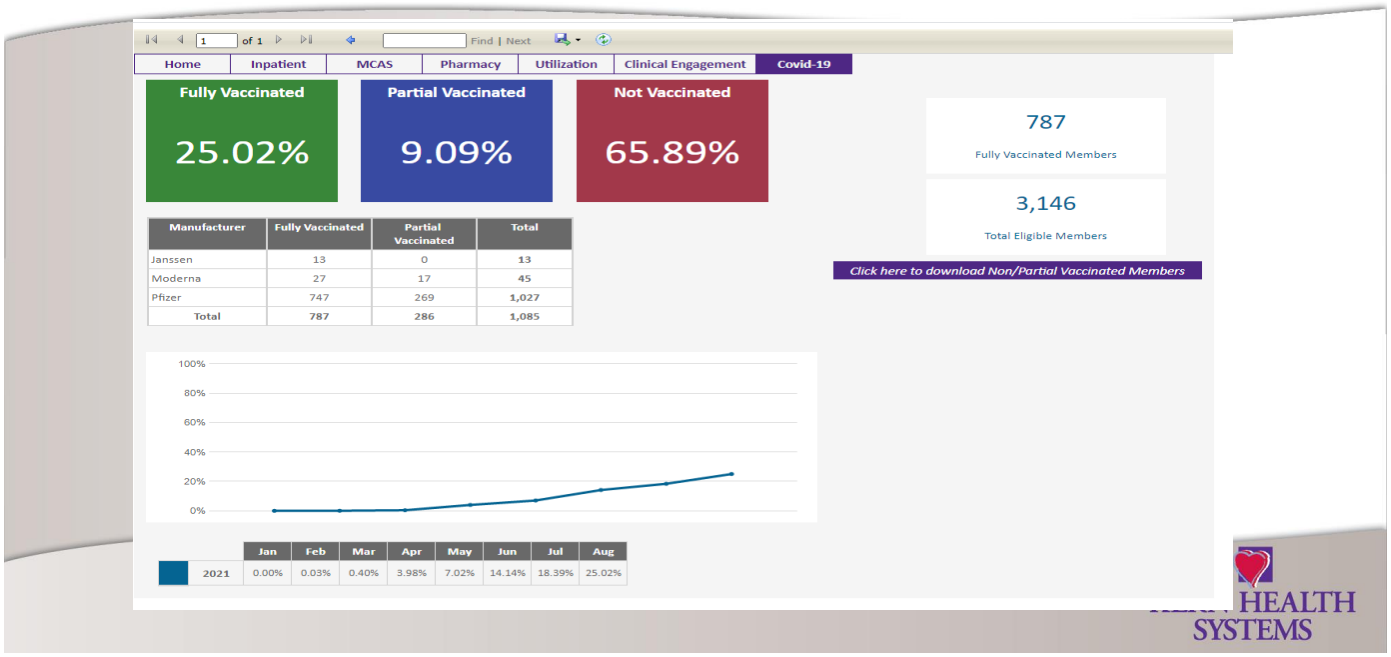
Vaccine Incentive Program Structure:

Measure Reporting Period	Outcome Measure Goal	Measure Incentive
10/31/2021	10% increase over baseline	Measure 1 25% payout
01/02/2022	20% increase over baseline	Measure 2 25% payout
02/28/2022	30% increase over baseline	Measure 3 50% payout

Primary Care Physicians	With over 1,000 members eligible for vaccination	$ 1,000,000
Safety Net Providers	KM, CSV, OMNI	$ 3,000,000
Specialists	$100 per fully vaccinated member	$ 500,000
Pharmacies	$100 per fully vaccinated member	$ 1,000,000

KERN HEALTH SYSTEMS

Portal Report Card



Media Campaign

- Billboards in targeted locations
- PSAs and Television Ads – collaborating with partners such as Latino COVID Task Force, Kern Public Health, and Dignity Health to produce and purchase ads
- GET Bus Fall Pocket Map
- Digital Advertising – targeted display ads on mobile devices and social media platforms

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COVID-19 Pop-Up Clinics

- **Kern County Latino-COVID 19 Taskforce** – provide vaccination events throughout the county along with a Mental Health and Help Lines. To date, the Taskforce has held over 53 COVID-19 Vaccination clinics throughout the county.
- **Cal State University Bakersfield Vaccination Clinic** – KFHC and Kern Medical are providing on-campus vaccination clinic once a week (Wednesday's from 10am-2pm) for 6 weeks and longer if needed. Clinic is for students and open to the public.
- **KHS Facility Vaccination Fairs –** Planning COVID-19 vaccination events at our Administrative Office building in conjunction with the Latino COVID Taskforce and Kern Medical on October 16th and November 6th from 12-5pm.
- **Other Vaccination Clinics** – KHS is organizing targeted Pop-Up clinics at COVID-19 unvaccinated "hot spots" such as Wasco, Taft, Southeast Bakersfield, and East Kern.

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COVID-19 Community Efforts

- **Door to Door Partnership** with Supervisor Leticia Perez, Bakersfield College, Dignity Health, and Hall Ambulance.
- **African American Collaborative** – partnering with the African American Chamber of Commerce and local churches
- **Farmworker Outreach** – California Farmworker Foundation will provide 12 vaccination clinics at worksites in northern and southern Kern County and provide direct education to 20,000+ Kern County Farmworkers and 20 Agricultural employers.
- **Vision y Compromiso** – Work closely with community partners and gate keepers including collaboratives, family resource centers, promotoras/es de salud, and community health workers to share information.
- **Support Other Stakeholders** (Kern County Behavioral Health & Recovery Services, KCDPH Black Infant Health Program, Central CA Asthma Collaborative) to increase vaccination rates among the members they serve.

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Direct Member Incentive

A proven successful strategy to encourage vaccinations are monetary incentives such as gift cards. DHCS has provided a maximum allowance of up to $50 to each fully vaccinated individual.

- KHS will be offering an incentive to our members who become fully vaccinated against COVID-19. Members who were not fully vaccinated by September 1, 2021 are eligible.
- KHS will be offering a $25 gift card for each COVID-19 vaccination for both the Moderna and Pfizer vaccine, or $50 for the Johnson & Johnson.
- Members will automatically be mailed a gift card to the address on file.
- For Pop-Up clinics, members will be provided a gift card at the event

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COVID-19 Vaccine Reservation Specialists

KHS Member Services Reservation Specialists are dedicated phone staff making outreach calls to encourage members to get the COVID-19 vaccine.

- Guide members through the MyTurn website to schedule
- Refer Members to walk-in vaccination sites
- Transfer members to Teledoc if medical advice is requested
- Assist in scheduling transportation to and from vaccination appointment

KERN HEALTH SYSTEMS

Thank You

For additional information,
please contact:

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

KERN HEALTH SYSTEMS

To: KHS Board of Directors

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

Date: October 14, 2021

Re: KHS Health Services Department- Utilization Management Program Documents

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Background

All Medi-Cal Managed Care Plan Utilization Management (UM) Programs are defined by the following documents:

- The Utilization Management Program Evaluation
- The Utilization Management Program Description

These documents are updated annually and reviewed by KHS's Physician Advisory Committee and KHS's QI-UM Committee. Following their review and acceptance, the documents are referred to the KHS Board of Directors for final approval.

2020 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 subsequent year's UM Program Description is modified to include previous years unmet or partially met goals.

2021 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

Approve the 2020 UM Program Evaluation and 2021 UM Program Description.

2020 Utilization Management (UM) Program Evaluation and 2021 Utilization Management Program Description

October 14, 2021

Deborah Murr, RN, BS-HCM
Chief Health Services Officer

Agenda

- Overview/Purpose
- 2020 UM Program Evaluation
- 2021 UM Program Description

KERN HEALTH SYSTEMS

Overview

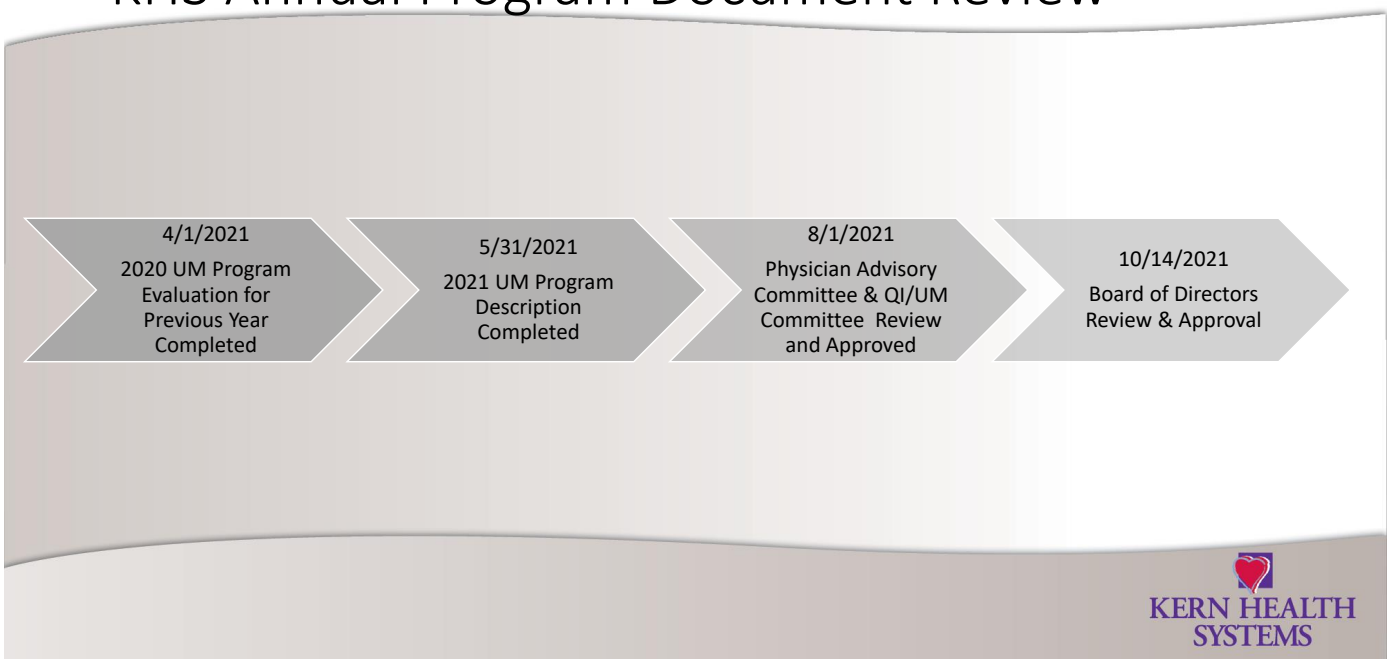
DHCS contract requirement

- 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

KHS Annual Program Document Review



2020 UM Program Evaluation

- Evaluate effectiveness of UM Program annually
- COVID impact
- 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

2020 UM Program Evaluation Results

<u>Goals Met</u>

- Delegated Oversight
  - Kaiser/Vision Service Plan/Health Dialog
- Clinical Training/Evaluation-IRR
- UM Key Performance Indicators
  - Turnaround times (Urgent/Routine)
  - Notifications (Provider/member)
- DHCS Report Submission

<u>Goals Not Met</u>

- Policy updates-*partially*
- Inpatient
  - COVID impact
  - Transitions of Care
  - Length of stay

KERN HEALTH SYSTEMS

2021 UM Program Description

Purpose

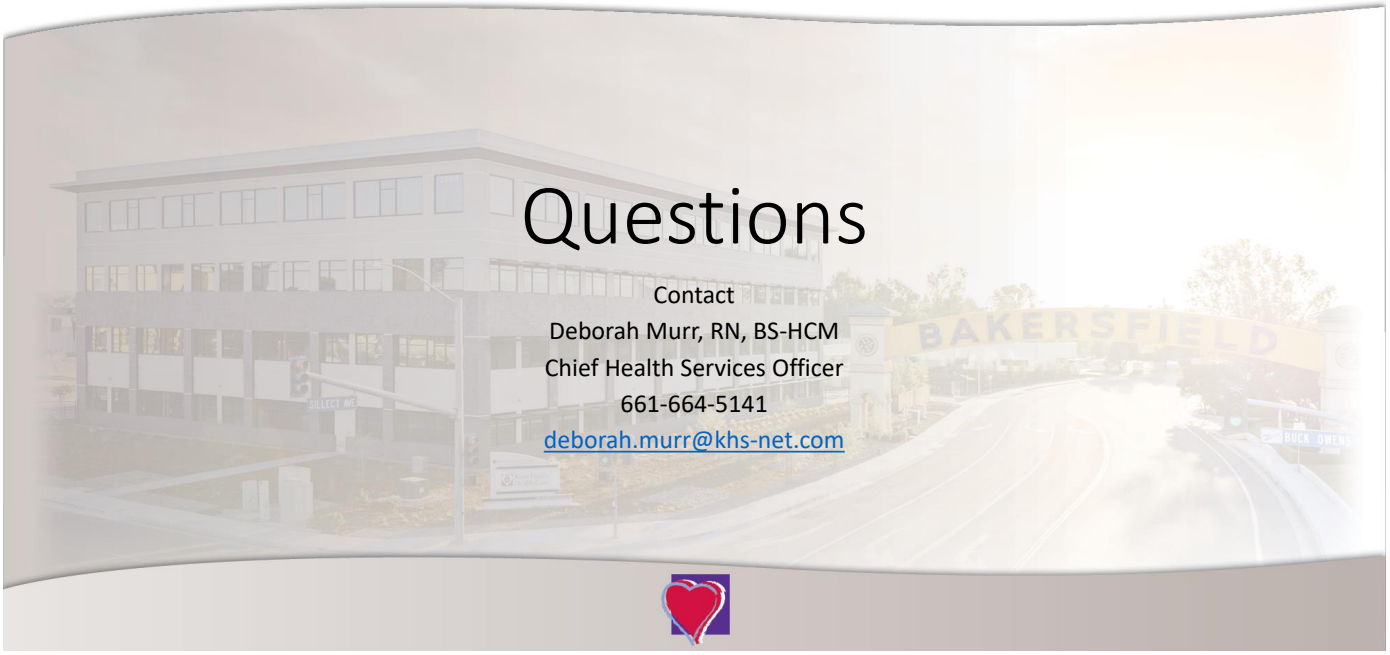
- Overview of the comprehensive health care and applicable processes and resources
- Develops, implements, continuously updates, and improves the UM program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services
- Scope of the program is defined and integrated throughout all the departments in the organization

KERN HEALTH SYSTEMS

2021 UM Program Description Contents

- Regulatory requirements
- UM process
- Delegation oversight
- Authority and Roles/Responsibility
  - Board/Executives/Committees/Departmental
- Training
- Special programs
- Collaboration with Community Entities

KERN HEALTH SYSTEMS



Questions

Contact
Deborah Murr, RN, BS-HCM
Chief Health Services Officer
661-664-5141
deborah.murr@khs-net.com


BAKERSFIELD
SILLECT AVE
BUCK OWENS
KERN HEALTH
SYSTEMS

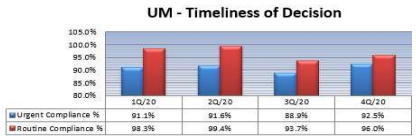
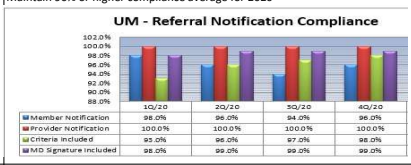
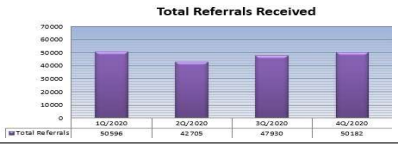
Attachment A

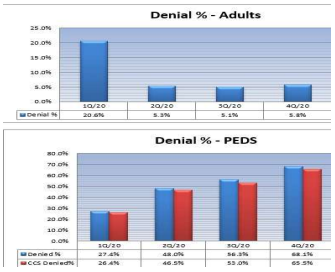
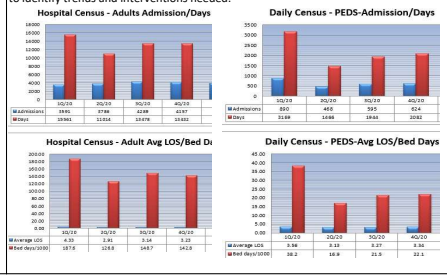
2020 Utilization Management Program Evaluation

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 2020 Annual UM Program Evaluation ☒ Development and implementation of 2020 UM Program Description	Met/Not Met	Year End 2020	1. Review and revise the annual UM Program Description and Complete prior year UM Program Evaluation 2. Obtain approval of the 2020 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 2020	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 and completed May 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 2020	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 2020 without any interruptions to service.
UM	Update UM Training Programs	Met/Not Met	Year End 2020	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 2020	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 2020	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
UM	Quarterly State Reports Timely Submission	Met/Not Met	Year End 2020	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 2020	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 2020
DHCS	Physician Advisory Committee (PAC)	Met/Not Met	Year End 2020	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
DHCS	Pharmacy and Therapeutics Committee (P&T)	Met/Not Met	Year End 2020	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
DHCS	Public Policy/Community Advisory Committee (PP/CAC)	Met/Not Met	Year End 2020	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.	Goal Met

UM	Utilization Management Policy & Procedure Review, Revision/Development, and Implementation	Met/Not Met	Year End 2020	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 2020 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 2021
UM	Monitoring UM Decision Turn-Around Times, Volume, and Denial Rates	Met/Not Met	Year End 2020	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.	
UM	Timeliness of Decisions	Met/Not Met	Year End 2020	Maintain 90% or higher compliance average for 2020  1Q/20 2Q/20 3Q/20 4Q/20 Urgent Compliance % 91.1% 91.6% 88.9% 92.5% Routine Compliance % 98.3% 99.4% 93.7% 96.0%	Goal Met: > 90% compliance rate for 2020 although did have slight drop in Urgent compliance in 3rd Quarter 2020.
UM	Referral Notification Compliance	Met/Not Met	Year End 2020	Maintain 90% or higher compliance average for 2020  1Q/20 2Q/20 3Q/20 4Q/20 Member Notification 98.0% 96.0% 94.0% 96.0% Provider Notification 100.0% 100.0% 100.0% 100.0% Criteria Included 93.0% 96.0% 97.0% 98.0% MD Signature Included 98.0% 99.0% 99.0% 99.0%	Goal Met
UM	Referral Count Monitoring	Met/Not Met	Year End 2020	Monitor the referral volume received on quarterly basis  1Q/2020 2Q/2020 3Q/2020 4Q/2020 Total Referrals 50596 42705 47930 50182	Goal Met Membership continues to grow with new populations anticipated in 2021

UM	Denial Percentage Monitoring	Met/Not Met	Year End 2020	Monitor the denial percentage on quarterly basis 	Goal Met
UM	Monitoring of After Hours call and nurse triage line services by Health Dialog	Met/Not Met	Year End 2020	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	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 2020	Closely monitor inpatient utilization trends using various reports and monitoring tools to identify trends and interventions needed. 	Goal Met

UM	Monitoring under-utilization	Met/Not Met	Year End 2020	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 2020	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.	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 Additional oversight and monitoring strategies are planned for 2021
UM	CCS Collaboration	Met/Not Met	Year End 2020	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.	Goal Met
UM	Community Housing Support	Met/Not Met	Year End 2020	The Permanent Supportive Housing Case Management Program in collaboration with the Kern County Housing Authority will afford KHS patients an opportunity to exit homelessness and receive decent, safe, and affordable housing. These case management services will be matched with a housing resource that already exists in our community, such as, short term rental assistance, housing choice vouchers, and low income public housing. By providing case management services to these housing options it now allows homeless persons to access them and to thrive.	Goal Met

UM	COPD Program	Met/Not Met	Year End 2020	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 20%	Goal Met Next Steps: Identify methods to improve member enrollment and participation in program, develop robust program monitoring tool.
UM	Medical Loss Ratio (MLR)	Met/Not Met	Year End 2020	Continued efforts that support maintaining MLR of < 92% 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	Goal Not Met: MLR remains at 92%. Various program initiative to directly impact MLR were challenged with identifying providers and their capacity to participate due to impacts from COVID-19.
UM	Increase KHS program referrals for members by UM staff	Met/Not Met	Year End 2020	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.

Attachment B

KERN FAMILY HEALTH CARE
UTILIZATION MANAGEMENT
2021 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 305,000 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 clinical 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.

In order to ensure efficacy 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 in order 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 other 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 Policy 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 and Basic Case Management, and other Health Education and preventative services 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 results, 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/gender
- 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
- Local hospitals' ability to provide all recommended services within the estimated length of stay

Delivery system capabilities and limitations 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.

Regulations and guidelines include but not limited to:

Regulations

- 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
- DHCS/DMHC Guidelines
- All Plan Letters (APL)
- Policy and Procedure Letters (PPL)
- MCG Health LLC (Milliman Care Guidelines)
- UpToDate

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, Basic 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 Pharmacy Department
- 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 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 which is dependent on the individual's 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 standard care in: reductions in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs.

- *Avoidance of hospital readmissions for primary and complicating conditions***.** TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are 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, KHS 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.

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 the plan's membership.

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 and aggregate 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 Population Health, 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 ensure 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 time-frame;
- 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. 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.

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.

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 in order 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, 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 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;
- 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 Policy 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 e.g., 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)

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, Recuperative, 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 e.g. CCS, Long Term Care, State Waiver Programs;
- Participates in UM and QI data and statistical gathering, collation, and reporting; and
- Assess for over and underutilization and identify potential fraud, waste, and abuse.

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), Health Services Manager, 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 e.g. CCS, Long Term Care, State Waiver Programs.

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 in an effort 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
- Provide 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

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
- Knox Keene License
- CMS Federal Regulations

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 on or before 2019.

Pre-authorization

With the exception of 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.

Regular analytics are completed to reevaluate the need for prior authorization requirements as part of over and underutilization monitoring.

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 make arrangements 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 make a determination.

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:

- Medi-Cal Criteria: Updated by the Department of Health Services, current year at their discretion
- Medicare Criteria: Updated by the Center of Medicare Services, current year at their discretion
- All Plan Letter (APL) guidance as received from DHCS/DMHC
- Milliman Care Guidelines (MCG): Updated annually by vendor
- UpToDate: 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.

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;
- Nondiscrimination language;
- 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 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 KHSUM goals and objectives. KHS also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KHS retains accountability 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.

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.

Ensuring Appropriate Utilization

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 trends in utilization across all UM

functions to determine if fraud, waste, abuse, or quality concerns warrant investigation. Suspected or identified Fraud, waste, and abuse is reported to the Compliance department for investigation to determine if additional actions are required.

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.

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 provide transparency to the plan's Executive leadership of all identified KPI.

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

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 other clinical department directors, consult 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 Health Services 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.

COVID -19 Impact to KHS Member and Providers

As the State of California responded to the COVID-19 pandemic, the Department of Health Care Services (DHCS) outlined several contractual requirements to ensure KHS members were able to access medically necessary services in a timely manner.

These provisions included:

- Covering all medically necessary emergency care without prior authorization, whether that care is provided by an in-network or out-of-network provider;
- Complying with utilization review timeframes for approving requests for urgent and non-urgent covered services;
- Ensuring KHS provider networks are adequate to handle an increase in the need for services, including offering access to out-of-network services where appropriate and required;
- Ensuring 24-hour access to an KHS representative with the authority to authorize services;
- Waive prior authorization and/or step therapy requirements if the member's prescribing provider recommends the member take a different drug to treat the member's condition;
- Offering members and providers the option to utilize telehealth services to deliver care when medically appropriate; and
- Approving transportation requests in a timely manner.

Additionally, provisions were implemented in coordination with KHS's provider network and vendor partners to facilitate timely and uninterrupted care.

- Authorizations extensions from April 2020 to December 2020 to allow for completion of services;
- Creation of COVID hotline and specialty clinic for immediate access to COVID screening and treatment;
- Organizational wide approach to member information dissemination for testing, screening, and treatment as warranted.

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.

_____ Date _____

KHS Board of Directors (Chair/Designee)

_____ Date _____

Chief Executive Officer

_____ Date _____

Chief Medical Officer

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Jane Daughenbaugh, Director of Quality Improvement

Date: October 14, 2021

Re: KHS Health Services Department - Quality Improvement Program Documents

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Background

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

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

These documents are reviewed and updated annually. In turn, they are presented to the KHS Physician Advisory Committee and KHS QI-UM Committee for comment before recommending for approval by the KHS Board of Directors.

Quality Improvement Program Evaluation (Attachment A)

The QI Program Evaluation is performed annually and shows the results for the KHS Quality Improvement Program objectives and activities. Outcomes from the annual program evaluations may drive changes to the QI Program Description for the next year.

Quality Improvement 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 it describes integration of the program 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.

Quality Improvement 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 and / or reoccurring or special projects or improvement plans. Outcomes of the Work Plan are key to the program evaluation.

Attached is a PPT presentation describing the three documents and summarizing their content.

Requested Action

Approve the 2020 QI Program Evaluation, 2021 QI Program Description, and the 2021 QI Program Work Plan.

Quality Improvement Program, 2021

Agenda

- ❖Annual Documents Development & Review Timeline
- ❖Primary Impacts of COVID
- ❖2020 Quality Improvement Program Evaluation
- ❖2021 Quality Improvement Program Description
- ❖2021 Quality Improvement Workplan

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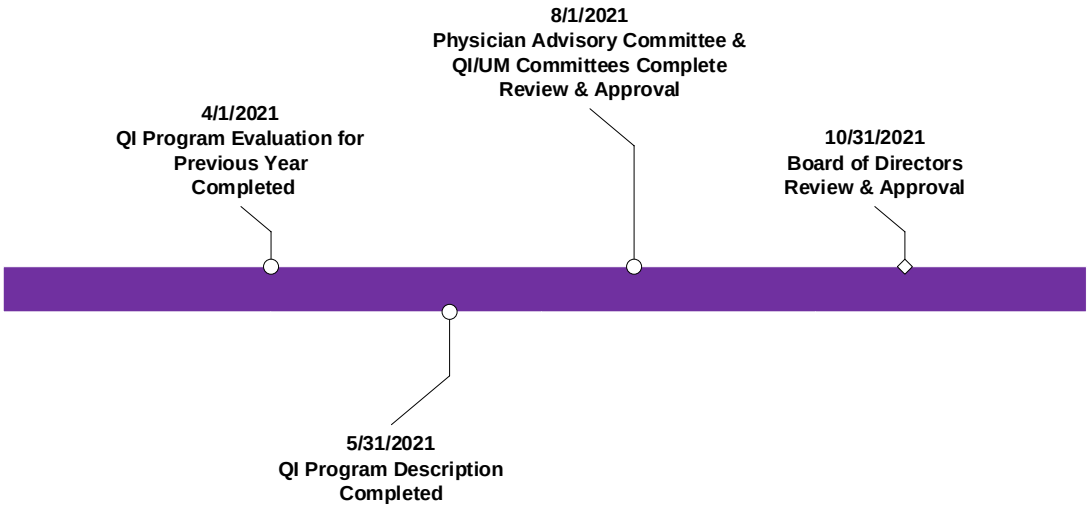
Quality Improvement Program: Annual Documents Development & Review Timeline



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Quality Improvement Program
Primary Impacts of COVID

- Stopped In-Person Provider Site Review activity
  - Shifted to virtual reviews
- Limited volume of medical records retrieved for MCAS/HEDIS audit
- Stopped 2 Performance Improvement Projects for Asthma & Well Child Visits that were underway

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Quality Improvement
2020 Program Evaluation

- Focus:

1) Managed Care Accountability Set (MCAS)

   - 21 measures (2 measures met minimum performance levels (MPL) & 19 did not)
   - Cause for non-compliance:
     - Change in Minimum Performance Level &
     - COVID-19 Pandemic

2) Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey

   - KHS ranked 7 of 26 health plans among adult members
   - KHS ranked 9 of 26 health plan s among child members
   - Both rankings consistent with National Average for health plans

3) Performance Improvement Projects (PIPs) stopped & two started

4) Facility Site & Medical Record Reviews – conducted virtually due to pandemic

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Quality Improvement
2021 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 2021:

- Member Engagement & Rewards Program – 2 Campaigns Scheduled
- Initiation of new MCAS Committee
- SWOT Action Plan work for MCAS
- COVID Vaccine & Back to Care Promotion
- Focused meetings for MCAS improvement with healthcare providers
- Increase visibility for individual member gaps in care

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Quality Improvement
2021 Workplan

The 2021 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

Quality Improvement
Requested Action

Approve:

- the 2020 QI Program Evaluation
- 2021 QI Program Description
- 2021 QI Program Work Plan.

KERN HEALTH SYSTEMS

Thank You

For questions, please contact:

Jane Daughenbaugh, RN, PHN, CM, BSN, MA
Jane.Daughenbaugh@khs-net.com
(661) 664-5080

KERN HEALTH SYSTEMS

Attachment A

Kern Health Systems
Quality Improvement Program Evaluation
Reporting Period: January 1, 2020 – December 31, 2020

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 2020 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) 2020 results shown in this report reflect Measurement Year (MY) 2019 data. MCAS RY 2020 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).

QI Program Evaluation
2020

In March of 2020, the world entered a pandemic for the COVID-19 virus. At that time, stay at home orders were initiated and staff from KHS were set up to work from home. Visits by KHS staff to provider offices were stopped for the protection of KHS staff, providers, and members. One of the results of this action was that we were not able to collect the number of medical records that would have normally been retrieved as part of the process for measuring compliance outcomes of MCAS for MY2019/RY2020. Most MCPs throughout California incurred this same impact. This led to significantly lower than normal rates for the MCAS measures that would likely would have seen in the absence of the pandemic.

KHS was compliant with 3 out of 18 MCAS Measures (see Appendix A):

- IMA-2: Immunizations for Adolescents (met MPL)
- PPC-Pre: Timeliness of Prenatal Care (met MPL)
- PPC-Post: Timeliness of Postpartum Care (met MPL)
- KHS was not compliant with the remaining 15 measures we are held to meet the MPL:
- AWC: Adolescent Well-Care Visits
- ABA: Adult Body Mass Index Assessment
- CCS: Cervical Cancer Screening
- CIS-10: Childhood Immunization Status
- CDC-HT: Comprehensive Diabetes Care HbA1c Testing
- CDC-H9: HbA1c Poor Control (>9.0%)
- CBP: Controlling High Blood Pressure <140/90 mm Hg
- WCC-BMI: Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents
- W15: Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits
- W34: Well-Child Visits in the 3rd 4th 5th & 6th Years of Life

Factors impacting compliance with MCAS measures included:

- Change of the MPL benchmark from the 25th percentile to the 50th percentile for MY2019
- Reduced volume of medical records retrieved due to the COVID-19 pandemic

DHCS is not imposing sanctions or corrective action plans for MY2019 MCAS results. However, DHCS presented KHS an opportunity to conduct a Strengths-Weaknesses-Opportunities-Threats project over the next 2 years with a goal of establishing an organization-wide infrastructure for managing compliance with the MCAS measures. DHCS offered to serve in a consulting role with KHS and we did choose to move forward with this project. 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 2020 and will continue through 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 2019 and results were provided in 2020 by DHCS. DHCS provided the sample of member information for contracted health plans to the EQRO. The CAHPS survey summary results are as follows:

Overall, KHS' scores improved in comparison to the 2016 CAHPS results. Key improvement areas in the adult population were in the areas of:

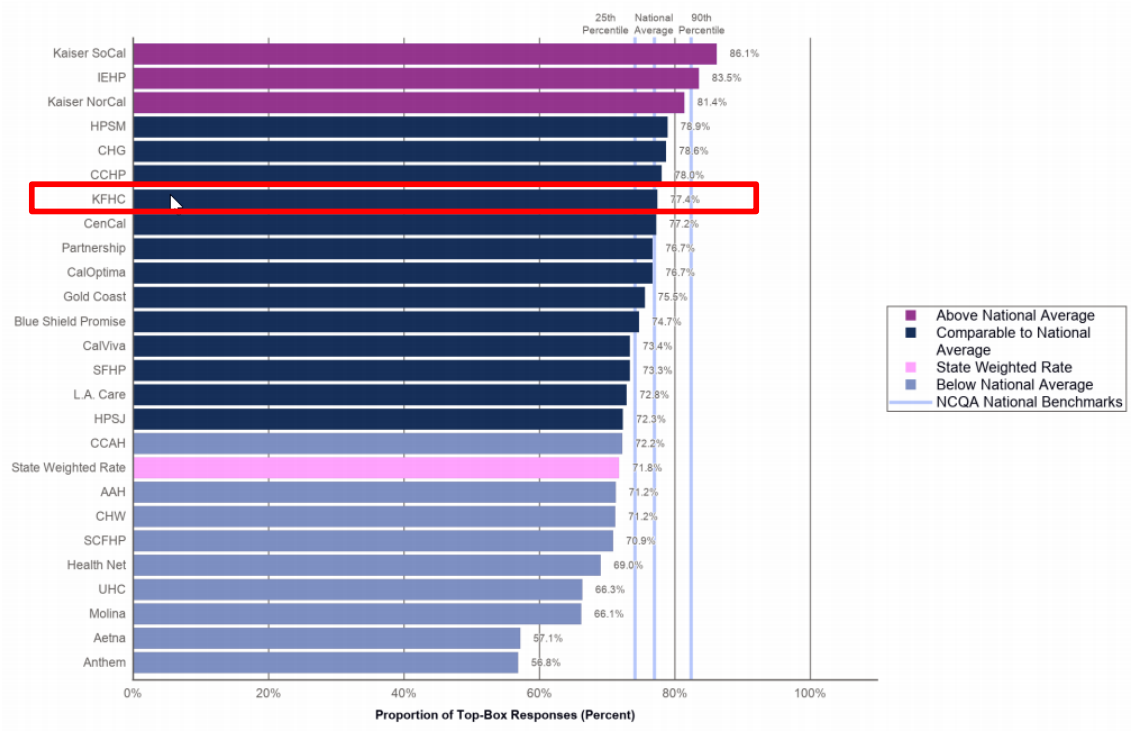
- Getting Needed Care
  - Getting care, tests, or treatments necessary
  - Obtained appointment with specialist as soon as needed
- Getting Care Quickly
  - Obtaining needed care right away
  - Obtained appointment for care as soon as needed
- Health Promotion and Education
- Access to Tobacco Cessation Medication and Strategies to Quit

Although 83% of KHS' provider network understands how to access interpreting services for KHS members, the remaining 17% needs reminders of this member benefit. An opportunity was identified for KHS Health Education, Cultural & Linguistics Department to continue to partner with the Provider Network Management (PNM) and QI Departments to help coordinate in-services and refresher trainings for providers who are identified as non-compliant through the quarterly interpreter access survey; have had a cultural and linguistic grievance filed against the office site; or, have been identified as an office site that would benefit from additional training.

Below is a comparison of Kern Family Health Care (KFHC) to other MCPs in California for an overall rating as a health plan. For this measure, KFHC was comparable to the National Average for both adult and child populations.

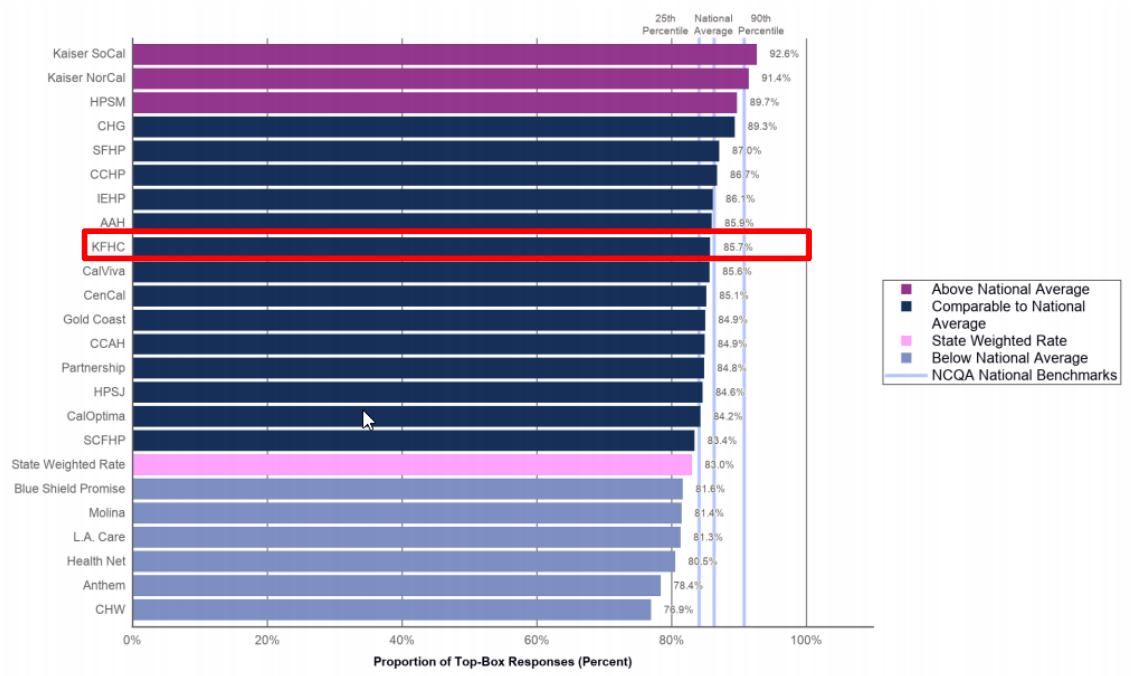
QI Program Evaluation
2020

Rating of Health Plan: Adult Top-Box Scores (MCP Level)



QI Program Evaluation
2020

Rating of Health Plan: Child Top-Box Scores (MCP Level)



QI Program Evaluation
2020

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 that started in 2019 were

1. Health Equity PIP: Improving Asthma Medication Ratio Compliance in Children 5-11 & 12-18 years of age, and
2. Health Disparity PIP: Improving the health and well-being of low-income children, ages 3 – 6 years, through Well Child 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 above were on track up until July of 2020. At that time, DHCS halted the two PIPs due to EQRO contract activities. In the fall of 2020, DHCS initiated a new cycle of PIPs and allowed MCPs to use the same topics they had underway prior to July of 2020 or select new topics. KHS opted to retain the two topics listed above and modify it to incorporate impacts of the pandemic. Both topics were accepted by DHCS and Module 1, 2 and 3 will be underway in 2021.

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 a delay by MCPs from conducting on-site, site and medical record reviews until 6 months after the covid-19 public health emergency (PHE) has ended. 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. 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. KHS conducted these reviews virtually.

In the fall of 2020, our certified Master Trainer left KHS. Another QI Department RN is in the process of obtaining her Master Trainer certification. However, due to the inability to perform reviews in person, this could not be completed. We continue to communicate with DHCS on any alternative options available.

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.

QI PROGRAM OVERVIEW

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Oversight of all delegated QI functions for the following services: • Kaiser	Met	8/31/2020	QI and UM evaluations, programs and work plans for Kaiser and VSP will be presented to the Physician Advisory Committee and QI-UM Committee by the end of August 2020.	Not completed due to the pandemic. Delegation

QI Program Evaluation
2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
• VSP				oversight has been managed through report and document submissions from vendors. Next review for Kaiser will cover the time frame that would have been covered in last year's review, April 1, 2019 – 3/31/2021
QI Policies and Procedures	Not 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. Policy 2.01-P General Exam Guidelines, was updated.	Partial Completion for 2020 Site review policy and procedures

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Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			4. 2.70-I, Potential Inappropriate Care Issues, was updated. 5. 2.22-P, Facility Site Review, was updated. 6. 2.26-I, Hospital Re-admissions – Identification of 7. Potential Inappropriate Care Issues, was updated. 8. 2.21-P, Management of Biohazards Waste, was updated. 9. 2.20-P, Infection Control Program, was updated. 10. 2.17-P, Access – Treatment of a Minor, was updated. 11. Revisions to current QI policies and procedures have been taken to the QI/UM committee.	will be updated after COVID pandemic PHE is over.
Audits				
Site review (SR) timeliness audit	Met	12/31/2020	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 developed during the summer. KHS has been working with providers to complete as many as possible virtually based on the resource capacity of providers. Below is a table summarizing the reviews that were due in 2020 and the number completed. The number completed within timeliness standards and those that were not completed. Priority was given to the full site and medical record reviews. For that reason, interim reviews did not occur.	Partially Complete for 2020

QI Program Evaluation
2020

<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><th>Type of Review</th><th>Total Number of Reviews Due</th><th>Number of Reviews Completed</th><th>Number of Reviews Completed & Met Timeliness Stds</th><th>Number of Reviews Not Completed</th></tr>
<tr><td>Initial full site reviews</td><td>9</td><td>9</td><td>9</td><td>0</td></tr>
<tr><td>Initial medical record reviews</td><td>3</td><td>3</td><td>3</td><td>0</td></tr>
<tr><td>Periodic full site reviews</td><td>26</td><td>11</td><td>2</td><td>15</td></tr>
<tr><td>Periodic medical record reviews</td><td>23</td><td>9</td><td>2</td><td>14</td></tr>
<tr><td>Interim reviews</td><td>40</td><td>0</td><td>0</td><td>40</td></tr>
<tr><td>Total – All reviews</td><td>101</td><td>32</td><td>16</td><td>69</td></tr>
</table>
</td><td></td></tr>
<tr><td>Staying Healthy Assessment</td><td>Met</td><td>12/1/2020</td><td>407 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.</td><td>Complete for 2020</td></tr>
<tr><td>30-day readmission</td><td>Met</td><td>Ongoing</td><td>• 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 2020. 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.</td><td>Complete for 2020</td></tr>
<tr><td>Notifications (Death, General)</td><td>Met</td><td>Ongoing</td><td>The QI department reviewed all death notification referrals from the UM Department. The UM nurses only refer those notifications in which there is a suspected or potential quality of care concern. In 2020, there were a total of 33 referrals</td><td>Complete for 2020</td></tr>
</table>

QI Program Evaluation
2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			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.	
Grievances	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Grievance process. 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 2020, QI received 1,033 PIC referrals from the Grievance team which represents 17.22% of all Grievances received.	Complete for 2020
Resources				
• Director of Quality Improvement	Not Met	12/31/2020	A Director of QI is currently in place.	Completed for 2020
• QI Clinical Manager	Met	12/31/2020	This position was approved for hire in 2020. A nurse was recruited at the end of 2020 to start in her position in January of 2021.	Complete for 2020
• QI Operations Supervisor	Met	12/31/2020	This position was created and includes duties of the previous Operations Analyst role. Primary duties focus on to oversee the	Completed for 2020

QI Program Evaluation
2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			department's day-to-day, non-clinical operations. They are responsible for providing an advanced role in the analysis of health care information as it relates to MCAS and other activities within the QI department such as Performance Improvement Projects (PIPs). They support regulatory or accreditation audits and quality improvement initiatives for Performance Improvement Projects (PIPs). The Supervisor oversees compliance with the Facility Site Reviews (FSRs) and other external quality reviews.	
• QI RN II	Met	12/31/2020	We had 2 QI RN II positions last year. However, both nurses left the organization in the 4th quarter. The positions were posted to replace them with either a QI RN I or QI RN II. We have two QI RN I nurses who are on track for promotion next year. It should be noted that one of the nurses who left was the only certified site review Master Trainer (MT). One of the other QI RNs was in training to complete her MT certification.	Partially Complete for 2020
• QI RN I	Met	12/31/2020	All QI RN I positions were filled with a total of 8 nurses.	Complete for 2020
• QI Coordinator	Met	12/31/2020	Position filled with no changes in 2020. This position's primary focus is on the Managed Care Accountability Set (MCAS) annual audit and ongoing activities to support provider compliance.	Complete for 2019
• QI Assistant	Met	12/31/2020	Position filled with no changes in 2020. This position assists with MCAS Medical Record retrieval and for supporting Member Incentive initiatives sponsored by QI.	Complete for 2020
• Operational Analyst	Met	12/31/2020	Position filled with no changes in 2020. This analyst is responsible for providing an advanced role in the analysis of health care information as it relates to MCAS and other activities within the QI department such as Performance Improvement Projects (PIPs).	Complete for 2020

QI Program Evaluation
2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
• Senior QI Technician and Trainer	Met	12/31/2020	This position was approved for inclusion in the QI Operations Supervisor role. The position no longer exists as a standalone position.	Complete for 2020
• Senior Support Clerk	Met	12/31/22020	QI has one staff in this position and there were no changes in 2020. QI has one SSC who supports the clerical needs of the department.	Complete for 2020
QI Projects				
QI Facility Site and Medical Record Review automation	Met	3/31/2020	A new tool, EzTracker, from the vendor, Healthy Data Systems, was implemented during the 3rd quarter. The tool is in the process of being updated to incorporate the requirements for a new FSR/MRR APL20-006 that will take effect 6 months after the end of the public health emergency status related to the COVID-19 pandemic.	Completed for 2020
Member Education Material	Met	12/31/2020	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 • Nutrition Booklets • Immunization Growth Charts Due to the pandemic, distribution of these educational materials stopped around March of 2020. After March, 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 pandemic.	Partially Completed for 2020

QI Program Evaluation
2020

<table>
<tr><th>Goal</th><th>Metrics</th><th>Target Completion</th><th>Action Steps and Monitoring</th><th>Results</th></tr>
<tr><td>Member Incentive</td><td>Met</td><td>12/31/2020</td><td>The following is a summary of member incentives that were made available to members and managed by the Health Education Department.
<table><tr><th>Member Incentive Program (MIP)</th><th>Total Members who received incentive</th></tr><tr><td>1. Health Home MIP</td><td>2,702</td></tr><tr><td>2. Asthma Class MIP</td><td>51</td></tr><tr><td>3. Healthy Eating, Active Lifestyle MIP</td><td>815</td></tr><tr><td>4. Asthma Impact Model Pilot MIP</td><td>34</td></tr><tr><td>5. Member Portal MIP</td><td>11573</td></tr><tr><td>6. IHA MIP</td><td>7533</td></tr><tr><td>7. 1 Year Well Baby MIP</td><td>2321</td></tr><tr><td>8. Prenatal Care MIP</td><td>237</td></tr><tr><td>9. Postpartum Care MIP</td><td>2928</td></tr><tr><td>10. Diabetes Prevention MIP</td><td>23 (closed after Feb. due to COVID)</td></tr><tr><td>11. Perinatal Survey MIP</td><td>400</td></tr><tr><td>TOTAL Incentives</td><td>28,617</td></tr></table>MIP = Member Incentive Program
DPP = Diabetes Prevention Program</td><td>Complete for 2020</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>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 2020</td></tr>
</table>

QI Program Evaluation
2020

<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. Nine (9) 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>4 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>3 meetings</td></tr>
<tr><td>FQHC Provider</td><td>4 meetings</td></tr>
<tr><td>Pharmacy Provider</td><td>4 meetings</td></tr>
<tr><td>Public Health Department</td><td>3 meetings</td></tr>
<tr><td>Home Health/Hospice Provider</td><td>1 meeting</td></tr>
<tr><td>DME Provider</td><td>4 meetings</td></tr>
</table></td><td></td></tr>
<tr><td></td><td>Met</td><td>12/31/2020</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. The extent of participation must be relevant to the QI activities undertaken by KHS.</td><td>Complete for 2020</td></tr>
</table>

QI Program Evaluation
2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
	Met	12/31/2020	1. Practitioner participation and attendance for this reporting period continue to result in improved communication. 2. Participating practitioners involved in the QI Program serve as a communication representation for the practitioner community. 3. These practitioners provide input and support toward educating participating providers about the principles of QI, and specific quality activities.	Complete for 2020
Physician Advisory Committee (PAC)	Met	12/31/2020	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 2019.	Complete for 2020
	Met	12/31/2019	Ten (10) PAC meetings were held during the reporting period with attendance as follows: **Physician Advisory Committee Members** / **Attended** CMO — 8 meetings Pediatrician — 8 meetings Clinical Psychologist — Open Position Eye Specialist — 8 meetings OB/GYN Provider — 4 meetings	Complete for 2019

QI Program Evaluation
2020

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			Pain Medicine Provider: 6 meetings Family Practitioner: Open Position Internal Medicine Provider: 7 meetings	
Pharmacy and Therapeutics Committee (P&T)	Met	12/31/2020	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.	Complete for 2020

QI Program Evaluation
2020

<table>
<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>3 meetings</td></tr>
<tr><td>Pediatrician</td><td>4 meetings</td></tr>
<tr><td>Retail Pharmacy/Chain</td><td>2 meetings</td></tr>
<tr><td>Board Member/Rx Representative</td><td>4 meetings</td></tr>
<tr><td>Pharmacy/Specialty Practice</td><td>4 meetings</td></tr>
<tr><td>Pharmacy/Geriatric Specialist</td><td>Open Position</td></tr>
<tr><td>Internal Medicine</td><td>0 meetings</td></tr>
<tr><td>General Practice/Geriatrics</td><td>Open Position</td></tr>
<tr><td>KHS Pharmacy Director/Alternate Chairperson</td><td>4 meetings</td></tr>
</table>
</td>
<td>Complete for 2020</td>
</tr>
<tr>
<td>Public Policy/Community Advisory Committee (PP/CAC)</td>
<td>Met</td>
<td>12/31/2020</td>
<td>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 four months and provides recommendations and reports findings to the Board of Directors.</td>
<td>Complete for 2020</td>
</tr>
</table>

QI Program Evaluation
2020

<table>
<tr><td></td><td>Met</td><td>12/31/2020</td><td>PP/CAC has eight (8) committee positions. All eight (8) positions were filled; Four (4) PP/CAC meetings were held in the reporting period with attendance as follows:

<table><tr><th>Public Policy Committee Members</th><th>Attended</th></tr><tr><td>Chair</td><td>4 meetings</td></tr><tr><td>KHS Member</td><td>4 meetings</td></tr><tr><td>KHS Member</td><td>2 meetings</td></tr><tr><td>KHS Member</td><td>2 meetings</td></tr><tr><td>KHS Member</td><td>2 meetings</td></tr><tr><td>KHS Member</td><td>3 meetings</td></tr><tr><td>KHS Member</td><td>2 meetings</td></tr><tr><td>KHS Member</td><td>1 meetings</td></tr><tr><td>1 Member of KHS Board of Directors</td><td>2 meetings</td></tr><tr><td>1 Participating Healthcare Provider</td><td>2 meetings</td></tr><tr><td>Community Representative</td><td>2 meetings</td></tr><tr><td>Community Representative</td><td>3 meetings</td></tr><tr><td>Kern County Department of Public Health</td><td>4 meetings</td></tr><tr><td>Kern County Department of Human Services</td><td>3 meetings</td></tr></table></td><td>Complete for 2020</td></tr>
<tr><td colspan="5">Regulatory Compliance</td></tr>
<tr><td>DHCS audit</td><td>Postponed</td><td>8/6/2019 – 8/9/2019</td><td>Due to the COVID-19 pandemic, DHCS did not complete an audit in 2020.</td><td>Not Completed for 2020</td></tr>
<tr><td>DMHC Audit</td><td>Pending</td><td>8/6/19 – 8/8/20</td><td>The Department of Managed Health Care (DMHC) audits Knox-Keene licensed health plans every 3 years. DMHC audited KHS in 2019. The next scheduled audit will be in 2022.</td><td>Complete for 2020</td></tr>
</table>

			A non-routine medical survey was done in November 16th – 18th, 2020. Results of this review were provided by DHMC in 2020 and follow up on correction of the items will occur in 2021.	
Managed Care Accountability Set (MCAS) RY2020 Audit	Partially Met	7/2020	On 7/11/2020 we received our Medi-Cal Managed Care, HEDIS® 2019 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 Due to the pandemic, DHCS is not imposing sanctions or corrective action plans for MCAS RY2020 results.	Complete for 2020
Improvement Plans (IPs)PIP				
Asthma Medication Ratio	N/A	07/2020	Due to the pandemic, DHCS is not imposing sanctions or corrective action plans for MCAS RY2020 results.	N/A
Performance Improvement Projects (PIPs)				
Disparities in Well Child Visits	New	Ongoing	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. This measure was selected due to the importance of this	Complete for 2020

			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 around the 2nd half of 2022.	
Child/Adolescent Health Asthma Medication Ratio (AMR)	New	Ongoing	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. This measure was selected based on our measurement year 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 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 around the 2nd half of 2022.	Ongoing
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

			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 the pandemic causing many offices to close or to experience severe staffing shortages.	Partially Completed for 2020

Attachment A

2019 Measurement Year and 2020 Report Year
EAS/HEDIS Results

QI Program Evaluation
2020

RY2020 MCAS Rate Tracking Report								
Hybrid Measures Held to MPL								
Measure		Current RY2020 Rate	RY2020 MPL	RY2020 HPL	RY2019 KHS Rate	Current Vs. RY2020 MPL	Current Vs. RY2020 HPL	Current Vs. RY2019 KHS
AWC	Adolescent Well-Care Visits	36.01	54.26	68.14	N/A	-18.25	-32.13	N/A
ABA	Adult Body Mass Index Assessment	78.10	90.27	95.88	N/A	-12.17	-17.78	N/A
CCS	Cervical Cancer Screening	56.20	60.65	72.02	60.34	-4.45	-15.82	-4.14
CIS-10	Childhood Immunization Status	29.93	34.79	49.27	N/A	-4.86	-19.34	N/A
CDC-HT	Comprehensive Diabetes Care HbA1c Testing	85.16	88.55	92.94	89.13	-3.39	-7.78	-3.97
CDC-H9*	HbA1c Poor Control (>9.0%)	57.91	38.52	27.98	33.15	-19.39	-29.93	-24.76
CBP	Controlling High Blood Pressure <140/90 mm Hg	38.93	61.04	72.26	54.26	-22.11	-33.33	-15.33
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	41.36	34.43	47.2	40.63	6.93	-5.84	0.73
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	84.18	83.76	90.98	81.27	0.42	-6.80	2.91
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	81.02	65.69	74.36	67.64	15.33	6.66	13.38
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	66.42	79.09	90.4	N/A	-12.67	-23.98	N/A
W15	Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits	32.60	65.83	73.24	N/A	-33.23	-40.64	N/A
W34	Well-Child Visits in the 3rd 4th 5th & 6th Years of Life	65.21	72.87	83.85	63.99	-7.66	-18.64	1.22

* A lower rate indicates better performance therefore the number of required numerators must decrease by the number shown.

QI Program Evaluation
2020

Administrative Measures Held to MPL								
Measure		Current RY2020 Rate	RY2020 MPL	RY2020 HPL	RY2019 KHS Rate	Current Vs. RY2020 MPL	Current Vs. RY2020 HPL	Current Vs. RY2019 KHS
AMM - Acute	Antidepressant Medication Management – Acute Phase Treatment	50.24	52.33	65.95	N/A	-2.09	-15.71	N/A
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	32.64	36.51	48.68	N/A	-3.87	-16.04	N/A
AMR	AsthmaMedication Ratio	48.78	63.58	71.62	21.49	-14.80	-22.84	27.29
BCS	Breast Cancer screening	57.29	58.67	69.23	56.57	-1.38	-11.94	0.72
CHL	Chlamydia Screening in Women Ages 16 – 24	55.29	58.34	71.58	N/A	-3.05	-16.29	N/A

Indicates we met or exceeded MPL/RY2019 rate/Health Net RY2019 rate

Indicates we met the HPL.

N/A' is for measures that were not reported for RY2019

Attachment B

KERN HEALTH SYSTEMS

Quality Improvement Program Description

2021

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 Organization (MCO). 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 through the development and maintenance of an interactive health care system that includes the following elements:

1. Development and implementation of a structure for measurement, assessment and evaluation, and problem resolution of health and vision needs of members.
2. A process and structure for quality improvement with contracting providers.
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 and 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,
   - Accessibility of health care services,
   - Pharmacy services,
   - 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. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.

8. 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.

9. Identifying and meeting external federal and state regulatory requirements for licensure.

10. Continuously monitoring internal processes in an effort to improve and enhance services to members and contracting providers.

11. Performing an annual assessment and evaluation (updating as necessary) of the effectiveness of the QI Program and its activities to determine how well resources have been deployed in the previous year to improve the quality and safety of clinical care and the quality of service provided to members. These results 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 contracting provider to the provision and institutionalization of the commitment to environments 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. 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. 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. Most members remain children comprising 51% or KHS' membership. 46% 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. There has been no significant change between the child and adult distribution compared to 2019. There has also been insignificant change in gender distribution between this year and last with 54% female members and 46% male members. The main ethnicity of our members is reported as Hispanic at 63%.

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 (BHRS) 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, preventive health and 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, evaluate effectiveness 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 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):

        1) Oversight of the QI Program
        2) Chairperson of the QI/UM Committee
        3) Chairperson of associated subcommittees
        4) Supervision of Health Services staff
        5) Oversight and coordination of continuity of care activities for members
        6) Proactive incorporation of quality outcomes into operational policies and procedures
        7) Oversight of all committee reporting activities so as 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. **Pharmacy and Therapeutics (P&T) Committee:** performs ongoing review and modification of the KHS formulary and related processes, oversight of contracting pharmacies, including monitoring processes, development of pharmacologic guidelines and other related functions.

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 actions and ensure follow-up
vi. Develop and assign responsibility for achieving goals
vii. Monitor quality improvement
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. Pharmacy and Therapeutics Committee (P&T):

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.

b. **Function –** the functions of the P&T Committee are as follows:

i. 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;
ii. Evaluate the clinical use of medications and develop policies for managing drug use and administration;
iii. Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
iv. Provide recommendations regarding protocols and procedures for the use of non-formulary medications;
v. Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
vi. 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;
vii. Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling.

c. **Structure –** The QI/UM Committee has delegated the responsibility of oversight of pharmaceutical activities related to members to the P&T 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 P&T 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.

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

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

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' QI-UM Committee summarizing our strategies and level of compliance with MCAS measures. Outstanding issues from the Committee may be advanced to KHS' QI-UM Committee 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 P&T 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)** - 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, Case and Disease 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.
   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.
   - 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.

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 healthcare field from an accredited college or university. A minimum of five years of experience in an health maintenance organization (HMO) 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 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 contracting 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.

   The Director of Quality Improvement is responsible for the oversight and direction of the KHS Quality Improvement staff.

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. The Manager has a working knowledge of HEDIS measures and the HEDIS audit process or the ability to readily learn and apply this information. They also possess working knowledge of State and Federal regulatory requirements, particularly related to QI activities.

5. **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's role is to manage, plan, coordinate and monitor Quality Improvement Special Programs including but not limited to:

   - Annual Managed Care Accountability Set (MCAS) audit and measurement results submission,

- QI Department Strategic Goals,
- QI Department project planning,
- Special Programs (such as member incentives and engagement, DHCS-required project improvement plans, site reviews, etc.), Develop and Organize Ongoing Provider Training, Contract Pricing Software, and PR & Credentialing Department Auditing functions.

6. **Quality Improvement Operations Supervisor –** The Quality Improvement Operations Supervisor possesses a master's degree in health or business administration, an associate degree in Nursing or a bachelor's degree in Nursing. The position requires 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. Working knowledge of HEDIS measures and the HEDIS audit process or ability to readily learn and apply this information is required along with a working knowledge of State and Federal regulatory requirements, particularly related to QI activities, or ability to readily learn and apply this information.

The QI Operations Supervisor conducts oversight and management of state and regulatory and contractual compliance for the QI program. They also coordinate quality improvement initiatives for Performance Improvement Projects (PIPs), Improvement Plans (IPs), Facility Site Reviews (FSRs), delegation audits, and other external quality reviews. The supervisor provides oversight for day-to-day operations of the QI team. This position also supports the QI Director and QI Manager in the QI Department's processes related to data collection for evaluation of department's work and for identification of staff training needs and development of training programs. He/She leads training and orientation of new staff in QI processes and procedures, and other relevant information.

7. **QI Program Staffing** – the Director oversees 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. **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 HEDIS process including but not limited to producing and validating the chase list, producing fax lists, collecting data and reporting essential elements of the HEDIS process.

c. **QI Assistant** - The QI Assistant is a graduate from a licensed Medical Assistant training institution with 2 years' experience in a provider office setting. The QI Assistant assists in validating the chase list, produces fax lists, performs follow-up calls to verify receipt, collects data and reports essential elements of the HEDIS process.

d. **QI Senior Support Clerk** – The QI Senior Support Clerk has a high school diploma or equivalent; two years' experience in the field of medical care, a typing skill of 45 net wpm, and at least one year data entry experience. Assists in the promotion of QI activities related to monitoring, assessing and improving performance in health care delivery of covered services to members.

e. **QI Operations Analyst**: The QI Operations Analyst has a bachelor's degree in Business, Business Management, Mathematics, from an accredited school or equivalent; or related field with an academic demonstration of analytical skills required; **AND** two (2) years' working experience with a Managed Care Organization (MCO) or similar type organization OR six (6) years of experience with a Managed Care Organization (MCO) or similar type organization in a business role with a minimum of two (2) years acting primarily in a business analytical capacity**; OR,** equivalent combination of education and business analytical experience on a year for year exchange of experience for education. This position is responsible for providing information with data query and self-service reporting tools. The Operational Analyst plays a central role in addressing various needs of the assigned operational business unit, leveraging data analytics, and facilitates operational discussions internally and externally to the department.

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 and UM 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) 2021. Results for the 2021 measures will be calculated and submitted in report year (RY) 2022,

#	**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	Yes
3	Child and Adolescent Well-Care Visits	WCV	Administrative	Yes i, iii
4	Childhood Immunization Status: Combination 10	CIS-10	Hybrid	Yes
5	Chlamydia Screening in Women	CHL	Administrative	Yesiii
6	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CDC-H9	Hybrid	Yes
7	Controlling High Blood Pressure	CBP	Hybrid	Yes
8	Immunizations for Adolescents: Combination 2	IMA-2	Hybrid	Yes
9	Prenatal and Postpartum Care: Postpartum Care	PPC-Pst	Hybrid	Yes
10	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-Pre	Hybrid	Yes
11	Weight Assessment and Counseling for Nutrition and	WCC-BMI	Hybrid	Yes iii

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
	Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents			
12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	WCC-N	Hybrid	Yes iii
13	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	WCC-PA	Hybrid	Yes iii
14	Well-Child Visits in the First 30 Months of Life - Well-Child Visits in the First 15 Months	W30	Administrative	Yes i
15	Well-Child Visits in the First 30 Month of Life - Well-Child Visits for Age 15 Months - 30 Months	W30	Administrative	Yes
16	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED	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	Concurrent Use of Opioids and Benzodiazepines	COB	Administrative	No
21	Contraceptive Care—All Women: Long Acting Reversible Contraception	CCW-LARC	Administrative	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
	(LARC)			
22	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
23	Contraceptive Care—Postpartum Women: LARC—3 Days	CCP-LARC3	Administrative	No
24	Contraceptive Care—Postpartum Women: LARC—60 Days	CCW-LARC60	Administrative	No
25	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days	CCW-MMEC3	Administrative	No
26	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days	CCW-MMEC60	Administrative	No
27	Developmental Screening in the First Three Years of Life	DEV	Administrative	No
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	Administrative	No
30	Follow-Up After Emergency Department Visit for Mental Illness	FUM	Administrative	No
31	Follow-Up Care for Children	ADD-C&M	Administrative	No

#	MEASURE Total Number of Measures = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
	Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase			
32	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Plan All-Cause Readmissions	PCR	Administrative	No
35	Screening for Depression and Follow-Up Plan ii	CDF	Administrative	No
36	Use of Opioids at High Dosage in Persons Without Cancer	OHD	Administrative	No

i Currently, the National Committee for Quality Assurance (NCQA) has not developed benchmarks for these measures; when NCQA does develop benchmarks for the measures, MCPs will be held to the MPL.

ii Measure is part of both the CMS Adult and Child Core Sets. Though MCPs will report the "Total" rate, data will be collected stratified by the child and adult age groups.

iii MCPs held to the MPL on the total rate only.

KHS's 2020 MCAS rate results can be found in Appendix A.

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 for MY2019 and RY2020 were significantly impacted by the COVID-19 pandemic. The primary impact was in KHS' reduced ability to obtain medical records for the purpose of measuring compliance for the MCAS measures. As a result, only three (3) of the MCAS measures met the MPL. They were

- Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV),
- Prenatal & Postpartum Care – Timeliness of Prenatal Care, and

- Prenatal & Postpartum Care – Postpartum Care.

DHCS advised the MCPs that financial penalties would not be imposed for RY2020 non-compliant MCAS measures. They provided an option for KHS to conduct a 2-year Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis and plan in lieu of a rapid-cycle process improvement project. KHS is taking advantage of this and will continue completion of the SWOT analysis and development and implementation of an action plan based on that analysis. The 4 key strategies for 2021 include:

- **Strategy 1**: Increase number of members attending preventive care appointments for well care visits for ages 0 - 21, Breast Cancer Screening, Childhood Immunization Status, Immunizations for Adolescents, Timeliness of Prenatal and Postpartum Care MCAS measures.
- **Strategy 2:** Increase compliance of MCAS Well Child Visits and Prenatal and Post-Partum Visits by 5 percentage points compared to the previous year and for each year after until the minimum performance level is met.
- **Strategy 3:** Increase preventive care compliance for MCAS measures by implementing new processes within the health plan aimed at decreasing members' gaps in care.
- **Strategy 4:** Increase compliance with MCAS Asthma Medication Ratio measure by 5 percentage points compared to the previous year and for each year after that until the minimum performance level is met.

3. **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 Disease Management Program

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) - The CAHPS **Member Satisfaction Survey** will be administered by a DHCS-contracted, third party vendor, HSAG in 2021. Results for the survey will be provided by DHCS to MCPs by the first quarter of 2022.

   The CAHPS Health Plan Survey is a tool for collecting standardized information on members' experiences with health plans and their services. Survey results can

be used to identify the strengths and weaknesses of a health plan and target areas for improvement. They survey was developed by the Agency for Health Research & Quality (AHRQ) in 1997 and has become the national standard for measuring and reporting on the experiences of consumers with their health plans. The Medicaid version of the questionnaire asks about experiences of members within the past 6 months.

Each of the members sampled receive both English and Spanish versions of the survey. There are ten areas measured in both the Adult and Child Member Satisfaction Survey:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- All Health Care Received Rating
- Personal Doctor/Nurse Rating
- Specialist Seen Most Often Rating
- Health Plan Rating
- Health Promotion & Education
- Coordination of Care

5. **Potential Inappropriate Care (PIC) Issues -** 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.
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.
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 Inappropriate Care (PIC).* All access compliance activities are reported to the Director of Provider Network Management 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 P&T 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 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 an inappropriate care issue exists and follow up corrective action based on the level of inappropriate care identified. These referrals may include member deaths, delay in service or treatment, or other opportunities for care improvement.

   Grievances with a potential inappropriate care issue identified are referred to the QI department as a PIC referral for further investigation and action. All 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 request(s) for a CAP for issues or concerns identified during review.

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 6 months after the public health emergency from the pandemic. The QI Department will update policies and procedures, implement the new review tools, educate KHS staff and KHS' provider network.

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. **PIC 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 Director of Provider Network Management, 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 Paper 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

Appendix A

2020 Measurement Year and 2021 Report Year

MY2020 MCAS Rates Report
Rates submitted on 6/1/21 to NCQA and HSAG

Hybrid Measures Held to MPL

Measure		MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
CCS	Cervical Cancer Screening	54.01	61.31	56.20	-7.30	-2.19
CIS-10	Childhood Immunization Status	22.87	37.47	29.93	-14.60	N/A
CDC-H9*	HbA1c Poor Control (>9.0%)	50.85	37.47	57.91	-13.38	7.06
CBP	Controlling High Blood Pressure <140/90 mm Hg	52.07	61.8	38.93	-9.73	13.14
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	33.09	36.86	41.36	-3.77	-8.27
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	70.07	89.05	84.18	-18.98	-14.11
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	77.62	76.4	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	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	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	NA	-15.70	N/A

Administrative Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
AMM - Acute	Antidepressant Medication Management – Acute Phase Treatment	48.05	53.57	50.24	-5.52	-2.19
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	31.77	38.18	32.64	-6.41	-0.87
APM–B	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing	50.00	54.42	NA	-4.42	N/A
APM–C	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Cholesterol Testing	16.67	37.08	NA	-20.41	N/A
APM–BC	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing and Cholesterol Testing	16.67	35.43	NA	-18.76	N/A
AMR	AsthmaMedication Ratio	54.39	62.43	48.78	-8.04	5.61
BCS	Breast Cancer Screening	54.50	58.82	57.29	-4.32	-2.79
CHL	Chlamydia Screening in Women Ages 16 – 24	54.02	58.44	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	NA	10.22	N/A

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

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

Attachment C

Kern Health Systems
2021 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 2020 QI Program Evaluation	9/1/2021	Chief Medical Officer (CMO) / QI Director	None	Board of Directors Meeting Agenda August 2021
2. Review/Update and Approval of QI Program Description	Approval of 2021 QI Program Description	9/1/2021	Chief Medical Officer (CMO) / QI Director	None	Board of Directors Meeting Agenda August 2021
3. Review/Update and Approval of QI Work Plan	Approval of 2021 QI Work Plan	9/1/2021	Chief Medical Officer (CMO) / QI Director	None	Board of Directors Meeting Agenda August 2021
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	Ongoing into 2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing through 2022
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.	Ongoing into 2022	Chief Medical Officer (CMO) / QI Director	None	Ongoing through 2022
C. RY 2021 MCAS Monitoring (Medi-Cal) / Quality Measurements					
1. MCAS Audit Roadmap	Report to State EQRO Auditor - HSAG	1/29/2021	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)	Vendor, Cotiviti, to have all new measure configured, tested and changes approved by NCQA	3/31/2021	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	3/31/2021	QI Director/ IT Director	None	Complete
4. Educate KHS Staff on MY2021 measures	KHS to educate internal staff on new requirements for MCAS	3/31/2021	Chief Medical Officer (CMO)/ QI Director	None	Complete
5. Educate providers on MY2021 measures	KHS to educate providers on new requirements for MCAS	7/1/2021	Chief Medical Officer (CMO)/ QI Director/ PNM Director	None	In Progress
6. Antidepressant Medication Management – Acute & Continuation Phase Treatment (AMM-Acute and AMM-Cont)	Report final rate annually to QI/UM Committee/Board of Directors (BOD)/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
7. Asthma Medication Ratio (AMR)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
8. Breast Cancer Screening (BCS)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
9. Cervical Cancer Screening (CCS)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
10. Child and Adolescent Well-Care Visits (WCV)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
11. Chlamydia Screening in Women (CHL)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
12. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
13. Controlling High Blood Pressure (CBP)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
14. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
15. Immunizations for Adolescents: Combination 2 (IMA-2)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
16. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
17. Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
18. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
19. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents (WCC-BMI)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
20. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition (WCC-N)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
21. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity (WCC-PA)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
22. Well-Child Visits in the First 30 Months of Life (W30)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
23. Ambulatory Care: Emergency Department (ED) Visits (AMB-ED)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
24. Concurrent Use of Opioids and Benzodiazepine (COB)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
25. Contraceptive Care—All Women: Long Acting Reversible Contraception (CCW-LARC)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
26. Contraceptive Care—All Women: Most or Moderately Effective Contraception (CCW-MMEC)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
27. Contraceptive Care—Postpartum Women: LARC—3 Days (CCW-LARC3)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
28. Contraceptive Care—Postpartum Women: LARC—60 Days (CCP-LARC60)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
29. Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days (CCP-MMEC3)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
30. Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days (CCP-MMEC60)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
31. Developmental Screening in the First Three Years of Life (DEV)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
32. Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase (ADD-C&M)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
33. Follow-Up Care for Children Prescribed Attention-D (ADD-Init)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
34. Plan All-Cause Readmissions (PCR)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
35. Screening for Depression and Follow-Up Plan (CDF)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
36. Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	Chief Medical Officer (CMO) / QI Director	None	In Progress
36. Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Report annually to QI/UM Committee/BOD/DHCS	8/12/2021	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 2020 to QI/UMC & BOD in 2021	Annually	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2021
2. Potential Inappropriate Care (PIC)	In annual QI Plan Evaluation for 2020 to QI/UMC & BOD in 2021	Annually	Chief Medical Officer (CMO) / QI Director	None	Ongoing 2021
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	Medium	Ongoing 2021 - 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		Medium	
b. IHEBA - Staying Healthy Assessment	Physician Site Monitoring / Quarterly reporting	Quarterly		Medium	
c. Initial Health Assessment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly		Medium	
d. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly		Medium	
e. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		Medium	

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
f. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		Medium	
g. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		Medium	
4. 2021 Facility Site Review - DHCS New APL 20-006	DHCS updated the requirements for Site and Medical Record Reviews that were supposed to take effect July 1, 2020. Due to the pandemic, implementation has been delayed until 6 months after the public health emergency related to the pandemic ends.	Contingent on DHCS identification of effective date	QI Director / Chief Network Administration Officer		Ongoing 2021
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	
E. Safety of Clinical Care				Medium	Ongoing 2021 - 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.
1. Autoclave	Credentialing/Recredentialing/As necessary	12/31/2021	Chief Medical Officer (CMO) / QI Director	Medium	Ongoing 2021
2. Bio-hazardous waste	Credentialing/Recredentialing/As necessary	12/31/2021	Chief Medical Officer (CMO) / QI Director	Medium	Ongoing 2021
3. Infection Control	Credentialing/Recredentialing/As necessary	12/31/2021	Chief Medical Officer (CMO) / QI Director	Medium	Ongoing 2021
4. Facility Site Review (FSR) DHS Database	FSR database of completed site reviews	12/31/2021	Chief Medical Officer (CMO) / QI Director	Medium	Ongoing 2021
5. Focused Reviews - Critical Elements	Physician Site Monitoring / Quarterly Reporting to QI/UMC	Quarterly	Chief Medical Officer (CMO) / QI Director	Medium	Ongoing 2021
F. Availability				Medium	Ongoing 2021 - 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.
1. Primary Care Practitioners				Medium	
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
2. Specialty Practitioners				Medium	
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
b. Geographic Standard	Measure and Report	Annually	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
G. Access				Medium	Ongoing 2021 - 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.
1. Primary Care Appointments					
a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
e. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
2. Telephone access to Member Services					
a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
3. Mental Health Appointment	Quarterly MOU Meetings/Grievances	As necessary	Director of UM; Director of CM	Medium	Ongoing 2021
a. Life-threatening Emergency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
c. Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
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	Medium	Ongoing 2021
e. Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance	Medium	Ongoing 2021
- 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 2021
I. CAHPS Survey	State administered survey every 2 years	12/31/2021	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	Results should be distributed by DHCS by March 2022
1. Member data provided to EQRO to conduct CAHPS survey in 2021	Provide member data per EQRO specifications	2/28/2021	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	Completed
2. Results reported to QI/UMC	Report to QI/UMC	12/31/2021	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	On Track
3. Results reported to practitioners and providers	Report to Physician Advisory Committee	12/31/2021	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	On Track
J. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2021
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2021
2. PCP & Mental Health	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2021
3. Specialist	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2021
K. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes ongoing reporting of Grievances, QI Program, Evaluation and Work plan	12/31/2021	QI Director		Ongoing 2021
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		Ongoing 2021
M. QI/UM Committee					
1. Reports and agenda items	Gathered from pertinent departments	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		Ongoing 2021
2. Minutes	Attached to next meetings agenda and sent to Board of Directors	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		Ongoing 2021
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		Ongoing 2021
4. PO's and Check Requests	Fill out for each member attending meeting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		Ongoing 2021
N. MCAS Member Engagement & Incentive Program	Implement program for using Interactive Voice Recognition, Text messaging and Mailers to contact members with Gaps in Care related to the MCAS measures either providing health education or reminders about preventive health measures. The program includes establishing specific member incentives for completion of health care activities that resolve their care gaps. At least 2 member outreach campaigns will be completed this year.	12/31/2021	Chief Health Services Officer/QI Director/Health Education Director		Ongoing 2021

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
O. MCAS Committee	Establish new, multi-department committee to - provide direction and oversight of KHS' level of compliance with the MCAS measures and - provide 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 DHCS.	2/26/2021	Chief Health Services Officer/QI Director		Completed
1. Strengths, Weaknesses, Opportunities and Threats (SWOT) Action Plan for MCAS measures compliance	An action plan to develop KHS' infrastructure for compliance with MCAS measures will be developed based on a SWOT analysis done in the fall of 2020. The Action plan is a 2 year effort with support and collaboration from DHCS.	12/31/2022	Chief Health Services Officer/QI Director		Ongoing through 2022
2. Update and disseminate MCAS Provider Guide and MCAS Coding Card for MY2021 MCAS Measures	Update the KHS MCAS Provider Guide to reflect measures for MY2021. 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.	8/1/2021	Director of Quality Improvement/Provider Network Management/Provider Relations Manager		In process
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 2021	10/1/2021	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		QI/UMC August 2021 Agenda
	Evaluation 2020	10/1/2021	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		QI/UMC August 2021 Agenda
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		Ongoing 2021
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	At least quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		Ongoing 2021
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		Ongoing 2021
2. SNF's	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer		Ongoing 2021
3. Home Health Agencies	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer		Ongoing 2021
4. Free-Standing Surgery Centers	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer		Ongoing 2021
5. Impatient MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer		Ongoing 2021
6. Residential MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer		Ongoing 2021
7. Ambulatory MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Chief Network Administration Officer		Ongoing 2021
C. Ongoing Monitoring of Sanctions and Complaints	Ongoing; time sensitive; sanctions; grievance process	Ongoing	Chief Network Administration Officer/Compliance		Ongoing 2021

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
D. Credentialing / Recredentialing File Audit	Ongoing KHS/Compliance random audits	Ongoing	Chief Network Administration Officer		Ongoing 2021
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is TJC accredited	Annually / as necessary	Chief Network Administration Officer		Ongoing 2021
F. Annual Review of Credentialing/Recredentialing Policies and Proc	Ongoing	Annually / as necessary	Chief Network Administration Officer		Ongoing 2021
IV. MEMBER RIGHTS AND RESPONSIBILITIES					
A. Statement of Members' Rights and Responsibilities	Review, annually / revise as necessary	Annually / as necessary	Director of Member Services		Ongoing 2021
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services		Ongoing 2021
C. Complaints and Appeals	Aggregate/analyze/report to QI/UM Committee Quarterly	Quarterly	Director of Member Services		Ongoing 2021
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		Ongoing 2021 Ongoing 2021 Ongoing 2021
E. Annual Analysis of Privacy and Confidentiality Policies	Review annually / Revise as needed	Ongoing	Director Compliance		Ongoing 2021
F. Delegation of Members' Rights and Responsibilities Activities	Non-delegated. Grievance committee	N/A	Grievance Committee		Ongoing 2021
G. Annual Review of Member Rights Policies and Procedures	Non-delegated	N/A	Grievance Committee		Ongoing 2021
VI. MEDICAL RECORDS					
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2021	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2021
B. Distribution of Standards to New Providers	Ongoing / as necessary	Ongoing	Director of Provider Network Management		Ongoing 2021
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		Ongoing 2021
D. Annual Review of Policies and Procedures	Annually and as necessary	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2021
VII. AD HOC PROJECT					
A. Request for Proposal for MCAS data collection and rate measurement software vendor	Complete a request for proposal to evaluate current and available vendors to license and service NCQA certified HEDIS software. This software is a requirement by DHCS for annual submission of reports and MCAS rates. The RFP is intended to serve as an evaluation to decide whether KHS continues using the current software vendor or transitions to a different vendor in 2022. A recommendation will be presented to KHS' Board of Directors.	Aug-21	Chief Health Services Officer (CHSO)/Director of Quality Improvement		In process

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Jane Daughenbaugh, Director of Quality Improvement

Date: October 14, 2020

Re: Managed Care Accountability Set (MCAS) Update

Background

The Department of Health Care Services (DHCS) of California has established a set of performance measures for Medi-Cal managed care health plans (MCPs) such as KHS. The measures are known as the Managed Care Accountability Set (MCAS). These measures focus on services related to two key areas:

- Preventive health care (e.g., well care visits, mammograms, immunizations, etc.) and
- Chronic condition management (e.g., diabetes, hypertension, asthma, etc.).

Two events radically changed KHS's approach to achieving measure targets since last presented to the Board:

1. DHCS has reset minimum performance levels (MPL) for all measures now requiring achieving the 50th percentile or better for each of these measures instead of the previous level of 25th percentile; essentially doubling the previous goal. Given the magnitude of "lift" associated with this change, DHCS is sensitive to the challenge this represents to health plans and cooperation required from network providers. Although health plans are subject to sanctions from failing to achieve the new minimum, time is being given to allow health plans to modify its strategies for achieving greater member participation and provider cooperation.

2. The introduction of the COVID-19 virus last year significantly impacted the ability of all health plans (including KHS) to meet the MPLs due to access to professional services falling off from public travel restrictions or fear of exposure during a doctor's visit. DHCS is not holding health plan's accountable to the MPLs for measurement year 2019 nor 2020. They have indicated that accountability will resume for measurement year 2021. However, the progress toward resolution of the pandemic may change in that decision.

Discussion

A presentation is included with this memo to provide an overview of the MCAS measures to which KHS is accountable. It offers a brief review of the audit process Kern Health Systems completes as part of our submission of compliance rates for the measures. The audit process is performed by the National Committee for Quality Assurance (NCQA). It provides assurance to DHCS that data collected, and calculation methodologies used for determining our compliance rates meet national standards.

Since COVID-19 eschewed 2020 results, KHS is using this experience to aid with creating more effective intervention strategy to help improve future results. To this end, KHS has pro-actively undergone a QI Department SWOT analysis. The analysis illustrates internal strengths and weaknesses and identifies opportunities where resources invested could yield favorable results. In addition, the analysis reveals the challenge the QI Department faces leading to less than optimum results. From the analysis, an immediate action plan has been developed along with a 2-year strategy. Both plans establish our approach for achieving and monitoring MCAS measures. The strategies and interventions provide an overall objective of meeting the minimum performance levels in at least 90% of measures for which the plan is held accountable by reporting year 2022.

The Short-Term Plan and Two-Year Plan for improving MCAS scores was launched earlier this year. In 1st Quarter 2022, the Board will receive an update on how well we are progressing toward achieving our short-term objectives and whether the 2-year strategy is on schedule to meet our long-term goal to perform at the new minimum performance level (50%) for measurement year 2023.

Requested Action

Receive and File.

Managed Care Accountability Set Presentation

Agenda

- Definition of MCAS Measures
- Annual DHCS Audit & Rate Submission (Key Components)
- Strategic Action for Recent Requirement Changes
- KHS Approach to Meet Compliance Benchmark
- KHS Short-Term Strategy
- KHS 2 Year Plan
- Appendix A: MCAS Measures, 2021

KERN HEALTH SYSTEMS

MCAS - Definition

- Managed Care Accountability Sets (MCAS)
  - Performance measures set by CA Department of Health Care Services (DHCS)
  - Used by DHCS to evaluate Medi-Cal managed care plans annually
- MCAS are clinical measures focused on provider delivery of preventive health & chronic condition management services
- MCAS measures use 2 collection techniques:
  - Administrative: Information from data systems only (e.g., claims, lab results)
  - Hybrid: Information through medical record review
- MCAS Measures may change from year to year *(see Appendix A for current list)*

KERN HEALTH SYSTEMS

Annual DHCS Audit & Rate Submission

Key components to the DHCS Audit and Rate Submission Process:

- DHCS validates methodology health plans use for capturing & measuring performance and compliance
  - National Committee for Quality Assurance (NCQA) reviews & approves KHS's audit techniques to ensure submitted data & information reflect accurate & valid performance outcomes
- Using approved methodology for collecting and reporting data, KHS compiles and transmits its data for evaluation against defined DHCS performance measure outcomes
- Process is complete with final submission of compliance rates for each measure to DHCS in June

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Strategic Action Required

- Two factors require a more aggressive approach:
  - DHCS reset minimum performance levels (MPL) effective 2019 from 25th to 50th percentile of patient compliance **AND**
  - COVID-19 pandemic erupted
- Approach focuses on:
  - Proactive planning & increased collaboration between KHS Staff, Providers, & applicable members,
  - Timely monitoring & reporting of outcomes for each strategy to drive decisions, and
  - Flexibility within KHS shift strategies based on outcomes.

KERN HEALTH SYSTEMS

Approach to Meet New MCAS Benchmarks

Objective:

- Meet new MCAS minimum performance levels for measurement year 2022/report year 2023

3 Critical Elements for Achieving Objective

- Conduct **SWOT** (Strengths-Weaknesses-Opportunities-Threats) Analysis for Children's Health Domain to identify improvement opportunities
- Evolve role of **MCAS Committee** for input & direction of MCAS scores
- Implement **Strategic Action Plan** with two Key Features:
    - 1-year SWOT Strategic Action Plan focused on children's health measures
    - 4 Process Improvement Projects using Plan, Do, Study, Act (PDSA) model focusing on Children & Women's Health Domains

KERN HEALTH SYSTEMS

Short-Term Strategy for MCAS Compliance

- **Continue COVID Vaccination & Back to Care Promotion**
- Implement MCAS Committee to oversee MCAS compliance, outcomes and strategic direction
- Meet with **Kern Medical, Clinica Sierra Vista and Omni** on strategies to improve MCAS measures
- Establish **annual schedule of meetings with other network providers** for MCAS improvement
- Establish **trending reports & outcome measures** to outcomes of MCAS initiatives
- **Gaps in** Care visibility for member-facing, **KHS departments**
- **Gaps in Care visibility** for members in **Member Portal**
- Educate & support providers with **effective coding for MCAS measures**
- Increase KHS access to provider **EMR systems**

KERN HEALTH SYSTEMS

Member Engagement & Rewards Outcomes

- Campaign Focus:
  - Initial Health Assessments
  - Timely Prenatal Visits, 1st Trimester
  - Timely Post-Partum Visits
  - Infant Well Care Visits
  - Child & Adolescent Well Care Visits
- Outreach:
  - **118k** members were **contacted**
- Compliance & Rewards Achieved after two campaigns:
  - **60% Improvement 2021 Year-to-Date** for MCAS Measures
  - **January - August 2021: 36,500** members compliant after **1st 2 campaigns,**
  - **June – August 2021: 3,500** members compliant after **2nd Campaign alone**

KERN HEALTH SYSTEMS

2 Year Plan to Achieve MCAS New MCAS Benchmarks

- Solidify Process for MCAS Committee Evaluation of Outcomes to Drive Decisions for New MCAS Strategies & Initiatives
- Improve Provider Rewards for Outcomes-Based Performance
- Leverage Mobile Delivery of Preventive Health Services
- Increase Electronic Data Measurement of MCAS Measurement Compliance
- Establish Population Health Management Program in Support of Preventive Health Care Compliance

KERN HEALTH SYSTEMS

Appendix A:
MCAS Measures, 2021

Measure	Acronym	Measure Type
Breast Cancer Screening	BCS	Administrative
Cervical Cancer Screening	CCS	Hybrid
Child and Adolescent Well-Care Visits	WCV	Administrative
Childhood Immunization Status	CIS-10	Hybrid
Chlamydia Screening in Women	CHL	Administrative
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CDC-H9	Hybrid
Controlling High Blood Pressure	CBP	Hybrid
Immunizations for Adolescents	IMA-2	Hybrid
Timeliness of Postpartum Care	PPC-Pst	Hybrid
Timeliness of Prenatal Care	PPC-Pre	Hybrid

KERN HEALTH SYSTEMS

MCAS Measures, 2021, continued

Measure	Acronym	Measure Type
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment	WCC-BMI	Hybrid
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	WCC-N	Hybrid
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	WCC-PA	Hybrid
Well-Child Visits 1st 30 Months of Life	W30	Administrative

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

TO: KHS Board of Directors

FROM: Anita Martin, Chief Human Resources Officer

Date: October 14, 2021

SUBJECT: Employee Benefits Renewal 2022

Background

Kern Health Systems ("KHS") annually reviews and evaluates the employee benefit package. During the evaluation period factors taken into consideration are the improvements of benefits, cost of premium, feasibility of continuation of current plan(s), comprehensive administrative services provided by the carrier(s), plan documents, summary plan descriptions and the employee communication process i.e., clearly written program material including comprehensive summary of benefits, etc.

Of the 6 core benefit categories (Medical, Dental, Vision, Life, Short and Long-Term Disability and Long-Term Care), we were able to secure the 2022 premium renewals at a very reasonable overall annual increase of $140,720. As notated below, an additional benefit offering is being proposed with a cost of $29,808 for a total increase in all benefits of $170,528.

Management is proposing the following:

A renewal with Kaiser Permanente HMO with no benefit changes. The annual increase of this benefit will equate to approximately $147,422.

Dental to be moved from Lincoln to Premier Access Dental. In doing so, the Annual Max benefit would increase from $2,500 to $5,000. It will also provide Ortho coverage for both Adults and Children as well as cover dental implants. The annual savings this change would provide is $29,177.

KHS is seeking a benefit enhancement for the VSP Vision benefit to a 12-month frame frequency and increasing the material allowance to $180. The annual increase of this benefit will equate to approximately $22,475.

KHS is also seeking a stand-alone enhanced virtual Mental Health benefit that would provide coverage for employees and their families. The annual increase of this benefit will equate to approximately $29,808.

For the 2022 renewal of employee benefits, management is proposing the following:

Maintain the current Employee Medical Insurance with Kaiser Permanente. For the current renewal period, Kaiser Permanente initially requested an increase of 14%. The Medical Loss Ratio during this renewal cycle was 72%. After several negotiation discussions, our insurance broker was able to secure an increase of 2.5%. Based on current staffing levels, the current monthly premium will be approximately $469,190 or $5,630,281 annually.

- Maintain VSP as the vision provider. The current monthly cost if enrollment stays at the current level will be $5,316 per month or $63,793 annually. With the benefit enhancement requested, the monthly cost would be $7,189 or $86,268 annually. This equates to an annual increase of approximately $22,475.

- Move the dental to Premier Access. For the current renewal period, Lincoln gave KHS a rate pass on all policies. Premier Access offered additional benefits at a much lower cost. Based on renewal date staffing levels, the monthly premium will be approximately $30,702 or $368,431 annually. This is an annual decrease of $29,177.

- Maintain Lincoln as the current Basic Life Insurance carrier. The overall annual cost will be approximately $70,621.

- Maintain Lincoln as the Short-term Disability ("STD") and Long Term Disability ("LTD") carrier. The current monthly premium based on renewal date staffing levels for both STD and LTD combined is approximately $252,174 annually.

- Maintain current Long-term Care Policy with Unum. The current monthly premium based on current staffing levels is approximately $82,190 annually. This policy has not received an increase in rates since 2020.

- Overall KHS had an increase of $147,422 in Kaiser medical premiums, $29,177 savings in dental premiums, $0 increase in basic life, $0 increase in Short-term and Long-Term Disability and $0 increase in long-term care. With the addition of the Mental Health benefits at a cost of $29,808, KHS has an overall benefits renewal increase of approximately 2.7% with the requested benefit enhancements.

Representatives from Walter Mortensen Insurance/INSURICA will be available to answer questions relating to all of the employee benefit renewals.

Requested Action

Approve the renewal and binding of employee benefit plans for medical, vision, dental, life insurance, short-term and long-term disability and long-term care.

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
October 14, 2021

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 09/01/2021				
Bakersfield Hematology Oncology Group Inc.	Hematology / Oncology	9800 Brimhall Rd Ste. 200 Bakersfield CA 93312	New Group / Similar name to existing group	10/1/2021
Kingston Healthcare Center LLC	SNF	329 Real Road Bakersfield CA 93309		10/1/2021
Maya Borna Inc dba: Therapy Lounge Center	Speech Therapy	1505 West Ave J Ste. 301 Lancaster CA 93534		10/1/2021
Maheep Singh Birdi, MD dba: Maheep Virdi MD & Associates	Neurology	8307 Brimhall Rd Ste 1702 Bakersfield CA 93312	Existing Providers: Birdi & Natali	**Retro-Eff 9/1/2021**
PAC 10/06/2021				
Coram Healthcare Corporation of Southern California	Infusion Therapy	2710 Media Ctr Dr Bldg 6 Ste 150 Los Angeles CA 90065		11/01/0221
Planned Parenthood Mar Monte, Inc. dba: Planned Parenthood Mar Monte-Bakersfield	Gender Affirming & Hormone Therapy	2633 16th Street Bakersfield CA 93301		11/01/0221
Sunbeam, LLC dba: Stonebridge Manor	SNF / Congregate Living Facility	44723 Stonebridge Ln Lancaster CA 93536		11/01/0221
Pacific Central Coast Health Centers dba: Dignity Health Centers - Bakersfield	Multi-Specialty	300 Old River Road 500 Old River Road Ste. 200 9500 Stockdale Hwy Ste. 109 Bakersfield CA	Existing Providers: J. Lee, B. Stone, J. Tammela & C. Wong	11/01/0221

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
October 14, 2021

Legal Name DBA	Specialty	Address	Comments	Term Effective Date
PAC 10/06/2021				
Sheikh Latif, DO PC	General/Vascular Surgery	1519 Garces Hwy Ste. 3 Delano CA	Site Closed / Moved out of State	7/31/2021
Autism Learning Partners, LLC	Behavioral Health	1201 24th St Ste. B110 Bakersfield CA	Resigned/Termed Contract	8/21/2021
Santa Barbara Pulmonary Consultants	Pulmonary Disease	2403 Castillo St Ste. 206 Santa Barbara CA	Change TIN	8/31/2021
Rio Bravo Oncology Inc.	Hemtology/Oncology & Radiation Onc.	4500 Morning Dr Ste. 105 Bakersfield CA	Change TIN/Ownership	8/31/2021
Pavel Moldavskiy, MD Inc	Orthopedic Surgery	300 Old River Rd Ste. 200 Bakersfield, CA 93311	Joining Adventist Health Physicians Network	10/1/2021

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: October 14, 2021

Re: July 31, 2021 Financial Results

The July results reflect a $2,105,493 Net Increase in Net Position which is a $3,378,071 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $19.6 million unfavorable variance primarily due to:

   A) $5.9 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $1.8 million favorable variance primarily from a retro-active Pharmacy rate increase to January 1, 2021 that allowed for additional cost trends and risk adjustments relating to the Pharmacy Benefit being extended from April 1, 2021 to the end of the year.

   C) $2.3 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated rates for calendar year 2021 from DHCS and higher than expected membership offset against amounts included in 2B below.

   D) $29.1 million unfavorable variance in Premium-Hospital Directed Payments primarily due to receiving updated final rates for the period July 2019-December 2019 from DHCS offset against amounts included in 2C below.

2) Total Medical Costs reflect a $22.1 million favorable variance primarily due to:

   A) $5.1 million unfavorable variance in Inpatient primarily due to higher-than-expected utilization over the last several months.

   B) $2.3 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rates for calendar year 2021 from DHCS and higher than expected membership offset against amounts included in 1C above.

   C) $29.1 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated final rates for the period July 2019-December 2019 from DHCS offset against amounts included in 1D above.

The July Medical Loss Ratio is 90.9% which is favorable to the 93.2% budgeted amount. The July Administrative Expense Ratio is 5.7% which is favorable to the 6.7% budgeted amount.

The results for the 7 months ended July 31, 2021 reflect a Net Increase in Net Position of $11,643,979. This is a $14,011,850 favorable variance to budget and includes approximately $2.5 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 93.2 % which is slightly unfavorable to the 93.1% budgeted amount. The year-to-date Administrative Expense Ratio is 5.5% which is favorable to the 6.7% budgeted amount.

Kern Health Systems
Financial Packet
July 2021

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF JULY 31, 2021

ASSETS	JULY 2021	JUNE 2021	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 82,224,554	$ 79,830,015	$ 2,394,539
Short-Term Investments	168,754,740	177,394,888	(8,640,148)
Premiums Receivable - Net	108,230,699	106,156,355	2,074,344
Premiums Receivable - Hospital Direct Payments	285,287,509	298,099,551	(12,812,042)
Interest Receivable	96,209	584,568	(488,359)
Provider Advance Payment	5,267,051	5,286,547	(19,496)
Other Receivables	1,171,013	1,015,728	155,285
Prepaid Expenses & Other Current Assets	3,597,595	2,222,270	1,375,325
Total Current Assets	$ 654,629,370	$ 670,589,922	$ (15,960,552)
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,794,708	1,841,168	(46,460)
Computer Hardware and Software - Net	13,103,814	13,407,181	(303,367)
Building and Building Improvements - Net	34,818,422	34,894,116	(75,694)
Capital Projects in Progress	13,985,345	13,417,023	568,322
Total Capital Assets	$ 67,792,995	$ 67,650,194	$ 142,801
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,597,244	1,597,244	-
Total Long Term Assets	$ 1,897,244	$ 1,897,244	$ -
DEFERRED OUTFLOWS OF RESOURCES	$ 3,018,341	$ 3,018,341	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 727,337,950	$ 743,155,701	$ (15,817,751)
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 3,907,640	$ 3,653,652	253,988
Accrued Other Operating Expenses	1,565,571	1,378,654	186,917
Accrued Taxes and Licenses	9,744,181	26,564,073	(16,819,892)
Claims Payable (Reported)	21,866,724	17,483,523	4,383,201
IBNR - Inpatient Claims	40,423,174	34,190,863	6,232,311
IBNR - Physician Claims	14,900,539	15,134,753	(234,214)
IBNR - Accrued Other Medical	23,742,925	23,891,464	(148,539)
Risk Pool and Withholds Payable	8,073,020	7,520,158	552,862
Statutory Allowance for Claims Processing Expense	2,157,367	2,157,367	-
Other Liabilities	71,052,313	69,337,902	1,714,411
Accrued Hospital Directed Payments	285,287,509	298,099,561	(12,812,052)
Total Current Liabilities	$ 482,720,963	$ 499,411,970	$ (16,691,007)
NONCURRENT LIABILITIES:			
Net Pension Liability	5,800,140	7,032,377	(1,232,237)
TOTAL NONCURRENT LIABILITIES	$ 5,800,140	$ 7,032,377	$ (1,232,237)
DEFERRED INFLOWS OF RESOURCES	$ 86,684	$ 86,684	$ -
NET POSITION:			
Net Position - Beg. of Year	227,086,184	227,086,184	-
Increase (Decrease) in Net Position - Current Year	11,643,979	9,538,486	2,105,493
Total Net Position	$ 238,730,163	$ 236,624,670	$ 2,105,493
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 727,337,950	$ 743,155,701	$ (15,817,751)

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JULY 31, 2021

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
190,154	183,800	6,354	Family Members	1,303,814	1,278,200	25,614
76,614	70,565	6,049	Expansion Members	516,418	493,955	22,463
15,800	15,230	570	SPD Members	113,239	106,610	6,629
8,412	7,000	1,412	Other Members	56,973	49,000	7,973
11,983	10,500	1,483	Kaiser Members	80,624	73,500	7,124
302,963	287,095	15,868	Total Members - MCAL	2,071,068	2,001,265	69,803
			REVENUES			
35,761,670	32,115,351	3,646,319	Title XIX - Medicaid - Family and Other	240,459,563	223,942,046	16,517,517
29,676,566	26,523,701	3,152,865	Title XIX - Medicaid - Expansion Members	199,818,775	185,665,906	14,152,869
16,260,445	15,294,634	965,811	Title XIX - Medicaid - SPD Members	109,887,807	107,062,436	2,825,371
10,025,153	9,894,054	131,099	Premium - MCO Tax	68,656,827	63,321,947	5,334,880
16,337,340	14,057,475	2,279,865	Premium - Hospital Directed Payments	111,323,423	98,143,322	13,180,101
(39,267)	166,842	(206,109)	Investment Earnings And Other Income	(175,404)	1,160,546	(1,335,950)
-	80,213	(80,213)	Reinsurance Recoveries	-	559,052	(559,052)
(29,149,066)	-	(29,149,066)	Rate Adjustments - Hospital Directed Payments	49,150,621	-	49,150,621
(294,637)	-	(294,637)	Rate/Income Adjustments	3,395,878	-	3,395,878
78,578,204	98,132,269	(19,554,065)	TOTAL REVENUES	782,517,490	679,855,255	102,662,235
			EXPENSES			
			Medical Costs:			
15,305,367	15,167,292	(138,075)	Physician Services	107,580,381	105,833,483	(1,746,898)
4,604,443	4,729,211	124,768	Other Professional Services	33,184,590	33,049,737	(134,853)
4,833,831	5,573,871	740,040	Emergency Room	32,828,291	38,871,584	6,043,293
20,542,490	15,416,353	(5,126,137)	Inpatient	137,032,428	107,658,365	(29,374,063)
84,045	80,213	(3,832)	Reinsurance Expense	573,447	559,052	(14,395)
7,937,455	6,994,346	(943,109)	Outpatient Hospital	55,141,150	48,849,203	(6,291,947)
9,927,247	10,162,161	234,914	Other Medical	76,096,221	70,907,911	(5,188,310)
9,774,211	10,499,384	725,173	Pharmacy	67,428,287	73,356,083	5,927,796
552,862	525,531	(27,332)	Pay for Performance Quality Incentive	3,764,400	3,662,754	(101,647)
-	-	-	Risk Corridor Expense	-	-	-
16,337,330	14,057,475	(2,279,855)	Hospital Directed Payments	111,323,423	98,143,322	(13,180,101)
(29,149,382)	-	29,149,382	Hospital Directed Payment Adjustment	48,277,113	-	(48,277,113)
(11,833)	-	11,833	Non-Claims Expense Adjustment	898,737	-	(898,737)
406,066	-	(406,066)	IBNR, Incentive, Paid Claims Adjustment	1,106,986	-	(1,106,986)
61,144,132	83,205,838	22,061,706	Total Medical Costs	675,235,454	580,891,492	(94,343,962)
17,434,072	14,926,432	2,507,640	GROSS MARGIN	107,282,036	98,963,762	8,318,274
			Administrative:			
2,805,915	2,881,030	75,115	Compensation	19,115,403	20,042,212	926,809
939,689	1,071,006	131,317	Purchased Services	6,492,800	7,497,042	1,004,242
156,626	133,106	(23,520)	Supplies	551,311	931,744	380,433
425,522	500,520	74,998	Depreciation	2,972,490	3,503,643	531,153
274,638	385,959	111,321	Other Administrative Expenses	1,634,485	2,701,714	1,067,229
(1,674)	-	1,674	Administrative Expense Adjustment	(266,281)	-	266,281
4,600,716	4,971,622	370,906	Total Administrative Expenses	30,500,208	34,676,355	4,176,147
65,744,848	88,177,460	22,432,612	TOTAL EXPENSES	705,735,662	615,567,847	(90,167,815)
12,833,356	9,954,809	2,878,547	OPERATING INCOME (LOSS) BEFORE TAX	76,781,828	64,287,407	12,494,421
9,894,054	9,894,054	-	MCO TAX	63,349,744	63,321,947	(27,797)
2,939,302	60,755	2,878,547	OPERATING INCOME (LOSS) NET OF TAX	13,432,084	965,460	12,466,624
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
(853,525)	(1,166,666)	313,141	Provider Recruitment and Retention Grants	(1,266,155)	(2,166,666)	900,511
19,716	(166,667)	186,383	Health Home	(521,950)	(1,166,665)	644,715
(833,809)	(1,333,333)	499,524	TOTAL NONOPERATING REVENUE (EXPENSE)	(1,788,105)	(3,333,331)	1,545,226
2,105,493	(1,272,578)	3,378,071	NET INCREASE (DECREASE) IN NET POSITION	11,643,979	(2,367,871)	14,011,850
90.9%	93.2%	2.3%	MEDICAL LOSS RATIO	93.2%	93.1%	-0.1%
5.7%	6.7%	1.0%	ADMINISTRATIVE EXPENSE RATIO	5.5%	6.7%	1.2%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED JULY 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
190,154	183,800	6,354	Family Members	1,303,814	1,278,200	25,614
76,614	70,565	6,049	Expansion Members	516,418	493,955	22,463
15,800	15,230	570	SPD Members	113,239	106,610	6,629
8,412	7,000	1,412	Other Members	56,973	49,000	7,973
11,983	10,500	1,483	Kaiser Members	80,624	73,500	7,124
302,963	287,095	15,868	Total Members - MCAL	2,071,068	2,001,265	69,803
			REVENUES			
180.10	168.32	11.78	Title XIX - Medicaid - Family and Other	176.71	168.73	7.97
387.35	375.88	11.48	Title XIX - Medicaid - Expansion Members	386.93	375.88	11.06
1,029.14	1,004.24	24.90	Title XIX - Medicaid - SPD Members	970.41	1,004.24	(33.84)
34.45	35.77	(1.32)	Premium - MCO Tax	34.49	32.85	1.65
56.15	50.82	5.32	Premium - Hospital Directed Payments	55.93	50.91	5.02
(0.13)	0.60	(0.74)	Investment Earnings And Other Income	(0.09)	0.60	(0.69)
0.00	0.29	(0.29)	Reinsurance Recoveries	0.00	0.29	(0.29)
(100.18)	0.00	(100.18)	Rate Adjustments - Hospital Directed Payments	24.69	0.00	24.69
(1.01)	0.00	(1.01)	Rate/Income Adjustments	1.71	0.00	1.71
270.05	354.79	(84.74)	TOTAL REVENUES	393.14	352.67	40.47
			EXPENSES			
			Medical Costs:			
52.60	54.84	2.24	Physician Services	54.05	54.90	0.85
15.82	17.10	1.27	Other Professional Services	16.67	17.14	0.47
16.61	20.15	3.54	Emergency Room	16.49	20.16	3.67
70.60	55.74	(14.86)	Inpatient	68.85	55.85	(13.00)
0.29	0.29	0.00	Reinsurance Expense	0.29	0.29	0.00
27.28	25.29	(1.99)	Outpatient Hospital	27.70	25.34	(2.36)
34.12	36.74	2.62	Other Medical	38.23	36.78	(1.45)
33.59	37.96	4.37	Pharmacy	33.88	38.05	4.18
1.90	1.90	0.00	Pay for Performance Quality Incentive	1.89	1.90	0.01
0.00	0.00	0.00	Risk Corridor Expense	0.00	0.00	0.00
56.15	50.82	(5.32)	Hospital Directed Payments	55.93	50.91	(5.02)
(100.18)	0.00	100.18	Hospital Directed Payment Adjustment	24.25	0.00	(24.25)
(0.04)	0.00	0.04	Non-Claims Expense Adjustment	0.45	0.00	(0.45)
1.40	0.00	(1.40)	IBNR, Incentive, Paid Claims Adjustment	0.56	0.00	(0.56)
210.13	300.82	90.69	Total Medical Costs	339.24	301.33	(37.91)
59.92	53.96	5.95	GROSS MARGIN	53.90	51.34	2.56
			Administrative:			
9.64	10.42	0.77	Compensation	9.60	10.40	0.79
3.23	3.87	0.64	Purchased Services	3.26	3.89	0.63
0.54	0.48	(0.06)	Supplies	0.28	0.48	0.21
1.46	1.81	0.35	Depreciation	1.49	1.82	0.32
0.94	1.40	0.45	Other Administrative Expenses	0.82	1.40	0.58
(0.01)	0.00	0.01	Administrative Expense Adjustment	(0.13)	0.00	0.13
15.81	17.97	2.16	Total Administrative Expenses	15.32	17.99	2.66
225.94	318.80	92.85	TOTAL EXPENSES	354.56	319.32	(35.25)
44.10	35.99	8.11	OPERATING INCOME (LOSS) BEFORE TAX	38.58	33.35	5.23
34.00	35.77	1.77	MCO TAX	31.83	32.85	1.02
10.10	0.22	9.88	OPERATING INCOME (LOSS) NET OF TAX	6.75	0.50	6.25
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
(2.93)	(4.22)	1.28	Reserve Fund Projects/Community Grants	(0.64)	(1.12)	0.49
0.07	(0.60)	0.67	Health Home	(0.26)	(0.61)	0.34
(2.87)	(4.82)	1.96	TOTAL NONOPERATING REVENUE (EXPENSE)	(0.90)	(1.73)	0.83
7.24	(4.60)	11.84	NET INCREASE (DECREASE) IN NET POSITION	5.85	(1.23)	7.08
90.9%	93.2%	2.3%	MEDICAL LOSS RATIO	93.2%	93.1%	-0.1%
5.7%	6.7%	1.0%	ADMINISTRATIVE EXPENSE RATIO	5.5%	6.7%	1.2%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH JULY 31, 2021	JULY 2020	AUGUST 2020	SEPTEMBER 2020	OCTOBER 2020	NOVEMBER 2020	DECEMBER 2020	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	261,732	264,749	278,100	272,481	275,080	277,452	278,517	276,880	282,972	284,587	287,199	289,309	290,980	3,620,038
REVENUES														
Title XIX - Medicaid - Family and Other	29,997,411	30,548,160	30,419,692	33,387,274	30,920,096	32,216,002	33,254,490	33,365,704	33,587,650	33,739,041	34,872,666	35,878,342	35,761,670	427,948,198
Title XIX - Medicaid - Expansion Members	24,533,357	24,848,094	25,069,155	27,568,938	25,504,052	27,197,954	27,548,311	27,720,576	28,063,951	28,547,171	28,728,667	29,533,533	29,676,566	354,540,325
Title XIX - Medicaid - SPD Members	15,224,387	15,192,022	15,191,965	14,457,143	16,007,482	15,504,966	15,326,978	15,368,431	15,407,903	15,527,562	16,024,510	15,971,978	16,260,445	201,465,772
Premium - MCO Tax	8,236,232	8,333,151	8,332,682	9,166,454	8,420,487	8,830,398	9,577,432	9,657,982	9,752,737	9,805,142	9,876,747	9,961,634	10,025,153	119,976,231
Premium - Hospital Directed Payments	(8,860,821)	9,112,870	9,112,869	9,955,034	9,313,088	9,738,038	15,121,903	15,230,282	12,949,303	14,734,613	14,811,749	22,138,233	16,337,340	149,694,501
Investment Earnings And Other Income	315,583	173,465	(14,474)	151,948	166,556	147,197	4,303	116,471	(249,580)	205,894	195,233	(408,458)	(39,267)	764,871
Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	(52,075,301)	4,234	2,924	77	10,627	(2,692)	39,990	21,877	78,150,342	3,134	79,899	4,445	(29,149,066)	(2,909,510)
Rate/Income Adjustments	135,705	291,820	70,321	(582,499)	127,031	226,726	799,886	594,678	1,527,455	266,498	595,656	(93,658)	(294,637)	3,664,982
TOTAL REVENUES	17,506,553	88,503,816	88,185,134	94,104,369	90,469,419	93,858,589	101,673,293	102,076,001	179,189,761	102,829,055	105,185,127	112,986,049	78,578,204	1,255,145,370
EXPENSES														
Medical Costs:														
Physician Services	13,357,636	13,134,194	14,514,021	14,157,774	13,867,872	12,660,363	14,907,160	14,731,540	15,058,794	15,642,095	15,744,708	16,190,717	15,305,367	189,272,241
Other Professional Services	4,421,687	4,619,091	4,841,378	3,806,785	4,389,484	4,935,401	4,421,552	4,883,941	5,048,627	5,107,193	4,658,383	4,460,451	4,604,443	60,198,416
Emergency Room	3,651,975	4,813,363	4,926,059	4,814,428	4,638,713	3,194,257	4,676,327	4,420,437	4,353,449	4,480,205	5,023,372	5,040,670	4,833,831	58,867,086
Inpatient	17,082,368	16,635,497	17,879,275	17,137,251	17,212,070	19,183,080	19,853,180	19,321,533	17,577,565	18,419,878	20,578,157	20,739,625	20,542,490	242,161,969
Reinsurance Expense	75,202	76,284	76,523	77,652	84,521	77,390	81,215	80,770	80,461	80,129	84,297	82,530	84,045	1,041,019
Outpatient Hospital	6,446,825	6,894,371	6,804,640	6,653,372	6,209,999	6,565,195	7,108,674	6,610,422	7,160,111	8,681,740	8,842,725	8,800,023	7,937,455	94,715,552
Other Medical	11,504,806	9,055,443	14,033,235	12,916,278	10,958,385	13,070,247	10,641,113	10,412,229	11,840,899	9,883,445	10,960,637	12,430,651	9,927,247	147,634,615
Pharmacy	8,780,407	9,180,669	9,829,083	9,259,169	8,717,167	9,651,881	9,100,359	9,049,621	10,299,227	9,412,697	9,349,484	10,442,688	9,774,211	122,846,663
Pay for Performance Quality Incentive	523,464	529,498	529,498	556,200	544,962	-	529,182	529,183	526,070	540,715	540,715	545,673	552,862	6,448,022
Risk Corridor Expense	(2,000,000)	-	(2,700,000)	-	-	-	-	-	-	-	-	-	-	(4,700,000)
Hospital Directed Payments	(8,860,821)	9,112,870	9,112,869	9,955,034	9,313,088	9,738,038	15,121,903	15,230,282	12,949,303	14,734,613	14,811,759	22,138,233	16,337,330	149,694,501
Hospital Directed Payment Adjustment	(52,075,301)	(233,958)	4,234	77	6,596	(1,263)	39,990	21,878	77,356,953	3,134	597	3,943	(29,149,382)	(4,022,502)
Non-Claims Expense Adjustment	(23,790)	(157)	(777,546)	5,124	(209,309)	1,598	287,063	233,372	212,564	71,855	58,763	46,953	(11,833)	(105,343)
IBNR, Incentive, Paid Claims Adjustment	344,451	(120,764)	(4,317,566)	(5,474)	205,986	316,193	4,787	858,658	1,700,070	(85,946)	449,838	(2,226,487)	406,066	(2,470,188)
Total Medical Costs	3,228,909	73,696,401	74,755,703	79,333,670	75,939,534	79,392,380	86,772,505	86,383,866	164,164,093	86,971,753	91,103,435	98,695,670	61,144,132	1,061,582,051
GROSS MARGIN	14,277,644	14,807,415	13,429,431	14,770,699	14,529,885	14,466,209	14,900,788	15,692,135	15,025,668	15,857,302	14,081,692	14,290,379	17,434,072	193,563,319
Administrative:														
Compensation	2,732,099	2,597,575	2,636,509	2,613,272	2,456,357	2,766,869	2,772,584	2,908,104	2,457,160	2,691,957	2,748,394	2,731,289	2,805,915	34,918,084
Purchased Services	859,845	819,771	421,612	689,841	745,537	1,172,530	818,908	824,152	941,200	986,086	996,889	985,876	939,689	11,201,936
Supplies	71,551	63,919	71,111	34,967	106,489	39,305	57,592	57,416	4,446	131,712	57,943	85,576	156,626	938,653
Depreciation	417,768	418,389	419,251	419,796	419,850	421,301	422,833	422,834	426,541	426,541	422,382	425,837	425,522	5,488,845
Other Administrative Expenses	240,778	254,091	296,858	137,960	242,696	351,189	277,245	267,201	102,962	248,235	230,567	233,637	274,638	3,158,057
Administrative Expense Adjustment	-	-	-	-	-	1,407,045	18,296	(271,318)	57,294	(5,010)	(215)	(63,654)	(1,674)	1,140,764
Total Administrative Expenses	4,322,041	4,153,745	3,845,341	3,895,836	3,970,929	6,158,239	4,367,458	4,208,389	3,989,603	4,479,521	4,455,960	4,398,561	4,600,716	56,846,339
TOTAL EXPENSES	7,550,950	77,850,146	78,601,044	83,229,506	79,910,463	85,550,619	91,139,963	90,592,255	168,153,696	91,451,274	95,559,395	103,094,231	65,744,848	1,118,428,390
OPERATING INCOME (LOSS) BEFORE TAX	9,955,603	10,653,670	9,584,090	10,874,863	10,558,956	8,307,970	10,533,330	11,483,746	11,036,065	11,377,781	9,625,732	9,891,818	12,833,356	136,716,980
MCO TAX	8,904,648	8,905,117	8,904,649	8,904,648	8,904,649	8,904,649	8,902,943	8,904,649	8,933,228	8,905,080	8,905,142	8,904,648	9,894,054	89,074,260
OPERATING INCOME (LOSS) NET OF TAX	1,050,955	1,748,553	679,441	1,970,215	1,654,307	(596,679)	1,630,387	2,579,097	2,102,837	2,472,701	720,590	987,170	2,939,302	47,642,720
TOTAL NONOPERATING REVENUE (EXPENSE)	462,756	(687,453)	(176,843)	(1,188,755)	(931,682)	1,433,032	(137,472)	(151,159)	(88,366)	(167,372)	(245,779)	(164,148)	(833,809)	(2,877,050)
NET INCREASE (DECREASE) IN NET POSITION	1,513,711	1,061,100	502,598	781,460	722,625	836,353	1,492,915	2,427,938	2,014,471	2,305,329	474,811	823,022	2,105,493	44,765,670
MEDICAL LOSS RATIO	91.4%	91.2%	92.8%	92.5%	91.6%	92.5%	93.1%	92.2%	94.3%	92.3%	94.9%	94.6%	90.9%	92.7%
ADMINISTRATIVE EXPENSE RATIO	6.2%	5.8%	5.4%	5.2%	5.5%	8.2%	5.7%	5.5%	5.1%	5.7%	5.5%	5.4%	5.7%	5.8%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH JULY 31, 2021	JULY 2020	AUGUST 2020	SEPTEMBER 2020	OCTOBER 2020	NOVEMBER 2020	DECEMBER 2020	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	261,732	264,749	278,100	272,481	275,080	277,452	278,517	276,880	282,972	284,587	287,199	289,309	290,980	3,620,038
REVENUES														
Title XIX - Medicaid - Family and Other	165.45	166.87	166.16	173.40	164.62	168.64	174.01	177.17	172.94	173.28	177.71	181.55	180.10	172.17
Title XIX - Medicaid - Expansion Members	377.98	376.19	379.54	393.46	371.41	384.47	385.83	397.58	382.20	385.72	381.99	388.41	387.35	382.79
Title XIX - Medicaid - SPD Members	981.08	972.23	972.22	945.03	1,012.68	989.03	957.28	816.21	1,005.21	978.42	1,017.24	1,020.90	1,029.14	975.20
Premium - MCO Tax	31.47	31.48	29.96	33.64	30.61	31.83	34.39	34.88	34.47	34.45	34.39	34.43	34.45	33.14
Premium - Hospital Directed Payments	(33.85)	34.42	32.77	36.53	33.86	35.10	54.29	55.01	45.76	51.78	51.57	76.52	56.15	41.35
Investment Earnings And Other Income	1.21	0.66	(0.05)	0.56	0.61	0.53	0.02	0.42	(0.88)	0.72	0.68	(1.41)	(0.13)	0.21
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	(198.96)	0.02	0.01	0.00	0.04	(0.01)	0.14	0.08	276.18	0.01	0.28	0.02	(100.18)	(0.80)
Rate/Income Adjustments	0.52	1.10	0.25	(2.14)	0.46	0.82	2.87	2.15	5.40	0.94	2.07	(0.32)	(1.01)	1.01
TOTAL REVENUES	66.89	334.29	317.10	345.36	328.88	338.29	365.05	368.67	633.24	361.33	366.24	390.54	270.05	346.72
EXPENSES														
Medical Costs:														
Physician Services	51.04	49.61	52.19	51.96	50.41	45.63	53.52	53.21	53.22	54.96	54.82	55.96	52.60	52.28
Other Professional Services	16.89	17.45	17.41	13.97	15.96	17.79	15.88	17.64	17.84	17.95	16.22	15.42	15.82	16.63
Emergency Room	13.95	18.18	17.71	17.67	16.86	11.51	16.79	15.97	15.38	15.74	17.49	17.42	16.61	16.26
Inpatient	65.27	62.83	64.29	62.89	62.57	69.14	71.28	69.78	62.12	64.72	71.65	71.69	70.60	66.89
Reinsurance Expense	0.29	0.29	0.28	0.28	0.31	0.28	0.29	0.29	0.28	0.28	0.29	0.29	0.29	0.29
Outpatient Hospital	24.63	26.04	24.47	24.42	22.58	23.66	25.52	23.87	25.30	30.51	30.79	30.42	27.28	26.16
Other Medical	43.96	34.20	50.46	47.40	39.84	47.11	38.21	37.61	41.84	34.73	38.16	42.97	34.12	40.78
Pharmacy	33.55	34.68	35.34	33.98	31.69	34.79	32.67	32.68	36.40	33.07	32.55	36.10	33.59	33.94
Pay for Performance Quality Incentive	2.00	2.00	1.90	2.04	1.98	0.00	1.90	1.91	1.86	1.90	1.88	1.89	1.90	1.78
Risk Corridor Expense	(7.64)	0.00	(9.71)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(1.30)
Hospital Directed Payments	(33.85)	34.42	32.77	36.53	33.86	35.10	54.29	55.01	45.76	51.78	51.57	76.52	56.15	41.35
Hospital Directed Payment Adjustment	(198.96)	(0.88)	0.02	0.00	0.02	(0.00)	0.14	0.08	273.37	0.01	0.00	0.01	(100.18)	(1.11)
Non-Claims Expense Adjustment	(0.09)	(0.00)	(2.80)	0.02	(0.76)	0.01	1.03	0.84	0.75	0.25	0.20	0.16	(0.04)	(0.03)
IBNR, Incentive, Paid Claims Adjustment	1.32	(0.46)	(15.53)	(0.02)	0.75	1.14	0.02	3.10	6.01	(0.30)	1.57	(7.70)	1.40	(0.68)
Total Medical Costs	12.34	278.36	268.81	291.15	276.06	286.15	311.55	311.99	580.14	305.61	317.21	341.14	210.13	293.25
GROSS MARGIN	54.55	55.93	48.29	54.21	52.82	52.14	53.50	56.67	53.10	55.72	49.03	49.39	59.92	53.47
Administrative:														
Compensation	10.44	9.81	9.48	9.59	8.93	9.97	9.95	10.50	8.68	9.46	9.57	9.44	9.64	9.65
Purchased Services	3.29	3.10	1.52	2.53	2.71	4.23	2.94	2.98	3.33	3.46	3.47	3.41	3.23	3.09
Supplies	0.27	0.24	0.26	0.13	0.39	0.14	0.21	0.21	0.02	0.46	0.20	0.30	0.54	0.26
Depreciation	1.60	1.58	1.51	1.54	1.53	1.52	1.52	1.53	1.51	1.50	1.47	1.47	1.46	1.52
Other Administrative Expenses	0.92	0.96	1.07	0.51	0.88	1.27	1.00	0.97	0.36	0.87	0.80	0.81	0.94	0.87
Administrative Expense Adjustment	0.00	0.00	0.00	0.00	0.00	5.07	0.07	(0.98)	0.20	(0.02)	(0.00)	(0.22)	(0.01)	0.32
Total Administrative Expenses	16.51	15.69	13.83	14.30	14.44	22.20	15.68	15.20	14.10	15.74	15.52	15.20	15.81	15.70
TOTAL EXPENSES	28.85	294.05	282.64	305.45	290.50	308.34	327.23	327.19	594.24	321.35	332.73	356.35	225.94	308.95
OPERATING INCOME (LOSS) BEFORE TAX	38.04	40.24	34.46	39.91	38.39	29.94	37.82	41.48	39.00	39.98	33.52	34.19	44.10	37.77
MCO TAX	34.02	33.64	32.02	32.68	32.37	32.09	31.97	32.16	31.57	31.29	31.01	30.78	34.00	24.61
OPERATING INCOME (LOSS) NET OF TAX	4.02	6.60	2.44	7.23	6.01	(2.15)	5.85	9.31	7.43	8.69	2.51	3.41	10.10	13.16
TOTAL NONOPERATING REVENUE (EXPENSE)	1.77	(2.60)	(0.64)	(4.36)	(3.39)	5.16	(0.49)	(0.55)	(0.31)	(0.59)	(0.86)	(0.57)	(2.87)	(0.79)
NET INCREASE (DECREASE) IN NET POSITION	5.78	4.01	1.81	2.87	2.63	3.01	5.36	8.77	7.12	8.10	1.65	2.84	7.24	12.37
MEDICAL LOSS RATIO	91.4%	91.2%	92.8%	92.5%	91.6%	92.5%	93.1%	92.2%	94.3%	92.3%	94.9%	94.6%	90.9%	92.7%
ADMINISTRATIVE EXPENSE RATIO	6.2%	5.8%	5.4%	5.2%	5.5%	8.2%	5.7%	5.5%	5.1%	5.7%	5.5%	5.4%	5.7%	5.8%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED JULY 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
28,090,609	24,815,196	3,275,413	Premium - Medi-Cal	187,551,283	173,013,985	14,537,298
2,673,599	2,520,887	152,712	Premium - Maternity Kick	16,179,584	17,646,209	(1,466,625)
26,209	79,448	(53,239)	Premium - Hep C Kick	283,934	552,640	(268,706)
632,373	491,086	141,287	Premium - BHT Kick	4,275,604	3,415,984	859,620
183,231	177,624	5,607	Premium - Health Home Kick	1,132,432	1,235,550	(103,118)
3,691,270	3,493,556	197,714	Premium - Provider Enhancement	25,206,934	24,332,085	874,849
194,084	169,581	24,503	Premium - Ground Emergency Medical Transportation	1,264,750	1,182,362	82,388
153,731	276,127	(122,396)	Premium - Behavorial Health Integration Program	3,783,293	1,920,730	1,862,563
116,564	91,846	24,718	Other	781,749	642,502	139,247
35,761,670	32,115,351	3,646,319	Total Title XIX - Medicaid - Family & Other	240,459,563	223,942,047	16,517,516
			Title XIX - Medicaid - Expansion Members			
27,193,501	24,002,303	3,191,198	Premium - Medi-Cal	180,631,076	168,016,121	12,614,955
212,110	214,253	(2,143)	Premium - Maternity Kick	2,366,033	1,499,771	866,262
139,783	202,017	(62,234)	Premium - Hep C Kick	1,362,885	1,414,118	(51,233)
295,627	356,121	(60,494)	Premium - Health Home Kick	1,940,098	2,492,847	(552,749)
1,552,878	1,455,050	97,828	Premium - Provider Enhancement	10,608,918	10,185,350	423,568
190,890	165,235	25,655	Premium - Ground Emergency Medical Transportation	1,273,686	1,156,645	117,041
59,148	102,122	(42,974)	Premium - Behavorial Health Integration Program	1,414,652	714,854	699,798
32,629	26,600	6,029	Other	221,427	186,200	35,227
29,676,566	26,523,701	3,152,865	Total Title XIX - Medicaid - Expansion Members	199,818,775	185,665,906	14,152,869
			Title XIX - Medicaid - SPD Members			
14,689,042	13,474,791	1,214,251	Premium - Medi-Cal	99,372,518	94,323,534	5,048,984
69,892	100,288	(30,396)	Premium - Hep C Kick	314,512	702,014	(387,502)
637,960	763,566	(125,606)	Premium - BHT Kick	4,020,263	5,344,961	(1,324,698)
249,519	351,842	(102,323)	Premium - Health Home Kick	1,693,475	2,462,894	(769,419)
464,371	454,632	9,739	Premium - Provider Enhancement	3,229,409	3,182,424	46,985
137,491	127,475	10,016	Premium - Ground Emergency Medical Transportation	935,027	892,325	42,702
12,170	22,041	(9,871)	Premium - Behavorial Health Integration Program	322,603	154,287	168,316
16,260,445	15,294,634	965,811	Total Title XIX - Medicaid - SPD Members	109,887,807	107,062,438	2,825,369

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JULY 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
3,239,377	3,070,233	(169,144)	Primary Care Physician Services	23,716,261	21,404,317	(2,311,944)
10,801,894	10,585,339	(216,555)	Referral Specialty Services	74,879,959	73,894,477	(985,482)
1,254,796	1,502,420	247,624	Urgent Care & After Hours Advise	8,920,561	10,471,088	1,550,527
9,300	9,300	-	Hospital Admitting Team	63,600	63,600	-
15,305,367	15,167,292	(138,075)	TOTAL PHYSICIAN SERVICES	107,580,381	105,833,483	(1,746,898)
			OTHER PROFESSIONAL SERVICES			
304,301	295,514	(8,787)	Vision Service Capitation	2,076,275	2,059,638	(16,637)
200,446	212,115	11,669	221 - Business Intelligence	1,472,901	1,484,805	11,904
626,829	597,920	(28,909)	310 - Health Services - Utilization Management - UM Allocation *	4,215,098	4,185,440	(29,658)
148,762	189,152	40,390	311 - Health Services - Quality Improvement - UM Allocation *	995,137	1,324,064	328,927
121,160	123,337	2,177	312 - Health Services - Education - UM Allocation *	827,411	863,357	35,946
76,519	80,283	3,764	313 - Health Services - Pharmacy - UM Allocation *	528,875	561,981	33,106
139,741	210,465	70,724	314 - Health Homes - UM Allocation *	953,011	1,473,255	520,244
293,801	270,692	(23,109)	315 - Case Management - UM Allocation *	1,898,482	1,894,844	(3,638)
58,576	56,773	(1,803)	616 - Disease Management - UM Allocation *	421,474	397,411	(24,063)
1,269,876	1,254,652	(15,224)	Behavior Health Treatment	8,389,593	8,760,943	371,350
95,878	189,650	93,772	Mental Health Services	935,655	1,324,371	388,716
1,268,554	1,248,659	(19,895)	Other Professional Services	10,470,678	8,719,627	(1,751,051)
4,604,443	4,729,211	124,768	TOTAL OTHER PROFESSIONAL SERVICES	33,184,590	33,049,737	(134,853)
4,833,831	5,573,871	740,040	EMERGENCY ROOM	32,828,291	38,871,584	6,043,293
20,542,490	15,416,353	(5,126,137)	INPATIENT HOSPITAL	137,032,428	107,658,365	(29,374,063)
84,045	80,213	(3,832)	REINSURANCE EXPENSE PREMIUM	573,447	559,052	(14,395)
7,937,455	6,994,346	(943,109)	OUTPATIENT HOSPITAL SERVICES	55,141,150	48,849,203	(6,291,947)
			OTHER MEDICAL			
1,328,439	1,552,226	223,787	Ambulance and NEMT	9,224,272	10,829,164	1,604,892
749,534	426,034	(323,500)	Home Health Services & CBAS	5,005,416	2,975,439	(2,029,977)
373,641	491,325	117,684	Utilization and Quality Review Expenses	2,963,483	3,439,275	475,792
1,204,596	1,301,063	96,467	Long Term/SNF/Hospice	9,345,340	9,095,853	(249,487)
162,780	395,087	232,307	Health Home Capitation & Incentive	1,872,487	2,758,979	886,492
5,433,266	5,133,844	(299,422)	Provider Enhancement Expense - Prop. 56	37,164,858	35,788,000	(1,376,858)
449,942	462,291	12,349	Provider Enhancement Expense - GEMT	3,073,917	3,231,332	157,415
-	-	-	Provider COVID-19 Expenes	2,125,900	-	(2,125,900)
225,049	400,289	175,240	Behaviorial Health Integration Program	5,320,548	2,789,870	(2,530,678)
9,927,247	10,162,161	234,914	TOTAL OTHER MEDICAL	76,096,221	70,907,911	(5,188,310)
			PHARMACY SERVICES			
8,878,267	9,380,400	502,133	RX - Drugs & OTC	60,480,420	65,536,800	5,056,380
239,266	381,753	142,487	RX - HEP-C	1,914,799	2,668,771	753,972
791,678	770,575	(21,103)	Rx - DME	5,865,658	5,383,478	(482,180)
(135,000)	(33,344)	101,656	RX - Pharmacy Rebates	(832,590)	(232,966)	599,624
9,774,211	10,499,384	725,173	TOTAL PHARMACY SERVICES	67,428,287	73,356,083	5,927,796
552,862	525,531	(27,332)	PAY FOR PERFORMANCE QUALITY INCENTIVE	3,764,400	3,662,754	(101,647)
-	-	-	RISK CORRIDOR EXPENSE	-	-	-
16,337,330	14,057,475	(2,279,855)	HOSPITAL DIRECTED PAYMENTS	111,323,423	98,143,322	(13,180,101)
(29,149,382)	-	29,149,382	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	48,277,113	-	(48,277,113)
(11,833)	-	11,833	NON-CLAIMS EXPENSE ADJUSTMENT	898,737	-	(898,737)
406,066	-	(406,066)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	1,106,986	-	(1,106,986)
61,144,132	83,205,838	22,061,706	Total Medical Costs	675,235,454	580,891,492	(94,343,962)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED JULY 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
11.13	11.10	(0.03)	Primary Care Physician Services	11.92	11.10	(0.81)
37.12	38.27	1.15	Referral Specialty Services	37.62	38.33	0.71
4.31	5.43	1.12	Urgent Care & After Hours Advise	4.48	5.43	0.95
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
52.60	54.84	2.24	TOTAL PHYSICIAN SERVICES	54.05	54.90	0.85
			OTHER PROFESSIONAL SERVICES			
1.05	1.07	0.02	Vision Service Capitation	1.04	1.07	0.03
0.69	0.77	0.08	221 - Business Intelligence	0.74	0.77	0.03
2.15	2.16	0.01	310 - Health Services - Utilization Management - UM Allocation *	2.12	2.17	0.05
0.51	0.68	0.17	311 - Health Services - Quality Improvement - UM Allocation *	0.50	0.69	0.19
0.42	0.45	0.03	312 - Health Services - Education - UM Allocation *	0.42	0.45	0.03
0.26	0.29	0.03	313 - Health Services - Pharmacy - UM Allocation *	0.27	0.29	0.03
0.48	0.76	0.28	314 - Health Homes - UM Allocation *	0.48	0.76	0.29
1.01	0.98	(0.03)	315 - Case Management - UM Allocation *	0.95	0.98	0.03
0.20	0.21	0.00	616 - Disease Management - UM Allocation *	0.21	0.21	(0.01)
4.36	4.54	0.17	Behavior Health Treatment	4.21	4.54	0.33
0.33	0.69	0.36	Mental Health Services	0.47	0.69	0.22
4.36	4.51	0.15	Other Professional Services	5.26	4.52	(0.74)
15.82	17.10	1.27	TOTAL OTHER PROFESSIONAL SERVICES	16.67	17.14	0.47
16.61	20.15	3.54	EMERGENCY ROOM	16.49	20.16	3.67
70.60	55.74	(14.86)	INPATIENT HOSPITAL	68.85	55.85	(13.00)
0.29	0.29	0.00	REINSURANCE EXPENSE PREMIUM	0.29	0.29	0.00
27.28	25.29	(1.99)	OUTPATIENT HOSPITAL SERVICES	27.70	25.34	(2.36)
			OTHER MEDICAL			
4.57	5.61	1.05	Ambulance and NEMT	4.63	5.62	0.98
2.58	1.54	(1.04)	Home Health Services & CBAS	2.51	1.54	(0.97)
1.28	1.78	0.49	Utilization and Quality Review Expenses	1.49	1.78	0.30
4.14	4.70	0.56	Long Term/SNF/Hospice	4.70	4.72	0.02
0.56	1.43	0.87	Health Home Capitation & Incentive	0.94	1.43	0.49
18.67	18.56	(0.11)	Provider Enhancement Expense - Prop. 56	18.67	18.56	(0.11)
1.55	1.67	0.13	Provider Enhancement Expense - GEMT	1.54	1.68	0.13
0.00	0.00	0.00	Provider COVID-19 Expenes	1.07	0.00	(1.07)
0.77	1.45	0.67	Behaviorial Health Integration Program	2.67	1.45	(1.23)
34.12	36.74	2.62	TOTAL OTHER MEDICAL	38.23	36.78	(1.45)
			PHARMACY SERVICES			
30.51	33.91	3.40	RX - Drugs & OTC	30.39	34.00	3.61
0.82	1.38	0.56	RX - HEP-C	0.96	1.38	0.42
2.72	2.79	0.07	Rx - DME	2.95	2.79	(0.15)
(0.46)	(0.12)	0.34	RX - Pharmacy Rebates	(0.42)	(0.12)	0.30
33.59	37.96	4.37	TOTAL PHARMACY SERVICES	33.88	38.05	4.18
1.90	1.90	0.00	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.89	1.90	0.01
0.00	0.00	0.00	RISK CORRIDOR EXPENSE	0.00	0.00	0.00
56.15	50.82	(5.32)	HOSPITAL DIRECTED PAYMENTS	55.93	50.91	(5.02)
(100.18)	0.00	100.18	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	24.25	0.00	(24.25)
(0.04)	0.00	0.04	NON-CLAIMS EXPENSE ADJUSTMENT	0.45	0.00	(0.45)
1.40	0.00	(1.40)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.56	0.00	(0.56)
210.13	300.82	90.69	Total Medical Costs	339.24	301.33	(37.91)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH JULY 31, 2021	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	YEAR TO DATE 2021
PHYSICIAN SERVICES								
Primary Care Physician Services	2,962,264	2,963,060	3,567,494	3,563,867	3,699,457	3,720,742	3,239,377	23,716,261
Referral Specialty Services	10,512,215	10,171,851	9,997,168	11,114,617	11,103,264	11,178,950	10,801,894	74,879,959
Urgent Care & After Hours Advise	1,423,381	1,588,229	1,484,832	954,611	932,687	1,282,025	1,254,796	8,920,561
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300	9,000	9,300	63,600
TOTAL PHYSICIAN SERVICES	14,907,160	14,731,540	15,058,794	15,642,095	15,744,708	16,190,717	15,305,367	107,580,381
OTHER PROFESSIONAL SERVICES								
Vision Service Capitation	294,054	292,442	292,443	289,005	305,213	298,817	304,301	2,076,275
221 - Business Intelligence	210,663	222,415	197,310	217,207	221,546	203,314	200,446	1,472,901
310 - Health Services - Utilization Management - UM Allocation *	595,003	563,907	605,345	602,798	602,089	619,127	626,829	4,215,098
311 - Health Services - Quality Improvement - UM Allocation *	138,388	123,443	154,295	136,098	147,314	146,837	148,762	995,137
312 - Health Services - Education - UM Allocation *	120,621	124,149	95,259	119,982	120,314	125,926	121,160	827,411
313 - Health Services - Pharmacy - UM Allocation *	75,046	75,369	75,552	75,945	76,277	74,167	76,519	528,875
314 - Health Homes - UM Allocation *	120,170	119,317	173,098	121,413	138,809	140,463	139,741	953,011
315 - Case Management - UM Allocation *	270,657	261,834	281,125	260,034	269,323	261,708	293,801	1,898,482
616 - Disease Management - UM Allocation *	62,998	58,064	72,219	57,851	56,419	55,347	58,576	421,474
Behavior Health Treatment	867,517	947,944	1,407,309	1,506,149	1,204,226	1,186,572	1,269,876	8,389,593
Mental Health Services	292,517	181,749	96,618	153,559	43,140	72,194	95,878	935,655
Other Professional Services	1,373,918	1,913,308	1,598,054	1,567,152	1,473,713	1,275,979	1,268,554	10,470,678
TOTAL OTHER PROFESSIONAL SERVICES	4,421,552	4,883,941	5,048,627	5,107,193	4,658,383	4,460,451	4,604,443	33,184,590
EMERGENCY ROOM	4,676,327	4,420,437	4,353,449	4,480,205	5,023,372	5,040,670	4,833,831	32,828,291
INPATIENT HOSPITAL	19,853,180	19,321,533	17,577,565	18,419,878	20,578,157	20,739,625	20,542,490	137,032,428
REINSURANCE EXPENSE PREMIUM	81,215	80,770	80,461	80,129	84,297	82,530	84,045	573,447
OUTPATIENT HOSPITAL SERVICES	7,108,674	6,610,422	7,160,111	8,681,740	8,842,725	8,800,023	7,937,455	55,141,150
OTHER MEDICAL								
Ambulance and NEMT	1,400,971	1,208,039	1,444,178	1,338,929	1,314,492	1,189,224	1,328,439	9,224,272
Home Health Services & CBAS	490,933	582,371	853,147	657,817	707,296	964,318	749,534	5,005,416
Utilization and Quality Review Expenses	228,696	372,499	688,633	430,683	359,626	509,705	373,641	2,963,483
Long Term/SNF/Hospice	1,616,577	1,132,832	1,933,711	1,041,624	1,114,812	1,301,188	1,204,596	9,345,340
Health Home Capitation & Incentive	211,140	294,005	334,675	299,855	228,752	341,280	162,780	1,872,487
Provider Enhancement Expense - Prop. 56	5,190,164	5,226,990	5,265,692	5,318,961	5,342,952	5,386,833	5,433,266	37,164,858
Provider Enhancement Expense - GEMT	456,380	456,381	265,311	423,904	494,669	527,330	449,942	3,073,917
Provider COVID-19 Expenes	674,580	767,440	683,880	-	-	-	-	2,125,900
Behaviorial Health Integration Program	371,672	371,672	371,672	371,672	1,398,038	2,210,773	225,049	5,320,548
TOTAL OTHER MEDICAL	10,641,113	10,412,229	11,840,899	9,883,445	10,960,637	12,430,651	9,927,247	76,096,221
PHARMACY SERVICES								
RX - Drugs & OTC	8,174,252	8,080,594	9,316,542	8,462,224	8,518,642	9,049,899	8,878,267	60,480,420
RX - HEP-C	245,144	264,815	249,449	260,020	290,418	365,687	239,266	1,914,799
Rx - DME	815,963	839,212	868,236	825,453	690,067	1,035,049	791,678	5,865,658
RX - Pharmacy Rebates	(135,000)	(135,000)	(135,000)	(135,000)	(149,643)	(7,947)	(135,000)	(832,590)
TOTAL PHARMACY SERVICES	9,100,359	9,049,621	10,299,227	9,412,697	9,349,484	10,442,688	9,774,211	67,428,287
PAY FOR PERFORMANCE QUALITY INCENTIVE	529,182	529,183	526,070	540,715	540,715	545,673	552,862	3,764,400
RISK CORRIDOR EXPENSE	-	-	-	-	-	-	-	-
HOSPITAL DIRECTED PAYMENTS	15,121,903	15,230,282	12,949,303	14,734,613	14,811,759	22,138,233	16,337,330	111,323,423
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	39,990	21,878	77,356,953	3,134	597	3,943	(29,149,382)	48,277,113
NON-CLAIMS EXPENSE ADJUSTMENT	287,063	233,372	212,564	71,855	58,763	46,953	(11,833)	898,737
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	4,787	858,658	1,700,070	(85,946)	449,838	(2,226,487)	406,066	1,106,986
Total Medical Costs	86,772,505	86,383,866	164,164,093	86,971,753	91,103,435	98,695,670	61,144,132	675,235,454

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH JULY 31, 2021	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	YEAR TO DATE 2021
PHYSICIAN SERVICES								
Primary Care Physician Services	10.64	10.70	12.61	12.52	12.88	12.86	11.13	11.92
Referral Specialty Services	37.74	36.74	35.33	39.06	38.66	38.64	37.12	37.62
Urgent Care & After Hours Advise	5.11	5.74	5.25	3.35	3.25	4.43	4.31	4.48
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	53.52	53.21	53.22	54.96	54.82	55.96	52.60	54.05
OTHER PROFESSIONAL SERVICES								
Vision Service Capitation	1.06	1.06	1.03	1.02	1.06	1.03	1.05	1.04
221 - Business Intelligence	0.76	0.80	0.70	0.76	0.77	0.70	0.69	0.74
310 - Health Services - Utilization Management - UM Allocation *	2.14	2.04	2.14	2.12	2.10	2.14	2.15	2.12
311 - Health Services - Quality Improvement - UM Allocation *	0.50	0.45	0.55	0.48	0.51	0.51	0.51	0.50
312 - Health Services - Education - UM Allocation *	0.43	0.45	0.34	0.42	0.42	0.44	0.42	0.42
313 - Health Services - Pharmacy - UM Allocation *	0.27	0.27	0.27	0.27	0.27	0.26	0.26	0.27
314 - Health Homes - UM Allocation *	0.43	0.43	0.61	0.43	0.48	0.49	0.48	0.48
315 - Case Management - UM Allocation *	0.97	0.95	0.99	0.91	0.94	0.90	1.01	0.95
616 - Disease Management - UM Allocation *	0.23	0.21	0.26	0.20	0.20	0.19	0.20	0.21
Behavior Health Treatment	3.11	3.42	4.97	5.29	4.19	4.10	4.36	4.21
Mental Health Services	1.05	0.66	0.34	0.54	0.15	0.25	0.33	0.47
Other Professional Services	4.93	6.91	5.65	5.51	5.13	4.41	4.36	5.26
TOTAL OTHER PROFESSIONAL SERVICES	15.88	17.64	17.84	17.95	16.22	15.42	15.82	16.67
EMERGENCY ROOM	16.79	15.97	15.38	15.74	17.49	17.42	16.61	16.49
INPATIENT HOSPITAL	71.28	69.78	62.12	64.72	71.65	71.69	70.60	68.85
REINSURANCE EXPENSE PREMIUM	0.29	0.29	0.28	0.28	0.29	0.29	0.29	0.29
OUTPATIENT HOSPITAL SERVICES	25.52	23.87	25.30	30.51	30.79	30.42	27.28	27.70
OTHER MEDICAL								
Ambulance and NEMT	5.03	4.36	5.10	4.70	4.58	4.11	4.57	4.63
Home Health Services & CBAS	1.76	2.10	3.01	2.31	2.46	3.33	2.58	2.51
Utilization and Quality Review Expenses	0.82	1.35	2.43	1.51	1.25	1.76	1.28	1.49
Long Term/SNF/Hospice	5.80	4.09	6.83	3.66	3.88	4.50	4.14	4.70
Health Home Capitation & Incentive	0.76	1.06	1.18	1.05	0.80	1.18	0.56	0.94
Provider Enhancement Expense - Prop. 56	18.63	18.88	18.61	18.69	18.60	18.62	18.67	18.67
Provider Enhancement Expense - GEMT	1.64	1.65	0.94	1.49	1.72	1.82	1.55	1.54
Provider COVID-19 Expenes	2.42	2.77	2.42	0.00	0.00	0.00	0.00	1.07
Behaviorial Health Integration Program	1.33	1.34	1.31	1.31	4.87	7.64	0.77	2.67
TOTAL OTHER MEDICAL	38.21	37.61	41.84	34.73	38.16	42.97	34.12	38.23
PHARMACY SERVICES								
RX - Drugs & OTC	29.35	29.18	32.92	29.74	29.66	31.28	30.51	30.39
RX - HEP-C	0.88	0.96	0.88	0.91	1.01	1.26	0.82	0.96
Rx - DME	2.93	3.03	3.07	2.90	2.40	3.58	2.72	2.95
RX - Pharmacy Rebates	(0.48)	(0.49)	(0.48)	(0.47)	(0.52)	(0.03)	(0.46)	(0.42)
TOTAL PHARMACY SERVICES	32.67	32.68	36.40	33.07	32.55	36.10	33.59	33.88
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.90	1.91	1.86	1.90	1.88	1.89	1.90	1.89
RISK CORRIDOR EXPENSE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
HOSPITAL DIRECTED PAYMENTS	54.29	55.01	45.76	51.78	51.57	76.52	56.15	55.93
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.14	0.08	273.37	0.01	0.00	0.01	(100.18)	24.25
NON-CLAIMS EXPENSE ADJUSTMENT	1.03	0.84	0.75	0.25	0.20	0.16	(0.04)	0.45
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.02	3.10	6.01	(0.30)	1.57	(7.70)	1.40	0.56
Total Medical Costs	311.55	311.99	580.14	305.61	317.21	341.14	210.13	339.24

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED JULY 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
361,179	402,031	40,852	110 - Executive	2,605,344	2,689,218	83,874
202,043	212,651	10,608	210 - Accounting	1,322,571	1,488,558	165,987
325,601	362,443	36,842	220 - Management Information Systems	2,515,197	2,537,103	21,906
14,545	64,468	49,923	221 - Business Intelligence	97,148	451,276	354,128
253,485	281,931	28,446	222 - Enterprise Development	1,721,204	1,973,516	252,312
459,826	448,524	(11,302)	225 - Infrastructure	2,727,122	3,139,665	412,543
539,331	576,323	36,992	230 - Claims	3,730,941	4,034,262	303,321
160,413	149,779	(10,634)	240 - Project Management	945,942	1,048,455	102,513
91,643	101,775	10,132	310 - Health Services - Utilization Management	728,481	712,424	(16,057)
25,067	27,902	2,835	311 - Health Services - Quality Improvement	147,916	195,315	47,399
-	55	55	312 - Health Services - Education	59	385	326
150,515	142,146	(8,369)	313- Pharmacy	1,025,512	995,021	(30,491)
-	6,642	6,642	314 - Health Homes	4,225	46,492	42,267
25,548	22,357	(3,191)	315 - Case Management	165,086	156,497	(8,589)
30,175	29,325	(850)	616 - Disease Management	217,140	205,277	(11,863)
286,715	323,502	36,787	320 - Provider Network Management	1,928,358	2,264,517	336,159
624,470	656,475	32,005	330 - Member Services	4,073,694	4,595,327	521,633
620,533	702,275	81,742	340 - Corporate Services	3,972,190	4,915,924	943,734
68,450	66,363	(2,087)	360 - Audit & Investigative Services	441,944	464,540	22,596
88,385	69,250	(19,135)	410 - Advertising Media	466,058	484,750	18,692
37,987	73,950	35,963	420 - Sales/Marketing/Public Relations	382,201	517,647	135,446
236,479	251,455	14,976	510 - Human Resourses	1,548,156	1,760,185	212,029
(1,674)	-	1,674	Administrative Expense Adjustment	(266,281)	-	266,281
4,600,716	4,971,622	370,906	Total Administrative Expenses	30,500,208	34,676,355	4,176,147

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED JULY 31, 2021	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	YEAR TO DATE 2021
110 - Executive	353,943	483,744	293,288	272,219	482,689	358,282	361,179	2,605,344
210 - Accounting	203,619	198,129	146,511	287,032	86,601	198,636	202,043	1,322,571
220 - Management Information Systems (MIS)	340,212	345,719	394,230	384,019	349,136	376,280	325,601	2,515,197
221 - Business Intelligence	-	-	-	12,308	46,180	24,115	14,545	97,148
222 - Enterprise Development	250,306	269,236	185,800	249,199	261,073	252,105	253,485	1,721,204
225 - Infrastructure	365,340	337,172	345,070	407,880	459,371	352,463	459,826	2,727,122
230 - Claims	550,124	558,095	460,086	554,302	542,410	526,593	539,331	3,730,941
240 - Project Management	99,808	119,159	128,304	121,381	127,251	189,626	160,413	945,942
310 - Health Services - Utilization Management	103,641	120,732	82,239	113,686	116,283	100,257	91,643	728,481
311 - Health Services - Quality Improvement	18,870	16,833	21,040	18,597	20,088	27,421	25,067	147,916
312 - Health Services - Education	-	-	-	59	-	-	-	59
313- Pharmacy	141,859	137,379	151,340	147,394	145,687	151,338	150,515	1,025,512
314 - Health Homes	-	-	4,225	-	-	-	-	4,225
315 - Case Management	23,536	22,769	24,444	22,612	23,420	22,757	25,548	165,086
616 - Disease Management	32,453	29,912	37,220	29,802	29,065	28,513	30,175	217,140
320 - Provider Network Management	304,995	273,211	231,758	274,082	295,300	262,297	286,715	1,928,358
330 - Member Services	567,625	586,939	545,846	622,842	566,155	559,817	624,470	4,073,694
340 - Corporate Services	561,450	559,640	535,874	586,682	567,567	540,444	620,533	3,972,190
360 - Audit & Investigative Services	68,976	83,366	38,089	60,406	61,212	61,445	68,450	441,944
410 - Advertising Media	27,368	39,637	81,326	55,258	21,513	152,571	88,385	466,058
420 - Sales/Marketing/Public Relations	53,401	69,703	46,252	65,999	51,803	57,056	37,987	382,201
510 - Human Resourses	281,636	228,332	179,367	198,772	203,371	220,199	236,479	1,548,156
Total Department Expenses	4,349,162	4,479,707	3,932,309	4,484,531	4,456,175	4,462,215	4,602,390	30,766,489
ADMINISTRATIVE EXPENSE ADJUSTMENT	18,296	(271,318)	57,294	(5,010)	(215)	(63,654)	(1,674)	(266,281)
Total Administrative Expenses	4,367,458	4,208,389	3,989,603	4,479,521	4,455,960	4,398,561	4,600,716	30,500,208

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF JULY 31, 2021

ASSETS	JULY 2021	JUNE 2021	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,137,662	$ 1,136,738	924
Interest Receivable	300	924	(624)
TOTAL CURRENT ASSETS	$ 1,137,962	$ 1,137,662	$ 300
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,138,066	1,138,066	-
Increase (Decrease) in Net Position - Current Year	(104)	(404)	300
Total Net Position	$ 1,137,962	$ 1,137,662	$ 300
TOTAL LIABILITIES AND NET POSITION	$ 1,137,962	$ 1,137,662	$ 300

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JULY 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
300	-	300	Interest	2,459	-	2,459
-	-	-	Other Investment Income	(2,563)	-	(2,563)
300	-	300	TOTAL REVENUES	(104)	-	(104)
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
300	-	300	GROSS MARGIN	(104)	-	(104)
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
300	-	300	OPERATING INCOME (LOSS)	(104)	-	(104)
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
300	-	300	NET INCREASE (DECREASE) IN NET POSITION	(104)	-	(104)
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	2021 MEMBER MONTHS	JAN'21	FEB'21	MAR'21	APR'21	MAY'21	JUN'21	JUL'21	AUG'21	SEP'21	OCT'21	NOV'21	DEC'21
ADULT AND FAMILY													
ADULT	**375,525**	51,548	53,449	52,941	53,378	54,092	54,867	55,250	0	0	0	0	0
CHILD	**928,289**	131,669	126,764	133,240	133,228	133,944	134,540	134,904	0	0	0	0	0
SUB-TOTAL ADULT & FAMILY	**1,303,814**	**183,217**	**180,213**	**186,181**	**186,606**	**188,036**	**189,407**	**190,154**	**0**	**0**	**0**	**0**	**0**
OTHER MEMBERS													
PARTIAL DUALS - FAMILY	**3,764**	403	523	529	576	563	576	594	0	0	0	0	0
PARTIAL DUALS - CHILD	**-1**	0	-1	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	**18**	2	2	2	2	2	4	4	0	0	0	0	0
BCCTP - TABACCO SETTLEMENT	**0**	0	0	0	0	0	0	0	0	0	0	0	0
FULL DUALS (SPD)													
SPD FULL DUALS	**53,192**	7,484	7,591	7,505	7,523	7,635	7,640	7,814	0	0	0	0	0
SUBTOTAL OTHER MEMBERS	**56,973**	**7,889**	**8,115**	**8,036**	**8,101**	**8,200**	**8,220**	**8,412**	**0**	**0**	**0**	**0**	**0**
TOTAL FAMILY & OTHER	**1,360,787**	**191,106**	**188,328**	**194,217**	**194,707**	**196,236**	**197,627**	**198,566**	**0**	**0**	**0**	**0**	**0**
SPD													
SPD (AGED AND DISABLED)	**113,239**	16,011	18,829	15,328	15,870	15,756	15,645	15,800	0	0	0	0	0
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	**510,038**	70,649	69,251	72,532	73,089	74,161	74,905	75,451	0	0	0	0	0
ACA Expansion Duals	**6,380**	751	472	895	921	1,046	1,132	1,163	0	0	0	0	0
SUB-TOTAL MED-CAL EXPANSION	**516,418**	**71,400**	**69,723**	**73,427**	**74,010**	**75,207**	**76,037**	**76,614**	**0**	**0**	**0**	**0**	**0**
TOTAL KAISER	**80,624**	**11,047**	**11,196**	**11,349**	**11,505**	**11,692**	**11,852**	**11,983**	**0**	**0**	**0**	**0**	**0**
TOTAL MEDI-CAL MEMBERS	**2,071,068**	**289,564**	**288,076**	**294,321**	**296,092**	**298,891**	**301,161**	**302,963**	**0**	**0**	**0**	**0**	**0**

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: October 14, 2021

Re: August 31, 2021 Financial Results

The August results reflect a $629,453 Net Increase in Net Position which is a $1,921,800 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $8.6 million favorable variance primarily due to:

   A) $6.3 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $2.3 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated rates for calendar year 2021 from DHCS and higher than expected membership offset against amounts included in 2B below.

2) Total Medical Costs reflect a $7.6 million unfavorable variance primarily due to:

   A) $5.2 million unfavorable variance in Inpatient primarily due to higher-than-expected utilization.

   B) $2.3 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rates for calendar year 2021 from DHCS and higher than expected membership offset against amounts included in 1B above.

The August Medical Loss Ratio is 92.7% which is favorable to the 93.2% budgeted amount. The August Administrative Expense Ratio is 5.6% which is favorable to the 6.7% budgeted amount.

The results for the 8 months ended August 31, 2021 reflect a Net Increase in Net Position of $12,273,432. This is a $15,933,650 favorable variance to budget and includes approximately $2.1 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 93.1 % which is equal to the 93.1% budgeted amount. The year-to-date Administrative Expense Ratio is 5.5% which is favorable to the 6.7% budgeted amount.

Kern Health Systems
Financial Packet
August 2021

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF AUGUST 31, 2021

ASSETS	AUGUST 2021	JULY 2021	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 101,079,711	$ 82,224,554	$ 18,855,157
Short-Term Investments	168,987,982	168,754,740	233,242
Premiums Receivable - Net	109,595,332	108,230,699	1,364,633
Premiums Receivable - Hospital Direct Payments	301,656,818	285,287,509	16,369,309
Interest Receivable	194,134	96,209	97,925
Provider Advance Payment	5,225,521	5,267,051	(41,530)
Other Receivables	1,326,074	1,171,013	155,061
Prepaid Expenses & Other Current Assets	3,154,865	3,597,595	(442,730)
Total Current Assets	$ 691,220,437	$ 654,629,370	$ 36,591,067
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,756,636	1,794,708	(38,072)
Computer Hardware and Software - Net	12,953,613	13,103,814	(150,201)
Building and Building Improvements - Net	34,742,727	34,818,422	(75,695)
Capital Projects in Progress	14,326,024	13,985,345	340,679
Total Capital Assets	$ 67,869,706	$ 67,792,995	$ 76,711
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,597,244	1,597,244	-
Total Long Term Assets	$ 1,897,244	$ 1,897,244	$ -
DEFERRED OUTFLOWS OF RESOURCES	$ 3,018,341	$ 3,018,341	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 764,005,728	$ 727,337,950	$ 36,667,778
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 4,277,081	$ 3,907,640	369,441
Accrued Other Operating Expenses	1,404,166	1,565,571	(161,405)
Accrued Taxes and Licenses	19,638,235	9,744,181	9,894,054
Claims Payable (Reported)	27,408,253	21,866,724	5,541,529
IBNR - Inpatient Claims	42,659,402	40,423,174	2,236,228
IBNR - Physician Claims	15,210,414	14,900,539	309,875
IBNR - Accrued Other Medical	22,345,096	23,742,925	(1,397,829)
Risk Pool and Withholds Payable	7,912,360	8,073,020	(160,660)
Statutory Allowance for Claims Processing Expense	2,157,367	2,157,367	-
Other Liabilities	74,090,096	71,052,313	3,037,783
Accrued Hospital Directed Payments	301,656,818	285,287,509	16,369,309
Total Current Liabilities	$ 518,759,288	$ 482,720,963	$ 36,038,325
NONCURRENT LIABILITIES:			
Net Pension Liability	5,800,140	5,800,140	-
TOTAL NONCURRENT LIABILITIES	$ 5,800,140	$ 5,800,140	$ -
DEFERRED INFLOWS OF RESOURCES	$ 86,684	$ 86,684	$ -
NET POSITION:			
Net Position - Beg. of Year	227,086,184	227,086,184	-
Increase (Decrease) in Net Position - Current Year	12,273,432	11,643,979	629,453
Total Net Position	$ 239,359,616	$ 238,730,163	$ 629,453
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 764,005,728	$ 727,337,950	$ 36,667,778

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED AUGUST 31, 2021

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
190,539	184,200	6,339	Family Members	1,494,353	1,462,400	31,953
77,567	70,565	7,002	Expansion Members	593,985	564,520	29,465
15,749	15,230	519	SPD Members	128,988	121,840	7,148
8,416	7,000	1,416	Other Members	65,389	56,000	9,389
12,108	10,500	1,608	Kaiser Members	92,732	84,000	8,732
304,379	287,495	16,884	Total Members - MCAL	2,375,447	2,288,760	86,687
			REVENUES			
34,569,656	32,156,561	2,413,095	Title XIX - Medicaid - Family and Other	275,029,219	256,098,607	18,930,612
29,540,608	26,523,701	3,016,907	Title XIX - Medicaid - Expansion Members	229,359,383	212,189,607	17,169,776
16,115,519	15,294,634	820,885	Title XIX - Medicaid - SPD Members	126,003,326	122,357,070	3,646,256
10,069,582	9,894,054	175,528	Premium - MCO Tax	78,726,409	73,216,001	5,510,408
16,361,944	14,069,809	2,292,135	Premium - Hospital Directed Payments	127,685,367	112,213,131	15,472,236
567,469	167,191	400,278	Investment Earnings And Other Income	392,065	1,327,737	(935,672)
-	80,329	(80,329)	Reinsurance Recoveries	-	639,380	(639,380)
7,365	-	7,365	Rate Adjustments - Hospital Directed Payments	49,157,986	-	49,157,986
(458,866)	-	(458,866)	Rate/Income Adjustments	2,937,012	-	2,937,012
106,773,277	98,186,279	8,586,998	TOTAL REVENUES	889,290,767	778,041,533	111,249,234
			EXPENSES			
			Medical Costs:			
15,819,470	15,183,367	(636,103)	Physician Services	123,399,851	121,016,850	(2,383,001)
4,825,412	4,731,818	(93,594)	Other Professional Services	38,010,002	37,781,555	(228,447)
4,472,304	5,580,800	1,108,496	Emergency Room	37,300,595	44,452,383	7,151,788
20,581,248	15,428,548	(5,152,700)	Inpatient	157,613,676	123,086,913	(34,526,763)
84,997	80,329	(4,668)	Reinsurance Expense	658,444	639,380	(19,064)
7,942,981	6,999,642	(943,339)	Outpatient Hospital	63,084,131	55,848,845	(7,235,286)
9,914,269	10,172,981	258,712	Other Medical	86,010,490	81,080,892	(4,929,598)
10,298,442	10,506,032	207,590	Pharmacy	77,726,729	83,862,116	6,135,387
552,862	526,291	(26,572)	Pay for Performance Quality Incentive	4,317,262	4,189,044	(128,218)
-	-	-	Risk Corridor Expense	-	-	-
16,361,944	14,069,809	(2,292,135)	Hospital Directed Payments	127,685,367	112,213,131	(15,472,236)
7,365	-	(7,365)	Hospital Directed Payment Adjustment	48,284,478	-	(48,284,478)
34,433	-	(34,433)	Non-Claims Expense Adjustment	933,170	-	(933,170)
(55,915)	-	55,915	IBNR, Incentive, Paid Claims Adjustment	1,051,071	-	(1,051,071)
90,839,812	83,279,617	(7,560,195)	Total Medical Costs	766,075,266	664,171,109	(101,904,157)
15,933,465	14,906,662	1,026,803	GROSS MARGIN	123,215,501	113,870,424	9,345,077
			Administrative:			
2,781,896	2,881,030	99,134	Compensation	21,897,299	22,923,242	1,025,943
845,393	1,071,006	225,613	Purchased Services	7,338,193	8,568,048	1,229,855
193,504	133,106	(60,398)	Supplies	744,815	1,064,850	320,035
427,805	500,520	72,715	Depreciation	3,400,295	4,004,163	603,868
214,396	385,959	171,563	Other Administrative Expenses	1,848,881	3,087,674	1,238,793
(2,367)	-	2,367	Administrative Expense Adjustment	(268,648)	-	268,648
4,460,627	4,971,622	510,995	Total Administrative Expenses	34,960,835	39,647,977	4,687,142
95,300,439	88,251,239	(7,049,200)	TOTAL EXPENSES	801,036,101	703,819,087	(97,217,014)
11,472,838	9,935,039	1,537,799	OPERATING INCOME (LOSS) BEFORE TAX	88,254,666	74,222,446	14,032,220
9,894,055	9,894,054	(1.18)	MCO TAX	73,243,799	73,216,001	(27,798)
1,578,783	40,986	1,537,797	OPERATING INCOME (LOSS) NET OF TAX	15,010,867	1,006,446	14,004,421
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
(917,074)	(1,166,666)	249,592	Provider Recruitment and Retention Grants	(2,183,229)	(3,333,332)	1,150,103
(32,256)	(166,667)	134,411	Health Home	(554,206)	(1,333,332)	779,126
(949,330)	(1,333,333)	384,003	TOTAL NONOPERATING REVENUE (EXPENSE)	(2,737,435)	(4,666,664)	1,929,229
629,453	(1,292,347)	1,921,800	NET INCREASE (DECREASE) IN NET POSITION	12,273,432	(3,660,218)	15,933,650
92.7%	93.2%	0.5%	MEDICAL LOSS RATIO	93.1%	93.1%	0.0%
5.6%	6.7%	1.1%	ADMINISTRATIVE EXPENSE RATIO	5.5%	6.7%	1.2%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED AUGUST 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
190,539	184,200	6,339	Family Members	1,494,353	1,462,400	31,953
77,567	70,565	7,002	Expansion Members	593,985	564,520	29,465
15,749	15,230	519	SPD Members	128,988	121,840	7,148
8,416	7,000	1,416	Other Members	65,389	56,000	9,389
12,108	10,500	1,608	Kaiser Members	92,732	84,000	8,732
304,379	287,495	16,884	Total Members - MCAL	2,375,447	2,288,760	86,687
			REVENUES			
173.76	168.18	5.57	Title XIX - Medicaid - Family and Other	176.33	168.66	7.67
380.84	375.88	4.96	Title XIX - Medicaid - Expansion Members	386.14	375.88	10.26
1,023.27	1,004.24	19.03	Title XIX - Medicaid - SPD Members	976.86	1,004.24	(27.38)
34.45	35.72	(1.27)	Premium - MCO Tax	34.49	33.21	1.28
55.98	50.79	5.19	Premium - Hospital Directed Payments	55.94	50.90	5.04
1.94	0.60	1.34	Investment Earnings And Other Income	0.17	0.60	(0.43)
0.00	0.29	(0.29)	Reinsurance Recoveries	0.00	0.29	(0.29)
0.03	0.00	0.03	Rate Adjustments - Hospital Directed Payments	21.53	0.00	21.53
(1.57)	0.00	(1.57)	Rate/Income Adjustments	1.29	0.00	1.29
365.32	354.47	10.85	TOTAL REVENUES	389.58	352.89	36.68
			EXPENSES			
			Medical Costs:			
54.13	54.81	0.69	Physician Services	54.06	54.89	0.83
16.51	17.08	0.57	Other Professional Services	16.65	17.14	0.49
15.30	20.15	4.85	Emergency Room	16.34	20.16	3.82
70.42	55.70	(14.72)	Inpatient	69.05	55.83	(13.22)
0.29	0.29	(0.00)	Reinsurance Expense	0.29	0.29	0.00
27.18	25.27	(1.91)	Outpatient Hospital	27.64	25.33	(2.30)
33.92	36.73	2.80	Other Medical	37.68	36.78	(0.90)
35.24	37.93	2.69	Pharmacy	34.05	38.04	3.99
1.89	1.90	0.01	Pay for Performance Quality Incentive	1.89	1.90	0.01
0.00	0.00	0.00	Risk Corridor Expense	0.00	0.00	0.00
55.98	50.79	(5.19)	Hospital Directed Payments	55.94	50.90	(5.04)
0.03	0.00	(0.03)	Hospital Directed Payment Adjustment	21.15	0.00	(21.15)
0.12	0.00	(0.12)	Non-Claims Expense Adjustment	0.41	0.00	(0.41)
(0.19)	0.00	0.19	IBNR, Incentive, Paid Claims Adjustment	0.46	0.00	(0.46)
310.81	300.65	(10.15)	Total Medical Costs	335.60	301.24	(34.35)
54.52	53.82	0.70	GROSS MARGIN	53.98	51.65	2.33
			Administrative:			
9.52	10.40	0.88	Compensation	9.59	10.40	0.80
2.89	3.87	0.97	Purchased Services	3.21	3.89	0.67
0.66	0.48	(0.18)	Supplies	0.33	0.48	0.16
1.46	1.81	0.34	Depreciation	1.49	1.82	0.33
0.73	1.39	0.66	Other Administrative Expenses	0.81	1.40	0.59
(0.01)	0.00	0.01	Administrative Expense Adjustment	(0.12)	0.00	0.12
15.26	17.95	2.69	Total Administrative Expenses	15.32	17.98	2.67
326.07	318.60	(7.47)	TOTAL EXPENSES	350.91	319.23	(31.69)
39.25	35.87	3.39	OPERATING INCOME (LOSS) BEFORE TAX	38.66	33.66	5.00
33.85	35.72	1.87	MCO TAX	32.09	33.21	1.12
5.40	0.15	5.25	OPERATING INCOME (LOSS) NET OF TAX	6.58	0.46	6.12
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
(3.14)	(4.21)	1.07	Reserve Fund Projects/Community Grants	(0.96)	(1.51)	0.56
(0.11)	(0.60)	0.49	Health Home	(0.24)	(0.60)	0.36
(3.25)	(4.81)	1.57	TOTAL NONOPERATING REVENUE (EXPENSE)	(1.20)	(2.12)	0.92
2.15	(4.67)	6.82	NET INCREASE (DECREASE) IN NET POSITION	5.38	(1.66)	7.04
92.7%	93.2%	0.5%	MEDICAL LOSS RATIO	93.1%	93.1%	0.0%
5.6%	6.7%	1.1%	ADMINISTRATIVE EXPENSE RATIO	5.5%	6.7%	1.2%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH AUGUST 31, 2021	AUGUST 2020	SEPTEMBER 2020	OCTOBER 2020	NOVEMBER 2020	DECEMBER 2020	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	AUGUST 2021	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	264,749	278,100	272,481	275,080	277,452	278,517	276,880	282,972	284,587	287,199	289,309	290,980	292,271	3,650,577
REVENUES														
Title XIX - Medicaid - Family and Other	30,548,160	30,419,692	33,387,274	30,920,096	32,216,002	33,254,490	33,365,704	33,587,650	33,739,041	34,872,666	35,878,342	35,761,670	34,569,656	432,520,443
Title XIX - Medicaid - Expansion Members	24,848,094	25,069,155	27,568,938	25,504,052	27,197,954	27,548,311	27,720,576	28,063,951	28,547,171	28,728,667	29,533,533	29,676,566	29,540,608	359,547,576
Title XIX - Medicaid - SPD Members	15,192,022	15,191,965	14,457,143	16,007,482	15,504,966	15,326,978	15,368,431	15,407,903	15,527,562	16,024,510	15,971,978	16,260,445	16,115,519	202,356,904
Premium - MCO Tax	8,333,151	8,332,682	9,166,454	8,420,487	8,830,398	9,577,432	9,657,982	9,752,737	9,805,142	9,876,747	9,961,634	10,025,153	10,069,582	121,809,581
Premium - Hospital Directed Payments	9,112,870	9,112,869	9,955,034	9,313,088	9,738,038	15,121,903	15,230,282	12,949,303	14,734,613	14,811,749	22,138,233	16,337,340	16,361,944	174,917,266
Investment Earnings And Other Income	173,465	(14,474)	151,948	166,556	147,197	4,303	116,471	(249,580)	205,894	195,233	(408,458)	(39,267)	567,469	1,016,757
Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	4,234	2,924	77	10,627	(2,692)	39,990	21,877	78,150,342	3,134	79,899	4,445	(29,149,066)	7,365	49,173,156
Rate/Income Adjustments	291,820	70,321	(582,499)	127,031	226,726	799,886	594,678	1,527,455	266,498	595,656	(93,658)	(294,637)	(458,866)	3,070,411
TOTAL REVENUES	88,503,816	88,185,134	94,104,369	90,469,419	93,858,589	101,673,293	102,076,001	179,189,761	102,829,055	105,185,127	112,986,049	78,578,204	106,773,277	1,344,412,094
EXPENSES														
Medical Costs:														
Physician Services	13,134,194	14,514,021	14,157,774	13,867,872	12,660,363	14,907,160	14,731,540	15,058,794	15,642,095	15,744,708	16,190,717	15,305,367	15,819,470	191,734,075
Other Professional Services	4,619,091	4,841,378	3,806,785	4,389,484	4,935,401	4,421,552	4,883,941	5,048,627	5,107,193	4,658,383	4,460,451	4,604,443	4,825,412	60,602,141
Emergency Room	4,813,363	4,926,059	4,814,428	4,638,713	3,194,257	4,676,327	4,420,437	4,353,449	4,480,205	5,023,372	5,040,670	4,833,831	4,472,304	59,687,415
Inpatient	16,635,497	17,879,275	17,137,251	17,212,070	19,183,080	19,853,180	19,321,533	17,577,565	18,419,878	20,578,157	20,739,625	20,542,490	20,581,248	245,660,849
Reinsurance Expense	76,284	76,523	77,652	84,521	77,390	81,215	80,770	80,461	80,129	84,297	82,530	84,045	84,997	1,050,814
Outpatient Hospital	6,894,371	6,804,640	6,653,372	6,209,999	6,565,195	7,108,674	6,610,422	7,160,111	8,681,740	8,842,725	8,800,023	7,937,455	7,942,981	96,211,708
Other Medical	9,055,443	14,033,235	12,916,278	10,958,385	13,070,247	10,641,113	10,412,229	11,840,899	9,883,445	10,960,637	12,430,651	9,927,247	9,914,269	146,044,078
Pharmacy	9,180,669	9,829,083	9,259,169	8,717,167	9,651,881	9,100,359	9,049,621	10,299,227	9,412,697	9,349,484	10,442,688	9,774,211	10,298,442	124,364,698
Pay for Performance Quality Incentive	529,498	529,498	556,200	544,962	-	529,182	529,183	526,070	540,715	540,715	545,673	552,862	552,862	6,477,420
Risk Corridor Expense	-	(2,700,000)	-	-	-	-	-	-	-	-	-	-	-	(2,700,000)
Hospital Directed Payments	9,112,870	9,112,869	9,955,034	9,313,088	9,738,038	15,121,903	15,230,282	12,949,303	14,734,613	14,811,759	22,138,233	16,337,330	16,361,944	174,917,266
Hospital Directed Payment Adjustment	(233,958)	4,234	77	6,596	(1,263)	39,990	21,878	77,356,953	3,134	597	3,943	(29,149,382)	7,365	48,060,164
Non-Claims Expense Adjustment	(157)	(777,546)	5,124	(209,309)	1,598	287,063	233,372	212,564	71,855	58,763	46,953	(11,833)	34,433	(47,120)
IBNR, Incentive, Paid Claims Adjustment	(120,764)	(4,317,566)	(5,474)	205,986	316,193	4,787	858,658	1,700,070	(85,946)	449,838	(2,226,487)	406,066	(55,915)	(2,870,554)
Total Medical Costs	73,696,401	74,755,703	79,333,670	75,939,534	79,392,380	86,772,505	86,383,866	164,164,093	86,971,753	91,103,435	98,695,670	61,144,132	90,839,812	1,149,192,954
GROSS MARGIN	14,807,415	13,429,431	14,770,699	14,529,885	14,466,209	14,900,788	15,692,135	15,025,668	15,857,302	14,081,692	14,290,379	17,434,072	15,933,465	195,219,140
Administrative:														
Compensation	2,597,575	2,636,509	2,613,272	2,456,357	2,766,869	2,772,584	2,908,104	2,457,160	2,691,957	2,748,394	2,731,289	2,805,915	2,781,896	34,967,881
Purchased Services	819,771	421,612	689,841	745,537	1,172,530	818,908	824,152	941,200	986,086	996,889	985,876	939,689	845,393	11,187,484
Supplies	63,919	71,111	34,967	106,489	39,305	57,592	57,416	4,446	131,712	57,943	85,576	156,626	193,504	1,060,606
Depreciation	418,389	419,251	419,796	419,850	421,301	422,833	422,834	426,541	426,541	422,382	425,837	425,522	427,805	5,498,882
Other Administrative Expenses	254,091	296,858	137,960	242,696	351,189	277,245	267,201	102,962	248,235	230,567	233,637	274,638	214,396	3,131,675
Administrative Expense Adjustment	-	-	-	-	1,407,045	18,296	(271,318)	57,294	(5,010)	(215)	(63,654)	(1,674)	(2,367)	1,138,397
Total Administrative Expenses	4,153,745	3,845,341	3,895,836	3,970,929	6,158,239	4,367,458	4,208,389	3,989,603	4,479,521	4,455,960	4,398,561	4,600,716	4,460,627	56,984,925
TOTAL EXPENSES	77,850,146	78,601,044	83,229,506	79,910,463	85,550,619	91,139,963	90,592,255	168,153,696	91,451,274	95,559,395	103,094,231	65,744,848	95,300,439	1,206,177,879
OPERATING INCOME (LOSS) BEFORE TAX	10,653,670	9,584,090	10,874,863	10,558,956	8,307,970	10,533,330	11,483,746	11,036,065	11,377,781	9,625,732	9,891,818	12,833,356	11,472,838	138,234,215
MCO TAX	8,905,117	8,904,649	8,904,648	8,904,649	8,904,649	8,902,943	8,904,649	8,933,228	8,905,080	8,905,142	8,904,648	9,894,054	9,894,055	117,767,511
OPERATING INCOME (LOSS) NET OF TAX	1,748,553	679,441	1,970,215	1,654,307	(596,679)	1,630,387	2,579,097	2,102,837	2,472,701	720,590	987,170	2,939,302	1,578,783	20,466,704
TOTAL NONOPERATING REVENUE (EXPENSE)	(687,453)	(176,843)	(1,188,755)	(931,682)	1,433,032	(137,472)	(151,159)	(88,366)	(167,372)	(245,779)	(164,148)	(833,809)	(949,330)	(4,289,136)
NET INCREASE (DECREASE) IN NET POSITION	1,061,100	502,598	781,460	722,625	836,353	1,492,915	2,427,938	2,014,471	2,305,329	474,811	823,022	2,105,493	629,453	16,177,568
MEDICAL LOSS RATIO	91.2%	92.8%	92.5%	91.6%	92.5%	93.1%	92.2%	94.3%	92.3%	94.9%	94.6%	90.9%	92.7%	92.8%
ADMINISTRATIVE EXPENSE RATIO	5.8%	5.4%	5.2%	5.5%	8.2%	5.7%	5.5%	5.1%	5.7%	5.5%	5.4%	5.7%	5.6%	5.7%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH AUGUST 31, 2021	AUGUST 2020	SEPTEMBER 2020	OCTOBER 2020	NOVEMBER 2020	DECEMBER 2020	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	AUGUST 2021	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	264,749	278,100	272,481	275,080	277,452	278,517	276,880	282,972	284,587	287,199	289,309	290,980	292,271	3,650,577
REVENUES														
Title XIX - Medicaid - Family and Other	166.87	166.16	173.40	164.62	168.64	174.01	177.17	172.94	173.28	177.71	181.55	180.10	173.76	172.72
Title XIX - Medicaid - Expansion Members	376.19	379.54	393.46	371.41	384.47	385.83	397.58	382.20	385.72	381.99	388.41	387.35	380.84	382.73
Title XIX - Medicaid - SPD Members	972.23	972.22	945.03	1,012.68	989.03	957.28	816.21	1,005.21	978.42	1,017.24	1,020.90	1,029.14	1,023.27	977.68
Premium - MCO Tax	31.48	29.96	33.64	30.61	31.83	34.39	34.88	34.47	34.45	34.39	34.43	34.45	34.45	33.37
Premium - Hospital Directed Payments	34.42	32.77	36.53	33.86	35.10	54.29	55.01	45.76	51.78	51.57	76.52	56.15	55.98	47.91
Investment Earnings And Other Income	0.66	(0.05)	0.56	0.61	0.53	0.02	0.42	(0.88)	0.72	0.68	(1.41)	(0.13)	1.94	0.28
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	0.02	0.01	0.00	0.04	(0.01)	0.14	0.08	276.18	0.01	0.28	0.02	(100.18)	0.03	13.47
Rate/Income Adjustments	1.10	0.25	(2.14)	0.46	0.82	2.87	2.15	5.40	0.94	2.07	(0.32)	(1.01)	(1.57)	0.84
TOTAL REVENUES	334.29	317.10	345.36	328.88	338.29	365.05	368.67	633.24	361.33	366.24	390.54	270.05	365.32	368.27
EXPENSES														
Medical Costs:														
Physician Services	49.61	52.19	51.96	50.41	45.63	53.52	53.21	53.22	54.96	54.82	55.96	52.60	54.13	52.52
Other Professional Services	17.45	17.41	13.97	15.96	17.79	15.88	17.64	17.84	17.95	16.22	15.42	15.82	16.51	16.60
Emergency Room	18.18	17.71	17.67	16.86	11.51	16.79	15.97	15.38	15.74	17.49	17.42	16.61	15.30	16.35
Inpatient	62.83	64.29	62.89	62.57	69.14	71.28	69.78	62.12	64.72	71.65	71.69	70.60	70.42	67.29
Reinsurance Expense	0.29	0.28	0.28	0.31	0.28	0.29	0.29	0.28	0.28	0.29	0.29	0.29	0.29	0.29
Outpatient Hospital	26.04	24.47	24.42	22.58	23.66	25.52	23.87	25.30	30.51	30.79	30.42	27.28	27.18	26.36
Other Medical	34.20	50.46	47.40	39.84	47.11	38.21	37.61	41.84	34.73	38.16	42.97	34.12	33.92	40.01
Pharmacy	34.68	35.34	33.98	31.69	34.79	32.67	32.68	36.40	33.07	32.55	36.10	33.59	35.24	34.07
Pay for Performance Quality Incentive	2.00	1.90	2.04	1.98	0.00	1.90	1.91	1.86	1.90	1.88	1.89	1.90	1.89	1.77
Risk Corridor Expense	0.00	(9.71)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.74)
Hospital Directed Payments	34.42	32.77	36.53	33.86	35.10	54.29	55.01	45.76	51.78	51.57	76.52	56.15	55.98	47.91
Hospital Directed Payment Adjustment	(0.88)	0.02	0.00	0.02	(0.00)	0.14	0.08	273.37	0.01	0.00	0.01	(100.18)	0.03	13.17
Non-Claims Expense Adjustment	(0.00)	(2.80)	0.02	(0.76)	0.01	1.03	0.84	0.75	0.25	0.20	0.16	(0.04)	0.12	(0.01)
IBNR, Incentive, Paid Claims Adjustment	(0.46)	(15.53)	(0.02)	0.75	1.14	0.02	3.10	6.01	(0.30)	1.57	(7.70)	1.40	(0.19)	(0.79)
Total Medical Costs	278.36	268.81	291.15	276.06	286.15	311.55	311.99	580.14	305.61	317.21	341.14	210.13	310.81	314.80
GROSS MARGIN	55.93	48.29	54.21	52.82	52.14	53.50	56.67	53.10	55.72	49.03	49.39	59.92	54.52	53.48
Administrative:														
Compensation	9.81	9.48	9.59	8.93	9.97	9.95	10.50	8.68	9.46	9.57	9.44	9.64	9.52	9.58
Purchased Services	3.10	1.52	2.53	2.71	4.23	2.94	2.98	3.33	3.46	3.47	3.41	3.23	2.89	3.06
Supplies	0.24	0.26	0.13	0.39	0.14	0.21	0.21	0.02	0.46	0.20	0.30	0.54	0.66	0.29
Depreciation	1.58	1.51	1.54	1.53	1.52	1.52	1.53	1.51	1.50	1.47	1.47	1.46	1.46	1.51
Other Administrative Expenses	0.96	1.07	0.51	0.88	1.27	1.00	0.97	0.36	0.87	0.80	0.81	0.94	0.73	0.86
Administrative Expense Adjustment	0.00	0.00	0.00	0.00	5.07	0.07	(0.98)	0.20	(0.02)	(0.00)	(0.22)	(0.01)	(0.01)	0.31
Total Administrative Expenses	15.69	13.83	14.30	14.44	22.20	15.68	15.20	14.10	15.74	15.52	15.20	15.81	15.26	15.61
TOTAL EXPENSES	294.05	282.64	305.45	290.50	308.34	327.23	327.19	594.24	321.35	332.73	356.35	225.94	326.07	330.41
OPERATING INCOME (LOSS) BEFORE TAX	40.24	34.46	39.91	38.39	29.94	37.82	41.48	39.00	39.98	33.52	34.19	44.10	39.25	37.87
MCO TAX	33.64	32.02	32.68	32.37	32.09	31.97	32.16	31.57	31.29	31.01	30.78	34.00	33.85	32.26
OPERATING INCOME (LOSS) NET OF TAX	6.60	2.44	7.23	6.01	(2.15)	5.85	9.31	7.43	8.69	2.51	3.41	10.10	5.40	5.61
TOTAL NONOPERATING REVENUE (EXPENSE)	(2.60)	(0.64)	(4.36)	(3.39)	5.16	(0.49)	(0.55)	(0.31)	(0.59)	(0.86)	(0.57)	(2.87)	(3.25)	(1.17)
NET INCREASE (DECREASE) IN NET POSITION	4.01	1.81	2.87	2.63	3.01	5.36	8.77	7.12	8.10	1.65	2.84	7.24	2.15	4.43
MEDICAL LOSS RATIO	91.2%	92.8%	92.5%	91.6%	92.5%	93.1%	92.2%	94.3%	92.3%	94.9%	94.6%	90.9%	92.7%	92.8%
ADMINISTRATIVE EXPENSE RATIO	5.8%	5.4%	5.2%	5.5%	8.2%	5.7%	5.5%	5.1%	5.7%	5.5%	5.4%	5.7%	5.6%	5.7%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED AUGUST 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			R E V E N U E S			
			Title XIX - Medicaid - Family & Other			
27,460,638	24,848,166	2,612,472	Premium - Medi-Cal	215,011,921	197,862,151	17,149,770
2,174,573	2,520,887	(346,314)	Premium - Maternity Kick	18,354,157	20,167,096	(1,812,939)
34,946	79,615	(44,669)	Premium - Hep C Kick	318,880	632,255	(313,375)
631,446	492,116	139,330	Premium - BHT Kick	4,907,050	3,908,100	998,950
175,270	177,997	(2,727)	Premium - Health Home Kick	1,307,702	1,413,547	(105,845)
3,674,365	3,499,404	174,961	Premium - Provider Enhancement	28,881,299	27,831,489	1,049,810
184,875	169,805	15,070	Premium - Ground Emergency Medical Transportation	1,449,625	1,352,166	97,459
153,574	276,705	(123,131)	Premium - Behavorial Health Integration Program	3,936,867	2,197,435	1,739,432
79,969	91,866	(11,897)	Other	861,718	734,368	127,350
34,569,656	32,156,561	2,413,095	Total Title XIX - Medicaid - Family & Other	275,029,219	256,098,607	18,930,612
			Title XIX - Medicaid - Expansion Members			
26,793,097	24,002,303	2,790,794	Premium - Medi-Cal	207,424,173	192,018,424	15,405,749
451,435	214,253	237,182	Premium - Maternity Kick	2,817,468	1,714,024	1,103,444
148,519	202,017	(53,498)	Premium - Hep C Kick	1,511,404	1,616,135	(104,731)
303,604	356,121	(52,517)	Premium - Health Home Kick	2,243,702	2,848,968	(605,266)
1,570,879	1,455,050	115,829	Premium - Provider Enhancement	12,179,797	11,640,400	539,397
188,709	165,235	23,474	Premium - Ground Emergency Medical Transportation	1,462,395	1,321,880	140,515
59,255	102,122	(42,867)	Premium - Behavorial Health Integration Program	1,473,907	816,976	656,931
25,110	26,600	(1,490)	Other	246,537	212,800	33,737
29,540,608	26,523,701	3,016,907	Total Title XIX - Medicaid - Expansion Members	229,359,383	212,189,607	17,169,776
			Title XIX - Medicaid - SPD Members			
14,453,853	13,474,791	979,062	Premium - Medi-Cal	113,826,371	107,798,324	6,028,047
69,891	100,288	(30,397)	Premium - Hep C Kick	384,403	802,301	(417,898)
717,749	763,566	(45,817)	Premium - BHT Kick	4,738,012	6,108,526	(1,370,514)
256,085	351,842	(95,757)	Premium - Health Home Kick	1,949,560	2,814,736	(865,176)
469,721	454,632	15,089	Premium - Provider Enhancement	3,699,130	3,637,056	62,074
136,000	127,475	8,525	Premium - Ground Emergency Medical Transportation	1,071,027	1,019,800	51,227
12,220	22,041	(9,821)	Premium - Behavorial Health Integration Program	334,823	176,328	158,495
16,115,519	15,294,634	820,885	Total Title XIX - Medicaid - SPD Members	126,003,326	122,357,070	3,646,256

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED AUGUST 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
3,824,662	3,074,391	(750,271)	Primary Care Physician Services	27,540,923	24,478,708	(3,062,215)
10,559,258	10,595,001	35,743	Referral Specialty Services	85,439,217	84,489,479	(949,738)
1,426,250	1,504,675	78,425	Urgent Care & After Hours Advise	10,346,811	11,975,763	1,628,952
9,300	9,300	-	Hospital Admitting Team	72,900	72,900	-
15,819,470	15,183,367	(636,103)	TOTAL PHYSICIAN SERVICES	123,399,851	121,016,850	(2,383,001)
			OTHER PROFESSIONAL SERVICES			
307,745	295,940	(11,805)	Vision Service Capitation	2,384,020	2,355,578	(28,442)
223,488	212,115	(11,373)	221 - Business Intelligence	1,696,389	1,696,920	531
630,253	597,920	(32,333)	310 - Health Services - Utilization Management - UM Allocation *	4,845,351	4,783,360	(61,991)
131,293	189,152	57,859	311 - Health Services - Quality Improvement - UM Allocation *	1,126,430	1,513,216	386,786
120,267	123,337	3,070	312 - Health Services - Education - UM Allocation *	947,678	986,694	39,016
76,279	80,283	4,004	313 - Health Services - Pharmacy - UM Allocation *	605,154	642,264	37,110
170,731	210,465	39,734	314 - Health Homes - UM Allocation *	1,123,742	1,683,720	559,978
259,955	270,692	10,737	315 - Case Management - UM Allocation *	2,158,437	2,165,536	7,099
1,733	-	(1,733)	316 - Population Health Management - UM Allocation *	1,733	-	(1,733)
58,684	56,773	(1,911)	616 - Disease Management - UM Allocation *	480,158	454,184	(25,974)
1,426,863	1,255,681	(171,182)	Behavior Health Treatment	9,816,456	10,016,625	200,169
114,350	189,801	75,451	Mental Health Services	1,050,005	1,514,172	464,167
1,303,771	1,249,658	(54,113)	Other Professional Services	11,774,449	9,969,286	(1,805,163)
4,825,412	4,731,818	(93,594)	TOTAL OTHER PROFESSIONAL SERVICES	38,010,002	37,781,555	(228,447)
4,472,304	5,580,800	1,108,496	EMERGENCY ROOM	37,300,595	44,452,383	7,151,788
20,581,248	15,428,548	(5,152,700)	INPATIENT HOSPITAL	157,613,676	123,086,913	(34,526,763)
84,997	80,329	(4,668)	REINSURANCE EXPENSE PREMIUM	658,444	639,380	(19,064)
7,942,981	6,999,642	(943,339)	OUTPATIENT HOSPITAL SERVICES	63,084,131	55,848,845	(7,235,286)
			OTHER MEDICAL			
1,323,146	1,553,961	230,815	Ambulance and NEMT	10,547,418	12,383,125	1,835,707
599,655	426,358	(173,297)	Home Health Services & CBAS	5,605,071	3,401,797	(2,203,274)
230,711	491,325	260,614	Utilization and Quality Review Expenses	3,194,194	3,930,600	736,406
1,258,956	1,301,615	42,659	Long Term/SNF/Hospice	10,604,296	10,397,468	(206,828)
267,430	395,403	127,973	Health Home Capitation & Incentive	2,139,917	3,154,382	1,014,465
5,440,313	5,140,935	(299,378)	Provider Enhancement Expense - Prop. 56	42,605,171	40,928,936	(1,676,235)
569,010	462,515	(106,495)	Provider Enhancement Expense - GEMT	3,642,927	3,693,846	50,919
-	-	-	Provider COVID-19 Expenes	2,125,900	-	(2,125,900)
225,048	400,868	175,820	Behaviorial Health Integration Program	5,545,596	3,190,738	(2,354,858)
9,914,269	10,172,981	258,712	TOTAL OTHER MEDICAL	86,010,490	81,080,892	(4,929,598)
			PHARMACY SERVICES			
9,311,107	9,386,400	75,293	RX - Drugs & OTC	69,791,527	74,923,200	5,131,673
251,754	381,919	130,165	RX - HEP-C	2,166,553	3,050,691	884,138
870,581	771,078	(99,503)	Rx - DME	6,736,239	6,154,556	(581,683)
(135,000)	(33,365)	101,635	RX - Pharmacy Rebates	(967,590)	(266,331)	701,259
10,298,442	10,506,032	207,590	TOTAL PHARMACY SERVICES	77,726,729	83,862,116	6,135,387
552,862	526,291	(26,572)	PAY FOR PERFORMANCE QUALITY INCENTIVE	4,317,262	4,189,044	(128,218)
-	-	-	RISK CORRIDOR EXPENSE	-	-	-
16,361,944	14,069,809	(2,292,135)	HOSPITAL DIRECTED PAYMENTS	127,685,367	112,213,131	(15,472,236)
7,365	-	(7,365)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	48,284,478	-	(48,284,478)
34,433	-	(34,433)	NON-CLAIMS EXPENSE ADJUSTMENT	933,170	-	(933,170)
(55,915)	-	55,915	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	1,051,071	-	(1,051,071)
90,839,812	83,279,617	(7,560,195)	Total Medical Costs	766,075,266	664,171,109	(101,904,157)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED AUGUST 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
13.09	11.10	(1.99)	Primary Care Physician Services	12.06	11.10	(0.96)
36.13	38.25	2.12	Referral Specialty Services	37.43	38.32	0.89
4.88	5.43	0.55	Urgent Care & After Hours Advise	4.53	5.43	0.90
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
54.13	54.81	0.69	TOTAL PHYSICIAN SERVICES	54.06	54.89	0.83
			OTHER PROFESSIONAL SERVICES			
1.05	1.07	0.02	Vision Service Capitation	1.04	1.07	0.02
0.76	0.77	0.00	221 - Business Intelligence	0.74	0.77	0.03
2.16	2.16	0.00	310 - Health Services - Utilization Management - UM Allocation *	2.12	2.17	0.05
0.45	0.68	0.23	311 - Health Services - Quality Improvement - UM Allocation *	0.49	0.69	0.19
0.41	0.45	0.03	312 - Health Services - Education - UM Allocation *	0.42	0.45	0.03
0.26	0.29	0.03	313 - Health Services - Pharmacy - UM Allocation *	0.27	0.29	0.03
0.58	0.76	0.18	314 - Health Homes - UM Allocation *	0.49	0.76	0.27
0.89	0.98	0.09	315 - Case Management - UM Allocation *	0.95	0.98	0.04
0.01	0.00	(0.01)	316 - Population Health Management - UM Allocation *	0.00	0.00	(0.00)
0.20	0.20	0.00	616 - Disease Management - UM Allocation *	0.21	0.21	(0.00)
4.88	4.53	(0.35)	Behavior Health Treatment	4.30	4.54	0.24
0.39	0.69	0.29	Mental Health Services	0.46	0.69	0.23
4.46	4.51	0.05	Other Professional Services	5.16	4.52	(0.64)
16.51	17.08	0.57	TOTAL OTHER PROFESSIONAL SERVICES	16.65	17.14	0.49
15.30	20.15	4.85	EMERGENCY ROOM	16.34	20.16	3.82
70.42	55.70	(14.72)	INPATIENT HOSPITAL	69.05	55.83	(13.22)
0.29	0.29	(0.00)	REINSURANCE EXPENSE PREMIUM	0.29	0.29	0.00
27.18	25.27	(1.91)	OUTPATIENT HOSPITAL SERVICES	27.64	25.33	(2.30)
			OTHER MEDICAL			
4.53	5.61	1.08	Ambulance and NEMT	4.62	5.62	1.00
2.05	1.54	(0.51)	Home Health Services & CBAS	2.46	1.54	(0.91)
0.79	1.77	0.98	Utilization and Quality Review Expenses	1.40	1.78	0.38
4.31	4.70	0.39	Long Term/SNF/Hospice	4.65	4.72	0.07
0.92	1.43	0.51	Health Home Capitation & Incentive	0.94	1.43	0.49
18.61	18.56	(0.05)	Provider Enhancement Expense - Prop. 56	18.66	18.56	(0.10)
1.95	1.67	(0.28)	Provider Enhancement Expense - GEMT	1.60	1.68	0.08
0.00	0.00	0.00	Provider COVID-19 Expenes	0.93	0.00	(0.93)
0.77	1.45	0.68	Behaviorial Health Integration Program	2.43	1.45	(0.98)
33.92	36.73	2.80	TOTAL OTHER MEDICAL	37.68	36.78	(0.90)
			PHARMACY SERVICES			
31.86	33.89	2.03	RX - Drugs & OTC	30.57	33.98	3.41
0.86	1.38	0.52	RX - HEP-C	0.95	1.38	0.43
2.98	2.78	(0.19)	Rx - DME	2.95	2.79	(0.16)
(0.46)	(0.12)	0.34	RX - Pharmacy Rebates	(0.42)	(0.12)	0.30
35.24	37.93	2.69	TOTAL PHARMACY SERVICES	34.05	38.04	3.99
1.89	1.90	0.01	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.89	1.90	0.01
0.00	0.00	0.00	RISK CORRIDOR EXPENSE	0.00	0.00	0.00
55.98	50.79	(5.19)	HOSPITAL DIRECTED PAYMENTS	55.94	50.90	(5.04)
0.03	0.00	(0.03)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	21.15	0.00	(21.15)
0.12	0.00	(0.12)	NON-CLAIMS EXPENSE ADJUSTMENT	0.41	0.00	(0.41)
(0.19)	0.00	0.19	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.46	0.00	(0.46)
310.81	300.65	(10.15)	Total Medical Costs	335.60	301.24	(34.35)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH AUGUST 31, 2021	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	AUGUST 2021	YEAR TO DATE 2021
PHYSICIAN SERVICES									
Primary Care Physician Services	2,962,264	2,963,060	3,567,494	3,563,867	3,699,457	3,720,742	3,239,377	3,824,662	27,540,923
Referral Specialty Services	10,512,215	10,171,851	9,997,168	11,114,617	11,103,264	11,178,950	10,801,894	10,559,258	85,439,217
Urgent Care & After Hours Advise	1,423,381	1,588,229	1,484,832	954,611	932,687	1,282,025	1,254,796	1,426,250	10,346,811
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300	9,000	9,300	9,300	72,900
TOTAL PHYSICIAN SERVICES	14,907,160	14,731,540	15,058,794	15,642,095	15,744,708	16,190,717	15,305,367	15,819,470	123,399,851
OTHER PROFESSIONAL SERVICES									
Vision Service Capitation	294,054	292,442	292,443	289,005	305,213	298,817	304,301	307,745	2,384,020
221 - Business Intelligence	210,663	222,415	197,310	217,207	221,546	203,314	200,446	223,488	1,696,389
310 - Health Services - Utilization Management - UM Allocation *	595,003	563,907	605,345	602,798	602,089	619,127	626,829	630,253	4,845,351
311 - Health Services - Quality Improvement - UM Allocation *	138,388	123,443	154,295	136,098	147,314	146,837	148,762	131,293	1,126,430
312 - Health Services - Education - UM Allocation *	120,621	124,149	95,259	119,982	120,314	125,926	121,160	120,267	947,678
313 - Health Services - Pharmacy - UM Allocation *	75,046	75,369	75,552	75,945	76,277	74,167	76,519	76,279	605,154
314 - Health Homes - UM Allocation *	120,170	119,317	173,098	121,413	138,809	140,463	139,741	170,731	1,123,742
315 - Case Management - UM Allocation *	270,657	261,834	281,125	260,034	269,323	261,708	293,801	259,955	2,158,437
316 - Population Health Management - UM Allocation *	-	-	-	-	-	-	-	1,733	1,733
616 - Disease Management - UM Allocation *	62,998	58,064	72,219	57,851	56,419	55,347	58,576	58,684	480,158
Behavior Health Treatment	867,517	947,944	1,407,309	1,506,149	1,204,226	1,186,572	1,269,876	1,426,863	9,816,456
Mental Health Services	292,517	181,749	96,618	153,559	43,140	72,194	95,878	114,350	1,050,005
Other Professional Services	1,373,918	1,913,308	1,598,054	1,567,152	1,473,713	1,275,979	1,268,554	1,303,771	11,774,449
TOTAL OTHER PROFESSIONAL SERVICES	4,421,552	4,883,941	5,048,627	5,107,193	4,658,383	4,460,451	4,604,443	4,825,412	38,010,002
EMERGENCY ROOM	4,676,327	4,420,437	4,353,449	4,480,205	5,023,372	5,040,670	4,833,831	4,472,304	37,300,595
INPATIENT HOSPITAL	19,853,180	19,321,533	17,577,565	18,419,878	20,578,157	20,739,625	20,542,490	20,581,248	157,613,676
REINSURANCE EXPENSE PREMIUM	81,215	80,770	80,461	80,129	84,297	82,530	84,045	84,997	658,444
OUTPATIENT HOSPITAL SERVICES	7,108,674	6,610,422	7,160,111	8,681,740	8,842,725	8,800,023	7,937,455	7,942,981	63,084,131
OTHER MEDICAL									
Ambulance and NEMT	1,400,971	1,208,039	1,444,178	1,338,929	1,314,492	1,189,224	1,328,439	1,323,146	10,547,418
Home Health Services & CBAS	490,933	582,371	853,147	657,817	707,296	964,318	749,534	599,655	5,605,071
Utilization and Quality Review Expenses	228,696	372,499	688,633	430,683	359,626	509,705	373,641	230,711	3,194,194
Long Term/SNF/Hospice	1,616,577	1,132,832	1,933,711	1,041,624	1,114,812	1,301,188	1,204,596	1,258,956	10,604,296
Health Home Capitation & Incentive	211,140	294,005	334,675	299,855	228,752	341,280	162,780	267,430	2,139,917
Provider Enhancement Expense - Prop. 56	5,190,164	5,226,990	5,265,692	5,318,961	5,342,952	5,386,833	5,433,266	5,440,313	42,605,171
Provider Enhancement Expense - GEMT	456,380	456,381	265,311	423,904	494,669	527,330	449,942	569,010	3,642,927
Provider COVID-19 Expenes	674,580	767,440	683,880	-	-	-	-	-	2,125,900
Behaviorial Health Integration Program	371,672	371,672	371,672	371,672	1,398,038	2,210,773	225,049	225,048	5,545,596
TOTAL OTHER MEDICAL	10,641,113	10,412,229	11,840,899	9,883,445	10,960,637	12,430,651	9,927,247	9,914,269	86,010,490
PHARMACY SERVICES									
RX - Drugs & OTC	8,174,252	8,080,594	9,316,542	8,462,224	8,518,642	9,049,899	8,878,267	9,311,107	69,791,527
RX - HEP-C	245,144	264,815	249,449	260,020	290,418	365,687	239,266	251,754	2,166,553
Rx - DME	815,963	839,212	868,236	825,453	690,067	1,035,049	791,678	870,581	6,736,239
RX - Pharmacy Rebates	(135,000)	(135,000)	(135,000)	(135,000)	(149,643)	(7,947)	(135,000)	(135,000)	(967,590)
TOTAL PHARMACY SERVICES	9,100,359	9,049,621	10,299,227	9,412,697	9,349,484	10,442,688	9,774,211	10,298,442	77,726,729
PAY FOR PERFORMANCE QUALITY INCENTIVE	529,182	529,183	526,070	540,715	540,715	545,673	552,862	552,862	4,317,262
RISK CORRIDOR EXPENSE	-	-	-	-	-	-	-	-	-
HOSPITAL DIRECTED PAYMENTS	15,121,903	15,230,282	12,949,303	14,734,613	14,811,759	22,138,233	16,337,330	16,361,944	127,685,367
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	39,990	21,878	77,356,953	3,134	597	3,943	(29,149,382)	7,365	48,284,478
NON-CLAIMS EXPENSE ADJUSTMENT	287,063	233,372	212,564	71,855	58,763	46,953	(11,833)	34,433	933,170
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	4,787	858,658	1,700,070	(85,946)	449,838	(2,226,487)	406,066	(55,915)	1,051,071
Total Medical Costs	86,772,505	86,383,866	164,164,093	86,971,753	91,103,435	98,695,670	61,144,132	90,839,812	766,075,266

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH AUGUST 31, 2021	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	AUGUST 2021	YEAR TO DATE 2021
PHYSICIAN SERVICES									
Primary Care Physician Services	10.64	10.70	12.61	12.52	12.88	12.86	11.13	13.09	12.06
Referral Specialty Services	37.74	36.74	35.33	39.06	38.66	38.64	37.12	36.13	37.43
Urgent Care & After Hours Advise	5.11	5.74	5.25	3.35	3.25	4.43	4.31	4.88	4.53
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	53.52	53.21	53.22	54.96	54.82	55.96	52.60	54.13	54.06
OTHER PROFESSIONAL SERVICES									
Vision Service Capitation	1.06	1.06	1.03	1.02	1.06	1.03	1.05	1.05	1.04
221 - Business Intelligence	0.76	0.80	0.70	0.76	0.77	0.70	0.69	0.76	0.74
310 - Health Services - Utilization Management - UM Allocation *	2.14	2.04	2.14	2.12	2.10	2.14	2.15	2.16	2.12
311 - Health Services - Quality Improvement - UM Allocation *	0.50	0.45	0.55	0.48	0.51	0.51	0.51	0.45	0.49
312 - Health Services - Education - UM Allocation *	0.43	0.45	0.34	0.42	0.42	0.44	0.42	0.41	0.42
313 - Health Services - Pharmacy - UM Allocation *	0.27	0.27	0.27	0.27	0.27	0.26	0.26	0.26	0.27
314 - Health Homes - UM Allocation *	0.43	0.43	0.61	0.43	0.48	0.49	0.48	0.58	0.49
315 - Case Management - UM Allocation *	0.97	0.95	0.99	0.91	0.94	0.90	1.01	0.89	0.95
316 - Population Health Management - UM Allocation *	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00
616 - Disease Management - UM Allocation *	0.23	0.21	0.26	0.20	0.20	0.19	0.20	0.20	0.21
Behavior Health Treatment	3.11	3.42	4.97	5.29	4.19	4.10	4.36	4.88	4.30
Mental Health Services	1.05	0.66	0.34	0.54	0.15	0.25	0.33	0.39	0.46
Other Professional Services	4.93	6.91	5.65	5.51	5.13	4.41	4.36	4.46	5.16
TOTAL OTHER PROFESSIONAL SERVICES	15.88	17.64	17.84	17.95	16.22	15.42	15.82	16.51	16.65
EMERGENCY ROOM	16.79	15.97	15.38	15.74	17.49	17.42	16.61	15.30	16.34
INPATIENT HOSPITAL	71.28	69.78	62.12	64.72	71.65	71.69	70.60	70.42	69.05
REINSURANCE EXPENSE PREMIUM	0.29	0.29	0.28	0.28	0.29	0.29	0.29	0.29	0.29
OUTPATIENT HOSPITAL SERVICES	25.52	23.87	25.30	30.51	30.79	30.42	27.28	27.18	27.64
OTHER MEDICAL									
Ambulance and NEMT	5.03	4.36	5.10	4.70	4.58	4.11	4.57	4.53	4.62
Home Health Services & CBAS	1.76	2.10	3.01	2.31	2.46	3.33	2.58	2.05	2.46
Utilization and Quality Review Expenses	0.82	1.35	2.43	1.51	1.25	1.76	1.28	0.79	1.40
Long Term/SNF/Hospice	5.80	4.09	6.83	3.66	3.88	4.50	4.14	4.31	4.65
Health Home Capitation & Incentive	0.76	1.06	1.18	1.05	0.80	1.18	0.56	0.92	0.94
Provider Enhancement Expense - Prop. 56	18.63	18.88	18.61	18.69	18.60	18.62	18.67	18.61	18.66
Provider Enhancement Expense - GEMT	1.64	1.65	0.94	1.49	1.72	1.82	1.55	1.95	1.60
Provider COVID-19 Expenes	2.42	2.77	2.42	0.00	0.00	0.00	0.00	0.00	0.93
Behaviorial Health Integration Program	1.33	1.34	1.31	1.31	4.87	7.64	0.77	0.77	2.43
TOTAL OTHER MEDICAL	38.21	37.61	41.84	34.73	38.16	42.97	34.12	33.92	37.68
PHARMACY SERVICES									
RX - Drugs & OTC	29.35	29.18	32.92	29.74	29.66	31.28	30.51	31.86	30.57
RX - HEP-C	0.88	0.96	0.88	0.91	1.01	1.26	0.82	0.86	0.95
Rx - DME	2.93	3.03	3.07	2.90	2.40	3.58	2.72	2.98	2.95
RX - Pharmacy Rebates	(0.48)	(0.49)	(0.48)	(0.47)	(0.52)	(0.03)	(0.46)	(0.46)	(0.42)
TOTAL PHARMACY SERVICES	32.67	32.68	36.40	33.07	32.55	36.10	33.59	35.24	34.05
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.90	1.91	1.86	1.90	1.88	1.89	1.90	1.89	1.89
RISK CORRIDOR EXPENSE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
HOSPITAL DIRECTED PAYMENTS	54.29	55.01	45.76	51.78	51.57	76.52	56.15	55.98	55.94
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.14	0.08	273.37	0.01	0.00	0.01	(100.18)	0.03	21.15
NON-CLAIMS EXPENSE ADJUSTMENT	1.03	0.84	0.75	0.25	0.20	0.16	(0.04)	0.12	0.41
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.02	3.10	6.01	(0.30)	1.57	(7.70)	1.40	(0.19)	0.46
Total Medical Costs	311.55	311.99	580.14	305.61	317.21	341.14	210.13	310.81	335.60

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED AUGUST 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
347,546	402,031	54,485	110 - Executive	2,952,890	3,091,249	138,359
228,799	212,651	(16,148)	210 - Accounting	1,551,370	1,701,209	149,839
386,243	362,443	(23,800)	220 - Management Information Systems	2,901,440	2,899,546	(1,894)
11,545	64,468	52,923	221 - Business Intelligence	108,693	515,744	407,051
225,132	281,931	56,799	222 - Enterprise Development	1,946,336	2,255,447	309,111
393,273	448,524	55,251	225 - Infrastructure	3,120,395	3,588,189	467,794
558,400	576,323	17,923	230 - Claims	4,289,341	4,610,585	321,244
89,609	149,779	60,170	240 - Project Management	1,035,551	1,198,235	162,684
121,643	101,775	(19,868)	310 - Health Services - Utilization Management	850,124	814,199	(35,925)
5,726	27,902	22,176	311 - Health Services - Quality Improvement	153,642	223,217	69,575
-	55	55	312 - Health Services - Education	59	440	381
155,464	142,146	(13,318)	313- Pharmacy	1,180,976	1,137,166	(43,810)
-	6,642	6,642	314 - Health Homes	4,225	53,133	48,908
22,605	22,357	(248)	315 - Case Management	187,691	178,854	(8,837)
30,230	29,325	(905)	616 - Disease Management	247,370	234,602	(12,768)
280,971	323,502	42,531	320 - Provider Network Management	2,209,329	2,588,020	378,691
570,700	656,475	85,775	330 - Member Services	4,644,394	5,251,802	607,408
709,892	702,275	(7,617)	340 - Corporate Services	4,682,082	5,618,199	936,117
28,549	66,363	37,814	360 - Audit & Investigative Services	470,493	530,903	60,410
11,477	69,250	57,773	410 - Advertising Media	477,535	554,000	76,465
55,545	73,950	18,405	420 - Sales/Marketing/Public Relations	437,746	591,597	153,851
229,645	251,455	21,810	510 - Human Resourses	1,777,801	2,011,641	233,840
(2,367)	-	2,367	Administrative Expense Adjustment	(268,648)	-	268,648
4,460,627	4,971,622	510,995	Total Administrative Expenses	34,960,835	39,647,977	4,687,142

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED AUGUST 31, 2021	JANUARY 2021	FEBRUARY 2021	MARCH 2021	APRIL 2021	MAY 2021	JUNE 2021	JULY 2021	AUGUST 2021	YEAR TO DATE 2021
110 - Executive	353,943	483,744	293,288	272,219	482,689	358,282	361,179	347,546	2,952,890
210 - Accounting	203,619	198,129	146,511	287,032	86,601	198,636	202,043	228,799	1,551,370
220 - Management Information Systems (MIS)	340,212	345,719	394,230	384,019	349,136	376,280	325,601	386,243	2,901,440
221 - Business Intelligence	-	-	-	12,308	46,180	24,115	14,545	11,545	108,693
222 - Enterprise Development	250,306	269,236	185,800	249,199	261,073	252,105	253,485	225,132	1,946,336
225 - Infrastructure	365,340	337,172	345,070	407,880	459,371	352,463	459,826	393,273	3,120,395
230 - Claims	550,124	558,095	460,086	554,302	542,410	526,593	539,331	558,400	4,289,341
240 - Project Management	99,808	119,159	128,304	121,381	127,251	189,626	160,413	89,609	1,035,551
310 - Health Services - Utilization Management	103,641	120,732	82,239	113,686	116,283	100,257	91,643	121,643	850,124
311 - Health Services - Quality Improvement	18,870	16,833	21,040	18,597	20,088	27,421	25,067	5,726	153,642
312 - Health Services - Education	-	-	-	59	-	-	-	-	59
313- Pharmacy	141,859	137,379	151,340	147,394	145,687	151,338	150,515	155,464	1,180,976
314 - Health Homes	-	-	4,225	-	-	-	-	-	4,225
315 - Case Management	23,536	22,769	24,444	22,612	23,420	22,757	25,548	22,605	187,691
616 - Disease Management	32,453	29,912	37,220	29,802	29,065	28,513	30,175	30,230	247,370
320 - Provider Network Management	304,995	273,211	231,758	274,082	295,300	262,297	286,715	280,971	2,209,329
330 - Member Services	567,625	586,939	545,846	622,842	566,155	559,817	624,470	570,700	4,644,394
340 - Corporate Services	561,450	559,640	535,874	586,682	567,567	540,444	620,533	709,892	4,682,082
360 - Audit & Investigative Services	68,976	83,366	38,089	60,406	61,212	61,445	68,450	28,549	470,493
410 - Advertising Media	27,368	39,637	81,326	55,258	21,513	152,571	88,385	11,477	477,535
420 - Sales/Marketing/Public Relations	53,401	69,703	46,252	65,999	51,803	57,056	37,987	55,545	437,746
510 - Human Resourses	281,636	228,332	179,367	198,772	203,371	220,199	236,479	229,645	1,777,801
Total Department Expenses	4,349,162	4,479,707	3,932,309	4,484,531	4,456,175	4,462,215	4,602,390	4,462,994	35,229,483
ADMINISTRATIVE EXPENSE ADJUSTMENT	18,296	(271,318)	57,294	(5,010)	(215)	(63,654)	(1,674)	(2,367)	(268,648)
Total Administrative Expenses	4,367,458	4,208,389	3,989,603	4,479,521	4,455,960	4,398,561	4,600,716	4,460,627	34,960,835

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF AUGUST 31, 2021

ASSETS	AUGUST 2021	JULY 2021	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,137,662	$ 1,137,662	-
Interest Receivable	600	300	300
TOTAL CURRENT ASSETS	$ 1,138,262	$ 1,137,962	$ 300
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,138,066	1,138,066	-
Increase (Decrease) in Net Position - Current Year	196	(104)	300
Total Net Position	$ 1,138,262	$ 1,137,962	$ 300
TOTAL LIABILITIES AND NET POSITION	$ 1,138,262	$ 1,137,962	$ 300

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED AUGUST 31, 2021

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
300	-	300	Interest	2,759	-	2,759
-	-	-	Other Investment Income	(2,563)	-	(2,563)
300	-	300	TOTAL REVENUES	196	-	196
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
300	-	300	GROSS MARGIN	196	-	196
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
300	-	300	OPERATING INCOME (LOSS)	196	-	196
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
300	-	300	NET INCREASE (DECREASE) IN NET POSITION	196	-	196
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	2021 MEMBER MONTHS	JAN'21	FEB'21	MAR'21	APR'21	MAY'21	JUN'21	JUL'21	AUG'21	SEP'21	OCT'21	NOV'21	DEC'21
ADULT AND FAMILY													
ADULT	**431,216**	51,548	53,449	52,941	53,378	54,092	54,867	55,250	55,691	0	0	0	0
CHILD	**1,063,137**	131,669	126,764	133,240	133,228	133,944	134,540	134,904	134,848	0	0	0	0
SUB-TOTAL ADULT & FAMILY	**1,494,353**	**183,217**	**180,213**	**186,181**	**186,606**	**188,036**	**189,407**	**190,154**	**190,539**	**0**	**0**	**0**	**0**
OTHER MEMBERS													
PARTIAL DUALS - FAMILY	**4,437**	403	523	529	576	563	576	594	673	0	0	0	0
PARTIAL DUALS - CHILD	**-1**	0	-1	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	**22**	2	2	2	2	2	4	4	4	0	0	0	0
BCCTP - TABACCO SETTLEMENT	**0**	0	0	0	0	0	0	0	0	0	0	0	0
FULL DUALS (SPD)													
SPD FULL DUALS	**60,931**	7,484	7,591	7,505	7,523	7,635	7,640	7,814	7,739	0	0	0	0
SUBTOTAL OTHER MEMBERS	**65,389**	**7,889**	**8,115**	**8,036**	**8,101**	**8,200**	**8,220**	**8,412**	**8,416**	**0**	**0**	**0**	**0**
TOTAL FAMILY & OTHER	**1,559,742**	**191,106**	**188,328**	**194,217**	**194,707**	**196,236**	**197,627**	**198,566**	**198,955**	**0**	**0**	**0**	**0**
SPD													
SPD (AGED AND DISABLED)	**128,988**	16,011	18,829	15,328	15,870	15,756	15,645	15,800	15,749	0	0	0	0
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	**586,563**	70,649	69,251	72,532	73,089	74,161	74,905	75,451	76,525	0	0	0	0
ACA Expansion Duals	**7,422**	751	472	895	921	1,046	1,132	1,163	1,042	0	0	0	0
SUB-TOTAL MED-CAL EXPANSION	**593,985**	**71,400**	**69,723**	**73,427**	**74,010**	**75,207**	**76,037**	**76,614**	**77,567**	**0**	**0**	**0**	**0**
TOTAL KAISER	**92,732**	**11,047**	**11,196**	**11,349**	**11,505**	**11,692**	**11,852**	**11,983**	**12,108**	**0**	**0**	**0**	**0**
TOTAL MEDI-CAL MEMBERS	**2,375,447**	**289,564**	**288,076**	**294,321**	**296,092**	**298,891**	**301,161**	**302,963**	**304,379**	**0**	**0**	**0**	**0**

KERN·HEALTH SYSTEMS

July AP Vendor Report

Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T2686	ALLIANT INSURANCE SERVICES INC ****	929,163.33	929,163.33	2021 -2022 INSURANCE PREMIUMS -EXCESS COMMERCIAL, MANAGED CARE, FIDUCIARY, ACIP CRIME, COMMERCIAL CYBER, WORKERS COMP, MISC LIABILITY (SEXUAL ABUSE), WORK PLACE VIOLENCE, PROPERTLY AND LIABILITY, SLIP, POLLUTION	ADMINISTRATION
T2704	MCG HEALTH LLC ****	906,762.11	1,648,909.88	HEALTH CARE MANAGEMENT & SOFTWARE LICENSE 8/5/2021 -08/04/2022	UTILIZATION MANAGEMENT
T1845	DEPARTMENT OF MANAGED HEALTH CARE ****	310,874.85	310,874.85	2021-2022 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T4350	COMPUTER ENTERPRISE INC.	232,834.10	1,500,169.88	MAY , JUN. & JUL. 2021 PROFESSIONAL SERVICES / CONSULTING SERVICES	CAPITAL PROJECT
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC ****	136,306.82	136,306.82	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE/CAPITAL PROJECT
T4237	FLUIDEDGE CONSULTING, INC.	135,629.10	544,854.10	JUN. 2021 CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T5319	CITIUSTECH INC ****	125,000.00	125,000.00	CITIUS TECH'S FAST AND IMPLEMENTATION FEES	CAPITAL PROJECT
T4982	NGC US, LLC	122,500.00	1,157,245.88	PREFUND HEALTH HOMES INCENTIVES & HEALTH EDUCATION MEMBER & DISEASE MANAGEMENT & QUALITY IMPROVEMENT INCENTIVES	VARIOUS
T2726	DST PHARMACY SOLUTIONS, INC.	119,012.60	794,590.89	JUN. 2021 PHARMACY CLAIMS	PHARMACY
T5111	ENTISYS 360 ****	106,978.30	207,184.58	ANNUAL RUBRIK SUPPORT RENEWAL & SUBSCRIPTION & CONSULTING HOURS	MIS INFRASTRUCTURE/CAPITAL PROJECT

KERN·HEALTH SYSTEMS

July AP Vendor Report

Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T1960	LOCAL HEALTH PLANS OF CALIFORNIA ****	100,173.93	100,730.76	2021 ANNUAL DUE ASSESSMENT & TRAINING REGISTRATION	VARIOUS
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	69,227.74	482,905.98	JUL. 2021 VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T1180	LANGUAGE LINE SERVICES INC.	56,379.84	285,515.94	JUN. 2021 INTERPRETATION SERVICES	MEMBER SERVICES
T2580	GOLDEN EMPIRE TRANSIT DISTRICT ****	53,735.75	53,735.75	2021-2022 OUTDOOR ADVERTISING	MARKETING
T1957	FRIENDS OF MERCY FOUNDATION ****	50,000.00	54,000.00	COVID VACCINE CAMPAIGN SPONSORHIP	MARKETING
T4582	HEALTHX, INC.	41,576.00	299,032.00	JUL. 2021 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5015	SENTINEL ENGINEERING ****	40,380.00	40,380.00	JUNIPER ANNUAL SUPPORT RENEWAL	MIS INFRASTRUCTURE
T5346	TURNKEY ENERGY ****	40,352.00	40,352.00	EV CHARGING STATIONS	CORPORATE SERVICES
T3011	OFFICE ALLY, INC ****	36,923.50	128,934.00	MAY & JUN. 2021 EDI CLAIM PROCESSING	CLAIMS
T5022	SVAM INTERNATIONAL INC	34,367.50	144,101.00	JUN. 2021 PROFESSIONAL SERVICES/UPDATE TO STANDARD BUSINESS REPORTING	IT BUSINESS INTELLIGENCE
T5005	CRAYON SOFTWARE EXPERTS LLC ****	26,930.15	745,491.64	MAY 2021 ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T4575	SCHNEIDER ELECTRIC IT CORPORATION ****	26,791.50	26,791.50	APC ANNUAL MAINTENACE	CORPORATE SERVICES
T4663	DEVELOPMENT DIMENSIONS INTERNATIONAL,	25,000.00	25,000.00	LEADERSHIP FOUNDATION LICENSE	HUMAN RESOURCES
T5376	KCHCC ****	25,000.00	25,000.00	COVID TASK FORCE SPONSOR	MARKETING
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	24,960.00	123,240.00	JUN. 2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T5337	CAZADOR CONSULTING GROUP INC	24,361.95	79,723.53	JUL. 2021 TEMPORARY HELP - (10) MS	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	24,243.25	163,627.00	JUN. 2021 EDI CLAIM PROCESSING (EMDEON)	CLAIMS

KERN·HEALTH SYSTEMS

July AP Vendor Report

Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4733	UNITED STAFFING ASSOCIATES	22,400.11	133,920.51	JUN. & JUL. 2021 TEMPORARY HELP - (2) MS; (1) HHP; (1) HE	VARIOUS
T4699	ZEOMEGA, INC ****	22,313.33	68,053.47	JUN. 2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T1861	CERIDIAN HCM, INC. ****	22,052.12	149,581.32	JUN. & JUL. 2021 MONTHLY SUBSCRIPTION FEES/ PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	21,538.44	303,931.94	JUN. 2021 PROFESSIONAL SERVICES	VARIOUS
T2458	HEALTHCARE FINANCIAL, INC	21,500.00	287,000.00	JUN. 2021 PROFESSIONAL SERVICES	ADMINISTRATION
T4460	PAYSPAN, INC	19,059.16	122,673.52	JUN. 2021 ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T5128	STANDARD SCHOOL DISTRICT ****	18,000.00	18,000.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T4193	STRIA LLC	17,835.10	187,249.56	JUN., 2021 OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T5322	MANINDER KHALSA ****	17,680.00	24,212.50	JUN. 2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T5109	RAND EMPLOYMENT SOLUTIONS ****	17,674.63	305,869.73	JUN. & JUL. 2021 TEMPORARY HELP - (1) MS; (1) HHP; (1) HE (1) IT	VARIOUS
T4585	DELANO UNION SCHOOL DISTRICT ****	17,500.00	17,500.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T4962	LIBERTY DATA, INC ****	17,000.00	17,000.00	PROFESSIONAL SERVICES ANNUAL RENEWAL	MIS INFRASTRUCTURE
T5145	CCS ENGINEERING FRESNO INC ****	13,809.64	110,913.48	JUL. 2021 JANITORIAL & ADDITIONAL DAY PORTER	CORPORATE SERVICES
T1128	HALL LETTER SHOP ****	13,640.75	78,484.48	NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, WELLNESS & REWARDS LETTER	VARIOUS

KERN·HEALTH SYSTEMS

July AP Vendor Report

Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4165	SHI INTERNATIONAL CO ****	13,293.00	142,111.06	ANNUAL RENEWAL INFORMATION SECURITY SYSTEMS	MIS INFRASTRUCTURE
T4501	ALLIED UNIVERSAL SECURITY SERVICES ****	13,004.31	102,529.16	JUN. & JUL. 2021 ONSITE SECURITY	CORPORATE SERVICES
T4657	DAPONDE SIMPSON ROWE PC	12,381.00	71,509.00	MAY & JUN. 2021 LEGAL FEES	VARIOUS
		4,126,145.91			
	TOTAL VENDORS OVER $10,000	4,126,145.91			
	TOTAL VENDORS UNDER $10,000	178,540.81			
	TOTAL VENDOR EXPENSES- JULY	**$ 4,304,686.72**			

Note:
****New vendors over $10,000 for the month of July

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	3,038,855.25	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T2704	MCG HEALTH LLC	1,648,909.88	HEALTH CARE MANAGEMENT & SOFTWARE LICENSE 8/5/2021 - 08/04/2022	UTILIZATION MANAGEMENT
T4350	COMPUTER ENTERPRISE INC.	1,500,169.88	PROFESSIONAL SERVICES / CONSULTING SERVICES	CAPITAL PROJECT
T4982	NGC US, LLC	1,157,245.88	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	HEALTH EDUCATION
T3130	OPTUMINSIGHT, INC.	1,043,176.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T2686	ALLIANT INSURANCE SERVICES INC ****	929,163.33	ANNUAL INSURANCE PREMIUMS	ADMINISTRATION
T2726	DST PHARMACY SOLUTIONS, INC.	794,590.89	PHARMACY CLAIMS	PHARMACY
T5005	CRAYON SOFTWARE EXPERTS LLC	745,491.64	ANNUAL SOFTWARE LICENSE AND ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T4237	FLUIDEDGE CONSULTING, INC.	544,854.10	CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING	VARIOUS
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	482,905.98	VOLUNTARY LIFE, AD&D, DENTAL INSURANCE PREMIUM	VARIOUS
T1845	DEPARTMENT OF MANAGED HEALTH CARE ****	310,874.85	2021-2022 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	303,931.94	PROFESSIONAL SERVICES	VARIOUS
T4582	HEALTHX, INC.	299,032.00	MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5109	RAND EMPLOYMENT SOLUTIONS	295,900.35	TEMPORARY HELP & ACA INSURANCE	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T2458	HEALTHCARE FINANCIAL, INC.	287,000.00	PROFESSIONAL SERVICES	ADMINISTRATION
T1180	LANGUAGE LINE SERVICES INC.	285,515.94	INTERPRETATION SERVICES	MEMBER SERVICES
T4391	OMNI FAMILY HEALTH	259,144.10	SHAFTER HEALTH HOME GRANT	COMMUNITY GRANTS
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	217,442.81	HEALTH HOME GRANT	COMMUNITY GRANTS
T5111	ENTISYS 360	207,184.58	ANNUAL DISASTER RECOVERY CONTINUITY PROJECT	CAPITAL PROJECT/MIS INFRASTRUCTURE
T4193	STRIA LLC	187,249.56	OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T5022	SVAM INTERNATIONAL INC	178,468.50	PROFESSIONAL SERVICES/UPDATE TO STANDARD BUSINESS REPORTING	IT BUSINESS INTELLIGENCE
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	163,627.00	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T2584	UNITED STATES POSTAL SVC.-HASLER	150,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T1861	CERIDIAN HCM, INC.	149,581.32	MONTHLY SUBSCRIPTION FEES/ PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4165	SHI INTERNATIONAL CO.	142,111.06	SOFTWARE LICENSES	MIS INFRASTRUCTURE
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC ****	136,306.82	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T4733	UNITED STAFFING ASSOCIATES	133,920.51	TEMPORARY HELP & ACA INSURANCE	VARIOUS
T4967	ADMINISTRATIVE SOLUTIONS, INC.	132,964.12	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T3011	OFFICE ALLY, INC.	128,934.00	EDI CLAIM PROCESSING	CLAIMS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T4483	INFUSION AND CLINICAL SERVICES, INC.	127,606.88	HEALTH HOMES GRANT	COMMUNITY GRANT
T5319	CITIUSTECH INC ****	125,000.00	CITIUS TECH'S FAST AND IMPLEMENTATION FEES	MIS INFRASTRUCTURE
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	123,240.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T4460	PAYSPAN, INC	122,673.52	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T2167	PG&E	120,369.89	USAGE/UTILITIES	CORPORATE SERVICES
T5145	CCS ENGINEERING FRESNO INC.,	110,913.48	JANITORIAL SERVICES	CORPORATE SERVICES
T2850	QUEST SOFTWARE INC.	109,598.00	SQL LICENSE / SPOTLIGHT SOFTWARE	MIS INFRASTRUCTURE
T5344	SIGNATURE STAFF RESOURCES LLC	104,052.00	PROJECT MANAGEMENT CONSULTING	PROJECT MANAGEMENT
T4501	ALLIED UNIVERSAL SECURITY SERVICES	102,529.16	ONSITE SECURITY	CORPORATE SERVICES
T1960	LOCAL HEALTH PLANS OF CALIFORNIA ****	100,730.76	2021 ANNUAL DUE ASSESSMENT & TRAINING REGISTRATION	VARIOUS
T5185	HOUSING AUTHORITY COUNTY OF KERN	91,750.00	2020 HOUSING AUTHORITY GRANT	UTILIZATION MANAGEMENT - UM WELLNESS
T4353	TWE SOLUTIONS, INC.	87,518.01	ANNUAL TECHNICAL SUPPORT AND MAINTENANCE FOR NIMBLE STORAGE SOLUTIONS	MIS INFRASTRUCTURE
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	84,395.67	EMPLOYEE PREMIUM - ACCIDENT & CRITICAL ILLNESS	VARIOUS
T3448	SYNERGY HEALTHCARE, INC.	84,100.00	ASTHMA PROGRAM GRANT	COMMUNITY GRANTS
T5337	CAZADOR CONSULTING GROUP INC	79,723.53	TEMPORARY HELP	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T1128	HALL LETTER SHOP, INC.	78,484.48	NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, CLINICAL CARE MANUAL FOR HH, NEW MEMBER PACKETS & POSTERS	VARIOUS
T4963	LINKEDIN CORPORATION	78,275.00	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T4813	ADVENTIST HEALTH TEHACHAPI VALLEY	77,925.82	2020 PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T3449	CDW GOVERNMENT	72,660.28	ANNUAL ADOBE TEAM LICENSING	MIS INFRASTRUCTURE
T4657	DAPONDE SIMPSON ROWE PC	71,509.00	LEGAL FEES	VARIOUS
T4396	KAISER FOUNDATION HEALTH-DHMO	68,207.47	EMPLOYEE HEALTH BENEFITS	VARIOUS
T4699	ZEOMEGA, INC	68,053.47	PROFESSIONAL SERVICES AND TRAVEL EXP.	UTILIZATION MANAGEMENT
T4960	ZELIS CLAIMS INTEGRITY, LLC	67,536.96	POST EDITING SYSTEMS FOR CLAIMS PROCESSING	CLAIMS
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	65,000.00	ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4261	KAISER FOUNDATION HEALTH PLAN - TX PPO	61,392.28	TX-PPO EMPLOYEE HEALTH BENEFITS	VARIOUS
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	61,141.97	TEMPORARY HELP	MIS ADMINISTRATION
T1272	COFFEY COMMUNICATIONS INC.	60,642.91	MEMBER NEWSLETTER/ WEBSITE IMPLEMENTATION	HEALTH EDUCATION/ MIS INFRASTRUCTURE
T1957	FRIENDS OF MERCY FOUNDATION ****	54,000.00	COVID VACCINE CAMPAIGN SPONSORSHIP	MARKETING
T2580	GOLDEN EMPIRE TRANSIT DISTRICT ****	53,735.75	2021-2022 OUTDOOR ADVERTISING	MARKETING
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	49,950.00	2020 AUDIT FEES	FINANCE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5121	TPx COMMUNICATIONS	49,061.76	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T1022	UNUM LIFE INSURANCE CO.	47,584.80	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5329	RELAY NETWORK, LLC	46,666.69	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T2961	SOLUTION BENCH, LLC	46,414.59	M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE
T5132	TIME WARNER CABLE LLC	45,417.17	INTERNET SERVICES	MIS INFRASTRUCTURE
T4792	KP LLC	44,183.19	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PHARMACY/PROVIDER RELATIONS
T4182	THE LAMAR COMPANIES	44,130.00	OUTDOOR ADVERTISEMENT-BILLBOARDS	ADVERTISING
T4781	EDRINGTON HEALTH CONSULTING, LLC	43,943.75	CONSULTING SERVICES	ADMINISTRATION
T4785	COMMGAP	43,911.25	INTERPRETATION SERVICES	HEALTH EDUCATION
T5015	SENTINEL ENGINEERING ****	40,380.00	JUNIPER ANNUAL SUPPORT RENEWAL	MIS INFRASTRUCTURE
T5346	TURNKEY ENERGY ****	40,352.00	EV CHARGING STATIONS	CORPORATE SERVICES
T2413	TREK IMAGING INC	39,486.86	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T4503	VISION SERVICE PLAN	38,654.34	EMPLOYEE HEALTH BENEFITS	VARIOUS
T5340	GARTNER INC	38,500.00	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	MIS ADMINISTRATION
T4563	SPH ANALYTICS	38,108.20	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T5107	CITRIX SYSTEMS, INC	37,350.00	ANNUAL LICENSE AND SUPPORT FEES	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5292	ALL'S WELL HEALTH CARE SERVICES	37,179.00	TEMPORARY HELP	VARIOUS
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	35,449.00	ANNUAL DUES ASSESSMENT	ADMINISTRATION
T3986	JACQUELYN S. JANS	34,600.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T5325	WADE A MCNAIR	32,995.00	LEADABILITY PROGRAM FACILITATION-CONSULTING SERVICES/ONSITE TRAINING	HUMAN RESOURCES
T4731	LOGMEIN USA, INC.	32,515.35	INTERNET SERVICES	MIS INFRASTRUCTURE
T5201	JAC SERVICES, INC.	32,150.00	AC MAINTENANCE & SERVICE	CORPORATE SERVICES
T2441	LAURA J. BREZINSKI	30,350.00	MARKETING MATERIALS	MARKETING
T2446	AT&T MOBILITY	30,305.05	CELLULAR PHONE / INTERNET USAGE	MIS INFRASTRUCTURE
T2407	KAISER FOUNDATION HEALTH -COBRA	29,771.68	COBRA EMPLOYEE HEALTH BENEFITS	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	27,913.60	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T1408	DELL MARKETING L.P. ****	26,945.65	HARDWARE & COMPUTER EQUIPMENT	MIS INFRASTRUCTURE
T4575	SCHNEIDER ELECTRIC IT CORPORATION ****	26,791.50	APC COOLING UNITS - ANNUAL MAINTENACE	CORPORATE SERVICES
T4216	NEXSTAR BROADCASTING INC	26,610.00	ADVERTISEMENT - MEDIA	MARKETING
T5269	KERN COMMUNITY FOUNDATION	26,311.00	ANNUAL CONTRIBUTION - KERN CONNECTED COMMUNITY NETWORK MGMT FEE	UTILIZATION MANAGEMENT-OUTREACH
T2135	BAKERSFIELD CITY SCHOOL DISTRICT	26,205.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T1655	KERN,KKXX,KISV,KGEO,KGFM,KEBT,KZOZ,KKJG, KVEC,KSTT,KRQK,KPAT,	26,000.00	DIGITAL ADS	MARKETING

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5298	TOTALMED, INC.	25,591.00	DIRECT PLACEMENT FEES	HUMAN RESOURCES
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	25,000.01	COMMUNITY SPONSORSHIP	ADMINISTRATION
T4663	DEVELOPMENT DIMENSIONS INTERNATIONAL, INC ****	25,000.00	LEADERSHIP FOUNDATION LICENSE	HUMAN RESOURCES
T5376	KCHHC ****	25,000.00	COVID TASK FORCE SPONSORSHIP	MARKETING
T5322	MANINDER KHALSA ****	24,212.50	2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC.	24,075.03	HARDWARE BOARD ROOM REMOTE VIDEO CONFERENCING	MIS INFRASTRUCTURE
T5345	DEVVIO INC	23,250.00	ANNUAL SOFTWARE & HARDWARE DEVVTRACE WEARABLES & GATEWAYS - CONTRACT TRACING	MIS INFRASTRUCTURE/CAPITAL PROJECT
T4873	L5 HEALTHCARE SOLUTIONS, INC.	23,115.00	ANNUAL LICENSE AND SUPPORT FEES - CLAIMS AUDIT TOOL	CLAIMS
T4607	AGILITY RECOVERY SOLUTIONS INC.	22,842.00	PROFESSIONAL SERVICES	ADMINISTRATION
T5334	PACIFIC INTERPRETERS, INCORPORATED	21,443.57	INTERPRETATION SERVICES	HEALTH EDUCATION
T2918	STINSON'S	20,338.56	2021 OFFICE SUPPLIES	VARIOUS
T1183	MILLIMAN USA	20,144.25	CY2019/2020 RDT & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T2941	KERN PRINT SERVICES INC	19,702.67	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T4605	KERNVILLE UNION SCHOOL DISTRICT	19,500.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T2969	AMERICAN BUSINESS MACHINES INC	19,247.72	HARDWARE AND MAINTENANCE	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5128	STANDARD SCHOOL DISTRICT ****	18,000.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
Y4585	DELANO UNION SCHOOL DISTRICT ****	17,500.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T4802	KERN COUNTY SUPERINTENDENT OF SCHOOLS	17,500.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T5013	ELIZA CORPORATION ****	17,090.00	202 DATA MANAGEMENT FEE	CASE MANAGEMENT
T4962	LIBERTY DATA, INC ****	17,000.00	PROFESSIONAL SERVICES ANNUAL RENEWAL	MIS INFRASTRUCTURE
T1097	NCQA	16,895.25	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	QUALITY IMPROVEMENT
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO., INC.	16,745.45	2021 BUILDING MAINTENANCE	CORPORATE SERVICE
T1326	WALKER-LEWIS RENTS	16,218.16	COVID-19 TESTING SITE EQUIPMENT	MARKETING
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	15,936.00	CONSULTING SERVICES	ADMINISTRATION
T2787	SAGE SOFTWARE, INC	15,819.93	2020-21 SAGE300 ERP SILVER BUSINESS ANNUAL LICENSE	FINANCE
T5300	CENTRAL VALLEY OCCUPATION MEDICAL GROUP, INC	15,200.00	COVID-19 TESTING	HUMAN RESOURCES
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	15,025.00	ADVERTISEMENT - TELEVISION	MARKETING
T2578	AMERICAN HEART ASSOCIATION - KERN COUNTY	15,000.00	COMMUNITY ACTIVITIES-SPONSORSHIP	ADMINISTRATION
T4195	SCRIPPS MEDIA, INC DBA KERO-TV	14,935.00	ADVERTISEMENT - TELEVISION	MARKETING

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5159	AT&T CORP	14,322.37	INTERNET SERVICES	MIS INFRASTRUCTURE
T4228	THE SSI GROUP, LLC	14,209.60	EDI CLAIM PROCESSING	CLAIMS
T4389	EXACT STAFF, INC.	13,998.52	TEMPORARY HELP	VARIOUS
T5161	INTEGRATED HEALTHCARE ASSOCIATION	13,590.00	ADVERTISEMENT - FILMING SERVICES	MARKETING
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	13,347.94	EMPLOYEE PREMIUM	ADMINISTRATION
T2790	KERN COUNTY DEPT OF PUBLIC HEALTH	12,915.00	INFLUENZA VACCINATION SPONSORSHIP	MARKETING
T1650	UNIVISION TELEVISION GROUP ****	12,750.00	ADVERTISEMENT - TELEVISION	MARKETING
T2938	SAP AMERICA, INC	12,308.32	SAP BUSINESS OBJECTS SOFTWARE ANNUAL MAINTENANCE FEE	BUSINESS INTELLIGENCE
T3084	KERN COUNTY-COUNTY COUNSEL	12,015.30	LEGAL FEES	ADMINISTRATION
T4577	LA CAMPESINA, KBDS, KUFW, KMXY, KSEA, KBHH, KYLI, KCEC, KNAI	12,000.00	ADVERTISEMENT - RADIO	MARKETING
T4993	LEGALSHIELD	11,954.11	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5336	TEAMDYNAMIX SOLUTIONS LLC ****	11,800.00	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T1347	ADVANCED DATA STORAGE ****	11,661.55	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T2955	DELTA ELECTRIC INC ****	11,010.00	BUILDING MAINTENANCE	CORPORATE SERVICES
T5099	PROGRESS SOFTWARE CORPORATION	10,968.02	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T2840	ATALASOFT, INC.	10,254.00	ANNUAL DOTIMAGE DOCUMENT IMAGING MAINTENANCE	MIS INFRASTRUCTURE
T4932	SPECTRUM REACH (MEDIA)	10,200.00	ADVERTISEMENT - TELEVISION	MARKETING
T2869	COMMUNITY ACTION PARTNERSHIP OF KERN	10,000.00	COMMUNITY GRANTS	MARKETING
		20,370,136.84		
	TOTAL VENDORS OVER $10,000	20,370,136.84		
	TOTAL VENDORS UNDER $10,000	585,059.99		
	TOTAL VENDOR EXPENSES - JULY	**$20,955,196.83**		

Note:
****New vendors over $10,000 for the month of July

KERN·HEALTH SYSTEMS

August AP Vendor Report

Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO*****	424,728.64	3,463,583.89	AUG., 2021 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE INC.	260,926.80	1,761,096.68	MAY , JUN. & JUL. 2021 PROFESSIONAL SERVICES/ CONSULTING SERVICES	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC.	124,884.40	669,738.50	JUL. 2021 CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T2726	DST PHARMACY SOLUTIONS, INC.	117,721.01	912,311.90	JUL. 2021 PHARMACY CLAIMS	PHARMACY
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC	105,603.96	241,910.78	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT & r6404s 4 NODE, 48TB	MIS INFRASTRUCTURE/CAPITAL PROJECT
T5111	ENTISYS 360	99,400.36	306,584.94	3 YR RBK SONAR SOFTWARE SUBSCRIPTION	MIS INFRASTRUCTURE/CAPITAL PROJECT
T1408	DELL MARKETING L.P.*****	71,124.44	98,070.09	HARDWARE - 25 DELL LATITUDE 5420 W/4 YRS SUPPORT, 50 MONITORS P2319H, 3 LAPTOP BATTERY REPLACEMENTS	MIS INFRASTRUCTURE/CAPITAL PROJECT
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	69,630.18	552,536.16	AUG. 2021 VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T2167	PG&E ****	63,899.50	184,269.39	JUN/JUL & JUL/AUG USAGE / UTILITIES	CORPORATE SERVICES
T3448	SYNERGY HEALTHCARE INC ****	57,400.00	141,500.00	APRIL, MAY, AND JUNE ASTHMA PROGRAM GRANT	COMMUNITY GRANTS
T1180	LANGUAGE LINE SERVICES INC.	57,394.88	342,910.82	JUL. 2021 INTERPRETATION SERVICES	MEMBER SERVICES
T5337	CAZADOR CONSULTING GROUP INC	49,416.08	129,139.61	JUL. / AUG. 2021 TEMPORARY HELP - (10) MS	VARIOUS
T4982	NGC US, LLC	45,000.00	1,202,245.88	PREFUND HEALTH HOMES INCENTIVES & HEALTH EDUCATION MEMBER & DISEASE MANAGEMENT & QUALITY IMPROVEMENT INCENTIVES	VARIOUS

KERN·HEALTH SYSTEMS

August AP Vendor Report

Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4582	HEALTHX, INC.	41,576.00	340,608.00	AUG. 2021 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	34,073.23	338,005.17	JUL. 2021 PROFESSIONAL SERVICES	VARIOUS
T5022	SVAM INTERNATIONAL INC	32,427.50	210,896.00	JUL. 2021 PROFESSIONAL SERVICES/UPDATE TO STANDARD BUSINESS REPORTING	IT BUSINESS INTELLIGENCE
T4193	STRIA LLC	25,170.25	212,419.81	JUL., 2021 OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T4733	UNITED STAFFING ASSOCIATES	23,901.08	157,821.59	JUL. &AUG. 2021 TEMPORARY HELP - (2) MS; (1) HHP; (1) HE	VARIOUS
T1183	MILLIMAN USA ****	23,704.75	43,849.00	CY 2021 RDT & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	23,275.37	186,902.37	JUL. 2021 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T5322	MANINDER KHALSA	22,867.00	47,079.50	JUL. 2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4563	SPH ANALYTICS ****	21,880.60	59,988.80	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T5344	SIGNATURE STAFF RESOURCES LLC	19,872.00	123,924.00	PROJECT MANAGEMENT CONSULTING	ADMINISTRATION
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	19,500.00	142,740.00	JUL. 2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T3011	OFFICE ALLY, INC	17,972.25	146,906.25	JUL. 2021 EDI CLAIM PROCESSING	CLAIMS
T2933	SIERRA PRINTERS, INC ****	17,559.04	23,701.64	PRINT MEMBERS HANDBOOKS AND POSTCARDS	MEMBER SERVICES AND HE
T4967	ADMINISTRATIVE SOLUTIONS INC ****	17,349.95	150,314.07	JUL /AUG FSA EMPLOYEE PREMIUM & SECTION 125 FEES	VARIOUS

KERN·HEALTH SYSTEMS

August AP Vendor Report

Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4016	FIRST DATABANK INC *****	16,620.00	16,620.00	2021-2022 NATIONAL CODE DATABASE WITH THE GENERIC CODE NUMBER RENEWAL	MIS INFRASTRUCTURE
T4261	KAISER FOUNDATION HEALTH PLAN-TX PPO	16,161.16	77,553.44	AUG., 2021 EMPLOYEE PPO HEALTH BENEFITS PREMIUM	VARIOUS
T5005	CRAYON SOFTWARE EXPERTS LLC	16,024.79	761,516.43	JUL. 2021 ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T1861	CERIDIAN HCM, INC.	15,735.54	165,316.86	AUG. 2021 MONTHLY SUBSCRIPTION FEES/ PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T5145	CCS ENGINEERING FRESNO INC	13,515.64	124,429.12	AUG. 2021 JANITORIAL & ADDITIONAL DAY PORTER	CORPORATE SERVICES
T5109	RAND EMPLOYMENT SOLUTIONS	13,174.51	309,074.86	JUL. & AUG. 2021 TEMPORARY HELP - (1) MS; (1) HHP; (1) HE	VARIOUS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	12,575.70	115,104.86	JUL. & AUG. 2021 ONSITE SECURITY	CORPORATE SERVICES
T5185	HOUSING AUTHORITY COUNTY OF KERN *****	12,350.00	104,100.00	MAY 2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T1005	COLONIAL LIFE & ACCIDENT *****	11,915.48	96,311.15	AUG 2021 LIFE INSURANCE PREMIUM	VARIOUS
T4460	PAYSPAN, INC	11,384.85	134,058.37	JUL. 2021 ELECTRONIC CLAIMS/PAYMENTS	FINANCE
		2,027,716.94			
	TOTAL VENDORS OVER $10,000	2,027,716.94			
	TOTAL VENDORS UNDER $10,000	228,427.78			
	TOTAL VENDOR EXPENSES- AUGUST	**$ 2,256,144.72**			

Note:
****New vendors over $10,000 for the month of August

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	3,463,583.89	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE INC.	1,761,096.68	PROFESSIONAL SERVICES / CONSULTING SERVICES	CAPITAL PROJECT
T2704	MCG HEALTH LLC	1,648,909.88	HEALTH CARE MANAGEMENT & SOFTWARE LICENSE 8/5/2021 - 08/04/2022	UTILIZATION MANAGEMENT
T4982	NGC US, LLC	1,202,245.88	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	HEALTH EDUCATION
T3130	OPTUMINSIGHT, INC.	1,043,176.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T2686	ALLIANT INSURANCE SERVICES INC.	929,163.33	ANNUAL INSURANCE & ACIP CRIME PREMIUMS	ADMINISTRATION
T2726	DST PHARMACY SOLUTIONS, INC.	912,311.90	PHARMACY CLAIMS	PHARMACY
T5005	CRAYON SOFTWARE EXPERTS LLC	761,516.43	ANNUAL SOFTWARE LICENSE AND ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T4237	FLUIDEDGE CONSULTING, INC.	669,738.50	CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING	VARIOUS
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	552,536.16	VOLUNTARY LIFE, AD&D, DENTAL INSURANCE PREMIUM	VARIOUS
T1180	LANGUAGE LINE SERVICES INC.	342,910.82	INTERPRETATION SERVICES	MEMBER SERVICES
T4582	HEALTHX, INC.	340,608.00	MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	338,005.17	PROFESSIONAL SERVICES	VARIOUS
T1845	DEPARTMENT OF MANAGED HEALTH CARE	310,874.85	2021-2022 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T5109	RAND EMPLOYMENT SOLUTIONS	309,074.86	TEMPORARY HELP & ACA INSURANCE	VARIOUS
T5111	ENTISYS 360	306,584.94	ANNUAL DISASTER RECOVERY CONTINUITY PROJECT	CAPITAL PROJECT/MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T2458	HEALTHCARE FINANCIAL, INC.	287,000.00	PROFESSIONAL SERVICES	ADMINISTRATION
T4391	OMNI FAMILY HEALTH	259,144.10	HEALTH HOMES AND PROVIDER QUAILITY CARE GRANT	COMMUNITY GRANTS
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC.	241,910.78	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	217,442.81	HEALTH HOME GRANT	COMMUNITY GRANTS
T4193	STRIA LLC	212,419.81	OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T5022	SVAM INTERNATIONAL INC	210,896.00	PROFESSIONAL SERVICES/UPDATE TO STANDARD BUSINESS REPORTING	IT BUSINESS INTELLIGENCE
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	186,902.37	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T2167	PG&E	184,269.39	USAGE/UTILITIES	CORPORATE SERVICES
T1861	CERIDIAN HCM, INC.	165,316.86	MONTHLY SUBSCRIPTION FEES/ PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4733	UNITED STAFFING ASSOCIATES	157,821.59	TEMPORARY HELP & ACA INSURANCE	VARIOUS
T4967	ADMINISTRATIVE SOLUTIONS, INC.	150,314.07	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T2584	UNITED STATES POSTAL SVC.-HASLER	150,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T3011	OFFICE ALLY, INC.	146,906.25	EDI CLAIM PROCESSING	CLAIMS
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	142,740.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T4165	SHI INTERNATIONAL CO.	142,111.06	SOFTWARE LICENSES	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T3448	SYNERGY HEALTHCARE, INC.	141,500.00	ASTHMA PROGRAM GRANT	COMMUNITY GRANTS
T4460	PAYSPAN, INC	134,058.37	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T4483	INFUSION AND CLINICAL SERVICES, INC.	131,966.22	HEALTH HOMES GRANT	COMMUNITY GRANT
T5337	CAZADOR CONSULTING GROUP INC	129,139.61	TEMPORARY HELP	VARIOUS
T5319	CITIUSTECH INC.	125,000.00	CITIUS TECH'S FAST AND IMPLEMENTATION FEES	MIS INFRASTRUCTURE
T5145	CCS ENGINEERING FRESNO INC.,	124,429.12	JANITORIAL SERVICES	CORPORATE SERVICES
T5344	SIGNATURE STAFF RESOURCES LLC	123,924.00	PROJECT MANAGEMENT CONSULTING	PROJECT MANAGEMENT
T4501	ALLIED UNIVERSAL SECURITY SERVICES	115,104.86	ONSITE SECURITY	CORPORATE SERVICES
T2850	QUEST SOFTWARE INC.	109,598.00	SQL LICENSE / SPOTLIGHT SOFTWARE	MIS INFRASTRUCTURE
T5185	HOUSING AUTHORITY COUNTY OF KERN	104,100.00	2020 HOUSING AUTHORITY GRANT	UTILIZATION MANAGEMENT - UM WELLNESS
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	100,854.72	2021 ANNUAL DUE ASSESSMENT & TRAINING REGISTRATION	VARIOUS
T1408	DELL MARKETING L.P.	98,070.09	HARDWARE & COMPUTER EQUIPMENT	MIS INFRASTRUCTURE
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	96,311.15	EMPLOYEE PREMIUM - ACCIDENT & CRITICAL ILLNESS	VARIOUS
T4353	TWE SOLUTIONS, INC.	87,518.01	ANNUAL TECHNICAL SUPPORT AND MAINTENANCE FOR NIMBLE STORAGE SOLUTIONS	MIS INFRASTRUCTURE
T1128	HALL LETTER SHOP, INC.	85,794.16	NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, CLINICAL CARE MANUAL FOR HH, NEW MEMBER PACKETS & POSTERS	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T4657	DAPONDE SIMPSON ROWE PC	80,897.50	LEGAL FEES	VARIOUS
T4963	LINKEDIN CORPORATION	78,275.00	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T4813	ADVENTIST HEALTH TEHACHAPI VALLEY	77,925.82	2020 PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4261	KAISER FOUNDATION HEALTH PLAN -TX PPO	77,553.44	TX-PPO EMPLOYEE HEALTH BENEFITS	VARIOUS
T4396	KAISER FOUNDATION HEALTH-DHMO	76,849.14	EMPLOYEE HEALTH BENEFITS	VARIOUS
T3449	CDW GOVERNMENT	72,660.28	ANNUAL ADOBE TEAM LICENSING	MIS INFRASTRUCTURE
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	68,721.55	TEMPORARY HELP	MIS ADMINISTRATION
T4699	ZeOMEGA, INC.	68,653.47	PROFESSIONAL SERVICES AND TRAVEL EXP.	UTILIZATION MANAGEMENT
T1272	COFFEY COMMUNICATIONS INC.	67,549.28	MEMBER NEWSLETTER/ WEBSITE IMPLEMENTATION	HEALTH EDUCATION/ MIS INFRASTRUCTURE
T4960	ZELIS CLAIMS INTEGRITY, LLC	67,536.96	POST EDITING SYSTEMS FOR CLAIMS PROCESSING	CLAIMS
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	65,000.00	2021 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4563	SPH ANALYTICS	59,988.80	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T5121	TPx COMMUNICATIONS	56,102.75	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T2580	GOLDEN EMPIRE TRANSIT DISTRICT	54,735.75	2021-2022 OUTDOOR ADVERTISING	MARKETING
T1022	UNUM LIFE INSURANCE CO.	54,434.00	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T1957	FRIENDS OF MERCY FOUNDATION	54,000.00	COVID VACCINE CAMPAIGN SPONSORSHIP	MARKETING

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5329	RELAY NETWORK, LLC	53,333.36	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T5132	TIME WARNER CABLE LLC	51,905.44	INTERNET SERVICES	MIS INFRASTRUCTURE
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	49,950.00	2020 AUDIT FEES	FINANCE
T4792	KP LLC	48,880.29	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PHARMACY/PROVIDER RELATIONS
T4785	COMMGAP	48,848.75	INTERPRETATION SERVICES	HEALTH EDUCATION
T4781	EDRINGTON HEALTH CONSULTING, LLC	48,600.00	CONSULTING SERVICES	ADMINISTRATION
T5322	MANINDER KHALSA	47,079.50	2021 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T4182	THE LAMAR COMPANIES	46,945.00	OUTDOOR ADVERTISEMENT-BILLBOARDS	ADVERTISING
T2961	SOLUTION BENCH, LLC	46,414.59	M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE
T4503	VISION SERVICE PLAN	44,158.41	EMPLOYEE HEALTH BENEFITS	VARIOUS
T1183	MILLIMAN USA	43,849.00	CY2019/2020 RDT & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T5015	SENTINEL ENGINEERING	40,380.00	JUNIPER ANNUAL SUPPORT RENEWAL	MIS INFRASTRUCTURE
T5346	TURNKEY ENERGY	40,352.00	EV CHARGING STATIONS	CORPORATE SERVICES
T2413	TREK IMAGING INC	39,923.86	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T3986	JACQUELYN S. JANS	39,600.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T5340	GARTNER INC	38,500.00	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	MIS ADMINISTRATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5107	CITRIX SYSTEMS, INC.	37,350.00	ANNUAL LICENSE AND SUPPORT FEES	MIS INFRASTRUCTURE
T5292	ALL'S WELL HEALTH CARE SERVICES	37,179.00	TEMPORARY HELP	VARIOUS
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	36,199.00	2021 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T2441	LAURA J. BREZINSKI	34,200.00	MARKETING MATERIALS	MARKETING
T5325	WADE A MCNAIR	32,995.00	LEADABILITY PROGRAM FACILITATION-CONSULTING SERVICES/ONSITE TRAINING	HUMAN RESOURCES
T2407	KAISER FOUNDATION HEALTH -COBRA	32,984.45	COBRA EMPLOYEE HEALTH BENEFITS	VARIOUS
T4731	LOGMEIN USA, INC.	32,515.35	INTERNET SERVICES	MIS INFRASTRUCTURE
T5201	JAC SERVICES, INC.	32,150.00	AC MAINTENANCE & SERVICE	CORPORATE SERVICES
T4607	AGILITY RECOVERY SOLUTIONS INC.	30,416.00	PROFESSIONAL SERVICES	ADMINISTRATION
T2446	AT&T MOBILITY	30,305.05	CELLULAR PHONE / INTERNET USAGE	MIS INFRASTRUCTURE
T2969	AMERICAN BUSINESS MACHINES INC	28,649.29	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T2941	KERN PRINT SERVICES INC.	28,539.23	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	27,913.60	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4575	SCHNEIDER ELECTRIC IT CORPORATION	26,791.50	APC COOLING UNITS - ANNUAL MAINTENACE	CORPORATE SERVICES
T4216	NEXSTAR BROADCASTING INC	26,610.00	ADVERTISEMENT - MEDIA	MARKETING
T5269	KERN COMMUNITY FOUNDATION	26,311.00	ANNUAL CONTRIBUTION - KERN CONNECTED COMMUNITY NETWORK MGMT FEE	UTILIZATION MANAGEMENT-OUTREACH

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T2135	BAKERSFIELD CITY SCHOOL DISTRICT	26,205.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T1655	KERN,KKXX,KISV,KGEO,KGFM,KEBT,KZOZ,KKJG,KVEC,KSTT,KRQK,KPAT,	26,000.00	DIGITAL ADS	MARKETING
T5298	TOTALMED, INC.	25,591.00	DIRECT PLACEMENT FEES	HUMAN RESOURCES
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	25,000.01	COMMUNITY SPONSORSHIP	ADMINISTRATION
T4663	DEVELOPMENT DIMENSIONS INTERNATIONAL, INC.	25,000.00	LEADERSHIP FOUNDATION LICENSE	HUMAN RESOURCES
T5376	KCHCC	25,000.00	COVID TASK FORCE SPONSORSHIP	MARKETING
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC.	24,075.03	HARDWARE BOARD ROOM REMOTE VIDEO CONFERENCING	MIS INFRASTRUCTURE
T2933	SIERRA PRINTERS, INC. ****	23,701.64	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T5345	DEVVIO INC*****	23,250.00	ANNUAL SOFTWARE & HARDWARE DEVVTRACE WEARABLES & GATEWAYS - CONTRACT TRACING	MIS INFRASTRUCTURE/CAPITAL PROJECT
T4873	L5 HEALTHCARE SOLUTIONS, INC.	23,115.00	ANNUAL LICENSE AND SUPPORT FEES - CLAIMS AUDIT TOOL	CLAIMS
T5334	PACIFIC INTERPRETERS, INCORPORATED	21,443.57	INTERPRETATION SERVICES	HEALTH EDUCATION
T2918	STINSON'S	21,224.12	2021 OFFICE SUPPLIES	VARIOUS
T4605	KERNVILLE UNION SCHOOL DISTRICT	19,500.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T1326	WALKER-LEWIS RENTS	19,231.99	COVID-19 TESTING SITE EQUIPMENT	MARKETING
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO., INC.	18,745.45	2021 BUILDING MAINTENANCE	CORPORATE SERVICE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T4514	A.J. KLEIN, INC. T. DENATALE, B. GOLDNER ****	18,694.00	LEGAL FEES	ADMINISTRATION
T5128	STANDARD SCHOOL DISTRICT	18,000.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T4585	DELANO UNION SCHOOL DISTRICT	17,500.00	2019/2021 SCHOOL WELLNESS PROGRAM GRANT- FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T4802	KERN COUNTY SUPERINTENDENT OF SCHOOLS	17,500.00	2019/2020 SCHOOL WELLNESS PROGRAM GRANT - FINAL PAYMENT	UTILIZATION MANAGEMENT - HE WELLNESS
T5300	CENTRAL VALLEY OCCUPATION MEDICAL GROUP, INC	17,440.00	COVID-19 TESTING	HUMAN RESOURCES
T5013	ELIZA CORPORATION	17,100.00	202 DATA MANAGEMENT FEE	CASE MANAGEMENT
T4962	LIBERTY DATA, INC.	17,000.00	PROFESSIONAL SERVICES ANNUAL RENEWAL	MIS INFRASTRUCTURE
T1097	NCQA	16,895.25	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	QUALITY IMPROVEMENT
T4016	FIRST DATABANK, INC ****	16,620.00	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T5159	AT&T CORP	16,112.22	INTERNET SERVICES	MIS INFRASTRUCTURE
T4228	THE SSI GROUP, LLC.	16,048.00	EDI CLAIM PROCESSING	CLAIMS
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	15,936.00	CONSULTING SERVICES	ADMINISTRATION
T2787	SAGE SOFTWARE, INC	15,819.93	2020-21 SAGE300 ERP SILVER BUSINESS ANNUAL LICENSE	FINANCE
T5161	INTEGRATED HEALTHCARE ASSOCIATION	15,526.25	ADVERTISEMENT - FILMING SERVICES	MARKETING
T3084	KERN COUNTY-COUNTY COUNSEL	15,348.00	LEGAL FEES	ADMINISTRATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	15,260.86	EMPLOYEE PREMIUM	ADMINISTRATION
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	15,025.00	ADVERTISEMENT - TELEVISION	MARKETING
T2578	AMERICAN HEART ASSOCIATION - KERN COUNTY	15,000.00	COMMUNITY ACTIVITIES-SPONSORSHIP	ADMINISTRATION
T4195	SCRIPPS MEDIA, INC. DBA KERO-TV	14,935.00	ADVERTISEMENT - TELEVISION	MARKETING
T4389	EXACT STAFF, INC.	13,998.52	TEMPORARY HELP	VARIOUS
T4993	LEGALSHIELD	13,672.46	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION
T1347	ADVANCED DATA STORAGE	13,054.85	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T2790	KERN COUNTY DEPT OF PUBLIC HEALTH	12,915.00	INFLUENZA VACCINATION SPONSORSHIP	MARKETING
T1650	UNIVISION TELEVISION GROUP	12,750.00	ADVERTISEMENT - TELEVISION	MARKETING
T2938	SAP AMERICA, INC	12,308.32	SAP BUSINESS OBJECTS SOFTWARE ANNUAL MAINTENANCE FEE	BUSINESS INTELLIGENCE
T5215	RICHARD GARCIA ****	12,075.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T4577	LA CAMPESINA, KBDS, KUFW, KMYX, KSEA, KBHH, KYLI, KCEC, KNAI	12,000.00	ADVERTISEMENT - RADIO	MARKETING
T5336	TEAMDYNAMIX SOLUTIONS LLC	11,800.00	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T2955	DELTA ELECTRIC INC.	11,010.00	BUILDING MAINTENANCE	CORPORATE SERVICES
T5099	PROGRESS SOFTWARE CORPORATION	10,968.02	SOFTWARE LICENSE	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to Date	Description	Department
T5333	CENTRAL CALIFORNIA ASTHMA COLLABORATIVE ****	10,695.00	2021 CENTRAL CALIFORNIA ASTHMA COLLAB. GRANT	HE WELLNESS
T2840	ATALASOFT, INC.	10,254.00	ANNUAL DOTIMAGE DOCUMENT IMAGING MAINTENANCE	MIS INFRASTRUCTURE
T4932	SPECTRUM REACH (MEDIA)	10,200.00	ADVERTISEMENT - TELEVISION	MARKETING
T2869	COMMUNITY ACTION PARTNERSHIP OF KERN	10,000.00	COMMUNITY GRANTS	MARKETING
		22,602,157.59		
	TOTAL VENDORS OVER $10,000	22,601,657.09		
	TOTAL VENDORS UNDER $10,000	609,684.46		
	TOTAL VENDOR EXPENSES - AUGUST	**$23,211,341.55**		

Note:
****New vendors over $10,000 for the month of August

Admintrative Contracts

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
January							
Poppyrock Designs	$46,200.00	Yes	MRK	Louie Itturriria	Graphic design of KHS-KFHC member & provider MKT materials	1/1/2021	12/31/2021
Symplr/Cactus	$35,700.00	Yes	IT	Richard Pruitt	Annual SaaS Application manager & the DEA State license monitor	1/6/2021	1/5/2022
HD Dynamics	$50,000.00	Yes	PR	Emily Duran	Consulting Services	1/1/2021	12/31/2021
LinkedIn	$52,000.00	Yes	HR	Anita Martin	Online training for managed learners	1/1/2021	12/31/2021
Jacquelyn Jans	$60,000.00	Yes	MRK	Louie Itturriria	Marketing and Corporate Image Consulting	1/1/2021	12/31/2021
February							
CDW-G	$54,287.48	Yes	IT	Richard Pruitt	Dell 5420 (25) laptops and (25) Dockbolt stations	2/24/2021	2/24/2025
SPH Analytics	$87,010.00	Yes	PR	Emily Duran	Custom provider satisfaction survey	2/11/2021	12/31/2021
Lamar	$41,595.00	Yes	MRK	Louie Itturriria	Production of 5 Billboard advertisement	1/25/2021	1/24/2022
LifeSigns	$80,000.00	Yes	HE	Isabel Silva	ASL interpreting services for KHS members	2/23/2021	2/22/2023
Quest Software	$99,995.00	Yes	IT	Richard Pruitt	Unlimited Enterprise Spotlight on SQL server licenses	2/1/2021	1/31/2026
PMO Partners	$97,152.00	Yes	PM	Angela Ahsan	Professional consulting services	2/11/2021	6/18/2021
March							
Gartner	$38,500.00	Yes	IT	Richard Pruitt	One (1) license for individual access advisor	3/1/2021	2/28/2022
SHI	$33,432.79	Yes	IT	Richard Pruitt	Co-termed support for all Fortinet-Fortigate security appliances	3/15/2021	12/31/2022
April							
Citrix	$37,350.00	Yes	IT	Richard Pruitt	Maintenance and support for Citrix licenses	4/2/2021	4/1/2022
SHI	$58,469.60	Yes	IT	Richard Pruitt	Cisco SMARTnet renewal	4/22/2021	4/22/2022
TWE Solutions	$73,165.00	Yes	IT	Richard Pruitt	Cortex XDR Pro licenses	4/23/2021	4/22/2022
Presidio	$47,225.00	Yes	IT	Richard Pruitt	Security Program Assessment services	4/23/2021	4/22/2022
May							
Entisys360	$99,999.00	Yes	IT	Richard Pruitt	Xi Leap Cloud Services co-termed	5/26/2021	5/26/2022
June							
Milliman	$50,000.00	Yes	ACCT	Veronica Barker	Actuarial services (IBNP)	6/1/2021	5/31/2022
Dell	$62,756.60	Yes	IT	Richard Pruitt	25 Dell 5420 Laptops and 25 docking stations	6/24/2021	6/23/2025
Edrignton Health Consulting	$99,000.00	Yes	ACCT	Veronica Barker	Actuarial services (RDT, SDR's, rate analysis, discussion guide)	6/1/2021	5/31/2022
Presidio	$80,418.89	Yes	IT	Richard Pruitt	Node purchase to expand Rubrik backup and recovery solution	6/24/2021	6/23/2024
Entisys360	$99,400.36	Yes	IT	Richard Pruitt	Rubrik polaris Sonar software	6/24/2021	6/23/2024
July							
Solution Bench	$33,814.59	Yes	IT	Richard Pruitt	Subscription-based licensing program for all M-Files licenses	7/24/2021	7/23/2022
ABM	$91,854.00	Yes	IT	Richard Pruitt	Support and printing for all printing equipment	10/1/2021	9/30/2023
Golden Empire Transit (GET)	$53,735.75	Yes	MRK	Louie Itturriria	Four (4) King Kong outdoor advertisements	7/15/2021	6/30/2022
Sentinel	$40,380.00	Yes	IT	Richard Pruitt	Juniper Networks switches support and maintenance	7/1/2021	6/30/2022

2021 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	*Project Portfolio Management System*	*CA*	$154,562	$0	$0	$18,400	$0	$16,000	$43,040	$34,440	$17,600					$129,480	$25,082
2	*Community Based Organization Referral System*	*CA*	$359,653	$0	$0	$0	$0	$10,925	$55,209	$78,556	$85,816					$230,506	$129,147
3	*Enterprise Logging System*	*CA*	$333,996	$12,036	$15,200	$0	$17,600	$0	$0	$0	$14,960					$59,796	$274,200
4	*Interoperability*	*CA*	$162,044	$4,944	$0	$0	$0	$0	$0	$27,720	$16,500					$49,164	$112,880
5	*Enterprise Data Warehouse System*	*CA*	$673,553	$87,957	$94,932	$104,117	$111,364	$68,480	$29,040	$0	$0					$495,890	$177,663
6	*Major Organ Transplants*	*CA*	$62,000							$0	$17,290						$62,000
7	*Enhanced Care Management*	*CA*	$344,000							$0	$17,640						$344,000
8	*Staff Augmentation*	*EXP*	$1,918,488	$142,543	$142,108	$174,994	$156,367	$160,220	$166,264	$144,199	$154,486					$1,241,181	$677,307
	Totals:	**Totals**	**$4,008,296**	**$247,480**	**$252,240**	**$297,511**	**$285,331**	**$255,625**	**$293,553**	**$284,915**	**$324,292**	**$0**	**$0**	**$0**		**$2,206,017**	**$1,802,279**

Updated 9/20/21

KERN HEALTH SYSTEMS

TO: **KHS Board of Directors**

FROM: **Alan Avery, COO**

DATE: **October 14, 2021**

RE: **3rd Quarter 2021 Operations Report**

Kern Health Systems Operational Departments continue to meet the regulatory and health plan performance goals during the 3rd Quarter of 2021. This continued trend during the COVID-19 pandemic ensures provider claims are processed in a timely and accurate manner, member inquiries and questions are adequately addressed and all plan operational units are working efficiently and effectively together while most staff are working remotely in their respective homes.

Claims

Incoming provider claims receipts for the 3rd Quarter of 2021 increased by 40,000 claims over the previous quarter, continuing to follow the growth trend of the past three quarters in 2021, reaching 881,263 claims received during the quarter. Looking back to the 3rd Quarter of 2020, incoming claims have increased by 15% in the past twelve months. Even though claim receipts have increased significantly, we continue to benefit from claims being submitted electronically 98% of the time with only 2% of the claims received on paper. In addition, auto adjudication of claims, meaning claims received and processed without any manual intervention, reached a new milestone during the quarter. We were able to process 87% of the claims using auto adjudication. Combining improvements in electronic claim submission and auto adjudication percentage has greatly decreased processing time, improved quality, and increased timely payments to providers. The claims department continues to meet and often exceeds all regulatory payment requirements for the quarter-including claims processing timeliness and inventory measures.

Member Services

With the continued new member growth, member calls into the KHS Member Services Call Center also increased slightly by 4% during the 3rd Quarter at 69,132 calls, but still significantly under the pre-COVID call volume of 77,000 calls. As reported earlier in the year, Member Services has implemented a new software improvement tool we refer to as "Screen Pop" which automatically provides key member information to the member representatives computer screen when the call arrives on their desktop. This information includes the members name, Medi-Cal and KHS ID numbers, date of birth, phone numbers and eligibility status. Recently Gaps in Care along with COVID vaccination status have been added. The Gaps in Care listed include wellness checkups, well-women checkups, prescription refills, asthma, diabetes, high blood pressure wellness checks, child vaccinations, pre-natal & post-partum visits, and newborn wellness exams. The representative confirms the accuracy of this information along with discussing the Gaps in Care and vaccination status—often offering to schedule appointments and transportation for both.

During the latter part of the 3rd quarter, Member Services added a new service to assist in our execution of the COVID-19 Vaccination Action Plan. These COVID-19 Vaccination Reservation Specialists assists callers who want to schedule a vaccination appointment including arranging transportation if needed. In addition, these Reservation Specialists are making outbound phone calls to unvaccinated members, asking if they have been vaccinated and offering assistance in connecting them with a physician to address their questions, coordinating rides and scheduling appointments.

All key performance metrics (abandonment rate and average speed to answer) continue to be met even though we continued to experience a slight increase in the average talk time metric which we attribute to expanded customer service discussions being held with the members regarding COVID-19 vaccination status. The top five reasons for members calling Member Services changed in their order during the quarter with referral authorization status moving up to the #2 spot from the #5 spot. The remaining reasons retained their positions (1) New Member questions (2) Referral authorization status (3) Demographic updates/changes (4) ID Card replacement requests and (5) PCP changes. All the top five reasons for incoming calls could easily be handled by the member via the Member Portal, therefore, we continue to encourage members to sign onto the portal and use the self-service tools. During the 3rd quarter, Member Services received 2,842 new member portal account enrollments, for a total of 41,697 member accounts. This equates to over 14% of our members with online accounts compared to industry standard of 4%. Member Service Representatives continue to encourage members to sign up for a member portal account whenever they call.

Provider Relations

The Primary Care Provider network for the 3rd Quarter remained steady with 423 providers, losing 16 providers (3.64% decrease) during the quarter. From a regulatory perspective, there are 16 core specialists that we must continually monitor and report. These specialists include: Cardiology, Dermatology, Endocrinology, ENT, Gastroenterology, General Surgery, Hematology, HIV/AIDS/Infectious Disease, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Psychiatry and Pulmonology. In the core specialty category, we experienced a very minimal decrease of 4 providers (.94%). Our complete contracted provider network (PCP + Core Specialists + All others) = 2,503. The top two primary reasons for shrinkage of our provider network are (1) Provider is no longer with the contracted group (83%) and (2) Physician practice purchased by another Entity (8%).

Another key accessibility measurement is the network adequacy component. We are required to monitor and report to the State the adequacy of our PCP and Core Specialty provider network. This measurement is based on a provider to member ratio. For PCP's, the ratio is one PCP for every 2,000 members. We currently have one PCP for every 1837 members, thus meeting the requirement. For Core Specialists, the ratio is one Specialists for every 1,2000 members. We currently are reporting one for every 680 members, clearly exceeding the requirement. Even though we are currently meeting all regulatory accessibility requirements, we are continually accepting all providers who meet our participation requirements. The last key provider network indicator that we continually monitor and report is PCP and Specialty care appointment availability. Non-urgent PCP appointments must be available within 10 days. We are currently reporting 4.2 days for the 3rd Quarter. Non-urgent appointments with a specialist must be available within 15 days. We are currently reporting a little over 6 days, a significant improvement over the past two quarters.

Human Resources

Despite working remote during the 3rd Quarter, the Human Resources Department conducts staff recruitment, new employee orientation and training functions for the organization. With the pandemic still in force, the HR staff provided oversight and monitoring of employee COVID incidents for both remote and on-site employees, exposure contact tracing, scheduling COVID testing and reporting and reporting positive cases to our workmen's compensation carrier. The good news, on-site instances were very few and most exposure didn't reveal widespread infection issues. In addition, HR is finalizing a Safe Return-to-Work Plan which will outline the process by which staff will begin to return the building in three phases delayed until after the 1st of the year.

During the 3rd Quarter KHS staffing remained at 425 employees compared to a budget of 449. Employee turnover is 10.38% year to date.

Grievance Report

Formal Grievances during the 3rd Quarter increased slightly by 80 grievances or 12% over the previous quarter. The three categories that made up that increase included Access to Care, Quality of Service and Medical Necessity. We believe this increased trend is caused by the continued enrollment of new members to manage care along with existing members going back to the doctor. Within the category of Access to Care two areas were identified and forwarded to Provider Network Management to track and trend specific providers. The first area was regarding Telephone/Technology issues. Members had trouble reaching their provider through phone and/or email. The second area forwarded to PNM was timely access, meaning the members had trouble obtaining an appointment with their PCP or Specialists within the Access to Care standards or they waited longer than an hour for a scheduled appointment. No significant issues/trends were identified in the other two categories-Quality of Service or Medical Necessity, but we will continue to monitor these trends going forward.

Exempt Grievances decreased during the quarter. Exempt grievances are primarily simple service-related complaints, usually when the member doesn't want to file a Formal complaint. They can usually 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. The Grievance Department tracks and trends these by provider and results are reviewed by the KHS Physicians Advisory Committee as part of the recredentialing process. We are not overly concerned with the sizeable increase in exempt grievance, as we attribute the increase to the gradual increase in member calls into Member Services, the continued growth of new members and members returning to their primary and specialty care providers. However, we will continue to monitor closely monthly to identify any unusual trends.

Part two of the Grievance Report is the disposition of the Formal Grievances. This report indicates what decisions were made by the KHS Grievance Committee regarding Formal Grievances. As the report indicates, 164 Potential Inappropriate Care Formal Grievances were forwarded to the Quality Department, 62 were investigated and QI upheld the decision by the Grievance Committee, 98 cases required further review by the QI department and 4 cases were overturned and upheld the position of the member. The other major category was Medical Necessity where 329 cases were reported, 188 cases where the decision of the Grievance

Committee was upheld, and 66 grievance decisions were reversed in favor of the member and 75 cases were still under review. The Quality Department has not identified any trends that need to be addressed. The primary reason for overturning the original decision of the grievance occurs when we receive additional supporting documentation from the member or the provider.

Transportation Update

Transportation activity during the 3rd quarter followed similar trends throughout 2021, with 75,066 rides being provided during the quarter. Both ride share programs (GET OnDemand and Uber) showed slight gains in ridership during the 3rd quarter. In addition, the Member Reimbursement transportation mode continued to receive increase support by our members, most likely a result of the lack of drivers supporting the ride share programs during peak demand times. All other transportation options had minor increases/decreases. Overall, the use of transportation services continues at 50% of pre-COVID activity.

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

2021 3rd Quarter Operational Report

Alan Avery
Chief Operating Officer

KERN HEALTH SYSTEMS
kernhealthsystems.com

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3rd Quarter 2021 Claims Department Indicators

Activity	Goal	3rd Quarter	Status	2nd Quarter	1st Quarter	4th Quarter	3rd Quarter
Claims Received		**881,263**		840,553	827,140	812,995	752,017
Electronic	95%	**98%**		98%	98%	98%	96%
Paper	5%	**2%**		2%	2%	2%	4%
Claims Processed Within 30 days	90%	**99%**		98%	99%	99%	96%
Claims Processed within 45 days	95%	**99%**		99%	99%	99%	99%
Claims Processed within 90 days	99%	**100%**		99%	99%	99%	99%
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%**		0	<1%	<1%	<1%
Auto Adjudication	85%	**87%**		85%	85%	85%	84%
Audited Claims with Errors	<3%	**<1%**		1%	2%	2%	2%
Claims Disputes	<5%	**1%**		1%	1%	1%	1%

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3rd Quarter 2021 Member Service Indicators

Activity	Goal	2nd Quarter	Status	2nd Quarter	1st Quarter	4th Quarter	3rd Quarter
Incoming Calls		**69,132**		65,968	64,320	61,469	66,882
Abandonment Rate	<5%	**3%**		2%	1.4%	1.19%	2.6%
Avg. Answer Speed	<2:00	**:40**		:26	:16	:11	:26
Average Talk Time	<8:00	**8:19**		8:13	8:06	7:50	7:52
Top Reasons for Member Calls	Trend	**1. New Member 2. Referrals 3. Demographic 4. ID Card 5. PCP Change**		1. New Member 2. Demographic 3. ID Card 4. PCP Change 5. Referrals	Same	Same	Same
Outbound Calls	Trend	**69,826**		69,608	66,148	63,979	78,915
# of Walk Ins	Trend	**0**		0	0	0	0
Member Portal Accounts-Q/Total	4%	**2842 41,697 (14.18%)**		2740 38,858 (13.34%)	3062 36,025 12.65%	2948 33,053 (11.8%)	3347 30,106 (11.19%)

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3rd Quarter Provider Network Indicators

Activity	Goal	3rd Quarter	Status	2nd Quarter	1st Quarter	4th Quarter	3rd Quarter
Provider Counts							
# of PCP		423		439	417	408	408
% Growth		[3.64%]		5.28%	2.21%	0%	.99%
# of Specialist		422		426	441	447	445
% Growth		[.94%]		[3.40%]	[1.34%]	.45%	.45%
FTE PCP Ratio	1:2000	1:1837		1:1742	1:1798	1:1773	1:1773
FTE Physician Ratio	1:1200	1:680		1:620	1:614	1:1571	1:542
PCP	< 10 days	4.2 days		3.0 days	2.3 days	5.2 days	9.0 Days
Specialty	< 15 days	6 days		11.4 days	10.5 days	5.7 days	8.5 Days

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3rd Quarter Human Resources Indicators

Activity	Budget	3rd Quarter	Status	2nd Quarter	1st Quarter	4th Quarter	3rd Quarter
Staffing Count	449	**425**		425	425	422	422
Employee Turnover	12%	**10.38%**		10.38%	7.55%	6.68	6.69%
Turnover Reasons	Voluntary Involuntary Retired Deceased	**66.67** **23.24** **3.03** **6.06**		63.64% 22.73% 4.54% 9.09%	75% 12.5% 0 12.5%	85.8% 7.1% 7.1%	80.94% 9.53% 9.53%

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3rd Quarter 2021 Grievance Report

Category	3rd Quarter 2021	Status	Issue	Q2 2021	Q1 2021	Q4 2020	Q3 2020
Access to Care	148		Appointment Availability	90	77	72	52
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	329		Questioning denial of service	308	308	317	288
Other Issues	18		Miscellaneous	20	11	14	10
Potential Inappropriate Care	164		Questioning services provided. All cases forwarded to Quality Dept.	183	156	200	263
Quality of Service	53		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	31	8	7	5
Total Formal Grievances	712			632	560	610	618
Exempt**	1520		Exempt Grievances-	1570	1179	1050	1041
Total Grievances (Formal & Exempt)	2232			2202	1739	1660	1659

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Additional Insights-Formal Grievance Detail

Issue	3rd Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	97	33	0	28	36
Coverage Dispute	0	0	0	0	0
Specialist Access	51	23	0	13	15
Medical Necessity	329	188	0	66	75
Other Issues	18	8	0	3	7
Potential Inappropriate Care	164	62	98	4	0
Quality of Service	53	21	0	12	20
Total	712	335	98	126	153

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3rd Quarter 2021 Transportation Update

Operational Statistics	Q3 2021	Q2 2021	Q1 2021	Q4 2020	Q3 2020
ALC Calls	**67,680**	69,978	77,033	81,672	81,359
One Way Rides Scheduled	**75,066**	70,643	73,836	79,456	78,988
NMT	**37,936**	34,256	41,433	46,071	48,245
Bus Passes Distributed	**1065**	833	670	869	989
GET Van Share	**8253**	7619	3303	3725	1094
Ride Share Rides	**28,618**	25,804	37,460	41,477	46,162
No Shows	**5103**	3669	3156	3640	3396
NEMT	**37,129**	36,387	32,403	33,385	30,743
Van Rides Scheduled	**36,546**	35,797	31,626	32,636	29,958
Gurney Rides Scheduled	**583**	590	777	749	785
Member Reimbursement	**2496**	2377	1707	1834	1930
ALC Admin Expense	**$415,333.25**	$387,345.71	$415,080.00	$444,850.78	$459,741.50

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KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Martha Tasinga M.D, MPH, MBA, Chief Medical Officer

Date: October 14, 2021

Re: CMO BOARD REPORT

Medical Cost and Utilization Trend Analyses: (Attachment A)

Physician Services: *(*PCPs, Specialists, Hospitalist, Other Professional and Urgent Care):

The utilization of physician services has remained relatively stable since the spike in March 2021. In August 2021, we note a spike in professional services utilization mostly in the SPD Aid code. We will watch this and analyze the data to determine the root cause should the trend continue. The top reason for physician services utilization in August 2021 was wellness and preventive services. This is encouraging pointing out members are returning to their doctor for routine care. The combined PMPM cost shown in orange is stable, even though for SPD's it remains higher than expected. With the implementation of enhanced case management and our continued focus on population health, overtime a downward trend in PMPM cost should occur for all Aid categories as patient's conditions stabilize.

Pharmacy

The combined PMPM prescription cost remains below budget for all aid categories except for SPDs. We continue to analyze utilization patterns and cost of utilization to identify ways to better manage this benefit. Some of our programs will initially increase use of appropriate medications but in long-term there will be a reduction in the use of high-cost services such as acute care. There was a spike in August for the cost per script for the Family and other Aid code. We are monitoring that spike and analyzing data to see if the trend continues or is just a one-month event. We continue to work with the Pharmacy and Therapeutic Committee to identify less expensive bioequivalent formulations of expensive medications when available to add to our formulary.

Inpatient Services

Prior to the recent surge in COVID -19 cases, the overall PMPM cost, cost per bed-day, bed-days incurred and average length of stay in the acute hospital had been at or below budget except the SPDs. The PMPM for SPDs is higher than budgeted and appears to mirror spikes coincidental with COVID-19 surges. In August 2021, we noted the first spike for our overall admissions; based on what happened in September 2021, this was probably the beginning of the latest COVID-19 Surge which is still occurring. COVID -19 accounts for 40 to 60 patients each day in the hospital and represents the most frequent diagnosis for in-patient admissions for our SPDs and expansion populations. Should more members become vaccinated, the next wave of Covid-19 will have less impact on our acute care hospital utilization.

Most admissions continue to be at BMH. **(Attachment B).**

Hospital Outpatient

We saw an increase in hospital outpatient visits starting in June 2021 and continuing in August. We will watch this to see if it is a trend that needs further analysis. We continue to work with our hospitalist teams to increase use of observation units for patient who do not need to be in an acute hospital for more than 72 hours. The observation stays are considered and counted as outpatient hospital services for reporting.

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. We saw some increase in utilization starting in March but remain below pre pandemic utilization levels. The most frequent diagnosis for the ER for all AID codes in August 2021 is COVID-19 acute respiratory disease. In June before the new surge of the COVID-19, the most frequent reason for ER visits was disorders of the urinary system.

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. The sudden drop in the KM line is due to claims submission issues and the KHS is working with them to resolve the issues. When we look at our inpatient data, we see that the number of deliveries is stable and deliveries were not affected even during the lock down. Our C/Section rate of 14% 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 19 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 improve their quality metrics scores.

In response to these requirements, KHS has revised the Provider P4P to be aligned it with the new MCAS measures and requirements. KHS has continued to find new ways to engage and provide routine care to our members during this time with the COVID-19 Pandemic. The trending report presented under **Attachment E** is real-time trending on how we are performing compared to the previous measurement year (at a similar point in time). The new Minimum Performance Level CMPL) is shown in the green line above each measure to indicate the gap between current actual performance and target. The goal being to meet or exceed the MPL by the end of the recording year which is the end of December.

The report shows that 13 of the 18 measures are in Green. The Green boxes represent the measures that our performance this year is better than how we performed last year at the same time. The 5 Yellow boxes are measures that we need less than 5% improvement to be where we were last year. At this point we do not have red boxes which would have indicated that we need more that 5% improvement to be where we were last year at this time.

The Department of Health Care Services (DHCS) decided not to hold health plans like KHS accountable to meet the MPL for any hybrid measure for RY 2020, due to the COVID-19 public health crisis. Similarly, DHCS had elected **not** to impose sanctions or corrective action plans on any health plans for failing to meet the MPL for any measure, administrative or hybrid, for recording year 2020. Since we are now in year 2021, DHCS has yet to decide if health plans will be held accountable for MCAS performance given the pandemic continues to negatively impact provider and patient behavior.

Although, we were given this "pass" for 2020, we saw it as an opportunity to undertake an internal assessment of the MCAS Program. This assessment gave us new insights and helped us develop a comprehensive strategic plan to improve our MCAS performance in order to achieve levels at or above the new minimum performance levels imposed by DHCS. The strategic plan may be found under Agenda Item CA-11.

KERN HEALTH SYSTEMS

Attachment A
Governed Reporting System

Kern Health Systems

KHS Medical Management Performance Dashboard (Critical Performance Measurements)

KERN HEALTH SYSTEMS

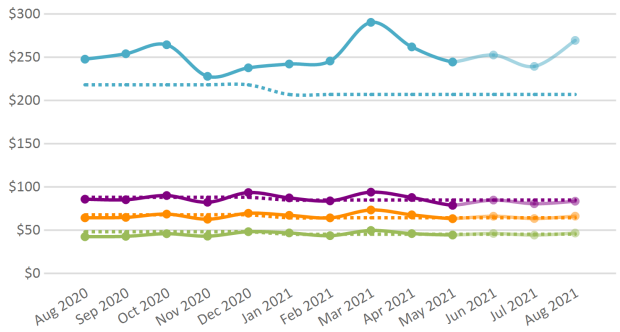
Governed Reporting System

Physician Services

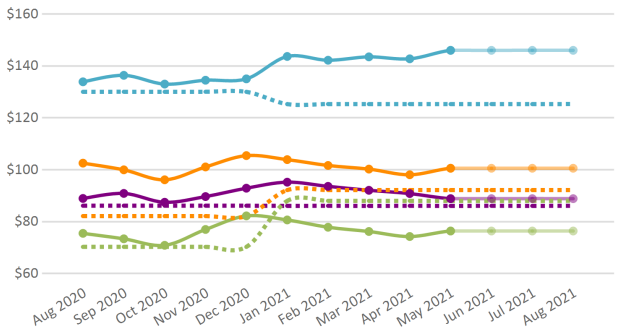
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

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

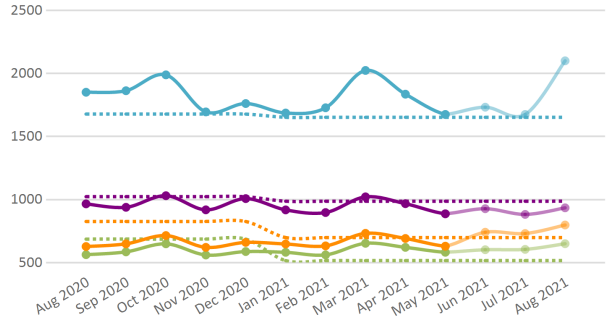
Professional Services Incurred by Aid Group PMPM



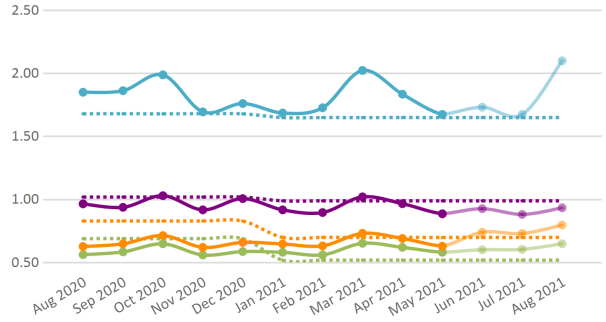
Cost per Professional Service Visit by Aid Group



Professional Service Visits per 1,000 per Month by Aid Group



Professional Service Visits per Member per Month by Aid Group

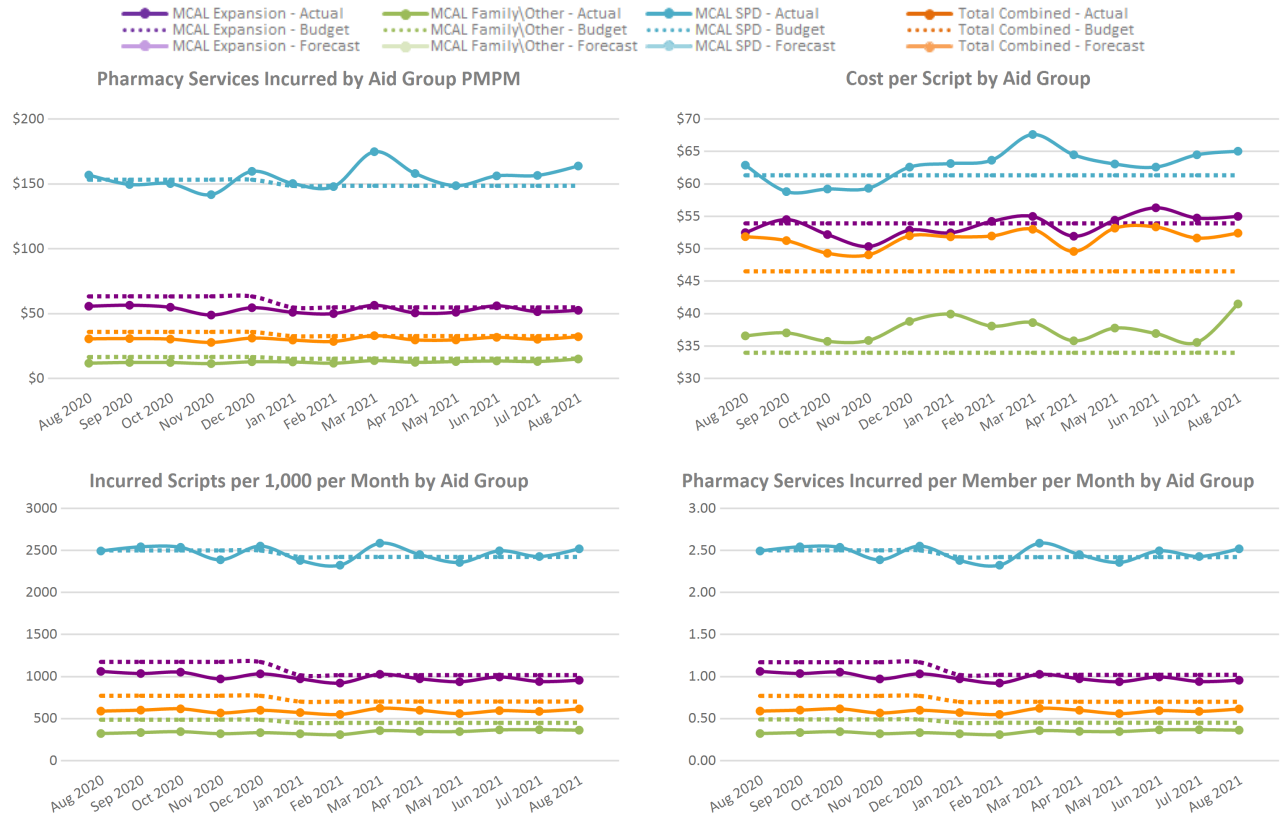


KERN HEALTH SYSTEMS

Governed Reporting System

Pharmacy

(Includes: Claims paid by PBM)



KERN HEALTH SYSTEMS

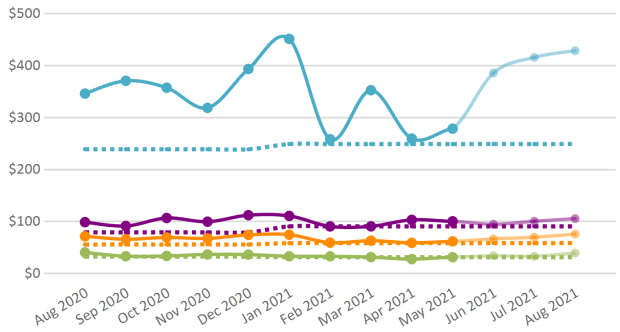
Governed Reporting System

Inpatient

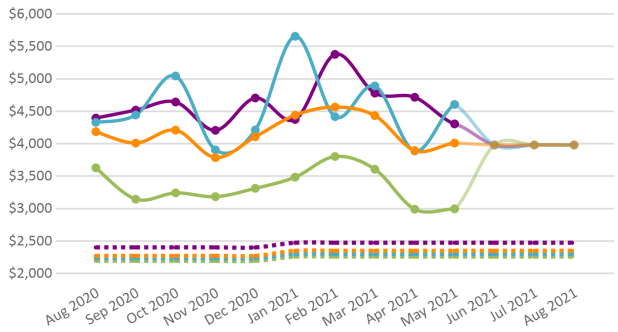
(Includes: Inpatient Hospital Claims)

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

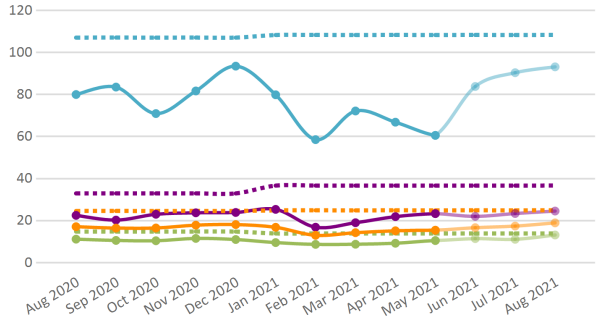
Inpatient Services Incurred by Aid Group PMPM



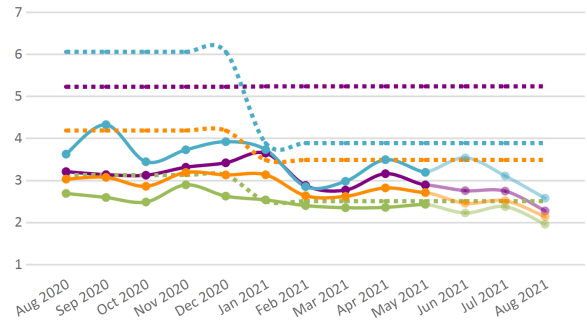
Cost Per Bed Day by Aid Group



Incurred Bed Days per 1,000 per Month by Aid Group



Average Length of Stay in Days by Aid Group

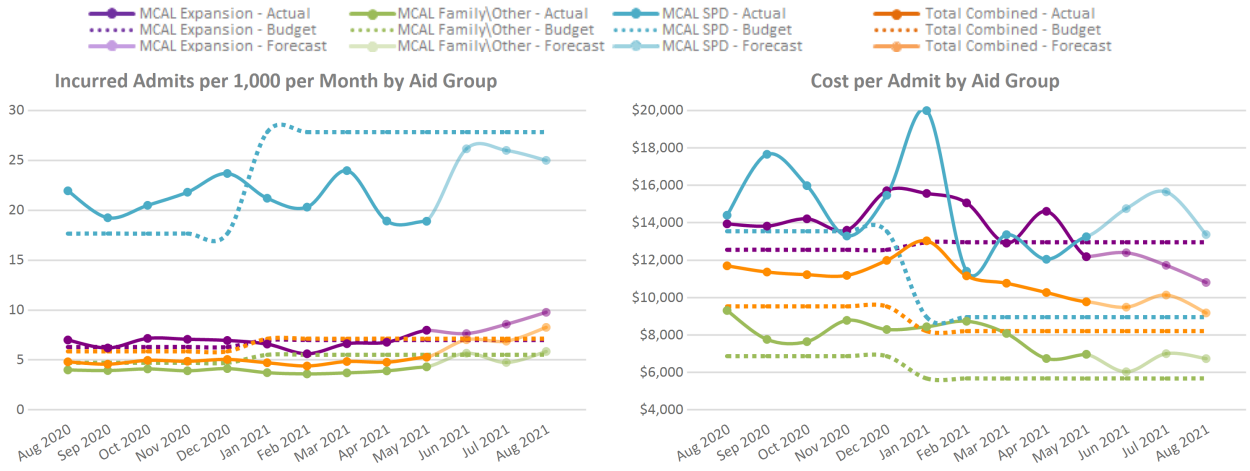


KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient

(Includes: Inpatient Hospital Claims)



KERN HEALTH SYSTEMS

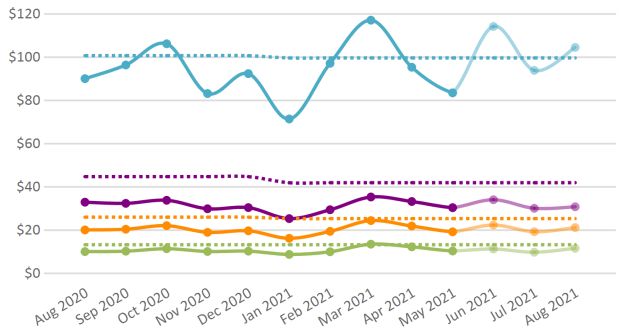
Governed Reporting System

Outpatient Hospital

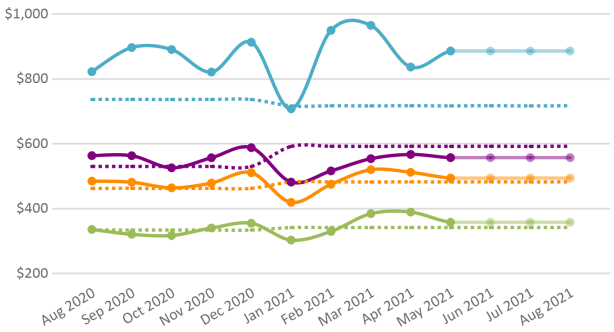
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

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

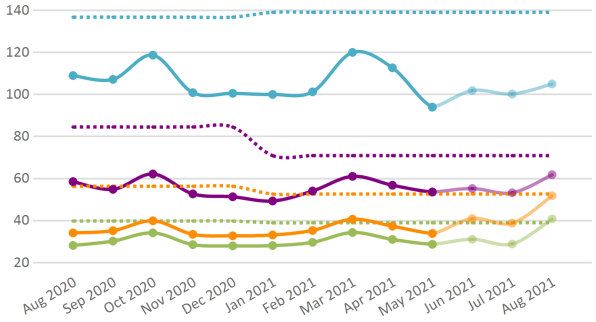
Outpatient Services Incurred by Aid Group PMPM



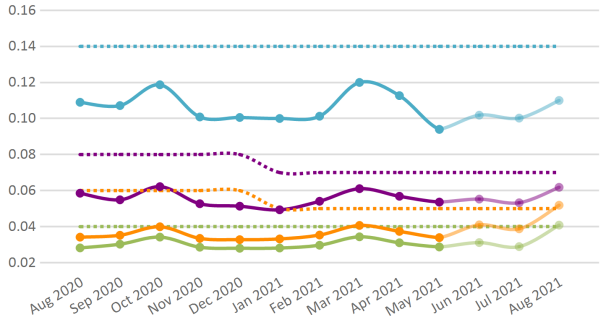
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



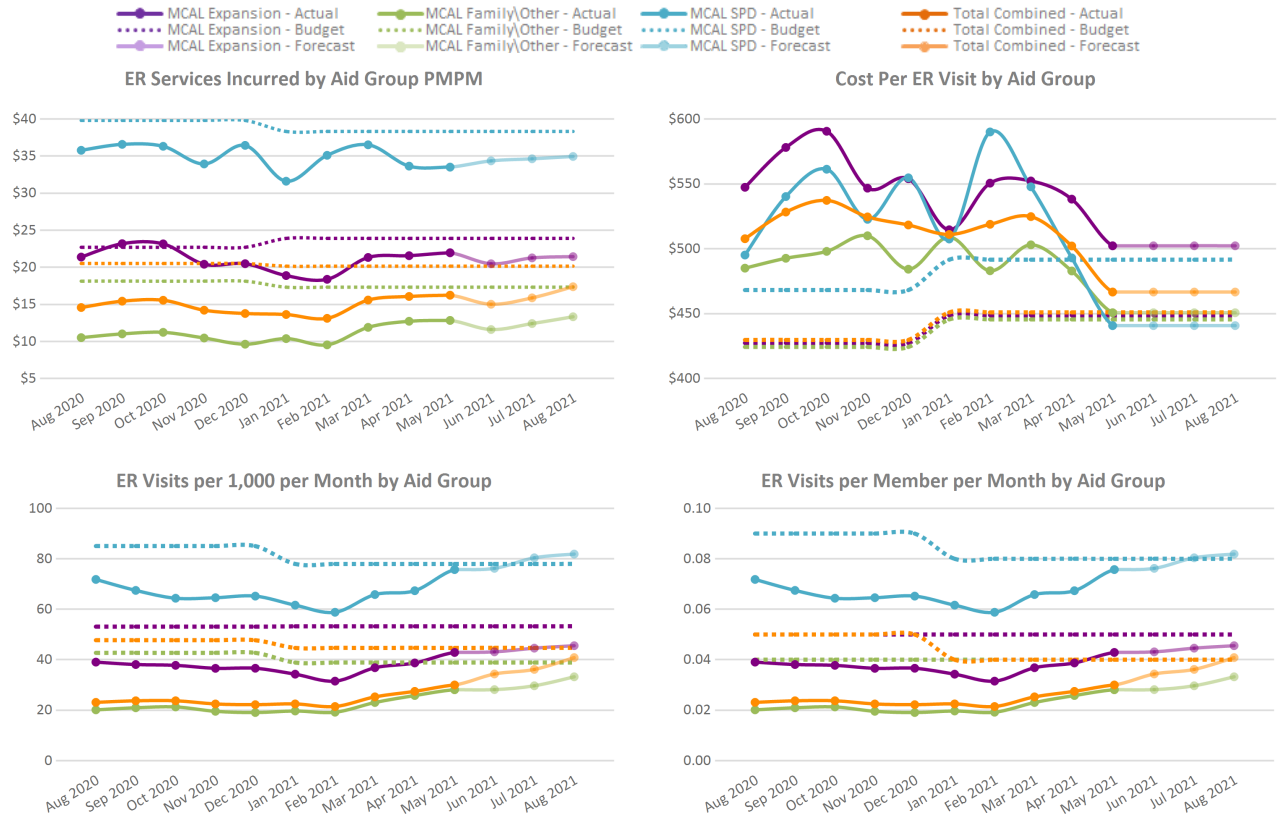
Outpatient Visits per Member per Month by Aid Group



KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Room

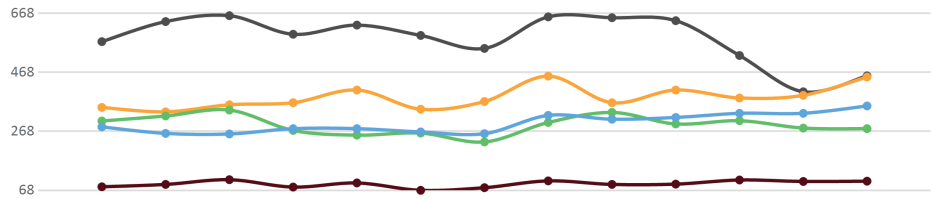


KERN HEALTH SYSTEMS

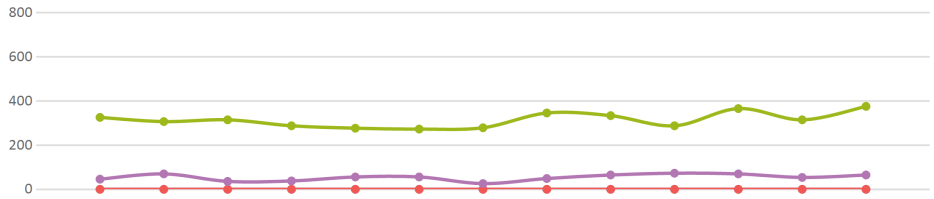
Attachment B

Governed Reporting System

Inpatient Admits by Hospital



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
BAKERSFIELD MEMORIAL	572	640	660	597	628	593	549	656	653	643	525	402	456
KERN MEDICAL	349	334	358	365	408	343	369	455	365	408	381	390	452
MERCY HOSPITAL	303	320	340	271	255	262	232	298	332	293	304	279	277
ADVENTIST HEALTH	283	261	259	277	277	266	260	322	309	315	329	329	354
GOOD SAMARITAN HOSPITAL	80	88	104	79	93	68	77	100	88	89	103	98	99



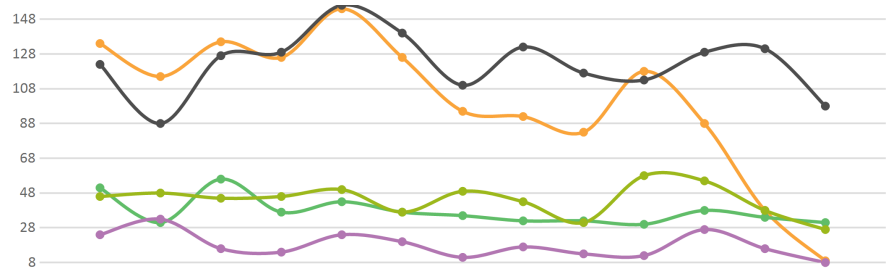
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
BAKERSFIELD HEART HOSP	68	82	65	41	54	54	57	44	63	46	37	44	35
DELANO REGIONAL HOSPITAL	46	70	36	38	56	56	26	49	65	73	70	54	65
OUT OF AREA	326	307	315	288	277	273	279	346	334	288	366	315	376

KERN HEALTH SYSTEMS

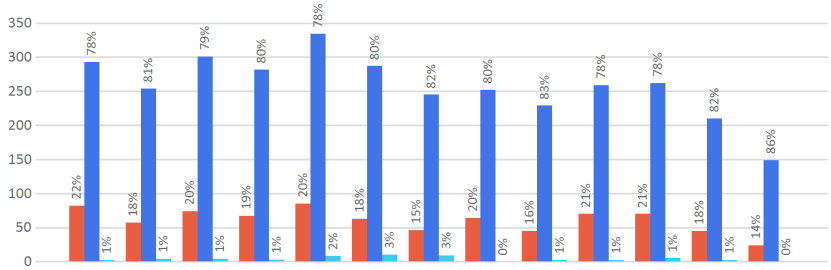
Attachment C

Governed Reporting System

Obstetrics Metrics



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
BAKERSFIELD MEMORIAL	122	88	127	129	156	140	110	132	117	113	129	131	98
KERN MEDICAL	134	115	135	126	154	126	95	92	83	118	88	38	9
MERCY HOSPITAL	51	31	56	37	43	37	35	32	32	30	38	34	31
OTHER	46	48	45	46	50	37	49	43	31	58	55	38	27
DELANO REGIONAL HOSPITAL	24	33	16	14	24	20	11	17	13	12	27	16	8



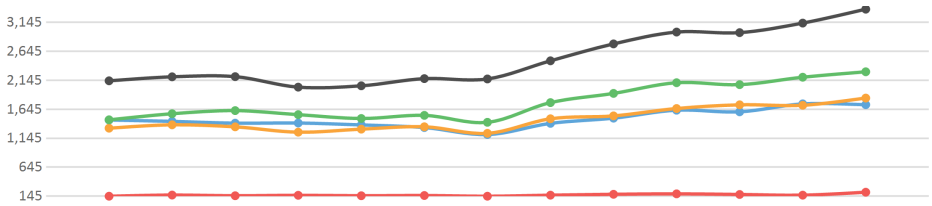
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
VAGINAL DELIVERY	293	254	301	282	334	287	245	252	229	259	262	210	149
C-SECTION DELIVERY	82	57	74	67	85	63	46	64	45	70	70	45	24
PREVIOUS C-SECTION DELIVERY	2	4	4	3	8	10	9	0	2	2	5	2	0

KERN HEALTH SYSTEMS

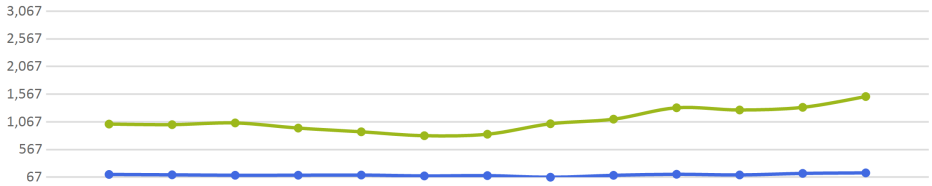
Attachment D

Governed Reporting System

Emergency Visits by Hospital



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
BAKERSFIELD MEMORIAL	2,136	2,205	2,208	2,027	2,050	2,174	2,168	2,481	2,773	2,977	2,967	3,132	3,372
MERCY HOSPITAL	1,463	1,568	1,622	1,552	1,486	1,540	1,420	1,760	1,919	2,103	2,070	2,198	2,292
ADVENTIST HEALTH	1,460	1,436	1,405	1,408	1,375	1,330	1,209	1,402	1,492	1,629	1,601	1,738	1,724
KERN MEDICAL	1,319	1,377	1,342	1,250	1,302	1,343	1,230	1,481	1,531	1,658	1,722	1,714	1,838
BAKERSFIELD HEART HOSP	145	165	153	161	153	157	145	163	178	186	175	163	214



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
OUT OF AREA	1,027	1,017	1,048	955	888	817	844	1,033	1,116	1,322	1,282	1,330	1,525
KERN VLY HLTHCRE HOSP	117	110	102	103	106	90	96	67	101	120	108	136	145

KERN HEALTH SYSTEMS *Governed Reporting System* **Attachment E**

MCAS MY2021 Performance Trending Metrics through September 2021

AMR	BCS	CBP	CCS	CDC HBA1C >9
58.05 %	48.04 %	6.94 %	47.21 %	70.89 %
MPL: 75.32% Under MPL by 17.27% AMR is not held to MPL Previous YTD: 54.68%	MPL: 63.77% Under MPL by 15.73% Previous YTD: 48.94%	MPL: 66.79% Under MPL by 59.85% Previous YTD: 3.60%	MPL: 67.99% Under MPL by 20.78% Previous YTD: 46.84%	MPL: 34.06% Under MPL by 36.83% Inverted Measure Previous YTD: 72.60%

CHL Adults and Peds	CHL Adults	CHL Peds	CIS	IMA
51.77 %	57.11 %	45.55 %	17.85 %	29.90 %
MPL: 66.15% Under MPL by 14.38% Previous YTD: 50.57%	MPL: 66.15% Under MPL by 9.04% Previous YTD: 56.02%	MPL: 66.15% Under MPL by 20.60% Previous YTD: 44.45%	MPL: 53.66% Under MPL by 35.81% Previous YTD: 15.98%	MPL: 50.61% Under MPL by 20.71% Previous YTD: 33.60%

PPC Post	PPC Pre	W30 0 - 15 Months	W30 15 - 30 Months	WCC BMI
58.19 %	43.85 %	30.70 %	51.42 %	26.46 %
MPL: 83.70% Under MPL by 25.51% Previous YTD: 61.98%	MPL: 92.21% Under MPL by 48.36% Previous YTD: 46.10%	MPL: 82.82% Under MPL by 52.12% Previous YTD: 29.92%	MPL: 68.33% Under MPL by 16.91% Previous YTD: 55.30%	MPL: 87.18% Under MPL by 60.72% Previous YTD: 22.37%

KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS MY2021 Performance Trending Metrics through September 2021

WCC NC	WCC PAC	WCV
18.22 %	17.58 %	28.45 %
MPL: 79.32% Under MPL by 61.10% Previous YTD: 10.20%	MPL: 82.48% Under MPL by 64.90% Previous YTD: 8.87%	MPL: 61.97% Under MPL by 33.52% Previous YTD: 24.21%

Measure rates are thru claims only - no supplemental data nor medical record reviews are included

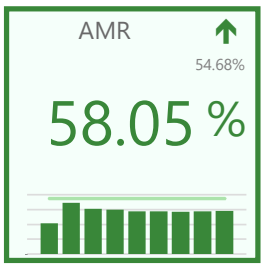
KERN HEALTH SYSTEMS

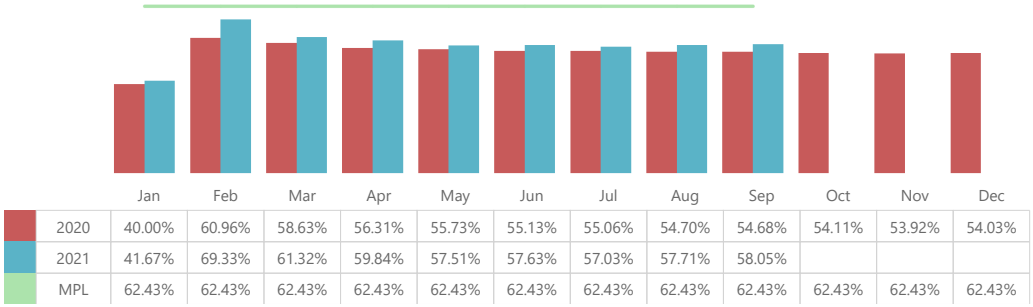
Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

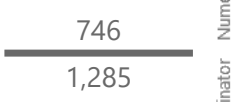
Asthma Medication Ratio

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
This measure is not held to MPL.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	40.00%	60.96%	58.63%	56.31%	55.73%	55.13%	55.06%	54.70%	54.68%	54.11%	53.92%	54.03%
2021	41.67%	69.33%	61.32%	59.84%	57.51%	57.63%	57.03%	57.71%	58.05%			
MPL	62.43%	62.43%	62.43%	62.43%	62.43%	62.43%	62.43%	62.43%	62.43%	62.43%	62.43%	62.43%



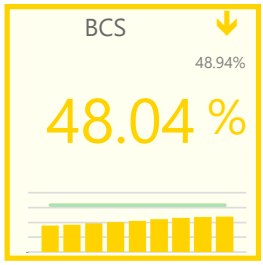
KERN HEALTH SYSTEMS

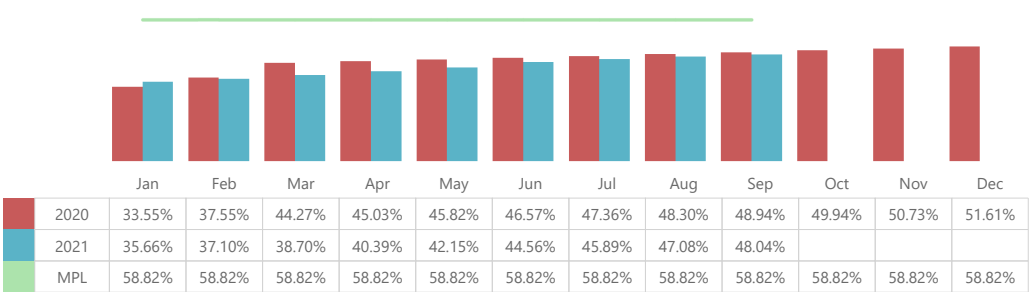
Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

Breast Cancer Screening

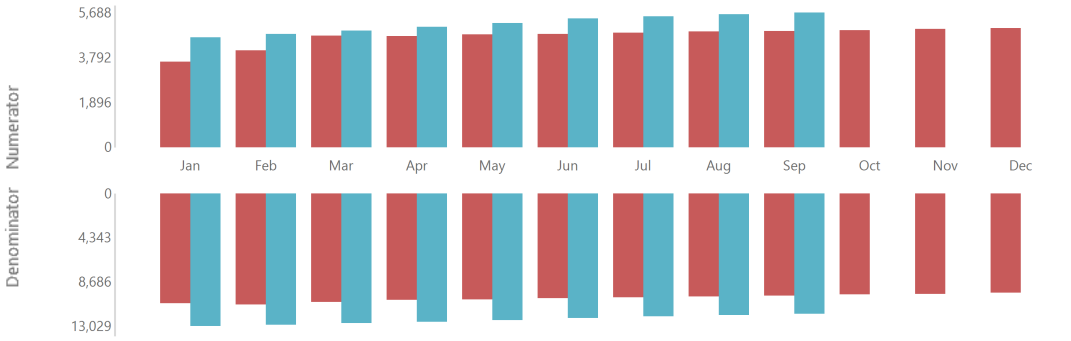
The percentage of women 50–74 years of age who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	33.55%	37.55%	44.27%	45.03%	45.82%	46.57%	47.36%	48.30%	48.94%	49.94%	50.73%	51.61%
2021	35.66%	37.10%	38.70%	40.39%	42.15%	44.56%	45.89%	47.08%	48.04%			
MPL	58.82%	58.82%	58.82%	58.82%	58.82%	58.82%	58.82%	58.82%	58.82%	58.82%	58.82%	58.82%

5,688
11,839



KERN HEALTH SYSTEMS

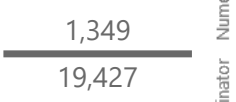
Governed Reporting System

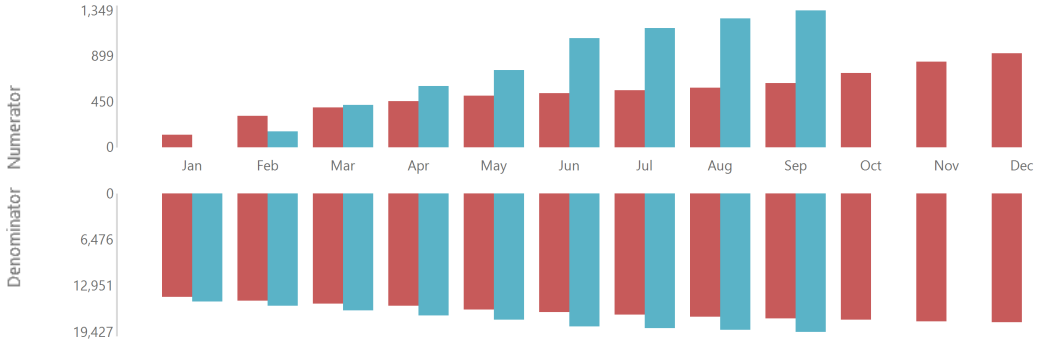
MCAS MY2021 Performance Trending Metrics through September 2021

Controlling High Blood Pressure

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	0.85%	2.06%	2.53%	2.87%	3.11%	3.21%	3.30%	3.40%	3.60%	4.15%	4.70%	5.13%
2021	0.00%	0.99%	2.56%	3.51%	4.31%	5.77%	6.22%	6.64%	6.94%			
MPL	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%



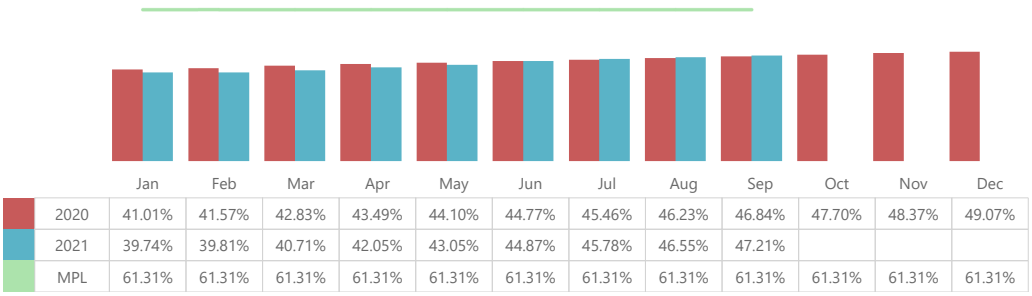


KERN HEALTH SYSTEMS *Governed Reporting System*

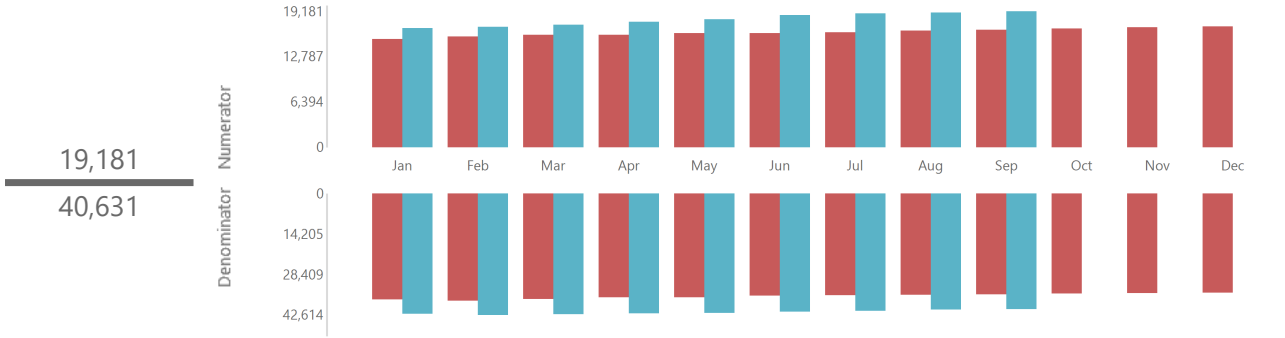
MCAS MY2021 Performance Trending Metrics through September 2021

Cervical Cancer Screening

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	41.01%	41.57%	42.83%	43.49%	44.10%	44.77%	45.46%	46.23%	46.84%	47.70%	48.37%	49.07%
2021	39.74%	39.81%	40.71%	42.05%	43.05%	44.87%	45.78%	46.55%	47.21%			
MPL	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%

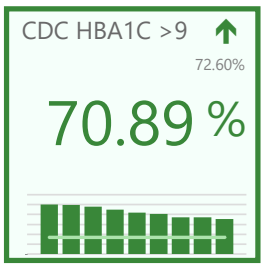


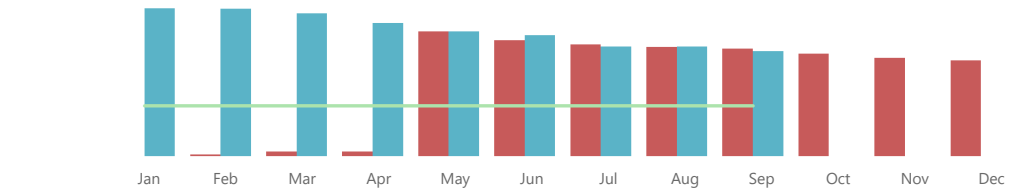
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS MY2021 Performance Trending Metrics through September 2021

Comprehensive Diabetes Care

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Inverted Measure - a lower rate is desired for this measure.





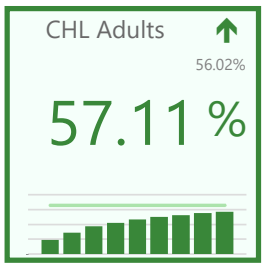
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	0.00%	0.99%	3.01%	3.03%	84.38%	78.25%	75.43%	73.89%	72.60%	69.21%	66.32%	64.77%
2021	100.00%	99.74%	96.42%	90.02%	84.24%	81.70%	73.96%	74.00%	70.89%			
MPL	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%

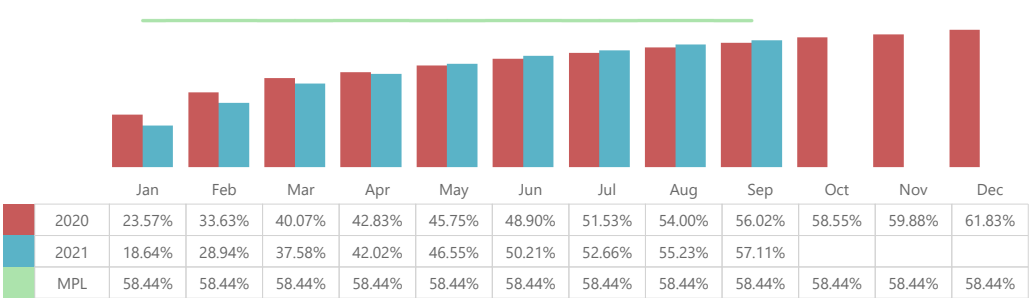
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS MY2021 Performance Trending Metrics through September 2021

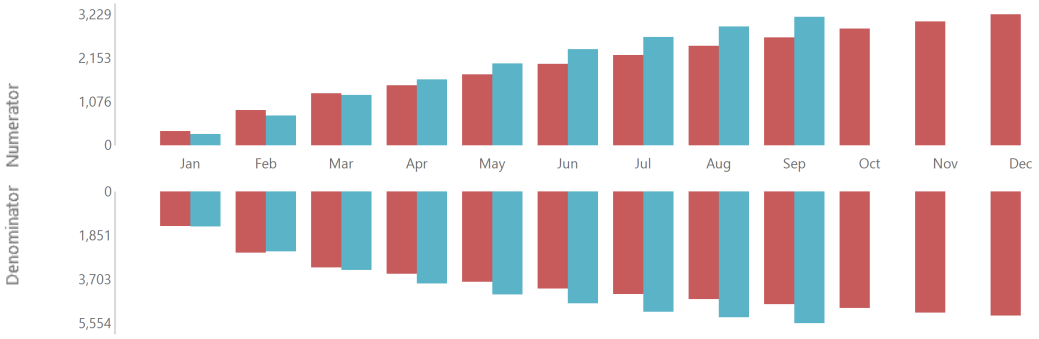
Chlamydia Screening in Women

The percentage of women 21–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	23.57%	33.63%	40.07%	42.83%	45.75%	48.90%	51.53%	54.00%	56.02%	58.55%	59.88%	61.83%
2021	18.64%	28.94%	37.58%	42.02%	46.55%	50.21%	52.66%	55.23%	57.11%			
MPL	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%



KERN HEALTH SYSTEMS

Governed Reporting System

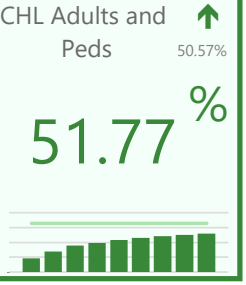
MCAS MY2021 Performance Trending Metrics through September 2021

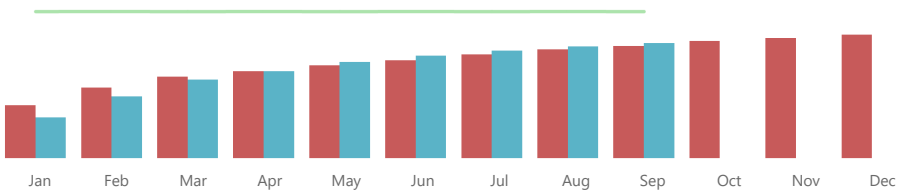
Chlamydia Screening in Women

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

CHL Adults and Peds ↑ 50.57%

51.77 %

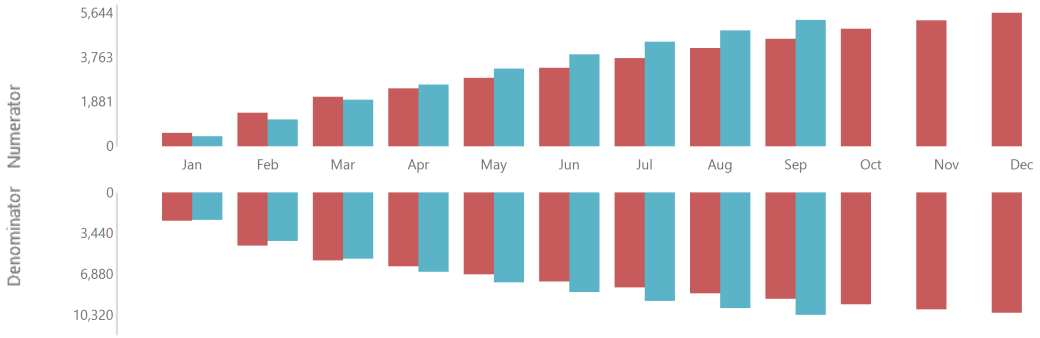




	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	23.85%	31.72%	36.70%	39.23%	41.73%	44.14%	46.70%	48.98%	50.57%	52.75%	54.07%	55.68%
2021	18.37%	27.83%	35.37%	39.07%	43.30%	46.23%	48.38%	50.36%	51.77%			
MPL	58.34%	58.34%	58.34%	58.34%	58.34%	58.34%	58.34%	58.34%	58.34%	58.34%	58.34%	58.34%

5,343

10,320



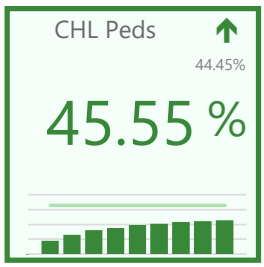
KERN HEALTH SYSTEMS

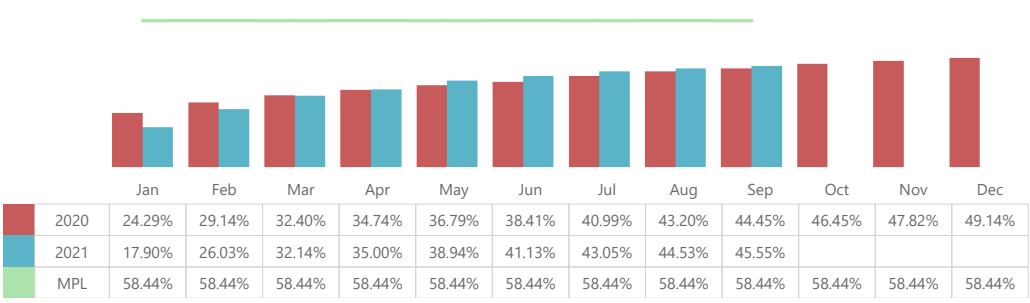
Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

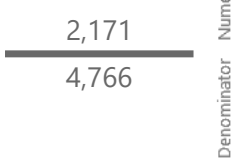
Chlamydia Screening in Women

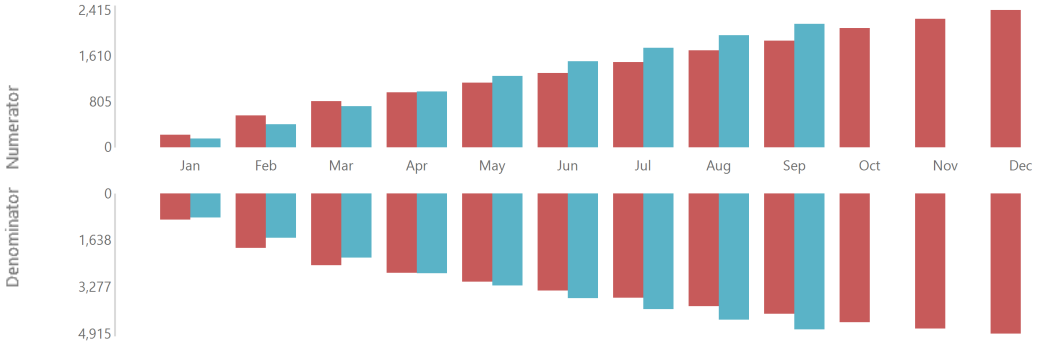
The percentage of women 16–20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	24.29%	29.14%	32.40%	34.74%	36.79%	38.41%	40.99%	43.20%	44.45%	46.45%	47.82%	49.14%
2021	17.90%	26.03%	32.14%	35.00%	38.94%	41.13%	43.05%	44.53%	45.55%			
MPL	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%	58.44%





KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS MY2021 Performance Trending Metrics through September 2021

Childhood Immunization Status

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

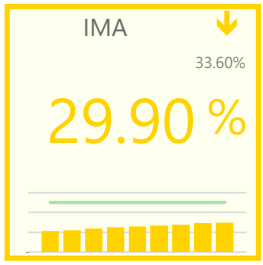
KERN HEALTH SYSTEMS

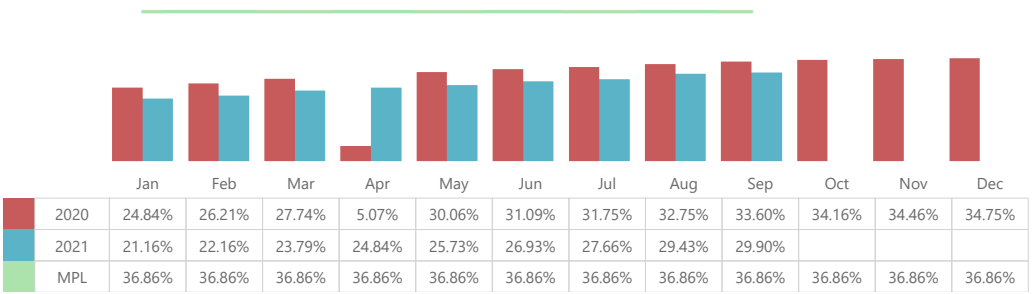
Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

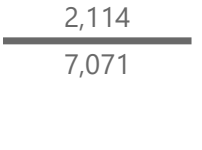
Immunizations for Adolescents

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	24.84%	26.21%	27.74%	5.07%	30.06%	31.09%	31.75%	32.75%	33.60%	34.16%	34.46%	34.75%
2021	21.16%	22.16%	23.79%	24.84%	25.73%	26.93%	27.66%	29.43%	29.90%			
MPL	36.86%	36.86%	36.86%	36.86%	36.86%	36.86%	36.86%	36.86%	36.86%	36.86%	36.86%	36.86%



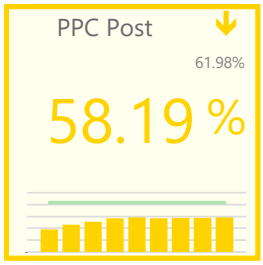
KERN HEALTH SYSTEMS

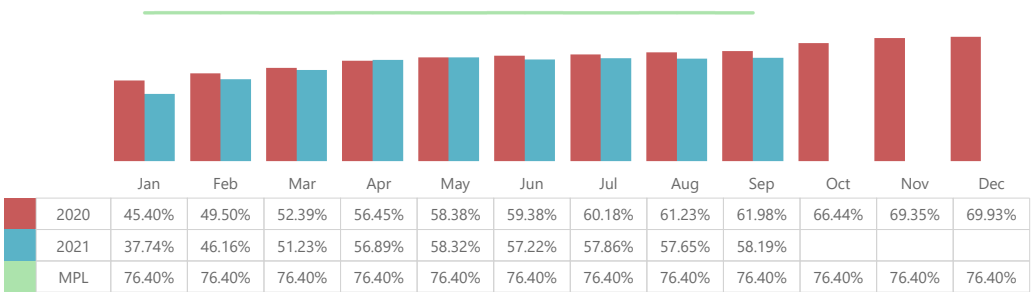
Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

Postpartum Care

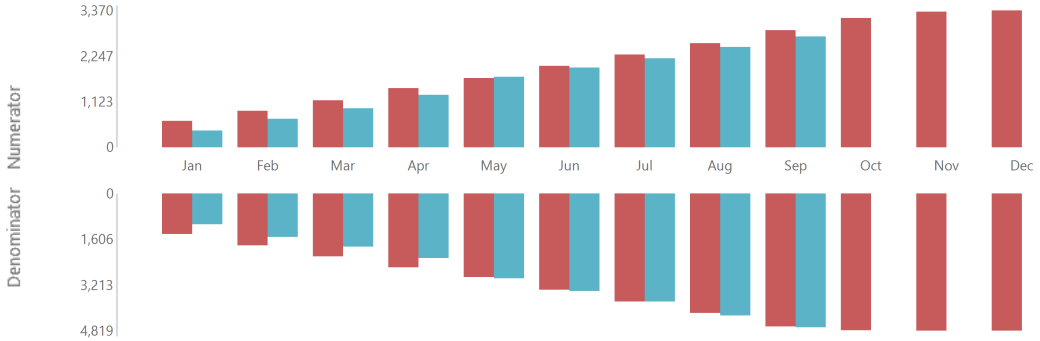
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	45.40%	49.50%	52.39%	56.45%	58.38%	59.38%	60.18%	61.23%	61.98%	66.44%	69.35%	69.93%
2021	37.74%	46.16%	51.23%	56.89%	58.32%	57.22%	57.86%	57.65%	58.19%			
MPL	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%

2,734
4,698

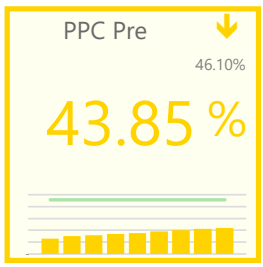


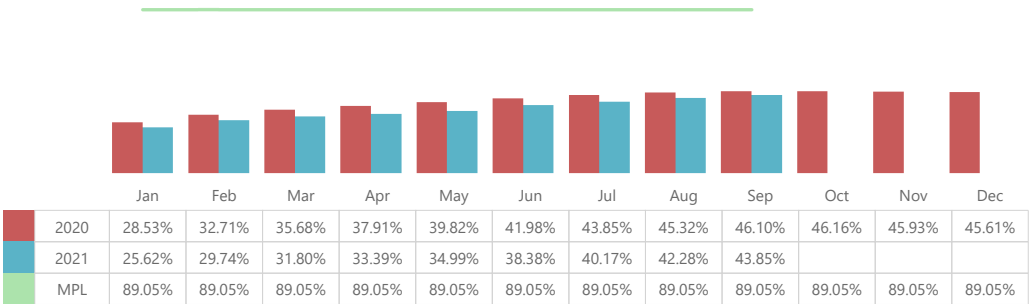
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS MY2021 Performance Trending Metrics through September 2021

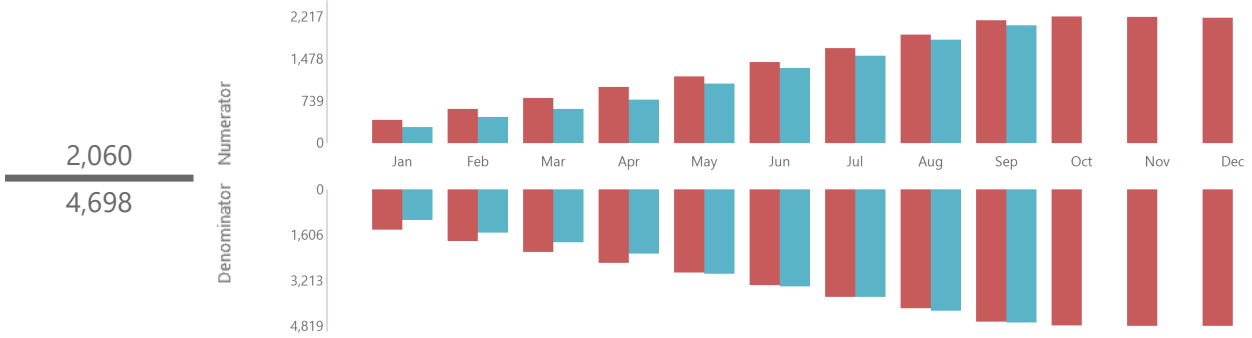
Prenatal Care

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.
Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	28.53%	32.71%	35.68%	37.91%	39.82%	41.98%	43.85%	45.32%	46.10%	46.16%	45.93%	45.61%
2021	25.62%	29.74%	31.80%	33.39%	34.99%	38.38%	40.17%	42.28%	43.85%			
MPL	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%



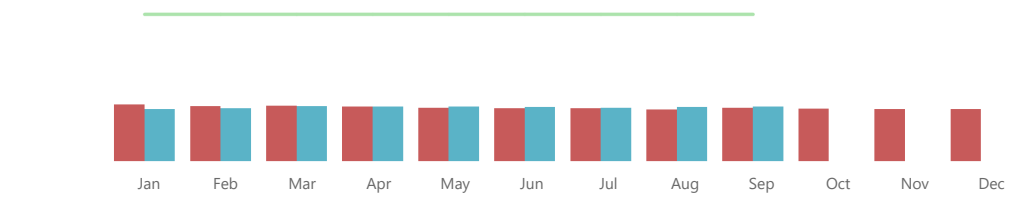
KERN HEALTH SYSTEMS

Governed Reporting System

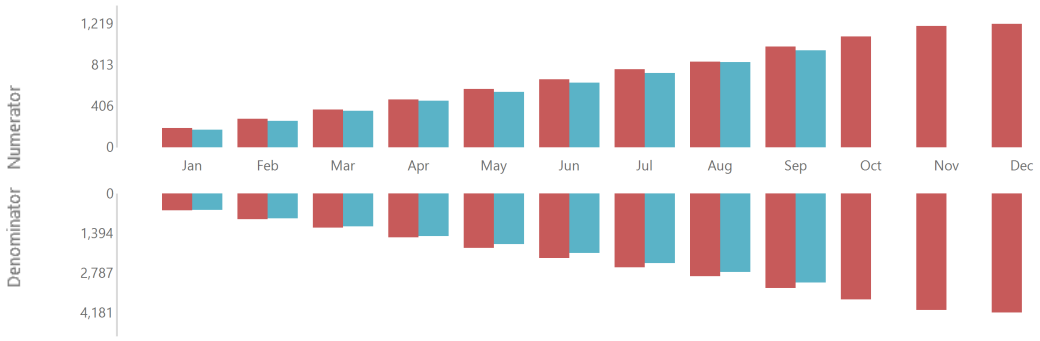
MCAS MY2021 Performance Trending Metrics through September 2021

Well-Child Visits in the First 30 Months of Life

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months.
Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	31.91%	30.98%	31.27%	30.63%	29.98%	29.65%	29.69%	29.14%	29.92%	29.40%	29.36%	29.16%
2021	29.33%	29.77%	31.03%	30.74%	30.75%	30.35%	29.98%	30.51%	30.70%			
MPL	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%



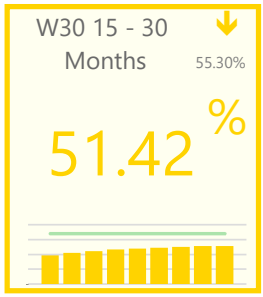
KERN HEALTH SYSTEMS

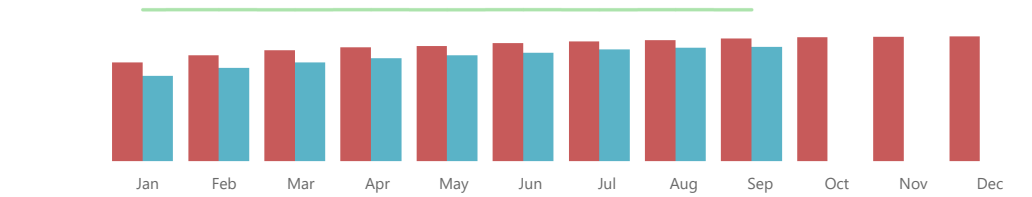
Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

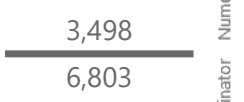
Well-Child Visits in the First 30 Months of Life

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months.
Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	44.45%	47.67%	50.03%	51.28%	51.92%	53.12%	53.96%	54.57%	55.30%	55.78%	56.02%	56.20%
2021	38.39%	41.98%	44.41%	46.39%	47.65%	48.91%	50.24%	51.09%	51.42%			
MPL	74.70%	74.70%	74.70%	74.70%	74.70%	74.70%	74.70%	74.70%	74.70%	74.70%	74.70%	74.70%



KERN HEALTH SYSTEMS

Governed Reporting System

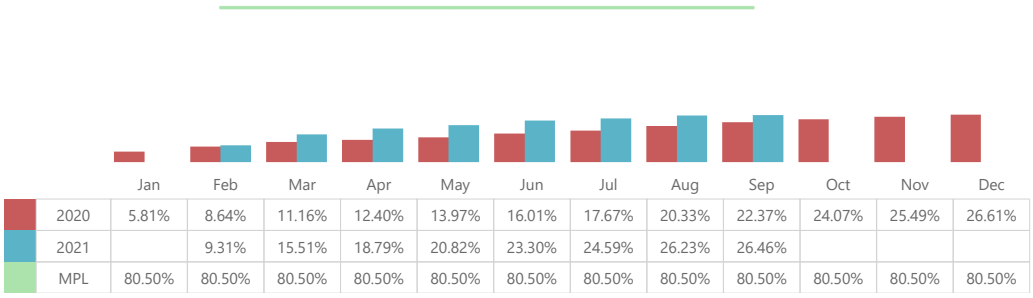
MCAS MY2021 Performance Trending Metrics through September 2021

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The percentage of members 3-17 years of age who had BMI Percentile documented during the measurement year.

WCC BMI ↑ 22.37%

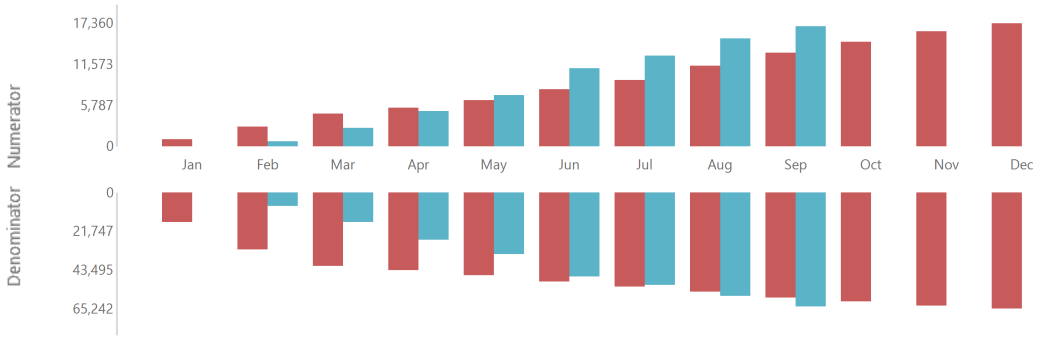
26.46 %



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	5.81%	8.64%	11.16%	12.40%	13.97%	16.01%	17.67%	20.33%	22.37%	24.07%	25.49%	26.61%
2021		9.31%	15.51%	18.79%	20.82%	23.30%	24.59%	26.23%	26.46%			
MPL	80.50%	80.50%	80.50%	80.50%	80.50%	80.50%	80.50%	80.50%	80.50%	80.50%	80.50%	80.50%

16,940

64,022



KERN HEALTH SYSTEMS

Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

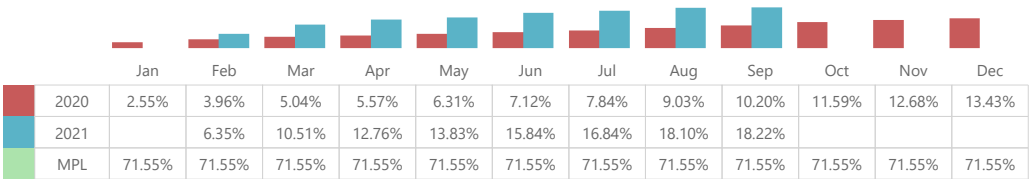
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The percentage of members 3–17 years of age who had Counseling for nutrition documented during the measurement year.

WCC NC

10.20%

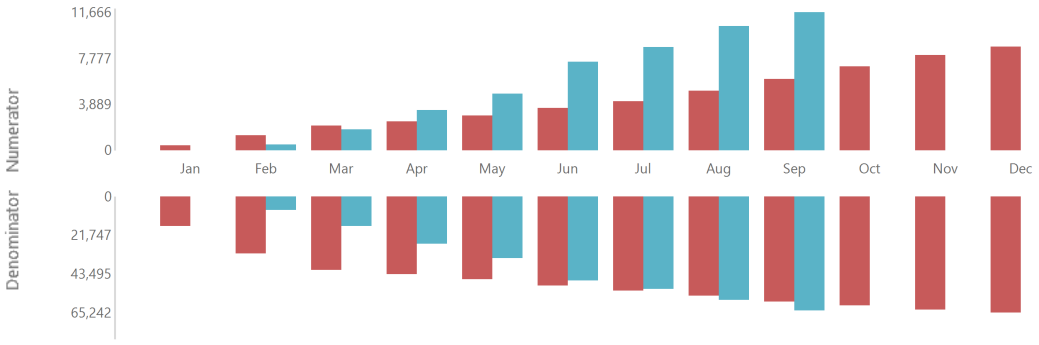
18.22 %



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	2.55%	3.96%	5.04%	5.57%	6.31%	7.12%	7.84%	9.03%	10.20%	11.59%	12.68%	13.43%
2021		6.35%	10.51%	12.76%	13.83%	15.84%	16.84%	18.10%	18.22%			
MPL	71.55%	71.55%	71.55%	71.55%	71.55%	71.55%	71.55%	71.55%	71.55%	71.55%	71.55%	71.55%

11,666

64,022



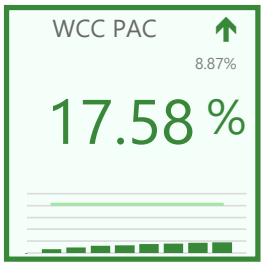
KERN HEALTH SYSTEMS

Governed Reporting System

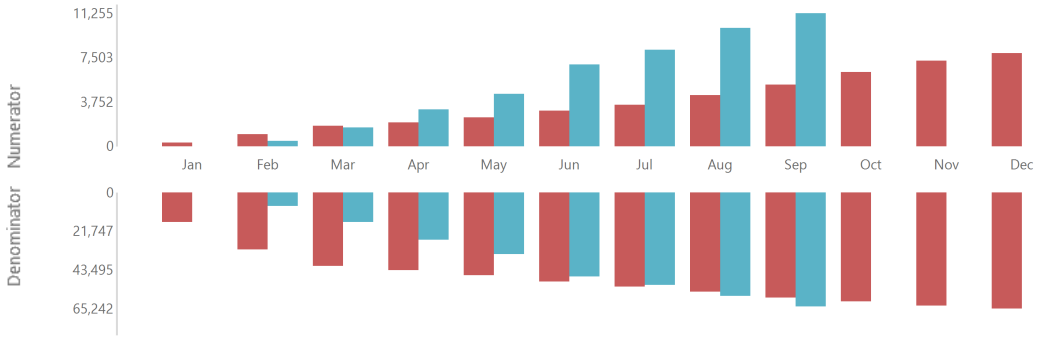
MCAS MY2021 Performance Trending Metrics through September 2021

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The percentage of members 3–17 years of age who had Counseling for physical activity documented during the measurement year.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	1.91%	3.16%	4.15%	4.60%	5.27%	6.04%	6.64%	7.72%	8.87%	10.24%	11.38%	12.06%
2021		5.84%	9.39%	11.77%	12.83%	14.68%	15.74%	17.28%	17.58%			
MPL	66.79%	66.79%	66.79%	66.79%	66.79%	66.79%	66.79%	66.79%	66.79%	66.79%	66.79%	66.79%



11,255

64,022

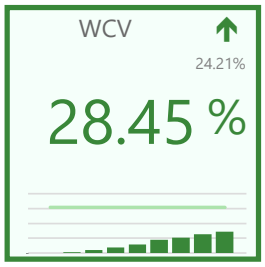
KERN HEALTH SYSTEMS

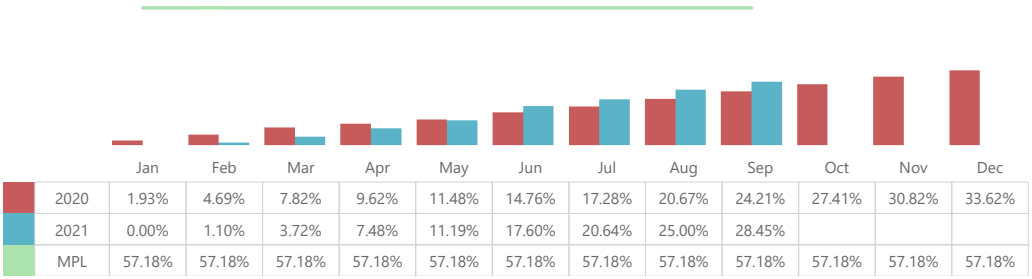
Governed Reporting System

MCAS MY2021 Performance Trending Metrics through September 2021

Child and Adolescent Well-Care Visits

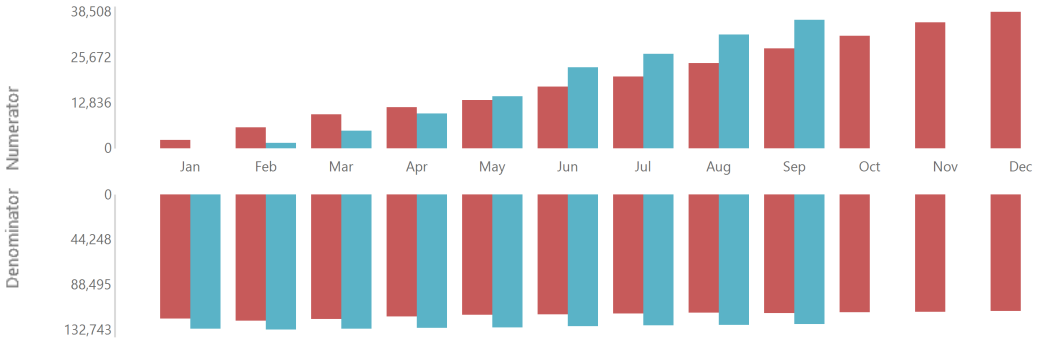
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	1.93%	4.69%	7.82%	9.62%	11.48%	14.76%	17.28%	20.67%	24.21%	27.41%	30.82%	33.62%
2021	0.00%	1.10%	3.72%	7.48%	11.19%	17.60%	20.64%	25.00%	28.45%			
MPL	57.18%	57.18%	57.18%	57.18%	57.18%	57.18%	57.18%	57.18%	57.18%	57.18%	57.18%	57.18%

36,178
127,179



KERN HEALTH SYSTEMS
CHIEF EXECUTIVE OFFICER'S REPORT
October 14th, 2021
BOARD OF DIRECTORS MEETING

COMPLIANCE AND REGULATORY ACTIVITIES

Compliance and Regulatory Affairs Report

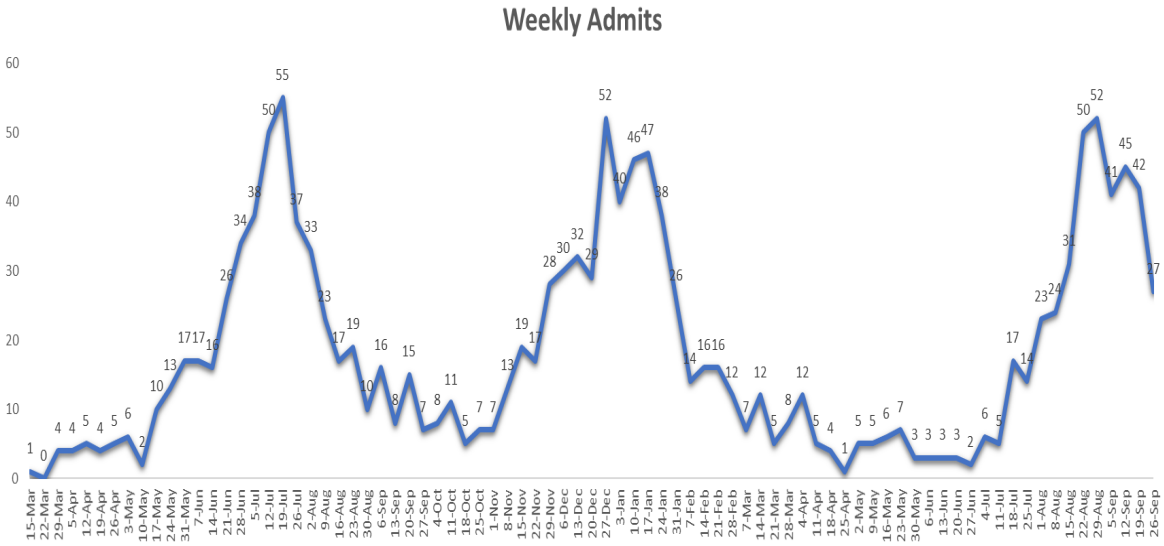
The October Compliance and Regulatory Affair's Report showing August and September activities is included under Attachment A to this report.

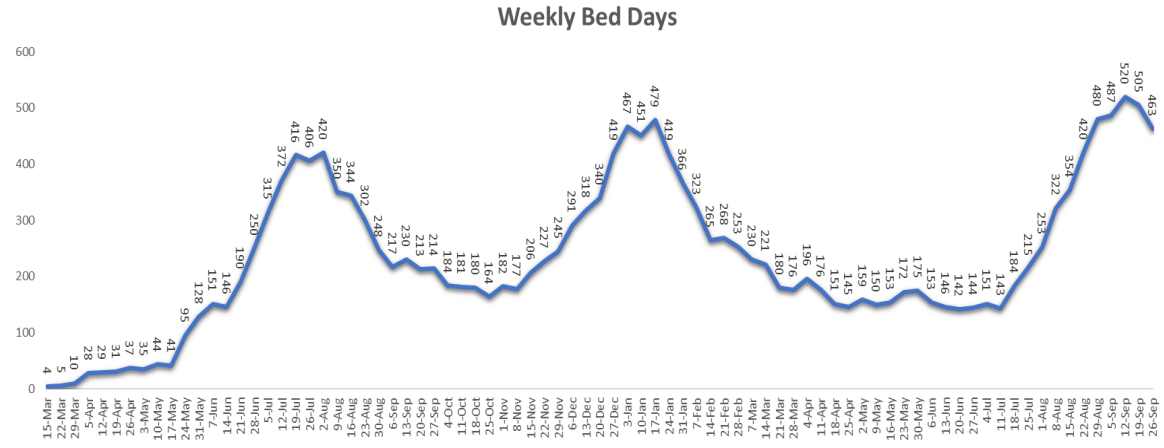
COVID-19 UPDATE

COVID-19 is now referred to as the pandemic of the unvaccinated with a disproportionate amount of hospital admissions and serious cases coming from the unvaccinated segment of the population. An analysis of federal data showed COVID-19 hospitalizations among unvaccinated adults cost the US health care system around $2.3 billion in June and July. The study, conducted by the Peterson Center on Healthcare and the Kaiser Family Foundation, estimated that there were roughly 113,000 preventable COVID-19 hospitalizations during the two-month period, and the average cost of hospitalization was $20,000 per patient.

Hospital Admissions and Bed Day Trends Showing Slight Deceleration in Cases

KHS's upward trajectory has slightly declined over the past month but still at numbers consistent with two previous surges occurring in the summer of 2020 and winter of 2021. The latest surge is attributed to the highly contagious Delta variant and low vaccine rate in Kern County. The grafts on the following page show weekly totals for admissions and hospital beds days for KFHC enrollees since the pandemic's inception.


Weekly Admits


Weekly Bed Days

Vaccine Distribution and Monitoring

Kern County has administered more than 812,152 doses of the COVID-19 vaccine, as of October 7th, according to data from DataBases.com. 44% of the eligible population living in Kern County are fully vaccinated as of that date. Vaccination rates for our eligible members continue to be below the County average with 32% fully vaccinated.

September 1st, KHS began a new COVID -19 Vaccination Incentive Program focused on identifying unvaccinated beneficiaries, educating them as to the vaccine's importance, increasing access to COVID-19 vaccination sites and providing incentives to encourage becoming vaccinated (see Agenda Item 7). Included under Attachment B and C are informational pieces to aid with educating the public on the importance of immunizations and addressing vaccine hesitation.

PROGRAM DEVELOPMENT ACTIVITIES (UPDATES)

Rx Carve-Out

In late July DHCS announced the Medi-Cal Rx transition would resume with an effective date of 1/1/22. The transition had previously been delayed since February due to a potential conflict of interest involving the vendor in charge of administering this benefit (Magellan). DHCS has re-engaged all stakeholders in preparation for this transition. DHCS will take the necessary steps to ensure beneficiaries are able to receive their prescriptions, and that pharmacies will have available needed information regarding claims and prior authorizations. DHCS will also ensure that Medi-Cal managed care plans will receive the necessary data to ensure appropriate utilization and continuity of care for beneficiaries enrolled in managed care. The internal KHS project team has resumed work in preparation for this transition. Much of the transition work had been completed prior to the delay and any remaining work will be completed as needed.

CalAIM

Since the release of updated CalAIM materials in January, KHS has engaged in many conversations with DHCS, our trade associations, and other stakeholders. There is also an internal workgroup continuously reviewing the initiatives and developing implementation strategies. In July the final State Budget was passed and included full funding for CalAIM. Several of the initiatives that are scheduled to begin 1/1/22 are being worked on internally.

This includes the transition of the Health Homes Program to Enhanced Care Management (ECM), implementation of community supports (formerly ILOS), coverage of Major Organ Transplants, and enrolling new populations into Medi-Cal Managed Care.

Youth Behavioral Health Initiative

The State Budget for 2021-2022 included five years of funding for several initiatives aimed at improving behavioral health services for students. This includes $400 million statewide over three years in incentives funding to build infrastructure, partnerships, and capacity for school behavioral health services. With the program set to begin January 1, 2022 DHCS has engaged stakeholders in monthly planning conversations since August. At this time DHCS is still defining many aspects of this program. KHS leadership is strategizing the approach to engaging local schools and County Behavioral Health in these opportunities. Some preliminary conversations have taken place, but more information will be needed from DHCS to proceed with local planning efforts. A few other programs related to youth behavioral health would be implemented in future years. KHS staff will remain engaged with DHCS and other stakeholders as these programs proceed.

LEGISLATIVE SUMMARY UPDATE

State Legislative Session

The legislature reconvened from summer recess in mid-August and finalized this year's session on September 10th. Staff worked with internal and external stakeholders throughout the entirety of the legislative session to assess impacts to KHS' constituents and to advocate as needed. The number of bills of interest to KHS that ultimately passed was whittled down significantly. Those bills which made it through the legislature are now being reviewed by the Governor with a deadline to sign or veto by October 10th. Given the timing of this veto period, Management will wait until December's meeting to review the final list of passed bills with the Board of Directors.

The Legislative Summary of current Bills being followed by KHS is located under Attachment D.

KHS OCTOBER 2021 ENROLLMENT:

Medi-Cal Enrollment

As of October 1, 2021, Medi-Cal enrollment is 202,933 which represents an increase of 0.5% from September enrollment.

Seniors and Persons with Disabilities (SPDs)

As of October 1, 2021, SPD enrollment is 15,408, which represents an increase of 0.08% from September enrollment.

Expanded Eligible Enrollment

As of October 1, 2021, Expansion enrollment is 78,240, which represents an increase of 1.1% from September enrollment.

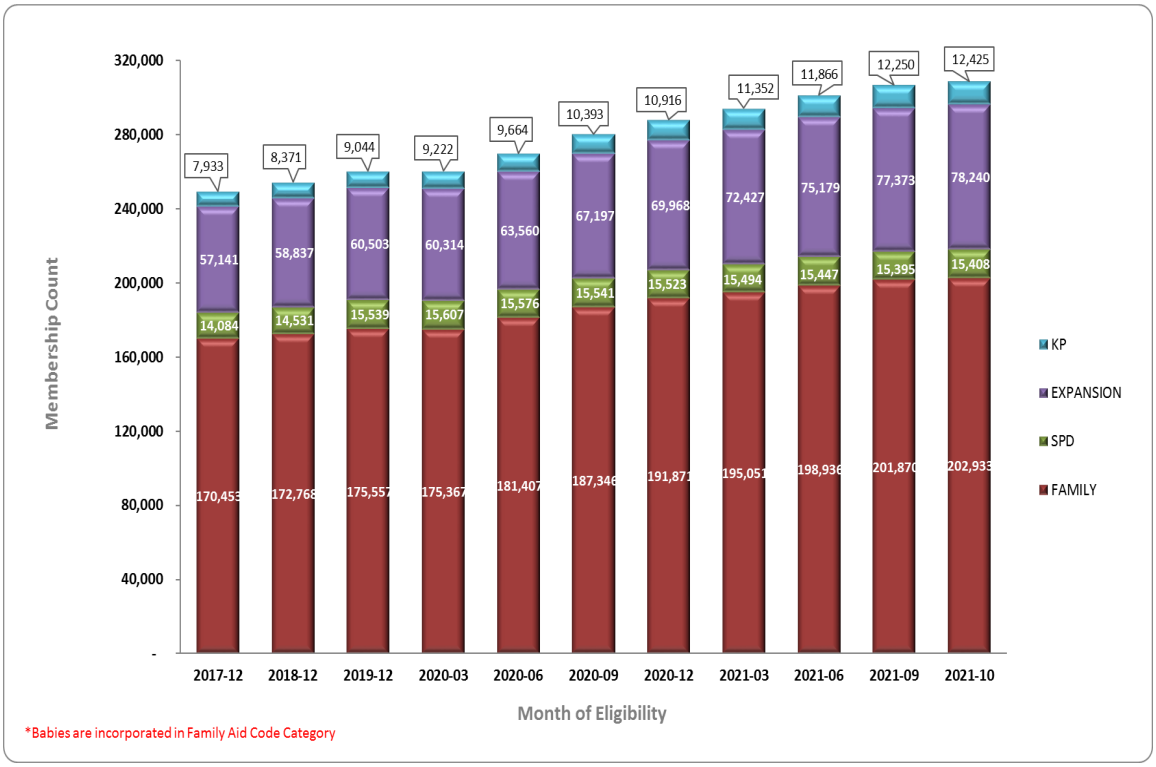
Kaiser Permanente (KP)

As of October 1, 2021, Kaiser enrollment is 12,425 which represents an increase of 1.4% from September enrollment.

Total KHS Medi-Cal Managed Care Enrollment

As of October 1, 2021, total Medi-Cal enrollment is 309,006 which represents an increase of 0.7% from September 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
2020-03	174,938	15,607	60,314	9,222	429	260,510
2020-06	180,985	15,576	63,560	9,664	422	270,207
2020-09	186,878	15,541	67,197	10,393	468	280,477
2020-12	191,465	15,523	69,968	10,916	406	288,278
2021-03	194,666	15,494	72,427	11,352	385	294,324
2021-06	198,541	15,447	75,179	11,866	395	301,428
2021-09	201,382	15,395	77,373	12,250	488	306,888
2021-10	202,491	15,408	78,240	12,425	442	309,006



Enrollment Note

The U.S. Department of Health & Human Services continued its public health emergency order resulting in the Department of Health Care Services extending the freeze on redeterminations. Thus, the Kern County Department of Human Services' suspension of their "automated discontinuance process" for Medi-Cal Redeterminations continues. Halting the process means members are not required to demonstrate they remain eligible for Medi-Cal which ordinarily they would have to prove or be eliminated from receiving benefits. In the meantime, Kern DHS continues working new Medi-Cal applications, reenrollments, successful renewals, additions, etc. The impact from members remaining eligible and new members being added inflates KHS's enrollment because deletions are not occurring as it would normally occur had the automated discontinuance process remained in place.

KHS MARKETING AND PUBLIC RELATIONS

KHS Sponsorships

KHS will share sponsorship in the following upcoming activities:

- KHS donated $2,500 to Links for Life to sponsor their Lace'n It Up 5K Run & Celebration Walk on October 2nd.
- KHS donated $500 to Centro de Unidad Popular Benito Juarez to sponsor their Quelaquetza folkloric celebration in Lamont on October 10th
- KHS donated $1,500 to Bakersfield Ronald McDonald House to sponsor A Galactic Gala Under the Galaxy on October 14th.
- KHS donated $1,500 to Bakersfield ARC & Boy Scouts of America to sponsor their Annual Golf Tournament on October 18th.
- KHS donated $2,500 to Links for Life to sponsor their Hot Pink Celebration on October 22nd.
- KHS donated $1,000 to CASA of Kern County to sponsor their 2021 CASA Superhero Run on October 30th.
- KHS donated $1,000 to Kern County Cancer Foundation to sponsor their Campout Against Cancer on November 6th and 7th.

Member Newsletter

Click on the link below to access the Fall 2021 KFHC Member Newsletter.
Kern Family Health Care | Family Health | Fall 2021 (flippublication.com)

Employee Newsletters

KHS Employee Newsletters can be seen by clicking the links below:

August: Keeping Up with KHS 28th Edition - August 2021 (campaign-archive.com)
September: Keeping Up with KHS 29th Edition - September 2021 (campaign-archive.com)

KERN HEALTH SYSTEMS

Compliance and Regulatory Affairs Update

Board of Directors Meeting

Jane MacAdam
Acting Director of Compliance and Regulatory Affairs
October 14, 2021

Attachment A

STATE REGULATORY AFFAIRS

All Plan Letters and Regulatory Guidance released since the August 12, 2021 Kern Health Systems Board of Directors' meeting:

Department of Health Care Services (DHCS) released four All Plan Letters that were relevant to the Plan during this time period.

- APL21-009 Collecting Social Determinants of Health Data
  The purpose of this APL is to provide guidance to Medi-Cal managed care health plans on using the Department of Health Care Services Priority Social Determinants of Health Codes to collect reliable data.
- APL21-010 Medi-Cal COVID-19 Vaccination Incentive Program
  The purpose of this APL is to provide guidance to Medi-Cal managed care health plans regarding the Medi-Cal COVID-19 Vaccination Incentive Program.
- APL21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates
  The purpose of this APL is to provide Medi-Cal managed care health plans with clarification and guidance regarding the application of federal and state legal requirements for processing grievances and appeals
- APL21-012 Enhanced Care Management Requirements
  The purpose of this APL is to provide guidance to all Medi-Cal managed care health plans regarding the provision of the Enhanced Care Management (ECM) benefit.

All Plan Letters and Regulatory Guidance released since the August 12, 2021 Kern Health Systems Board of Directors' meeting by the Department of Health Care Services

APL 21-021 - Transfer of Hospitalized Enrollees per Regulation Section 1300.67.02

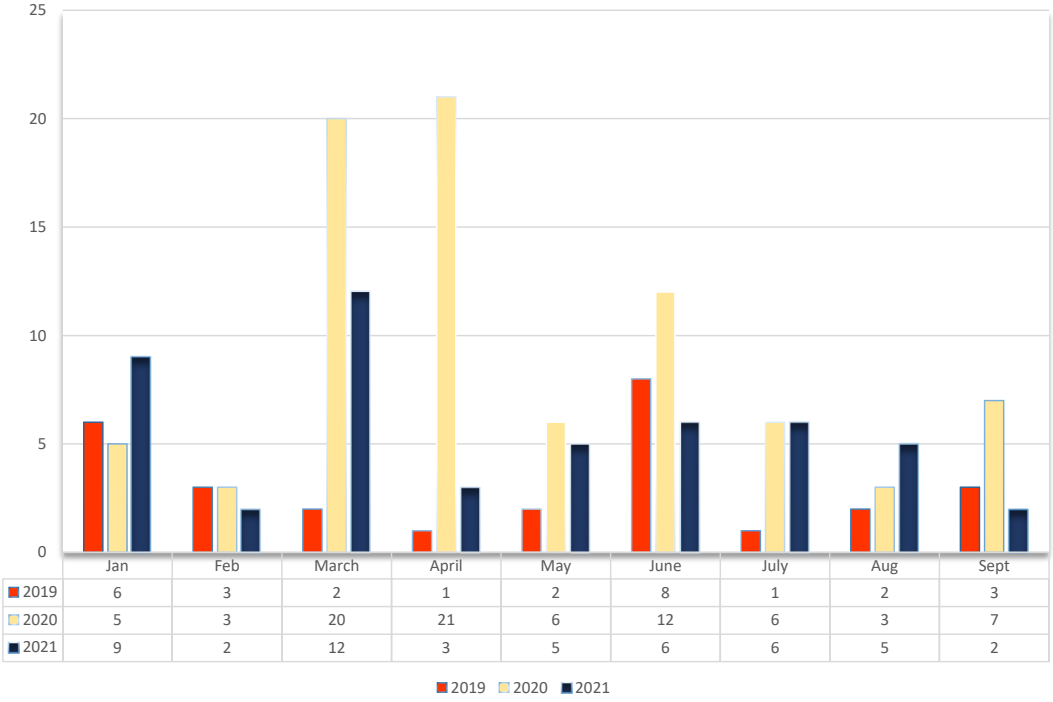
- This APL reminds health plans of their obligations to comply with California Code of Regulations, title 28, section 1300.67.02. That section directs plans to remove certain barriers to enrollee transfers between hospitals when such transfers are made pursuant to a public health order. Section 1300.67.02 also specifies how plans must reimburse for the transfer and continued hospitalization of enrollees transferred pursuant to a public health order.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

Regulatory All Plan Letters and Guidance Received for 2021

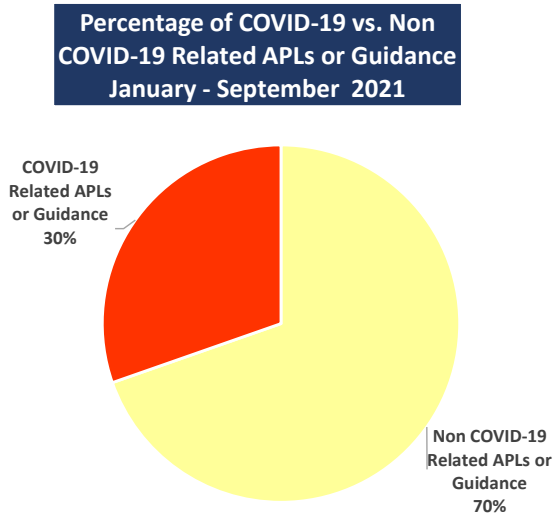
Number of Regulatory All Plan Letters and Guidance Letters Received by the Plan

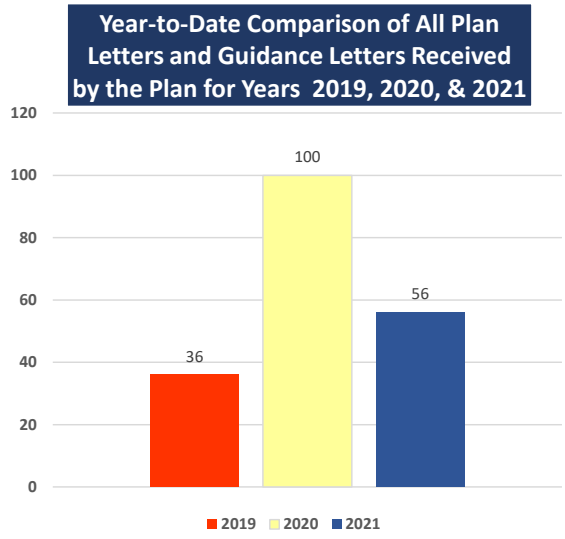


	Jan	Feb	March	April	May	June	July	Aug	Sept
2019	6	3	2	1	2	8	1	2	3
2020	5	3	20	21	6	12	6	3	7
2021	9	2	12	3	5	6	6	5	2

Continued...

Regulatory All Plan Letters and Guidance
COVID-19 Impact 2021





KERN HEALTH SYSTEMS

Number of Regulatory Reports Sent to Government Agencies for August and September 2021

Regulatory Agency	August 2021	September 2021
DHCS	11	17
DMHC	4	2

2021 KHS Delegated Entity Audit of Kaiser Permanente

The preliminary report is currently being reviewed by Plan Stakeholders and the Executive Summary preparation is in process by the Compliance Department.

KERN HEALTH SYSTEMS

2020 Non-Routine Survey by the DMHC

October 7, 2021 Update

The Plan is awaiting the preliminary report of the non-routine survey by the DMHC.

2021 Routine Regulatory Audits

- **DMHC Follow-Up Review Survey - August 10, 2021 – August 12, 2021**
  - As required by Health and Safety Code section 1380(i)(2), the Department of Managed Health Care conducted a Follow-Up Review Survey of the outstanding deficiencies identified in the July 10, 2020, Final Report of the Routine Survey of Kern Health Systems. The Plan is waiting for the DMHC to provide a preliminary report.
- **DHCS Medical Audit – September 13, 2021**
  - DHCS conducted a medical audit of Kern Health Systems beginning September 13, 2021 through September 24, 2021. The survey period was August 1, 2019 through July 31, 2021. The Plan is waiting for the DHCS to provide a preliminary report.

KERN HEALTH SYSTEMS

Compliance Department: Fraud, Waste, & Abuse Activity for August and September 2021

KERN HEALTH SYSTEMS

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 and the US Department of Justice Requests for Information August and September 2021

Providers

The Plan received three requests for information from the State Medi-Cal Program Integrity Unit - related to potential provider fraud, waste, or abuse. Additionally, during the same time period, the Plan received an information request from the Kern County District Attorney regarding a request for Provider claims information.

Members

During August and September 2021, the Plan received a request for information from the State Medi-Cal Program Integrity Unit, which involved fourteen Plan Members.

The Plan is not provided with an outcome in relation to the information requests by the two regulatory agencies.

Continued…

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.

Summary of Alleged Fraud, Waste, & Abuse Allegations Reported to the Plan during August and September 2021

Members

During August and September 2021, the Compliance Department did not receive any allegations of fraud, waste, or abuse involving Plan Members.

Providers

During August and September 2021, the Compliance Department received one allegation of Provider fraud from the public. The Plan reported the incident to the Department of Health Care Services.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

Compliance Department: HIPAA Breach Activity for August and September 2021

Summary of Potential Protected Health Information ("PHI") Disclosures for August and September 2021

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 August and September 2021, the Compliance Department investigated and reported on four allegation of privacy concerns. Three of the four were closed as non-breaches and one of the incidents is still under review.

RECOMMENDATIONS DURING COVID-19

Attachment B

IMPROVING CHILD IMMUNIZATIONS (PART 1)

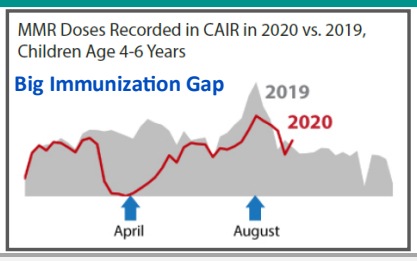
Routine vaccination is an essential preventive care service for children, adolescents, and adults (including pregnant women) that should not be delayed because of the COVID-19 pandemic.

Centers for Disease Control and Prevention (CDC)

A REMINDER OF RESOURCES TO INCREASE ADULT IMMUNIZATION

Immunization rates in California have dropped precipitously during the COVID-19 pandemic, raising alarm bells for the health and safety of our children, patients and family.

California Immunization Coalition



Health Plans and Providers: Engaging Parents	▸ Watch case testimonials by parents on how vaccination can impact lives (e.g., Rory's story, Hailey's story; the story of three families, etc.); use information snippets as voice mail message script. ▸ Watch featured videos by CDC on effective strategies for recommending childhood immunizations to parents of young children. Use resources that can be shared with parents. ▸ Use communication tips in addressing vaccination questions from parents that come in printable handouts including scripts on structuring effective communication strategies around vaccines.
Providers: Mobilizing Vaccination Efforts	▸ Ensure health workers in other areas (e.g., prenatal, post-natal, primary care) check vaccination status at any clinical service and vaccinate or refer to immunization clinic. ▸ Allow catch-up immunization visits and implement the WHO guidance that outlines considerations for prioritizing strategies for restarting immunization and vaccine catch-up strategies. ▸ Use CAIR status reports at each essential childhood clinic visit. Use reminder/recall systems to bring back patients that may have deferred routine visits during COVID-19.
Health Plans and Providers: Messaging for Targeted Member Groups	▸ Use the San Diego Pediatric Provider Toolkit and the California #DontWaitVaccinate Campaign (Toolkit) for various messaging approaches to parents, adolescents, adults and pregnant women. ▸ Adapt sample media/twitter posts on social media platforms regarding the benefits of vaccination for children and adolescents. ▸ Mail the childhood immunization schedule to members who are in their third trimester of pregnancy.

RECOMMENDATIONS DURING COVID-19

IMPROVING ADULT IMMUNIZATIONS (PART 2)

Routine vaccination is an essential preventive care service for children, adolescents, and adults (including pregnant women) that should not be delayed because of the COVID-19 pandemic.

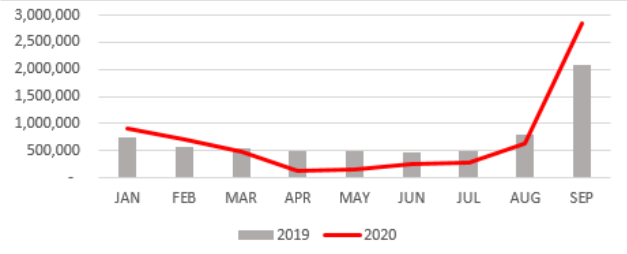
Centers for Disease Control and Prevention (CDC)

A REMINDER OF RESOURCES TO INCREASE ADULT IMMUNIZATION

A moderately severe influenza season in the presence of circulating SARS-CoV-2 would significantly amplify cases of acute respiratory illness. Less than half of US adults received influenza vaccine in 2018-2019.

Vaccine Doses, Patients 19 years and older, Submitted to the California Immunization Registry January-September 2019 & January-September 2020

California Department of Public Health



Providers: Addressing Flu Vaccine Hesitancy	▸ See #HowIRecommend videos for strategies to make effective recommendation and address immunization questions including flu vaccine hesitancy. Infographics in multiple languages. ▸ Refer to CDC study, published August 25, 2020, linking sudden heart complications called "acute cardiac events", common in adults hospitalized with flu (infographic). ▸ Watch case testimonials on the importance of immunizations (e.g., Influenza, pneumococcal, etc.). ▸ Be a role model and take the vaccine (infographic). Use top flu strategies gathered from providers.
Providers: Mobilizing Vaccination Efforts	▸ Partner with pharmacists as essential access points for vaccination services in the community. ▸ Utilize mobile vaccination vans out in the community and/or pop-up tent clinics in parking lots. ▸ Use on-hold flu messages when the member calls the provider's office. ▸ Use standing order templates to streamline practice workflows in clinics.
Health Plans and Providers: Messaging for Targeted Member Groups	▸ Use targeted communication campaigns for different segments and hard to reach populations (e.g., elderly, pregnant women, special health conditions, etc.). ▸ Essential key messages regarding the importance of immunizations to pregnant women. ▸ Engage key community influencers regarding the benefits of vaccination. Adapt sample media/ twitter posts on social media platforms. ▸ Pop-up announcements on immunization campaigns via the health plan website.

RECOMMENDATIONS DURING COVID-19

Attachment C

ADDRESSING VACCINE HESITANCY

A significant portion of the U.S. population may experience vaccine hesitancy of a new COVID-19 vaccine, which poses dangers to both the individual and their community. Vaccination is one of the most important tools to end the COVID-19 pandemic.

Journal of Ambulatory Care Management

STRATEGIES AND TECHNIQUES FOR ADDRESSING VACCINE HESITANCY

COMMUNICATE

- Explore COVID-19 One-Stop Shop Toolkits and learn practical strategies for engaging communities to build public confidence and promote acceptance of COVID-19 vaccines.
- Learn strategies to leverage positive emotional appeals when framing vaccine strategies such as highlighting the importance of family and social connections associated with vaccination.
- Employ tailored strategies for messaging that are tested and evidence-informed such as giving facts, then addressing myths with the use of visual aids.

EDUCATE

- Promote access to COVID-19 educational materials such as webinars and ways to address vaccine hesitancy in minority groups.
- Support educational initiatives in routine processes such as clinic registration and procedures.
- Educate the community on ways to find credible vaccine information.

COLLABORATE

- Engage community and religious/influential leaders to promote vaccination.
- Employ community-level interventions that address access barriers by offering vaccination programs in various settings such as WIC programs, child care centers, etc.
- Collaborate with Health Departments to assist with COVID-19 vaccine registration in hard hit communities or mobile vaccination clinics/testing (See the story of farmworkers in Riverside county).

RECOMMENDATIONS DURING COVID-19

ADDRESSING VACCINE HESITANCY

Strong confidence in the vaccines within communities leads to more people getting vaccinated, which leads to fewer COVID-19 illnesses, hospitalizations, and deaths.

Centers for Disease Control and Prevention

STRATEGIES TO REINFORCE CONFIDENCE IN COVID-19 VACCINES

PROVIDER TOOLS

- Adapt a sample personal letter message written by a clinical executive staff describing their own vaccine experience, published on their website.
- Consider tailoring patient reminders based on patient values and text reminders to vaccinate.
- Learn techniques to communicate effectively about vaccines to vaccine-hesitant parents.
- Share with members 12 facts and insights from Dr. Golden (Johns Hopkins Medicine) on "what the COVID-19 vaccines can do to benefit you and your family".
- Explore ready-to-use digital resources for members in multiple languages that can be shared in the community and on social media by providers.

MEMBER TOOLS

- Share discussion strategies for when members talk about vaccination with family or friends.
- Encourage members to promote and celebrate their vaccination on social media to influence others.
- Share key messages that members can use during COVID discussions to elicit trust and promote action within their social network.
- Share with members factual information about vaccines.
- Consider educational outreach in barbershops and beauty salons to dispel vaccine disinformation in Black, Latino and communities of color (such as Shots at the Shop and MCP member education outreach).

Attachment D

Legislative Summary – October 2021

State Legislative Session –

The list of bills attached this month include those that have passed the legislature but are awaiting final review by the Governor.

Title	Description	Status
AB 361 (Rivas)	This bill would, until 1/1/24, authorize a local agency to use teleconferencing without complying with the teleconferencing requirements imposed by the Ralph M. Brown Act when a legislative body of a local agency holds a meeting during a declared state of emergency, as the term is defined, when state or local health officials have imposed or recommended measures to promote social distancing, during a proclaimed state of emergency held for the purpose of determining, by majority vote, whether meeting in person would present imminent risks to the health or safety of attendees, and during a proclaimed state of emergency when the legislative body has determined that meeting in person would present imminent risks to the health or safety of attendees, as provided. The bill would require legislative bodies that hold teleconferenced meetings under these abbreviated teleconferencing procedures to give notice of the meeting and post agendas, as described, to allow members of the public to access the meeting and address the legislative body, to give notice of the means by which members of the public may access the meeting and offer public comment, including an opportunity for all persons to attend via a call-in option or an internet-based service option, and to conduct the meeting in a manner that protects the statutory and constitutional rights of the parties and the public appearing before the legislative body. The bill would require the legislative body to take no further action on agenda items when there is a disruption which prevents the public agency from broadcasting the meeting, or in the event of a disruption within the local agency's control which prevents members of the public from offering public comments, until public access is restored. The bill would specify that actions taken during the disruption are subject to challenge proceedings, as specified. The bill would prohibit the legislative body from requiring public comments to be submitted in advance of the meeting and would specify that the legislative body must provide an opportunity for the public to address the legislative body and offer comment in real time. When there is a continuing state of emergency, local emergency, or when state or local officials have imposed or recommended measures to promote social distancing, the bill would require a legislative body to make specified findings not later than 30 days after the first teleconferenced meeting pursuant to these provisions, and to make those findings every 30 days thereafter, in order to continue to meet under these abbreviated teleconferencing procedures. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB361	09/16/21 - Chaptered by Secretary of State

AB 369 (Kamlager)	This bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness, under which a person would receive full-scope Medi-Cal benefits without a share of cost. The bill would require the department to authorize an enrolled Medi-Cal provider to issue a temporary Medi-Cal benefits identification card to a person experiencing homelessness, and would prohibit the department from requiring a person experiencing homelessness to present a valid California driver's license or identification card issued by the Department of Motor Vehicles to receive Medi-Cal services if the provider verifies the person's eligibility. This bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for a person experiencing homelessness. The bill would require the department to reimburse an enrolled Medi-Cal provider who bills the Medi-Cal program for Medi-Cal services provided off the premises to a person experiencing homelessness, as specified. The bill would require a Medi-Cal managed care plan to allow a beneficiary to seek those services and to reimburse a provider for providing those services, but would authorize a Medi-Cal managed care plan to establish reasonable requirements governing network participation. The bill would require a Medi-Cal managed care plan to reimburse a participating Medi-Cal provider providing covered services, without requiring the provider to obtain prior approval, as specified. The bill would authorize an enrolled Medi-Cal provider to refer a Medi-Cal beneficiary who is experiencing homelessness for specialist care and diagnostics. The bill would require the insurance affordability program's application to include information collection means for the applicant to indicate if they are experiencing homelessness at the time of application. If Medi-Cal covered health care services covered by a Medi-Cal managed care plan are not provided within the first 60 calendar days of enrollment to a Medi-Cal beneficiary who has indicated that they are a person experiencing homelessness at the time of application, the bill would require the department to deduct the capitation payments made by the department to the plan from subsequent payments due to the plan for the time period from when the person was initially enrolled into a plan until the first receipt of plan-covered services. If a person experiencing homelessness who is assigned a primary care provider (PCP) receives services by another provider off the premises of the assigned PCP, the bill would require the department or the Medi-Cal managed care plan to notify the assigned PCP that their patient was seen by another provider. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB369	09/10/21 - Enrolled and presented to the Governor at 4 p.m.
AB 1064 (Fong)	This bill would recast the existing provision allowing pharmacists to administer COVID-19 vaccines to instead authorize a pharmacist to independently initiate and administer any vaccine that has been approved or authorized by the FDA and received an ACIP individual vaccine recommendation published by the CDC for persons 3 years of age and older. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1064	09/10/21 - Enrolled and presented to the Governor at 4 p.m.

AB 1104 (Grayson)	Effective January 1, 2023, subject to appropriation by the Legislature, this bill would require the department to design and implement a supplemental payment program for emergency medical air transportation services to increase the Medi-Cal reimbursement in an amount not to exceed normal and customary charges charged by qualified emergency medical air transportation providers. The bill would require the department to seek any necessary federal approvals to implement these provisions and would make these provisions inoperative if the federal Centers for Medicare or Medicaid Services denies approval for the implementation of these provisions, if the Legislature fails to appropriate funds, as specified, or if a lawsuit related to this implementation is filed against the state and a preliminary injunction or other order is issued that results in a financial disadvantage to the state, including, but not limited to, a loss of federal financial participation. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1104	09/10/21 - Enrolled and presented to the Governor at 4 p.m.
SB 48 (Limon)	Would expand the schedule of benefits to include an annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program. The bill would make a Medi-Cal provider eligible to receive the payment for this benefit only if they comply with certain requirements, including completing cognitive health assessment training. By January 1, 2024, and every 2 years thereafter, the bill would require the department to consolidate and analyze data related to the benefit, and to post information on the utilization and payment of the benefit on its internet website. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB48	09/17/21 - Enrolled and presented to the Governor at 1:30 p.m.
SB 65 (Skinner)	This bill would require the department to convene a workgroup to examine the implementation of the Medi-Cal doula benefit, as specified. No later than July 1, 2024, the bill would require the department to publish a report that addresses the number of Medi-Cal recipients utilizing doula services and identifies barriers that impede access to doula services. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB65	09/17/21 - Enrolled and presented to the Governor at 1:30 p.m.
SB 306 (Pan)	This bill would require health care service plans and insurers to provide coverage for home test kits for sexually transmitted diseases, as defined, and the laboratory costs for processing those kits that are deemed medically necessary or appropriate and ordered directly by a health care provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. This bill would require every licensed health care professional engaged in providing prenatal care or attending a birthing patient at the time of delivery to provide syphilis screening and testing as outlined in the most recent guidelines published by the State Department of Public Health. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB306	CAHP Oppose 09/17/21 - Enrolled and presented to the Governor at 1:30 p.m.

SB 365 (Caballero)	This bill would make electronic consultation services reimbursable under the Medi-Cal program for enrolled providers, including FQHCs or RHCs, subject to federal approval and matching funds. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB365	LHPC Support 09/09/21 - Enrolled and presented to the Governor at 1 p.m.
SB 510 (Pan)	This bill would require a health care service plan contract or a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, to cover the costs for COVID-19 testing and health care services related to the testing for COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, and would prohibit that contract or policy from imposing cost sharing or prior authorization requirements for that coverage. The bill would also require a contract or policy to cover without cost sharing or prior authorization an item, service, or immunization intended to prevent or mitigate COVID-19, or a future disease when declared a public health emergency by the Governor of the State of California, that is recommended by the United States Preventive Services Task Force or the federal Centers for Disease Control and Prevention, as specified. The bill would also apply these provisions retroactively beginning from the Governor's declared State of Emergency related to COVID-19 on March 4, 2020. The bill would make the provisions of the act severable. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB510	CAHP Opposed unless amended. 09/17/21 - Enrolled and presented to the Governor at 1:30 p.m.
SB 524 (Skinner)	This bill would prohibit a health care service plan or a health insurer from engaging in patient steering. The bill would define "patient steering" to mean communicating to an enrollee or insured that they are required to have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy, as specified, or offering group health care coverage contracts or policies that include provisions that limit access to only pharmacy providers that are owned or operated by the health care service plan. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202120220SB524	CAHP Oppose 09/09/21 - Enrolled and presented to the Governor at 1 p.m.

SB 535 (Limon)	The bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for an enrollee or insured with advanced or metastatic stage 3 or 4 cancer. Also prohibits requiring prior authorization for biomarker testing for cancer progression or recurrence in the enrollee or insured with advanced or metastatic stage 3 or 4 cancer. The bill would provide that its provisions do not limit, prohibit, or modify an enrollee's or insured's rights to biomarker testing as part of an approved clinical trial, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB535	CAHP Oppose 09/09/21 - Enrolled and presented to the Governor at 3:30 p.m.
SB 682 (Rubio)	This bill would establish the End Racial Inequities in Children's Health in California Initiative (EnRICH CA Initiative). The bill would require the California Health and Human Services Agency, in collaboration with other specified groups and entities, to convene an advisory workgroup, as specified, to develop and implement a plan, as specified, that establishes targets to reduce racial disparities in health outcomes by at least 50% by December 31, 2030, in chronic conditions affecting children, including, but not limited to, asthma, diabetes, dental caries, depression, and vaping-related diseases. The bill would require the agency to convene the advisory workgroup as soon as January 31, 2022, and would allow the workgroup to disband after the implementation of the plan. The bill would require the agency to submit the plan to the Legislature and post the plan on its internet website on or before January 1, 2023, and to commence implementation of the plan no later than June 30, 2023. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB682	09/17/21 - Enrolled and presented to the Governor at 1:30 p.m.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Bruce Wearda, R.Ph.

Date: October 14, 2021

Re: Pharmacy & Therapeutics (P&T) Committee Recommended Formulary Modifications

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Background:

With the proposed changes outlined under Requested Action below, the P&T Committee has determined the KHS formulary concerning Pulmonology adequately provides medically necessary drug classes and appropriate limits to help ensure that the pharmaceuticals available and their manner prescribed will provide appropriate care for members treated for pulmonary conditions. The formulary was evaluated not only on upcoming therapies and medicines available, but also scrutinized for older medications for continued relevance. Additionally, the P&T Committee evaluates each new addition to assure the pharmaceuticals are effective, and safe.

Requested Action:

Accept the following recommendation of the P&T Committee.

1) Add **Savaysa (edoxaban tosylate)** an anticoagulant to the formulary.

2) Modify the formulary for the following:

    a. **Clotrimazole cream**: Remove restriction to OTC formulation only
    b. **Hydrocortisone cream:** Remove restriction to OTC formulation only
    c. Remove step therapy requirement for inhaled steroid, **Advair Diskus and AirDuo** (fluticasone/salmeterol) and Symbicort (budesonide/formoterol): and allow to process as first line agent.

SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, August 6, 2021

8:00 A.M.

COMMITTEE RECONVENED

Members: Deats, Martinez, McGlew, Melendez, Rhoades
ROLL CALL: All Present

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

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-3) Minutes for Kern Health Systems Finance Committee meeting on June 4, 2021- APPROVED
Rhoades-Melendez: All Ayes

4) Report on Kern Health Systems investment portfolio for the second quarter ending June 30, 2021 (Fiscal Impact: None) – IRA COHEN, UBS FINANCIAL SERVICES, INC., HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Rhoades-Melendez: All Ayes

5) Report from the Milliman actuary firm regarding capital reserves (Fiscal Impact: None) – CRAIG B. KEIZUR, MILLIMAN, HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Rhoades-Melendez: All Ayes

6) Proposed Agreement with Commercial Cleaning Systems, Inc., for janitorial services for 2900 Buck Owens Blvd., from September 6, 2021 through September 5, 2022 (Fiscal Impact: $192,000; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Rhoades-Melendez: All Ayes

DIRECTOR MELENDEZ LEFT THE DAIS AT 9:07 A.M. AND DID NOT RETURN

7) Request to Issue an RFP to Expand Kern Health Systems' Solar System Panels (Fiscal Impact: None) –
APPROVED
McGlew-Rhoades: 4 Ayes; 1 Absent - Melendez

8) Report on Kern Health Systems financial statements for May 2021 and June 2021 (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Rhoades: 4 Ayes; 1 Absent - Melendez

9) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for May 2021 and June 2021 and IT Technology Consulting Resources for the period ended June 30, 2021 (Fiscal Impact: None) – RECEIVED AND FILED; REFER TO KHS BOARD OF DIRECTORS
Rhoades-McGlew: 4 Ayes; 1 Absent - Melendez

ADJOURN TO FRIDAY, OCTOBER 8, 2021 AT 8:00 A.M.