REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, June 11, 2020
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, June 11, 2020

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

BOARD TO RECONVENE

Directors: McGlew, Judd, Stewart, Hinojosa, Deats, Hoffmann, Melendez, Patel, Patrick, Rhoades

ADJOURN TO CLOSED SESSION

CLOSED SESSION

1) PUBLIC EMPLOYEE PERFORMANCE EVALUATION –
Title: Chief Executive Officer (Government Code Section 54957) –

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

8:20 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 April 16, 2020 (Fiscal Impact: None) –
APPROVE

6) Proposed Reappointment of three current Board Members and recommend new slate of candidates to serve on the Kern Health Systems Board of Directors (Fiscal Impact: None) –
APPROVE; RECOMMEND TO KERN COUNTY BOARD OF SUPERVISORS FOR REAPPOINTMENT

CA-7) Report on Kern Health Systems Quality Improvement (QI) 2019 Program Evaluation, 2020 QI Program Description, and the 2020 QI Program Work Plan (Fiscal Impact: None) –
APPROVE

CA-8) Report on Kern Health Systems 2019 Utilization Management (UM) Program Evaluation and the 2020 UM Program Description (Fiscal Impact: None) –
APPROVE

CA-9) Report on Kern Health Systems investment portfolio for the first quarter ending March 31, 2020 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-10) Proposed Amendments to the Kern Health Systems Investment Policy (Fiscal Impact: None) –
APPROVE

CA-11) 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 September 1, 2020 (Fiscal Impact: $6,000,000 Estimated; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-12) Proposed renewal and binding of insurance coverages for crime, excess crime, property, general liability, excess liability, workers' compensation, fiduciary liability, excess cyber insurance, managed care errors and omissions, earthquake insurance, flood insurance and deadly weapon response program from July 1, 2020 through June 30, 2021 (Fiscal Impact: $1,000,000 Estimated; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-13) Proposed Agreement with MCG Health, LLC., for access to the medical care guidelines Care Web QI product, from July 5, 2020 through July 4, 2025 (Fiscal Impact: $4,019,712; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-14) Proposed Agreement with CommGap-International Language Services, for face-to-face Interpreter Services, from July 5, 2020 through July 4, 2022 (Fiscal Impact: $350,000 estimated; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

15) Report on Kern Health Systems financial statements for February 2020, March 2020 and April 2020 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-16) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for February 2020, March 2020 and April 2020 and IT Technology Consulting Resources for the period ending March 31, 2020 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-17) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

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

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

ADJOURN TO AUGUST 13, 2020 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.

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, April 16, 2020

8:00 A.M.

BOARD RECONVENED

Directors present: McGlew, Judd, Stewart, Hinojosa, Deats, Hoffmann, Patel, Patrick, Rhoades

Directors absent: Melendez

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
Deats

CLOSED SESSION

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

8:20 A.M.

BOARD RECONVENED AT 8:20 A.M.

REPORT ON ACTIONS TAKEN IN CLOSED SESSION –

Item No. 1 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING MARCH 2020** 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 STEWART ABSTAINED FROM VOTING ON BUTLER, STOCKER, WALKER; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON NOBLEZA, PARRA,

Item No. 1 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING MARCH 2020** 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 GROSS; DIRECTOR STEWART ABSTAINED FROM VOTING ON JOHN; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON PRESLAR, STEWART-HAYOSTEK,

Item No. 1 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING APRIL 2020** 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 STEWART ABSTAINED FROM VOTING ON BEJAR LUA, CAMBRAY, NAIL; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON ROBB, WASHINGTON

Item No. 1 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING APRIL 2020** 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 ROWLAND; DIRECTOR STEWART ABSTAINED FROM VOTING ON DAUG, FLOREK, IDEA, LOO, MAY, MUNNAINATHAN; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON KERN MEDICAL SAGEBRUSH PHARMACY, ARREAZA, FRAZIN, HOFFMANN HOSPICE OF THE VALLEY, MOLLA, PADHY

PUBLIC PRESENTATIONS

2) 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. THANK YOU!

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 THAT THE CALAIM PROGRAM HAS BEEN DELAYED FOR ONE YEAR; DIRECTOR JUDD THANKED DOUG FOR HIS GUIDANCE AND INDICATED THAT HE WAS THANKFUL FOR THE ADDITIONAL TIME

DIRECTOR MCGLEW REMINDED THE BOARD OF THE UPCOMING NOMINATING COMMITTEE APPOINTMENTS AND STATED THAT AN EMAIL WAS SENT OUT

CA-4) Minutes for Kern Health Systems Board of Directors regular meeting on February 13, 2020 (Fiscal Impact: None) –
APPROVED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

5) Report by Daniells Phillips Vaughan & Bock on the audited financial statements of Kern Health Systems for the year ending December 31, 2019 (Fiscal Impact: None) – NANCY BELTON, SHANNON WEBSTER, DANIELLS PHILLIPS VAUGHAN & BOCK, HEARD; APPROVED
Deats-Patel: 9 Ayes; 1 Absent – Melendez

6) Report on Kern Health Systems financial statements for January 2020 (Fiscal Impact: None) –
RECEIVED AND FILED
Patrick-Hinojosa: 9 Ayes; 1 Absent - Melendez

7) Report on Kern Health Systems Donation to the Kern Community Foundation in Support of the “Kern County COVID-19 Relief Fund” (Fiscal Impact: $100,000) –
APPROVED
Rhoades-Patrick: 9 Ayes; 1 Absent - Melendez

CA-8) Report on Kern Health Systems Strategic Plan for first quarter ending March 31, 2020 (Fiscal Impact: $100,000) –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-9) Report on Kern Health Systems financial statements for December 2019 (Fiscal Impact: None) –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-10) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for December 2019 and January 2020 and IT Technology Consulting Resources for the period ending December 31, 2019 (Fiscal Impact: None) –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-11) Report on 2019 Annual Report of Disposal Assets (Fiscal Impact: None) –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

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
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-13) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-14) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-15) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-16) Proposed modifications to Kern Health Systems Formulary (Fiscal Impact: None) –
APPROVED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

CA-17) Miscellaneous Documents –
RECEIVED AND FILED
Rhoades-Deats: 9 Ayes; 1 Absent – Melendez

A) Minutes for KHS Finance Committee meeting on February 7, 2020

ADJOURN TO THURSDAY, JUNE 11, 2020 AT 8:00 A.M.
Patrick

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

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Tim McGlew, Chairman

Date: June 11th, 2020

Re: Nominating Committee Report and Recommendations

Background

At the Board of Director's meeting in April 2020, a Nominating Committee was formed and charged with recommending for reappoint, three current Board members and identifying six new candidates to fill current vacancies on the Kern Health System's Board.

Committee members included: Tim McGlew, Barbara Patrick, Cindy Stewart, Wayne Deats and Larry Rhoades.

KHS Board Members Appointment and Reappointment Process and Timeframe

1. The KHS Nominating Committee makes its recommendations to the Kern Health Systems Board of Directors at its June 2020 Board meeting.
2. Kern Health Systems Board votes on the Nominating Committee's recommendations at its regularly scheduled meeting in June.
3. A Letter of Recommendation (from the KHS Board Chairman) is sent to the Kern County Board of Supervisors requesting appointment of new Board candidates and reappointment of current Board members renewing their term in office as voted on by the KHS Board of Directors.
4. The Kern County Board of Supervisors schedules the vote for appointment and reappointment at one of its upcoming Board meetings.
5. Kern Health Systems is notified of the outcome of the vote.
6. Confirmed members are seated at the next scheduled KHS Board of Directors meeting.

Reappointment of Board Members

At its meeting of June 5th, the Nominating Committee voted to recommend the following Board members for reappointment to the Kern Health Systems Board:

- Tim McGlew, Rural Acute Care General Hospital Representative
- Linda Hinojosa, District 1, Community Representative
- Vijay Patel, MD Outside Metro Bakersfield Primary Care Representative

Recommended Candidates for Board Vacancies

With 6 openings on our Board, the Nominating Committee sought to fortify our Board of Directors with qualified candidates from different backgrounds and with different skills. The goal was to enrich our existing representation with complimentary expertise so the Board may continue to perform its duties at the highest level. To this end, the Committee received 21 inquiries resulting in 13 applications with backgrounds in:

Backgrounds	Number
Law	2
Business	3
Nonprofit Agency	2
Consumer Advocacy	1
Insurance Services	1
Public Service	3
Education	1

Each Candidate (see attachment) completed an application and questionnaire covering their experience, interest and the value they would bring to the role of board member. Follow up conversations were conducted with Candidates where necessary. Endorsements were sought from outside references for Candidates unfamiliar to the Committee. Selection criteria was developed to rank Candidates by priority.

From this vetting process, the Committee identified 6 Candidates to present to the Board for consideration:

Candidate	Title	Company	Category	Background
Alex Garcia	**City Councilman**	**City of Wasco**	**Local Government**	**Public Service**
Jan Hefner	**Exec. Dir.**	**The Center for Sexuality & Gender Diversity**	**Nonprofit**	**Advocacy**
Kristen Beall Watson	**President & CEO**	**Kern Community Foundation**	**Community resource agency**	**Nonprofit**
Matthew Clark	**Sr. Partner**	**Chain, Cohn, Stiles**	**Attorney**	**Law**
Quon Louey	**Exec. Dir.**	**Telehealthdocs Inc.**	**Business**	**Health care**
Roland Maier	**Exec. Dir.**	**First 5 Kern**	**Nonprofit**	**Advocacy**

Requested Action

1. The Committee recommends the Kern Health Systems Board of Directors request the Kern County Board of Supervisors reappoint the following individuals to serve another term as members of the Kern Health Systems Board:

    - Tim McGlew, Rural Acute Care General Hospital Representative
    - Linda Hinojosa, District 1, Community Representative
    - Vijay Patel, MD Outside Metro Bakersfield Primary Care Representative

2. The Committee recommends the Kern Health Systems Board of Directors requests the Kern County Board of Supervisors appoint the following individuals to serve on the Kern Health Systems Board of Directors:

- Alex Garcia
- Jan Hefner
- Kristen Beall Watson
- Matthew Clark
- Quon Louey
- Roland Maier

Attachments:

- *Endorsement letter for:*
    - *Tim McGlew Rural Acute Care General Hospital Representative*

- *Prospective Candidates*

Hospital Council
Northern & Central California

April 20, 2020

The Honorable Leticia Perez, Chairperson
Kern County Board of Supervisors
1115 Truxton Avenue, 5th Floor
Bakersfield, CA 93301

Dear Chairperson Perez:

On behalf of the hospitals in Kern County and the Hospital Council, Northern & Central California, we are pleased to recommend the reappointment of Tim McGlew, CEO of Kern Valley Healthcare District, to continue serving on the Kern Healthy Systems Board of Directors. We recommend Mr. McGlew to serve as the "Rural Acute Care Hospital within Kern County Representative" member.

Mr. McGlew will continue to provide a knowledgeable link between Kern Health Systems and all hospitals in the County. The Hospital Council appreciates the opportunity to submit Mr. McGlew's official recommendation for reappointment for this vital work.

Please feel free to reach out with any questions or if there is a way the Hospital Council can support you.

Thank you,

Regional Vice President
Hospital Council – Northern & Central California
dbacci@hospitalcouncil.org

CC:
Tim McGlew, CEO Kern Valley Healthcare District
Doug Hayward, CEO, Kern Health Systems

List of Potential Board Applicants

First Name	Last Name	Title	Company Name	City	Zip	App. Rec'd
Alex	Garcia	Council Member	City of Wasco	Wasco	93280	X
Craig	Braun	Attorney	Braun Gosling	Bakersfield	93311	X
Debbie	Wood	Retired Coordinator of School Health	Bakersfield City School District	Bakersfield	93306	X
Jan	Hefner	Executive Director	The Center for Sexuality & Gender Diversity	Bakersfield	93309	X
John	Nilon	County Administrative Officer (Retired)	County of Kern	Bakersfield	93304	X *
Kelly	Gladden	PR Consultant	Self employed	Bakersfield	93312	X
Kristen Beall	Watson	President & CEO	Kern Community Foundation	Bakersfield	93314	X
Matthew	Clark	Attorney - Senior Partner	Chain, Cohn, Stiles	Bakersfield	93301	X
Michael	Moore	CEO	Walter Mortensen Insurance	Bakersfield	93311	X
Quon	Louey	Executive Director	Telehealthdocs	Bakersfield	93312	X
Roland	Maier	Executive Director	First 5 Kern	Bakersfield	93312	X
Ross	Elliott	Executive Director (Retired)	California Ambulance Association	Bodfish	93205	X*
Sam	Mohan	Owner	OM Management & Business Ass. & Arvin Medical Clinic	Bakersfield	93311	X

Rev. 5.27.2020

* - App. Received via County Clerk's Office

To: KHS Board of Directors

From: Jane Daughenbaugh, Director of Quality Improvement

Date: June 11, 2020

Re: Quality Improvement Program Documents

Background

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

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

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

Discussion

Quality Improvement Program Description (Attachment A)

The QI Program Description provides an overview of KHS's QI Program objectives and program functions. The scope of the program is defined and describes how the program is integrated throughout all departments in the organization. The QI Program Description defines the lines of authority, with the CMO having primary responsibility and reporting up to the CEO and Board of Directors.

The program description describes the role of KHS's Board (pg. 4) as well as the CMO and the associated committees (QI-UM Committee, Physician Advisor Committee, Pharmacy & Therapeutics Committee, the Public Policy/Community Advisory Committee and the Grievance Review Team). The structure of each of these committees is also defined.

Quality Improvement Program Evaluation (Attachment B)

The QI Program Evaluation reflects the outcomes for the primary QI program activities. Outcomes oftentimes drive changes to the QI Program Description or the next year.

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

The QI Program Evaluation shows favorable results for completion of all goals scheduled for completion or partially scheduled for completion.

HEDIS / MCAS metrics for the measurement year were mostly met with the exception being Asthma Medication Ratio and Well Child Visits. Both measures are included in the 2020 QI Work Plan.

Quality Improvement Program Work Plan (Attachment C)

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

Requested Action

Approve the 2019 QI Program Evaluation, 2020 QI Program Description, and 2020 QI Program Work Plan.

KERN HEALTH SYSTEMS
Quality Improvement Program Description
2020

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 under utilization 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. The majority of members remain children comprising approximately 50% or KHS' membership. Approximately 40% of the membership falls into the adult age group up to age 55 years and approximately 10% fall into the age of 55 years or older. There has been no significant change in these breakdowns compared to 2019. There has also been no change in gender distribution between this year and last with 55% female members and 45% 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:** 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: of the Senior Director of Health Services, 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 that covered medical and behavioral health care provided meets 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.

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, Senior Director of Health Services, Director of Quality Improvement, Director of Health Education and Cultural & Linguistics Services, Case Management Director (includes Disease Management) 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 under utilization 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 Chief Medical Officer 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 Chief Health Services Officer
viii. 1 Home Health/Hospice Provider
ix. 1 DME Provider
x. 1 Director of Quality Improvement,
xi. 1 Director of Health Education and Cultural & Linguistics Services
xii. Staff (Committee staff support)

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 Chief Medical Officer 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 Chief Medical Officer (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 Chief Medical Officer (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 Specialty Practice Pharmacist
vii. 1 General Practice Provider
viii. 1 Pediatrician
ix. 1 Internal Medicine Provider
x. 1 Obstetrician/Gynecologist

d. **Meetings –** The P&T Committee meets quarterly with additional meetings as necessary.

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

a. **Role –** 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.

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 Group 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. Review changes in policy or procedure that affects public policy;
x. Advise on educational and operational issues affecting members who speak a primary language other than English;
xi. Advise on cultural and linguistic issues.

c. **Structure** – 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:

i. 1 Ex-officio Non-Voting Member: KHS Director of Marketing and Member Services (Chairperson)
ii. 5 subscribers/members
iii. 2 Community Representatives
iv. 2 Participating Health Care Practitioners
v. 1 Kern County Public Health Officer or Representative
vi. 1 Director, Kern County Department of Human Services or Representative

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

5. Grievance Review Team (GRT)

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 GRT 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 time-frame.
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 Chief Medical Officer (Chairperson) or designee
ii. 1 KHS Director of Marketing and Member Services
iii. 1 KHS Director of Provider Network Management
iv. 1 KHS Chief Operations Officer
v. 1 KHS Grievance Coordinator (Staff)
vi. 1 KHS Director of Compliance and Regulatory Affairs
vii. 1 KHS Director of Quality Improvement or designee
viii. 1 KHS Chief of Health Services Officer or designee
ix. 1 KHS Pharmacy Director

d. Meetings - The GRT meets on a weekly basis.

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), Chief Medical Officer, 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 Chief Medical Officer 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 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 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 his 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. **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 Associates Degree or higher 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 Operations Supervisor –** The Quality Improvement Operations Supervisor possesses a Master's Degree in health or business administration, an Associate's 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.

   a. **QI Program Staffing** – the Director oversees a QI Program staff consisting of the following:

      i. 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.

ii. 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.

iii. 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.

iv. 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.

v. 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 Senior Director Health Services 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 MCP's 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) 2020. Results for the 2020 measures will be calculated and submitted in report year (RY) 2021,

#	MEASURE Total Number of Measures = 36 (14 Hybrid and 22 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
1	Adolescent Well-Care Visits	AWC	Hybrid	Yes
2	Adult Body Mass Index (BMI) Assessment	ABA	Hybrid	Yes
3	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	Yes
4	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont.	Administrative	Yes
5	Asthma Medication Ratio(ii)	AMR	Administrative	Yes(iii)
6	Breast Cancer Screening	BCS	Administrative	Yes
7	Cervical Cancer Screening	CCS	Hybrid	Yes
8	Childhood Immunization Status: Combination 10	CIS-10	Hybrid	Yes
9	Chlamydia Screening in Women(ii)	CHL	Administrative	Yes(iii)
10	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CDC-H9	Hybrid	Yes
11	Controlling High Blood Pressure	CBP	Hybrid	Yes
12	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	Yes
13	Immunizations for Adolescents: Combination 2	IMA-2	Hybrid	Yes
14	Metabolic Monitoring for Children and Adolescents	APM	Administrative	Yes
15	Prenatal and Postpartum Care:	PPC-Pst	Hybrid	Yes

#	MEASURE Total Number of Measures = 36 (14 Hybrid and 22 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
	Postpartum Care			
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-Pre	Hybrid	Yes
17	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	WCC-BMI	Hybrid	Yes
18	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	WCC-N	Hybrid	Yes
19	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	WCC-PA	Hybrid	Yes
20	Well-Child Visits in the First 15 Months of Life: Six or More Well-Child Visits	W15	Hybrid	Yes
21	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	W34	Hybrid	Yes
22	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED(i)	Administrative	No
23	Concurrent Use of Opioids and Benzodiazepines	COB	Administrative	No
24	Contraceptive Care—All Women: Long Acting Reversible Contraception (LARC)ii	CCW-LARC	Administrative	No
25	Contraceptive Care—All Women: Most or Moderately Effective Contraception ii	CCW-MMEC	Administrative	No

#	MEASURE Total Number of Measures = 36 (14 Hybrid and 22 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
26	Contraceptive Care—Postpartum Women: LARC—3 Days ii	CCP-LARC3	Administrative	No
27	Contraceptive Care—Postpartum Women: LARC—60 Days ii	CCP-LARC60	Administrative	No
28	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days ii	CCP-MMEC3	Administrative	No
29	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days ii	CCP-MMEC60	Administrative	No
30	Developmental Screening in the First Three Years of Life	DEV	Administrative	No
31	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Human Immunodeficiency Virus (HIV) Viral Load Suppression	HVL	Administrative	No
34	Plan All-Cause Readmissions	PCR(i)	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 Stratified by Seniors and Persons with Disabilities (SPD).

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 2019 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. There were two EAS measures not met for RY2019. Those measures were the Asthma Medication Ratio (AMR) and Well Child Visits for children ages 3 through 6 years old (W34). The required Improvement Project (IP) for these two measures were included in the two Performance Improvement Projects described below. DHCS accepted this approach.

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 2019-2021, 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 (W34), 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.
   - The second PIP is focused on improving the health of members, ages 5-18 years with persistent asthma and who have a ratio of controller medication to total asthma medications of 0.5 or greater.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) - In 2019, the CAHPS **Member Satisfaction Survey** was administered by a DHCS-contracted, third party vendor, HSAG. 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.

   CAHPS results were delivered in the 1st quarter of 2020 and offer an indication of how well health care organizations meet member expectations. Results will be reviewed this year to evaluate opportunities for focused improvement in the QI/UMC.

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

The Director of Member Services reports at least monthly to the CEO, Chief Medical Officer and Chief Operations Officer. At least quarterly, reports are furnished to the QI/UM Committee.

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, Chief Medical Officer and Chief Operations Officer. At least quarterly, reports are presented to the QI/UM Committee along.

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 Chief Medical Officer, 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 2.04-P Provider Disciplinary Action*. 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, Chief Medical Officer, 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. M 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 in patient 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 forwarded to the QI department for further review and action. 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 Audit and Medical Record Review** – Facility site audits 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 takes effect July 1, 2020. 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 Chief Medical Officer, 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 Chief Medical Officer 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 Chief Health Services Officer 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

2018 Measurement Year and 2019 Report Year
EAS/HEDIS Results

Hybrid Measures

Measure		Accronym	Current 2019 Rate	2019 MPL	Current Vs. 2019 MPL
CCS	Cervical Cancer Screening	CCS	60.34	54.26	6.08
CIS-3	CIS – Combo 3	CIS-3	65.45	65.45	0.00
CDC-E	Eye Exam (Retinal) Performed	CDC-E	56.88	50.85	6.03
CDC-HT	HbA1c Testing	CDC-HT	89.13	84.93	4.20
CDC-H9 *	HbA1c Poor Control (>9.0%)	CDC-H9 *	33.15	47.20	14.05
CDC-H8	HbA1c Control (<8.0%)	CDC-H8	55.43	44.44	10.99
CDC-N	Medical Attn. for Nephropathy	CDC-N	92.93	88.56	4.37
CDC-BP	Blood Pressure Control <140/90	CDC-BP	65.58	56.20	9.38
CBP	Controlling High Blood Pressure	CBP	54.26	49.15	5.11
IMA-2	Immunizations for Adolescents (Combo 2)	IMA-2	40.63	26.28	14.35
PPC-Pre	Timeliness of Prenatal Care	PPC-Pre	81.27	76.89	4.38
PPC-Pst	Postpartum Care	PPC-Pst	67.64	59.61	8.03
WCC-N	Counseling for Nutrition	WCC-N	70.56	59.85	10.71
WCC-PA	Counseling for Phys Activity	WCC-PA	65.21	52.31	12.90
W-34	Well-Child Visits	W-34	63.99	67.15	-3.16

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

Administrative Measures

Adminis **Administrative Measures**

Measure			Current 2019 Rate	2019 MPL	Current Vs. 2019 MPL
AAB**	Avoidance of Antibiotic Treatment	AAB	31.33	27.63	3.70
AMR	Asthma Medication Ratio	AMR	21.49	56.85	-35.36
BCS	Breast Cancer Screening	BCS	56.57	51.78	4.79
CAP-1224	12-24 Months	CAP	89.62	93.64	-4.02
CAP-256	25 Months – 6 Years	CAP	80.28	84.39	-4.11
CAP-711	7-11 Years	CAP	79.9	87.73	-7.83
CAP-1219	12-19 Years	CAP	78.35	85.81	-7.46
DSF	Depression Screening and Follow-Up for Adolescents and Adults	DSF	0.00	N/A	N/A
LBP**	Use of Imaging for Low Back Pain	LBP	73.33	67.19	6.14
MPM-ACE	ACE inhibitors or ARBs	MPM-ACE	89.71	85.97	3.74
MPM-Diu	Diuretics	MPM-Diu	90.50	86.06	4.44

****** Rate for these measures derived by an inverse calculation. The number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS 2019 (measurement year 2018).

QI Program Evaluation
2019

Kern Health Systems
Quality Improvement Program Evaluation
Reporting Period: January 1, 2019 – December 31, 2019

1. QI ACTIVITIES

According to the California Department of Health Care Services (DHCS) All Plan Letter (APL) 17-014 and APL 19-017 (effective 12/26/2019), Quality and Performance Improvement Requirements, all Medi-Cal managed care health plans are contractually required to report an annual performance measurements results, participate in a consumer satisfaction survey when indicated by DHCS and conduct ongoing quality performance improvement projects (PIPs).

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS):

HEDIS 2019 is the edition of the Healthcare Effectiveness Data and Information Set, 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 measurement scores for the required External Accountability Set (EAS) performance measures. DHCS currently requires all contracted health plans to report selected HEDIS measures to comply with the EAS reporting requirement.

The previous calendar year is the standard measurement year for HEDIS data. Therefore, the HEDIS 2019 results shown in this report are based on 2018 data. HEDIS 2019 results can be found in Appendix A. APL 17-014 states that for each measure below the established Minimum Performance Level (MPL) or with an audit result of “Not Reportable” (NR), the health plan must submit a rapid-cycle improvement and implementation of PDSA cycles to increase the potential for improved outcomes within 60 days of being notified by DHCS of the measures for which IPs are required.

KHS did not meet the MPL for two EAS measures. One was the Asthma Medication Ratio (AMR) and the other was for Well-Child Visits (W34 - ages 3-6 years old).Two new Performance Improvement Projects (PIPs) were initiated in 2019 and DHCS allowed KHS to

incorporate the required rapid-cycle improvement PDSA cycles into those two projects One PIP is for the Asthma Medication Ratio (AMR) in children ages 5-18 years who were identified as having persistent asthma and had a ratio of controller medication to total asthma medications of 0.5 or greater during the measurement year. KHS has partnered with providers in Bakersfield that have a large number of pediatric patients with a diagnosis of persistent asthma.

CONSUMER STATISFACTION SURVEYS (CAHPS):

Per MMCD APL 17-014, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both adults and children was administered by the EQRO in 2017. DHCS provided the "sample frame" member information for contracted health plans to the EQRO. The CAHPS survey was conducted in 2019 and results will be reported in next year's QI Program Evaluation.

PROCESS IMPROVEMENT PROJECTS (PIPs):

Each PIP runs approximately 18 months. KHS's PIPs that started in 2018 were Increasing Appropriate Use of Imaging Studies for Uncomplicated Low Back Pain and Improving Immunization Compliance Among African American Children. These PIPs were completed after successful submission following the PDSA format. KHS has submitted all Modules on time and they were accepted. Results for both PIPs were did not demonstrate improvement primarily due to challenges related to engagement in the projects by the participating providers.

Two new PIPs were selected for initiation in 2019. Both were submitted to DHCS as proposals and were accepted to implement.

One was to improve the health of our members 5-18 years of age who were identified as having persistent. Based on the minimum performance level (MPL) benchmark from NCQA, the PIP team identified that the AMR measure has been below the MPL for 2 consecutive years. Since KHS did not meet the MPL for this measure, DHCS requires rapid-cycle improvement PDSA cycles and accepted KHS utilizing this PIP for that purpose. KHS partnered with providers in Bakersfield that have a large number of pediatric patients with a diagnosis of persistent asthma.

The second PIP that was selected was to improve the health and well-being of low income children, ages 3 to 6 years old, by having them complete their annual Well Child Visit (WCV). KHS partnered with a Provider located in Central Bakersfield where the population they serve is among the lowest median household income within the Bakersfield city limits. By having children complete

their annual WCV, early detection, intervention and treatment of health and functional issues can improve the child's overall health and may prevent more complex health issues from occurring. These outcomes also have a positive impact on overall health care utilization.

2. FACILITY SITE REVIEWS AND COLLABORATION

Kern Health Systems (KHS) personnel 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.

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
• Initial Health Assessment (IHA)	• Tobacco use
• IHEBA aka Staying Healthy Assessment	• Other preventive care services
• California Children's Service (CCS)	

Beginning in the 4th quarter of 2019, the QI Department initiated implementation of a Site and Medical Record Review System, EzTracker, to manage and document all FSR and MRR activity. This system is being used by many other Managed Care Plans, including Health Net. The system is targeted for implementation completion within the 1st quarter of 2020.

QI PROGRAM OVERVIEW

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Oversight of all delegated QI functions for the following services:	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.	Complete for 2019

QI Program Evaluation
2019

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
• Kaiser • VSP				
QI Policies and Procedures	Not Met	Ongoing	1. QI Policies and Procedures are updated every 3 years as well as reviewed periodically in order to comply with any new regulatory requirements. 2. Each policy and procedure is reviewed against the DHCS contract and regulatory requirements and revised as needed to ensure compliance. 3. 2.26-I Hospital Re-admissions - Quality of Care Issues 2015-05, was updated. 4. Preparation for updates to the Facility Site Review policy and procedure initiated in anticipation of significant changes to the process in 2020. 5. Revisions to current QI policies and procedures have been taken to the QI/UM committee.	Partial Completion for 2019
Audits				
Site review timeliness audit	Met	12/31/2019	Site Review Timeliness – A spreadsheet of reviews due and reviews completed was manually maintained. In 2019, a total of 30 initial site reviews and 35 periodic site reviews were performed and all met required timeliness.	Complete for 2019
Staying Healthy Assessment	Met	12/1/2019	123 positive Staying Healthy Assessments (SHAs) were identified through and HEDIS chart review. These were forwarded to Health Education for follow up member outreach and education.	Complete for 2019
30 day readmission	Met	Ongoing	The QI department continues to look for opportunities for improvement in members who are readmitted within 30 days of discharge. This organization-wide focus has the following changes:	Complete for 2019

QI Program Evaluation
2019

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			• Transition of Care program is ongoing, identifying members at risk of readmission and linking them to appropriate services including medication reconciliation and a Discharge Clinic. • Health Homes continues to expand. There are currently 6 number of Community-Based Care Management Entities (CB-CMEs). • Changes were implemented to the QI Department's review of 30 day readmissions. Instead of reviewing every re-admission within 30 days, 50 cases are selected per quarter and investigation is conducted per the standard process for potential quality of care referrals.	
Notifications (Death, General)	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Notification process. In 2019, we implemented a change to this process. Instead of reviewing every death notification from the UM Department, UM sends only those notifications in which there is a suspected or potential quality of care concern (PQOC). Each of these is investigated using the current PQOC process.	Complete for 2019
Grievances	Met	Ongoing	The QI department continues to look for opportunities for improvement through the Grievance process. All grievances classified as a potential quality of care concern are referred to the QI Department. These referrals are investigated according to our Potential Quality of Care referral process and all cases with a quality of care concern are reviewed by a KHS medical director for review, evaluation and identification of any follow up actions needed. Quality of care issues may result in tracking and trending or a corrective action plan. This	Complete for 2019

QI Program Evaluation
2019

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			information is shared with Chief Medical Officer during the re-credentialing process.	
Resources				
• Director of Quality Improvement	Not Met	12/31/2019	A Director of QI was hired in April of 2019.	Completed for 2019
• QI Manager	Met	12/31/2019	This position was approved for hire in 2020.	Complete for 2019
• QI RN II	Met	12/31/2019	One QI RN I staff was approved for promotion to QI RN II. All QI RN II positions are filled with a total of 2 nurses.	Complete for 2019
• QI RN I	Met	12/31/2019	One vacancy was filled and QI RN I positions are filled with a total of 5 nurses.	Complete for 2019
• QI Coordinator	Met	12/31/2019	Position filled with no changes in 2019. 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	12/31/2019	Position filled with no changes in 2019. This position assists with MCAS Medical Record retrieval and for supporting Member Incentive initiatives sponsored by QI.	Complete for 2019
• Operational Analyst	Met	12/31/2019	This position was vacated last year and a replacement hired in the later portion of 2019. 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 2019
• Senior QI Technician and Trainer	Met	12/31/2019	This position was approved for elevation from QI Technician and Trainer to a senior level to support a higher degree of qualifications. They provide reporting support to the QI department and focus on reporting actionable data,	Complete for 2019

QI Program Evaluation
2019

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			streamlining current processes, developing new processes, and training staff.	
• Senior Support Clerk	Met	12/31/2019	QI has one staff in this position and there were no changes in 2019. QI has one SSC who supports the clerical needs of the department.	Complete for 2019
QI Projects				
QI Facility Site and Medical Record Review automation	Met	3/31/2020	A determination was made that the software tool used for automation of the FSR and MRR work did not meet the needs of KHS. A new tool, EzTracker, from the vendor, Healthy Data Systems, was obtained during the 4th quarter and was in the implementation process through the end of 2019. 15 – 20 other Medi-Cal MCPs are using this software to manage their FSR and MRR work. The tool is in the process of being updated to incorporate the requirements for a new FSR/MRR APL that will take effect July 1, 2020.	On track for completion by Target Date
Member Education Material	Met	12/31/2019	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 A new process was established to contact providers on a regular basis to see what educational materials were needed and deliver them.	Completed for 2019

QI Program Evaluation
2019

<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>12/31/2019</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 Homes MIP</td><td>2,480</td></tr><tr><td>2. Asthma Class MIP</td><td>118</td></tr><tr><td>3. Healthy Eating, Active Lifestyle MIP</td><td>469</td></tr><tr><td>4. Asthma Impact Model Pilot MIP</td><td>25</td></tr><tr><td>5. Member Portal MIP</td><td>11,881</td></tr><tr><td>6. IHA MIP</td><td>8,157</td></tr><tr><td>7. 1 Year Well Baby MIP</td><td>5,775</td></tr><tr><td>8. Prenatal Care MIP</td><td>422</td></tr><tr><td>9. Postpartum Care MIP</td><td>2,710</td></tr><tr><td>10. Diabetes Prevention MIP</td><td>*see note below</td></tr><tr><td>11. Perinatal Survey MIP</td><td>400</td></tr></table>*DPP MI was made up of 10 different milestone incentives. Below is the breakdown of members who qualified for 1 or more of the incentives. Program ran from 3/4/19-2/28/20.

MIP = Member Incentive Program
DPP = Diabetes Prevention Program</td><td>Complete for 2019</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 Medical Director.
2. The QI_UM Committee disseminates the quality improvement process to participating groups and</td><td>Complete for 2019</td></tr>
</table>

QI Program Evaluation
2019

<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>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. 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>12/31/2019</td><td>1. Practitioner attendance and participation in the QI/UM Committee or subcommittees is required.</td><td>Complete for 2019</td></tr>
</table>

QI Program Evaluation
2019

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			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.	
	Met	12/31/2019	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 2019
Physician Advisory Committee (PAC)	Met	12/31/2019	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 on a monthly basis 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 2019

QI Program Evaluation
2019

<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>Met</td><td>12/31/2019</td><td>Ten (10) PAC meetings were held during the reporting period with attendance as follows:

<table><tr><th>Physician Advisory Committee Members</th><th>Attended</th></tr><tr><td>CMO</td><td>10 meetings</td></tr><tr><td>Pediatrician</td><td>9 meetings</td></tr><tr><td>Clinical Psychologist</td><td>7 meetings</td></tr><tr><td>Eye Specialist</td><td>9 meetings</td></tr><tr><td>OB/GYN Provider</td><td>8 meetings</td></tr><tr><td>Pain Medicine Provider</td><td>10 meetings</td></tr><tr><td>Family Practitioner</td><td>5 meetings</td></tr><tr><td>Internal Medicine Provider</td><td>7 meetings</td></tr></table></td><td>Complete for 2019</td></tr>
<tr><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met</td><td>12/31/2019</td><td>1. Serves to objectively appraise, evaluate, and select pharmaceutical products for formulary addition or deletion.
2. This is an ongoing process to ensure the optimal use of therapeutic agents.
3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost.
4. Medications are evaluated on their clinical use and develop policies for managing drug use and administration.</td><td>Complete for 2019</td></tr>
</table>

QI Program Evaluation
2019

<table>
<tr>
<td></td>
<td>Met</td>
<td>12/31/2019</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>2 meetings</td></tr>
<tr><td>Pediatrician</td><td>2 meetings</td></tr>
<tr><td>Retail Pharmacy/Chain</td><td>3 meetings</td></tr>
<tr><td>Board Member/Rx Representative</td><td>3 meetings</td></tr>
<tr><td>Pharmacy/Specialty Practice</td><td>Open Position</td></tr>
<tr><td>Pharmacy/Geriatric Specialist</td><td>3 meetings</td></tr>
<tr><td>Internal Medicine</td><td>2 meetings</td></tr>
<tr><td>General Practice/Geriatrics</td><td>3 meetings</td></tr>
<tr><td>KHS Pharmacy Director/Alternate Chairperson</td><td>4 meetings</td></tr>
</table>
</td>
<td>Complete for 2019</td>
</tr>
<tr>
<td>Public Policy/Community Advisory Committee (PP/CAC)</td>
<td>Met</td>
<td>12/31/2019</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.</td>
<td>Complete for 2019</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>3. The committee meets every four months and provides recommendations and reports findings to the Board of Directors.</td><td></td></tr>
<tr><td></td><td>Met</td><td>12/31/2019</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</td></tr>
<tr><td>KHS Member</td><td>4</td></tr>
<tr><td>KHS Member</td><td>2</td></tr>
<tr><td>KHS Member</td><td>0</td></tr>
<tr><td>Community Representative</td><td>4</td></tr>
<tr><td>Community Representative</td><td>1</td></tr>
<tr><td>Kern County Department of Public Health</td><td>4</td></tr>
<tr><td>Kern County Department of Human Services</td><td>3</td></tr>
</table></td><td>Complete for 2019</td></tr>
<tr><td colspan="5">Regulatory Compliance</td></tr>
<tr><td>DHCS audit</td><td>Partially Met</td><td>8/6/2019 – 8/9/2019</td><td>DHCS performed their annual managed care plan audit from August 6th – August 9th. There was one finding specific to Quality Management.
The finding was that information regarding member rights was not included in newly contracted provider training. The training material for provider training were updated along with the orientation checklist and submitted to DHCS. We are awaiting a response from DHCS for this submission.
There was another finding was in the area of the Grievance System. The finding was that grievances involving clinical issues that were inaccurately identified and classified as</td><td>Complete for 2019</td></tr>
</table>

			exempt. The finding included that non-clinical member service representatives received and resolved exempt grievances that were not referred to the Plan's medical director for final resolution. The QI Department collaborated with the Grievance Team in their process modification which involved referring all grievances with a clinical-related concern to the QI Department as a potential quality of care issue. The complete response to this finding was submitted to DHCS and we are awaiting their response.	
DMHC Audit	Partially met	8/6/19 – 8/8/20	The Department of Managed Health Care (DMHC) audits Knox-Keene licensed health plans every 3 years. DMHC audited KHS in 2019 and conducted the onsite portion of the audit from August 6th through August 8th. There were 2 findings under Quality Assurance. • The Plan does not have a Public Policy that complies with the required membership criteria. o KHS has protested this finding based on the regulatory guidelines for this requirement. We are awaiting response from DMHC • The Plan's governing body does not consistently review and approve its' Quality Improvement (QI) Program written documents. o KHS submitted the 2018 QI Program Evaluation, 2019 QI Program Plan and the 2019 QI Program Work Plan to KHS' Board of Directors for review, input and approval. Documentation of that submission and Board approval was submitted to DMHC.	Complete for 2019

			One other finding was identified from the audit under Grievances and Appeals. The finding was that KHS does not consistently identify potential quality issues (PQIs) in exempt grievances. This is similar to the finding from DHCS' audit. The QI Department collaborated with the Grievance Team in their process modification which involved referring all grievances with a clinical-related concern to the QI Department as a potential quality of care issue. The complete response to this finding was submitted to DMHC and we are awaiting their response.	
External Accountability Set (EAS)/HEDIS 2019 Audit	Partially Met	7/3/2019	On 7/3/2019 we received our Medi-Cal Managed Care, HEDIS® 2019 Compliance Audit™ Final Report. All elements of the HEDIS 2019 audit were complete and approved by HSAG and NCQA accepted our submission. Two measures submitted as part of the 2019 audit did not meet the minimum performance level (MPL). The first was the Asthma Medication Ratio (AMR) measure. The second was for Well Child Visits, Ages 3-6 years old (WC34). As a result, KHS is required to submit Improvement Project (IP). During the 2nd half of 2019, KHS was also required to initiate two Performance Improvement Projects (PIP). We requested that DHCS allow KHS to incorporate the required IPs for the non-compliant HEDIS measures into the two new PIPs and DHCS approved this approach. Both PIPs are underway with approval from DHCS and will continue into 2021.	Complete for 2019
Improvement Plans (IPs)PIP				
Asthma Medication Ratio	Met	6/30/2019	When a Managed Care Plan (MCP) does not meet the minimum performance level (MPL) on a HEDIS/External Accountability Set (EAS) measure, they are required to do an	Complete for 2019

			Improvement Plan (IP) to bring the outcome for the subsequent year up to the MPL. KHS did not meet the MPL for the AMR measure (Asthma Medication Ratio) in HEDIS Report Year 2018. As a result, a 12-month improvement project was submitted and approved. In May of 2019 the final IP was submitted to DHCS. In June DHCS accepted our submission and the IP is now complete and closed.	
Performance Improvement Projects (PIPs)				
Disparities - CIS	Met	9/9/2019	KHS met the MPL in the Childhood Immunizations measure for 2018, but we did not meet the state average. In order to improve our rate, this measure was chosen as our Disparities PIP. The CIS Disparity PIP was submitted to HSAG/DHCS on September 9th, 2019 with final results received on October 31st, 2019. The submission was approved. However, it was noted that we did not achieve the SMART Aim goal to increase the percentage rate of immunization compliance of 2 year-old African American children residing in Kern County due to challenges participating providers had with resources to devote to the project. This resulted in a final rating of Low Confidence in the project by HSAG/DHCS.	Complete for 2019
Low Back Pain	Met	8/16/2019	KHS did not meet MPL in the LBP measure in HEDIS 2017. In order to improve rates, this measure was chosen as our PIP. The measurement is for members at a select clinic who did not receive an imaging study within the first 28 days of acute lower back pain diagnosis (higher is better in most instances). This results did not achieve the targeted outcome. The clinic did not follow through with some interventions due to resource constraints. The final PIP was submitted on August 16, 2019. We received a response from HSAG/DHCS on September 25, 2019 accepting the final submission and	Complete for 2019

			indicating rating this project as Low Confidence since KHS did not achieve the SMART Aim goal.	
Disparities in Well Child Visits (W34)	New	March 2021 (approximate)	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 based on our measurement year 2018 HEDIS/EAS results not meeting the MPL. We requested and were approved by HSAG/DHCS to incorporate the required IP into this PIP. The first module for this PIP was submitted on October 23rd, 2019, and the first module was approved by HSAG/DHCS on November 15th, 2019.	Ongoing
Child/Adolescent Health Asthma Medication Ratio (AMR)	New	April 2021 (approximate)	This PIP focuses on improving the health of members, ages 5-18 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 2018 HEDIS/EAS results not meeting the MPL. We requested and were approved by HSAG/DHCS to incorporate the required IP into this PIP. The first module for this PIP was submitted on November 22nd, 2019, and the first module was approved by HSAG/DHCS on January 28th, 2020.	Ongoing
Site Reviews				
• Initial	Met	12/31/2019	16 Initial Medical Record Reviews and 19 Initial Full Site Reviews were completed. All subsequent medical record reviews were complete. All CAPS and required follow-up visits were completed and closed.	Completed for 2019
• Periodic	Met	12/31/2019	16 Periodic Medical Record and Full Site Reviews were completed. PARS were reviewed and completed if needed.	Completed for 2019

QI Program Evaluation
2019

			All CAPS and required follow-up visits were completed and closed.	
• Focused	Met	12/31/2019	58 Focus reviews were completed. All CAPS and required follow-up visits were completed and closed.	Completed for 2019
• Pending F/U	Met	12/31/2019	There are no pending follow-up visits. All CAPS and required follow-up visits were completed and closed.	Completed for 2019

QI Program Evaluation
2019

Attachment A
2018 Measurement Year and 2019 Report Year
EAS/HEDIS Results

Hybrid Measures

Measure		Current 2019 Rate	2019 MPL	2019 HPL	2018 KHS Rate	Current Vs. 2019 MPL	Current Vs. 2019 HPL	Current Vs. 2018 KHS
CCS	Cervical Cancer Screening	60.34	54.26	70.68	58.39	6.08	-10.34	1.95
CIS-3	CIS – Combo 3	65.45	65.45	79.56	68.86	0.00	-14.11	-3.41
CDC-E	Eye Exam (Retinal) Performed	56.93	50.85	68.61	58.94	6.08	-11.68	-2.01
CDC-HT	HbA1c Testing	89.13	84.93	92.70	89.60	4.20	-3.57	-0.47
CDC-H9 *	HbA1c Poor Control (>9.0%)	33.15	47.20	29.68	30.66	14.05	-3.47	-2.49
CDC-H8	HbA1c Control (<8.0%)	55.43	44.44	59.49	58.21	10.99	-4.06	-2.78
CDC-N	Medical Attn. for Nephropathy	92.93	88.56	93.43	92.88	4.37	-0.50	0.05
CDC-BP	Blood Pressure Control <140/90	65.58	56.20	77.50	69.89	9.38	-11.92	-4.31
CBP	Controlling High Blood Pressure	54.26	49.15	71.04	58.39	5.11	-16.78	-4.13
IMA-2	Immunizations for Adolescents (Combo 2)	40.63	26.28	46.72	36.74	14.35	-6.09	3.89
PPC-Pre	Timeliness of Prenatal Care	81.27	76.89	90.75	82.48	4.38	-9.48	-1.21
PPC-Pst	Postpartum Care	67.64	59.61	73.97	66.67	8.03	-6.33	0.97
WCC-N	Counseling for Nutrition	70.56	59.85	83.45	63.02	10.71	-12.89	7.54
WCC-PA	Counseling for Phys Activity	65.21	52.31	78.35	57.91	12.90	-13.14	7.30
W-34	Well-Child Visits	63.99	67.15	83.70	66.67	-3.16	-19.71	-2.68

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

QI Program Evaluation
2019

Administrative Measures

Measure		Current 2019 Rate	2019 MPL	2019 HPL	2018 KHS Rate	Current Vs. 2019 MPL	Current Vs. 2019 HPL	Current Vs. 2018 KHS
AAB**	Avoidance of Antibiotic Treatment	31.33	27.63	44.64	27.63	3.70	-13.31	3.70
AMR	Asthma Medication Ratio	21.49	56.85	71.93	49.80	-35.36	-50.44	N/A
BCS	Breast Cancer Screening	56.57	51.78	68.94	55.98	4.79	-12.37	N/A
CAP-1224	12-24 Months	89.62	93.64	97.71	89.69	-4.02	-8.09	-0.07
CAP-256	25 Months – 6 Years	80.28	84.39	92.88	81.44	-4.11	-12.60	-1.16
CAP-711	7-11 Years	79.9	87.73	96.18	80.88	-7.83	-16.28	-0.98
CAP-1219	12-19 Years	78.35	85.81	94.75	78.84	-7.46	-16.40	-0.49
DSF	Depression Screening and Follow-Up for Adolescents and Adults	0.00	N/A	N/A	0.00	N/A	N/A	N/A
LBP**	Use of Imaging for Low Back Pain	73.33	67.19	79.88	71.59	6.14	-6.55	1.74
MPM-ACE	ACE inhibitors or ARBs	89.71	85.97	92.87	90.19	3.74	-3.16	-0.48
MPM-Diu	Diuretics	90.50	86.06	92.90	89.79	4.44	-2.40	0.71

** Rate for these measures derived by an inverse calculation. The number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS Report Year 2019 (Measurement Year 2018).

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

Kern Health Systems
2020 Quality Improvement Program Work plan

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
A. Annual Review/Approval of QI Program (QIP) Documents					
1. Approval QI Evaluation	Approval of 2019 QI Program Evaluation	8/31/2020	Chief Medical Officer (CMO) / QI Director		QI/UMC Agenda May 2020
2. Review/Update and Approval of QI Program Description	Approval of 2020 QI Program Description	8/31/2020	Chief Medical Officer (CMO) / QI Director		QI/UMC Agenda May 2020
3. Review/Update and Approval of QI Work Plan	Approval of 2020 QI Work Plan	8/31/2020	Chief Medical Officer (CMO) / QI Director		QI/UMC Agenda May 2020
B. Clinical - Focused Studies					
1. State Required					
a. Asthma Medication Ration PIP - Improving Asthma Medication Ratio Compliance in Children 5-11 & 12-18 years of age	Incorporates IP due to not meeting 2018 MY MPL - 18 month quality improvement project overseen by HSAG	Ongoing through 2020	Chief Medical Officer (CMO) / QI Director		Ongoing through 2020
b. Improving the Health and Well Being of low income children, ages 3- 6 years, through Well Child Visits (WCV)	Incorporates IP due to not meeting 2018 MY MPL - 18 month quality improvement project overseen by HSAG	Ongoing through 2020	Chief Medical Officer (CMO) / QI Director		Ongoing through 2020
C. RY 2020 MCAS Monitoring (Medi-cal) / Quality Measurements					
1. MCAS Audit Roadmap	Report to State EQRO Auditor - HSAG	2/29/2020	Director of QI/Director of Business Intelligence/Director of Claims/Director of IT/Chief Network Administration Officer		Completed
2. Adolescent Well-Care Visits (AWC)	Report final rate annually to QI/UM Committee/Board of Directors (BOD)/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
3. Cervical Cancer Screening (CCS)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
3. Adult Body Mass Index (BMI) Assessment (ABA)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
4. Childhood Immunization Status: Combination 10 (CIS-10)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
5. Comprehensive Diabetes Care HbA1c Testing (CDC-HT)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
6. HbA1c Poor Control (>9.0%) (CDC-H9)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
7. Controlling High Blood Pressure (CBP)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
8. Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV) (IMA-2)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
9. Prenatal & Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
10. Prenatal & Postpartum Care – Postpartum Care (PPC-Post)					
11. Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BMI)					
12. Well-Child Visits in the First 15 months of Life – Six or More Well Child Visits (W15)					
13. Well-Child Visits in the 3rd 4th 5th & 6th Years of Life (W34)					
14. Antidepressant Medication Management: Acute Phase Treatment (AMM-Acute)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
15. Antidepressant Medication Management: Acute Phase Treatment (AMM=Cont)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
16. Asthma Medication Ratio (AMR)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
17. Breast Cancer Screening (BCS)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
18. Chlamydia Screening in Women (CHL)	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
19. All Cause Readmissions	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress
20. ED Visit Rates	Report annually to QI/UM Committee/BOD/DHCS	10/31/2020	Chief Medical Officer (CMO) / QI Director		In Progress

KERN HEALTH SYSTEMS
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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
18. Configure and implement New Managed Care Accountability Set (MCAS) measures for measurement year 2020 for HSAG/NCQA/DHCS audit reporting	Technical specifications and audit requirements from HSAG/DHCS for MCAS measurements included in RY2020's audit submission	3/31/2020	QI Director/ IT Director	Medium	Complete. However, vendor, Cotiviti, has had issues configuring non-HEDIS measures. HSAG has been in communication with Cotiviti and has advised CA MCPs contracted with them to report what data we have available.
- Configure MCAS/HEDIS software for new measures (Cotiviti)	Vendor, Cotiviti, to have all new measure configured, tested and changes approved by NCQA	3/31/2020	QI Director/ IT Director	Medium	Complete. However, vendor, Cotiviti, has had issues configuring non-HEDIS measures. HSAG has been in communication with Cotiviti and has advised CA MCPs contracted with them to report what data we have available.
- Configure KHS data and reports for new measures	KHS to modify data receipt, storage and reports to meet new DHCS MCAS specifications	3/31/2020	QI Director/ IT Director		Complete
- Educate providers on MY2020 measures	KHS to educate providers on new requirements for MCAS	2/1/2020	Chief Medical Officer (CMO)/ QI Director/ PNM Director		Complete
- Educate KHS Staff on MY2021 measures	KHS to educate internal staff on new requirements for MCAS	3/1/2020	Chief Medical Officer (CMO)/ QI Director		In Progress
D. Other On-going Monitoring					
1. 30 day re-admissions	In annual QI Plan Evaluation for 2019 to QI/UMC & BOD in 2020	Annually	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
2. Potential Inappropriate Care (PIC)	In annual QI Plan Evaluation for 2019 to QI/UMC & BOD in 2020	Annually	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
3. Facility Site Reviews (FSR)					
a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
b. IHEBA - Staying Healthy Assessment	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
c. Initial Health Assessment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
d. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
e. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
f. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
g. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
5. 2020 Facility Site Review - DHCS Form & Process Changes					
a. Implement Form Changes	Identify and implement process for documenting each type of FSR using the new forms finalized by DHCS	7/1/2020	QI Director / Chief Network Administration Officer		Ongoing 2020
b. Implement Reporting Changes	Identify changes to existing FSR reports and new reports needed based on the new, finalized FSR guidelines from DHCS	7/1/2020	QI Director / Chief Network Administration Officer		Ongoing 2020

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
c. Educate Staff on New Forms & Requirements	Develop and deliver educational information for KHS staff on the changes to the forms and FSR requirements	7/1/2020	QI Director / Chief Network Administration Officer		Ongoing 2020
d. Educate Providers on New Requirements	Develop and deliver educational information for network providers on the new FSR requirements by DHCS	Dependent on final delivery of forms and guidelines from DHCS	QI Director / Chief Network Administration Officer		Ongoing 2020
E. Safety of Clinical Care					
1. Autoclave	Credentialing/Recredentialing/As necessary	12/31/2020	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
2. Bio-hazardous waste	Credentialing/Recredentialing/As necessary	12/31/2020	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
3. Infection Control	Credentialing/Recredentialing/As necessary	12/31/2020	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
4. Facility Site Review (FSR) DHS Database	FSR database of completed site reviews	12/31/2020	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
5. Focused Reviews - Critical Elements	Physician Site Monitoring / Quarterly Reporting to QI/UMC	Quarterly	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
F. Availability					
1. Primary Care Practitioners					
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Chief Network Administration Officer, Director Compliance		Ongoing 2020
2. Specialty Practitioners					
a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Chief Network Administration Officer, Director Compliance		Ongoing 2020
b. Geographic Standard	Measure and Report	Annually	Chief Network Administration Officer, Director Compliance		Ongoing 2020
G. Access					
1. Primary Care Appointments					
a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance		Ongoing 2020
b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance		Ongoing 2020
c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance		Ongoing 2020
e. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Chief Network Administration Officer, Director Compliance		Ongoing 2020
2. Telephone access to Member Services					
a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Chief Network Administration Officer, Director Compliance		Ongoing 2020
b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Chief Network Administration Officer, Director Compliance		Ongoing 2020
3. Mental Health Appointment	Quarterly MOU Meetings/Grievances	As necessary	Director of UM; Director of CM		Ongoing 2020
a. Life-threatening Emergency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance		Ongoing 2020
b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance		Ongoing 2020
c. Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance		Ongoing 2020
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		Ongoing 2020
e. Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Chief Network Administration Officer, Director Compliance		Ongoing 2020
- 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		Ongoing 2020
I. CAHPS Survey	State administered survey every 5 years - DHCS reduce the frequency but has not done so yet	10/1/2020	State Administered/CIO/Chief Medical Officer (CMO) / QI Director		Results received March 2020
1. Results reported to QI/UMC	Report to QI/UMC	9/1/2020	State Administered/CIO/Chief Medical Officer (CMO) / QI Director		On Track
2. Results reported to practitioners and providers	Report to QI/UMC	9/1/2020	State Administered/CIO/Chief Medical Officer (CMO) / QI Director		On Track
J. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
2. PCP & Mental Health	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
3. Specialist	Monitored through Grievances, Peer Review, HEDIS	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2020
K. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes ongoing reporting of Grievances, QI Program, Evaluation and Work plan	12/31/2020	QI Director		Ongoing 2020
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 2020
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 2020

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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
2. Minutes	Attached to next meetings agenda and sent to BoD	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		Ongoing 2020
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 2020
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 2020
II. UTILIZATION MANAGEMENT - See UM Work Plan					
A. Annual Review/Approval of UM Program Documents	Program Description 2020	9/1/2020	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		QI/UMC May 2020 Agenda
	Evaluation 2018	9/1/2020	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		QI/UMC May 2020 Agenda
III. CREDENTIALING AND RECREDENTIALING					
A. Initial Credentialing Site Visit & Medical Record	Upon Credentialing/Quarterly FSR Summary	Ongoing	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		Ongoing 2020
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/Compliance/MS for any opportunities form improvement identified. QI Department quality reviews of readmissions withing30 days, member deaths and notifications. See 1F	At least quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director		Ongoing 2020
1. Hospitals	Tracking grievances, Notifications, Deaths and QI issues	Ongoing	Chief Network Administration Officer		Ongoing 2020
2. SNF's	Tracking grievances, Notifications, Deaths and QI issues	Ongoing	Chief Network Administration Officer		Ongoing 2020
3. Home Health Agencies	Tracking grievances, Notifications, Deaths and QI issues	Ongoing	Chief Network Administration Officer		Ongoing 2020
4. Free-Standing Surgery Centers	Tracking grievances, Notifications, Deaths and QI issues	Ongoing	Chief Network Administration Officer		Ongoing 2020
5. Impatient MH/SA Facilities	Tracking grievances, Notifications, Deaths and QI issues	Ongoing	Chief Network Administration Officer		Ongoing 2020
6. Residential MH/SA Facilities	Tracking grievances, Notifications, Deaths and QI issues	Ongoing	Chief Network Administration Officer		Ongoing 2020
7. Ambulatory MH/SA Facilities	Tracking grievances, Notifications, Deaths and QI issues	Ongoing	Chief Network Administration Officer		Ongoing 2020
C. Ongoing Monitoring of Sanctions and Complaints	Ongoing; time sensitive; sanctions, grievance process	Ongoing	Chief Network Administration Officer/Compliance		Ongoing 2020
D. Credentialing / Recredentialing File Audit	Ongoing KHS/Compliance random audits	Ongoing	Chief Network Administration Officer		Ongoing 2020
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is JCI accredited	Annually / as necessary	Chief Network Administration Officer		Ongoing 2020
F. Annual Review of Credentialing/Recredentialing Policies and Proc	Ongoing	Annually / as necessary	Chief Network Administration Officer		Ongoing 2020
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 2020
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services		Ongoing 2020
C. Complaints and Appeals	Aggregate/analyze/report to QI/UM Committee Quarterly	Quarterly	Director of Member Services		Ongoing 2020
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 2020
E. Annual Analysis of Privacy and Confidentiality Policies	Review annually / Revise as needed	Ongoing	Director Compliance		Ongoing 2020
F. Marketing Information	Focus Groups, Public Policy/Community Advisory Committee	Ongoing	Director of Marketing		Focus groups will be continued in 2020
G. Delegation of Members' Rights and Responsibilities Activities	Non-delegated. Grievance committee	N/A	Grievance Committee		Ongoing 2020
H. Annual Review of Member Rights Policies and Procedures	Non-delegated	N/A	Grievance Committee		Ongoing 2020
VI. MEDICAL RECORDS					
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2020	Chief Medical Officer (CMO) / Chief Health Services Officer/ Director QI		Ongoing 2020
B. Distribution of Standards to New Providers	Ongoing / as necessary	Ongoing	Director of Provider Network Management		Ongoing 2020

KERN HEALTH SYSTEMS
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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
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 2020
D. Annual Review of Policies and Procedures	Annually and as necessary	Ongoing	Chief Medical Officer (CMO) / QI Director		Ongoing 2020

KERN HEALTH SYSTEMS

To: KHS Board of Directors

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

Date: June 11, 2020

Re: Utilization Management Program Documents

Background

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

- The Utilization Management Program Description, and
- The Utilization Management Program Evaluation

These documents are updated annually and presented to the Physician Advisory Committee, QI-UM Committee, and the Board of Directors for review, input and approval.

Discussion

2019 UM Program Evaluation (Attachment A)

The UM Program Evaluation is performed annually to review the effectiveness of the UM Program on how well it has deployed its resources to improve the quality and safety of clinical care and decision making. Where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Description.

2020 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.

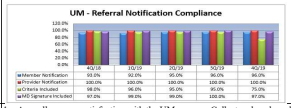
Requested Action

Review and approve the 2019 UM Program Evaluation and the 2020 UM Program Description.

2019 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. UM Management, in coordination with Human Resource and the Executive team, continue to develop alternative methods to attract and retain qualified RN candidates. 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 unprecedented growth as a result of the Affordable Care Act. With this growth came increasing medical complexity as the addition of the new aid categories and expanded eligibility that primarily consisted of adults. The Statement of Work completed in 2019 is as follows:

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	□ Leadership Support □ Mentoring	Met/Not Met	Year End 2019	1. Managerial training is provided to all onboarding of new management staff as well as ongoing opportunities for current levels of management, including Clinical and Non-Clinical staff in UM a. Outpatient Clinical Supervisor hired b. Director of Utilization Management hired	□ Goal met
UM	□ Staff Realignment of Health Service Departments	Met/Not Met	Year End 2019	1. Revised organizational structure chart conducted ad hoc 2. Developed, transitioned and implemented chart. 3. Created new job descriptions reviewed and approved by Human Resources. 4. Staffing cross training for outpatient, inpatient, California Children Services, Claims and Disputes review.	□ Goal met
UM	□ Update UM Program Description □ Completion of 2019 Annual UM Program Evaluation □ Development and implementation of 2019 UM Program Description	Met/Not Met	Year End 2019	1. Review, and revise the annual UM Program Description, Program Plan, and Evaluation including Medical and Behavioral Health. 2. Acquire approval of 2019 UM Program Description and the 2019 UM Program Evaluation from the appropriate utilization and quality committees within 12 months of the prior year approval. 3. Evaluate the adequacy of resources, committee structure, practitioner participation and leadership involvement in the UM Program to restructure or change the UM program for the subsequent year as necessary.	□ Goal met □ All documents reviewed, revised, and approved in 2019 □ Annual UM 2019 Program Evaluation was completed and approved □ UM 2019 Program Description was reviewed, revised and approved
UM	□ Resources for growth and development-Certified Case Manager	Met/Not Met	Year End 2019	1. Case Management Society of America – standards of practice provided to the Case Management staff-all Case Managers are Registered Nurses 2. Organizational Membership recommended for the team that allows for Director, Managers, and Supervisors to both access educational and training materials as well as allowing for annual conference attendance for leadership team. 3. Local Community Resources information provided. 4. Case Management, MCG Evidence Based Clinical Guidelines, Inpatient Concurrent Review Documentation, Ethics Training – resources on all these provided to team. 5. Trauma informed Care and ACE Awareness training completed.	□ Goal met -(6) staff attained CCM in 2019-(4) MSW, (2) RN
UM	□ Oversight of all delegated UM functions for the following services: Kaiser VSP Health Dialog	Met	Year End 2019	1. Evaluate effectiveness of the UM program for policy adherence to include compliance with state, federal, and NCQA standards. 2. Approve 2019 UM program evaluation for delegated services delegated services . 4. Submit delegated UM program information for approval at all applicable UM and Quality Committees	□ Goal met- Kaiser onsite audit conducted May 2019. VSP and Health Dialog quarterly JOC monitoring of activity. Next Steps: □ Continue quarterly review of delegated services UM reports, annual audit of Policy and Procedures, collaborations annual denial file review. Ad hoc review as identified. □ Report delegated services findings to KHS PAC and UM/QI Committees.
UM	□ Remote workforce support	Met	Year End 2019	1. VPN/RDP connectivity support for weekend coverage and UM staff remote workforce 2. Expanded remote workforce to facilities and other states to meet needs of the dept.	□ Goal met
UM	□ Provide UM Training Programs	Met	Year End 2019	1. Review, revise, and implement UM Training Program for UM stakeholders as applicable for ongoing process improvements. This includes inpatient, outpatient, CCS (Peds), Call tracking, QNXT and Jiva processes for both medical and mental//behavioral health conditions	□ Goal met Next Steps: □ Continue to update and provide training as needed □ Training is based on Regulatory standards and changes □ Training needs are identified through a Needs Assessment Trainings included rounds training tools, discharge planning tools, documentation recommendations and ethics training tools.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	☐ Review of 2019 Behavioral Health and Non- Behavioral Health UM criteria used for authorization decisions ☐ BH UM criteria revision approvals at Quality Committee and Executive Resource Committee	Met/Not Met	Year End 2019	1. UM Criteria used for Behavioral Health and Non- Behavioral Health authorization decisions reflect updates based on evidence based medicine, DHCS APL notifications, current medical literature, EOC, and formulary changes 2. Policy recommendations related to APL language or DHCS/DMHC guidance applied to policy and procedures. 3. Transition of all BHT services from Regional Center to Kern Health Systems.	☐ Goal met ☐ All criteria were reviewed by PAC committee, CMO and designees, and staff at various times throughout the year Next Steps: ☐ Continue annual review, update and approval of UM Criteria for 2019/2019 ☐ Dedicated team to review, monitor, and execute ABA and Mental Health services
UM	☐ Periodic reports to Quality Committee and Executive Committee	Met/Not Met	Year End 2019	1. Establish effective lines of communication regarding UM processes, new programs and issues/concerns: a) Executive Committee b) Physicians Advisory Committee c) UM/QI Committee d) Public Policy Committee e) Pharmacy and Therapeutics Committee f) Grievance Committee 2. Oversee the development, implementation and completion of corrective action plans (CAPS) related to regulatory survey findings.	☐ Goal met ☐ Periodic reporting is ongoing and completed to provide an update on UM processes, new programs and various UM related issues and/or concerns ☐ Determines necessity of implementing corrective action plans Next Steps: ☐ Continue to review, revise and approve Utilization management policies and procedures at designated timeframes. Ongoing and ad hoc report to committees
UM	☐ Timely and complete notification of denials of care	Met/Not Met	Year End 2019	1. Monitor, analyze and evaluate denial notices for compliance with federal, state, contractual requirements 2. Based on results of the analysis and evaluation: review, revise, approve and implement UM policies and procedures as needed as well as review staffing ratios to support compliance.  	☐ Goal Not Met -In one category, Q4 criteria inclusions with decisions fell below expectation to remain consistently at 90% or greater. JIVA implementation impacted notification related to new platform functionality and user learning curve ☐ Staff re-education/training on JIVA system and criteria attachment ongoing as warranted
UM	☐ Member Satisfaction with UM processes completion and analysis ☐ Physician satisfaction with UM programs; i.e. communication, access, authorization process	Met/Not Met	Year End 2019	1. Annually survey satisfaction with the UM process: Collect and analyze data on member and practitioner satisfaction to identify improvement opportunities and take action designed to improve member and practitioner satisfaction a. Report the annual survey results and opportunities to improve are approved by the appropriate UM and Quality Committees 2. Develop and Implement Corrective Action Plans (CAP) as needed based on results	☐ Goal Met Physician Satisfaction Survey completed in 2019 by SPH Analytics Member Satisfaction Survey completed in 2019 by SPH Analytics ☐ Favorable/consistent feedback received from various areas in assisting to provide quality patient care ☐ Results remained stable from past years, no significant changes
UM	Health Services P&Ps	Met/Not Met	Year End 2019	1. UM, DM, CM policies and procedures reviewed. Revisions to current UM and QI policies and procedures provided to PAC and QI/UM committee. Compliance department ownership for policy update timelines. 2. Delegated services to VSP, Health Dialog, and Kaiser 3. APL/PPL updates as warranted throughout the year	☐ Goal Met
UM	Interrater reliability audits	Met/Not Met	Year End 2019	1. Interrater reliability audits completed bi-annually with minimum 80% passing for all clinical staff and Medical Directors who render decision outcomes completed to support consistent application of medical necessity in the decision making process.	☐ Goal Met
UM	Emergency Room (ER) Utilization	Met/Not Met	Year End 2019	1. ER intensive case management follow up for the top 50 ER utilizers conducted by Case Management MSW. 2. Regular monthly report and ongoing program. Interventions include contacting the member, providing education, making the follow up appointment, and checking to ensure that the appointment was kept. 3. Partnerships with community entities to support efforts for educational support and coordination of care. 4. Social Workers providing resources to high ER utilizers 5. Transitional Care involving immediate post acute interventions to avoid readmission, ER utilization through coordination of care and member education.	☐ Goal Met

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	UM Senior Health Services Program Administrator (additional duties)	Met/Not Met	Year End 2019	1.Medication Therapy Management, Synagis, BHT reporting, Diabetic clinics, Clinical Engagement and multiple analytical reports completed. 2. UM Senior Health Services Program Administrator partners with KHS Business Intelligence team to develop more system driven outcomes reporting for new programs and expanded benefits. Respite, Pulmonary Rehab added as KHS benefit not reimbursed by DHCS but deemed critical to health outcomes for vulnerable populations. 3. Medical Loss Ratio project to optimize cost savings and improve delivery of care as defined in Triple Aim 4. Over and under utilization analysis on various specialty services	□ Goal Met
UM	DHCS/DMHC Audit	Met/Not Met	Year End 2019	DHCS performed a medical audit in August 2019. Category 2-Case Management and Coordination of Care- 1. The plan did not have written procedures to monitor completion of required member Initial Health Assessment (IHA) conducted by primary care providers. *Audit response and CAP approved by DHCS as follows:* a. Education to providers and members concerning IHA and SHA completion. 1/1/2020- Provider bulletin to be sent outlining timelines with links to age appropriate SHA for IHA/SHA completion--https://www.kernfamilyhealthcare.com/providers/provider-resources/manuals-and-forms/ b. 1/1/2020-Health Education/Health Promotion will continue to send monthly member incentives for IHA completion. c. 1/1/2020- New member enrollment outreach will remind members of IHA/SHA timelines and offer to schedule appt with PCP d. Pay for Performance for providers will continue with clams submission for IHA/SHA completion (billed ICD10 and IHA CPT code)- DHCS MRR hyperlink to Ped/Adult SHA link to KHS website e. Business Intelligence report to be created to be reviewed monthly by clinical staff and reconciling with claims data at 30, 60, and 90 day increments to determine which members have not completed the IHA/SHA to perform outreach for gap closure. f. 1/1//2020 Provider Gaps in Care Scoreboard elements will be mirrored for new internal report g. Update Policy 3.61 to reflect new process 2. The plan did not have a system to monitor and ensure member notification letters include all the required Continuity of Care (COC) transition information. *Audit response and CAP approved by DHCS as follows:* 1. Re-education to UM staff regarding selection of appropriate COC decision within JIVA Medical Mgmt. Platform (MMP) a. 12/9/19-re-eduction on JIVA dropdown for COC (see training reference b. Creation of new NOA letter specific for COC in JIVA MMP c. 11/6/19-Inital notification letter created for selection in JIVA MMP detailing COC process d. Configuration of JIVA to create activities to trigger automated letter generation for COC timeline notification e.11/8/19- NOA for COC sent to DHCS for approval f. 1/15/2020-JIVA MMP will need to be configured to auto-generate an activity 11 months after original COC letter sent (at least 30 days prior to end of COC period to complete the transition process. f. Update attachment COC NOA to policy 3.40 (upon approval by DHCS) g.Update monitoring process in policy 3.40 h. Periodic auditing, at a minimum of quarterly, of COC NOA applicable use	□ Goal Met
UM	Systems Review	Met/Not Met	Year End 2019	1. Systems review by component completed. 2. Clinical criteria, predictive modeling, workflows and educational tools integrated within the system. 3. JIVA Medical Management System implemented to include UM, CM, DM, HE, QI, and Health Homes	□ Goal Met
UM	Quarterly State Reports Timely Submission	Met/Not Met	Year End 2019	Quarterly report and mailing- a) Out of Network; b) CBAS; c) Mental Health; e) BHT-CDE and BHT-Quarterly; f) Dental Anesthesia; g) Palliative; h) QI-UM meeting minutes Delegated Kaiser reporting required for all reports listed to DHCS	□ Goal Met
DHCS	Quality Improvement/Utilization Management Committee (QI/UMC)	Met/Not Met	Year End 2019	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

<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>DHCS</td><td>Quality Improvement/Utilization Management Committee (QI/UMC)</td><td>Met/Not Met</td><td>Year End 2019</td><td>Nine (9) of the ten (10) positions were filled; Four (4) QI/UMC meetings were held in the reporting period with attendance
<table><tr><th>Role</th><th>Attended</th></tr><tr><td>CMO</td><td>4</td></tr><tr><td>Family Practitioner #1</td><td>4</td></tr><tr><td>Family Practitioner #2</td><td>OPEN</td></tr><tr><td>Specialist #1 (ENT)</td><td>4</td></tr><tr><td>Specialist #2 (OB/GYN)</td><td>3</td></tr><tr><td>FQHC Provider</td><td>4</td></tr><tr><td>Pharmacy Provider</td><td>4</td></tr><tr><td>County Public Health</td><td>3</td></tr><tr><td>Home Health-Hospice Provide</td><td>1</td></tr><tr><td>DME Provider</td><td>4</td></tr></table></td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Physician Advisory Committee (PAC)</td><td>Met/Not Met</td><td>Year End 2019</td><td>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</td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Physician Advisory Committee (PAC)</td><td>Met/Not Met</td><td>Year End 2019</td><td>Ten (10) PAC meetings were held during the reporting period with attendance as follows:
<table><tr><th>Role</th><th>Attended</th></tr><tr><td>CMO</td><td>10</td></tr><tr><td>Pediatrician</td><td>9</td></tr><tr><td>Clinical Psychologist</td><td>7</td></tr><tr><td>Eye Specialist</td><td>9</td></tr><tr><td>OB/GYN</td><td>8</td></tr><tr><td>Pain Medicine</td><td>10</td></tr><tr><td>Family Practicioner</td><td>5</td></tr><tr><td>Int Med</td><td>7</td></tr></table></td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met/Not Met</td><td>Year End 2019</td><td>1. Serves to objectively appraise, evaluate and select pharmaceutical products for formulary addition or deletion.
2. This is an ongoing process to ensure the optimal use of therapeutic agents.
3. P&T meet quarterly to review products to evaluate efficacy, safety, ease of use and cost.
4. Medications are evaluated on their clinical use and develop policies for managing drug use and administration.</td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Pharmacy and Therapeutics Committee (P&T)</td><td>Met/Not Met</td><td>Year End 2019</td><td>The Pharmacy and Therapeutics Committee has a total of (12) committee positions as follows:
<table><tr><th>Role</th><th>Attended</th></tr><tr><td>CMO</td><td>4</td></tr><tr><td>RX Dir</td><td>4</td></tr><tr><td>Bd Member</td><td>3</td></tr><tr><td>Rx Ind</td><td>2</td></tr><tr><td>Rx Chain</td><td>3</td></tr><tr><td>Rx Spec</td><td>Open</td></tr><tr><td>Rx Geriatric</td><td>3</td></tr><tr><td>Pediatrician</td><td>2</td></tr><tr><td>Int Med</td><td>2</td></tr><tr><td>GP</td><td>1</td></tr><tr><td>MD Geriatric</td><td>Open</td></tr><tr><td>OB</td><td>2</td></tr></table></td><td>☐ Goal Met</td></tr>
<tr><td>DHCS</td><td>Public Policy/Community Advisory Committee (PP/CAC)</td><td>Met/Not Met</td><td>Year End 2019</td><td>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.</td><td>☐ Goal Met</td></tr>
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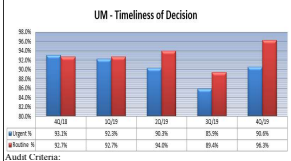
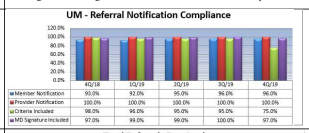
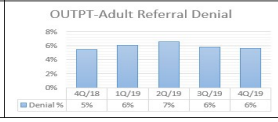
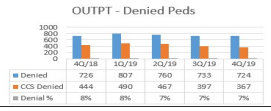
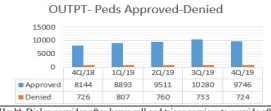
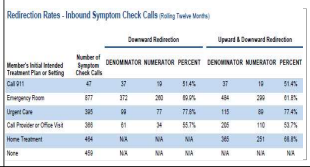
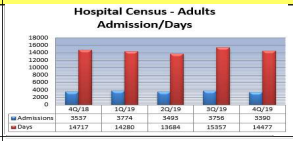
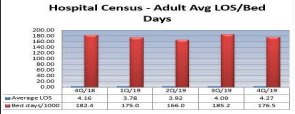
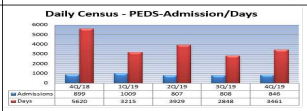
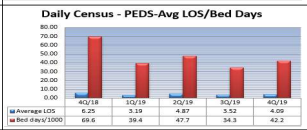
<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>DHCS</td><td>Public Policy/Community Advisory Committee (PP/CAC)</td><td>Met/Not Met</td><td>Year End 2019</td><td>Public Policy has 10 committee positions. In addition, the Participant Health Care Practitioner has been reduced to only 1 position.

<table><tr><th>Public Policy Committee Members</th><th>Attended</th></tr><tr><td>KHS Member</td><td>1</td></tr><tr><td>KHS Member</td><td>1</td></tr><tr><td>KHS Member</td><td>Vacant</td></tr><tr><td>KHS Member</td><td>Vacant</td></tr><tr><td>KHS Member</td><td>Vacant</td></tr><tr><td>Community Representative</td><td>1</td></tr><tr><td>Community Representative</td><td>1</td></tr><tr><td>Participant Health Care Practitioner</td><td>Vacant</td></tr><tr><td>Kern County Department of Public Health</td><td>1</td></tr><tr><td>Kern County Department of Human Services</td><td>1</td></tr></table></td><td>□ Goal Met</td></tr>
<tr><td>UM</td><td>Utilization Management Process

Policy/Procedure Revision/Development and Implementation</td><td>Met/Not Met</td><td>Year End 2019</td><td>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 DHCS contract and regulatory requirements and 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) in APL. Mega Regs and contract update necessitated multiple policy updates for 2019.</td><td>□ Goal Not Met-all P&P were not reviewed for routine review. P&P were updated according to APL/PPL/PL and all DMHC/DHCS releases.</td></tr>
<tr><td>UM</td><td>Revisions in Criteria and/or Approach to UM Activities</td><td>Met/Not Met</td><td>Year End 2019</td><td>1. Milliman Care Guidelines (MCG), an evidence based web criteria utilized by KHS, are updated annually by MCG. MCG provides KHS UM with training and documentation of changes that have occurred.
2. The Clinical Intake Coordinators and Chief Medical Officer, and Medical Directors utilize MCG, Medi-Cal Guidelines, DHCS and DMHC contract language, and KHS Internal Guidelines to determine if a referral reviewed for medical necessity should be denied, modified and deferred.
3. MCG Inter-Reviewer Reliability is performed bi-annually to promote consistency of the application of guideline utilization by all clinical UM staff
4. Presently there are 60+ internally created medical guidelines referenced by the staff for decision making.
5. Internal guidelines based on Medi-Cal and other evidence based sources are drafted in 2019 by the Director of Utilization Management or Chief Health Services Officer and approved for implementation by the KHS Chief Medical Officer for presentation to the PAC and QI/UM Committees to provide additional support in the decision making process.
6. As part of the JIVA Medical Management implementation project, KHS transitioned from static MCG criteria to interactive Care Web QI format that allows for interactive criteria application and detailed summary of decision making to providers</td><td>□ Goal Met - Next steps in CQWI JIVA implementation will be to incorporate a Point of Service Decision Making tool through a direct interface to the MCG criteria with the providers who submit authorization requests electronically via the Provider Portal.</td></tr>
<tr><td>UM</td><td>Monitoring UM Decision Turn-Around Times, Volume, and Denial Rates</td><td>Met/Not Met</td><td>Year End 2019</td><td>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 five-day turnaround time.
3. A formal timeliness report is provided by the Director of Utilization Management on a quarterly basis to the QI/UM Committee.</td><td>□ Goal Not Met for monitoring/oversight-90% in each quarter</td></tr>
</table>

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Timeliness of Decision Trending	Met/Not Met	Year End 2019	Quarterly audits are conducted to ensure compliance with regulatory requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral. Urgent: Response back to Provider in 3 business days Routine: Response back to Provider in 5 business day  Audit Criteria: - Member Nonfiction: Letter of referral decision sent to member within 24 hours - Provider Notification: Referral is faxed back to the provider with 24 hours of decision - Criteria Included: Criteria provided to provider on denial reason - MD Signature: MD Signature included all referrals/NOA letters upon denial	☐ Goal Not Met -Q3 2019 challenged with staff vacancies and new hire training gaps coupled with increase referral volume impacted compliance rate.
UM	Timeliness of Decision Trending	Met/Not Met	Year End 2019		☐ Goal Not Met Q4 >90% in 2019 for criteria included related to new staff hires and training gaps impacted compliance rate.
UM	Referral Count	Met/Not Met	Year End 2019		☐ Goal Met
UM	Denial % - Adults	Met/Not Met	Year End 2019		☐ Goal Met- goal is to remain below 10% overall denial rate

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Approved/Denied Adult Referral Count	Met/Not Met	Year End 2019		□Goal Met
UM	Denial % - Peds	Met/Not Met	Year End 2019		□ Goal Met- majority of denials related to carved out services; i.e. CCS, Kern Regional Center- not under KHS benefit
UM	Approved/Denied Peds Referral Count	Met/Not Met	Year End 2019		□ Goal Met
UM	Monitoring of Emergency Services - -Health Dialog	Met/Not Met	Year End 2019	1. Health Dialog provides after-hours call and triage services to provide after hours medical triage, eligibility information, and determine appropriate place of service disposition. 2. Health Dialog provides monthly summary reports which are reviewed to monitor trends and reports to the Executive Staff to determine if additional steps are needed to educate the providers and members in efforts to decrease ER usage and increase the member's ability to seek care of their assigned PCP office. 3. Health Dialog Quarterly JOC are held to resolve any issues, develop partnerships, and review data for process improvement. 	□Goal Met
UM	Monitoring of Inpatient Admissions	Met/Not Met	Ongoing	1. Daily census and rounding reports were expanded in the Business Intelligence to identify all reported hospital and other facility admissions. 2. These reports are reviewed daily by the UM Management team to assess inpatient volume and determine length of stay appropriateness as documented by the UM Inpatient team. 3. These reports have been refined to provide financial obligations on a daily basis as well as detailed information on discharges, real time level of care and anticipated bed days. 4. Business decisions can be formulated based on details contained in the reports.	□ Goal Not Met- ALOS not met for overall goal of 3.5 days or less for acute setting

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Monitoring of Inpatient Admissions-Adults	Met/Not Met	Ongoing		□Goal Met
UM	Monitoring of Inpatient Admissions-Adults Average LOS	Met/Not Met	Year End 2019		□ Goal Not Met-GLOS <4 days. SNF/rehab stays impact LOS when included.
UM	Monitoring of Inpatient Admissions-PEDS	Met/Not Met	Year End 2019		□ Goal Met-admissions impacted by CCS eligibility and transition of financial responsibility.
UM	Monitoring of Inpatient Admissions-PEDS Average LOS	Met/Not Met	Year End 2019		□ Goal Met -GLOS <5 days
UM	Transition of Care Program-30 day Readmissions	Met/Not Met	Year End 2019	Tracking and trending continues as a collaborative effort between UM and QI for 30 readmissions. Care/Case management perform outreach for post discharge members for care coordination and resources allocation. Transitional care clinics were created to enhance immediate access to either members PCP or specialized clinic to perform medication reconciliation, DME procurement, and promote medical and behavioral condition stabilization. MSW are placed in the TOC clinics to provide care coordination and resource information for housing, food, and other social determinants of health.	□ Goal Met -readmission rate <12%, although not solely related to TOC clinics and CM efforts. Other disease specific programs such as palliative care, COPD, MTM, and MSW SDoH interventions, etc. all contribute to the readmission rate.
UM	Transition of Care Program-Medication Reconciliation with Pharmacist Education and intervention	Met/Not Met	Year End 2019		□ Goal Met-cost savings experienced in reduction in ER although increases seen in UC utilization related to ER diversion.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Monitoring Under-utilization	Met/Not Met	Year End 2019	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
UM	Process for Monitoring Over-utilization	Met/Not Met	Year End 2019	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. Specialty referrals for the members are reviewed concurrently by the RN Clinical Intake Coordinators. The medical necessity for the referral is considered as well as determining the appropriateness of locally provided care versus out of area tertiary facility treatment. 4. Durable medical equipment continues to be tracked for duplication and rental items are monitored for the appropriateness of continued use. 5. Other areas of ongoing audits involve Mental Health, Applied Behavior (ABA), Pain management, Physical and occupational therapy, and review of providers requesting services outside of their specialty. termination letter is drafted after review of the documentation by the Chief Medical Officer or designee.	□ Goal Met -MH, ABA, DME, Pain management and other completed in 2019
UM	Process for Monitoring Over-utilization (continued)	Met/Not Met	Year End 2019	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
UM	CCS Collaboration	Met/Not Met	Year End 2019	Ongoing supportive and collaborative partnership with county CCS. KHS worked with CCS to identify transportation duplication among KHS membership. KHS has co-located a CCS staff RN 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	Health Home Program	Met/Not Met	Year End 2019	Six Health Home Models were fully implemented and aligned with the State HHP Program by 7/1/2019. One HHP site combined the 2 existing sites to meet the requirement of Serious Mental Illness (SMI) integration. This reduces the total of HHP sites to 5. KHS has provided continued oversight, administrative and financial assistance to the HHP sites while closely monitoring quality and compliance to the State HHP guidelines through Medical Record clinical audits. Sites are provided with frequent feedback and reporting to monitor for program effectiveness and to ensure the provision of Medical, Behavioral, and Social aspects of member care.	□ Goal Met The 2019 goal of aligning the 6 HHP sites with the State Program has been met (5 total after combining of 1 provider). The second of Kern County FQHC providers is planned for an additional 1-2 HHP sites in 2020. KHS is also preparing to open two Distributive Model HHP sites in 2020. The Distributive Model sites will utilize an existing provider in the KHS network to serve as HHP PCP while the support staff including Nurse, Care Coordinator, Social Worker, and Pharmacist will be supplied by KHS to meet the member at their PCP, telephonically, and/or at the member's home.
UM	Point of Service MCG Clinical guideline Integration	Met/Not Met	Year End 2019	Product expansion with current Evidence based criteria vendor MCG to include Care Web QI to allow for point of service authorization for providers via portal entry; promote consistent application of guidelines; increase reporting capabilities in the goal of operational efficiency with one system versus multiple internal workflows.	□ Goal Met- MCG CWQI functionality incorporated into the JIVA Medical Management platform in November 2018. Versioning updates will continue through 2019 to ensure access to the most current guidelines. □ Goal Not Met-MCG product was ready for integration and implementation in 2019. Due to technical issues with certification and integration into the JIVA medical management platform, the MCG POS was not completed. Sentinel rule and configuration issues are near completion and anticipated implementation is planned for Q2 2020.

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Physician Profiling	Met/Not Met	Year End 2019	Track and trend physician pattern of Utilization to address outliers in the deviation from standard of care in a goal towards value based purchasing alternative payment methodologies. Areas of focus include Inpatient, Outpatient, ER utilization, Pharmacy, Specialty referral, HEDIS/MCAS and DME/ancillary utilization, etc. that allows for drill down to costs, utilization, and comparison among peers. The tool is used as an educational component to the contracted provider network to foster appropriate utilization, reduce burden administrative burden to the provider, reduce medical costs, and reward providers whose practice patterns are aligned with industry standards that in turn improve health and consistency among the community providers.	Goal Met - 2D profiling will be used by Medical Mgmt. and Executives for physician trending and educational opportunities conducted by KHS clinical staff. Phase 2 of the Physician Profiling project was completed Q4 2019.

KERN FAMILY HEALTH CARE
UTILIZATION MANAGEMENT
2020 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 258,000 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. KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to elevate the health status of all community members.

The purpose of the Utilization Management (UM) Program is to provide members with comprehensive health care and health education, within available resources, and to achieve the optimum level of quality health care in a cost-effective manner. Coordination with various internal departments such as Case Management, Pharmacy, Disease Management, Transitional Care, Health Homes, 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 efficiency and continuity in this program, policies and procedures have been developed to define major functions and accountabilities. All activities described in the UM Program are conducted with oversight by the Quality Improvement/Utilization Management (QI/UM) Committee.

Most requests for routine, non-emergent medical care (unless otherwise specified) are authorized prospectively by the UM department for Kern Family Health Care (KFHC) members. Prior authorization is required for specific identified services 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 facility
- Abortion Services,
- Dialysis,
- Hospice Care,
- Transportation (verification of visit location required),
- Sexually Transmitted Disease treatments,
- HIV Services,
- Family Planning Services,
- Mental Health,
- 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 Case Management, Disease Management, and Health Education through the referral/authorization review process;
- Foster Transitional Care to enhance the continuum of care;
- Develop programs that address specific needs of the KHS population;

- Educate members, practitioners and provider organizations of objectives for providing high quality and value enhanced managed health care; and
- Identify potential quality of care issues.

Objectives

The KHS UM Program develops, implements, continuously updates, and annually improves a UM program that ensures 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;
- Established criteria for approving, modifying, deferring, delaying, terminating, or denying 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 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 x-rays
- Specialty Consultation reports, including photographs, operative, and pathology reports
- Pharmacy profiles
- Telehealth communications
- Hospital records
- Behavioral Health/Mental Health
- 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 when needed
- Delivery system capabilities and limitations such as availability of behavioral health services, skilled nursing facilities, sub-acute care facilities or home care in the service area that supports the patient after discharge DME or ancillary needs

Local hospitals' ability to provide all recommended services within the estimated length of stay
The KHS UM Program verifies that its pre-authorization, concurrent reviews, 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;
- 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 regarding the particular patient is also considered when making decisions. 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
- MCG Hearst Health Network
- UpToDate
- Medi-Cal /Medicare Guidelines
- KHS Internally generated Medical Criteria
- DHCS/DMHC Guidelines
- All Plan Letters (APL)
- Policy and Procedure Letters (PPL)

Scope

Kern Health Systems Utilization Management Program provides comprehensive health care services. The scope of covered services defined by the UM Program includes:

- Prior authorizations/referral management
- Primary and Specialty Care
- Tertiary referral coordination
- Behavioral/Mental Health
- Autism Spectrum Disorder/Behavioral Intervention Services
- Concurrent review
- Retrospective review
- Continuity of Care
- Recommendations for policy decisions
- Guidance of studies and improvement activities
- Complex/Targeted Case management
- Chronic Condition Management (specialized programs)
- Medication Therapy Management
- Transitional Care
- Community Based Adult Services (CBAS)
- Respite Care (DHCS approved KHS benefit enhancement)
- Pulmonary Rehabilitation (DHCS approved KHS benefit enhancement)
- Maternity Care
- Gender Dysphoria
- Acupuncture
- Chiropractic
- Dental Anesthesia
- Genetics
- Specialty Medication (Pharmacy coordination)
- Major Organ Transplants (kidney only)
- Durable Medical Equipment (DME)/Prosthetics and Orthotics (P&O)/Soft Goods
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Supplemental Shift Nursing Services
- External (Out-of-Plan) referrals (including post stabilization care requests)
- Discharge planning/Rehabilitation Services
- Occupational and Physical Therapy Services
- Speech and Language Therapy Services
- Prescription Drug Program in coordination with the Director of Pharmacy
- Out-of-area Case management
- Emergency service management
- Emergent/Non-emergent Medical Transportation

- Ancillary service management
- Home Health
- Cardiac Rehabilitation
- Hospice Services
- Palliative Care
- Pain Management Diagnostic Services; including laboratory, radiology, and genetic counseling
- Inpatient certification
- Skilled Nursing and Long-Term Care (limited benefit)
- Denial/Notice of Action
- Utilization data management
- Social Services (i.e. tracking of appropriate usage of services, mental health service assistance, social services assistance
- After Hours Nurse Triage Services
- Appeals and Grievance
- Claims and Disputes
- Recommendations for any additional needed actions

The UM Program addresses the technical, professional and clinical aspects of patient care, which includes but is 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
- Valid data management to include the following data sources:
  - Claims and encounter submission
  - Medical Records
  - Medical Utilization data
  - Pharmacy Utilization data
  - Predictive Modeler data
- Identification of potential quality of care issues
- Clinical staff training for quality and accuracy

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. 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. For those Kern Family Health Care members not currently receiving ABA treatment from the local Regional Center, 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, 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 Continuity of Care for the defined members.

Respite/Recuperative Care

The purpose of Respite/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.

Respite/ 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 five (5) to sixty (60) days is dependent on each 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

Health Home Program

The Health Homes Program (HHP) is an option afforded to states under Section 2703 of the Affordable Care Act. It allows states to create Medicaid Health Homes to coordinate the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by beneficiaries with chronic conditions.

Program eligibility is based on meeting a set of chronic physical/Substance Use Disorder (SUD) or Severe Mental Illness (SMI) conditions as well as specified acuity criteria. The HHP will serve as the central point for coordinating patient-centered care and will be accountable for:

- Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long-Term care, palliative care, and social support needs
- Reducing avoidable health care costs, including hospital admissions/readmissions, Emergency Department visits, and nursing facility stays

Improving member outcomes and reducing health care costs will be accomplished through the partnership between KHS and the Community Based Care Management Entities (CB-CME), either through direct provision of HHP services, or through contractual or non-contractual

arrangements with appropriate entities that will be providing components of the HHP services and planning and coordination of other services.

KHS is responsible for providing the following six core HHP services:

- Comprehensive care management,
- Care coordination,
- Health promotion,
- Comprehensive transitional care,
- Individual and family support, and

Referral to community and social support services. The HHP is structured as a health home network with entities functioning as a team to provide whole-person care coordination as outlined by the Department of Health Care Services. These include but not limited to:

• *Improve care coordination*. A primary function of the HHP is to provide increased care coordination for individuals with chronic conditions. This increased care coordination will be provided through HHP Services, which include homelessness, physical and behavioral health, and care coordination.

• *Integrate palliative care into primary care delivery.* To strengthen the foundation for palliative care delivery, palliative care will be included in an HHP member's needs assessment. Care coordinators may also emphasize the importance of using advanced directives and Physician Orders for Life-Sustaining Treatment (POLST) forms.

• *Strengthen community linkages within health homes.* Linkages to housing and social services are critical to providing comprehensive care coordination in HHP. Requirements for strong linkages to, and assistance and follow-up with, community resources will ensure that these resources are available to HHP members. In addition to linking and coordinating available social services, the multi-disciplinary care team will also encourage HHP members to participate in evidence-based prevention programs such as diabetes management and smoking cessation, and other available programs that are documented to use best practices and have positive outcomes. Information about the availability of these programs will be provided to the member.

• *Strengthen team-based care, including use of community health workers/ promotoras/other frontline workers.* HHPs will be required to have team-based care, including community health workers where appropriate. Because of the linkages to housing and other social services, and

potential outreach activities, community health workers will have a role in providing HHP services.

• Improve the health outcomes of people with high-risk chronic diseases.

To date, KHS has fully implemented four (4) HHP facilities in collaboration with our Federally Qualified Health Center (FQHC), public hospitals, and community at large providers. Two additional locations are in progress with an anticipated implementation of Q2/Q3 2020.

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 rehospitalized, 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 linkages and partnerships;
- Quality and value based system of care;
- Create robust inpatient discharge coordination and develop cross-system transfer of care protocols;
- Expand strategy and education opportunities;
- Improve patient experience and quality outcomes; and
- Implement model of care that is sustainable and cost effective

Collaboration of Services

The scope of the UM Nurse and Clinical Intake Coordinator extends beyond the management of referrals. While performing UM activities, any quality of care issues or concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential in order to ensure the delivery of quality care to the plan's membership.

Continuity of Care is coordinated upon enrollment for those members with established relationships with Primary Care Providers, Specialists, ancillary or DME providers to promote uninterrupted services that may have been initiated prior to the member's enrollment with KHS.

KHS is required to provide beneficiaries with the completion of certain covered services that the beneficiary was receiving 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 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 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.

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 so as to link information.

The Board of Directors delegate's responsibility for monitoring the quality of health care delivered to members to the Chief Medical Officer or designee, and the QI/UMC with administrative processes and direction for the overall UM Program initiated through the Chief Medical Officer.

Chief Medical Officer (CMO) Responsibilities:

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

- Application of the UM Program, by KHS staff and contracting providers;
- Participation in provider quality activities, as necessary;
- Monitoring and oversight of provider QI and UM programs, activities and processes including policies;

- Oversight of KHS delegated credentialing and recredentialing activities;
- Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care;
- Final authority and oversight of KHS non-delegated credentialing and recredentialing activities;
- Monitoring and oversight of any delegated UM activities;
- Supervision of Health Services staff involved in the UM Program, including: Chief Health Services Officer, Director of Pharmacy, and Clinical director staff;
- 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;
- 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;

- Supports, communicates, and collaborates with KHS Clinical Intake Coordinators and UM Nurses in order to resolve case management and referral issues;
- Implements the Disease Management, Health Education, Case Management, Health Homes, and Quality Improvement Program(s).

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 (1) OPEN
2	Participating Specialty Physicians-OB/GYN 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	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
3	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 Chief Network Administration Officer, or designee
1	KHS Chief Operations Officer
1	KHS Grievance Coordinator (Staff)
1	KHS Director of 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.

The duties of the position include but 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

- 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.

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.

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.

- 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.

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.

- 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 time cards, for all clerical hourly staff in the UM;
- Monitor UM processes for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes;
- Train staff, as appropriate, regarding use of the Medical Management systems as it relates to the UM and Pharmacy processes;
- Generates reports for CMO and Chief Health Services Officer to support business decisions;
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental analyst(s) and Senior Health Services Program Administrator;
- Works in collaboration with the Senior Health Services Program Administrator to develop and facilitate new program processes and guidelines under the supervision of the Chief Health Services Officer.

UM Outpatient Clinical Supervisor

The UM Outpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Outpatient Medical, Behavioral, Mental Health, and Social Services within the UM Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient and productive operations within the UM Department, as directed by the Chief Health Services Officer. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision making process.

- 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.

- 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 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 /LVN)

Under the direction of the Kern Health Systems (KHS) Director of Utilization Management, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The UM Nurse and Clinical Intake Coordinators are supported by a Non-Clinical team for administrative duties and coordination. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent, and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload on a monthly basis.

- Promote coordination and continuity of care and quality improvement in both the inpatient and ambulatory care setting;
- Evaluate the appropriateness of care using established criteria and KHS' benefit guidelines;
- Support KHS developed programs through member identification for participation; i.e. Diabetic Clinic, Health Home, Complex Case Management, Respite, Palliative, Transitional Care, Health Home, and Social Worker interventions;

- Review and approve specialty and ancillary service referrals using established criteria for purposes of pre-authorization of payment;
- Review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership;
- Coordinates discharge planning activities with facility discharge planners;
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan 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)

- 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.

- 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.

- Responsible for the promotion of coordination, continuity of care and quality improvement in both the inpatient and ambulatory care settings;
- Assists the members with psychosocial and discharge planning needs as well as community resources;
- Performs reviews available reports for frequent usages of services and inappropriate usage of services by members;
- Identifies environmental impediments to client or patient progress through both personal or telephonic interviews and review of medical records;
- Investigates suspected child/elder abuse or neglect cases and notify authorized protective agencies when necessary.
- Refers member to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, or education.
- Advocates for members to resolve crises and demonstrate proficiency in de-escalation and interventional techniques
- Provides assistance and education to members as appropriate and in coordination with disease management, works to improve member participation in regular testing and screening along with follow-up visits to their PCP;
- Works collaboratively with the Care Management team to assist with identified social issues;
- Provide guidance and recommendations for the Behavioral and Mental Health Benefits (mild to moderate), including Autism Spectrum Disorders and Behavioral intervention.

Senior Health Services Program Administrator

The Senior Health Program Administrator is responsible for oversight, coordination, planning, management, execution, and finalization of Business related programs that require Business resources. The Senior Health Program Administrator will be required to conduct program analysis, comprehend technical requirements, define plans for execution, coordinate technical resources assigned to tasks or programs, create program tracking reports, and accurately report to all levels of management on a program(s) status. This position requires the ability to maintain an interdependent relationship with providers, staff and members by providing administrative support on sponsored projects.

- 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, researches 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.

- 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.

- 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.

- 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.

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 Health Education 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 Health Services Management leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

KHS UM Management staff evaluates competency of the clinical decision making staff with bi-annual assessment through the MCG IRR training module for Medical Directors and Clinical Intake Coordinators and UM Nurse staff. The Director of UM selects specific topics for completion by the Medical Directors, Clinical Intake Coordinators and UM Nurse staff. The IRR training module records the completion for each user, along with the test results. Successful completion is required as a fulfillment of the clinical staff outlined job duties.

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.

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

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.

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.

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 utilize health care services for members provided by KHS network providers, and/or providers approved through the Utilization Management Letter of

Agreement process, unless medical necessity or emergency dictates otherwise. KHS utilizes a member centric medical management documentation platform, JIVA system by Zeomega, to house all clinical information for each member. All health services departments with the exception of Pharmacy, have been implemented on the new platform in 2019.

Out of Plan Referrals

Prior authorization is required for all out of plan referrals requesting consultation and/or treatment. Physician requested Out of Area/Out of Network referrals are processed through Provider Relations Department with Letters of Agreement (LOA) for financial reimbursement methodology.

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.

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.

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.

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.

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.

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.

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.
Members with a need for a standing referral are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity.

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 Condition
- 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.

Durable Medical Equipment (DME)

Provider requests for DME, including Prosthetics and Orthotics (P&O), requires prior authorization and benefit coverage review using DME Formulary UM criteria. In the event a request does not meet DME UM criteria, a Medical Director reviews the request for medical appropriateness. All DME benefit decisions are made by trained staff; medical necessity denial decisions are rendered by KHS Medical directors and appropriate denial notices are issued to the provider and member by KHS.

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:

- Milliman Care Guidelines (MCG)– Updated annually by vendor in 1st Quarter
- 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
- Internally generated Medical Criteria derived from evidence based medical references and reviewed annually for revisions or appropriateness based on MCAL guidelines.
- Up to Date- evidence-based physician-authored clinical decision support resource which clinicians utilize to determine point-of-care decisions, including a collection of medical and patient information, access to Lexi-comp drug monographs and drug-to-drug, drug-to-herb and herb-to-herb interactions information, and a number of medical calculators.

- All Plan Letter (APL) guidance as received from DHCS/DMHC
- All criteria are available to the public upon request.

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 every two years and updated if necessary.

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.

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.

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 have been created for transparency of all identified KP.

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

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.

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. Additionally, KHS Facility Based UM Nurses perform concurrent inpatient review for members on location at specific contracted local area facilities. The purpose of the services was to provide real time record review and promote early discharge planning as well as assist with decreasing length of stay and facilitate services requested during the hospital admission. Members are also triaged in the ER to assist in decreasing unnecessary admissions through prompt recognition of services needed prior to receiving a retro notification from the hospital regarding an admission by our hospitalist or the RN.

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.

Discharge Planning

UM Nurse staff 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 placement, DME, Home Health, specialist follow-up visits, social determinants, and any other services pertinent to the member's recovery. Provision and coordination for immediate post discharge care through Respite, Acute/Pulmonary/Cardiac Rehabilitation, and Transitional Care Clinics are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

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 discrimination clauses and tagline notations.

When a physician requests a health care service that is subject to prior authorization and the request has been reviewed, denied, delayed, or modified as a result of UM review, the member and provider are provided a written communication that includes the following required elements:

- A clear and concise explanation of the reasons for the Plan's decision;
- A description of the utilization review criteria used, and the clinical reasons for the decision regarding medical necessity;
- Information as to how the member may file a grievance or appeal with the Plan and, in case of Medi- Cal members, information and explanation on how to request an administrative hearing in compliance with Title 22 of the California Code of Regulations;
- Notice of availability of language assistance services;
- Written notice to physicians or other health care providers of a denial, delay, or modification of a request, including the name and telephone number of the health care professional responsible for the decision. The telephone number is a direct number or an extension that allows the physician or health care provider easy access to the professional responsible for the UM decision. UM staff and physicians are available during normal business hours to assist members and physicians with UM concerns;
- Written Notice to the physician and member includes information on Independent Medical Review.

Denial notices are issued in accordance with applicable regulations and accreditation standards. The Department of Health Care Services and Department of Managed Health Care provide direction to and oversight of the process of issuing written notification of non-coverage to KHS members.

Appeal Process

KFHC members are notified in writing of his/her right to appeal through the Member Grievance Process within the Notice of Action letter correspondence. The notice includes member's right to request a State Fair Hearing, member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend, or other spokesperson, the name, address, and phone number of KHS, toll free number for obtaining information on legal service organizations for representation, and the right to request an Independent Medical Review.

Practitioners/providers may submit a written appeal for referrals that have been denied on the member behalf with a member's consent. KHS has established a fast, fair and cost-effective appeal resolution mechanism to process and resolve practitioner/provider prior auth appeals. A practitioner or provider appeal is defined as "A contracted, or non-contracted practitioner's or providers written notice to KHS seeking resolution of a denial of service referral request." The appeal must contain the practitioner/provider 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.

Evaluation of New Medical Technologies

KHS evaluates a variety of web-based interactive applications for future consideration of medical technologies adoption. KHS MIS department develops and implements new technologies as they emerge to provide efficient methods of tracking member activity and report generation. UM clinical staff have direct access to various websites for review and reference for discussions on innovative methods not currently in use by KHS that may be implemented in the delivery of healthcare to KHS members. New technologies are vetted with MCAL guidelines for coverage, then forwarded to the PAC and QI/UM committees before board approval.

The following information is gathered, documented and considered for determination:

- Proposed procedure/treatment/medication device
- Length of time the treating practitioner has been performing the procedure/treatment
- Number of cases the practitioner has performed
- Privileging or certification requirements to perform this procedure
- Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated
- Identification of other treatment modalities available
- Consideration as to whether Medicare/Medi-Cal approves the service/procedure
- Whether the medication/procedure is FDA approved
- Literature search findings
- Input from network Specialist

The CMO, or designee, or the Director of Pharmacy, consults specialists, market colleagues, the Physicians Advisory Committee (PAC) and/or the Pharmacy and Therapeutics Committee (P&T) as needed to assist in making coverage determinations and/or recommendations.

Telemedicine/Telehealth

Telemedicine and other remote monitoring capability is 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.

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 is 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.

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.

Medical Reviews and Audits by Regulatory Agencies

KHS' Director of Compliance and Regulatory Affairs, in collaboration with the CMO, Chief Health Services Officer, and other Clinical leadership, provides direct oversight to all KHS medical audits and other inquiries by our regulatory agencies, DHCS and DMHC. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

Integration of Study Outcomes with KHS Operational Policies and Procedures

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

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 and incorporates quality, risk and safety processes and initiatives into prospective, concurrent review, identification of quality, safety and risk incidents, patterns and trends through UM clinical review are escalated to the appropriate quality department in a timely manner. Results of monitoring and analysis of utilization of care and services, including over- and under-utilization trends, are integrated into the KHS Quality Program through reports to the Program's UM/Quality Committees. Utilization reports that display metrics across regional, service area, and medical center level performance are collected and analyzed to identify improvement opportunities, ensure consistency, and decrease variation in practice and care delivery.

The Board of Directors is responsible for the direction of the UM Program and actively evaluates the annual plan to determine areas for improvement. Board of Director comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of UM activities and progress toward meeting UM goals is available to members and contracting providers upon request.

_____

KHS Board of Directors (Chair) Date

_____

Chief Executive Officer Date

_____

Chief Medical Officer Date

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: June 11, 2020

Re: Quarterly Review of Kern Health Systems Investment Portfolio

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Background

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

- Preservation of principal
- Liquidity
- Yield

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

Short-Term Portfolio (Under 1 year)

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

Long-Term Portfolio (1-5 years)

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

Requested Action

Receive and File.

Kern Health Systems
Investment Portfolio
March 31, 2020

Short Term Portfolio (under 1 year)

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

Description			Dollar Amount	% of Portfolio	Maximum Allowed Per Policy	Approximate Current Yield	Liquidity	Principal Fluctuation
Wells Fargo - Cash		(1)	$ 2,600,000	1.75%	100%	1.00%	1 Day	None
JP Morgan Money Market	(A)	(1)	$ 12,000,000	8.07%	20%	0.24%	1 Day	None
Local Agency Investment Fund (LAIF)	(B)	(2)	$ 60,000,000	40.35%	50%	1.89%	2 Days	None
US T-Bills at Wells Fargo		(1)	$ -	0.00%	100%	0.00%	1 Day	Subject to Interest Rate Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)	(1)	$ 13,000,000	8.74%		1.56%	3 Days	Subject to Interest Rate Fluctuations
Sub-Total			$ 87,600,000	58.91%		1.59%		

Long Term Port Folio (1 - 5 years)

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

UBS Managed Portfolio	(D)		$ 58,100,000	39.07%		1.53%	3 Days	Subject to Interest Rate and Credit Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)		$ 3,000,000	2.02%		1.92%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 61,100,000	41.09%		1.55%		
Total Portfolio			$ 148,700,000	100.00%		1.57%		

Yield Curve

Yield Curve	Treasuries	AA Corporate Bonds	A Corporate Bonds	CD's
I year	0.15%	0.85%	1.00%	0.85%
2 year	0.20%	0.95%	1.15%	0.90%
3 year	0.25%	1.10%	1.30%	1.00%
5 year	0.36%	1.35%	1.50%	1.15%

(A) $121.0 Billion money market fund managed by JP Morgan comprised of US Treasury Obligations.
(B) LAIF is part of a $98.1 Billion Pooled Money Investment Account managed by the State Treasurer of CA. Majority of portfolio is comprised of Treasuries, CD's, Time Deposits and Commercial Paper.
(C) High quality diversified portfolio comprising commercial paper, corporate bonds and notes.
(D) High quality diversified portfolio comprising certificate of deposits, corporate bonds and notes, municipal securities and US Treasury Securities. Includes investments maturing in less than 1 year that will be re-invested for over 1 year at maturity.

(1) Funds are utilized to pay providers, meet operating expenses, distribute pass-through monies waiting for additional approvals and/or support, amounts owed to the State for MCO Taxes, potential State premium recoupments and for amounts owed under the Expansion Risk Corridor. Extra liquidity is maintained in the event the State is late with its monthly capitation payment.
(2) Funds are primarily utilized to fund various Grant Programs and 2020 capital projects.

UBS

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

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

UBS Client Review

as of March 31, 2020

Prepared for

Kern Health Systems

Accounts included in this review

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

What's inside

UBS

Portfolio review

as of March 31, 2020

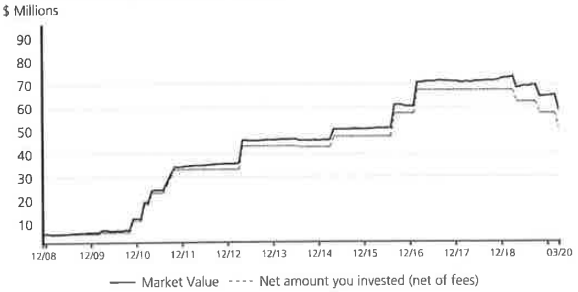
EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for **Kern Health Systems**
Risk profile Conservative
Return Objective Current Income

Asset allocation review

		Value on 03/31/2020 ($)	% of Portfolio
A	**Cash**	**7,458,544.55**	**12.83**
	Cash	7,458,544.55	12.83
B	**Fixed Income**	**50,671,252.83**	**87.17**
	US	50,671,252.83	87.17
C	**Equity**	**0.00**	**0.00**
D	**Commodities**	**0.00**	**0.00**
E	**Non-Traditional**	**0.00**	**0.00**
F	**Other**	**0.00**	**0.00**
	Total Portfolio	**$58,129,797.38**	**100%**

Balanced mutual funds are allocated in the 'Other' category

Sources of portfolio value



Portfolio value and investment results

	Performance returns (annualized > 1 year)			
	For the period of 12/31/2019 to 03/31/2020	For the period of 12/31/2019 to 03/31/2020	2019 12/31/2018 to 12/31/2019	2019 12/31/2018 to 12/31/2019
Opening value	**64,774,148.39**	**64,774,148.39**	**72,312,732.45**	**72,312,732.45**
Net deposits/withdrawals	-7,028,930.59	-7,028,930.59	-10,132,680.50	-10,132,680.50
Div./interest income	344,471.43	344,471.43	1,519,927.03	1,519,927.03
Change in accr. interest	-54,177.38	-54,177.38	-87,250.44	-87,250.44
Change in value	94,285.53	94,285.53	1,161,419.85	1,161,419.85
Closing value	**58,129,797.38**	**58,129,797.38**	**64,774,148.39**	**64,774,148.39**
Net Time-weighted ROR	0.64	0.64	3.61	3.61

Net deposits and withdrawals include program and account fees.

Summary of gains and losses

	Short term ($)	Long term ($)	Total ($)
2019 Realized gains and losses	**6,267.00**	**32,265.75**	**38,532.75**
Taxable	6,267.00	32,265.75	38,532.75
Tax-deferred	0.00	0.00	0.00
2020 Year to date	**23,165.79**	**39,909.91**	**63,075.70**
Taxable	23,165.79	39,909.91	63,075.70
Tax-deferred	0.00	0.00	0.00

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

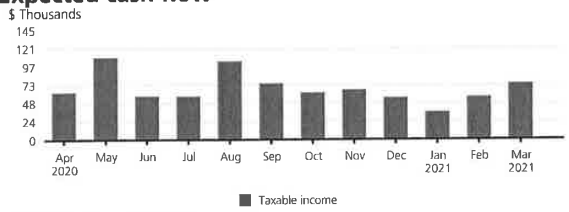
Report created on: May 04, 2020

UBS

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

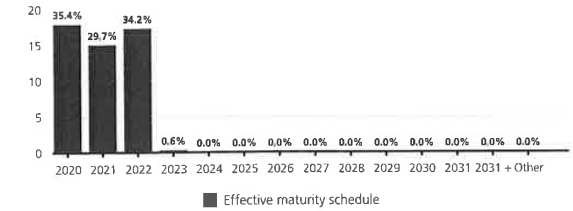
Portfolio review - as of March 31, 2020 (continued)

Expected cash flow



Total taxable income: $833,153.52
Total expected cash flow: $833,153.52
Cash flows displayed account for known events such as maturities and mandatory puts.

Bond maturity schedule



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

Equity sector analysis

Compared to S&P 500 index

	Value on 03/31/2020 ($)	Actual (%)	Model (%)	Gap (%)
Communication Services	0.00	0.00	11.23	-11.23
Consumer Discretionary	0.00	0.00	10.86	-10.86
Consumer Staples	0.00	0.00	8.30	-8.30
Energy	0.00	0.00	2.87	-2.87
Financials	0.00	0.00	10.12	-10.12
Health Care	0.00	0.00	15.16	-15.16
Industrials	0.00	0.00	7.23	-7.23
Information Technology	0.00	0.00	25.27	-25.27
Materials	0.00	0.00	2.48	-2.48
Real Estate	0.00	0.00	2.85	-2.85
Utilities	0.00	0.00	3.19	-3.19
Total classified equity	**$0.00**			
Unclassified Securities	0.00			

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

Report created on: May 04, 2020

Portfolio review - as of March 31, 2020 (continued)

Summary of performance by account

		Performance start date	Value on 03/31/2020 ($)	% of portfolio		Performance returns (annualized > 1 year) For the period of 12/31/2019 to 03/31/2020	For the period of 12/31/2019 to 03/31/2020	2019 12/31/2018 to 12/31/2019	2019 12/31/2018 to 12/31/2019
EX XX120	BOND PORTFOLIO•PMP•The Cohen Group Fixed Income - PIV Risk profile: Conservative Return objective: Current Income	Dec 08, 2008	58,129,797.38	100.00%	Net time-weighted	0.64%	0.64%	3.61%	3.61%
Total Portfolio		**Dec 08, 2008**	**$58,129,797.38**	**100%**	**Net time-weighted**	**0.64%**	**0.64%**	**3.61%**	**3.61%**

Benchmarks - Annualized time-weighted returns	For the period of 12/31/2019 to 03/31/2020	For the period of 12/31/2019 to 03/31/2020	2019 12/31/2018 to 12/31/2019	2019 12/31/2018 to 12/31/2019
Blended Index	0.24%	0.24%	8.87%	8.87%
US Treasury Bill - 3 Mos	0.47%	0.47%	2.21%	2.21%
Barclays US Agg 1-3Y	1.79%	1.79%	4.04%	4.04%
S&P 500	-19.60%	-19.60%	31.49%	31.49%

Blended Index 11/04/2019 - Current: 45% Barclays Corp 1-3Y, 55% Barclays Govt/Credit 1-3Y+
+ Additional benchmark information can be found on the benchmark composition page.
Past performance does not guarantee future results and current performance may be lower/higher than past data presented.

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Asset allocation by account

as of March 31, 2020

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

		Equities ($/%)			Fixed Income ($/%)						
	Cash ($/%)	U.S.	Global	International	U.S.	Global	International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	**Total**
	7,458,544.55	**0.00**	**0.00**	**0.00**	**50,671,252.83**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$58,129,797.38**
Total Portfolio	**12.83**	**0.00**	**0.00**	**0.00**	**87.17**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**
	7,458,544.55	0.00	0.00	0.00	50,671,252.83	0.00	0.00	0.00	0.00	0.00	**$58,129,797.38**
	12.83	0.00	0.00	0.00	87.17	0.00	0.00	0.00	0.00	0.00	**100.00%**

EX XX120 . BOND PORTFOLIO . BSA PMP

Risk profile: Conservative
Return objective: Current Income

		Equities ($/%)			Fixed Income ($/%)						
	Cash ($/%)	U.S.	Global	International	U.S.	Global	International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	**Total**
	7,458,544.55	**0.00**	**0.00**	**0.00**	**50,671,252.83**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$58,129,797.38**
Total Portfolio	**12.83**	**0.00**	**0.00**	**0.00**	**87.17**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**

Balanced mutual funds are allocated in the 'Other' category

UBS

Asset allocation review

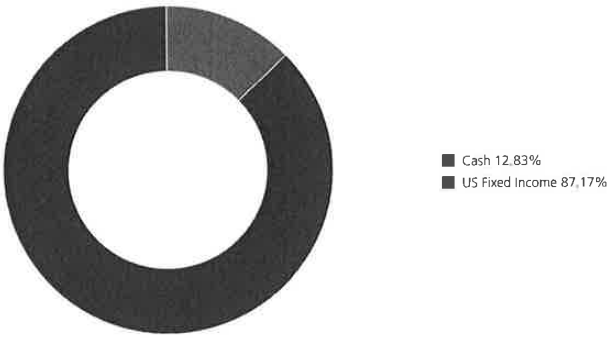
as of March 31, 2020

Summary of asset allocation

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

	Market value ($)	% of Portfolio
Cash	**7,458,544.55**	**12.83**
Cash	**7,458,544.55**	**12.83**
US	7,458,544.55	12.83
Fixed Income	**50,671,252.83**	**87.17**
US	**50,671,252.83**	**87.17**
US Fixed Income	451,253.22	0.78
Government	18,404,331.55	31.66
Municipals	2,511,404.08	4.32
Corporate IG Credit	29,304,263.98	50.41
Equity	**0.00**	**0.00**
Commodities	**0.00**	**0.00**
Non-Traditional	**0.00**	**0.00**
Other	**0.00**	**0.00**
Total Portfolio	**$58,129,797.38**	**100%**

Balanced mutual funds are allocated in the 'Other' category



Report created on: May 04, 2020

UBS

Bond summary

as of March 31, 2020

Bond overview

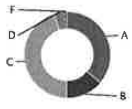
Total quantity	50,252,000
Total market value	$50,441,075.69
Total accrued interest	$230,177.14
Total market value plus accrued interest	$50,671,252.83
Total estimated annual bond interest	$974,763.50
Average coupon	1.94%
Average current yield	1.93%
Average yield to maturity	1.78%
Average yield to worst	1.53%
Average modified duration	0.72
Average effective maturity	1.29

Investment type allocation

Investment type	Taxable ($)	Tax-exempt / deferred ($)	Total ($)	% of bond port.
Certificates of deposit	451,253.21	0.00	451,253.21	0.89
Municipals	2,511,404.08	0.00	2,511,404.08	4.96
U.S. corporates	29,304,263.98	0.00	29,304,263.98	57.83
U.S. federal agencies	18,404,331.55	0.00	18,404,331.55	36.32
Total	**$50,671,252.82**	**$0.00**	**$50,671,252.82**	**100%**

Credit quality of bond holdings

Effective credit rating		Issues	Value on 03/31/2020 ($)	% of port.
A	Aaa/AAA/AAA	10	18,404,331.55	36.39
B	Aa/AA/AA	5	7,091,064.92	13.99
C	A/A/A	17	22,758,353.15	44.85
D	Baa/BBB/BBB	1	1,966,250.00	3.87
E	Non-investment grade	0	0.00	0.00
F	Certificate of deposit	4	451,253.21	0.89
G	Not rated	0	0.00	0.00
Total		**37**	**$50,671,252.83**	**100%**



Bond maturity schedule

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

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

Report created on: May 04, 2020

UBS

Bond holdings

as of March 31, 2020

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

Summary of bond holdings

Maturity Year	Issues	Quantity	Est. annual income ($)	Current yield (%)	Yield to maturity (%)	Yield to worst (%)	Modified duration	Adjusted cost basis ($)	Unrealized gain/loss ($)	Mkt. value ($)	% of bond portfolio maturing
2020	14	17,898,000	356,721.00	2.00%	2.30 %	2.10 %	0.30	17,769,925.13	95,121.28	17,962,749.48	35.42%
2021	11	14,895,000	314,930.00	2.10%	1.63 %	1.31 %	0.94	14,866,419.95	123,347.40	15,057,662.44	29.72%
2022	11	17,139,000	297,112.50	1.72%	1.36 %	1.13 %	0.96	17,142,112.44	123,551.09	17,328,159.18	34.23%
2023	1	320,000	6,000.00	1.87%	1.81 %	0.65 %	0.15	319,888	710.40	322,681.73	0.64%
2024	0	0			NA	NA	NA				
2025	0	0			NA	NA	NA				
2026	0	0			NA	NA	NA				
2027	0	0			NA	NA	NA				
2028	0	0			NA	NA	NA				
2029	0	0			NA	NA	NA				
2030	0	0			NA	NA	NA				
2031	0	0			NA	NA	NA				
2032	0	0			NA	NA	NA				
2033	0	0			NA	NA	NA				
2034	0	0			NA	NA	NA				
2035	0	0			NA	NA	NA				
2036	0	0			NA	NA	NA				
2037	0	0			NA	NA	NA				
2038	0	0			NA	NA	NA				
2039	0	0			NA	NA	NA				
2040	0	0			NA	NA	NA				
2041	0	0			NA	NA	NA				
2042	0	0			NA	NA	NA				
2043	0	0			NA	NA	NA				
2044	0	0			NA	NA	NA				
2045	0	0			NA	NA	NA				
2046	0	0			NA	NA	NA				
2047	0	0			NA	NA	NA				
2048	0	0			NA	NA	NA				
2049	0	0			NA	NA	NA				
2049 +	0	0			NA	NA	NA				
Other	0	0			NA	NA	NA				
Total	**37**	**50,252,000**	**$974,763.50**	**1.93%**	**1.78 %**	**1.53 %**	**0.72**	**$50,098,345.52**	**$342,730.17**	**$50,671,252.83**	

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

Report created on: May 04, 2020

UBS

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

Bond holdings - as of March 31, 2020 (continued)

Details of bond holdings

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Total Bond Portfolio		**50,252,000**	**1.94%**	**07/14/2021**	**NA**	**$974,763.50** **1.93%**	**1.78%** **1.53%**	**0.72**	**$50,098,345.5** **$342,730.17**	**NA**	**$50,441,075.69** **$230,177.14** **$50,671,252.83**	**100%**
Maturing 2020												
BK OF AMER CORP NTS B/E 02.250% 042120 DTD042115 FC102115	A2/A+/A- NR/NR/NR	750,000	2.25%	04/21/2020		16,875.00 2.25%	2.51% 2.51%	0.05	739,950.00 9,930.00	99.984	749,880.00 7,500.00	1.49%
QUALCOMM INC NTS B/E 02.250% 052020 DTD052015 FC112015	A2/NR/A- NR/NR/NR	2,879,000	2.25%	05/20/2020		64,777.50 2.25%	2.33% 2.33%	0.13	2,879,580.68 -954.95	99.987	2,878,625.73 23,571.81	5.71%
AMERICAN EXPRESS CRD 2.375% 052620 DTD052615 FC112615 CORP NTS	A2/A/A- NR/NR/NR	900,000	2.38%	05/26/2020	04/25/2020 100.00	21,375.00 2.38%	2.38% 2.38%	0.15	889,414.07 10,549.93	99.996	899,964.00 7,421.88	1.78%
CITIBANK NA NTS B/E 02.100% 061220 DTD061217 FC121217	Aa3/A+/A+ NR/NR/NR	550,000	2.10%	06/12/2020	05/12/2020 100.00	11,550.00 2.10%	3.05% 3.05%	0.19	539,005.50 9,949.50	99.810	548,955.00 3,497.08	1.09%
SYNCHRONY BANK UT US RT 02.1500% MAT 06/19/20 FIXED RATE CD /UT	CD	99,000	2.15%	06/19/2020		2,128.50 2.15%	1.13% 1.13%	0.21	98,522.82 696.96	100.222	99,219.78 600.65	0.20%
WELLS FARGO BK NA SD US RT 02.8000% MAT 06/29/20 FIXED RATE CD /SD	CD	50,000	2.80%	06/29/2020		1,400.00 2.79%	1.00% 1.00%	0.24	50,036.06 185.94	100.444	50,222.00 7.67	0.10%
INTEL CORP NTS B/E 02.450% 072920 DTD072915 FC012916 CALL@MW+15BP	A1/A+/A+ NR/NR/NR	1,750,000	2.45%	07/29/2020		42,875.00 2.45%	2.06% 2.06%	0.32	1,734,110.00 18,042.50	100.123	1,752,152.50 7,384.03	3.47%
AMAZON COM INC NTS B/E 01.900% 082120 DTD022118 FC082118 CALL@MW+7.5BP	A2/A+/AA- NR/NR/NR	2,500,000	1.90%	08/21/2020		47,500.00 1.90%	2.00% 2.00%	0.38	2,479,925.00 19,075.00	99.960	2,499,000.00 5,277.78	4.95%
FNMA NTS 01.350 % DUE 082420 DTD 082416 FC 02242017	Aaa/AAA/AA+ NR/NR/NR	3,500,000	1.35%	08/24/2020	05/24/2020 100.00	47,250.00 1.35%	0.78% -0.19%	0.14	3,498,250.00 9,695.00	100.227	3,507,945.00 4,856.25	6.95%
J P MORGAN CHASE & CO 02.550% 102920 DTD102915 FC042916 NTS B/E	A2/AA-/A- NR/NR/NR	1,000,000	2.55%	10/29/2020	09/29/2020 100.00	25,500.00 2.55%	2.55% 2.55%	0.56	994,430.00 5,580.00	100.001	1,000,010.00 10,766.67	1.98%
BOEING CO B/E 01.650% 103020 DTD102915 FC043016 CALL@MW+10BP	Baa1/BBB/BBB NR/NR/NR	2,000,000	1.65%	10/30/2020	09/30/2020 100.00	33,000.00 1.69%	5.85% 5.85%	0.56	1,969,800.00 -17,300.00	97.625	1,952,500.00 13,750.00	3.87%

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

Report created on: May 04, 2020

Bond holdings - as of March 31, 2020 (continued)

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2020												
PNC BK NTS B/E 02.450% 110520 DTD110315 FC050516	A2/A+/A NR/NR/NR	320,000	2.45%	11/05/2020	10/05/2020 100.00	7,840.00 2.45%	2.15% 2.10%	0.49	316,736.00 3,830.40	100.177	320,566.40 3,179.56	0.64%
JPMORGAN CHASE BK OH US RT 01.6500% MAT 12/13/20 FIXED RATE CD /OH	CD	100,000	1.65%	12/13/2020	06/12/2020 100.00	1,650.00 1.65%	1.45% 0.95%	0.20	99,950.00 191.00	100.141	100,141.00 81.37	0.20%
VISA INC NTS B/E 2.200% 121420 DTD121415 FC061416 CALL@MW+10BP	Aa3/NR/AA- NR/NR/NR	1,500,000	2.20%	12/14/2020	11/14/2020 100.00	33,000.00 2.19%	1.64% 1.56%	0.60	1,480,215.00 25,650.00	100.391	1,505,865.00 9,808.33	2.99%
Total 2020		**17,898,000**	**1.99%**	**08/16/2020**		**$356,721.00 2.00%**	**2.30% 2.10%**	**0.30**	**$17,769,925.1 $95,121.28**		**$17,865,046.41 $97,703.07**	**35.42%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2021												
WELLS FARGO NATL B NV US RT 01.6500% MAT 01/13/21 FIXED RATE CD /NV	CD	200,000	1.65%	01/13/2021		3,300.00 1.64%	1.13% 1.13%	0.78	199,800.00 1,018.00	100.409	200,818.00 162.74	0.40%
JPMORGAN CHASE & CO NTS 02.550% 030121 DTD030116 FC090116 B/E	A2/AA-/A- NR/NR/NR	1,000,000	2.55%	03/01/2021	02/01/2021 100.00	25,500.00 2.54%	2.28% 2.26%	0.81	1,008,337.29 -5,947.29	100.239	1,002,390.00 2,125.00	1.99%
GENL DYNAMICS CORP NTS 03.000% 051121 DTD051118 FC111118 CALL@MW+10BP	A2/WD/A- NR/NR/NR	1,000,000	3.00%	05/11/2021		30,000.00 2.98%	2.29% 2.29%	1.07	994,790.00 12,900.00	100.769	1,007,690.00 11,666.67	2.00%
BURLINGTON NTHN SANTA FE 04.100% 060121 DTD051911 CALL@MW +15BP CORP NTS	A3/NR/A+ NR/NR/NR	1,000,000	4.10%	06/01/2021	03/01/2021 100.00	41,000.00 4.02%	2.29% 1.82%	0.89	1,018,984.73 1,675.27	102.066	1,020,660.00 13,666.67	2.02%
PFIZER INC NTS B/E 01.950% 060321 DTD060316 FC120316 CALL@MW+10BP	A1/A/AA- NR/NR/NR	1,070,000	1.95%	06/03/2021		20,865.00 1.94%	1.33% 1.33%	1.15	1,065,645.10 12,091.00	100.723	1,077,736.10 6,839.08	2.14%
FNMA NTS 01.530 % DUE 072821 DTD 072816 FC 01282017	Aaa/AAA/AA+ NR/NR/NR	3,750,000	1.53%	07/28/2021	04/28/2020 100.00	57,375.00 1.53%	1.46% 0.36%	0.07	3,750,000.00 3,300.00	100.088	3,753,300.00 10,040.63	7.44%
CATERPILLAR FINANCIAL SE 01.700% 080921 DTD080916 FC020917 NTS B/E	A3/A/A NR/NR/NR	2,000,000	1.70%	08/09/2021		34,000.00 1.70%	1.83% 1.83%	1.33	1,984,080.00 12,400.00	99.824	1,996,480.00 4,911.11	3.96%
LOS ANG CAL TAX SR A BE/R/ 2.150 090121 DTD 122116 /CA	Aa2/NR/NR Aa2/NR/NR	1,000,000	2.15%	09/01/2021		21,500.00 2.13%	1.49% 1.49%	1.39	994,250.00 14,900.00	100.915	1,009,150.00 1,791.67	2.00%
ORACLE CORP NTS B/E 01.900% 091521 DTD070716 FC031517 CALL@MW+15BP	A3/A-/A+ NR/NR/NR	1,425,000	1.90%	09/15/2021	08/15/2021 100.00	27,075.00 1.89%	1.69% 1.68%	1.34	1,399,934.25 29,269.50	100.295	1,429,203.75 1,203.33	2.83%

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

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

Bond holdings - as of March 31, 2020 (continued)

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2021												
CISCO SYSTEMS INC B/E 01.850% 092021 DTD092016 FC032017 CALL@MW+10BP	A1/NR/AA- NR/NR/NR	1,000,000	1.85%	09/20/2021	08/20/2021 100.00	18,500.00 1.84%	1.38% 1.35%	1.36	993,660.00 13,140.00	100.680	1,006,800.00 565.28	2.00%
MISSISSIPPI ST TAX SR G BE/R/ 2.470 110121 DTD 120815 /MS	Aa2/AA/AA Aa2/AA/NR	1,450,000	2.47%	11/01/2021		35,815.00 2.41%	0.91% 0.91%	1.54	1,456,938.58 28,600.92	102.451	1,485,539.50 14,922.92	2.95%
Total 2021		**14,895,000**	**2.12%**	**07/24/2021**		**$314,930.00 2.10%**	**1.63% 1.31%**	**0.94**	**$14,866,419.9 $123,347.40**		**$14,989,767.35 $67,895.09**	**29.72%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2022												
FFCB BOND 01.580 % DUE 011322 DTD 011320 FC 07132020	Aaa/AAA/AA+ NR/NR/NR	1,100,000	1.58%	01/13/2022	01/13/2021 100.00	17,380.00 1.57%	1.07% 0.44%	0.77	1,099,175.00 10,615.00	100.890	1,109,790.00 3,765.67	2.20%
APPLE INC NTS B/E 02.500% 020922 DTD020917 FC080917 CALL@MW+10BP	Aa1/NR/AA+ NR/NR/NR	2,000,000	2.50%	02/09/2022	01/09/2022 100.00	50,000.00 2.44%	1.15% 1.09%	1.72	2,002,244.85 47,155.15	102.470	2,049,400.00 7,222.22	4.06%
FFCB BOND 01.000 % DUE 031122 DTD 031120 FC 09112020	Aaa/AAA/AA+ NR/NR/NR	2,000,000	1.00%	03/11/2022	06/11/2020 100.00	20,000.00 1.00%	0.99% 0.91%	0.19	2,000,000.00 360.00	100.018	2,000,360.00 1,111.11	3.97%
FFCB BOND 01.625 % DUE 042922 DTD 012920 FC 04292020	Aaa/AAA/AA+ NR/NR/NR	2,000,000	1.63%	04/29/2022	04/29/2020 100.00	32,500.00 1.62%	1.62% 1.50%	0.07	1,999,500.00 680.00	100.009	2,000,180.00 5,597.22	3.97%
PEPSICO INC NTS B/E 02.250% 050222 DTD050217 FC110217 CALL@MW+10BP	A1/A/A+ NR/NR/NR	1,089,000	2.25%	05/02/2022	04/02/2022 100.00	24,502.50 2.21%	1.33% 1.30%	1.93	1,087,301.16 22,139.37	101.877	1,109,440.53 10,141.31	2.20%
QUALCOMM INC NTS B/E 03.000% 052022 DTD052015 FC112015 CALL@MW+15BP	A2/NR/A- NR/NR/NR	1,000,000	3.00%	05/20/2022		30,000.00 2.94%	2.02% 2.02%	2.04	1,013,032.58 7,237.42	102.027	1,020,270.00 10,916.67	2.02%
FHLB BOND 01.020 % DUE 062422 DTD 032420 FC 06242020	Aaa/AAA/AA+ NR/NR/NR	1,700,000	1.02%	06/24/2022	06/24/2020 100.00	17,340.00 1.02%	0.99% 0.75%	0.23	1,700,000.00 1,071.00	100.063	1,701,071.00 337.17	3.37%
FHLB BOND 01.600 % DUE 080422 DTD 020420 FC 08042020	Aaa/NR/AA+ NR/NR/NR	1,150,000	1.60%	08/04/2022	08/04/2020 100.00	18,400.00 1.59%	1.46% 0.67%	0.34	1,149,655.00 3,979.00	100.316	1,153,634.00 2,913.33	2.29%
FFCB BOND 01.630 % DUE 080522 DTD 020520 FC 08052020	Aaa/AAA/AA+ NR/NR/NR	800,000	1.63%	08/05/2022	05/05/2020 100.00	13,040.00 1.63%	1.62% 1.41%	0.09	799,920.00 240.00	100.020	800,160.00 2,028.44	1.59%
WALT DISNEY CO NTS B/E 01.650% 090122 DTD090619 FC030120	A2/A/A NR/NR/NR	2,300,000	1.65%	09/01/2022		37,950.00 1.64%	1.43% 1.43%	2.35	2,290,501.00 21,597.00	100.526	2,312,098.00 3,162.50	4.58%
FNMA NTS 01.800 % DUE 102822 DTD 102819 FC 04282020	Aaa/AAA/AA+ NR/NR/NR	2,000,000	1.80%	10/28/2022	10/28/2020 100.00	36,000.00 1.79%	1.62% 0.99%	0.56	2,000,782.85 8,477.15	100.463	2,009,260.00 15,300.00	3.98%
Total 2022		**17,139,000**	**1.74%**	**06/02/2022**		**$297,112.50 1.72%**	**1.36% 1.13%**	**0.96**	**$17,142,112.4 $123,551.09**		**$17,265,663.53 $62,495.65**	**34.23%**

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

Report created on: May 04, 2020

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EX XX120 • BOND PORTFOLIO • Portfolio Management Program

Prepared for **Kern Health Systems**
Risk profile Conservative
Return Objective Current Income

Bond holdings - as of March 31, 2020 (continued)

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2023												
FHLMC MED TERM NTS 01.875 % DUE 052623 DTD 112619 FC 05262020	Aaa/AAA/NR NR/NR/NR	320,000	1.88%	05/26/2023	05/26/2020 100.00	6,000.00 1.87%	1.81% 0.65%	0.15	319,888.00 710.40	100.187	320,598.40 2,083.33	0.64%
Total 2023		**320,000**	**1.87%**	**05/26/2023**		**$6,000.00 1.87%**	**1.81% 0.65%**	**0.15**	**$319,888.00 $710.40**		**$320,598.40 $2,083.33**	**0.64%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Total Bond Portfolio		**50,252,000**	**1.94%**	**07/14/2021**	**NA**	**$974,763.50 1.93%**	**1.78% 1.53%**	**0.72**	**$50,098,345.5 $342,730.17**	**NA**	**$50,441,075.69 $230,177.14 $50,671,252.83**	**100%**

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

Report created on: May 04, 2020

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Additional information about your portfolio

as of March 31, 2020

Benchmark composition

Account EX XX120

Blended Index
Start - 05/15/2017: 50% Barclays US Gov 1-3Y; 50% Barclays Govt/Credit 1-5Y
05/15/2017 - 05/31/2018: 100% Barclays Agg Bond
05/31/2018 - 11/04/2019: 100% Barclays Agg Bond
11/04/2019 - Current: 45% Barclays Corp 1-3Y; 55% Barclays Govt/Credit 1-3Y

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Disclosures applicable to accounts at UBS Financial Services Inc.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Net Deposits/Withdrawals: When shown on a report, this information represents the net value of all cash and securities contributions and withdrawals, program fees (including wrap fees) and other fees added to or subtracted from your accounts from the first day to the last day of the period. When fees are shown separately, net deposits / withdrawals does not include program fees (including wrap fees). When investment return is displayed net deposits / withdrawals does not include program fees (including wrap fees). For security contributions and withdrawals, securities are calculated using the end of day UBS FS price on the day securities are delivered in or out of the accounts. Wrap fees will be included in this calculation except when paid via an invoice or through a separate accounts billing arrangement. When shown on Client summary and/or Portfolio review report, program fees (including wrap fees) may not be included in net deposits/withdrawals.

PACE Program fees paid from sources other than your PACE account are treated as a contribution. A PACE

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

Program Fee rebate that is not reinvested is treated as a withdrawal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This information is supplied by Morningstar, Inc. on a

UBS

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

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

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

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

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

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

Estimated Annual Income: The Estimated Annual Income is calculated by summing the previous four dividend rates per share and multiplying by the quantity of shares held in the selected account(s) as of the End Date of Report.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UBS

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

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

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

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

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

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

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

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

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

Report created on: May 04, 2020

UBS

Your Financial Advisor:
THE COHEN GROUP
Phone: 661-663-3200/800-628-8022

Kern Health Systems

Account Number: EBXXX20

Filtered by: Entry Date 01/01/2020-03/31/2020, Call/Redemption

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
03/30/20	03/30/20	CALL REDEMPTION	FHLMC MED TERM NTS 01.500 % DUE 062920	F05QW7	-3,500,000.000	REDEMPTION	3,500,000.00
03/30/20	03/30/20	CALL REDEMPTION	FHLMC MED TERM NTS 01.500 % DUE 033021	F07N17	-3,525,000.000	REDEMPTION	3,525,000.00
03/27/20	03/27/20	CALL REDEMPTION	FHLB BOND 01.520 % DUE 092321	F07RE9	-2,200,000.000	REDEMPTION	229,000.00
03/23/20	03/23/20	CALL REDEMPTION	FNMA NTS 01.500 % DUE 032320	F04EP7	-1,750,000.000	REDEMPTION	1,750,000.00
03/13/20	03/13/20	CALL REDEMPTION	FHLB NTS 01.550 % DUE 090121	F07F31	-500,000.000	REDEMPTION	500,000.00
03/13/20	03/13/20	CALL REDEMPTION	FFCB BOND 01.470 % DUE 021721	F067A5	-4,500,000.000	REDEMPTION	4,500,000.00
03/13/20	03/13/20	CALL REDEMPTION	FHLB BOND 01.600 % DUE 092721	F07UY7	-255,000.000	REDEMPTION	255,000.00
03/03/20	03/03/20	CALL REDEMPTION	FFCB BOND 01.890 % DUE 051223	FD9BP9	-3,450,000.000	REDEMPTION	3,450,000.00
02/24/20	02/24/20	CALL REDEMPTION	MORGAN STANLEY BK UT US RT 02.5000% MAT 02/24/20	N03002	-140,000.000	REDEMPTION	140,000.00
02/20/20	02/20/20	CALL REDEMPTION	UNITED STATES TREAS BILL DUE 02/20/20	FD28Q6	-1,500,000.000	REDEMPTION	1,500,000.00
02/18/20	02/18/20	CALL REDEMPTION	BANK OF AMERICA NA NC US RT 02.4500% MAT 02/18/20	N03K91	-240,000.000	REDEMPTION	240,000.00
02/05/20	02/05/20	CALL REDEMPTION	FHLB NTS 02.000 % DUE 090122	FA0Y52	-3,000,000.000	REDEMPTION	3,000,000.00
02/04/20	02/04/20	CALL REDEMPTION	GOLDMAN SACHS BANK NY US RT 02.0000% MAT 02/04/2(	N31N61	-100,000.000	REDEMPTION	100,000.00
01/10/20	01/10/20	CALL REDEMPTION	CATERPILLAR FINL SVCS 02.100% 011020 DTD011217	671DG9	-850,000.000	REDEMPTION	850,000.00

Filtered by: Entry Date 01/01/2020-03/31/2020, Bought

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
03/18/20	03/20/20	BOUGHT	CATERPILLAR FINANCIAL SE 01.700% 080921	667HW2	2,000,000.000	$99.204	-1,987,952.52
03/05/20	03/24/20	BOUGHT	FHLB BOND 01.020 % DUE 062422	FE9P38	1,700,000.000	$100.000	-1,700,000.00
03/05/20	03/11/20	BOUGHT	FFCB BOND 01.000 % DUE 031122	FE9P89	2,000,000.000	$100.000	-2,000,000.00
02/24/20	02/26/20	BOUGHT	JPMORGAN CHASE & CO NTS 02.550% 030121	731H11	1,000,000.000	$100.924	-1,021,635.83
02/24/20	02/25/20	BOUGHT	FFCB BOND 01.630 % DUE 080522	FE6V93	800,000.000	$99.990	-800,644.44
02/10/20	02/11/20	BOUGHT	FHLB BOND 01.600 % DUE 080422	FE64F1	1,150,000.000	$99.970	-1,150,017.78
02/10/20	02/11/20	BOUGHT	FFCB BOND 01.625 % DUE 042922	FE6F23	2,000,000.000	$99.975	-2,000,583.33
01/21/20	01/22/20	BOUGHT	FFCB BOND 01.580 % DUE 011322	FE4EJ5	1,100,000.000	$99.925	-1,099,509.50

WELLS FARGO SECURITIES

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

JONATHAN CHUANG
1-213-253-6202

Bank Account Statement
Wells Fargo Bank, N.A.

Statement Period
03/01/2020 - 03/31/2020

KERN HEALTH SYSTEMS
2900 BUCK OWENS BOULEVARD

Account Number
[redacted]

Account Value Summary *USD*

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

	Amount Last Statement Period	Amount This Statement Period	% Portfolio
Cash	$ 0.00	**0.00**	0%
Money Market Mutual Funds	35,048,000.39	**12,008,356.25**	43%
Bonds	40,102,020.92	**15,980,806.07**	57%
Stocks	0.00	**0.00**	0%
Total Account Value	**$ 75,150,021.31**	**$ 27,989,162.32**	100%
Value Change Since Last Statement Period		**$ (47,160,858.99)**	
Percent Decrease Since Last Statement Period		**63%**	
Value Last Year-End		**$ 72,702,342.87**	
Percent Decrease Since Last Year-End		**62%**	

Income Summary *USD*

	This Period	Year-To-Date
Interest	$ 26,223.02	$ 82,309.22
Dividends/Capital Gains	0.00	0.00
Money Market Mutual Funds Dividends	32,019.71	104,570.47
Other	0.00	0.00
Income Total	**$ 58,242.73**	**$ 186,879.69**

Interest Charged *USD*

Description	This Period
Debit Interest For March 2020	0.00
Total Interest Charged	**$ 0.00**

Money Market Mutual Funds Summary *USD*

Description	Amount
Opening Balance	**$ 35,048,000.39**
Deposits and Other Additions	235,131,318.65
Distributions and Other Subtractions	(258,202,982.50)
Dividends Reinvested	32,019.71
Change in Value	0.00
Closing Balance	**$ 12,008,356.25**

[machine data]

Safekeeping

Important Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial Statements: WFS financial statements are available upon request.

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

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

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

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

Customers may also report complaints, inaccuracies or discrepancies by calling 1-800-645-3751 option 5. International callers should call 1-877-856-8878. To further protect their rights, including rights under the Securities Investor Protection Act, customers should also re-confirm in writing to the above address any oral communications with WFS relating to the inaccuracies or discrepancies.

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

Statement Ending: **March 31, 2020**

KERN HEALTH SYSTEMS
Account Number: [redacted]

Portfolio Holdings

Security positions held with Wells Fargo Bank N.A.

Security ID	Description	Maturity Date	Coupon	Current Par / Original Par	Market Price*	Market Value	Original Par Pledged**	Callable
Bonds *USD*								
89236TDV4	TOYOTA MOTOR CREDIT CORP	04/17/20	2.096%	2,000,000.000	99.9569	1,999,137.20		N
90328AF32	USAA CAPITAL CORP DISCOUNTED COMMERCIAL PAPER	06/03/20	0.000%	3,000,000.000	99.7712	2,993,136.00		
24422ETS8	JOHN DEERE CAPITAL CORP	06/22/20	1.950%	3,000,000.000	99.9160	2,997,480.00		N
55279HAN0	MANUF & TRADERS TRUST CO	08/17/20	2.050%	3,000,000.000	99.7484	2,992,451.55		Y
0258M0DX4	AMERICAN EXPRESS CREDIT	09/14/20	2.600%	2,000,000.000	99.9451	1,998,901.32		Y
17305EGB5	CCCIT 2017-A3 A3	04/07/22	1.920%	3,000,000.000	99.9900	2,999,700.00		N
				16,000,000.000		15,980,806.07	0.00	

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

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

Daily Account Activity

Your investment transactions during this statement period.

Transaction / Trade Date	Settlement / Effective Date	Activity	Security ID	Description	Par / Quantity	Price	Principal Amount	Income Amount	Debit / Credit Amount
Transaction Activity *USD*									
03/04/20	03/06/20	Security Receipt	90328AF32	USAA CAPITAL CORP DISCOUNTED	3,000,000.00	99.7775000	(2,993,325.00)	0.00	(2,993,325.00)
03/12/20	03/12/20	Security Receipt	912796XB0	UNITED STATES TREASURY BILL	30,000,000.00	99.9937500	(29,998,125.00)	0.00	(29,998,125.00)
03/12/20	03/12/20	Security Receipt	912796XB0	UNITED STATES TREASURY BILL	50,000,000.00	99.9937500	(49,996,875.00)	0.00	(49,996,875.00)
03/16/20	03/17/20	Security Receipt	313384US6	FED HOME LN DISCOUNT NT	50,000,000.00	99.9902780	(49,995,139.00)	0.00	(49,995,139.00)
03/26/20	03/27/20	Security Receipt	24422ETS8	JOHN DEERE CAPITAL CORP	3,000,000.00	99.9740000	(2,999,220.00)	(15,437.50)	(3,014,657.50)
Income / Payment Activity *USD*									
03/10/20	03/10/20	Matured	912796XA2	UNITED STATES TREASURY BILL			30,000,000.00		30,000,000.00
03/16/20	03/16/20	Interest	0258M0DX4	AMERICAN EXPRESS CREDIT				26,000.00	26,000.00
03/17/20	03/17/20	Matured	912796XB0	UNITED STATES TREASURY BILL			80,000,000.00		80,000,000.00
03/23/20	03/23/20	Matured	43815HAB3	HAROT 2018-3 A2			100,234.63		100,234.63
03/23/20	03/23/20	Interest	43815HAB3	HAROT 2018-3 A2				223.02	223.02
03/24/20	03/24/20	Matured	313384US6	FED HOME LN DISCOUNT NT			50,000,000.00		50,000,000.00

Cash Activity *USD*

Transaction / Trade Date	Settlement / Eff. Date	Activity	Description	Debit Amount / Disbursements	Credit Amount / Receipts
03/03/20	03/03/20	ACH/DDA Transaction	DESIGNATED DDA	10,000,000.00	

Statement Ending: **March 31, 2020**

KERN HEALTH SYSTEMS
Account Number: [redacted]

Daily Account Activity (Continued)

Your investment transactions during this statement period.

Cash Activity *USD*

Transaction / Trade Date	Settlement / Eff. Date	Activity	Description	Debit Amount / Disbursements	Credit Amount / Receipts
03/04/20	03/04/20	ACH/DDA Transaction	DESIGNATED DDA	5,000,000.00	
03/05/20	03/05/20	ACH/DDA Transaction	DESIGNATED DDA	6,000,000.00	
03/10/20	03/10/20	ACH/DDA Transaction	DESIGNATED DDA	11,000,000.00	
03/11/20	03/11/20	ACH/DDA Transaction	DESIGNATED DDA	2,000,000.00	
03/12/20	03/12/20	ACH/DDA Transaction	DESIGNATED DDA		95,000,000.00
03/16/20	03/16/20	ACH/DDA Transaction	DESIGNATED DDA	13,000,000.00	
03/17/20	03/17/20	ACH/DDA Transaction	DESIGNATED DDA	10,000,000.00	
03/18/20	03/18/20	ACH/DDA Transaction	DESIGNATED DDA	7,500,000.00	
03/20/20	03/20/20	ACH/DDA Transaction	DESIGNATED DDA	42,000,000.00	
03/24/20	03/24/20	ACH/DDA Transaction	DESIGNATED DDA	20,000,000.00	
03/30/20	03/30/20	ACH/DDA Transaction	DESIGNATED DDA	700,000.00	
03/31/20	03/31/20	ACH/DDA Transaction	DESIGNATED DDA	15,000,000.00	

Money Market Fund Activity

Morgan Stan TreasSvc 8314 *As of March 31, 2020	Dividend paid this period	7 day* simple yield	30 day* simple yield
USD	32,019.71	0.070%	0.560%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**35,048,000.39**		**35,048,000.39000**
03/02/20	Reinvest	32,019.71000			32,019.71	35,080,020.10000
03/03/20	Redemption	(10,000,000.00000)		(10,000,000.00)		25,080,020.10000
03/04/20	Redemption	(5,000,000.00000)		(5,000,000.00)		20,080,020.10000
03/05/20	Redemption	(6,000,000.00000)		(6,000,000.00)		14,080,020.10000
03/06/20	Redemption	(2,993,325.00000)		(2,993,325.00)		11,086,695.10000
03/10/20	Purchase	30,000,000.00000		30,000,000.00		41,086,695.10000
03/10/20	Redemption	(11,000,000.00000)		(11,000,000.00)		30,086,695.10000
03/11/20	Redemption	(2,000,000.00000)		(2,000,000.00)		28,086,695.10000
03/12/20	Purchase	95,000,000.00000		95,000,000.00		123,086,695.10000
03/12/20	Redemption	(79,995,000.00000)		(79,995,000.00)		43,091,695.10000
03/16/20	Purchase	26,000.00000		26,000.00		43,117,695.10000
03/16/20	Redemption	(13,000,000.00000)		(13,000,000.00)		30,117,695.10000
03/17/20	Purchase	30,004,861.00000		30,004,861.00		60,122,556.10000
03/17/20	Redemption	(10,000,000.00000)		(10,000,000.00)		50,122,556.10000

KERN HEALTH SYSTEMS
Account Number: [redacted]

Statement Ending: **March 31, 2020**

Money Market Fund Activity (Continued)

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
03/18/20	Redemption	(7,500,000.00000)		(7,500,000.00)		42,622,556.10000
03/20/20	Redemption	(42,000,000.00000)		(42,000,000.00)		622,556.10000
03/23/20	Purchase	100,457.65000		100,457.65		723,013.75000
03/24/20	Purchase	50,000,000.00000		50,000,000.00		50,723,013.75000
03/24/20	Redemption	(30,000,000.00000)		(30,000,000.00)		20,723,013.75000
03/24/20	Redemption	(20,000,000.00000)		(20,000,000.00)		723,013.75000
03/30/20	Redemption	(700,000.00000)		(700,000.00)		23,013.75000
	Ending Balance		**1.0000**	**23,013.75**		**23,013.75000**

JPMorgan 100%UST Ins 199 *As of March 31, 2020	**Dividend paid this period**	**7 day* simple yield**	**30 day* simple yield**
USD	0.00	0.420%	0.890%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance					**0.00000**
03/24/20	Purchase	30,000,000.00000		30,000,000.00		30,000,000.00000
03/27/20	Redemption	(3,014,657.50000)		(3,014,657.50)		26,985,342.50000
03/31/20	Redemption	(15,000,000.00000)		(15,000,000.00)		11,985,342.50000
	Ending Balance		**1.0000**	**11,985,342.50**		**11,985,342.50000**

[redacted]

Safekeeping

PMIA/LAIF Performance Report as of 04/15/20

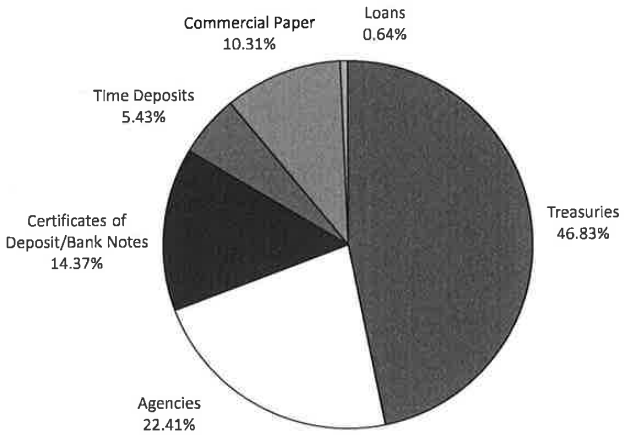
PMIA Average Monthly Effective Yields[1]

Mar	1.787
Feb	1.912
Jan	1.967

LAIF Quarterly Performance Quarter Ended 03/31/20

Apportionment Rate[2]:	2.03
Earnings Ratio[2]:	0.00005535460693046
Fair Value Factor[1]:	1.007481015
Daily[1]:	1.73%
Quarter to Date[1]:	1.89%
Average Life[1]:	208

Pooled Money Investment Account Portfolio Composition [1] 03/31/20 $98.1billion



Percentages may not total 100% due to rounding

Daily rates are now available here. View PMIA Daily Rates

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

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

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: June 11, 2020

Re: Amendments to Investment Policy

Background

All investments follow the Board approved Investment Policy that stipulates the following order of investment objectives:

- Preservation of principal
- Liquidity
- Yield

1) The current Investment Policy (attached) under the category Money Market Funds allows for a Maximum % of Portfolio at Time of Purchase of **20%.** Please see page 13 item J in the attached Investment Policy and Page 9 item J describing Money Market Funds

2) The current Investment Policy under the category Corporate Debt Securities allows for a Maximum % of Portfolio at Time of Purchase of **30%.** Please see page 12 item I in the attached Investment Policy and Page 9 item I describing Corporate Debt Securities

Discussion

Amendment 1:

Management would like to amend the Investment Policy by increasing the Maximum % of the Portfolio at Time of Purchase for Money Market Funds from 20% to 40% to be able to invest short-term funds with the ability to obtain higher yields on very short-term cash management needs. All Money Market Funds would still be required to be rated AAA (or equivalent highest ranking) by two of the largest nationally recognized rating services. Additionally, the maximum of such investment would be reduced from the current 10% to no more than 5% of the money market funds assets.

Amendment 2:

Management would like to amend the Investment Policy by increasing the Maximum % of the Portfolio at Time of Purchase for Corporate Debt Securities from 30% to 40% to be able to invest short-term funds with the ability to obtain higher yields on very short-term cash management needs. All Corporate Debt Securities would still be required to maintain an A or better rating, issued from corporations organized and operating in the United States with total assets in excess of $500,000,000 and the investment would be reduced from the current 10% to no more than 5% of the issue.

Requested Action

Approve Amendments to the Investment Policy.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Investment Policy				POLICY #: 80.11-I	
DEPARTMENT: Finance					
Effective Date:	Review/Revised Date:	DMHC		PAC	
2010-10	04/20/2015	DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 4/20/15

Chief Financial Officer — Date 4/20/15

Chief Operating Officer — Date 4/17/15

Controller — Date 4/17/15

POLICY:
This Annual Investment Policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of Kern Health Systems invested on and after the date of adoption. The objective of this Annual Investment Policy is to ensure Kern Health Systems' funds are prudently invested according to the Board of Director's objectives to preserve capital, provide necessary liquidity and to achieve a market-average rate of return through economic cycles.

Investments may only be made as authorized by this Annual Investment Policy. The Kern Health Systems Annual Investment Policy has been prepared in accordance with sections 53600 et seq. and 53630 et seq. of the California Government Code (the Code) as well as customary standards of prudent investment management. Irrespective of these policy provisions, should the provisions of the Code be or become more restrictive than those contained herein, such provisions will be considered immediately incorporated into the Annual Investment Policy and adhered to.

A. Safety of Principal -- Safety of principal is the foremost objective of Kern Health Systems. Each investment transaction shall seek to ensure that capital losses are avoided, whether from institutional default, broker-dealer default, or erosion of market value of securities.

B. Liquidity -- Liquidity is the second most important objective of Kern Health Systems. It is important that each portfolio contain investments for which there is a secondary market and which offer the flexibility to be easily sold at any time with minimal risk of loss of either the principal or interest based upon then prevailing rates.

C. Total Return -- Kern Health Systems' portfolios shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk.

II. OBJECTIVES

Safety of principal is the primary objective of Kern Health Systems. Each investment transaction shall seek to ensure that large capital losses are avoided from securities or broker-dealer default. Kern Health Systems shall seek to ensure that capital losses are minimized from the erosion of market value. Kern Health Systems shall seek to preserve principal by mitigating the two types of risk, credit risk and market risk.

Credit risk, the risk of loss due to failure of the issuer of a security, shall be mitigated by investing in only permitted investments and by diversifying the investment portfolio according to this Annual Investment Policy.

Market risk, the risk of market value fluctuations due to overall changes in the general level of interest rates, shall be mitigated by matching maturity dates, to the extent possible, with Kern Health Systems' expected cash flow draws. It is explicitly recognized herein, however that, in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

III. PRUDENCE

Kern Health Systems' Board of Directors or persons authorized to make investment decisions on behalf of Kern Health Systems are trustees and fiduciaries subject to the prudent investor standard. The standard of prudence to be used by investment officials shall be the "prudent person" standard as defined in Code Section 53600.3 and shall be applied in the context of managing an overall portfolio. Investment officers acting in accordance with written procedures and the Annual Investment Policy and exercising due diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and appropriate action is taken to control developments.

THE PRUDENT PERSON STANDARD: When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of Kern Health Systems, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency.

IV. ETHICS AND CONFLICTS OF INTEREST

Kern Health Systems' officers and employees involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. Kern Health Systems' officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with Kern Health Systems, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of Kern Health Systems' investments.

V. DELEGATION OF AUTHORITY

Authority to manage Kern Health Systems' investment program is derived from an order of the Board of Directors. Management responsibility for the investment program is hereby delegated to Kern Health Systems' Chief Financial Officer. No person may engage in an investment transaction except as provided under the terms of this Annual Investment Policy and the procedures established by the Chief Financial Officer.

The Chief Financial Officer shall be responsible for all actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials.

A. Financial Benchmarks

Kern Health Systems' portfolios shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk. The performance benchmark for each investment portfolio will be based upon the market indices for short-term investments of comparable risk and duration. These performance benchmarks will be agreed to by Kern Health Systems' Chief Financial Officer and the Investment Managers and will be reviewed by the Board of Directors quarterly.

B. Safekeeping

The investments purchased by the Investment Manager shall be held by Custodian Bank acting as the agent of Kern Health Systems under the terms of a custody agreement in compliance with Code Section 53608.

C. Periodic Review of the Annual Investment Policy

The Chief Financial Officer is responsible for providing the Board of Directors with a statement of investment policy, and the Board of Directors is responsible for adopting the Annual Investment Policy and ensuring investments are made in compliance with this Annual Investment Policy. This Annual Investment Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to Section 53646 (a) of the California Government Code.

The Chief Financial Officer is responsible for directing Kern Health Systems' investment program and for compliance with this policy pursuant to the delegation of authority to invest funds or to sell or exchange securities. The Chief Financial Officer shall make a quarterly report to the Board of Directors in accordance with Code Section 53646(b).

D. Chief Financial Officer's Procedures
The following procedures will be performed by the Chief Financial Officer:

1. The Operating Funds and Board-Designated Reserve Funds targeted average maturities will be established and reviewed periodically.

2. All Investment Managers will be provided a copy of the Annual Investment Policy, which will be appended to an Investment Manager's investment contract. Any investments made by the Investment Manager outside the Annual Investment Policy may subject the Investment Manager to termination for cause.

3. Investment diversification and portfolio performance will be reviewed monthly to ensure that risk levels and returns are reasonable and that investments are diversified in accordance with this policy.

4. The Chief Financial Officer will evaluate candidates for the role of Investment Manager. The candidates will be reviewed and approved by the CEO and the Board of Directors.

E. Duties and Responsibilities of Finance Committee:
The Chief Financial Officer and staff are responsible for the day-to-day management of Kern Health Systems' investment portfolio and the making of specific investments. The Board of Directors is responsible for Kern Health Systems' Annual Investment Policy. The Finance Committee shall not make or direct Kern Health Systems staff to make any particular investment, purchase any particular investment product, or do business with any particular investment companies or brokers. It shall not be the purpose of the Finance Committee to advise on particular investment decisions of Kern Health Systems.

The duties and responsibilities of the Finance Committee shall consist of the following:

1. Annually review Kern Health Systems' Annual Investment Policy before its consideration by the Board of Directors and recommend revisions, as necessary, to the Finance Committee of the Board of Directors.

2. Quarterly review Kern Health Systems' investment portfolio for conformance with Kern Health Systems' Annual Investment Policy diversification and maturity guidelines, and make recommendations to the Finance Committee of the Board of Directors as appropriate.

3. Provide comments to Kern Health Systems' staff regarding potential investments and potential investment strategies.

4. Perform such additional duties and responsibilities as may be required from time to time by specific action and direction of the Board of Directors.

VI. DEFINITIONS

A. Operating Funds are intended to serve as a money market account for Kern Health Systems to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent Kern Health Systems' monthly capitation revenues from its State contracts. Disbursements from this fund to Kern Health Systems' operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.

VII PERMITTED INVESTMENTS

Kern Health Systems' policy is to invest only in instruments as permitted by the Code, subject to the limitations of this Annual Investment Policy. Permitted investments are subject to a maximum stated term of five years. The Board of Directors must grant express written authority to make an investment or to establish an investment program of a longer term.

Maturity shall mean the stated final maturity of the security, or the unconditional put option date if the security contains such provision. Term or tenure shall mean the remaining time to maturity when purchased.

Permitted investments shall include:

A. U.S. Treasuries

These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

U.S. Government securities include:

1. Treasury Bills: U.S. government Securities issued and traded at a discount.

2. Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. government which guarantees interest and principal payments.

3. Treasury STRIPS: U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system.

4. Treasury Inflation Protected (TIPs) securities: Special Treasury notes or bonds that offer protection from inflation. Coupon payments and underlying principal are automatically increased to compensate for inflation as measured by the consumer price index (CPI).

U. S. Treasury coupon and principal STRIPS as well as TIPs are not considered to be derivatives for the purpose of this Annual Investment Policy and are, therefore, permitted investments pursuant to the Annual Investment Policy.

Maximum term: Five Years

B. Federal Agencies and U.S. Government Sponsored Enterprises

These investments represent obligations, participations, or other instruments of, or issued by, a federal agency or a United States government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (housing, agriculture). Often simply referred to as "Agencies", the following are specifically allowed:

1. Federal Home Loan Banks (FHLB)
2. Federal Home Loan Mortgage Corporation (FHLMC)
3. Federal National Mortgage Association (FNMA)
4. Federal Farm Credit Banks (FFCB)
5. Student Loan Marketing Association (SLMA)
6. Government National Mortgage Association (GNMA)
7. Small Business Administration (SBA)
8. Export-Import Bank of the United States
9. U.S. Maritime Administration
10. Washington Metro Area Transit
11. U.S. Department of Housing & Urban Development
12. Tennessee Valley Authority
13. Federal Agricultural Mortgage Company (FAMC)
14. Temporary Liquidity Guarantee (TLG) Program securities
15. Temporary Corporate Credit Union Liquidity Guarantee Program (TCCULGP) securities

Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

C. State of California and Local Agency Obligations

Registered state warrants, treasury notes or bonds of the State of California and bonds, notes, warrants or other evidences of indebtedness of any local agency of the State, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency or by a department, board, agency or authority of the State or local agency. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's and A-1 by Standard & Poor's or equivalent or better for short-term obligations, or A by Moody's or A by Standard & Poor's or better for long-term debt. Public agency bonds issued for private purposes (industrial development bonds) are specifically excluded as allowable investments.

Maximum Term: Five years

D. State and Local Agency Obligations Outside of California

Registered state warrants, treasury notes or bonds of any U.S. State and bonds, notes, warrants or other evidences of indebtedness of any local agency of the State, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state Such obligations must be issued by an entity whose general obligation debt is rated P-1 by

Moody's and A-1 by Standard & Poor's or equivalent or better for short-term obligations, or A by Moody's or A by Standard & Poor's or better for long-term debt. Public agency bonds issued for private purposes (industrial development bonds) are specifically excluded as allowable investments. Any single investment in a particular State is limited to 5% of portfolio at time of Purchase.

Maximum Term: Five years

Maximum of 20% of the portfolio

E. Bankers Acceptances

Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the bankers acceptance (BA) upon maturity if the drawer does not. Eligible bankers acceptances:

1. Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1 or better by Fitch Ratings or are rated A-1 for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

2. May not exceed the five percent (5%) limit of any one commercial bank and may not exceed the five percent limit for any security of any bank.

Maximum Term: 180 days

F. Commercial Paper

Commercial paper (CP) is unsecured promissory notes issued by companies and government entities at a discount. Commercial paper is negotiable (marketable or transferable), although it is typically held to maturity. The maximum maturity is 270 days, with most CP issued for terms of less than 30 days. Commercial paper must meet the following criteria:

1. Rated P-1 by Moody's and A-1 or better by Standard & Poor's, and

2. Have an A or higher rating for the issuer's debt, other than commercial paper, if any, as provided for by Moody's and Standard & Poor's, and

3. Issued by corporations organized and operating within the United States and having total assets in excess of five hundred million dollars ($500,000,000), and

4. May not represent more than ten percent (10%) of the outstanding commercial paper of the issuing corporation.

Maximum Term: 270 days

G. Negotiable Certificates of Deposit

A negotiable (marketable or transferable) receipt for a time deposit at a bank or other financial institution for a fixed time and interest rate. Negotiable Certificates of Deposit must be issued by a nationally or state-chartered bank or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better by Fitch Ratings, or are rated A-1 for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency. Maturities greater than one year and less than five years shall not exceed the FDIC Insurance maximum amount at the time of purchase.

Maximum term: Five years

H. Repurchase Agreements

A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.

Repurchase agreements collateralized by U. S. Treasuries, GNMAs, FNMAs or FHLMCs with any registered broker-dealer subject to the Securities Investors Protection Act or any commercial banks insured by the FDIC so long as at the time of the investment such primary dealer (or its parent) has an uninsured, unsecured and unguaranteed obligation rated P-1 short-term or A-2 long-term or better by Moody's, and A-1 short-term or A long-term or better by Standard & Poor's, provided:

1. A broker-dealer master repurchase agreement signed by the investment manager (acting as "Agent") and approved by Kern Health Systems; and,

2. The securities are held free and clear of any lien by Kern Health Systems' custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined capital, surplus and undivided profits of not less than $50 million and the custodian shall have received written confirmation from such third party that it holds such securities, free and clear of any lien, as agent for Kern Health Systems' custodian; and,

3. A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at 31 C.F.R. 306.1 et seq. or 31 C.F.R. 350.0 et seq. in such securities is created for the benefit of Kern Health Systems' custodian and Kern Health Systems; and

4. The Agent provides Kern Health Systems' custodian and Kern Health Systems with valuation of the collateral securities no less frequently than weekly and will liquidate the collateral securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within two business days of such valuation.

Maximum Term: One year

Reverse repurchase agreements are not allowed.

I. Corporate Debt Securities

Notes issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States.

1. For the purpose of this Annual Investment Policy, corporate securities that are rated A or better by both Moody's and Standard & Poor's, or by one of either of Moody's or Standard & Poor's and with a comparable rating by a nationally recognized rating service on longer term debt, and

2. Are issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States and have total assets in excess of five hundred million dollars ($500,000,000), and

3. May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to commercial paper, i.e. medium term notes ("MTNs"). Under no circumstance can the MTNs or any other corporate security of any one corporate issuer represent more than 5% of the portfolio.

Maximum Term: Five years

J. Money Market Funds

Shares of beneficial interest issued by diversified management companies (commonly called money market funds):

1. Which are rated AAA (or equivalent highest ranking) by two of the three largest nationally recognized rating services, and,

2. Such investment may not represent more than ten percent (10%) of the money market fund's assets.

K. Mortgage or Asset-backed Securities

Pass-through securities are instruments by which the cash flow from the mortgages, receivables or other assets underlying the security is passed-through as principal and interest payments to the investor.

Though these securities may contain a third party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt instruments have assets (such as leases or consumer receivables) pledged to support the debt service.

Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which

1. Are rated AAA (Code AA) by a nationally recognized rating service, and

2. Are issued by an issuer having an A or better rating by a nationally recognized rating service for its long-term debt.

Maximum Term: Operating Funds – Five years

L. Variable and Floating Rate Securities

Variable and floating rate securities are appropriate investments when used to enhance yield and reduce risk. They should have the same stability, liquidity and quality as traditional money market securities. A variable rate security provides for the automatic establishment of a new interest rate on set dates. For the purposes of this Annual Investment Policy, a Variable

Rate Security and Floating Rate Security where the rate of interest is readjusted no less frequently than every 762 calendar days shall be deemed to have a maturity equal to the period remaining until the next readjustment of the interest so long as the next readjustment period is within 5 years.

Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities and Negotiable Certificates of Deposit, must utilize traditional money market reset indices such as U. S. Treasury bills, Federal Funds, commercial paper or LIBOR. Investments in floating rate securities whose reset is calculated using more than one of the above indices are not permitted, i.e. dual index notes.
Maximum Term: Operating Funds – Five Years

M. Local Agency Investment Fund (LAIF)

The Local Agency Investment Fund (LAIF) is a voluntary program created by statute (Section 16429.1 et seq.) as an investment alternative for California's local governments and special districts managed by the State Treasurer. This program offers local agencies the opportunity to participate in a major portfolio, which invests hundreds of millions of dollars, using the investment expertise of the State Treasurer's Office investment staff at no additional cost to the taxpayer. All securities are purchased under the authority of Government Code Section 16430 and 16480.4. The State Treasurer's Office takes delivery of all securities purchased on a delivery versus payment basis using a third party custodian. All investments are purchased at market and a market valuation is conducted monthly. The investment objective of LAIF mirrors those of KHS' with preservation of capital being the primary objective and liquidity second. Any agency with funds on deposit with LAIF can withdraw those funds within 24 hours' notice.

Maximum Term: Five Years

VIII. POLICIES

A. Securities Lending

Investment securities shall not be lent to an Investment Manager or broker.

B. Leverage

The investment portfolio, or investment portfolios managed by an Investment Manager, cannot be used as collateral to obtain additional investable funds.

C. Other Investments

Any investment not specifically referred to herein will be considered a prohibited investment.

D. Underlying Nature of Investments

Kern Health Systems and its Investment Manager shall not make investments in organizations which have a line of business that is visibly in conflict with the interests of public health (which shall be defined by the Kern Health Systems Board of Directors). Furthermore, Kern Health Systems shall not make investments in organizations with which it has a business relationship through contracting, purchasing or other arrangements.

Kern Health Systems' Board of Directors will provide the Investment Manager with a list of corporations that do not comply with its Annual Investment Policy and shall immediately notify its Investment Manager of any changes.

E. Investment Managers

Outside Investment Managers must certify that they will purchase securities from broker/dealers (other than themselves) or financial institutions in compliance with Code Section 53601.5 and this Annual Investment Policy.

F. Derivatives

Except as expressly permitted by this policy, investments in derivative securities are not allowed.

G. Rating Category

Rating category shall mean with respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.

H. Rating Downgrades

Kern Health Systems may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this investment policy.

If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify the Chief Financial Officer or designee within two (2) business days of the downgrade. A decision to retain a downgraded security shall be approved by the Chief Financial Officer or designee within five (5) business days of the downgrade.

I. Maximum Stated Term

Maximum stated term for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security, or the unconditional put option date if the security contains such provision.

J. Diversification Guidelines

Diversification limits ensure the portfolio is not unduly concentrated in the securities of one type, industry, or entity, thereby assuring adequate portfolio liquidity should one sector or company experience difficulties.

Kern Health Systems' Investment Manager must review the portfolio it manages to ensure compliance with Kern Health Systems' diversification guidelines on an ongoing basis.

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100%
B. Federal Agencies and U.S. Government Sponsored Enterprises	100%
C. State of California and Local Agency Obligations	100%
D. State and Local Agency Obligations Outside of California	20%
E. Bankers Acceptances	40%
F. Commercial Paper	25%
G. Negotiable Certificates of Deposit	30%
H. Repurchase Agreements	100%
I. Corporate Securities	30%

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
J. Money Market Funds	20%
K. Mortgage and Asset-backed Securities	20%
L. Variable and Floating Rate Securities	30%
M. Local Agency Investment Fund (LAIF)	50%

a. Issuer/Counterparty Diversification Guidelines – The percentages specified below shall be adhered to on the basis of the entire portfolio:

i. Any one Federal Agency or Government Sponsored Enterprise 35%

ii. Any one repurchase agreement counterparty name

If maturity/term is $\leq$ 7 days 50%

If maturity/term is > 7 days 25%

b. Issuer/Counterparty Diversification Guidelines for All Other Securities described in Subsections A-K in VII. Permitted Investments of this Annual Investment Policy. Any one corporation, bank, local agency, or other corporate name for one or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage and asset-backed securities, the maximum applies to all such securities backed by the same type of assets of the same issuer. 5%

Negotiable Certificates of Deposit with maturities greater than one year and less than five years shall not exceed the FDIC Insurance maximum amount at the time of purchase.

Each Investment Advisor shall adhere to the diversification limits discussed in this section. If one Investment Advisor exceeds the aforementioned diversification limits, the Investment Advisor shall inform the Kern Health Systems Chief Financial Officer and second Investment Advisor (if any) by close of business on the day of the occurrence. Within the parameters authorized by the Government code, the Committee recognizes the practicalities of portfolio management, securities maturing, and changing status, and market volatility, and, as such, will consider breaches in:

i. The context of the amount in relation to the total portfolio concentration;
ii. Market and security specific conditions contributing to a breach in policy; and
iii. The managers' actions to enforce the spirit of the policy and decisions made in the best interest of the portfolio.

REFERENCE:

Revision 2016-01: Minor revision to correct acronym in §VIII Policies, item M. CFO request that policy goes to Board of Directors in February. **Revision 2015-04:** Item "M" Local Agency Investment Fund (LAIF) added to Section VII Permitted Investments as approved by KHS Board of Directors at April 2015 meeting. **Revision 2014-08:** Policy revised by Controller to allow for non-California municipal investments as approved by KHS Board of Directors. **Revision 2010-11:** Policy revised to conform to government code requirements. The Board of Directors approved current policy on October 14, 2010.

KERN HEALTH SYSTEMS

TO: KHS Board of Directors

FROM: Anita Martin, Chief Human Resources Officer

Date: June 11, 2020

SUBJECT: Employee Benefits Renewal 2020/2021

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 keep the 20/21 premium renewals at a net reduction compared to the previous year. Management is proposing a renewal with Kaiser Permanente HMO with no benefit changes. KHS is seeking a benefit enhancement for Class 1 basic life & AD&D, which includes Executives and Directors. The request is to increase the current life insurance amount from 2 X salary up to a $500,000 maximum to 3 X salary up to $1,000,000 maximum with a guarantee issue of $750,000.The annual increase of this benefit will equate to approximately $16,600.

For the 2020/2021 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 offered a decrease of 5% due to medical claims vs. premium. The Medical Loss Ratio during this renewal cycle was 66%. After initial discussions, our insurance broker was able to secure this decrease of 5% for an additional 4 months allowing our Employee Medical Insurance to renew on a calendar year, (next renewal will be 1/1/22) allowing greater consistency with our budgeting process. This is an even a greater reduction than the -2% that we were able to secure last year. Based on current staffing levels, the current monthly premium will be approximately $436,493 or $5,237,924 annually.

During the past two years, KHS focused on employee wellness programs so that KHS employees were kept informed about their health matters and were able to explore ways to eat healthier and to improve their overall level of physical fitness. To aid in this effort, KHS decided to partner with Kaiser Permanente. The new wellness initiative was very successful as demonstrated by the reduction in the Kaiser medical ratio from 86% to 66% and a 5% rate decrease in the Kaiser

renewal rate. KHS will continue offering new and exciting wellness programs during the 20/21 renewal period.

- Maintain VSP as the vision provider. The current monthly cost if enrollment stays at the current level will be $4,930 per month or $59,160 annually. This policy had no change in premium for the 2020/2021 renewal period.

- Maintain Lincoln as the dental carrier. For the current renewal period, Lincoln initially requested an increase of 9% on the PPO plan. Our insurance broker was able to reduce this increase to 3.5%. Based on renewal date staffing levels, the monthly premium will be approximately $33,000 or $396,000 annually. This equates to an annual increase of approximately $13,500.

- Maintain Lincoln as the current Basic Life Insurance carrier with the upgrade in benefits to Class 1 employees mentioned above. The overall annual cost will be approximately $67,000.

- Maintain Lincoln as the Short-term Disability ("STD") and Long Term Disability ("LTD") carrier. KHS moved to Lincoln two years ago with rate guarantees on the STD and LTD products. The STD is running at a 45% loss ratio and the LTD at 2% loss ratio. The current monthly premium based on renewal date staffing levels for both STD and LTD combined is approximately $176,000 annually.

- Maintain current Long-term Care Policy with Unum. The current monthly premium based on current staffing levels is approximately $80,000 annually. This policy had a 65% increase in rates as of February 2020, due to this plan no longer being offered by UNUM and the KHS policy being grandfathered in. This previous annual amount was $33,600.

- Overall KHS had a ($274,300) decrease in medical premiums, a $13,500 increase in dental premiums, a $16,600 increase in basic life and an increase of $46,400 in long-term care. KHS has an overall benefits renewal savings of approximately ($197,800).

Management is recommending a benefit change to the current KHS PTO policy of maximum accruals at 2 X's an employee's annual accrual. Due to the COVID-19 pandemic, employees are unable to use PTO and some employees are at or near their maximum accruals, forcing them to lose this benefit. With the Kern County accruals maximum at 3.25 X's their annual accruals, management is proposing to increase the KHS PTO maximum accruals to 3 X's the annual accrual.

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, and the increase of PTO maximum accruals to 3 X's the annual accrual rate.

To: KHS Board of Directors

From: Robert Landis, CFO

Date: June 11, 2020

Re: Analysis of Insurance Renewals

Background

KHS carries and seeks to renew and bind the following insurance coverages:

- Crime
- Excess Crime
- Property
- Liability
- Excess Liability
- Workers' Compensation
- Fiduciary Liability
- Excess Cyber Liability
- Managed Care Errors and Omissions Liability Insurance
- Earthquake Insurance
- Flood Insurance

KHS utilizes Alliant Insurance Services ("Alliant") as its insurance agent to access the insurance carrier market and perform the day to day servicing of the account. Alliant has provided early indications for the expiring coverage. It is recommended that Kern Health Systems renew coverages as outlined below.

- **Crime Insurance**
  Crime insures against employee theft of money and other property along with faithful performance of duty, forgery, robbery and safe burglary, computer fraud, funds transfer fraud and other social engineering. KHS Employee benefits plans are also covered for theft of funds. This coverage meets the DMHC requirement. Management recommends a renewal of the crime insurance policy.
    - National Union Fire Insurance Company of Pittsburgh, PA (AIG)
    - Rating: Carrier has an A XV rating from AM Best
    - Term: July 1, 2020 through June 30, 2021
    - Limits: $10,000,000
    - Deductible: $2,500
    - Annual Premium: $9,823. Prior year premium was $9,355.

  No claims were filed last year.

- **Excess Crime Insurance**
  KHS has additional Crime coverage limits of $5,000,000 in excess over the above crime insurance. Management recommends renewing coverage with Zurich (incumbent).
    - Zurich American Insurance Company
    - Rating: Carrier has an A+ XV rating from AM Best
    - Term: July 1, 2020 through June 30, 2021
    - Deductible: Excess of National Union Ins. Co. of Pittsburgh, PA (AIG)
    - Annual Premium $7,260. Prior year premium was $5,107.

  No Claims were filed last year

- **Property and Liability Insurance**
  The Property Coverage insures against first party losses to KHS owned property including buildings, contents, loss of income and auto physical damage. KHS has approximately $58 million in property values ($32M Building and $26M Contents) which is approximately an $8 million property value increase from expiring coverage.

  The Liability Coverage insures against third party losses for general liability, auto liability, public officials errors and omissions, employment related practices liability and sexual abuse or molestation liability.

  Primary Cyber Coverage is included at a limit of $2 million that insures against the damages that can occur related to computer system breaches and Pollution coverage is included with a limit of $2 million that insures against environmental hazards.

  Management recommends renewing participation in the property and liability program offered by the Joint Powers Authority, Special District Risk Management Authority (SDRMA). This agency was formed in 1986 to offer risk sharing and risk financing for California public agencies.

    - Special District Risk Management Authority (SDRMA)
    - Rating: SDRMA confidence level rating of 95%
    - Term: July 1, 2020 through June 30, 2021

    Property Coverage:
    - Limit per Occurrence - $1,000,000,000 repair or replacement cost
      - Business Income - $500,000
      - Flood - $10,000,000
      - Boiler and Machinery - $100,000,000
    - All Risk Deductible: $1,000 – Autos (Physical Damage $250/500) – Flood $250,000.

Liability Coverage:

- General Liability - $10,000,000
- Auto Liability - $10,000,000
- Uninsured Motorist - $1,000,000
- Public Officials' and Employees' Errors and Omissions - $10,000,000
- Personal Liability for Board Members - $500,000
- Employee Benefits Liability - $10,000,000
- Sexual Abuse - $5,000,000
- Sexual Harassment - $1,000,000
- Deductibles: Various - $500 Property Damage, $10,000 Property Damage

Uninsured/Underinsured Motorist and Employment Practices Liability (first $10,000 is paid by SDRMA – from $10,000 to $210,000 50% is paid by KHS with a maximum of $100,000, other 50% is paid by SDRMA)

Annual Estimated Premium $477,448 Prior year's premium $270,549.
The majority of the premium increase of 76% is represented as follows:
Property Coverage Rate Increase of $25,387
Property Total Insured Values Increase of $31,245
Liability Coverage Rate Increase of $41,010
Liability Increase (due to operating budget) increase $37,104
Liability Increase (due to payroll increase) $25,387
Liability Increase (elimination of volume discount) $35,151

1 Claim filed in 2018/2019 term and still remains open for Damage by Employee/Equipment $9,946 Paid, $15,054 Reserved, and $25,000 total incurred. This claim is expected to close within the next month.

- **Excess Liability Insurance**

  The excess liability provides additional limits over the Liability Coverage offered above with SDRMA - $15,000,000 excess of $10,000,000. This policy insures against losses from General Liability, Auto Liability, Public Officials Errors and Omissions and Employment Related Practices Liability.

  Management recommends renewing the excess liability program. Hallmark Specialty Insurance Company (1st $5,000,000) and Great American Assurance Company (2nd $10,000,000)

  - **1st Layer**
  - Hallmark Specialty Insurance Company
  - Rating: Carrier has an A- IX rating from AM Best
  - Per Occurrence or Wrongful Act Limit: $5,000,000 excess of $10,000,000 (SDRMA)
  - Term: July 1, 2020 through June 30, 2021
  - Annual Estimated Premium $52,657. Prior year's premium $41,280.

- **2nd Layer**
- Great American Assurance Company
- Rating: Carrier has an A+ XV rating from AM Best
- Per Occurrence or Wrongful Act Limit: $10,000,000 excess of $15,000,000 (Hallmark and SDRMA)
- Term: July 1, 2020 through June 30, 2021
- Annual Estimated Premium: $57,750. Prior year's premium was $46,200.

Deductibles: None, excess of primary limits of $10,000,000 for a total of liability limits of $25,000,000

Total Annual Estimated Premium $110,407. Prior year's premium was: $87,480. The 26% increase in premium is due to the primary Liability Coverage premium increase with SDRMA and overall rate increases in the marketplace.

No claims were filed last year.

- **Workers' Compensation Insurance**

Workers' Compensation coverage insures against losses from work related injuries and $1,000,000 employers' liability. Coverage is mandated by the state. Management recommends renewing coverage with Berkshire Homestate Insurance Company.

- Berkshire Hathaway Homestate Insurance Company
- Rating: Carrier has an A++ XV rating from AM Best
- Term: July 1, 2020 through June 30, 2021
- Limit per Occurrence: Statutory for Workers' Compensation and $1,000,000 for Employer's Liability
- Deductible: N/A
- The annual premium is a function of KHS' annual estimated payroll of $35,718,511 which is a 28% increase over the prior period. The insured has employees in 5 states, California, Texas, North Carolina, Florida and Oregon.
- Since 2010, KHS has filed 65 workers' compensation claims with estimated losses of $771,239.66. Three year loss ratio is 68%
- Annual Estimated Premium: $202,130. Prior year's estimated premium was $189,551.

Premium increase of 7% is represented as follows:
Payroll increase 28%
Rate decrease of 21%

2020 Published Experience Modification Factor is 85%. Last year's was 100%.

- **Fiduciary Liability Insurance**

  Fiduciary coverage insures against claims for administrative errors and omissions claims, breach of duty claims and defense for employee benefit claims, such as failure to timely distribute assets, failure to choose/offer prudent investments, failure to monitor investments, breach of responsibilities and negligence in the administration of a plan. Management recommends increasing the coverage for Fiduciary liability from $2 Million to $5 Million due to over $20 million of retirement assets.

  - Hudson Insurance Company
  - Rating: Carrier has an A XV rating from AM Best
  - Term: August 1, 2020 through August 1, 2021
  - Limit per occurrence: $2,000,000
  - Aggregate: $2,000,000
  - Self-Insured Retention: $0 Non-indemnifiable losses $25,000 All other losses

  Annual Premium $4,384. Prior year's premium was $4,384.

  Optional Limits:

  1) $3,000,000 Limit – Annual Indicated Premium: $8,266
  2) $5,000,000 Limit – Annual Indicated Premium: $11,443

  No claims were filed last year.

- **Excess Cyber Liability Insurance**

  Included in the SDRMA placement is the limit of $2,000,000 per incident and in the aggregate. This excess coverage provides KHS with an additional $8,000,000 in coverage for a total of $10,000,000. Management recommends renewing coverage for Excess Cyber liability.

  - **1st Excess Layer:**
  - AXIS Insurance Company
  - Rating: Carrier has an excellent A+ XV rating from AM Best
  - Term: July 1, 2020 through June 30, 2021
  - Limit per incident: $3,000,000
  - Aggregate: $3,000,000
  - Self-Insured Retention: Primary coverage within the SDRMA Program
  - Annual Premium: $2,784. Prior year's premium was $2,784.
  - **2nd Excess Layer:**
  - Greenwich Insurance Company
  - Rating: Carrier has an A+ XV rating from AM Best
  - Term: July 1, 2020 through June 30, 2021
  - Limit per incident: $5,000,000
  - Aggregate: $5,000,000
  - Self-Insured Retention: Excess of AXIS Excess Cyber Policy
  - Annual Premium: $10,000. Prior year's premium was $10,000.

  No claims were filed last year.

- **Managed Care Errors and Omissions Liability Insurance**
  Managed Care E&O insures against losses for KHS operations for an act, error or omission in the performance of any health care or managed care financial, management or insurance services performed; the design, development and marketing of such service; vicarious liability for the conduct of others performing any such service on our behalf. Alliant marketed the coverage this renewal and has presented one option for consideration – TDC National Assurance Company (incumbent) quoted $53,609, which is a 15% premium increase over last year's premium. We received an indication from ACE/Chubb for $85,599 however unfortunately not able to find another market to be as competitive at TDC. Management recommends renewing the coverage for the Managed Care E&O with TDC.
    - TDC National Assurance Company
    - Rating: Carrier has an A XV rating from AM Best
    - Term: July 1, 2020 through June 30, 2021
    - Limit per occurrence: $1,000,000
    - Aggregate: $3,000,000
    - Self-Insured Retention: $100,000 each claim
    - Annual Premium: $53,609. Prior year's premium was $46,440.

    - TDC confirmed the additional services requested are accounted for and included coverage for, per the policy wording, so no need to endorse. Pricing was included within the premium rating.
      - Comprehensive Care Management
      - Care Coordination
      - Health Promotion
      - Comprehensive Transitional Care
      - Individual and Family Support Services
      - Referral to Community and Social Supports

  1 claim was filed last year (Transportation Claim) $0 Paid

- **Earthquake Insurance –**
  Earthquake insures against the peril of earthquake for KHS owned property. Management recommends renewing the Earthquake insurance coverage.
    - Princeton Excess & Surplus Lines Insurance Company
    - Rating: Carrier has excellent A+ XV rating from AM Best
    - Term: October 15, 2020 through October 15, 2021
    - Limit per occurrence: $25,000,000
    - Aggregate: $25,000,000
    - Deductible 3% Per unit (unit is defined as replacement cost of the covered Property – Building, Contents and Business Income separately), subject to a minimum of $50,000
      All Other Perils $25,000 Deductible
    - Annual Premium: Not to Exceed $100,000. Prior year's premium was $45,954

  No claims were filed last year

- **Flood Insurance**
  Flood insurers against the peril of flood for KHS owned property. Management recommends renewing the Flood Insurance coverage.
    - Hartford Ins. Company of the Midwest
    - Rating: Carrier has a superior A+ XV rating from AM Best
    - Term: November 18, 2020 through November 18, 2021
      2900 Buck Owens Blvd – Building and Contents
      $500,000 Building (maximum limit available)
      $500,000 Contents (maximum limit available)
      $1,250.00 Deductible on both Building & Contents
      Annual Premium: Not to Exceed $5,000. Prior year's premium was $3, 553

No claims were filed last year.

- **Alliant Deadly Weapon Response Program (ADWRP)**
  The Alliant Deadly Weapon Response Program provides coverage for locations per our Property schedule on file where a weapon used by an Active Shooter for 1st Party Property Damage/Business Interruption, Crisis Management, Funeral Expense, Counseling Services and Demolition/Clearance and Memorialization. This is a new coverage for consideration. Management recommends purchasing this new coverage offered.
    - Underwriters at Lloyd's of London
    - Rating: Carrier has an Excellent A XV rating from AM Best
    - Term: July 1, 2020 to July 1, 2021
    - $1,000,000 Per Occurrence and Annual Aggregate
    - $10,000 Deductible Each Event including Claims Expenses
    - Annual Premium: Not to exceed $12,000

Representatives from Alliant will be available to answer questions relating to the insurance renewals.

Requested Action

Approve.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

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

Date: June 11, 2020

Re: Renewal of MCG Evidence Based Clinical Care Guidelines

Background

In order to consistently apply evidence-based criteria to decisions rendered for complex medical and behavioral health conditions and remain compliant with our contract with DHCS and DMHC, access to relevant and current care guidelines outlining medical necessity and levels of impairment are mandatory for the clinical staff to render informed and medically appropriate decisions for service requests.

Discussion

KHS has maintained a contract with MCG since 2008 for managing all aspects of medical and behavioral health conditions. This contract includes both static or web based access as well as a dynamic and interactive version that can be used by both KHS staff and Provider network. It was an essential integration component to the Medical Management platform implementation in 2017. Benefits include elimination of the manual process with accessing and publishing the guidelines for KHS staff and a training platform to ensure all clinical staff are consistently applying evidence based criteria while reviewing service requests. In addition, KHS Providers will have the option to perform point of service automatic authorization requests that provide immediate response to service requests. These components will foster KHS's mission to promote consistent decision making among the clinical staff to provide comprehensive, patient centered, and high-quality care and allow point of service decision making.

Financial Impact

Not to exceed $4,019,712 over five (5) years.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

KERN HEALTH SYSTEMS

MCG Clinical Guidelines

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

June 11, 2020

Agenda

- Overview
- Modules
- Pricing Model
- Board Request

KERN HEALTH SYSTEMS

Overview

- DHCS contract requirement
- Evidence-based criteria for complex medical and behavioral health conditions
- Partner since 2008
  - Membership growth
    - 100,000 in 2008
    - 185,000 in 2016
    - 250,000 in 2020
  - Non automated workflow-static version
- Evolution of material and method of accessing criteria
  - Integrated in JIVA Medical Management System
  - Sole source

KERN HEALTH SYSTEMS

Modules

Original Modules

- *Ambulatory Care*
- *Inpatient & surgical Care*
- *General Recovery Care*
- *Behavioral Health Care*
- *Multi-Condition Management-**not renewed for 2020***
- *Interrater Reliability Module-training*
- *CareWebQI* Guideline Modification Module-customization
- *Cite Auto Auth-Point of service authorization*
- *CareWebQI* Integrated API-JIVA automation

New Modules

- *Ambulatory Care*
- *Inpatient & Surgical Care*
- *General Recovery Care*
- *Behavioral Health Care*
- *Recovery Facility Care-new*
- *Home Care-new*
- *Interrater Reliability Module*
- *CareWebQI* Guideline Modification Module
- *Cite Auto Auth*
- *CareWebQI Integrated API*

Pricing Model

- KHS eligible membership 250,000 (excludes Kaiser)
- The fee for an increases is based on a Per Member Per Year PMPY basis.
- Year 1 - $742,148 Due 7/5/2020 PMPY $2.9686
- Year 2 - $771,834 Due 7/5/2021 PMPY $3.0873
- Year 3 - $802,707 Due 7/5/2022 PMPY $3.2108
- Year 4 - $834,815 Due 7/5/2023 PMPY $3.3392
- Year 5 - $868,208 Due 7/5/2024 PMPY $3.4728
- Assumes membership doesn't grow more than 10% over the term of the contract
- Per member per year has an annual 4% increase per year

KERN HEALTH SYSTEMS

Board Request

Authorize the CEO to approve contract associated to renewal of the MCG Clinical Guidelines for five (5) years in the amount not to exceed $4,019,712 to be allocated annually in the Utilization Management Medical Budget

KERN HEALTH SYSTEMS

Questions

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

KERN HEALTH SYSTEMS

Proposed Administrative Contract over $100,000, June 11, 2020

1. Operational Agreement with MCG.
   a. Recommended Action

      Approve; Authorize Chief Executive Officer to Sign
   b. Contact

      Deborah Murr, RN, BS-HCM, Chief Health Services Officer
   c. Background

      In order to consistently apply evidence-based criteria to decisions rendered for complex medical and behavioral health conditions and remain compliant with our contract with DHCS and DMHC, access to relevant and current care guidelines outlining medical necessity and levels of impairment are mandatory for the clinical staff to render informed and medically appropriate decisions for service requests.
   d. Discussion

      KHS has maintained a contract with MCG since 2008 for managing all aspects of medical and behavioral health conditions. This contract includes both static or web based access as well as a dynamic and interactive version that can be used by both KHS staff and Provider network. It was an essential integration component to the Medical Management platform implementation in 2017. Benefits include elimination of the manual process with accessing and publishing the guidelines for KHS staff and a training platform to ensure all clinical staff are consistently applying evidence based criteria while reviewing service requests. In addition, KHS Providers will have the option to

perform point of service automatic authorization requests that provide immediate response to service requests. These components will foster KHS's mission to promote consistent decision making among the clinical staff to provide comprehensive, patient centered, and high-quality care and allow point of service decision making.

e. Fiscal Impact

   Not to exceed $4,019,712 over five (5) years

f. Risk Assessment

   Clinical guidelines assist with ensuring medical necessity decisions rendered by KHS clinical staff are evidence based, consistent, and support the requirements of our DHCS contract. Guidelines referenced across Inpatient, Ambulatory Care, Behavioral Health, Home Care and Recover Facility settings, provide members and the provider network a clear explanation for medical necessity of services.

g. Attachments

   An Agreement at a Glance form is attached.

h. Reviewed by Chief Compliance Officer and/or Legal Counsel

   This contract is pending legal review.

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: UM

Department Head: Deborah Murr, RN, BS-HCM, Chief Health Services Office

Vendor Name: MCG

Contact name & e-mail: Richard Miller, richard.miller@mcg.com

What services will this vendor provide to KHS? Evidence Based Clinical Guidelines, Interrater Reliability module, Care Web QI Integrated API and Cite Auto Auth Point of Service.

Description of Contract	
Type of Agreement: Professional Services ☒ Contract ☐ Purchase ☒ New agreement ☐ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background: In order to consistently apply evidence-based criteria to decisions rendered for complex medical and behavioral health conditions and remain compliant with our contract with DHCS and DMHC, access to relevant and current care guidelines outlining medical necessity and levels of impairment are mandatory for the clinical staff to render informed and medically appropriate decisions for service requests. Brief Explanation: KHS has maintained a contract with MCG since 2008 for managing all aspects of medical and behavioral health conditions. This contract includes both static or web based access as well as a dynamic and interactive version that can be used by both KHS staff and Provider network. It was an essential integration component to the Medical Management platform implementation in 2017. Benefits include elimination of the manual process with accessing and publishing the guidelines for KHS staff and a training platform to ensure all clinical staff are consistently applying evidence based criteria while reviewing service requests. In addition, KHS Providers will have the option to perform point of service automatic authorization requests that provide immediate response to service requests. These components will foster KHS's mission to promote consistent decision making amoung the clinical staff to provide comprehensive, patient centered, and high-quality care and allow point of service decision making.
☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to Fifty Thousand Dollars or more if not budgeted ($50,000.00) and One Hundred Thousand Dollars or more if budgeted ($100,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over Fifty Thousand Dollars or more if not budgeted ($50,000.00) and One Hundred Thousand Dollars or more if budgeted ($100,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Fifty Thousand Dollars ($50,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)* Brief vendor selection justification:	
☒ Sole source – no competitive process can be performed.	

Form updated 11/21/19

Brief reason for sole source: MCG clinical guidelines are embedded into the ZeOmega Medical Management platform. If a vendor change was required, a rework of the entire Medical Management system involving authorization module would need to be completed, with significant associated costs and internal and external resource time.

☐ Conflict of Interest Form is required for this Contract

☒ HIPAA Business Associate Agreement is required for this Contract

Fiscal Impact

KHS Governing Board previously approved this expense in KHS' FY 2020 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☒ NO	☐ YES
Capital project	☒ NO	☐ YES

Project type:

Budgeted Cost Center 310 GL# 5645

Maximum cost of this agreement not to exceed: $4,019,712.00 over five (5) years

GROWTH CAP PERCENTAGE
The Growth Cap Percentage shall be 10%.

FEE SCHEDULE AND SUMMARY
Fees do not include applicable shipping or taxes. All annual fees include an Application Infrastructure fee.
Year 1 - $742,148.00 Due within thirty (30) days from receipt of invoice
Year 2 - $771,834.00 Due 7/5/2021
Year 3 - $802,707.00 Due 7/5/2022
Year 4 - $834,815.00 Due 7/5/2023
Year 5 - $868,208.00 Due 7/5/2024

Contract Terms and Conditions

Effective date: 7/5/2020 Termination date: 7/4/2025

Explain extension provisions, termination conditions and required notice: ____

Approvals

Compliance DMHC/DHCS Review:	**Legal Review:**
Director of Compliance and Regulatory Affairs	Legal Counsel
Date	Date
Contract Owner:	**Purchasing:**
Department Head	Director of Procurement and Facilities
Date	5/28/20 Date

Form updated 11/21/19

Contract Owner:

Department Head

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

5/28/20

Date

IT Approval:

Chief Information Officer or IT Director

Date

Purchasing:

Director of Procurement and Facilities

Date

Recommended by the Executive Committee:

Chief Operating Officer

5/28/2020

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Board of Directors approval is required on all contracts over $50,000 if not budgeted and $100,000 if budgeted.

KHS Board Chairman

Date

Form updated 11/21/19

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Isabel Silva, Director of Health Education, Cultural & Linguistics Services

Date: June 11, 2020

Re: Agreement with CommGap International Language Services

Background

Appropriate linguistic services will be available for medical and non-medical points of contact including membership services, appointment services and member orientation sessions. During regular business hours, members and providers who require the assistance of an in-person interpreter can contact KHS to set up an appointment with a qualified interpreter.

Discussion

In April 2020, KHS published an RFP for the selection of vendors that can provide in-person interpreting services in multiple languages, including American Sign Language to KHS members. KHS received four (4) proposals from CommGap, Global Interpreting Network, Accommodating Ideas, and LifeSigns. As a result, KHS selected CommGap as the most cost effective vendor for all languages with the exception of ASL, where LifeSigns will continue to service as the primary agency for ASL interpreting services.

CommGap has provided high quality interpreting services through medically qualified and certified interpreters for KHS members since 2017. Their pool of interpreters represent residents of Kern County and neighboring central valley counties and provide interpreting services for more than 200 languages. CommGap has proven to provide excellent customer service and has demonstrated prompt grievance resolutions within 24 hours and their quality assurance.

Financial Impact

Not to exceed $350,000 over the period of two (2) years.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

KERN HEALTH SYSTEMS

In-Person Interpreter Services

June 11, 2020

Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Services

KERN HEALTH SYSTEMS
kernhealthsystems.com

Agenda

- Background
- Scope of Services
- RFP Process and Responses
- Board Request

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Background

- All Medi-Cal Managed Care Plans shall comply with Title 22 CCR Section 53853(c) and ensure all monolingual, non-English speaking or limited English Proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact either through in-person, telephonic or video remote interpreting services.

- All Medi-Cal Managed Care Plans are required to provide interpreting services through a qualified interpreter under WIC 14029.91 and 45 CFR 92.4.

- In-person interpreters are used when telephonic and video remote interpreting services are not appropriate for the nature of the member's appointment (i.e. physical therapy, reproductive health exams, behavioral health assessments)

- Since 2017, KHS has maintained a contract with CommGap to provide non-American Sign Language (ASL) in-person interpreter services performed by qualified interpreters to members to allow LEP members to communicate with their health care team.
  - ASL Interpreting Services are performed by KHS' contracted vendor LifeSigns due to their vast pool of interpreters in Kern and neighboring counties.

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Scope of Services

- Ability to perform in-person interpreting anywhere in Kern County, California and furnish own transportation to and from the interpreting site.
- Available during regular KHS business hours, after hours, weekends and holiday.
- Ability to accommodate both urgent (24-48 hours) and routine requests
- Ability to perform site translations
- Meets definition of qualified interpreter under WIC 14029.91 and 45 CFR 92.4.
- At minimum, provide services for KHS' top language requests:
  - Arabic
  - Cantonese
  - Lao
  - Mandarin
  - Punjabi
  - Spanish
  - Tagalog
  - Vietnamese

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RFP Process and Responses

- In April 2020, KHS posted an RFP for In-Person Interpreting Services. CommGap International Language Services was selected as the vendor for non-ASL interpreting services based on experience, price, and current vendor.
- KHS received four (4) proposals of which two (2) proposals were for ASL interpreting services only (Accommodating Ideas and LifeSigns). Since KHS already holds a contract with LifeSigns for ASL interpreting services, only the vendors that provided non-ASL interpreting services were compared.

Fee Schedule	CommGap	Global Interpreting Network
Hourly Rate- Regular Business Hours	• $75.00 Spanish $105.00 ASL $95.00 Other Languages 1.5 hour minimum; charges after 1.5 hour minimum on 15-minute increments	• $75.00 Spanish $125.00 ASL $155.00 Other Languages 2 hour minimum; charges after 2 hour minimum unknown
Hourly Rate - After Business Hours, Holidays & Weekends	• $90.00 Spanish $125.00 ASL $115.00 Other Languages 1.5 hour minimum; charges after 1.5 hour minimum on 15-minute increments	• $95.00 Spanish $140.00 ASL $130.00 Other Languages 2 hour minimum; charges after 2 hour minimum unknown

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Utilization History

- Requests for in-person interpreting services have increased by 26.7% since the last contracting period.
- Hourly rate has not increased since the last contract renewal.

2018-2019	2019-2020
718 requests	910 requests

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Board Request

- Authorize the CEO to sign the budgeted contract renewal associated with the In-Person Interpreter Services from CommGap in the amount not to exceed $175,000 per year for two (2) years.

KERN HEALTH SYSTEMS
kernhealthsystems.com

Questions

Please contact:
Isabel Silva, MPH, CHES
661-664-5117
isabelc@khs-net.com

KERN HEALTH SYSTEMS
kernhealthsystems.com

Proposed administrative contract over $100,000, June 11, 2020

1. Operational Agreement with CommGap International Language Services
    a. Recommended Action

       Approve; Authorize Chief Executive Officer to Sign
    b. Contact

       Isabel Silva, Director of Health Education, Cultural & Linguistics Services
    c. Background

       All Medi-Cal Managed Care Plans shall comply with Title 22 CCR Section 53853(c) and ensure all monolingual, non-English speaking or limited English Proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact either through in-person, telephonic or video remote interpreting services. All Medi-Cal Managed Care Plans are required to provide interpreting services through a qualified interpreter under WIC 14029.91 and 45 CFR 92.4.

       Since 2017, KHS has maintained a contract with CommGap to provide non-American Sign Language (ASL) in-person interpreter services performed by qualified interpreters to members to allow LEP members to communicate with their health care team. ASL Interpreting Services are performed by KHS' contracted vendor LifeSigns due to their vast pool of interpreters in Kern and neighboring counties.
    d. Discussion

       In-person interpreters are used when telephonic and video remote interpreting services are not appropriate for the nature of the member's appointment (i.e. physical therapy, reproductive health exams, behavioral health assessments). In addition to employing qualified Spanish interpreters, KHS contracts with CommGap to increase member and provider access to in-person interpreting services for over 200 languages. In 2019, 942 requests for in-person interpreting services were received. The majority of the in-person interpreter requests received were for medical visits with a specialist, such as behavioral health and the top languages requested were for Spanish and Punjabi.

e. Fiscal Impact

Not to exceed $350,000 per two years.

f. Risk Assessment

Failure to contract with a vendor for in-person interpreting services hinders KHS' ability to meet the regulatory and contractual requirements for providing equal access to LEP members for all medical and non-medical points of contact. Additionally, KHS does not currently employ staff who are identified as a qualified interpreter for any other language outside of Spanish.

g. Attachments

An Agreement at a Glance form and bid matrix.

h. Reviewed by Chief Compliance Officer and/or Legal Counsel

This contract is pending legal approval.

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: HE

Department Head: Isabel Silva

Vendor Name: CommGap-International Language Services

Contact name & e-mail: Rachel Draut, racheld@commgap.com

What services will this vendor provide to KHS? KHS provides equal access to health services for limited English (LEP) members by arranging appropriate interpreter services in accordance with the statutory, regulatory, and contractual requirements.

Description of Contract	
Type of Agreement: Professional Services ☒ Contract ☐ Purchase ☐ New agreement ☒ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background: Appropriate linguistic services will be available for medical and non-medical points of contact including membership services, appointment services and member orientation sessions. During regular business hours, members and providers who require the assistance of an in-person interpreter can contact KHS to set up an appointment with a qualified interpreter. Brief Explanation: CommGap-International Language Services will provide appropriate interpreter services in accordance with the statutory, regulatory, and contractual requirements.
☒ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to Fifty Thousand Dollars or more if not budgeted ($50,000.00) and One Hundred Thousand Dollars or more if budgeted ($100,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over Fifty Thousand Dollars or more if not budgeted ($50,000.00) and One Hundred Thousand Dollars or more if budgeted ($100,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Fifty Thousand Dollars ($50,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)* Brief vendor selection justification: CommGap is the most cost effective vendor that utilizes medically qualified and certified interpreters from Kern County and neighboring counties and has proven to provide high quality interpreting services to KHS members since 2017. Global Interpreting Network was the only other vendor who responded to the RFP with services for all languages, including ASL. Although their hourly rate for Spanish interpreting during regular business hours is comparable to CommGap, their hourly rate for all other languages during and after business hours is significantly higher than CommGap. Additionally, Accommodating Ideas and LifeSigns responded to the RFP for ASL interpreting services only. In reviewing the ASL rates for these vendors, LifeSigns is the most cost effective vendor and has been providing ASL interpreting services to KHS members for over 15 years. With overall limited access to the pool of ASL interpreters in Kern County, the current contract with LifeSigns should be maintained and would serve as the primary vendor for ASL interpreting services and CommGap or Accommodating Ideas would serve as a secondary vendor.	
☐ Sole source – no competitive process can be performed. Brief reason for sole source: _____	

Form updated 11/21/19

☐ Conflict of Interest Form is required for this Contract

☐ HIPAA Business Associate Agreement is required for this Contract

Fiscal Impact

KHS Governing Board previously approved this expense in KHS' FY 2020 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☒ NO	☐ YES
Capital project	☒ NO	☐ YES

Project type: _____

Budgeted Cost Center 312 GL# 5645

Maximum cost of this agreement not to exceed: $350,000.00 per two years

Notes: Agreement is based on a fee-for-service billing schedule ($175,000/year).

Contract Terms and Conditions

Effective date: 7/06/20 Termination date: 7/05/22

Explain extension provisions, termination conditions and required notice: _____

Approvals

Compliance DMHC/DHCS Review:

Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

Date

Contract Owner:

Department Head

Date

Purchasing:

Director of Procurement and Facilities

5/26/20

Date

Reviewed as to Budget:

Robert Landis

Chief Financial Officer or Controller

5/26/20

Date

Recommended by the Executive Committee:

Chief Operating Officer

5/26/2020

Date

IT Approval:

Chief Information Officer or IT Director

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Form updated 11/21/19

Board of Directors approval is required on all contracts over $50,000 if not budgeted and $100,000 if budgeted.

_____

KHS Board Chairman

_____

Date

Form updated 11/21/19

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: June 11, 2020

Re: February 2020 Financial Results

The February results reflect a $124,910 Net Increase in Net Position which is a $708,818 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $8.4 million favorable variance primarily due to:

   A) $2.1 million favorable variance in Proposition 56 Supplemental Revenue due to an unbudgeted rate increase in tobacco tax revenue funds in fiscal year 19/20 for additional CPT procedure codes along with unbudgeted new Prop 56 program that became effective January 1, 2020 offset against amounts included in 2B below.

   B) $6.2 million favorable variance in Premium-MCO Tax due to CMS approving the DHCS request to continue the MCO Tax on April 3, 2020 with an effective date of January 1, 2020. Accordingly, KHS accrued the MCO Tax Revenue for the month of January in the February financial statements which is offset against MCO Tax Expense included in Item 3 below.

2) Total Medical Costs reflect a $2.4 million unfavorable variance primarily due to:

   A) $.4 million favorable variance in Physician Services primarily due to lower than expected utilization of Referral Specialty Services for Family and Expansion members.

   B) $3.0 million unfavorable variance in Other Medical primarily due to accruing for estimated Proposition 56 expenses relating to unbudgeted additional CPT procedure codes along with increases in supplemental allowable payable amounts offset against revenue included in 1A above.

3) $6.2 million unfavorable variance in MCO Tax expense due to CMS approving the DHCS request to continue the MCO Tax on April 3, 2020 with an effective date of January 1, 2020. Accordingly, KHS accrued the MCO Tax Expense for the month of January in the February financial statements which is offset against MCO Tax Premium included in 1B above.

The February Medical Loss Ratio is 93.4% which is slightly unfavorable to the 93.1% budgeted amount. The February Administrative Expense Ratio is 5.5% which is favorable to the 6.6% budgeted amount.

The results for the 2 months ended February 29, 2020 reflect a Net Increase in Net Position of $174,010. This is a $1,343,303 favorable variance to budget and includes approximately $1.3 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 93.0% which is equal to the 93.0% budgeted amount. The year-to-date Administrative Expense Ratio is 5.8% which is favorable to the 6.6% budgeted amount.

Kern Health Systems
Financial Packet
February 2020

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF FEBRUARY 29, 2020

ASSETS	FEBRUARY 2020	JANAURY 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 99,313,693	$ 84,860,622	$ 14,453,071
Short-Term Investments	68,247,383	106,975,167	(38,727,784)
Pass-through Monies Held for Future Payment	36,565,812	-	36,565,812
Premiums Receivable - Net	138,343,080	115,925,378	22,417,702
Premiums Receivable - Hospital Direct Payments	260,406,378	248,953,559	11,452,819
Interest Receivable	428,194	219,333	208,861
Other Receivables	959,467	1,005,109	(45,642)
Prepaid Expenses & Other Current Assets	2,358,480	2,675,655	(317,175)
Total Current Assets	$ 606,622,487	$ 560,614,823	$ 46,007,664
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	2,482,958	2,478,540	4,418
Computer Hardware and Software - Net	17,951,507	18,097,442	(145,935)
Building and Building Improvements - Net	36,028,441	36,103,975	(75,534)
Capital Projects in Progress	9,072,175	8,801,698	270,477
Total Capital Assets	$ 69,625,787	$ 69,572,361	$ 53,426
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	743,644	743,644	-
Total Long Term Assets	$ 1,043,644	$ 1,043,644	$ -
DEFERRED OUTFLOWS OF RESOURCES	$ 2,889,179	$ 2,889,179	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 680,181,097	$ 634,120,007	$ 46,061,090
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 3,077,726	$ 3,071,925	5,801
Accrued Other Operating Expenses	1,596,099	3,353,182	(1,757,083)
Accrued Taxes and Licenses	15,981,129	-	15,981,129
Other Medical Liabilities - Nonoperating Passthrough	36,565,812	-	36,565,812
Claims Payable (Reported)	22,580,773	21,148,377	1,432,396
IBNR - Inpatient Claims	27,978,749	30,185,522	(2,206,773)
IBNR - Physician Claims	19,480,210	19,061,305	418,905
IBNR - Accrued Other Medical	24,453,054	25,354,025	(900,971)
Risk Pool and Withholds Payable	2,772,609	4,272,595	(1,499,986)
Statutory Allowance for Claims Processing Expense	2,278,463	2,278,463	-
Other Liabilities	40,926,220	54,481,624	(13,555,404)
Accrued Hospital Directed Payments	260,164,967	248,712,613	11,452,354
Total Current Liabilities	$ 457,855,811	$ 411,919,631	$ 45,936,180
NONCURRENT LIABILITIES:			
Net Pension Liability	7,038,233	7,038,233	-
TOTAL NONCURRENT LIABILITIES	$ 7,038,233	$ 7,038,233	$ -
DEFERRED INFLOWS OF RESOURCES	$ 420,664	$ 420,664	$ -
NET POSITION:			
Net Position - Beg. of Year	214,692,379	214,692,379	-
Increase (Decrease) in Net Position - Current Year	174,010	49,100	124,910
Total Net Position	$ 214,866,389	$ 214,741,479	$ 124,910
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 680,181,097	$ 634,120,007	$ 46,061,090

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED FEBRUARY 29, 2020

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
167,240	167,900	(660)	Family Members	333,688	335,400	(1,712)
60,486	61,090	(604)	Expansion Members	120,385	122,180	(1,795)
15,493	14,730	763	SPD Members	31,160	29,460	1,700
6,788	6,205	583	Other Members	13,414	12,410	1,004
9,125	8,660	465	Kaiser Members	18,117	17,320	797
259,132	258,585	547	Total Members - MCAL	516,764	516,770	(6)
			REVENUES			
28,136,428	27,381,955	754,473	Title XIX - Medicaid - Family and Other	56,247,964	54,728,356	1,519,608
23,419,130	23,145,509	273,621	Title XIX - Medicaid - Expansion Members	46,554,934	46,291,018	263,916
15,113,713	14,884,621	229,092	Title XIX - Medicaid - SPD Members	30,134,444	29,769,242	365,202
16,158,895	9,997,000	6,161,895	Premium - MCO Tax	16,158,895	19,978,000	(3,819,105)
11,391,396	11,071,040	320,356	Premium - Hospital Directed Payments	22,667,980	22,137,797	530,183
301,265	397,140	(95,875)	Investment Earnings And Other Income	491,396	793,644	(302,248)
-	72,478	(72,478)	Reinsurance Recoveries	-	144,841	(144,841)
60,959	-	60,959	Rate Adjustments - Hospital Directed Payments	179,292	-	179,292
809,261	-	809,261	Rate/Income Adjustments	1,628,879	-	1,628,879
95,391,047	86,949,744	8,441,303	TOTAL REVENUES	174,063,784	173,842,898	220,886
			EXPENSES			
			Medical Costs:			
13,873,238	14,322,476	449,238	Physician Services	28,630,784	28,628,076	(2,708)
3,966,515	4,606,553	640,038	Other Professional Services	8,301,468	9,210,345	908,877
5,258,084	5,129,950	(128,134)	Emergency Room	10,485,031	10,252,648	(232,383)
13,893,706	13,465,191	(428,515)	Inpatient	28,805,383	26,917,624	(1,887,759)
144,425	72,478	(71,947)	Reinsurance Expense	216,745	144,841	(71,905)
6,204,610	6,534,432	329,822	Outpatient Hospital	12,939,005	13,063,547	124,542
10,021,013	6,985,927	(3,035,086)	Other Medical	15,682,797	13,964,399	(1,718,398)
9,246,208	9,691,338	445,130	Pharmacy	19,217,895	19,375,559	157,664
500,014	499,850	(164)	Pay for Performance Quality Incentive	997,294	998,900	1,606
11,391,396	11,071,040	(320,356)	Hospital Directed Payments	22,667,980	22,137,797	(530,183)
60,959	-	(60,959)	Hospital Directed Payment Adjustment	179,292	-	(179,292)
232,393	-	(232,393)	Non-Claims Expense Adjustment	289,565	-	(289,565)
(8,559)	-	8,559	IBNR, Incentive, Paid Claims Adjustment	(7,743)	-	7,743
74,784,002	72,379,235	(2,404,767)	Total Medical Costs	148,405,496	144,693,736	(3,711,760)
20,607,045	14,570,509	6,036,536	GROSS MARGIN	25,658,288	29,149,162	(3,490,874)
			Administrative:			
2,407,112	2,660,427	253,315	Compensation	4,984,460	5,320,853	336,393
833,909	859,226	25,317	Purchased Services	1,639,812	1,719,452	79,640
43,182	119,146	75,964	Supplies	78,988	238,626	159,638
287,536	330,375	42,839	Depreciation	574,926	659,750	84,824
181,493	347,151	165,658	Other Administrative Expenses	534,907	719,590	184,683
-	-	-	Administrative Expense Adjustment	-	-	-
3,753,232	4,316,325	563,093	Total Administrative Expenses	7,813,093	8,658,271	845,178
78,537,234	76,695,560	(1,841,674)	TOTAL EXPENSES	156,218,589	153,352,007	(2,866,582)
16,853,813	10,254,184	6,599,629	OPERATING INCOME (LOSS) BEFORE TAX	17,845,195	20,490,891	(2,645,696)
16,159,021	9,997,000	(6,162,021)	MCO TAX	16,159,021	19,978,000	3,818,979
694,792	257,184	437,608	OPERATING INCOME (LOSS) NET OF TAX	1,686,174	512,891	1,173,283
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
(341,696)	(333,333)	(8,363)	Provider Recruitment and Retention Grants	(721,776)	(666,666)	(55,110)
(228,186)	(507,759)	279,573	Health Home	(790,388)	(1,015,518)	225,130
(569,882)	(841,092)	271,210	TOTAL NONOPERATING REVENUE (EXPENSE)	(1,512,164)	(1,682,184)	170,020
124,910	(583,908)	708,818	NET INCREASE (DECREASE) IN NET POSITION	174,010	(1,169,293)	1,343,303
93.4%	93.1%	-0.4%	MEDICAL LOSS RATIO	93.0%	93.0%	0.1%
5.5%	6.6%	1.0%	ADMINISTRATIVE EXPENSE RATIO	5.8%	6.6%	0.8%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED FEBRUARY 29, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
167,240	167,900	(660)	Family Members	333,688	335,400	(1,712)
60,486	61,090	(604)	Expansion Members	120,385	122,180	(1,795)
15,493	14,730	763	SPD Members	31,160	29,460	1,700
6,788	6,205	583	Other Members	13,414	12,410	1,004
9,125	8,660	465	Kaiser Members	18,117	17,320	797
259,132	258,585	547	Total Members - MCAL	516,764	516,770	(6)
			REVENUES			
161.68	157.27	4.40	Title XIX - Medicaid - Family and Other	162.05	157.35	4.70
387.18	378.88	8.31	Title XIX - Medicaid - Expansion Members	386.72	378.88	7.84
975.52	1,010.50	(34.98)	Title XIX - Medicaid - SPD Members	967.09	1,010.50	(43.41)
64.63	40.00	24.63	Premium - MCO Tax	32.41	40.00	(7.59)
45.56	44.30	1.27	Premium - Hospital Directed Payments	45.46	44.32	1.13
1.21	1.59	(0.38)	Investment Earnings And Other Income	0.99	1.59	(0.60)
0.00	0.29	(0.29)	Reinsurance Recoveries	0.00	0.29	(0.29)
0.24	0.00	0.24	Rate Adjustments - Hospital Directed Payments	0.36	0.00	0.36
3.24	0.00	3.24	Rate/Income Adjustments	3.27	0.00	3.27
381.55	347.90	33.65	TOTAL REVENUES	349.07	348.07	1.00
			EXPENSES			
			Medical Costs:			
55.49	57.31	1.82	Physician Services	57.42	57.32	(0.10)
15.87	18.43	2.57	Other Professional Services	16.65	18.44	1.79
21.03	20.53	(0.51)	Emergency Room	21.03	20.53	(0.50)
55.57	53.88	(1.70)	Inpatient	57.77	53.89	(3.87)
0.58	0.29	(0.29)	Reinsurance Expense	0.43	0.29	(0.14)
24.82	26.15	1.33	Outpatient Hospital	25.95	26.16	0.21
40.08	27.95	(12.13)	Other Medical	31.45	27.96	(3.49)
36.98	38.78	1.79	Pharmacy	38.54	38.79	0.25
2.00	2.00	0.00	Pay for Performance Quality Incentive	2.00	2.00	0.00
45.56	44.30	(1.27)	Hospital Directed Payments	45.46	44.32	(1.13)
0.24	0.00	(0.24)	Hospital Directed Payment Adjustment	0.36	0.00	(0.36)
0.93	0.00	(0.93)	Non-Claims Expense Adjustment	0.58	0.00	(0.58)
(0.03)	0.00	0.03	IBNR, Incentive, Paid Claims Adjustment	(0.02)	0.00	0.02
299.13	289.60	(9.52)	Total Medical Costs	297.62	289.71	(7.91)
82.43	58.30	24.13	GROSS MARGIN	51.46	58.36	(6.91)
			Administrative:			
9.63	10.64	1.02	Compensation	10.00	10.65	0.66
3.34	3.44	0.10	Purchased Services	3.29	3.44	0.15
0.17	0.48	0.30	Supplies	0.16	0.48	0.32
1.15	1.32	0.17	Depreciation	1.15	1.32	0.17
0.73	1.39	0.66	Other Administrative Expenses	1.07	1.44	0.37
0.00	0.00	0.00	Administrative Expense Adjustment	0.00	0.00	0.00
15.01	17.27	2.26	Total Administrative Expenses	15.67	17.34	1.67
314.14	306.87	(7.27)	TOTAL EXPENSES	313.28	307.04	(6.24)
67.41	41.03	26.38	OPERATING INCOME (LOSS) BEFORE TAX	35.79	41.03	(5.24)
64.63	40.00	(24.63)	MCO TAX	32.41	40.00	7.59
2.78	1.03	1.75	OPERATING INCOME (LOSS) NET OF TAX	3.38	1.03	2.35
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
(1.37)	(1.33)	(0.03)	Reserve Fund Projects/Community Grants	(1.45)	(1.33)	(0.11)
(0.91)	(2.03)	1.12	Health Home	(1.59)	(2.03)	0.45
(2.28)	(3.37)	1.09	TOTAL NONOPERATING REVENUE (EXPENSE)	(3.03)	(3.37)	0.34
0.50	(2.34)	2.84	NET INCREASE (DECREASE) IN NET POSITION	0.35	(2.34)	2.69
93.4%	93.1%	-0.4%	MEDICAL LOSS RATIO	93.0%	93.0%	0.1%
5.5%	6.6%	1.0%	ADMINISTRATIVE EXPENSE RATIO	5.8%	6.6%	0.8%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH FEBRUARY 29, 2020	FEBRUARY 2019	MARCH 2019	APRIL 2019	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	247,101	247,836	248,254	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	249,193	250,007	3,242,638
REVENUES														
Title XIX - Medicaid - Family and Other	24,192,447	24,487,252	24,003,598	24,444,272	25,745,431	26,916,818	27,380,366	27,444,092	27,395,016	34,656,206	28,289,680	28,111,536	28,136,428	351,203,142
Title XIX - Medicaid - Expansion Members	23,396,309	22,894,496	23,046,615	23,133,193	23,356,415	21,829,172	22,748,791	23,117,928	22,908,874	25,545,000	24,658,622	23,135,804	23,419,130	303,190,349
Title XIX - Medicaid - SPD Members	12,067,762	12,439,467	12,488,048	13,147,466	13,032,438	14,355,421	14,965,261	15,059,382	15,759,913	16,141,207	15,294,321	15,020,731	15,113,713	184,885,130
Premium - MCO Tax	8,047,808	8,071,581	8,084,949	8,092,541	8,174,408	8,128,512	12,317,485	10,182,096	10,062,668	11,609,045	(52,290,862)	-	16,158,895	56,639,126
Premium - Hospital Directed Payments	-	-	-	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	158,831,446
Investment Earnings And Other Income	422,792	985,737	620,797	382,110	1,108,727	354,349	382,033	708,869	338,986	265,233	731,395	190,131	301,265	6,792,424
Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	-	-	-	-	-	-	-	62,733,334	-	-	101,394,310	118,333	60,959	164,306,936
Rate/Income Adjustments	5,819,936	626,404	(173,473)	178,336	(703,658)	132,080	329,476	103,418	318,771	(3,664)	(391,644)	819,618	809,261	7,864,861
TOTAL REVENUES	73,947,054	69,504,937	68,070,534	69,377,918	70,713,761	71,716,351	78,123,412	139,349,119	76,784,228	88,213,027	253,849,288	78,672,737	95,391,047	1,233,713,413
EXPENSES														
Medical Costs:														
Physician Services	13,768,201	15,391,612	15,885,936	14,054,383	13,468,415	13,912,712	13,516,282	12,473,244	13,286,040	14,396,081	15,556,899	14,757,546	13,873,238	184,340,589
Other Professional Services	3,447,281	3,652,683	3,718,600	3,960,952	4,388,042	3,849,695	3,775,027	3,913,361	4,483,269	3,596,983	4,371,702	4,334,953	3,966,515	51,459,063
Emergency Room	4,710,529	4,835,728	5,525,268	5,106,796	4,698,111	5,181,359	4,645,061	4,697,451	5,571,836	5,227,569	4,729,725	5,226,947	5,258,084	65,414,464
Inpatient	12,906,122	13,546,028	12,850,017	12,181,510	14,390,451	13,332,634	15,238,360	15,564,329	14,951,334	14,657,214	14,449,035	14,911,677	13,893,706	182,872,417
Reinsurance Expense	125,026	126,021	126,397	126,609	126,658	126,658	129,256	126,290	127,228	129,075	128,012	72,320	144,425	1,613,975
Outpatient Hospital	6,037,448	6,885,177	6,373,571	6,408,304	5,912,776	6,609,411	6,523,398	6,130,800	6,128,586	6,141,173	4,767,801	6,734,395	6,204,610	80,857,450
Other Medical	6,854,723	6,448,536	6,141,817	7,183,716	6,357,547	6,715,805	6,439,790	7,570,084	5,832,261	16,655,345	6,649,662	5,661,784	10,021,013	98,532,083
Pharmacy	9,033,300	9,671,212	9,293,776	9,659,273	8,508,813	9,183,446	9,336,978	9,145,904	9,834,755	9,282,817	9,267,277	9,971,687	9,246,208	121,435,446
Pay for Performance Quality Incentive	494,202	495,672	496,508	496,698	501,792	498,760	498,932	502,552	502,078	500,918	498,762	497,280	500,014	6,484,168
Hospital Directed Payments	-	-	-	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	158,831,446
Hospital Directed Payment Adjustment	-	-	-	-	-	-	-	62,605,426	-	-	101,154,229	118,333	60,959	163,938,947
Non-Claims Expense Adjustment	367,246	324,378	(736,017)	39,610	756,640	19,252	11,717	11,329	(5,919)	(18,762)	4,624	57,172	232,393	1,063,663
IBNR, Incentive, Paid Claims Adjustment	4,381,620	(3,810,327)	(3,425,856)	(2,087,231)	(704,885)	(350,851)	202,480	374,161	20,741	(40,346)	(259,737)	816	(8,559)	(5,707,974)
Total Medical Costs	62,125,698	57,566,720	56,250,017	57,130,620	58,404,360	59,078,881	60,317,281	123,114,931	60,732,209	70,528,067	297,481,457	73,621,494	74,784,002	1,111,135,737
GROSS MARGIN	11,821,356	11,938,217	11,820,517	12,247,298	12,309,401	12,637,470	17,806,131	16,234,188	16,052,019	17,684,960	(43,632,169)	5,051,243	20,607,045	122,577,676
Administrative:														
Compensation	1,953,045	2,094,504	2,121,314	2,336,685	2,155,354	2,297,855	2,254,325	2,343,633	2,510,126	2,403,604	2,589,213	2,577,348	2,407,112	30,044,118
Purchased Services	538,593	901,569	783,945	882,833	449,468	805,910	605,801	836,783	831,542	805,047	1,358,494	805,903	833,909	10,439,797
Supplies	78,778	93,764	93,770	15,577	59,549	47,853	49,290	76,514	203,279	58,830	(7,208)	35,806	43,182	848,984
Depreciation	179,517	211,201	179,515	179,516	179,516	151,640	151,655	151,656	355,208	280,129	304,894	287,390	287,536	2,899,373
Other Administrative Expenses	188,631	246,439	302,417	239,380	412,596	338,545	489,494	523,591	519,786	270,201	344,959	353,414	181,493	4,410,946
Administrative Expense Adjustment	-	-	-	-	-	-	-	-	-	-	1,325,136	-	-	1,325,136
Total Administrative Expenses	2,938,564	3,547,477	3,480,961	3,653,991	3,256,483	3,641,803	3,550,565	3,932,177	4,419,941	3,817,811	5,915,488	4,059,861	3,753,232	49,968,354
TOTAL EXPENSES	65,064,262	61,114,197	59,730,978	60,784,611	61,660,843	62,720,684	63,867,846	127,047,108	65,152,150	74,345,878	303,396,945	77,681,355	78,537,234	1,161,104,091
OPERATING INCOME (LOSS) BEFORE TAX	8,882,792	8,390,740	8,339,556	8,593,307	9,052,918	8,995,667	14,255,566	12,302,011	11,632,078	13,867,149	(49,547,657)	991,382	16,853,813	72,609,322
MCO TAX	8,087,918	8,087,918	8,087,918	8,087,918	8,087,917	8,051,211	12,279,276	10,165,243	10,057,218	12,283,003	(52,962,035)	-	16,159,021	56,472,526
OPERATING INCOME (LOSS) NET OF TAX	794,874	302,822	251,638	505,389	965,001	944,456	1,976,290	2,136,768	1,574,860	1,584,146	3,414,378	991,382	694,792	16,136,796
TOTAL NONOPERATING REVENUE (EXPENSE)	(104,330)	(133,960)	(191,455)	(359,160)	1,293,258	(306,804)	(151,504)	(380,606)	(236,574)	(885,928)	(425,785)	(942,282)	(569,882)	(3,395,012)
NET INCREASE (DECREASE) IN NET POSITION	690,544	168,862	60,183	146,229	2,258,259	637,652	1,824,786	1,756,162	1,338,286	698,218	2,988,593	49,100	124,910	12,741,784
MEDICAL LOSS RATIO	94.3%	93.7%	93.8%	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	92.3%
ADMINISTRATIVE EXPENSE RATIO	4.5%	5.8%	5.8%	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.9%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH FEBRUARY 29, 2020	FEBRUARY 2019	MARCH 2019	APRIL 2019	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	247,101	247,836	248,254	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	249,193	250,007	3,242,638
REVENUES														
Title XIX - Medicaid - Family and Other	140.03	141.35	138.32	140.92	147.25	155.06	157.80	157.10	157.23	199.08	162.50	162.42	161.68	155.46
Title XIX - Medicaid - Expansion Members	391.12	383.67	384.32	386.02	383.23	360.65	374.91	377.23	373.38	419.77	410.96	386.25	387.18	386.02
Title XIX - Medicaid - SPD Members	831.51	839.09	846.53	878.96	862.90	940.48	980.04	984.27	1,019.80	1,039.69	1,000.74	958.75	975.52	936.09
Premium - MCO Tax	32.57	32.57	32.57	32.59	32.58	32.59	49.38	40.52	40.08	46.35	(209.68)	0.00	64.63	17.47
Premium - Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.25	45.56	48.98
Investment Earnings And Other Income	1.71	3.98	2.50	1.54	4.42	1.42	1.53	2.82	1.35	1.06	2.93	0.76	1.21	2.09
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	0.00	0.00	0.00	0.00	0.00	0.00	0.00	249.66	0.00	0.00	406.58	0.47	0.24	50.67
Rate/Income Adjustments	23.55	2.53	(0.70)	0.72	(2.80)	0.53	1.32	0.41	1.27	(0.01)	(1.57)	3.29	3.24	2.43
TOTAL REVENUES	299.26	280.45	274.20	279.36	281.84	287.58	313.16	554.56	305.87	352.21	1,017.92	315.71	381.55	380.47
EXPENSES														
Medical Costs:														
Physician Services	55.72	62.10	63.99	56.59	53.68	55.79	54.18	49.64	52.92	57.48	62.38	59.22	55.49	56.85
Other Professional Services	13.95	14.74	14.98	15.95	17.49	15.44	15.13	15.57	17.86	14.36	17.53	17.40	15.87	15.87
Emergency Room	19.06	19.51	22.26	20.56	18.73	20.78	18.62	18.69	22.20	20.87	18.97	20.98	21.03	20.17
Inpatient	52.23	54.66	51.76	49.05	57.36	53.46	61.08	61.94	59.56	58.52	57.94	59.84	55.57	56.40
Reinsurance Expense	0.51	0.51	0.51	0.51	0.50	0.51	0.52	0.50	0.51	0.52	0.51	0.29	0.58	0.50
Outpatient Hospital	24.43	27.78	25.67	25.80	23.57	26.50	26.15	24.40	24.41	24.52	19.12	27.02	24.82	24.94
Other Medical	27.74	26.02	24.74	28.93	25.34	26.93	25.81	30.13	23.23	66.50	26.66	22.72	40.08	30.39
Pharmacy	36.56	39.02	37.44	38.89	33.91	36.83	37.43	36.40	39.18	37.06	37.16	40.02	36.98	37.45
Pay for Performance Quality Incentive	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.25	45.56	48.98
Hospital Directed Payment Adjustment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	249.15	0.00	0.00	405.62	0.47	0.24	50.56
Non-Claims Expense Adjustment	1.49	1.31	(2.96)	0.16	3.02	0.08	0.05	0.05	(0.02)	(0.07)	0.02	0.23	0.93	0.33
IBNR, Incentive, Paid Claims Adjustment	17.73	(15.37)	(13.80)	(8.40)	(2.81)	(1.41)	0.81	1.49	0.08	(0.16)	(1.04)	0.00	(0.03)	(1.76)
Total Medical Costs	251.42	232.28	226.58	230.04	232.78	236.90	241.79	489.96	241.92	281.60	1,192.88	295.44	299.13	342.66
GROSS MARGIN	47.84	48.17	47.61	49.31	49.06	50.68	71.38	64.61	63.94	70.61	(174.96)	20.27	82.43	37.80
Administrative:														
Compensation	7.90	8.45	8.54	9.41	8.59	9.21	9.04	9.33	10.00	9.60	10.38	10.34	9.63	9.27
Purchased Services	2.18	3.64	3.16	3.55	1.79	3.23	2.43	3.33	3.31	3.21	5.45	3.23	3.34	3.22
Supplies	0.32	0.38	0.38	0.06	0.24	0.19	0.20	0.30	0.81	0.23	(0.03)	0.14	0.17	0.26
Depreciation	0.73	0.85	0.72	0.72	0.72	0.61	0.61	0.60	1.41	1.12	1.22	1.15	1.15	0.89
Other Administrative Expenses	0.76	0.99	1.22	0.96	1.64	1.36	1.96	2.08	2.07	1.08	1.38	1.42	0.73	1.36
Administrative Expense Adjustment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.31	0.00	0.00	0.41
Total Administrative Expenses	11.89	14.31	14.02	14.71	12.98	14.60	14.23	15.65	17.61	15.24	23.72	16.29	15.01	15.41
TOTAL EXPENSES	263.31	246.59	240.60	244.75	245.76	251.51	256.02	505.61	259.53	296.84	1,216.60	311.73	314.14	358.07
OPERATING INCOME (LOSS) BEFORE TAX	35.95	33.86	33.59	34.60	36.08	36.07	57.14	48.96	46.34	55.37	(198.68)	3.98	67.41	22.39
MCO TAX	32.73	32.63	32.58	32.57	32.24	32.28	49.22	40.45	40.06	49.04	(212.37)	0.00	64.63	17.42
OPERATING INCOME (LOSS) NET OF TAX	3.22	1.22	1.01	2.03	3.85	3.79	7.92	8.50	6.27	6.32	13.69	3.98	2.78	4.98
TOTAL NONOPERATING REVENUE (EXPENSE)	(0.42)	(0.54)	(0.77)	(1.45)	5.15	(1.23)	(0.61)	(1.51)	(0.94)	(3.54)	(1.71)	(3.78)	(2.28)	(1.05)
NET INCREASE (DECREASE) IN NET POSITION	2.79	0.68	0.24	0.59	9.00	2.56	7.31	6.99	5.33	2.79	11.98	0.20	0.50	3.93
MEDICAL LOSS RATIO	94.3%	93.7%	93.8%	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	92.3%
ADMINISTRATIVE EXPENSE RATIO	4.5%	5.8%	5.8%	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.9%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED FEBRUARY 29, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE	REVENUES	ACTUAL	BUDGET	VARIANCE
			Title XIX - Medicaid - Family & Other			
22,119,605	22,088,867	30,738	Premium - Medi-Cal	43,937,705	44,148,591	(210,886)
2,110,599	2,375,503	(264,904)	Premium - Maternity Kick	4,208,250	4,751,006	(542,756)
31,383	72,480	(41,097)	Premium - Hep C Kick	52,306	144,793	(92,487)
294,899	593,799	(298,900)	Premium - BHT Kick	940,712	1,186,234	(245,522)
167,954	311,639	(143,685)	Premium - Health Home Kick	322,028	622,562	(300,534)
3,175,378	1,689,475	1,485,903	Premium - Provider Enhancement	6,312,145	3,375,050	2,937,095
152,112	156,241	(4,129)	Premium - Ground Emergency Medical Transportation	307,749	312,254	(4,505)
84,498	93,951	(9,453)	Other	167,069	187,866	(20,797)
28,136,428	27,381,955	754,473	Total Title XIX - Medicaid - Family & Other	56,247,964	54,728,356	1,519,608
			Title XIX - Medicaid - Expansion Members			
21,058,372	21,183,611	(125,239)	Premium - Medi-Cal	41,929,420	42,367,222	(437,802)
310,763	214,189	96,574	Premium - Maternity Kick	660,371	428,378	231,993
271,993	303,377	(31,384)	Premium - Hep C Kick	449,835	606,754	(156,919)
375,176	519,998	(144,822)	Premium - Health Home Kick	704,302	1,039,996	(335,694)
1,231,212	742,244	488,969	Premium - Provider Enhancement	2,452,508	1,484,487	968,021
145,388	152,964	(7,576)	Premium - Ground Emergency Medical Transportation	306,275	305,928	347
26,226	29,126	(2,900)	Other	52,223	58,252	(6,029)
23,419,130	23,145,509	273,621	Total Title XIX - Medicaid - Expansion Members	46,554,934	46,291,018	263,916
			Title XIX - Medicaid - SPD Members			
13,552,862	13,148,587	404,275	Premium - Medi-Cal	26,977,207	26,297,174	680,033
135,996	94,152	41,844	Premium - Hep C Kick	287,685	188,304	99,381
496,416	818,847	(322,431)	Premium - BHT Kick	1,023,562	1,637,694	(614,132)
346,175	416,635	(70,460)	Premium - Health Home Kick	677,000	833,270	(156,270)
451,504	282,521	168,983	Premium - Provider Enhancement	899,037	565,042	333,995
130,760	123,879	6,881	Premium - Ground Emergency Medical Transportation	269,953	247,758	22,195
15,113,713	14,884,621	229,092	Total Title XIX - Medicaid - SPD Members	30,134,444	29,769,242	365,202

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS - ALL COA FOR THE MONTH ENDED FEBRUARY 29, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
3,164,601	2,855,035	(309,566)	Primary Care Physician Services	6,072,873	5,705,672	(367,201)
8,803,273	10,041,380	1,238,107	Referral Specialty Services	19,228,358	20,072,708	844,350
1,896,664	1,417,361	(479,303)	Urgent Care & After Hours Advise	3,311,553	2,831,696	(479,857)
8,700	8,700	-	Hospital Admitting Team	18,000	18,000	-
13,873,238	14,322,476	449,238	TOTAL PHYSICIAN SERVICES	28,630,784	28,628,076	(2,708)
			OTHER PROFESSIONAL SERVICES			
261,072	269,809	8,737	Vision Service Capitation	560,561	539,360	(21,201)
204,745	212,779	8,034	221 - Business Intelligence	404,684	425,558	20,874
482,617	546,875	64,258	310 - Health Services - Utilization Management - UM Allocation *	1,033,522	1,093,750	60,228
131,973	169,504	37,531	311 - Health Services - Quality Improvement - UM Allocation *	262,692	339,007	76,315
102,037	127,990	25,953	312 - Health Services - Education - UM Allocation *	213,836	255,980	42,144
80,696	94,630	13,934	313 - Health Services - Pharmacy - UM Allocation *	168,849	189,261	20,412
88,868	129,020	40,152	314 - Health Homes - UM Allocation *	180,293	258,040	77,747
241,370	258,856	17,486	315 - Case Management - UM Allocation *	509,128	517,713	8,585
54,217	61,775	7,558	616 - Disease Management - UM Allocation *	110,552	123,550	12,998
935,456	1,412,646	477,190	Behavior Health Treatment	1,915,491	2,823,928	908,437
217,343	170,350	(46,993)	Mental Health Services	548,185	340,584	(207,601)
1,166,121	1,152,318	(13,803)	Other Professional Services	2,393,675	2,303,616	(90,059)
3,966,515	4,606,553	640,038	TOTAL OTHER PROFESSIONAL SERVICES	8,301,468	9,210,345	908,877
5,258,084	5,129,950	(128,134)	EMERGENCY ROOM	10,485,031	10,252,648	(232,383)
13,893,706	13,465,191	(428,515)	INPATIENT HOSPITAL	28,805,383	26,917,624	(1,887,759)
144,425	72,478	(71,947)	REINSURANCE EXPENSE PREMIUM	216,745	144,841	(71,905)
6,204,610	6,534,432	329,822	OUTPATIENT HOSPITAL SERVICES	12,939,005	13,063,547	124,542
			OTHER MEDICAL			
1,498,607	1,541,129	42,522	Ambulance and NEMT	3,097,982	3,080,739	(17,243)
393,491	388,468	(5,023)	Home Health Services & CBAS	785,898	776,666	(9,232)
229,353	488,855	259,502	Utilization and Quality Review Expenses	537,603	976,960	439,357
1,197,702	937,821	(259,881)	Long Term/SNF/Hospice	2,250,468	1,875,241	(375,227)
137,300	375,249	237,949	Health Home Capitation	303,360	750,283	446,923
6,564,560	3,146,823	(3,417,737)	Provider Enhancement Expense - Prop. 56 & GEMT	8,707,486	6,289,407	(2,418,079)
-	107,582	107,582	HHP Risk Pool/Incentive	-	215,103	215,103
10,021,013	6,985,927	(3,035,086)	TOTAL OTHER MEDICAL	15,682,797	13,964,399	(1,718,398)
			PHARMACY SERVICES			
8,470,785	8,679,215	208,430	RX - Drugs & OTC	17,608,782	17,351,954	(256,828)
331,788	470,008	138,220	RX - HEP-C	603,564	939,850	336,286
578,635	687,825	109,190	Rx - DME	1,275,549	1,375,149	99,600
(135,000)	(145,711)	(10,711)	RX - Pharmacy Rebates	(270,000)	(291,395)	(21,395)
9,246,208	9,691,338	445,130	TOTAL PHARMACY SERVICES	19,217,895	19,375,559	157,664
500,014	499,850	(164)	PAY FOR PERFORMANCE QUALITY INCENTIVE	997,294	998,900	1,606
11,391,396	11,071,040	(320,356)	HOSPITAL DIRECTED PAYMENTS	22,667,980	22,137,797	(530,183)
60,959	-	(60,959)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	179,292	-	(179,292)
232,393	-	(232,393)	NON-CLAIMS EXPENSE ADJUSTMENT	289,565	-	(289,565)
(8,559)	-	8,559	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(7,743)	-	7,743
74,784,002	72,379,235	(2,404,767)	Total Medical Costs	148,405,496	144,693,736	(3,711,760)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED FEBRUARY 29, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
12.66	11.42	(1.23)	Primary Care Physician Services	12.18	11.42	(0.75)
35.21	40.18	4.97	Referral Specialty Services	38.56	40.19	1.63
7.59	5.67	(1.92)	Urgent Care & After Hours Advise	6.64	5.67	(0.97)
0.03	0.03	0.00	Hospital Admitting Team	0.04	0.04	(0.00)
55.49	57.31	1.82	TOTAL PHYSICIAN SERVICES	57.42	57.32	(0.10)
			OTHER PROFESSIONAL SERVICES			
1.04	1.08	0.04	Vision Service Capitation	1.12	1.08	(0.04)
0.82	0.85	0.03	221 - Business Intelligence	0.81	0.85	0.04
1.93	2.19	0.26	310 - Health Services - Utilization Management - UM Allocation *	2.07	2.19	0.12
0.53	0.68	0.15	311 - Health Services - Quality Improvement - UM Allocation *	0.53	0.68	0.15
0.41	0.51	0.10	312 - Health Services - Education - UM Allocation *	0.43	0.51	0.08
0.32	0.38	0.06	313 - Health Services - Pharmacy - UM Allocation *	0.34	0.38	0.04
0.36	0.52	0.16	314 - Health Homes - UM Allocation *	0.36	0.52	0.16
0.97	1.04	0.07	315 - Case Management - UM Allocation *	1.02	1.04	0.02
0.22	0.25	0.03	616 - Disease Management - UM Allocation *	0.22	0.25	0.03
3.74	5.65	1.91	Behavior Health Treatment	3.84	5.65	1.81
0.87	0.68	(0.19)	Mental Health Services	1.10	0.68	(0.42)
4.66	4.61	(0.05)	Other Professional Services	4.80	4.61	(0.19)
15.87	18.43	2.57	TOTAL OTHER PROFESSIONAL SERVICES	16.65	18.44	1.79
21.03	20.53	(0.51)	EMERGENCY ROOM	21.03	20.53	(0.50)
55.57	53.88	(1.70)	INPATIENT HOSPITAL	57.77	53.89	(3.87)
0.58	0.29	(0.29)	REINSURANCE EXPENSE PREMIUM	0.43	0.29	(0.14)
24.82	26.15	1.33	OUTPATIENT HOSPITAL SERVICES	25.95	26.16	0.21
			OTHER MEDICAL			
5.99	6.17	0.17	Ambulance and NEMT	6.21	6.17	(0.04)
1.57	1.55	(0.02)	Home Health Services & CBAS	1.58	1.56	(0.02)
0.92	1.96	1.04	Utilization and Quality Review Expenses	1.08	1.96	0.88
4.79	3.75	(1.04)	Long Term/SNF/Hospice	4.51	3.75	(0.76)
0.55	1.50	0.95	Health Home Capitation	0.61	1.50	0.89
26.26	12.59	(13.67)	Provider Enhancement Expense - Prop. 56 & GEMT	17.46	12.59	(4.87)
0.00	0.43	0.43	HHP Risk Pool/Incentive	0.00	0.43	0.43
40.08	27.95	(12.13)	TOTAL OTHER MEDICAL	31.45	27.96	(3.49)
			PHARMACY SERVICES			
33.88	34.73	0.85	RX - Drugs & OTC	35.31	34.74	(0.57)
1.33	1.88	0.55	RX - HEP-C	1.21	1.88	0.67
2.31	2.75	0.44	Rx - DME	2.56	2.75	0.20
(0.54)	(0.58)	(0.04)	RX - Pharmacy Rebates	(0.54)	(0.58)	(0.04)
36.98	38.78	1.79	TOTAL PHARMACY SERVICES	38.54	38.79	0.25
2.00	2.00	0.00	PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	0.00
45.56	44.30	(1.27)	HOSPITAL DIRECTED PAYMENTS	45.46	44.32	(1.13)
0.24	0.00	(0.24)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.36	0.00	(0.36)
0.93	0.00	(0.93)	NON-CLAIMS EXPENSE ADJUSTMENT	0.58	0.00	(0.58)
(0.03)	0.00	0.03	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(0.02)	0.00	0.02
299.13	289.60	(9.52)	Total Medical Costs	297.62	289.71	(7.91)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH FEBRUARY 29, 2020	JANUARY 2020	FEBRUARY 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES			
Primary Care Physician Services	2,908,272	3,164,601	6,072,873
Referral Specialty Services	10,425,085	8,803,273	19,228,358
Urgent Care & After Hours Advise	1,414,889	1,896,664	3,311,553
Hospital Admitting Team	9,300	8,700	18,000
TOTAL PHYSICIAN SERVICES	14,757,546	13,873,238	28,630,784
OTHER PROFESSIONAL SERVICES			
Vision Service Capitation	299,489	261,072	560,561
221 - Business Intelligence	199,939	204,745	404,684
310 - Health Services - Utilization Management - UM Allocation *	550,905	482,617	1,033,522
311 - Health Services - Quality Improvement - UM Allocation *	130,719	131,973	262,692
312 - Health Services - Education - UM Allocation *	111,799	102,037	213,836
313 - Health Services - Pharmacy - UM Allocation *	88,153	80,696	168,849
314 - Health Homes - UM Allocation *	91,425	88,868	180,293
315 - Case Management - UM Allocation *	267,758	241,370	509,128
616 - Disease Management - UM Allocation *	56,335	54,217	110,552
Behavior Health Treatment	980,035	935,456	1,915,491
Mental Health Services	330,842	217,343	548,185
Other Professional Services	1,227,554	1,166,121	2,393,675
TOTAL OTHER PROFESSIONAL SERVICES	4,334,953	3,966,515	8,301,468
EMERGENCY ROOM	5,226,947	5,258,084	10,485,031
INPATIENT HOSPITAL	14,911,677	13,893,706	28,805,383
REINSURANCE EXPENSE PREMIUM	72,320	144,425	216,745
OUTPATIENT HOSPITAL SERVICES	6,734,395	6,204,610	12,939,005
OTHER MEDICAL			
Ambulance and NEMT	1,599,375	1,498,607	3,097,982
Home Health Services & CBAS	392,407	393,491	785,898
Utilization and Quality Review Expenses	308,250	229,353	537,603
Long Term/SNF/Hospice	1,052,766	1,197,702	2,250,468
Health Home Capitation	166,060	137,300	303,360
Provider Enhancement Expense - Prop. 56 & GEMT	2,142,926	6,564,560	8,707,486
HHP Risk Pool/Incentive	-	-	-
TOTAL OTHER MEDICAL	5,661,784	10,021,013	15,682,797
PHARMACY SERVICES			
RX - Drugs & OTC	9,137,997	8,470,785	17,608,782
RX - HEP-C	271,776	331,788	603,564
Rx - DME	696,914	578,635	1,275,549
RX - Pharmacy Rebates	(135,000)	(135,000)	(270,000)
TOTAL PHARMACY SERVICES	9,971,687	9,246,208	19,217,895
PAY FOR PERFORMANCE QUALITY INCENTIVE	497,280	500,014	997,294
HOSPITAL DIRECTED PAYMENTS	11,276,584	11,391,396	22,667,980
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	118,333	60,959	179,292
NON-CLAIMS EXPENSE ADJUSTMENT	57,172	232,393	289,565
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	816	(8,559)	(7,743)
Total Medical Costs	62,344,910	63,392,606	125,737,516

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH FEBRUARY 29, 2020	JANUARY 2020	FEBRUARY 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES			
Primary Care Physician Services	11.67	12.66	12.17
Referral Specialty Services	41.84	35.21	38.52
Urgent Care & After Hours Advise	5.68	7.59	6.63
Hospital Admitting Team	0.04	0.03	0.04
TOTAL PHYSICIAN SERVICES	59.22	55.49	57.35
OTHER PROFESSIONAL SERVICES			
Vision Service Capitation	1.20	1.04	1.12
221 - Business Intelligence	0.80	0.82	0.81
310 - Health Services - Utilization Management - UM Allocation *	2.21	1.93	2.07
311 - Health Services - Quality Improvement - UM Allocation *	0.52	0.53	0.53
312 - Health Services - Education - UM Allocation *	0.45	0.41	0.43
313 - Health Services - Pharmacy - UM Allocation *	0.35	0.32	0.34
314 - Health Homes - UM Allocation *	0.37	0.36	0.36
315 - Case Management - UM Allocation *	1.07	0.97	1.02
616 - Disease Management - UM Allocation *	0.23	0.22	0.22
Behavior Health Treatment	3.93	3.74	3.84
Mental Health Services	1.33	0.87	1.10
Other Professional Services	4.93	4.66	4.80
TOTAL OTHER PROFESSIONAL SERVICES	17.40	15.87	16.63
EMERGENCY ROOM	20.98	21.03	21.00
INPATIENT HOSPITAL	59.84	55.57	57.70
REINSURANCE EXPENSE PREMIUM	0.29	0.58	0.43
OUTPATIENT HOSPITAL SERVICES	27.02	24.82	25.92
OTHER MEDICAL			
Ambulance and NEMT	6.42	5.99	6.21
Home Health Services & CBAS	1.57	1.57	1.57
Utilization and Quality Review Expenses	1.24	0.92	1.08
Long Term/SNF/Hospice	4.22	4.79	4.51
Health Home Capitation	0.67	0.55	0.61
Provider Enhancement Expense - Prop. 56 & GEMT	8.60	26.26	17.44
HHP Risk Pool/Incentive	0.00	0.00	0.00
TOTAL OTHER MEDICAL	22.72	40.08	31.42
PHARMACY SERVICES			
RX - Drugs & OTC	36.67	33.88	35.27
RX - HEP-C	1.09	1.33	1.21
Rx - DME	2.80	2.31	2.56
RX - Pharmacy Rebates	(0.54)	(0.54)	(0.54)
TOTAL PHARMACY SERVICES	40.02	36.98	38.50
PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	2.00
HOSPITAL DIRECTED PAYMENTS	45.25	45.56	45.41
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.47	0.24	0.36
NON-CLAIMS EXPENSE ADJUSTMENT	0.23	0.93	0.58
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(0.03)	(0.02)
Total Medical Costs	295.44	299.13	297.29

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED FEBRUARY 29, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
293,820	314,514	20,694	110 - Executive	633,062	629,028	(4,034)
178,919	198,818	19,899	210 - Accounting	352,823	395,636	42,813
295,419	273,115	(22,304)	220 - Management Information Systems	676,930	546,232	(130,698)
11,648	13,054	1,406	221 - Business Intelligence	11,648	26,108	14,460
225,855	281,951	56,096	222 - Enterprise Development	437,154	563,902	126,748
241,507	415,724	174,217	225 - Infrastructure	600,522	831,449	230,927
498,960	556,612	57,652	230 - Claims	1,055,240	1,113,234	57,994
84,709	114,151	29,442	240 - Project Management	169,900	228,302	58,402
107,809	97,922	(9,887)	310 - Health Services - Utilization Management	206,338	196,594	(9,744)
41,860	55,091	13,231	311 - Health Services - Quality Improvement	52,684	110,182	57,498
60	217	157	312 - Health Services - Education	60	283	223
147,980	141,883	(6,097)	313- Pharmacy	304,927	287,340	(17,587)
15,046	-	(15,046)	314 - Health Homes	15,268	-	(15,268)
15,664	16,573	909	315 - Case Management	33,013	33,145	132
20,068	23,131	3,063	616 - Disease Management	40,904	46,262	5,358
252,748	313,552	60,804	320 - Provider Network Management	509,608	627,104	117,496
484,954	563,878	78,924	330 - Member Services	1,015,668	1,127,756	112,088
482,885	526,116	43,231	340 - Corporate Services	922,689	1,051,232	128,543
83,979	67,176	(16,803)	360 - Audit & Investigative Services	165,902	134,352	(31,550)
47,590	54,315	6,725	410 - Advertising Media	57,029	108,630	51,601
35,104	68,457	33,353	420 - Sales/Marketing/Public Relations	79,124	136,914	57,790
186,648	220,076	33,428	510 - Human Resourses	472,600	464,584	(8,016)
3,753,232	4,316,325	563,093	Total Administrative Expenses	7,813,093	8,658,271	845,178

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED FEBRUARY 29, 2020	JANUARY 2020	FEBRUARY 2020	YEAR TO DATE 2020
110 - Executive	339,242	293,820	633,062
210 - Accounting	173,904	178,919	352,823
220 - Management Information Systems (MIS)	381,511	295,419	676,930
221 - Business Intelligence	-	11,648	11,648
222 - Enterprise Development	211,299	225,855	437,154
225 - Infrastructure	359,015	241,507	600,522
230 - Claims	556,280	498,960	1,055,240
240 - Project Management	85,191	84,709	169,900
310 - Health Services - Utilization Management	98,529	107,809	206,338
311 - Health Services - Quality Improvement	10,824	41,860	52,684
312 - Health Services - Education	-	60	60
313- Pharmacy	156,947	147,980	304,927
314 - Health Homes	222	15,046	15,268
315 - Case Management	17,349	15,664	33,013
616 - Disease Management	20,836	20,068	40,904
320 - Provider Network Management	256,860	252,748	509,608
330 - Member Services	530,714	484,954	1,015,668
340 - Corporate Services	439,804	482,885	922,689
360 - Audit & Investigative Services	81,923	83,979	165,902
410 - Advertising Media	9,439	47,590	57,029
420 - Sales/Marketing/Public Relations	44,020	35,104	79,124
510 - Human Resourses	285,952	186,648	472,600
Total Department Expenses	4,059,861	3,753,232	7,813,093
ADMINISTRATIVE EXPENSE ADJUSTMENT	-	-	-
Total Administrative Expenses	4,059,861	3,753,232	7,813,093

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF FEBRUARY 29, 2020

ASSETS	FEBRUARY 2020	JANUARY 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,121,922	$ 1,216,318	(94,396)
Interest Receivable	5,280	2,640	2,640
Prepaid Expenses & Other Current Assets	3,334	4,167	(833)
TOTAL CURRENT ASSETS	$ 1,130,536	$ 1,223,125	$ (92,589)
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	94,396	(94,396)
TOTAL CURRENT LIABILITIES	$ -	$ 94,396	$ (94,396)
NET POSITION:			
Net Position- Beg. of Year	1,128,885	1,128,885	-
Increase (Decrease) in Net Position - Current Year	1,651	(156)	1,807
Total Net Position	$ 1,130,536	$ 1,128,729	$ 1,807
TOTAL LIABILITIES AND NET POSITION	$ 1,130,536	$ 1,223,125	$ (92,589)

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED FEBRUARY 29, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
2,640	-	2,640	Interest	5,280	-	5,280
-	-	-	Other Investment Income	(1,963)	-	(1,963)
2,640	-	2,640	TOTAL REVENUES	3,317	-	3,317
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
2,640	-	2,640	GROSS MARGIN	3,317	-	3,317
			Administrative			
833	-	(833)	Management Fee Expense and Other Admin Exp	1,666	-	(1,666)
833	-	(833)	Total Administrative Expenses	1,666	-	(1,666)
833	-	(833)	TOTAL EXPENSES	1,666	-	(1,666)
1,807	-	1,807	OPERATING INCOME (LOSS)	1,651	-	1,651
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
1,807	-	1,807	NET INCREASE (DECREASE) IN NET POSITION	1,651	-	1,651
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
32%	0%	-32%	ADMINISTRATIVE EXPENSE RATIO	50%	0%	-50%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2020 MEMBER MONTHS	JAN'20	FEB'20	MAR'20	APR'20	MAY'20	JUN'20	JUL'20	AUG'20	SEP'20	OCT'20	NOV'20	DEC'20
ADULT AND FAMILY													
ADULT	**87,286**	43,519	43,767	0	0	0	0	0	0	0	0	0	0
CHILD	**245,536**	122,496	123,040	0	0	0	0	0	0	0	0	0	0
SUB-TOTAL ADULT & FAMILY	**332,822**	**166,015**	**166,807**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
OTHER MEMBERS													
BCCTP-TOBACCO SETTLEMENT	**54**	26	28	0	0	0	0	0	0	0	0	0	0
DUALS													
PARTIAL DUALS - FAMILY	**864**	432	432	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - CHILD	**2**	1	1	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	**2**	1	1	0	0	0	0	0	0	0	0	0	0
SPD FULL DUALS	**13,358**	6,599	6,759	0	0	0	0	0	0	0	0	0	0
SUB-TOTAL DUALS	**14,226**	**7,033**	**7,193**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FAMILY & OTHER	**347,102**	**173,074**	**174,028**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SPD													
SPD (AGED AND DISABLED)	**31,160**	15,667	15,493	0	0	0	0	0	0	0	0	0	0
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	**119,780**	59,583	60,197	0	0	0	0	0	0	0	0	0	0
ACA Expansion Duals	**605**	316	289	0	0	0	0	0	0	0	0	0	0
SUB-TOTAL MED-CAL EXPANSION	**120,385**	**59,899**	**60,486**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL KAISER	**18,117**	**8,992**	**9,125**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL MEDI-CAL MEMBERS	**516,764**	**257,632**	**259,132**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: June 11, 2020

Re: March 2020 Financial Results

The March results reflect a $1,102,016 Net Increase in Net Position which is a $1,717,838 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $.6 million favorable variance primarily due to:

   A) $.8 million favorable variance primarily due to higher than expected budgeted SPD membership.

   B) $2.2 million favorable variance in Proposition 56 Supplemental Revenue due to an unbudgeted rate increase in tobacco tax revenue funds in fiscal year 19/20 for additional CPT procedure codes along with unbudgeted new Prop 56 program that became effective January 1, 2020 offset against amounts included in 2B below.

   C) $2.4 million unfavorable variance in Premium MCO Tax due to a revised reduction in our MCO tax liability rates that occurred with an agreement between CMS and DHCS which is offset against MCO Tax Expense included in Item 3 below.

2) Total Medical Costs reflect a $1.4 million unfavorable variance primarily due to:

   A) $1.3 million unfavorable variance in Inpatient due to higher than expected utilization in Expansion and SPD membership

   B) $3.7 million unfavorable variance in Other Medical primarily due to accruing for estimated Proposition 56 expenses relating to unbudgeted additional CPT procedure codes along with increases in supplemental allowable payable amounts offset against revenue included in 1B above.

   C) $.6 million unfavorable variance in Pharmacy primarily from a higher than expected number of prescriptions being filled along with larger quantity amounts per fill. These were a result of regulatory changes due to Covid-19.

   D) $1.6 million favorable variance in Non-Claim Expense Adjustment due to lower than expected Proposition 56 expense from the prior year.

   E) $2.6 million favorable variance primarily from IBNR adjustments relating to the prior year.

3) $2.4 million favorable variance in MCO Tax due to a revised reduction in our MCO tax liability rates that occurred with an agreement between CMS and DHCS which is offset against MCO Tax Premium included in Item 1C above.

The March Medical Loss Ratio is 91.0% which is favorable to the 93.1% budgeted amount. The March Administrative Expense Ratio is 5.8% which is favorable to the 6.6% budgeted amount.

The results for the 3 months ended March 31, 2020 reflect a Net Increase in Net Position of $1,276,026. This is a $3,061,141 favorable variance to budget and includes approximately $6.2 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 92.3% which is favorable to the 93.1% budgeted amount. The year-to-date Administrative Expense Ratio is 5.8% which is favorable to the 6.6% budgeted amount.

Kern Health Systems
Financial Packet
March 2020

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF MARCH 31, 2020

ASSETS	MARCH 2020	FEBRUARY 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 74,565,543	$ 99,313,693	$ (24,748,150)
Short-Term Investments	74,110,603	68,247,383	5,863,220
Pass-through Monies Held for Future Payment	-	36,565,812	(36,565,812)
Premiums Receivable - Net	152,239,159	138,343,080	13,896,079
Premiums Receivable - Hospital Direct Payments	237,766,343	260,406,378	(22,640,035)
Interest Receivable	318,678	428,194	(109,516)
Provider Advance Payment	16,000,000	-	16,000,000
Other Receivables	1,016,152	959,467	56,685
Prepaid Expenses & Other Current Assets	2,560,123	2,358,480	201,643
Total Current Assets	$ 558,576,601	$ 606,622,487	$ (48,045,886)
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	2,456,886	2,482,958	(26,072)
Computer Hardware and Software - Net	17,700,750	17,951,507	(250,757)
Building and Building Improvements - Net	36,028,517	36,028,441	76
Capital Projects in Progress	9,268,229	9,072,175	196,054
Total Capital Assets	$ 69,545,088	$ 69,625,787	$ (80,699)
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	743,320	743,644	(324)
Total Long Term Assets	$ 1,043,320	$ 1,043,644	$ (324)
DEFERRED OUTFLOWS OF RESOURCES	$ 2,889,179	$ 2,889,179	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 632,054,188	$ 680,181,097	$ (48,126,909)
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 3,138,360	$ 3,077,726	60,634
Accrued Other Operating Expenses	1,533,289	1,596,099	(62,810)
Accrued Taxes and Licenses	23,567,837	15,981,129	7,586,708
Other Medical Liabilities - Nonoperating Passthrough	-	36,565,812	(36,565,812)
Claims Payable (Reported)	23,074,011	22,580,773	493,238
IBNR - Inpatient Claims	36,643,160	27,978,749	8,664,411
IBNR - Physician Claims	14,024,295	19,480,210	(5,455,915)
IBNR - Accrued Other Medical	19,683,177	24,453,054	(4,769,877)
Risk Pool and Withholds Payable	2,724,303	2,772,609	(48,306)
Statutory Allowance for Claims Processing Expense	2,278,463	2,278,463	-
Other Liabilities	44,193,648	40,926,220	3,267,428
Accrued Hospital Directed Payments	237,766,343	260,164,967	(22,398,624)
Total Current Liabilities	$ 408,626,886	$ 457,855,811	$ (49,228,925)
NONCURRENT LIABILITIES:			
Net Pension Liability	7,038,233	7,038,233	-
TOTAL NONCURRENT LIABILITIES	$ 7,038,233	$ 7,038,233	$ -
DEFERRED INFLOWS OF RESOURCES	$ 420,664	$ 420,664	$ -
NET POSITION:			
Net Position - Beg. of Year	214,692,379	214,692,379	-
Increase (Decrease) in Net Position - Current Year	1,276,026	174,010	1,102,016
Total Net Position	$ 215,968,405	$ 214,866,389	$ 1,102,016
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 632,054,188	$ 680,181,097	$ (48,126,909)

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED MARCH 31, 2020

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
168,291	168,300	(9)	Family Members	501,979	503,700	(1,721)
60,634	61,090	(456)	Expansion Members	181,019	183,270	(2,251)
15,688	14,730	958	SPD Members	46,848	44,190	2,658
6,939	6,205	734	Other Members	20,353	18,615	1,738
9,169	8,660	509	Kaiser Members	27,286	25,980	1,306
260,721	258,985	1,736	Total Members - MCAL	777,485	775,755	1,730
			REVENUES			
28,589,738	27,417,510	1,172,228	Title XIX - Medicaid - Family and Other	84,837,702	82,145,866	2,691,836
23,548,401	23,145,509	402,892	Title XIX - Medicaid - Expansion Members	70,103,335	69,436,528	666,807
15,275,980	14,884,621	391,359	Title XIX - Medicaid - SPD Members	45,410,424	44,653,863	756,561
7,586,709	10,013,000	(2,426,291)	Premium - MCO Tax	23,745,604	29,991,000	(6,245,396)
11,495,457	11,075,324	420,133	Premium - Hospital Directed Payments	34,163,437	33,213,121	950,316
424,094	397,775	26,319	Investment Earnings And Other Income	915,490	1,191,419	(275,929)
-	72,594	(72,594)	Reinsurance Recoveries	-	217,435	(217,435)
42,436	-	42,436	Rate Adjustments - Hospital Directed Payments	221,728	-	221,728
616,798	-	616,798	Rate/Income Adjustments	2,245,677	-	2,245,677
87,579,613	87,006,334	573,279	TOTAL REVENUES	261,643,397	260,849,232	794,165
			EXPENSES			
			Medical Costs:			
14,351,280	14,339,352	(11,928)	Physician Services	42,982,064	42,967,428	(14,636)
4,024,762	4,609,313	584,551	Other Professional Services	12,326,230	13,819,658	1,493,428
5,370,795	5,137,203	(233,592)	Emergency Room	15,855,826	15,389,851	(465,975)
14,743,904	13,477,947	(1,265,957)	Inpatient	43,549,287	40,395,572	(3,153,715)
(213)	72,594	72,807	Reinsurance Expense	216,532	217,435	903
6,566,090	6,539,748	(26,342)	Outpatient Hospital	19,505,095	19,603,295	98,200
10,653,430	6,992,633	(3,660,797)	Other Medical	26,336,227	20,957,032	(5,379,195)
10,311,873	9,698,454	(613,419)	Pharmacy	29,529,768	29,074,013	(455,755)
503,104	500,650	(2,454)	Pay for Performance Quality Incentive	1,500,398	1,499,550	(848)
11,495,457	11,075,324	(420,133)	Hospital Directed Payments	34,163,437	33,213,121	(950,316)
42,436	-	(42,436)	Hospital Directed Payment Adjustment	221,728	-	(221,728)
(1,583,770)	-	1,583,770	Non-Claims Expense Adjustment	(1,294,205)	-	1,294,205
(2,649,204)	-	2,649,204	IBNR, Incentive, Paid Claims Adjustment	(2,656,947)	-	2,656,947
73,829,944	72,443,218	(1,386,726)	Total Medical Costs	222,235,440	217,136,954	(5,098,486)
13,749,669	14,563,116	(813,447)	GROSS MARGIN	39,407,957	43,712,278	(4,304,321)
			Administrative:			
2,447,667	2,660,428	212,761	Compensation	7,432,127	7,981,281	549,154
749,771	862,226	112,455	Purchased Services	2,389,583	2,581,678	192,095
99,552	119,143	19,591	Supplies	178,540	357,769	179,229
300,318	330,375	30,057	Depreciation	875,244	990,125	114,881
387,179	352,674	(34,505)	Other Administrative Expenses	922,086	1,072,264	150,178
-	-	-	Administrative Expense Adjustment	-	-	-
3,984,487	4,324,846	340,359	Total Administrative Expenses	11,797,580	12,983,117	1,185,537
77,814,431	76,768,064	(1,046,367)	TOTAL EXPENSES	234,033,020	230,120,071	(3,912,949)
9,765,182	10,238,270	(473,088)	OPERATING INCOME (LOSS) BEFORE TAX	27,610,377	30,729,161	(3,118,784)
7,586,709	10,013,000	2,426,291	MCO TAX	23,745,730	29,991,000	6,245,270
2,178,473	225,270	1,953,203	OPERATING INCOME (LOSS) NET OF TAX	3,864,647	738,161	3,126,486
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
(1,508,560)	(333,333)	(1,175,227)	Provider Recruitment and Retention Grants	(2,230,336)	(999,999)	(1,230,337)
432,103	(507,759)	939,862	Health Home	(358,285)	(1,523,277)	1,164,992
(1,076,457)	(841,092)	(235,365)	TOTAL NONOPERATING REVENUE (EXPENSE)	(2,588,621)	(2,523,276)	(65,345)
1,102,016	(615,822)	1,717,838	NET INCREASE (DECREASE) IN NET POSITION	1,276,026	(1,785,115)	3,061,141
91.0%	93.1%	2.1%	MEDICAL LOSS RATIO	92.3%	93.1%	0.8%
5.8%	6.6%	0.7%	ADMINISTRATIVE EXPENSE RATIO	5.8%	6.6%	0.8%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED MARCH 31, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
168,291	168,300	(9)	Family Members	501,979	503,700	(1,721)
60,634	61,090	(456)	Expansion Members	181,019	183,270	(2,251)
15,688	14,730	958	SPD Members	46,848	44,190	2,658
6,939	6,205	734	Other Members	20,353	18,615	1,738
9,169	8,660	509	Kaiser Members	27,286	25,980	1,306
260,721	258,985	1,736	Total Members - MCAL	777,485	775,755	1,730
			REVENUES			
163.16	157.12	6.04	Title XIX - Medicaid - Family and Other	162.42	157.27	5.15
388.37	378.88	9.49	Title XIX - Medicaid - Expansion Members	387.27	378.88	8.40
973.74	1,010.50	(36.76)	Title XIX - Medicaid - SPD Members	969.31	1,010.50	(41.18)
30.16	40.00	(9.84)	Premium - MCO Tax	31.65	40.00	(8.35)
45.70	44.24	1.45	Premium - Hospital Directed Payments	45.54	44.30	1.24
1.69	1.59	0.10	Investment Earnings And Other Income	1.22	1.59	(0.37)
0.00	0.29	(0.29)	Reinsurance Recoveries	0.00	0.29	(0.29)
0.17	0.00	0.17	Rate Adjustments - Hospital Directed Payments	0.30	0.00	0.30
2.45	0.00	2.45	Rate/Income Adjustments	2.99	0.00	2.99
348.16	347.57	0.58	TOTAL REVENUES	348.77	347.90	0.86
			EXPENSES			
			Medical Costs:			
57.05	57.28	0.23	Physician Services	57.29	57.31	0.01
16.00	18.41	2.41	Other Professional Services	16.43	18.43	2.00
21.35	20.52	(0.83)	Emergency Room	21.14	20.53	(0.61)
58.61	53.84	(4.77)	Inpatient	58.05	53.88	(4.17)
(0.00)	0.29	0.29	Reinsurance Expense	0.29	0.29	0.00
26.10	26.13	0.02	Outpatient Hospital	26.00	26.15	0.15
42.35	27.93	(14.42)	Other Medical	35.11	27.95	(7.15)
40.99	38.74	(2.25)	Pharmacy	39.36	38.78	(0.59)
2.00	2.00	0.00	Pay for Performance Quality Incentive	2.00	2.00	0.00
45.70	44.24	(1.45)	Hospital Directed Payments	45.54	44.30	(1.24)
0.17	0.00	(0.17)	Hospital Directed Payment Adjustment	0.30	0.00	(0.30)
(6.30)	0.00	6.30	Non-Claims Expense Adjustment	(1.73)	0.00	1.73
(10.53)	0.00	10.53	IBNR, Incentive, Paid Claims Adjustment	(3.54)	0.00	3.54
293.50	289.40	(4.10)	Total Medical Costs	296.24	289.60	(6.63)
54.66	58.18	(3.52)	GROSS MARGIN	52.53	58.30	(5.77)
			Administrative:			
9.73	10.63	0.90	Compensation	9.91	10.64	0.74
2.98	3.44	0.46	Purchased Services	3.19	3.44	0.26
0.40	0.48	0.08	Supplies	0.24	0.48	0.24
1.19	1.32	0.13	Depreciation	1.17	1.32	0.15
1.54	1.41	(0.13)	Other Administrative Expenses	1.23	1.43	0.20
0.00	0.00	0.00	Administrative Expense Adjustment	0.00	0.00	0.00
15.84	17.28	1.44	Total Administrative Expenses	15.73	17.32	1.59
309.34	306.67	(2.66)	TOTAL EXPENSES	311.96	306.92	(5.04)
38.82	40.90	(2.08)	OPERATING INCOME (LOSS) BEFORE TAX	36.80	40.98	(4.18)
30.16	40.00	9.84	MCO TAX	31.65	40.00	8.35
8.66	0.90	7.76	OPERATING INCOME (LOSS) NET OF TAX	5.15	0.98	4.17
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
(6.00)	(1.33)	(4.67)	Reserve Fund Projects/Community Grants	(2.97)	(1.33)	(1.64)
1.72	(2.03)	3.75	Health Home	(0.48)	(2.03)	1.55
(4.28)	(3.36)	(0.92)	TOTAL NONOPERATING REVENUE (EXPENSE)	(3.45)	(3.37)	(0.09)
4.38	(2.46)	6.84	NET INCREASE (DECREASE) IN NET POSITION	1.70	(2.38)	4.08
91.0%	93.1%	2.1%	MEDICAL LOSS RATIO	92.3%	93.1%	0.8%
5.8%	6.6%	0.7%	ADMINISTRATIVE EXPENSE RATIO	5.8%	6.6%	0.8%

KHS5/27/2020
Management Use Only

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH MARCH 31, 2020	MARCH 2019	APRIL 2019	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	247,836	248,254	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	249,193	250,007	251,552	3,247,089
REVENUES														
Title XIX - Medicaid - Family and Other	24,487,252	24,003,598	24,444,272	25,745,431	26,916,818	27,380,366	27,444,092	27,395,016	34,656,206	28,289,680	28,111,536	28,136,428	28,589,738	355,600,433
Title XIX - Medicaid - Expansion Members	22,894,496	23,046,615	23,133,193	23,356,415	21,829,172	22,748,791	23,117,928	22,908,874	25,545,000	24,658,622	23,135,804	23,419,130	23,548,401	303,342,441
Title XIX - Medicaid - SPD Members	12,439,467	12,488,048	13,147,466	13,032,438	14,355,421	14,965,261	15,059,382	15,759,913	16,141,207	15,294,321	15,020,731	15,113,713	15,275,980	188,093,348
Premium - MCO Tax	8,071,581	8,084,949	8,092,541	8,174,408	8,128,512	12,317,485	10,182,096	10,062,668	11,609,045	(52,290,862)	-	16,158,895	7,586,709	56,178,027
Premium - Hospital Directed Payments	-	-	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	170,326,903
Investment Earnings And Other Income	985,737	620,797	382,110	1,108,727	354,349	382,033	708,869	338,986	265,233	731,395	190,131	301,265	424,094	6,793,726
Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	-	-	-	-	-	-	62,733,334	-	-	101,394,310	118,333	60,959	42,436	164,349,372
Rate/Income Adjustments	626,404	(173,473)	178,336	(703,658)	132,080	329,476	103,418	318,771	(3,664)	(391,644)	819,618	809,261	616,798	2,661,723
TOTAL REVENUES	69,504,937	68,070,534	69,377,918	70,713,761	71,716,351	78,123,412	139,349,119	76,784,228	88,213,027	253,849,288	78,672,737	95,391,047	87,579,613	1,247,345,972
EXPENSES														
Medical Costs:														
Physician Services	15,391,612	15,885,936	14,054,383	13,468,415	13,912,712	13,516,282	12,473,244	13,286,040	14,396,081	15,556,899	14,757,546	13,873,238	14,351,280	184,923,668
Other Professional Services	3,652,683	3,718,600	3,960,952	4,388,042	3,849,695	3,775,027	3,913,361	4,483,269	3,596,983	4,371,702	4,334,953	3,966,515	4,024,762	52,036,544
Emergency Room	4,835,728	5,525,268	5,106,796	4,698,111	5,181,359	4,645,061	4,697,451	5,571,836	5,227,569	4,729,725	5,226,947	5,258,084	5,370,795	66,074,730
Inpatient	13,546,028	12,850,017	12,181,510	14,390,451	13,332,634	15,238,360	15,564,329	14,951,334	14,657,214	14,449,035	14,911,677	13,893,706	14,743,904	184,710,199
Reinsurance Expense	126,021	126,397	126,609	126,658	126,658	129,256	126,290	127,228	129,075	128,012	72,320	144,425	(213)	1,488,736
Outpatient Hospital	6,885,177	6,373,571	6,408,304	5,912,776	6,609,411	6,523,398	6,130,800	6,128,586	6,141,173	4,767,801	6,734,395	6,204,610	6,566,090	81,386,092
Other Medical	6,448,536	6,141,817	7,183,716	6,357,547	6,715,805	6,439,790	7,570,084	5,832,261	16,655,345	6,649,662	5,661,784	10,021,013	10,653,430	102,330,790
Pharmacy	9,671,212	9,293,776	9,659,273	8,508,813	9,183,446	9,336,978	9,145,904	9,834,755	9,282,817	9,267,277	9,971,687	9,246,208	10,311,873	122,714,019
Pay for Performance Quality Incentive	495,672	496,508	496,698	501,792	498,760	498,932	502,552	502,078	500,918	498,762	497,280	500,014	503,104	6,493,070
Hospital Directed Payments	-	-	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	170,326,903
Hospital Directed Payment Adjustment	-	-	-	-	-	-	62,605,426	-	-	101,154,229	118,333	60,959	42,436	163,981,383
Non-Claims Expense Adjustment	324,378	(736,017)	39,610	756,640	19,252	11,717	11,329	(5,919)	(18,762)	4,624	57,172	232,393	(1,583,770)	(887,353)
IBNR, Incentive, Paid Claims Adjustment	(3,810,327)	(3,425,856)	(2,087,231)	(704,885)	(350,851)	202,480	374,161	20,741	(40,346)	(259,737)	816	(8,559)	(2,649,204)	(12,738,798)
Total Medical Costs	57,566,720	56,250,017	57,130,620	58,404,360	59,078,881	60,317,281	123,114,931	60,732,209	70,528,067	297,481,457	73,621,494	74,784,002	73,829,944	1,122,839,983
GROSS MARGIN	11,938,217	11,820,517	12,247,298	12,309,401	12,637,470	17,806,131	16,234,188	16,052,019	17,684,960	(43,632,169)	5,051,243	20,607,045	13,749,669	124,505,989
Administrative:														
Compensation	2,094,504	2,121,314	2,336,685	2,155,354	2,297,855	2,254,325	2,343,633	2,510,126	2,403,604	2,589,213	2,577,348	2,407,112	2,447,667	30,538,740
Purchased Services	901,569	783,945	882,833	449,468	805,910	605,801	836,783	831,542	805,047	1,358,494	805,903	833,909	749,771	10,650,975
Supplies	93,764	93,770	15,577	59,549	47,853	49,290	76,514	203,279	58,830	(7,208)	35,806	43,182	99,552	869,758
Depreciation	211,201	179,515	179,516	179,516	151,640	151,655	151,656	355,208	280,129	304,894	287,390	287,536	300,318	3,020,174
Other Administrative Expenses	246,439	302,417	239,380	412,596	338,545	489,494	523,591	519,786	270,201	344,959	353,414	181,493	387,179	4,609,494
Administrative Expense Adjustment	-	-	-	-	-	-	-	-	-	1,325,136	-	-	-	1,325,136
Total Administrative Expenses	3,547,477	3,480,961	3,653,991	3,256,483	3,641,803	3,550,565	3,932,177	4,419,941	3,817,811	5,915,488	4,059,861	3,753,232	3,984,487	51,014,277
TOTAL EXPENSES	61,114,197	59,730,978	60,784,611	61,660,843	62,720,684	63,867,846	127,047,108	65,152,150	74,345,878	303,396,945	77,681,355	78,537,234	77,814,431	1,173,854,260
OPERATING INCOME (LOSS) BEFORE TAX	8,390,740	8,339,556	8,593,307	9,052,918	8,995,667	14,255,566	12,302,011	11,632,078	13,867,149	(49,547,657)	991,382	16,853,813	9,765,182	73,491,712
MCO TAX	8,087,918	8,087,918	8,087,918	8,087,917	8,051,211	12,279,276	10,165,243	10,057,218	12,283,003	(52,962,035)	-	16,159,021	7,586,709	55,971,317
OPERATING INCOME (LOSS) NET OF TAX	302,822	251,638	505,389	965,001	944,456	1,976,290	2,136,768	1,574,860	1,584,146	3,414,378	991,382	694,792	2,178,473	17,520,395
TOTAL NONOPERATING REVENUE (EXPENSE)	(133,960)	(191,455)	(359,160)	1,293,258	(306,804)	(151,504)	(380,606)	(236,574)	(885,928)	(425,785)	(942,282)	(569,882)	(1,076,457)	(3,290,682)
NET INCREASE (DECREASE) IN NET POSITION	168,862	60,183	146,229	2,258,259	637,652	1,824,786	1,756,162	1,338,286	698,218	2,988,593	49,100	124,910	1,102,016	14,229,713
MEDICAL LOSS RATIO	93.7%	93.8%	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%
ADMINISTRATIVE EXPENSE RATIO	5.8%	5.8%	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.0%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH MARCH 31, 2020	MARCH 2019	APRIL 2019	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	247,836	248,254	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	249,193	250,007	251,552	3,247,089
REVENUES														
Title XIX - Medicaid - Family and Other	141.35	138.32	140.92	147.25	155.06	157.80	157.10	157.23	199.08	162.50	162.42	161.68	163.16	157.23
Title XIX - Medicaid - Expansion Members	383.67	384.32	386.02	383.23	360.65	374.91	377.23	373.38	419.77	410.96	386.25	387.18	388.37	385.82
Title XIX - Medicaid - SPD Members	839.09	846.53	878.96	862.90	940.48	980.04	984.27	1,019.80	1,039.69	1,000.74	958.75	975.52	973.74	946.71
Premium - MCO Tax	32.57	32.57	32.59	32.58	32.59	49.38	40.52	40.08	46.35	(209.68)	0.00	64.63	30.16	17.30
Premium - Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.25	45.56	45.70	52.46
Investment Earnings And Other Income	3.98	2.50	1.54	4.42	1.42	1.53	2.82	1.35	1.06	2.93	0.76	1.21	1.69	2.09
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	0.00	0.00	0.00	0.00	0.00	0.00	249.66	0.00	0.00	406.58	0.47	0.24	0.17	50.61
Rate/Income Adjustments	2.53	(0.70)	0.72	(2.80)	0.53	1.32	0.41	1.27	(0.01)	(1.57)	3.29	3.24	2.45	0.82
TOTAL REVENUES	280.45	274.20	279.36	281.84	287.58	313.16	554.56	305.87	352.21	1,017.92	315.71	381.55	348.16	384.14
EXPENSES														
Medical Costs:														
Physician Services	62.10	63.99	56.59	53.68	55.79	54.18	49.64	52.92	57.48	62.38	59.22	55.49	57.05	56.95
Other Professional Services	14.74	14.98	15.95	17.49	15.44	15.13	15.57	17.86	14.36	17.53	17.40	15.87	16.00	16.03
Emergency Room	19.51	22.26	20.56	18.73	20.78	18.62	18.69	22.20	20.87	18.97	20.98	21.03	21.35	20.35
Inpatient	54.66	51.76	49.05	57.36	53.46	61.08	61.94	59.56	58.52	57.94	59.84	55.57	58.61	56.88
Reinsurance Expense	0.51	0.51	0.51	0.50	0.51	0.52	0.50	0.51	0.52	0.51	0.29	0.58	(0.00)	0.46
Outpatient Hospital	27.78	25.67	25.80	23.57	26.50	26.15	24.40	24.41	24.52	19.12	27.02	24.82	26.10	25.06
Other Medical	26.02	24.74	28.93	25.34	26.93	25.81	30.13	23.23	66.50	26.66	22.72	40.08	42.35	31.51
Pharmacy	39.02	37.44	38.89	33.91	36.83	37.43	36.40	39.18	37.06	37.16	40.02	36.98	40.99	37.79
Pay for Performance Quality Incentive	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.25	45.56	45.70	52.46
Hospital Directed Payment Adjustment	0.00	0.00	0.00	0.00	0.00	0.00	249.15	0.00	0.00	405.62	0.47	0.24	0.17	50.50
Non-Claims Expense Adjustment	1.31	(2.96)	0.16	3.02	0.08	0.05	0.05	(0.02)	(0.07)	0.02	0.23	0.93	(6.30)	(0.27)
IBNR, Incentive, Paid Claims Adjustment	(15.37)	(13.80)	(8.40)	(2.81)	(1.41)	0.81	1.49	0.08	(0.16)	(1.04)	0.00	(0.03)	(10.53)	(3.92)
Total Medical Costs	232.28	226.58	230.04	232.78	236.90	241.79	489.96	241.92	281.60	1,192.88	295.44	299.13	293.50	345.80
GROSS MARGIN	48.17	47.61	49.31	49.06	50.68	71.38	64.61	63.94	70.61	(174.96)	20.27	82.43	54.66	38.34
Administrative:														
Compensation	8.45	8.54	9.41	8.59	9.21	9.04	9.33	10.00	9.60	10.38	10.34	9.63	9.73	9.40
Purchased Services	3.64	3.16	3.55	1.79	3.23	2.43	3.33	3.31	3.21	5.45	3.23	3.34	2.98	3.28
Supplies	0.38	0.38	0.06	0.24	0.19	0.20	0.30	0.81	0.23	(0.03)	0.14	0.17	0.40	0.27
Depreciation	0.85	0.72	0.72	0.72	0.61	0.61	0.60	1.41	1.12	1.22	1.15	1.15	1.19	0.93
Other Administrative Expenses	0.99	1.22	0.96	1.64	1.36	1.96	2.08	2.07	1.08	1.38	1.42	0.73	1.54	1.42
Administrative Expense Adjustment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.31	0.00	0.00	0.00	0.41
Total Administrative Expenses	14.31	14.02	14.71	12.98	14.60	14.23	15.65	17.61	15.24	23.72	16.29	15.01	15.84	15.71
TOTAL EXPENSES	246.59	240.60	244.75	245.76	251.51	256.02	505.61	259.53	296.84	1,216.60	311.73	314.14	309.34	361.51
OPERATING INCOME (LOSS) BEFORE TAX	33.86	33.59	34.60	36.08	36.07	57.14	48.96	46.34	55.37	(198.68)	3.98	67.41	38.82	22.63
MCO TAX	32.63	32.58	32.57	32.24	32.28	49.22	40.45	40.06	49.04	(212.37)	0.00	64.63	30.16	17.24
OPERATING INCOME (LOSS) NET OF TAX	1.22	1.01	2.03	3.85	3.79	7.92	8.50	6.27	6.32	13.69	3.98	2.78	8.66	5.40
TOTAL NONOPERATING REVENUE (EXPENSE)	(0.54)	(0.77)	(1.45)	5.15	(1.23)	(0.61)	(1.51)	(0.94)	(3.54)	(1.71)	(3.78)	(2.28)	(4.28)	(1.01)
NET INCREASE (DECREASE) IN NET POSITION	0.68	0.24	0.59	9.00	2.56	7.31	6.99	5.33	2.79	11.98	0.20	0.50	4.38	4.38
MEDICAL LOSS RATIO	93.7%	93.8%	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%
ADMINISTRATIVE EXPENSE RATIO	5.8%	5.8%	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.0%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED MARCH 31, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
22,435,683	22,118,012	317,671	Premium - Medi-Cal	66,373,388	66,266,603	106,785
2,110,987	2,375,503	(264,516)	Premium - Maternity Kick	6,319,237	7,126,509	(807,272)
41,846	72,646	(30,800)	Premium - Hep C Kick	94,152	217,439	(123,287)
377,970	595,163	(217,193)	Premium - BHT Kick	1,318,682	1,781,397	(462,715)
168,185	312,355	(144,170)	Premium - Health Home Kick	490,213	934,917	(444,704)
3,212,090	1,693,375	1,518,715	Premium - Provider Enhancement	9,524,235	5,068,425	4,455,810
156,941	156,469	472	Premium - Ground Emergency Medical Transportation	464,690	468,723	(4,033)
86,036	93,987	(7,951)	Other	253,105	281,853	(28,748)
28,589,738	27,417,510	1,172,228	Total Title XIX - Medicaid - Family & Other	84,837,702	82,145,866	2,691,836
			Title XIX - Medicaid - Expansion Members			
21,160,769	21,183,611	(22,842)	Premium - Medi-Cal	63,090,189	63,550,833	(460,644)
213,650	214,189	(539)	Premium - Maternity Kick	874,021	642,567	231,454
400,144	303,377	96,767	Premium - Hep C Kick	849,979	910,131	(60,152)
355,062	519,998	(164,936)	Premium - Health Home Kick	1,059,364	1,559,994	(500,630)
1,237,842	742,244	495,599	Premium - Provider Enhancement	3,690,350	2,226,730	1,463,620
154,570	152,964	1,606	Premium - Ground Emergency Medical Transportation	460,845	458,892	1,953
26,364	29,126	(2,762)	Other	78,587	87,378	(8,791)
23,548,401	23,145,509	402,892	Total Title XIX - Medicaid - Expansion Members	70,103,335	69,436,526	666,809
			Title XIX - Medicaid - SPD Members			
13,666,899	13,148,587	518,312	Premium - Medi-Cal	40,644,106	39,445,761	1,198,345
177,842	94,152	83,690	Premium - Hep C Kick	465,527	282,456	183,071
491,781	818,847	(327,066)	Premium - BHT Kick	1,515,343	2,456,541	(941,198)
347,234	416,635	(69,401)	Premium - Health Home Kick	1,024,234	1,249,905	(225,671)
455,463	282,521	172,942	Premium - Provider Enhancement	1,354,500	847,563	506,937
136,761	123,879	12,882	Premium - Ground Emergency Medical Transportation	406,714	371,637	35,077
15,275,980	14,884,621	391,359	Total Title XIX - Medicaid - SPD Members	45,410,424	44,653,863	756,561

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS - ALL COA FOR THE MONTH ENDED MARCH 31, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
2,861,899	2,859,434	(2,465)	Primary Care Physician Services	8,934,772	8,565,106	(369,666)
10,044,984	10,051,433	6,449	Referral Specialty Services	29,273,342	30,124,140	850,798
1,435,097	1,419,186	(15,911)	Urgent Care & After Hours Advise	4,746,650	4,250,282	(496,368)
9,300	9,300	-	Hospital Admitting Team	27,300	27,900	600
14,351,280	14,339,352	(11,928)	TOTAL PHYSICIAN SERVICES	42,982,064	42,967,428	(14,636)
			OTHER PROFESSIONAL SERVICES			
261,072	270,068	8,996	Vision Service Capitation	821,633	809,428	(12,205)
195,081	212,779	17,698	221 - Business Intelligence	599,765	638,337	38,572
507,782	546,874	39,092	310 - Health Services - Utilization Management - UM Allocation *	1,541,304	1,640,624	99,320
135,845	169,504	33,659	311 - Health Services - Quality Improvement - UM Allocation *	398,537	508,511	109,974
108,402	127,990	19,588	312 - Health Services - Education - UM Allocation *	322,238	383,970	61,732
81,505	94,630	13,125	313 - Health Services - Pharmacy - UM Allocation *	250,354	283,891	33,537
104,710	129,020	24,310	314 - Health Homes - UM Allocation *	285,003	387,060	102,057
244,642	258,856	14,214	315 - Case Management - UM Allocation *	753,770	776,569	22,799
57,384	61,775	4,391	616 - Disease Management - UM Allocation *	167,936	185,324	17,388
999,720	1,414,010	414,290	Behavior Health Treatment	2,915,211	4,237,938	1,322,727
131,506	170,467	38,961	Mental Health Services	679,691	511,051	(168,640)
1,197,113	1,153,339	(43,774)	Other Professional Services	3,590,788	3,456,955	(133,833)
4,024,762	4,609,313	584,551	TOTAL OTHER PROFESSIONAL SERVICES	12,326,230	13,819,658	1,493,428
5,370,795	5,137,203	(233,592)	EMERGENCY ROOM	15,855,826	15,389,851	(465,975)
14,743,904	13,477,947	(1,265,957)	INPATIENT HOSPITAL	43,549,287	40,395,572	(3,153,715)
(213)	72,594	72,807	REINSURANCE EXPENSE PREMIUM	216,532	217,435	903
6,566,090	6,539,748	(26,342)	OUTPATIENT HOSPITAL SERVICES	19,505,095	19,603,295	98,200
			OTHER MEDICAL			
1,444,299	1,542,647	98,348	Ambulance and NEMT	4,542,281	4,623,386	81,105
349,594	388,738	39,144	Home Health Services & CBAS	1,135,492	1,165,404	29,912
247,983	488,855	240,872	Utilization and Quality Review Expenses	785,586	1,465,815	680,229
1,539,187	938,223	(600,964)	Long Term/SNF/Hospice	3,789,655	2,813,464	(976,191)
112,910	375,464	262,554	Health Home Capitation	416,270	1,125,747	709,477
6,564,136	2,717,750	(3,846,386)	Provider Enhancement Expense - Prop. 56	14,355,941	8,141,217	(6,214,724)
395,321	433,312	37,991	Provider Enhancement Expense - GEMT	1,311,002	1,299,252	(11,750)
-	107,644	107,644	HHP Risk Pool/Incentive	-	322,747	322,747
10,653,430	6,992,633	(3,660,797)	TOTAL OTHER MEDICAL	26,336,227	20,957,032	(5,379,195)
			PHARMACY SERVICES			
9,200,496	8,685,692	(514,804)	RX - Drugs & OTC	26,809,278	26,037,646	(771,632)
470,380	470,175	(205)	RX - HEP-C	1,073,944	1,410,025	336,081
675,997	688,325	12,328	Rx - DME	1,951,546	2,063,475	111,929
(35,000)	(145,738)	(110,738)	RX - Pharmacy Rebates	(305,000)	(437,133)	(132,133)
10,311,873	9,698,454	(613,419)	TOTAL PHARMACY SERVICES	29,529,768	29,074,013	(455,755)
503,104	500,650	(2,454)	PAY FOR PERFORMANCE QUALITY INCENTIVE	1,500,398	1,499,550	(848)
11,495,457	11,075,324	(420,133)	HOSPITAL DIRECTED PAYMENTS	34,163,437	33,213,121	(950,316)
42,436	-	(42,436)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	221,728	-	(221,728)
(1,583,770)	-	1,583,770	NON-CLAIMS EXPENSE ADJUSTMENT	(1,294,205)	-	1,294,205
(2,649,204)	-	2,649,204	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(2,656,947)	-	2,656,947
73,829,944	72,443,218	(1,386,726)	Total Medical Costs	222,235,440	217,136,954	(5,098,486)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED MARCH 31, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
11.38	11.42	0.05	Primary Care Physician Services	11.91	11.42	(0.49)
39.93	40.15	0.22	Referral Specialty Services	39.02	40.18	1.16
5.70	5.67	(0.04)	Urgent Care & After Hours Advise	6.33	5.67	(0.66)
0.04	0.04	0.00	Hospital Admitting Team	0.04	0.04	0.00
57.05	57.28	0.23	TOTAL PHYSICIAN SERVICES	57.29	57.31	0.01
			OTHER PROFESSIONAL SERVICES			
1.04	1.08	0.04	Vision Service Capitation	1.10	1.08	(0.02)
0.78	0.85	0.07	221 - Business Intelligence	0.80	0.85	0.05
2.02	2.18	0.17	310 - Health Services - Utilization Management - UM Allocation *	2.05	2.19	0.13
0.54	0.68	0.14	311 - Health Services - Quality Improvement - UM Allocation *	0.53	0.68	0.15
0.43	0.51	0.08	312 - Health Services - Education - UM Allocation *	0.43	0.51	0.08
0.32	0.38	0.05	313 - Health Services - Pharmacy - UM Allocation *	0.33	0.38	0.04
0.42	0.52	0.10	314 - Health Homes - UM Allocation *	0.38	0.52	0.14
0.97	1.03	0.06	315 - Case Management - UM Allocation *	1.00	1.04	0.03
0.23	0.25	0.02	616 - Disease Management - UM Allocation *	0.22	0.25	0.02
3.97	5.65	1.67	Behavior Health Treatment	3.89	5.65	1.77
0.52	0.68	0.16	Mental Health Services	0.91	0.68	(0.22)
4.76	4.61	(0.15)	Other Professional Services	4.79	4.61	(0.18)
16.00	18.41	2.41	TOTAL OTHER PROFESSIONAL SERVICES	16.43	18.43	2.00
21.35	20.52	(0.83)	EMERGENCY ROOM	21.14	20.53	(0.61)
58.61	53.84	(4.77)	INPATIENT HOSPITAL	58.05	53.88	(4.17)
(0.00)	0.29	0.29	REINSURANCE EXPENSE PREMIUM	0.29	0.29	0.00
26.10	26.13	0.02	OUTPATIENT HOSPITAL SERVICES	26.00	26.15	0.15
			OTHER MEDICAL			
5.74	6.16	0.42	Ambulance and NEMT	6.05	6.17	0.11
1.39	1.55	0.16	Home Health Services & CBAS	1.51	1.55	0.04
0.99	1.95	0.97	Utilization and Quality Review Expenses	1.05	1.96	0.91
6.12	3.75	(2.37)	Long Term/SNF/Hospice	5.05	3.75	(1.30)
0.45	1.50	1.05	Health Home Capitation	0.55	1.50	0.95
26.09	10.86	(15.24)	Provider Enhancement Expense - Prop. 56	19.14	10.86	(8.28)
1.57	1.73	0.16	Provider Enhancement Expense - GEMT	1.75	1.73	(0.01)
0.00	0.43	0.43	HHP Risk Pool/Incentive	0.00	0.43	0.43
42.35	27.93	(14.42)	TOTAL OTHER MEDICAL	35.11	27.95	(7.15)
			PHARMACY SERVICES			
36.57	34.70	(1.88)	RX - Drugs & OTC	35.74	34.73	(1.01)
1.87	1.88	0.01	RX - HEP-C	1.43	1.88	0.45
2.69	2.75	0.06	Rx - DME	2.60	2.75	0.15
(0.14)	(0.58)	(0.44)	RX - Pharmacy Rebates	(0.41)	(0.58)	(0.18)
40.99	38.74	(2.25)	TOTAL PHARMACY SERVICES	39.36	38.78	(0.59)
2.00	2.00	0.00	PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	0.00
45.70	44.24	(1.45)	HOSPITAL DIRECTED PAYMENTS	45.54	44.30	(1.24)
0.17	0.00	(0.17)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.30	0.00	(0.30)
(6.30)	0.00	6.30	NON-CLAIMS EXPENSE ADJUSTMENT	(1.73)	0.00	1.73
(10.53)	0.00	10.53	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(3.54)	0.00	3.54
293.50	289.40	(4.10)	Total Medical Costs	296.24	289.60	(6.63)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH MARCH 31, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES				
Primary Care Physician Services	2,908,272	3,164,601	2,861,899	8,934,772
Referral Specialty Services	10,425,085	8,803,273	10,044,984	29,273,342
Urgent Care & After Hours Advise	1,414,889	1,896,664	1,435,097	4,746,650
Hospital Admitting Team	9,300	8,700	9,300	27,300
TOTAL PHYSICIAN SERVICES	14,757,546	13,873,238	14,351,280	42,982,064
OTHER PROFESSIONAL SERVICES				
Vision Service Capitation	299,489	261,072	261,072	821,633
221 - Business Intelligence	199,939	204,745	195,081	599,765
310 - Health Services - Utilization Management - UM Allocation *	550,905	482,617	507,782	1,541,304
311 - Health Services - Quality Improvement - UM Allocation *	130,719	131,973	135,845	398,537
312 - Health Services - Education - UM Allocation *	111,799	102,037	108,402	322,238
313 - Health Services - Pharmacy - UM Allocation *	88,153	80,696	81,505	250,354
314 - Health Homes - UM Allocation *	91,425	88,868	104,710	285,003
315 - Case Management - UM Allocation *	267,758	241,370	244,642	753,770
616 - Disease Management - UM Allocation *	56,335	54,217	57,384	167,936
Behavior Health Treatment	980,035	935,456	999,720	2,915,211
Mental Health Services	330,842	217,343	131,506	679,691
Other Professional Services	1,227,554	1,166,121	1,197,113	3,590,788
TOTAL OTHER PROFESSIONAL SERVICES	4,334,953	3,966,515	4,024,762	12,326,230
EMERGENCY ROOM	5,226,947	5,258,084	5,370,795	15,855,826
INPATIENT HOSPITAL	14,911,677	13,893,706	14,743,904	43,549,287
REINSURANCE EXPENSE PREMIUM	72,320	144,425	(213)	216,532
OUTPATIENT HOSPITAL SERVICES	6,734,395	6,204,610	6,566,090	19,505,095
OTHER MEDICAL				
Ambulance and NEMT	1,599,375	1,498,607	1,444,299	4,542,281
Home Health Services & CBAS	392,407	393,491	349,594	1,135,492
Utilization and Quality Review Expenses	308,250	229,353	247,983	785,586
Long Term/SNF/Hospice	1,052,766	1,197,702	1,539,187	3,789,655
Health Home Capitation	166,060	137,300	112,910	416,270
Provider Enhancement Expense - Prop. 56	1,820,309	5,971,496	6,564,136	14,355,941
Provider Enhancement Expense - GEMT	322,617	593,064	395,321	1,311,002
HHP Risk Pool/Incentive	-	-	-	-
TOTAL OTHER MEDICAL	5,661,784	10,021,013	10,653,430	26,336,227
PHARMACY SERVICES				
RX - Drugs & OTC	9,137,997	8,470,785	9,200,496	26,809,278
RX - HEP-C	271,776	331,788	470,380	1,073,944
Rx - DME	696,914	578,635	675,997	1,951,546
RX - Pharmacy Rebates	(135,000)	(135,000)	(35,000)	(305,000)
TOTAL PHARMACY SERVICES	9,971,687	9,246,208	10,311,873	29,529,768
PAY FOR PERFORMANCE QUALITY INCENTIVE	497,280	500,014	503,104	1,500,398
HOSPITAL DIRECTED PAYMENTS	11,276,584	11,391,396	11,495,457	34,163,437
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	118,333	60,959	42,436	221,728
NON-CLAIMS EXPENSE ADJUSTMENT	57,172	232,393	(1,583,770)	(1,294,205)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	816	(8,559)	(2,649,204)	(2,656,947)
Total Medical Costs	62,344,910	63,392,606	62,334,487	188,072,003

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH MARCH 31, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES				
Primary Care Physician Services	11.67	12.66	11.38	11.90
Referral Specialty Services	41.84	35.21	39.93	38.99
Urgent Care & After Hours Advise	5.68	7.59	5.70	6.32
Hospital Admitting Team	0.04	0.03	0.04	0.04
TOTAL PHYSICIAN SERVICES	59.22	55.49	57.05	57.25
OTHER PROFESSIONAL SERVICES				
Vision Service Capitation	1.20	1.04	1.04	1.09
221 - Business Intelligence	0.80	0.82	0.78	0.80
310 - Health Services - Utilization Management - UM Allocation *	2.21	1.93	2.02	2.05
311 - Health Services - Quality Improvement - UM Allocation *	0.52	0.53	0.54	0.53
312 - Health Services - Education - UM Allocation *	0.45	0.41	0.43	0.43
313 - Health Services - Pharmacy - UM Allocation *	0.35	0.32	0.32	0.33
314 - Health Homes - UM Allocation *	0.37	0.36	0.42	0.38
315 - Case Management - UM Allocation *	1.07	0.97	0.97	1.00
616 - Disease Management - UM Allocation *	0.23	0.22	0.23	0.22
Behavior Health Treatment	3.93	3.74	3.97	3.88
Mental Health Services	1.33	0.87	0.52	0.91
Other Professional Services	4.93	4.66	4.76	4.78
TOTAL OTHER PROFESSIONAL SERVICES	17.40	15.87	16.00	16.42
EMERGENCY ROOM	20.98	21.03	21.35	21.12
INPATIENT HOSPITAL	59.84	55.57	58.61	58.01
REINSURANCE EXPENSE PREMIUM	0.29	0.58	0.00	0.29
OUTPATIENT HOSPITAL SERVICES	27.02	24.82	26.10	25.98
OTHER MEDICAL				
Ambulance and NEMT	6.42	5.99	5.74	6.05
Home Health Services & CBAS	1.57	1.57	1.39	1.51
Utilization and Quality Review Expenses	1.24	0.92	0.99	1.05
Long Term/SNF/Hospice	4.22	4.79	6.12	5.05
Health Home Capitation	0.67	0.55	0.45	0.55
Provider Enhancement Expense - Prop. 56	7.30	23.89	26.09	19.12
Provider Enhancement Expense - GEMT	1.29	2.37	1.57	1.75
HHP Risk Pool/Incentive	0.00	0.00	0.00	0.00
TOTAL OTHER MEDICAL	22.72	40.08	42.35	35.08
PHARMACY SERVICES				
RX - Drugs & OTC	36.67	33.88	36.57	35.71
RX - HEP-C	1.09	1.33	1.87	1.43
Rx - DME	2.80	2.31	2.69	2.60
RX - Pharmacy Rebates	(0.54)	(0.54)	(0.14)	(0.41)
TOTAL PHARMACY SERVICES	40.02	36.98	40.99	39.33
PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	2.00	2.00
HOSPITAL DIRECTED PAYMENTS	45.25	45.56	45.70	45.51
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.47	0.24	0.17	0.30
NON-CLAIMS EXPENSE ADJUSTMENT	0.23	0.93	(6.30)	(1.72)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(0.03)	(10.53)	(3.54)
Total Medical Costs	295.44	299.13	293.50	296.02

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED MARCH 31, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
365,045	314,514	(50,531)	110 - Executive	998,107	943,542	(54,565)
174,836	198,815	23,979	210 - Accounting	527,659	594,451	66,792
338,903	273,115	(65,788)	220 - Management Information Systems	1,015,833	819,347	(196,486)
20,702	13,054	(7,648)	221 - Business Intelligence	32,350	39,162	6,812
262,079	281,950	19,871	222 - Enterprise Development	699,233	845,852	146,619
308,323	415,723	107,400	225 - Infrastructure	908,845	1,247,172	338,327
493,312	558,612	65,300	230 - Claims	1,548,552	1,671,846	123,294
97,954	114,151	16,197	240 - Project Management	267,854	342,453	74,599
95,426	97,923	2,497	310 - Health Services - Utilization Management	301,764	294,517	(7,247)
43,027	55,091	12,064	311 - Health Services - Quality Improvement	95,711	165,273	69,562
-	67	67	312 - Health Services - Education	60	350	290
148,599	145,558	(3,041)	313- Pharmacy	453,526	432,898	(20,628)
98	-	(98)	314 - Health Homes	15,366	-	(15,366)
15,615	16,573	958	315 - Case Management	48,628	49,718	1,090
21,223	23,131	1,908	616 - Disease Management	62,127	69,394	7,267
291,995	313,552	21,557	320 - Provider Network Management	801,603	940,656	139,053
496,790	563,878	67,088	330 - Member Services	1,512,458	1,691,634	179,176
487,474	526,116	38,642	340 - Corporate Services	1,410,163	1,577,348	167,185
59,288	67,176	7,888	360 - Audit & Investigative Services	225,190	201,528	(23,662)
38,083	54,315	16,232	410 - Advertising Media	95,112	162,945	67,833
43,800	68,457	24,657	420 - Sales/Marketing/Public Relations	122,924	205,371	82,447
181,915	223,076	41,161	510 - Human Resourses	654,515	687,660	33,145
3,984,487	4,324,846	340,359	Total Administrative Expenses	11,797,580	12,983,117	1,185,537

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED MARCH 31, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	YEAR TO DATE 2020
110 - Executive	339,242	293,820	365,045	998,107
210 - Accounting	173,904	178,919	174,836	527,659
220 - Management Information Systems (MIS)	381,511	295,419	338,903	1,015,833
221 - Business Intelligence	-	11,648	20,702	32,350
222 - Enterprise Development	211,299	225,855	262,079	699,233
225 - Infrastructure	359,015	241,507	308,323	908,845
230 - Claims	556,280	498,960	493,312	1,548,552
240 - Project Management	85,191	84,709	97,954	267,854
310 - Health Services - Utilization Management	98,529	107,809	95,426	301,764
311 - Health Services - Quality Improvement	10,824	41,860	43,027	95,711
312 - Health Services - Education	-	60	-	60
313- Pharmacy	156,947	147,980	148,599	453,526
314 - Health Homes	222	15,046	98	15,366
315 - Case Management	17,349	15,664	15,615	48,628
616 - Disease Management	20,836	20,068	21,223	62,127
320 - Provider Network Management	256,860	252,748	291,995	801,603
330 - Member Services	530,714	484,954	496,790	1,512,458
340 - Corporate Services	439,804	482,885	487,474	1,410,163
360 - Audit & Investigative Services	81,923	83,979	59,288	225,190
410 - Advertising Media	9,439	47,590	38,083	95,112
420 - Sales/Marketing/Public Relations	44,020	35,104	43,800	122,924
510 - Human Resourses	285,952	186,648	181,915	654,515
Total Department Expenses	4,059,861	3,753,232	3,984,487	11,797,580
ADMINISTRATIVE EXPENSE ADJUSTMENT	-	-	-	-
Total Administrative Expenses	4,059,861	3,753,232	3,984,487	11,797,580

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF MARCH 31, 2020

ASSETS	MARCH 2020	FEBRUARY 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,121,924	$ 1,121,922	2
Interest Receivable	7,920	5,280	2,640
Prepaid Expenses & Other Current Assets	2,501	3,334	(833)
TOTAL CURRENT ASSETS	$ 1,132,345	$ 1,130,536	$ 1,809
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,128,885	1,128,885	-
Increase (Decrease) in Net Position - Current Year	3,460	1,651	1,809
Total Net Position	$ 1,132,345	$ 1,130,536	$ 1,809
TOTAL LIABILITIES AND NET POSITION	$ 1,132,345	$ 1,130,536	$ 1,809

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED MARCH 31, 2020

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE		YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET	YEAR-TO-DATE VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	
			REVENUES			
-	-	-	Premium	-	-	
2,640	-	2,640	Interest	7,920	-	7,92
2	-	2	Other Investment Income	(1,961)	-	(1,96
2,642	-	2,642	TOTAL REVENUES	5,959	-	5,95
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	
-	-	-	Total Medical Costs	-	-	
2,642	-	2,642	GROSS MARGIN	5,959	-	5,95
			Administrative			
833	-	(833)	Management Fee Expense and Other Admin Exp	2,499	-	(2,49
833	-	(833)	Total Administrative Expenses	2,499	-	(2,49
833	-	(833)	TOTAL EXPENSES	2,499	-	(2,49
1,809	-	1,809	OPERATING INCOME (LOSS)	3,460	-	3,46
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	
1,809	-	1,809	NET INCREASE (DECREASE) IN NET POSITION	3,460	-	3,46
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0
32%	0%	-32%	ADMINISTRATIVE EXPENSE RATIO	42%	0%	-42

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2020 MEMBER MONTHS	JAN'20	FEB'20	MAR'20	APR'20	MAY'20	JUN'20	JUL'20	AUG'20	SEP'20	OCT'20	NOV'20	DEC'20
ADULT AND FAMILY													
ADULT	**131,766**	43,519	43,767	44,480	0	0	0	0	0	0	0	0	0
CHILD	**368,893**	122,496	123,040	123,357	0	0	0	0	0	0	0	0	0
SUB-TOTAL ADULT & FAMILY	**500,659**	**166,015**	**166,807**	**167,837**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
OTHER MEMBERS													
BCCTP-TOBACCO SETTLEMENT	**80**	26	28	26	0	0	0	0	0	0	0	0	0
DUALS													
PARTIAL DUALS - FAMILY	**1,317**	432	432	453	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - CHILD	**3**	1	1	1	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	**4**	1	1	2	0	0	0	0	0	0	0	0	0
SPD FULL DUALS	**20,269**	6,599	6,759	6,911	0	0	0	0	0	0	0	0	0
SUB-TOTAL DUALS	**21,593**	**7,033**	**7,193**	**7,367**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FAMILY & OTHER	**522,332**	**173,074**	**174,028**	**175,230**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SPD													
SPD (AGED AND DISABLED)	**46,848**	15,667	15,493	15,688	0	0	0	0	0	0	0	0	0
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	**180,140**	59,583	60,197	60,360	0	0	0	0	0	0	0	0	0
ACA Expansion Duals	**879**	316	289	274	0	0	0	0	0	0	0	0	0
SUB-TOTAL MED-CAL EXPANSION	**181,019**	**59,899**	**60,486**	**60,634**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL KAISER	**27,286**	**8,992**	**9,125**	**9,169**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL MEDI-CAL MEMBERS	**777,485**	**257,632**	**259,132**	**260,721**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: June 11, 2020

Re: April 2020 Financial Results

The April results reflect a $1,116,283 Net Increase in Net Position which is a $1,769,907 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $6.6 million unfavorable variance primarily due to:

   A) $3.5 million unfavorable variance Rate/Income Adjustments primarily due to a 1 ½% retro-active rate adjustment for the period 1/1/20 -4/30/20 required under the Governor's revised May budget.

   B) $1.6 favorable variance due to higher than expected budgeted membership primarily with SPD members.

   C) $2.2 million favorable variance in Proposition 56 Supplemental Revenue due to an unbudgeted rate increase in tobacco tax revenue funds in fiscal year 19/20 for additional CPT procedure codes along with unbudgeted new Prop 56 program that became effective January 1, 2020 offset against amounts included in 2E below.

   D) $2.1 million unfavorable variance in Premium MCO Tax due to a revised reduction in our MCO tax liability rates that occurred with an agreement between CMS and DHCS which is offset against MCO Tax Expense included in Item 3 below.

   E) $4.5 million unfavorable variance Rate/Income Adjustments primarily due to a 1 ½% retro-active rate adjustment for the period 7/1/19 -12/31/19 required under the Governor's revised May budget.

2) Total Medical Costs reflect a $4.8 million favorable variance primarily due to:

   A) $1.9 million favorable variance in Physician Services due to lower than expected utilization of Specialty and Urgent Care services.

   B) $.7 million favorable variance in Other Professional Services due to lower than expected utilization of Behavioral Health Treatment, Mental Health Services and Other Professional Services such as Physical Therapy and Podiatry services.

   C) $1.3 million favorable variance in Emergency Room due to lower than expected utilization.

D) $2.5 million unfavorable variance in Inpatient due to higher than expected utilization for Expansion and SPD members that occurred during the first quarter of 2020.

E) $1.8 million unfavorable variance in Other Medical primarily due to accruing for estimated Proposition 56 expenses relating to unbudgeted additional CPT procedure codes along with increases in supplemental allowable payable amounts offset against revenue included in 1C above.

F) $1.0 million favorable variance in Pharmacy primarily from formulary modifications that capitalized on new generics that came to market and less costly brands within the same therapeutic class. There was also a timing impact from the lengthening of the day supply per prescription of maintenance medications that occurred during the month of March.

G) $4.4 million favorable variance primarily due from better than expected Inpatient utilization ($3.0 million) and lower than expected P4P payouts ($1.1 million) relating to the prior year.

3) $2.1 million favorable variance in MCO Tax due to a revised reduction in our MCO tax liability rates that occurred with an agreement between CMS and DHCS which is offset against MCO Tax Premium included in Item 1D above.

The April Medical Loss Ratio is 92.1% which is favorable to the 93.2% budgeted amount. The April Administrative Expense Ratio is 6.8% which is slightly unfavorable to the 6.6% budgeted amount primarily due to the unfavorable retro-active rate adjustment mentioned in 1E above (Administrative Expense Ratio would have been 6.3% without this adjustment).

The results for the 4 months ended April 30, 2020 reflect a Net Increase in Net Position of $2,392,309. This is a $4,831,048 favorable variance to budget and includes approximately $6.1 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 92.3% which is favorable to the 93.1% budgeted amount. The year-to-date Administrative Expense Ratio is 6.0% which is favorable to the 6.6% budgeted amount.

Kern Health Systems
Financial Packet
April 2020

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF APRIL 30, 2020

ASSETS	APRIL 2020	MARCH 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 107,152,379	$ 74,565,543	$ 32,586,836
Short-Term Investments	100,271,133	74,110,603	26,160,530
Premiums Receivable - Net	106,636,509	152,239,159	(45,602,650)
Premiums Receivable - Hospital Direct Payments	249,417,529	237,766,343	11,651,186
Interest Receivable	186,300	318,678	(132,378)
Provider Advance Payment	1,445,781	16,000,000	(14,554,219)
Other Receivables	1,171,172	1,016,152	155,020
Prepaid Expenses & Other Current Assets	1,791,315	2,560,123	(768,808)
Total Current Assets	$ 568,072,118	$ 558,576,601	$ 9,495,517
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	2,414,411	2,456,886	(42,475)
Computer Hardware and Software - Net	17,523,898	17,700,750	(176,852)
Building and Building Improvements - Net	35,952,529	36,028,517	(75,988)
Capital Projects in Progress	9,590,631	9,268,229	322,402
Total Capital Assets	$ 69,572,175	$ 69,545,088	$ 27,087
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	743,320	743,320	-
Total Long Term Assets	$ 1,043,320	$ 1,043,320	$ -
DEFERRED OUTFLOWS OF RESOURCES	$ 2,889,179	$ 2,889,179	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 641,576,792	$ 632,054,188	$ 9,522,604
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 3,254,546	$ 3,138,360	116,186
Accrued Other Operating Expenses	1,375,721	1,533,289	(157,568)
Accrued Taxes and Licenses	31,483,081	23,567,837	7,915,244
Claims Payable (Reported)	13,909,456	23,074,011	(9,164,555)
IBNR - Inpatient Claims	28,462,611	36,643,160	(8,180,549)
IBNR - Physician Claims	17,651,340	14,024,295	3,627,045
IBNR - Accrued Other Medical	22,567,072	19,683,177	2,883,895
Risk Pool and Withholds Payable	2,146,369	2,724,303	(577,934)
Statutory Allowance for Claims Processing Expense	2,278,463	2,278,463	-
Other Liabilities	44,487,019	44,193,648	293,371
Accrued Hospital Directed Payments	249,417,529	237,766,343	11,651,186
Total Current Liabilities	$ 417,033,207	$ 408,626,886	$ 8,406,321
NONCURRENT LIABILITIES:			
Net Pension Liability	7,038,233	7,038,233	-
TOTAL NONCURRENT LIABILITIES	$ 7,038,233	$ 7,038,233	$ -
DEFERRED INFLOWS OF RESOURCES	$ 420,664	$ 420,664	$ -
NET POSITION:			
Net Position - Beg. of Year	214,692,379	214,692,379	-
Increase (Decrease) in Net Position - Current Year	2,392,309	1,276,026	1,116,283
Total Net Position	$ 217,084,688	$ 215,968,405	$ 1,116,283
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 641,576,792	$ 632,054,188	$ 9,522,604

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED APRIL 30, 2020

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
168,551	168,700	(149)	Family Members	670,530	672,400	(1,870)
61,457	61,090	367	Expansion Members	242,476	244,360	(1,884)
15,992	14,730	1,262	SPD Members	62,840	58,920	3,920
6,950	6,205	745	Other Members	27,303	24,820	2,483
9,262	8,660	602	Kaiser Members	36,548	34,640	1,908
262,212	259,385	2,827	Total Members - MCAL	1,039,697	1,035,140	4,557
			REVENUES			
27,567,358	27,453,065	114,293	Title XIX - Medicaid - Family and Other	112,405,060	109,598,931	2,806,129
22,679,789	23,145,509	(465,720)	Title XIX - Medicaid - Expansion Members	92,783,124	92,582,037	201,087
14,884,891	14,884,621	270	Title XIX - Medicaid - SPD Members	60,295,315	59,538,485	756,830
7,915,338	10,029,000	(2,113,662)	Premium - MCO Tax	31,660,942	40,020,000	(8,359,058)
11,614,664	11,079,608	535,056	Premium - Hospital Directed Payments	45,778,101	44,292,729	1,485,372
266,256	398,411	(132,155)	Investment Earnings And Other Income	1,181,746	1,589,830	(408,084)
-	72,710	(72,710)	Reinsurance Recoveries	-	290,145	(290,145)
36,523	-	36,523	Rate Adjustments - Hospital Directed Payments	258,251	-	258,251
(4,529,302)	-	(4,529,302)	Rate/Income Adjustments	(2,283,625)	-	(2,283,625)
80,435,517	87,062,925	(6,627,408)	TOTAL REVENUES	342,078,914	347,912,157	(5,833,243)
			EXPENSES			
			Medical Costs:			
12,418,888	14,356,228	1,937,340	Physician Services	55,400,952	57,323,656	1,922,704
3,908,759	4,627,799	719,040	Other Professional Services	16,234,989	18,447,457	2,212,468
3,813,875	5,144,456	1,330,581	Emergency Room	19,669,701	20,534,307	864,606
15,995,368	13,490,704	(2,504,664)	Inpatient	59,544,655	53,886,276	(5,658,379)
77,341	72,710	(4,631)	Reinsurance Expense	293,873	290,145	(3,728)
6,270,816	6,545,064	274,248	Outpatient Hospital	25,775,911	26,148,359	372,448
8,832,073	6,998,589	(1,833,484)	Other Medical	35,168,300	27,955,621	(7,212,679)
8,667,925	9,705,570	1,037,645	Pharmacy	38,197,693	38,779,583	581,890
509,814	501,450	(8,364)	Pay for Performance Quality Incentive	2,010,212	2,001,000	(9,212)
11,614,664	11,079,608	(535,056)	Hospital Directed Payments	45,778,101	44,292,729	(1,485,372)
36,523	-	(36,523)	Hospital Directed Payment Adjustment	258,251	-	(258,251)
1,420	-	(1,420)	Non-Claims Expense Adjustment	(1,292,785)	-	1,292,785
(4,444,586)	-	4,444,586	IBNR, Incentive, Paid Claims Adjustment	(7,101,533)	-	7,101,533
67,702,880	72,522,179	4,819,299	Total Medical Costs	289,938,320	289,659,133	(279,187)
12,732,637	14,540,746	(1,808,109)	GROSS MARGIN	52,140,594	58,253,024	(6,112,430)
			Administrative:			
2,678,816	2,662,119	(16,697)	Compensation	10,110,943	10,643,399	532,456
931,815	862,305	(69,510)	Purchased Services	3,321,398	3,443,983	122,585
60,138	119,155	59,017	Supplies	238,678	476,924	238,246
300,318	332,375	32,057	Depreciation	1,175,562	1,322,500	146,938
154,706	348,324	193,618	Other Administrative Expenses	1,076,792	1,420,589	343,797
-	-	-	Administrative Expense Adjustment	-	-	-
4,125,793	4,324,278	198,485	Total Administrative Expenses	15,923,373	17,307,395	1,384,022
71,828,673	76,846,457	5,017,784	TOTAL EXPENSES	305,861,693	306,966,528	1,104,835
8,606,844	10,216,468	(1,609,624)	OPERATING INCOME (LOSS) BEFORE TAX	36,217,221	40,945,629	(4,728,408)
7,915,243	10,029,000	2,113,757	MCO TAX	31,660,973	40,020,000	8,359,027
691,601	187,468	504,133	OPERATING INCOME (LOSS) NET OF TAX	4,556,248	925,629	3,630,619
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
680,840	(333,333)	1,014,173	Provider Recruitment and Retention Grants	(1,549,496)	(1,333,332)	(216,164)
(256,158)	(507,759)	251,601	Health Home	(614,443)	(2,031,036)	1,416,593
424,682	(841,092)	1,265,774	TOTAL NONOPERATING REVENUE (EXPENSE)	(2,163,939)	(3,364,368)	1,200,429
1,116,283	(653,624)	1,769,907	NET INCREASE (DECREASE) IN NET POSITION	2,392,309	(2,438,739)	4,831,048
92.1%	93.2%	1.1%	MEDICAL LOSS RATIO	92.3%	93.1%	0.8%
6.8%	6.6%	-0.2%	ADMINISTRATIVE EXPENSE RATIO	6.0%	6.6%	0.5%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED APRIL 30, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
168,551	168,700	(149)	Family Members	670,530	672,400	(1,870)
61,457	61,090	367	Expansion Members	242,476	244,360	(1,884)
15,992	14,730	1,262	SPD Members	62,840	58,920	3,920
6,950	6,205	745	Other Members	27,303	24,820	2,483
9,262	8,660	602	Kaiser Members	36,548	34,640	1,908
262,212	259,385	2,827	Total Members - MCAL	1,039,697	1,035,140	4,557
			REVENUES			
157.08	156.96	0.12	Title XIX - Medicaid - Family and Other	161.08	157.19	3.88
369.04	378.88	(9.84)	Title XIX - Medicaid - Expansion Members	382.65	378.88	3.77
930.77	1,010.50	(79.73)	Title XIX - Medicaid - SPD Members	959.51	1,010.50	(50.99)
31.29	40.00	(8.71)	Premium - MCO Tax	31.56	40.00	(8.44)
45.92	44.19	1.73	Premium - Hospital Directed Payments	45.63	44.27	1.36
1.05	1.59	(0.54)	Investment Earnings And Other Income	1.18	1.59	(0.41)
0.00	0.29	(0.29)	Reinsurance Recoveries	0.00	0.29	(0.29)
0.14	0.00	0.14	Rate Adjustments - Hospital Directed Payments	0.26	0.00	0.26
(17.91)	0.00	(17.91)	Rate/Income Adjustments	(2.28)	0.00	(2.28)
317.99	347.24	(29.25)	TOTAL REVENUES	341.01	347.74	(6.73)
			EXPENSES			
			Medical Costs:			
49.10	57.26	8.16	Physician Services	55.23	57.30	2.07
15.45	18.46	3.00	Other Professional Services	16.18	18.44	2.25
15.08	20.52	5.44	Emergency Room	19.61	20.52	0.92
63.24	53.81	(9.43)	Inpatient	59.36	53.86	(5.50)
0.31	0.29	(0.02)	Reinsurance Expense	0.29	0.29	(0.00)
24.79	26.10	1.31	Outpatient Hospital	25.69	26.14	0.44
34.92	27.91	(7.00)	Other Medical	35.06	27.94	(7.12)
34.27	38.71	4.44	Pharmacy	38.08	38.76	0.68
2.02	2.00	(0.02)	Pay for Performance Quality Incentive	2.00	2.00	(0.00)
45.92	44.19	(1.73)	Hospital Directed Payments	45.63	44.27	(1.36)
0.14	0.00	(0.14)	Hospital Directed Payment Adjustment	0.26	0.00	(0.26)
0.01	0.00	(0.01)	Non-Claims Expense Adjustment	(1.29)	0.00	1.29
(17.57)	0.00	17.57	IBNR, Incentive, Paid Claims Adjustment	(7.08)	0.00	7.08
267.65	289.25	21.60	Total Medical Costs	289.03	289.51	0.49
50.34	57.99	(7.66)	GROSS MARGIN	51.98	58.22	(6.25)
			Administrative:			
10.59	10.62	0.03	Compensation	10.08	10.64	0.56
3.68	3.44	(0.24)	Purchased Services	3.31	3.44	0.13
0.24	0.48	0.24	Supplies	0.24	0.48	0.24
1.19	1.33	0.14	Depreciation	1.17	1.32	0.15
0.61	1.39	0.78	Other Administrative Expenses	1.07	1.42	0.35
0.00	0.00	0.00	Administrative Expense Adjustment	0.00	0.00	0.00
16.31	17.25	0.94	Total Administrative Expenses	15.87	17.30	1.43
283.96	306.50	22.53	TOTAL EXPENSES	304.90	306.81	1.91
34.03	40.75	(6.72)	OPERATING INCOME (LOSS) BEFORE TAX	36.10	40.93	(4.82)
31.29	40.00	8.71	MCO TAX	31.56	40.00	8.44
2.73	0.75	1.99	OPERATING INCOME (LOSS) NET OF TAX	4.54	0.93	3.62
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
2.69	(1.33)	4.02	Reserve Fund Projects/Community Grants	(1.54)	(1.33)	(0.21)
(1.01)	(2.03)	1.01	Health Home	(0.61)	(2.03)	1.42
1.68	(3.35)	5.03	TOTAL NONOPERATING REVENUE (EXPENSE)	(2.16)	(3.36)	1.21
4.41	(2.61)	7.02	NET INCREASE (DECREASE) IN NET POSITION	2.38	(2.44)	4.82
92.1%	93.2%	1.1%	MEDICAL LOSS RATIO	92.3%	93.1%	0.8%
6.8%	6.6%	-0.2%	ADMINISTRATIVE EXPENSE RATIO	6.0%	6.6%	0.5%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH APRIL 30, 2020	APRIL 2019	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	248,254	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	249,193	250,007	251,552	252,950	3,252,203
REVENUES														
Title XIX - Medicaid - Family and Other	24,003,598	24,444,272	25,745,431	26,916,818	27,380,366	27,444,092	27,395,016	34,656,206	28,289,680	28,111,536	28,136,428	28,589,738	27,567,358	358,680,539
Title XIX - Medicaid - Expansion Members	23,046,615	23,133,193	23,356,415	21,829,172	22,748,791	23,117,928	22,908,874	25,545,000	24,658,622	23,135,804	23,419,130	23,548,401	22,679,789	303,127,734
Title XIX - Medicaid - SPD Members	12,488,048	13,147,466	13,032,438	14,355,421	14,965,261	15,059,382	15,759,913	16,141,207	15,294,321	15,020,731	15,113,713	15,275,980	14,884,891	190,538,772
Premium - MCO Tax	8,084,949	8,092,541	8,174,408	8,128,512	12,317,485	10,182,096	10,062,668	11,609,045	(52,290,862)	-	16,158,895	7,586,709	7,915,338	56,021,784
Premium - Hospital Directed Payments	-	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	11,614,664	181,941,567
Investment Earnings And Other Income	620,797	382,110	1,108,727	354,349	382,033	708,869	338,986	265,233	731,395	190,131	301,265	424,094	266,256	6,074,245
Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	-	-	-	-	-	62,733,334	-	-	101,394,310	118,333	60,959	42,436	36,523	164,385,895
Rate/Income Adjustments	(173,473)	178,336	(703,658)	132,080	329,476	103,418	318,771	(3,664)	(391,644)	819,618	809,261	616,798	(4,529,302)	(2,493,983)
TOTAL REVENUES	68,070,534	69,377,918	70,713,761	71,716,351	78,123,412	139,349,119	76,784,228	88,213,027	253,849,288	78,672,737	95,391,047	87,579,613	80,435,517	1,258,276,552
EXPENSES														
Medical Costs:														
Physician Services	15,885,936	14,054,383	13,468,415	13,912,712	13,516,282	12,473,244	13,286,040	14,396,081	15,556,899	14,757,546	13,873,238	14,351,280	12,418,888	181,950,944
Other Professional Services	3,718,600	3,960,952	4,388,042	3,849,695	3,775,027	3,913,361	4,483,269	3,596,983	4,371,702	4,334,953	3,966,515	4,024,762	3,908,759	52,292,620
Emergency Room	5,525,268	5,106,796	4,698,111	5,181,359	4,645,061	4,697,451	5,571,836	5,227,569	4,729,725	5,226,947	5,258,084	5,370,795	3,813,875	65,052,877
Inpatient	12,850,017	12,181,510	14,390,451	13,332,634	15,238,360	15,564,329	14,951,334	14,657,214	14,449,035	14,911,677	13,893,706	14,743,904	15,995,368	187,159,539
Reinsurance Expense	126,397	126,609	126,658	126,658	129,256	126,290	127,228	129,075	128,012	72,320	144,425	(213)	77,341	1,440,056
Outpatient Hospital	6,373,571	6,408,304	5,912,776	6,609,411	6,523,398	6,130,800	6,128,586	6,141,173	4,767,801	6,734,395	6,204,610	6,566,090	6,270,816	80,771,731
Other Medical	6,141,817	7,183,716	6,357,547	6,715,805	6,439,790	7,570,084	5,832,261	16,655,345	6,649,662	5,661,784	10,021,013	10,653,430	8,832,073	104,714,327
Pharmacy	9,293,776	9,659,273	8,508,813	9,183,446	9,336,978	9,145,904	9,834,755	9,282,817	9,267,277	9,971,687	9,246,208	10,311,873	8,667,925	121,710,732
Pay for Performance Quality Incentive	496,508	496,698	501,792	498,760	498,932	502,552	502,078	500,918	498,762	497,280	500,014	503,104	509,814	6,507,212
Hospital Directed Payments	-	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	11,614,664	181,941,567
Hospital Directed Payment Adjustment	-	-	-	-	-	62,605,426	-	-	101,154,229	118,333	60,959	42,436	36,523	164,017,906
Non-Claims Expense Adjustment	(736,017)	39,610	756,640	19,252	11,717	11,329	(5,919)	(18,762)	4,624	57,172	232,393	(1,583,770)	1,420	(1,210,311)
IBNR, Incentive, Paid Claims Adjustment	(3,425,856)	(2,087,231)	(704,885)	(350,851)	202,480	374,161	20,741	(40,346)	(259,737)	816	(8,559)	(2,649,204)	(4,444,586)	(13,373,057)
Total Medical Costs	56,250,017	57,130,620	58,404,360	59,078,881	60,317,281	123,114,931	60,732,209	70,528,067	297,481,457	73,621,494	74,784,002	73,829,944	67,702,880	1,132,976,143
GROSS MARGIN	11,820,517	12,247,298	12,309,401	12,637,470	17,806,131	16,234,188	16,052,019	17,684,960	(43,632,169)	5,051,243	20,607,045	13,749,669	12,732,637	125,300,409
Administrative:														
Compensation	2,121,314	2,336,685	2,155,354	2,297,855	2,254,325	2,343,633	2,510,126	2,403,604	2,589,213	2,577,348	2,407,112	2,447,667	2,678,816	31,123,052
Purchased Services	783,945	882,833	449,468	805,910	605,801	836,783	831,542	805,047	1,358,494	805,903	833,909	749,771	931,815	10,681,221
Supplies	93,770	15,577	59,549	47,853	49,290	76,514	203,279	58,830	(7,208)	35,806	43,182	99,552	60,138	836,132
Depreciation	179,515	179,516	179,516	151,640	151,655	151,656	355,208	280,129	304,894	287,390	287,536	300,318	300,318	3,109,291
Other Administrative Expenses	302,417	239,380	412,596	338,545	489,494	523,591	519,786	270,201	344,959	353,414	181,493	387,179	154,706	4,517,761
Administrative Expense Adjustment	-	-	-	-	-	-	-	-	1,325,136	-	-	-	-	1,325,136
Total Administrative Expenses	3,480,961	3,653,991	3,256,483	3,641,803	3,550,565	3,932,177	4,419,941	3,817,811	5,915,488	4,059,861	3,753,232	3,984,487	4,125,793	51,592,593
TOTAL EXPENSES	59,730,978	60,784,611	61,660,843	62,720,684	63,867,846	127,047,108	65,152,150	74,345,878	303,396,945	77,681,355	78,537,234	77,814,431	71,828,673	1,184,568,736
OPERATING INCOME (LOSS) BEFORE TAX	8,339,556	8,593,307	9,052,918	8,995,667	14,255,566	12,302,011	11,632,078	13,867,149	(49,547,657)	991,382	16,853,813	9,765,182	8,606,844	73,707,816
MCO TAX	8,087,918	8,087,918	8,087,917	8,051,211	12,279,276	10,165,243	10,057,218	12,283,003	(52,962,035)	-	16,159,021	7,586,709	7,915,243	55,798,642
OPERATING INCOME (LOSS) NET OF TAX	251,638	505,389	965,001	944,456	1,976,290	2,136,768	1,574,860	1,584,146	3,414,378	991,382	694,792	2,178,473	691,601	17,909,174
TOTAL NONOPERATING REVENUE (EXPENSE)	(191,455)	(359,160)	1,293,258	(306,804)	(151,504)	(380,606)	(236,574)	(885,928)	(425,785)	(942,282)	(569,882)	(1,076,457)	424,682	(3,808,497)
NET INCREASE (DECREASE) IN NET POSITION	60,183	146,229	2,258,259	637,652	1,824,786	1,756,162	1,338,286	698,218	2,988,593	49,100	124,910	1,102,016	1,116,283	14,100,677
MEDICAL LOSS RATIO	93.8%	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%	91.9%
ADMINISTRATIVE EXPENSE RATIO	5.8%	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.8%	6.0%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH APRIL 30, 2020	APRIL 2019	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	248,254	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	249,193	250,007	251,552	252,950	3,252,203
REVENUES														
Title XIX - Medicaid - Family and Other	138.32	140.92	147.25	155.06	157.80	157.10	157.23	199.08	162.50	162.42	161.68	163.16	157.08	158.46
Title XIX - Medicaid - Expansion Members	384.32	386.02	383.23	360.65	374.91	377.23	373.38	419.77	410.96	386.25	387.18	388.37	369.04	385.07
Title XIX - Medicaid - SPD Members	846.53	878.96	862.90	940.48	980.04	984.27	1,019.80	1,039.69	1,000.74	958.75	975.52	973.74	930.77	955.34
Premium - MCO Tax	32.57	32.59	32.58	32.59	49.38	40.52	40.08	46.35	(209.68)	0.00	64.63	30.16	31.29	17.23
Premium - Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.25	45.56	45.70	45.92	55.94
Investment Earnings And Other Income	2.50	1.54	4.42	1.42	1.53	2.82	1.35	1.06	2.93	0.76	1.21	1.69	1.05	1.87
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	0.00	0.00	0.00	0.00	0.00	249.66	0.00	0.00	406.58	0.47	0.24	0.17	0.14	50.55
Rate/Income Adjustments	(0.70)	0.72	(2.80)	0.53	1.32	0.41	1.27	(0.01)	(1.57)	3.29	3.24	2.45	(17.91)	(0.77)
TOTAL REVENUES	274.20	279.36	281.84	287.58	313.16	554.56	305.87	352.21	1,017.92	315.71	381.55	348.16	317.99	386.90
EXPENSES														
Medical Costs:														
Physician Services	63.99	56.59	53.68	55.79	54.18	49.64	52.92	57.48	62.38	59.22	55.49	57.05	49.10	55.95
Other Professional Services	14.98	15.95	17.49	15.44	15.13	15.57	17.86	14.36	17.53	17.40	15.87	16.00	15.45	16.08
Emergency Room	22.26	20.56	18.73	20.78	18.62	18.69	22.20	20.87	18.97	20.98	21.03	21.35	15.08	20.00
Inpatient	51.76	49.05	57.36	53.46	61.08	61.94	59.56	58.52	57.94	59.84	55.57	58.61	63.24	57.55
Reinsurance Expense	0.51	0.51	0.50	0.51	0.52	0.50	0.51	0.52	0.51	0.29	0.58	(0.00)	0.31	0.44
Outpatient Hospital	25.67	25.80	23.57	26.50	26.15	24.40	24.41	24.52	19.12	27.02	24.82	26.10	24.79	24.84
Other Medical	24.74	28.93	25.34	26.93	25.81	30.13	23.23	66.50	26.66	22.72	40.08	42.35	34.92	32.20
Pharmacy	37.44	38.89	33.91	36.83	37.43	36.40	39.18	37.06	37.16	40.02	36.98	40.99	34.27	37.42
Pay for Performance Quality Incentive	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.02	2.00
Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.25	45.56	45.70	45.92	55.94
Hospital Directed Payment Adjustment	0.00	0.00	0.00	0.00	0.00	249.15	0.00	0.00	405.62	0.47	0.24	0.17	0.14	50.43
Non-Claims Expense Adjustment	(2.96)	0.16	3.02	0.08	0.05	0.05	(0.02)	(0.07)	0.02	0.23	0.93	(6.30)	0.01	(0.37)
IBNR, Incentive, Paid Claims Adjustment	(13.80)	(8.40)	(2.81)	(1.41)	0.81	1.49	0.08	(0.16)	(1.04)	0.00	(0.03)	(10.53)	(17.57)	(4.11)
Total Medical Costs	226.58	230.04	232.78	236.90	241.79	489.96	241.92	281.60	1,192.88	295.44	299.13	293.50	267.65	348.37
GROSS MARGIN	47.61	49.31	49.06	50.68	71.38	64.61	63.94	70.61	(174.96)	20.27	82.43	54.66	50.34	38.53
Administrative:														
Compensation	8.54	9.41	8.59	9.21	9.04	9.33	10.00	9.60	10.38	10.34	9.63	9.73	10.59	9.57
Purchased Services	3.16	3.55	1.79	3.23	2.43	3.33	3.31	3.21	5.45	3.23	3.34	2.98	3.68	3.28
Supplies	0.38	0.06	0.24	0.19	0.20	0.30	0.81	0.23	(0.03)	0.14	0.17	0.40	0.24	0.26
Depreciation	0.72	0.72	0.72	0.61	0.61	0.60	1.41	1.12	1.22	1.15	1.15	1.19	1.19	0.96
Other Administrative Expenses	1.22	0.96	1.64	1.36	1.96	2.08	2.07	1.08	1.38	1.42	0.73	1.54	0.61	1.39
Administrative Expense Adjustment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.31	0.00	0.00	0.00	0.00	0.41
Total Administrative Expenses	14.02	14.71	12.98	14.60	14.23	15.65	17.61	15.24	23.72	16.29	15.01	15.84	16.31	15.86
TOTAL EXPENSES	240.60	244.75	245.76	251.51	256.02	505.61	259.53	296.84	1,216.60	311.73	314.14	309.34	283.96	364.24
OPERATING INCOME (LOSS) BEFORE TAX	33.59	34.60	36.08	36.07	57.14	48.96	46.34	55.37	(198.68)	3.98	67.41	38.82	34.03	22.66
MCO TAX	32.58	32.57	32.24	32.28	49.22	40.45	40.06	49.04	(212.37)	0.00	64.63	30.16	31.29	17.16
OPERATING INCOME (LOSS) NET OF TAX	1.01	2.03	3.85	3.79	7.92	8.50	6.27	6.32	13.69	3.98	2.78	8.66	2.73	5.51
TOTAL NONOPERATING REVENUE (EXPENSE)	(0.77)	(1.45)	5.15	(1.23)	(0.61)	(1.51)	(0.94)	(3.54)	(1.71)	(3.78)	(2.28)	(4.28)	1.68	(1.17)
NET INCREASE (DECREASE) IN NET POSITION	0.24	0.59	9.00	2.56	7.31	6.99	5.33	2.79	11.98	0.20	0.50	4.38	4.41	4.34
MEDICAL LOSS RATIO	93.8%	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%	91.9%
ADMINISTRATIVE EXPENSE RATIO	5.8%	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.8%	6.0%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED APRIL 30, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
21,100,348	22,147,156	(1,046,808)	Premium - Medi-Cal	87,473,736	88,413,759	(940,023)
2,524,950	2,375,503	149,447	Premium - Maternity Kick	8,844,187	9,502,012	(657,825)
41,845	72,813	(30,968)	Premium - Hep C Kick	135,997	290,252	(154,255)
241,847	596,527	(354,680)	Premium - BHT Kick	1,560,529	2,377,924	(817,395)
193,508	313,071	(119,563)	Premium - Health Home Kick	683,721	1,247,988	(564,267)
3,220,786	1,697,275	1,523,511	Premium - Provider Enhancement	12,745,021	6,765,700	5,979,321
157,262	156,697	565	Premium - Ground Emergency Medical Transportation	621,952	625,420	(3,468)
86,812	94,023	(7,211)	Other	339,917	375,876	(35,959)
27,567,358	27,453,065	114,293	Total Title XIX - Medicaid - Family & Other	112,405,060	109,598,931	2,806,129
			Title XIX - Medicaid - Expansion Members			
20,180,273	21,183,611	(1,003,338)	Premium - Medi-Cal	83,270,462	84,734,444	(1,463,982)
343,134	214,189	128,945	Premium - Maternity Kick	1,217,155	856,756	360,399
311,223	303,377	7,846	Premium - Hep C Kick	1,161,202	1,213,508	(52,306)
404,589	519,998	(115,409)	Premium - Health Home Kick	1,463,953	2,079,992	(616,039)
1,256,817	742,244	514,574	Premium - Provider Enhancement	4,947,167	2,968,974	1,978,194
156,960	152,964	3,996	Premium - Ground Emergency Medical Transportation	617,805	611,856	5,949
26,793	29,126	(2,333)	Other	105,380	116,504	(11,124)
22,679,789	23,145,509	(465,720)	Total Title XIX - Medicaid - Expansion Members	92,783,124	92,582,034	201,090
			Title XIX - Medicaid - SPD Members			
13,027,768	13,148,587	(120,819)	Premium - Medi-Cal	53,671,874	52,594,348	1,077,526
125,535	94,152	31,383	Premium - Hep C Kick	591,062	376,608	214,454
783,806	818,847	(35,041)	Premium - BHT Kick	2,299,149	3,275,388	(976,239)
347,234	416,635	(69,401)	Premium - Health Home Kick	1,371,468	1,666,540	(295,072)
461,856	282,521	179,335	Premium - Provider Enhancement	1,816,356	1,130,084	686,272
138,692	123,879	14,813	Premium - Ground Emergency Medical Transportation	545,406	495,516	49,890
14,884,891	14,884,621	270	Total Title XIX - Medicaid - SPD Members	60,295,315	59,538,484	756,831

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED APRIL 30, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
2,953,514	2,863,832	(89,682)	Primary Care Physician Services	11,888,286	11,428,938	(459,348)
8,437,260	10,061,485	1,624,225	Referral Specialty Services	37,710,602	40,185,626	2,475,024
1,019,114	1,421,911	402,797	Urgent Care & After Hours Advise	5,765,764	5,672,193	(93,571)
9,000	9,000	-	Hospital Admitting Team	36,300	36,900	600
12,418,888	14,356,228	1,937,340	TOTAL PHYSICIAN SERVICES	55,400,952	57,323,656	1,922,704
			OTHER PROFESSIONAL SERVICES			
263,942	270,327	6,385	Vision Service Capitation	1,085,575	1,079,754	(5,821)
233,961	212,779	(21,182)	221 - Business Intelligence	833,726	851,116	17,390
619,537	556,461	(63,076)	310 - Health Services - Utilization Management - UM Allocation *	2,160,841	2,197,085	36,244
172,419	169,504	(2,915)	311 - Health Services - Quality Improvement - UM Allocation *	570,956	678,014	107,058
122,087	127,990	5,903	312 - Health Services - Education - UM Allocation *	444,325	511,960	67,635
86,248	94,630	8,382	313 - Health Services - Pharmacy - UM Allocation *	336,602	378,522	41,920
127,755	135,159	7,404	314 - Health Homes - UM Allocation *	412,758	522,219	109,461
304,832	258,856	(45,976)	315 - Case Management - UM Allocation *	1,058,602	1,035,425	(23,177)
69,526	61,775	(7,751)	616 - Disease Management - UM Allocation *	237,462	247,099	9,637
1,194,682	1,415,374	220,692	Behavior Health Treatment	4,109,893	5,653,312	1,543,419
4,228	170,584	166,356	Mental Health Services	683,919	681,636	(2,283)
709,542	1,154,360	444,818	Other Professional Services	4,300,330	4,611,314	310,984
3,908,759	4,627,799	719,040	TOTAL OTHER PROFESSIONAL SERVICES	16,234,989	18,447,457	2,212,468
3,813,875	5,144,456	1,330,581	EMERGENCY ROOM	19,669,701	20,534,307	864,606
15,995,368	13,490,704	(2,504,664)	INPATIENT HOSPITAL	59,544,655	53,886,276	(5,658,379)
77,341	72,710	(4,631)	REINSURANCE EXPENSE PREMIUM	293,873	290,145	(3,728)
6,270,816	6,545,064	274,248	OUTPATIENT HOSPITAL SERVICES	25,775,911	26,148,359	372,448
			OTHER MEDICAL			
670,262	1,544,165	873,903	Ambulance and NEMT	5,212,543	6,167,551	955,008
300,546	389,007	88,461	Home Health Services & CBAS	1,436,038	1,554,411	118,373
245,426	488,105	242,679	Utilization and Quality Review Expenses	1,031,012	1,953,920	922,908
1,549,960	938,624	(611,336)	Long Term/SNF/Hospice	5,339,615	3,752,088	(1,587,527)
263,565	483,385	219,820	Health Home Capitation & Incentive	679,835	1,931,879	1,252,044
4,841,254	2,721,762	(2,119,492)	Provider Enhancement Expense - Prop. 56	19,197,195	10,862,979	(8,334,216)
399,960	433,540	33,580	Provider Enhancement Expense - GEMT	1,710,962	1,732,792	21,830
561,100	-	(561,100)	Provider COVID-19 Expenes	561,100	-	(561,100)
8,832,073	6,998,589	(1,833,484)	TOTAL OTHER MEDICAL	35,168,300	27,955,621	(7,212,679)
			PHARMACY SERVICES			
7,803,679	8,692,169	888,490	RX - Drugs & OTC	34,612,957	34,729,815	116,858
364,602	470,341	105,739	RX - HEP-C	1,438,546	1,880,366	441,820
634,644	688,826	54,182	Rx - DME	2,586,190	2,752,300	166,110
(135,000)	(145,765)	(10,765)	RX - Pharmacy Rebates	(440,000)	(582,898)	(142,898)
8,667,925	9,705,570	1,037,645	TOTAL PHARMACY SERVICES	38,197,693	38,779,583	581,890
509,814	501,450	(8,364)	PAY FOR PERFORMANCE QUALITY INCENTIVE	2,010,212	2,001,000	(9,212)
11,614,664	11,079,608	(535,056)	HOSPITAL DIRECTED PAYMENTS	45,778,101	44,292,729	(1,485,372)
36,523	-	(36,523)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	258,251	-	(258,251)
1,420	-	(1,420)	NON-CLAIMS EXPENSE ADJUSTMENT	(1,292,785)	-	1,292,785
(4,444,586)	-	4,444,586	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(7,101,533)	-	7,101,533
67,702,880	72,522,179	4,819,299	Total Medical Costs	289,938,320	289,659,133	(279,187)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED APRIL 30, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
11.68	11.42	(0.25)	Primary Care Physician Services	11.85	11.42	(0.43)
33.36	40.13	6.77	Referral Specialty Services	37.59	40.17	2.57
4.03	5.67	1.64	Urgent Care & After Hours Advise	5.75	5.67	(0.08)
0.04	0.04	0.00	Hospital Admitting Team	0.04	0.04	0.00
49.10	57.26	8.16	TOTAL PHYSICIAN SERVICES	55.23	57.30	2.07
			OTHER PROFESSIONAL SERVICES			
1.04	1.08	0.03	Vision Service Capitation	1.08	1.08	(0.00)
0.92	0.85	(0.08)	221 - Business Intelligence	0.83	0.85	0.02
2.45	2.22	(0.23)	310 - Health Services - Utilization Management - UM Allocation *	2.15	2.20	0.04
0.68	0.68	(0.01)	311 - Health Services - Quality Improvement - UM Allocation *	0.57	0.68	0.11
0.48	0.51	0.03	312 - Health Services - Education - UM Allocation *	0.44	0.51	0.07
0.34	0.38	0.04	313 - Health Services - Pharmacy - UM Allocation *	0.34	0.38	0.04
0.51	0.54	0.03	314 - Health Homes - UM Allocation *	0.41	0.52	0.11
1.21	1.03	(0.17)	315 - Case Management - UM Allocation *	1.06	1.03	(0.02)
0.27	0.25	(0.03)	616 - Disease Management - UM Allocation *	0.24	0.25	0.01
4.72	5.65	0.92	Behavior Health Treatment	4.10	5.65	1.55
0.02	0.68	0.66	Mental Health Services	0.68	0.68	(0.00)
2.81	4.60	1.80	Other Professional Services	4.29	4.61	0.32
15.45	18.46	3.00	TOTAL OTHER PROFESSIONAL SERVICES	16.18	18.44	2.25
15.08	20.52	5.44	EMERGENCY ROOM	19.61	20.52	0.92
63.24	53.81	(9.43)	INPATIENT HOSPITAL	59.36	53.86	(5.50)
0.31	0.29	(0.02)	REINSURANCE EXPENSE PREMIUM	0.29	0.29	(0.00)
24.79	26.10	1.31	OUTPATIENT HOSPITAL SERVICES	25.69	26.14	0.44
			OTHER MEDICAL			
2.65	6.16	3.51	Ambulance and NEMT	5.20	6.16	0.97
1.19	1.55	0.36	Home Health Services & CBAS	1.43	1.55	0.12
0.97	1.95	0.98	Utilization and Quality Review Expenses	1.03	1.95	0.93
6.13	3.74	(2.38)	Long Term/SNF/Hospice	5.32	3.75	(1.57)
1.04	1.93	0.89	Health Home Capitation & Incentive	0.68	1.93	1.25
19.14	10.86	(8.28)	Provider Enhancement Expense - Prop. 56	19.14	10.86	(8.28)
1.58	1.73	0.15	Provider Enhancement Expense - GEMT	1.71	1.73	0.03
2.22	0.00	(2.22)	Provider COVID-19 Expenes	0.56	0.00	(0.56)
34.92	27.91	(7.00)	TOTAL OTHER MEDICAL	35.06	27.94	(7.12)
			PHARMACY SERVICES			
30.85	34.67	3.82	RX - Drugs & OTC	34.50	34.71	0.21
1.44	1.88	0.43	RX - HEP-C	1.43	1.88	0.45
2.51	2.75	0.24	Rx - DME	2.58	2.75	0.17
(0.53)	(0.58)	(0.05)	RX - Pharmacy Rebates	(0.44)	(0.58)	(0.14)
34.27	38.71	4.44	TOTAL PHARMACY SERVICES	38.08	38.76	0.68
2.02	2.00	(0.02)	PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	0.00
45.92	44.19	(1.73)	HOSPITAL DIRECTED PAYMENTS	45.63	44.27	(1.36)
0.14	0.00	(0.14)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.26	0.00	(0.26)
0.01	0.00	(0.01)	NON-CLAIMS EXPENSE ADJUSTMENT	(1.29)	0.00	1.29
(17.57)	0.00	17.57	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(7.08)	0.00	7.08
267.65	289.25	21.60	Total Medical Costs	289.03	289.51	0.49

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH APRIL 30, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES					
Primary Care Physician Services	2,908,272	3,164,601	2,861,899	2,953,514	11,888,286
Referral Specialty Services	10,425,085	8,803,273	10,044,984	8,437,260	37,710,602
Urgent Care & After Hours Advise	1,414,889	1,896,664	1,435,097	1,019,114	5,765,764
Hospital Admitting Team	9,300	8,700	9,300	9,000	36,300
TOTAL PHYSICIAN SERVICES	14,757,546	13,873,238	14,351,280	12,418,888	55,400,952
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	299,489	261,072	261,072	263,942	1,085,575
221 - Business Intelligence	199,939	204,745	195,081	233,961	833,726
310 - Health Services - Utilization Management - UM Allocation *	550,905	482,617	507,782	619,537	2,160,841
311 - Health Services - Quality Improvement - UM Allocation *	130,719	131,973	135,845	172,419	570,956
312 - Health Services - Education - UM Allocation *	111,799	102,037	108,402	122,087	444,325
313 - Health Services - Pharmacy - UM Allocation *	88,153	80,696	81,505	86,248	336,602
314 - Health Homes - UM Allocation *	91,425	88,868	104,710	127,755	412,758
315 - Case Management - UM Allocation *	267,758	241,370	244,642	304,832	1,058,602
616 - Disease Management - UM Allocation *	56,335	54,217	57,384	69,526	237,462
Behavior Health Treatment	980,035	935,456	999,720	1,194,682	4,109,893
Mental Health Services	330,842	217,343	131,506	4,228	683,919
Other Professional Services	1,227,554	1,166,121	1,197,113	709,542	4,300,330
TOTAL OTHER PROFESSIONAL SERVICES	4,334,953	3,966,515	4,024,762	3,908,759	16,234,989
EMERGENCY ROOM	5,226,947	5,258,084	5,370,795	3,813,875	19,669,701
INPATIENT HOSPITAL	14,911,677	13,893,706	14,743,904	15,995,368	59,544,655
REINSURANCE EXPENSE PREMIUM	72,320	144,425	(213)	77,341	293,873
OUTPATIENT HOSPITAL SERVICES	6,734,395	6,204,610	6,566,090	6,270,816	25,775,911
OTHER MEDICAL					
Ambulance and NEMT	1,599,375	1,498,607	1,444,299	670,262	5,212,543
Home Health Services & CBAS	392,407	393,491	349,594	300,546	1,436,038
Utilization and Quality Review Expenses	308,250	229,353	247,983	245,426	1,031,012
Long Term/SNF/Hospice	1,052,766	1,197,702	1,539,187	1,549,960	5,339,615
Health Home Capitation & Incentive	166,060	137,300	112,910	263,565	679,835
Provider Enhancement Expense - Prop. 56	1,820,309	5,971,496	6,564,136	4,841,254	19,197,195
Provider Enhancement Expense - GEMT	322,617	593,064	395,321	399,960	1,710,962
Provider COVID-19 Expenes	-	-	-	561,100	561,100
TOTAL OTHER MEDICAL	5,661,784	10,021,013	10,653,430	8,832,073	35,168,300
PHARMACY SERVICES					
RX - Drugs & OTC	9,137,997	8,470,785	9,200,496	7,803,679	34,612,957
RX - HEP-C	271,776	331,788	470,380	364,602	1,438,546
Rx - DME	696,914	578,635	675,997	634,644	2,586,190
RX - Pharmacy Rebates	(135,000)	(135,000)	(35,000)	(135,000)	(440,000)
TOTAL PHARMACY SERVICES	9,971,687	9,246,208	10,311,873	8,667,925	38,197,693
PAY FOR PERFORMANCE QUALITY INCENTIVE	497,280	500,014	503,104	509,814	2,010,212
HOSPITAL DIRECTED PAYMENTS	11,276,584	11,391,396	11,495,457	11,614,664	45,778,101
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	118,333	60,959	42,436	36,523	258,251
NON-CLAIMS EXPENSE ADJUSTMENT	57,172	232,393	(1,583,770)	1,420	(1,292,785)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	816	(8,559)	(2,649,204)	(4,444,586)	(7,101,533)
Total Medical Costs	62,344,910	63,392,606	62,334,487	56,088,216	244,160,219

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH APRIL 30, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES					
Primary Care Physician Services	11.67	12.66	11.38	11.68	11.84
Referral Specialty Services	41.84	35.21	39.93	33.36	37.57
Urgent Care & After Hours Advise	5.68	7.59	5.70	4.03	5.74
Hospital Admitting Team	0.04	0.03	0.04	0.04	0.04
TOTAL PHYSICIAN SERVICES	59.22	55.49	57.05	49.10	55.20
OTHER PROFESSIONAL SERVICES					
Vision Service Capitation	1.20	1.04	1.04	1.04	1.08
221 - Business Intelligence	0.80	0.82	0.78	0.92	0.83
310 - Health Services - Utilization Management - UM Allocation *	2.21	1.93	2.02	2.45	2.15
311 - Health Services - Quality Improvement - UM Allocation *	0.52	0.53	0.54	0.68	0.57
312 - Health Services - Education - UM Allocation *	0.45	0.41	0.43	0.48	0.44
313 - Health Services - Pharmacy - UM Allocation *	0.35	0.32	0.32	0.34	0.34
314 - Health Homes - UM Allocation *	0.37	0.36	0.42	0.51	0.41
315 - Case Management - UM Allocation *	1.07	0.97	0.97	1.21	1.05
616 - Disease Management - UM Allocation *	0.23	0.22	0.23	0.27	0.24
Behavior Health Treatment	3.93	3.74	3.97	4.72	4.09
Mental Health Services	1.33	0.87	0.52	0.02	0.68
Other Professional Services	4.93	4.66	4.76	2.81	4.28
TOTAL OTHER PROFESSIONAL SERVICES	17.40	15.87	16.00	15.45	16.18
EMERGENCY ROOM	20.98	21.03	21.35	15.08	19.60
INPATIENT HOSPITAL	59.84	55.57	58.61	63.24	59.33
REINSURANCE EXPENSE PREMIUM	0.29	0.58	0.00	0.31	0.29
OUTPATIENT HOSPITAL SERVICES	27.02	24.82	26.10	24.79	25.68
OTHER MEDICAL					
Ambulance and NEMT	6.42	5.99	5.74	2.65	5.19
Home Health Services & CBAS	1.57	1.57	1.39	1.19	1.43
Utilization and Quality Review Expenses	1.24	0.92	0.99	0.97	1.03
Long Term/SNF/Hospice	4.22	4.79	6.12	6.13	5.32
Health Home Capitation & Incentive	0.67	0.55	0.45	1.04	0.68
Provider Enhancement Expense - Prop. 56	7.30	23.89	26.09	19.14	19.13
Provider Enhancement Expense - GEMT	1.29	2.37	1.57	1.58	1.70
Provider COVID-19 Expenes	0.00	0.00	0.00	2.22	0.56
TOTAL OTHER MEDICAL	22.72	40.08	42.35	34.92	35.04
PHARMACY SERVICES					
RX - Drugs & OTC	36.67	33.88	36.57	31.43	34.49
RX - HEP-C	1.09	1.33	1.87	1.47	1.43
Rx - DME	2.80	2.31	2.69	2.56	2.58
RX - Pharmacy Rebates	(0.54)	(0.54)	(0.14)	(0.54)	(0.44)
TOTAL PHARMACY SERVICES	40.02	36.98	40.99	34.92	38.06
PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	2.00	2.05	2.00
HOSPITAL DIRECTED PAYMENTS	45.25	45.56	45.70	46.79	45.61
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.47	0.24	0.17	0.15	0.26
NON-CLAIMS EXPENSE ADJUSTMENT	0.23	0.93	(6.30)	0.01	(1.29)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(0.03)	(10.53)	(17.90)	(7.08)
Total Medical Costs	295.44	299.13	293.50	268.88	288.87

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED APRIL 30, 2020

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
399,347	314,514	(84,833)	110 - Executive	1,397,454	1,258,056	(139,398)
183,136	198,815	15,679	210 - Accounting	710,795	793,266	82,471
162,587	273,115	110,528	220 - Management Information Systems	1,178,420	1,092,462	(85,958)
22,767	13,054	(9,713)	221 - Business Intelligence	55,117	52,216	(2,901)
292,897	281,949	(10,948)	222 - Enterprise Development	992,130	1,127,801	135,671
274,546	415,723	141,177	225 - Infrastructure	1,183,391	1,662,895	479,504
543,105	559,702	16,597	230 - Claims	2,091,657	2,231,548	139,891
100,673	114,151	13,478	240 - Project Management	368,527	456,604	88,077
112,873	100,365	(12,508)	310 - Health Services - Utilization Management	414,637	394,882	(19,755)
54,448	55,092	644	311 - Health Services - Quality Improvement	150,159	220,365	70,206
61	67	6	312 - Health Services - Education	121	417	296
141,729	142,458	729	313- Pharmacy	595,255	575,355	(19,900)
(14,707)	-	14,707	314 - Health Homes	659	-	(659)
19,456	16,573	(2,883)	315 - Case Management	68,084	66,291	(1,793)
25,749	23,131	(2,618)	616 - Disease Management	87,876	92,525	4,649
307,450	313,552	6,102	320 - Provider Network Management	1,109,053	1,254,208	145,155
563,492	563,878	386	330 - Member Services	2,075,950	2,255,512	179,562
449,175	528,116	78,941	340 - Corporate Services	1,859,338	2,105,464	246,126
87,154	67,176	(19,978)	360 - Audit & Investigative Services	312,344	268,704	(43,640)
134,979	54,315	(80,664)	410 - Advertising Media	230,091	217,260	(12,831)
36,382	68,457	32,075	420 - Sales/Marketing/Public Relations	159,306	273,828	114,522
228,494	220,076	(8,418)	510 - Human Resourses	883,009	907,736	24,727
4,125,793	4,324,278	198,485	Total Administrative Expenses	15,923,373	17,307,395	1,384,022

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED APRIL 30, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	YEAR TO DATE 2020
110 - Executive	339,242	293,820	365,045	399,347	1,397,454
210 - Accounting	173,904	178,919	174,836	183,136	710,795
220 - Management Information Systems (MIS)	381,511	295,419	338,903	162,587	1,178,420
221 - Business Intelligence	-	11,648	20,702	22,767	55,117
222 - Enterprise Development	211,299	225,855	262,079	292,897	992,130
225 - Infrastructure	359,015	241,507	308,323	274,546	1,183,391
230 - Claims	556,280	498,960	493,312	543,105	2,091,657
240 - Project Management	85,191	84,709	97,954	100,673	368,527
310 - Health Services - Utilization Management	98,529	107,809	95,426	112,873	414,637
311 - Health Services - Quality Improvement	10,824	41,860	43,027	54,448	150,159
312 - Health Services - Education	-	60	-	61	121
313- Pharmacy	156,947	147,980	148,599	141,729	595,255
314 - Health Homes	222	15,046	98	(14,707)	659
315 - Case Management	17,349	15,664	15,615	19,456	68,084
616 - Disease Management	20,836	20,068	21,223	25,749	87,876
320 - Provider Network Management	256,860	252,748	291,995	307,450	1,109,053
330 - Member Services	530,714	484,954	496,790	563,492	2,075,950
340 - Corporate Services	439,804	482,885	487,474	449,175	1,859,338
360 - Audit & Investigative Services	81,923	83,979	59,288	87,154	312,344
410 - Advertising Media	9,439	47,590	38,083	134,979	230,091
420 - Sales/Marketing/Public Relations	44,020	35,104	43,800	36,382	159,306
510 - Human Resourses	285,952	186,648	181,915	228,494	883,009
Total Department Expenses	4,059,861	3,753,232	3,984,487	4,125,793	15,923,373
ADMINISTRATIVE EXPENSE ADJUSTMENT	-	-	-	-	-
Total Administrative Expenses	4,059,861	3,753,232	3,984,487	4,125,793	15,923,373

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF APRIL 30, 2020

ASSETS	APRIL 2020	MARCH 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,121,924	$ 1,121,924	-
Interest Receivable	9,720	7,920	1,800
Prepaid Expenses & Other Current Assets	1,667	2,501	(834)
TOTAL CURRENT ASSETS	$ 1,133,311	$ 1,132,345	$ 966
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,128,885	1,128,885	-
Increase (Decrease) in Net Position - Current Year	4,426	3,460	966
Total Net Position	$ 1,133,311	$ 1,132,345	$ 966
TOTAL LIABILITIES AND NET POSITION	$ 1,133,311	$ 1,132,345	$ 966

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED APRIL 30, 2020

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE		YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET	YEAR-TO-DATE VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	
			REVENUES			
-	-	-	Premium	-	-	
1,800	-	1,800	Interest	9,720	-	9,72
-	-	-	Other Investment Income	(1,961)	-	(1,96
1,800	-	1,800	TOTAL REVENUES	7,759	-	7,75
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	
-	-	-	Total Medical Costs	-	-	
1,800	-	1,800	GROSS MARGIN	7,759	-	7,75
			Administrative			
834	-	(834)	Management Fee Expense and Other Admin Exp	3,333	-	(3,33
834	-	(834)	Total Administrative Expenses	3,333	-	(3,33
834	-	(834)	TOTAL EXPENSES	3,333	-	(3,33
966	-	966	OPERATING INCOME (LOSS)	4,426	-	4,42
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	
966	-	966	NET INCREASE (DECREASE) IN NET POSITION	4,426	-	4,42
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0
46%	0%	-46%	ADMINISTRATIVE EXPENSE RATIO	43%	0%	-43

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2020 MEMBER MONTHS	JAN'20	FEB'20	MAR'20	APR'20	MAY'20	JUN'20	JUL'20	AUG'20	SEP'20	OCT'20	NOV'20	DEC'20
ADULT AND FAMILY													
ADULT	**176,168**	43,519	43,767	44,480	44,402	0	0	0	0	0	0	0	0
CHILD	**492,580**	122,496	123,040	123,357	123,687	0	0	0	0	0	0	0	0
SUB-TOTAL ADULT & FAMILY	**668,748**	**166,015**	**166,807**	**167,837**	**168,089**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
OTHER MEMBERS													
BCCTP-TOBACCO SETTLEMENT	**105**	26	28	26	25	0	0	0	0	0	0	0	0
DUALS													
PARTIAL DUALS - FAMILY	**1,778**	432	432	453	461	0	0	0	0	0	0	0	0
PARTIAL DUALS - CHILD	**4**	1	1	1	1	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	**6**	1	1	2	2	0	0	0	0	0	0	0	0
SPD FULL DUALS	**27,192**	6,599	6,759	6,911	6,923	0	0	0	0	0	0	0	0
SUB-TOTAL DUALS	**28,980**	**7,033**	**7,193**	**7,367**	**7,387**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FAMILY & OTHER	**697,833**	**173,074**	**174,028**	**175,230**	**175,501**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SPD													
SPD (AGED AND DISABLED)	**62,840**	15,667	15,493	15,688	15,992	0	0	0	0	0	0	0	0
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	**241,304**	59,583	60,197	60,360	61,164	0	0	0	0	0	0	0	0
ACA Expansion Duals	**1,172**	316	289	274	293	0	0	0	0	0	0	0	0
SUB-TOTAL MED-CAL EXPANSION	**242,476**	**59,899**	**60,486**	**60,634**	**61,457**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL KAISER	**36,548**	**8,992**	**9,125**	**9,169**	**9,262**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL MEDI-CAL MEMBERS	**1,039,697**	**257,632**	**259,132**	**260,721**	**262,212**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T4290	S.C. ANDERSON, INC.	1,518,507.33	1,555,542.74	NEW BUILDING - RETAINER	CAPITAL PROJECT - NEW
T1045	KAISER FOUNDATION HEALTH - HMO	447,760.50	894,175.71	FEB. 2020 HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T2726	DST PHARMACY SOLUTIONS, INC.*****	257,247.19	257,247.19	DEC.'19-JAN.'20 PHARMACY CLAIMS	PHARM
T4350	COMPUTER ENTERPRISE INC.	219,685.31	377,722.20	NOV.2019, JAN.2020 PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	CAPITAL PROJECTS IN PROCESS/ MIS
T4237	FLUIDEDGE CONSULTING, INC.	178,709.70	296,325.76	DEC..2019, JAN.2020 & FEB.2020 PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL	VARIOUS
T4483	INFUSION AND CLINICAL SERVICES, INC.*****	169,990.15	169,990.15	OCT.- DEC. 2019HEALTH HOMES GRANT	COMMUNITY GRANT
T5015	SENTINEL ENGINEERING*****	74,963.34	74,963.34	JUNIPER NETWORKS-FIBER OPTICS	MIS INFRASTRUCTURE
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	64,037.67	126,297.02	FEB. 2020 VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T2918	STINSON'S*****	62,727.78	71,129.52	JAN. 2019 OFFIICE SUPPLIES AND ADDITIONAL CUBICLES	VARIOUS
T4982	NGC US, LLC	45,000.00	221,510.99	FEB. 2020 PREFUND HEALTH HOMES INCENTIVES	HEALTH HOMES
T2167	PG&E	42,447.95	59,639.66	12/17/19-1/15/20 & 1/17/20-2/18/20 USAGE/UTILITIES	CORPORATE SERVICES
T4699	ZeOMEGA, INC.*****	40,519.13	42,646.52	NOV. 2019- JAN. 2019 PROFESSIONAL SERVICES AND TRAVEL EXP.	UM
T4582	HEALTHX, INC.*****	40,376.00	80,752.00	FEB. 2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T2584	UNITED STATES POSTAL SVC.-HASLER*****	40,000.00	40,000.00	2020 1ST POSTAGE (METER) FUND	CORPORATE SERVICES

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Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T5109	RAND EMPLOYMENT SOLUTIONS	34,554.57	64,417.30	JAN.-FEB. 2020 TEMPORARY HELP - 4 MS, 1 MIS, 1	VARIOUS
T4193	STRIA LLC	30,361.68	73,110.76	JAN.-FEB. 2020 OCR SERVICES AND	CLAIMS
T4967	ADMINISTRATIVE SOLUTIONS, INC.*****	25,345.02	35,135.58	FEB. 2020 FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T4460	PAYSPAN, INC	22,275.18	35,937.38	JAN. 2020 ELECTRONIC CLAIMS/PAYMENTS & PPD REIMBURSEMENTS	FINANCE
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	21,450.00	42,250.00	JAN. 2020 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T4546	LEVEL 3 COMMUNICATIONS, LLC*****	21,098.68	21,169.97	JAN. 2020 DISASTER RECOVERY, INTERNET, LONG DISTANCE CALLS	MIS INFRASTRUCTURE
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	20,679.10	24,232.65	JAN. 2020 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4733	UNITED STAFFING ASSOCIATES	19,995.98	56,146.41	JAN. 2020 TEMPORARY HELP - 3 MS, 1 HR, 1 CS, 1	VARIOUS
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	19,497.07	42,284.97	JAN. 2020 TEMPORARY HELP - 2 MIS, 1 HE	VARIOUS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	17,715.88	38,267.72	JAN. 2020 ONSITE SECURITY	CORPORATE SERVICES
T4785	COMMGAP	17,145.00	43,385.00	JAN. 2020 INTERPRETATION SERVICES	HEALTH EDUCATION
T3011	OFFICE ALLY, INC.	16,811.50	31,228.25	JAN. 2020 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC.	14,608.61	235,758.22	NEW BUILDING FURNITURE (LIVE STREAM VIA IP)	CAPITAL PROJECT - NEW BUILDING
T4657	DAPONDE SIMPSON ROWE PC	13,869.50	28,238.50	DEC. 2019 LEGAL SERVICES	PROVIDER RELATIONS
T1861	CERIDIAN HCM, INC.	13,252.84	27,289.87	FEB. 2020 MONTHLY SUBSCRIPTION FEES/ DEC. 2019 PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT IMPLEMENTATION	HUMAN RESOURCES

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Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T4396	KAISER FOUNDATION HEALTH-DHMO	12,775.06	25,550.12	FEB. 2020 DHMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T5145	CCS ENGINEERING FRESNO INC.,	12,691.68	23,883.36	FEB. 2020 JANITORIAL SERVICES	CORPORATE SERVICES
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	12,474.38	24,921.86	JAN. 2020 ACCIDENT & CRITICAL ILLNESS EMPLOYEE PREMIUM	VARIOUS
T2458	HEALTHCARE FINANCIAL, INC.	12,000.00	80,000.00	JAN. 2020 PROFESSIONAL SERVICES	ADMINISTRATION
T5236	BEST BEST & KRIEGER LLP*****	11,952.87	11,952.87	DEC.2019-JAN.2020 LEGAL SERVICES	ADMINISTRATION
T1180	LANGUAGE LINE SERVICES INC.*****	11,758.35	11,758.35	DEC. 2019-JAN.2020 INTERPRETATION SERVICES	MEMBER SERVICES
T4696	ZNALYTICS, LLC	11,520.00	20,880.00	JAN. 2020 PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE
T5185	HOUSING AUTHORITY COUNTY OF KERN	11,000.00	34,700.00	NOV. 2019 HOUSING AUTHORITY GRANT	UM
T4389	EXACT STAFF, INC.	10,368.70	24,516.10	JAN. & FEB. 2020 TEMPORARY HELP- 3 MS	VARIOUS
		3,617,173.70			
	TOTAL VENDORS OVER $10,000	3,617,173.70			
	TOTAL VENDORS UNDER $10,000	228,360.77			
	TOTAL VENDOR EXPENSES- FEBRUARY	$ 3,845,534.47			

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

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Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4290	S.C. ANDERSON, INC.*****	1,555,542.74	NEW BUILDING RETAINER	CAPITAL PROJECT - NEW BUILDING
T1045	KAISER FOUNDATION HEALTH - HMO*****	894,175.71	HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD*****	445,991.96	HEALTH HOMES GRANT	COMMUNITY GRANTS
T4350	COMPUTER ENTERPRISE INC.*****	377,722.20	PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	CAPITAL PROJECTS IN PROCESS/ MIS
T5005	CRAYON SOFTWARE EXPERTS LLC*****	321,430.55	2019 TRUE UP MAINTENANCE & 2020 ESD ANNUAL SUPPORT	MIS INFRASTRUCTURE
T4237	FLUIDEDGE CONSULTING, INC.*****	296,325.76	PROFESSIONAL SERVICES / CONSULTING SERVICES &	VARIOUS
T2726	DST PHARMACY SOLUTIONS, INC.*****	257,247.19	PHARMACY CLAIMS	PHARM
T5111	ENTISYS 360*****	255,400.18	HARDWARE- 2 NUTANIX PLATFORM WITH SUPPORT	CAPITAL PROJECT
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC.****	235,758.22	NEW BUILDING FURNITURE (LIVE STREAM VIA IP)	CAPITAL PROJECT - NEW BUILDING
T4982	NGC US, LLC*****	221,510.99	PREFUND HEALTH HOMES INCENTIVES & HE MEMBER INCENTIVES	VARIOUS
T4483	INFUSION AND CLINICAL SERVICES, INC.******	169,990.15	HEALTH HOMES GRANT	COMMUNITY GRANT
T2488	THE LINCOLN NATIONAL LIFE INSURANCE******	126,297.02	VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T4391	OMNI FAMILY HEALTH*****	116,210.53	HEALTH HOMES GRANT	COMMUNITY GRANT
T5217	AMERICAN TILE & BRICK VENEER, INC.*****	89,000.00	FINAL PAYMENT FOR BRICK WALL	BUILDING IMPROVEMENT
T4582	HEALTHX, INC.*****	80,752.00	2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T2458	HEALTHCARE FINANCIAL, INC.*****	80,000.00	PROFESSIONAL SERVICES	ADMINISTRATION

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Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5015	SENTINEL ENGINEERING*****	74,963.34	JUNIPER NETWORKS - FIBER OPTICS	MIS INFRASTRUCTURE
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS*****	73,500.00	2020 ANNUAL DUES, 2019 SALARY SURVEY, & LEADERSHIP FEES	VARIOUS
T4193	STRIA LLC*****	73,110.76	OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T2918	STINSON'S*****	71,129.52	OFFIICE SUPPLIES AND ADDITIONAL CUBICLES	VARIOUS
T5109	RAND EMPLOYMENT SOLUTIONS*****	64,417.30	TEMPORARY HELP & DIRECT HIRE SERVICES	VARIOUS
T1408	DELL MARKETING L.P.*****	60,491.57	HARDWARE & CUMPUTER EQUIPMENT	MIS INFRASTRUCTURE
T2167	PG&E******	59,639.66	USAGE/UTILITIES	CORPORATE SERVICES
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	57,389.74	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4733	UNITED STAFFING ASSOCIATES*****	56,146.41	TEMPORARY HELP	VARIOUS
T4963	LINKED CORPORATION*****	52,000.00	ONLINE TRAINING FOR EMPLOYEES	HUMAN RESOURCES
T3001	MERCER*****	47,500.00	CONSULTING SERVICES	HUMAN RESOURCES
T4785	COMMGAP*****	43,385.00	INTERPRETATION SERVICES	HEALTH EDUCATION
T5026	TEL-TEC SECURITY SYSTEMS*****	42,648.47	ADDITIONAL SECURITY SYSTEM & LABOR	CORPORATE SERVICES
T4699	ZeOMEGA, INC.*****	42,646.52	PROFESSIONAL SERVICES AND TRAVEL EXP.	UM
T1189	APPLE ONE INC, EMPLOYMENT SERVICES*****	42,284.97	TEMPORARY HELP	VARIOUS
T5076	MERIDIAN HEALTH SYSTEMS, P.C.*****	42,250.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T2584	UNITED STATES POSTAL SVC.-HASLER*****	40,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES

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Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4501	ALLIED UNIVERSAL SECURITY SERVICES*****	38,267.72	ONSITE SECURITY	CORPORATE SERVICES
T4460	PAYSPAN, INC*****	35,937.38	ELECTRONIC CLAIMS/PAYMENTS & PPD REIMBURSEMENTS	FINANCE
T4967	ADMINISTRATIVE SOLUTIONS, INC.*****	35,135.58	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T5185	HOUSING AUTHORITY COUNTY OF KERN*****	34,700.00	HOUSING AUTHORITY GRANT	UM
T5227	RIDGECREST MEDICAL TRANSPORTATION*****	32,935.41	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS*****	32,512.00	2020 ANNUAL DUES & CONFERENCE REGISTRATION	VARIOUS
T3011	OFFICE ALLY, INC.*****	31,228.25	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T2969	AMERICAN BUSINESS MACHINES INC****	29,727.24	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T4657	DAPONDE SIMPSON ROWE PC*****	28,238.50	LEGAL SERVICES	PROVIDER RELATIONS
T1861	CERIDIAN HCM, INC.*****	27,289.87	MONTHLY SUBSCRIPTION FEES,PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT IMPLEMENTATION & AMENDMENTS	HUMAN RESOURCES
T1272	COFFEY COMMUNICATIONS INC.*****	21,315.61	MEMBER NEWSLETTER/ WEBSITE IMPLEMENTATION	HEALTH EDUCATION/ MIS INFRASTRUCTURE
T4396	KAISER FOUNDATION HEALTH-DHMO*****	25,550.12	EMPLOYEE HEALTH BENEFITS - DHMO	VARIOUS
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM ****	24,921.86	EMPLOYEE PREMIUM - ACCIDENT & CRITICAL ILLNESS	VARIOUS
T4389	EXACT STAFF, INC.*****	24,516.10	TEMPORARY HELP	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC*****	24,232.65	EDI CLAIM PROCESSING	CLAIMS / MIS
T5145	CCS ENGINEERING FRESNO INC.,*****	23,883.36	JANITORIAL SERVICES	CORPORATE SERVICES
T3449	CDW GOVERNMENT*****	22,908.48	HARDWARE& COMPUTER SUPPLIES	VARIOUS

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Amounts over $10,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2232	DLT SOLUTIONS, LLC*****	22,499.80	SQL LICENSES	MIS INFRASTRUCTURE
T4546	LEVEL 3 COMMUNICATIONS, LLC*****	21,169.97	DISASTER RECOVERY, INTERNET, LONG DISTANCE CALLS	MIS INFRASTRUCTURE
T4696	ZNALYTICS, LLC*****	20,880.00	PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE MANAGEMENT
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.*****	20,313.35	PROFESSIONAL SERVICES	VARIOUS
T5132	TIME WARNER CABLE LLC*****	19,965.34	INTERNET SERVICES	MIS INFRASTRUCTURE
T2413	TREK IMAGING INC*****	19,923.27	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T4873	L5 HEALTHCARE SOLUTIONS, INC.*****	19,414.47	LICENSE AND SUPPORT FEES - CLAIMS AUDIT TOOL	MIS INFRASTRUCTURE
T2955	DELTA ELECTRIC INC.*****	18,600.00	BUILDING MAINTENANCE	CORPORATE SERVICES
T4521	PAYSCALE, INC.*****	16,000.00	COMPENSATION STUDY AND SALARY ANALYTICS	HUMAN RESOURCES
T5121	TPx COMMUNICATIONS*****	14,160.04	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T2562	CACTUS SOFTWARE LLC*****	14,131.31	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T4563	SPH ANALYTICS*****	13,782.00	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T4165	SHI INTERNATIONAL *****	13,367.26	VEEAM MANAGEMENT SOFTWARE	MIS INFRASTRUCTURE
T5240	ACE EYECARE INC*****	13,172.83	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5236	BEST BEST & KRIEGER LLP*****	11,952.87	LEGAL SERVICES	ADMINISTRATION
T1180	LANGUAGE LINE SERVICES INC.*****	11,758.35	INTERPRETATION SERVICES	MEMBER SERVICES

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2686	ALLIANT INSURANCE SERVICES INC.*****	11,183.88	PROPERTY AND LIABILITY COVERAGE UPDATES	ADMINISTRATION
T4503	VISION SERVICE PLAN*****	10,497.21	EMPLOYEE HEALTH BENEFITS	VARIOUS
T2840	ATALASOFT, INC*****	10,254.00	DOT IMAGING RENEWAL	MIS INFRASTRUCTURE
T2441	LAURA J. BREZISKI*****	10,100.00	MARKETING MATERIALS	MARKETING
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK*****	10,000.00	2019 AUDIT FEES	ADMINISTRATION
		7,283,284.54		
	TOTAL VENDORS OVER $10,000	7,283,284.54		
	TOTAL VENDORS UNDER $10,000	409,836.72		
	TOTAL VENDOR EXPENSES- FEBRUARY	$ 7,693,121.26		

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

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Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T4391	OMNI FAMILY HEALTH	1,067,027.00	1,183,237.53	2019-2020 PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T1045	KAISER FOUNDATION HEALTH - HMO	910,284.77	1,804,460.48	MAR. & APR. 2020 HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T4350	COMPUTER ENTERPRISE INC.	153,985.35	531,707.55	DEC.'19-FEB.'20 PROFESSIONAL SERVICES/CONSULTING SERVICES & TRAVEL EXP.	CAPITAL PROJECTS IN PROCESS/MIS
T2726	DST PHARMACY SOLUTIONS, INC.	127,515.49	384,762.68	FEB.2020 PHARMACY CLAIMS	PHARMACY
T4237	FLUIDEDGE CONSULTING, INC.	103,550.73	399,876.49	FEB. & MAR.2020 PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	VARIOUS
T4982	NGC US, LLC	100,000.00	321,510.99	FEB. 2020 PREFUND HEALTH HOMES, HEALTH ED INCENTIVES	HEALTH HOMES/ HEALTH ED
T4038	POLYCLINIC MEDICAL CENTER, INC****	68,658.81	68,658.81	OCT.'19- FEB.'20 PROVIDER QUALITY GRANT	COMMUNITY GRANTS
T5217	AMERICAN TILE & BRICK VENEER, INC.	68,500.00	157,500.00	FINAL PAYMENT - NEW BUILDING- EXTERIOR ADHERED MASONRY VENEER	BUILDING IMPROVEMENTS
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	64,072.68	190,369.70	MAR. 2020 VOLUNTARY LIFE, AD&D, DENTAL INSURANCE PREMIUM	VARIOUS
T4165	SHI INTERNATIONAL CO.	61,155.04	74,522.30	ANNUAL SOFTWARE MAINT. & 150 STANDING WORKING STATIONS	CAPITAL PROJECT
T4193	STRIA LLC	53,678.22	126,788.98	FEB. 2020 OCR SERVICES AND PROFESSIONAL	CLAIMS
T4265	SIERRA SCHOOL EQUIPMENT COMPANY	46,316.93	48,924.78	(3) OVERSIDED HIGH CHAIRS & (100) STANDARD SIZE HIGH BACK CHAIR	CORPORATE SERVICES
T2458	HEALTHCARE FINANCIAL, INC.	42,000.00	122,000.00	FEB. 2020 PROFESSIONAL SERVICES	ADMINISTRATION

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Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T4582	HEALTHX, INC.	40,376.00	121,128.00	MAR. 2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T4396	KAISER FOUNDATION HEALTH-DHMO	25,550.12	51,100.24	MAR.& APR. 2020 DHMO EMPLOYEE PREMIUM	VARIOUS
T5109	RAND EMPLOYMENT SOLUTIONS	33,460.44	97,877.74	FEB.& MAR. 2020 TEMP SERVICES- 5 MS, 1 HED	VARIOUS
T2584	UNITED STATES POSTAL SVC.-HASLER	30,000.00	70,000.00	2020 2ND POSTAGE (METER) FUND	CORPORATE SERVICES
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	26,500.98	50,733.63	JAN.& FEB. 2020 EDI CLAIMS PROCESSING	CLAIMS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	23,834.57	62,102.29	FEB. & MAR. 2020 ONSITE SECURITY	CORPORATE SERVICES
T4733	UNITED STAFFING ASSOCIATES	23,618.73	79,765.14	FEB.-MAR. 2020 TEMPORARY HELP - 3 MS, 1 HR, 1 CS, 1	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	22,657.01	80,046.75	FEB. 2020 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4785	COMMGAP	19,765.00	63,150.00	FEB. 2020 INTERPRETATION SERVICES	HEALTH EDUCATION
T2918	STINSON'S	17,689.21	88,818.73	FEB. 2020 OFFICE SUPPLIES,(6) CONFERENCE TABLES, OFFICE FURNITURE, CABINET FOR TRAINING &	VARIOUS
T2167	PG&E	17,496.92	77,136.58	2/18/20-3/17/20 USAGE/UTILITIES	CORPORATE SERVICES
T3011	OFFICE ALLY, INC.	17,440.25	48,668.50	FEB. 2020 EDI CLAIM PROCESSING	CLAIMS
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	16,770.00	59,020.00	FEB. 2020 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT

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Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T4652	BAKERSFIELD SYMPHONY ORCHESTRA****	16,600.00	16,600.00	FEB. & MAR. 2020 BSO NEXT SPONSORSHIP	COMMUNITY ACTIVITIES
T4967	ADMINISTRATIVE SOLUTIONS, INC.	16,435.97	51,571.55	MAR. FSA EMPLOYEE PREMIUM	VARIOUS
T4460	PAYSPAN, INC	16,221.83	52,159.21	FEB. 2020 ELECTRIC CLAIMS/PAYMENTS	FINANCE
T2955	DELTA ELECTRIC INC.	15,510.00	34,110.00	FEB.-MAR. '20 BUILDING ELECTRICAL UPGRADES	CORPORATE SERVICE
T4657	DAPONDE SIMPSON ROWE PC	14,669.00	42,907.50	JAN. & FEB. 2020 LEGAL SERVICES	PROVIDER RELATIONS/ ADMIN.
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	14,000.00	24,000.00	2019 YEAR END FINANCIAL AUDIT	FINANACE
T1861	CERIDIAN HCM, INC.	13,751.49	41,041.36	MAR. 2020 MONTHLY SUBSCRIPTION FEES/ JAN. 2020 PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT IMPLEMENTATION & AMENDMENTS	HUMAN RESOURCE
T4696	ZNALYTICS, LLC	13,680.00	34,560.00	FEB. 2020 PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE MANAGEMENT
T1022	UNUM LIFE INSURANCE CO.	13,628.80	23,623.20	MAR.& APR. 2020 EMPLOYEE PREMIUM	VARIOUS
T5132	TIME WARNER CABLE LLC	13,159.35	33,124.69	MAR. 2020 INTERNET SERVICES	MIS
T2961	SOLUTION BENCH, LLC****	12,600.00	12,600.00	SCANFINITY - ANNUAL SUPPORT	MIS
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	12,518.22	37,440.08	FEB.2020 ACCIDENT & CRITICAL ILLNESS EMPLOYEE PREMIUM	VARIOUS

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March AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T4052	RAHUL SHARMA****	12,184.40	12,184.40	JAN. & FEB. 2020 PROVIDER QUALITY GRANT	COMMUNITY GRANTS
T5246	ACCELEBRATE, INC.****	12,120.15	12,120.15	ASP.NET CORE 3 DEVELOPMENT TRAINING	BUSINESS INTELLIGENCE
T5258	GOOD SAMARITAN HOSPITAL, LLC****	11,605.00	11,605.00	OCT.-DEC 2019 PROVIDER QUALITY GRANT	PROVIDER QUALITY GRANT
T5145	CCS ENGINEERING FRESNO INC.,	11,491.68	35,375.04	MARCH 2020 JANITORIAL SERVICES & ADDITIONAL 2019 SERVICES	CORPORATE SERVICES
T1408	DELL MARKETING L.P.	11,163.13	71,654.70	COMPUTER EQUIPMENT - (57) 23" MONITORS	CAPITAL PROJECT
T4503	VISION SERVICE PLAN	10,657.49	21,154.70	MAR. & APR. 2020 EMPLOYEE PREMIUM	VARIOUS
		3,423,900.76			
	TOTAL VENDORS OVER $10,000	3,423,900.76			
	TOTAL VENDORS UNDER $10,000	308,561.97			
	TOTAL VENDOR EXPENSES- MARCH	$ 3,732,462.73			

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

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	1,804,460.48	HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T4290	S.C. ANDERSON, INC.	1,555,542.74	NEW BUILDING RETAINER	CAPITAL PROJECT - NEW BUILDING
T4391	OMNI FAMILY HEALTH	1,183,237.53	HEALTH HOMES AND PROVIDER QUAILITY CARE GRANT	COMMUNITY GRANTS
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	445,991.96	HEALTH HOMES GRANT	COMMUNITY GRANTS
T4350	COMPUTER ENTERPRISE INC.	531,707.55	PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	CAPITAL PROJECTS IN PROCESS/ MIS
T4237	FLUIDEDGE CONSULTING, INC.	399,876.49	PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	VARIOUS
T2726	DST PHARMACY SOLUTIONS, INC.	384,762.68	PHARMACY CLAIMS	PHARM
T4982	NGC US, LLC	321,510.99	PREFUND HEALTH HOMES INCENTIVES & HE MEMBER INCENTIVES	VARIOUS
T5005	CRAYON SOFTWARE EXPERTS LLC	321,430.55	2019 TRUE UP MAINTENANCE & 2020 ESD ANNUAL SUPPORT	MIS INFRASTRUCTURE
T5111	ENTISYS 360	255,400.18	HARDWARE- 2 NUTANIX PLATFORM WITH SUPPORT	CAPITAL PROJECT
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC.	235,758.22	NEW BUILDING FURNITURE (LIVE STREAM VIA IP)	CAPITAL PROJECT - NEW BUILDING
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	190,369.70	VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T4483	INFUSION AND CLINICAL SERVICES, INC.	169,990.15	HEALTH HOMES GRANT	COMMUNITY GRANT

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year- to-Date	Description	Department
T5217	AMERICAN TILE & BRICK VENEER, INC.	157,500.00	FINAL PAYMENT FOR BRICK WALL	BUILDING IMPROVEMENT
T4193	STRIA LLC	126,788.98	OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T2458	HEALTHCARE FINANCIAL, INC.	122,000.00	PROFESSIONAL SERVICES	ADMINISTRATION
T4582	HEALTHX, INC.	121,128.00	2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5109	RAND EMPLOYMENT SOLUTIONS	97,877.74	TEMPORARY HELP	VARIOUS
T2918	STINSON'S	88,818.73	2020 OFFICE SUPPLIES, CONFERENCE TABLES, OFFICE FURNITURE, CABINET FOR TRAINING & DEVELOPMENT ROOM	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	80,046.75	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4733	UNITED STAFFING ASSOCIATES	79,765.14	TEMPORARY HELP	VARIOUS
T2167	PG&E	77,136.58	USAGE/UTILITIES	CORPORATE SERVICES
T5015	SENTINEL ENGINEERING	74,963.34	JUNIPER NETWORKS - FIBER OPTICS	MIS INFRASTRUCTURE
T4165	SHI INTERNATIONAL CO.	74,522.30	STANDING WORKING STATIONS & LICENSES FEES	VARIOUS
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	73,500.00	2020 ANNUAL DUES, 2019 SALARY SURVEY, & LEADERSHIP FEES	VARIOUS
T1408	DELL MARKETING L.P.	71,654.70	HARDWARE & CUMPUTER EQUIPMENT	MIS INFRASTRUCTURE
T2584	UNITED STATES POSTAL SVC.-HASLER	70,000.00	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
T4038	POLYCLINIC MEDICAL CENTER, INC****	68,658.81	HEALTH HOME AND PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4785	COMMGAP	63,150.00	INTERPRETATION SERVICES	HEALTH EDUCATION
T4501	ALLIED UNIVERSAL SECURITY SERVICES	62,102.29	ONSITE SECURITY	CORPORATE SERVICES
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	59,020.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	52,282.77	TEMPORARY HELP	VARIOUS
T4460	PAYSPAN, INC	52,159.21	ELECTRONIC CLAIMS/PAYMENTS & PPD REIMBURSEMENTS	FINANCE
T4963	LINKEDIN CORPORATION	52,000.00	ONLINE TRAINING FOR EMPLOYEES	HUMAN RESOURCES
T4967	ADMINISTRATIVE SOLUTIONS, INC.	51,571.55	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T4396	KAISER FOUNDATION HEALTH-DHMO	51,100.24	EMPLOYEE HEALTH BENEFITS - DHMO	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	50,733.63	EDI CLAIM PROCESSING	CLAIMS / MIS
T4265	SIERRA SCHOOL EQUIPMENT COMPANY****	48,924.78	NEW FURNITURE & OFFICE CHAIRS FOR EMOPLYEES	CORPORATE SERVICES
T3011	OFFICE ALLY, INC.	48,668.50	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4699	ZeOMEGA, INC.	48,646.52	PROFESSIONAL SERVICES AND TRAVEL EXP.	UM
T3001	MERCER	47,500.00	CONSULTING SERVICES	HUMAN RESOURCES
T5026	TEL-TEC SECURITY SYSTEMS	44,732.28	ADDITIONAL SECURITY SYSTEM & LABOR	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
T4657	DAPONDE SIMPSON ROWE PC	42,907.50	LEGAL SERVICES	PROVIDER RELATIONS
T1861	CERIDIAN HCM, INC.	41,041.36	MONTHLY SUBSCRIPTION FEES,PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT IMPLEMENTATION & AMENDMENTS	HUMAN RESOURCES
T5227	RIDGECREST MEDICAL TRANSPORTATION	40,932.81	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T2969	AMERICAN BUSINESS MACHINES INC	39,380.07	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	37,440.08	EMPLOYEE PREMIUM - ACCIDENT & CRITICAL ILLNESS	VARIOUS
T5145	CCS ENGINEERING FRESNO INC.,	35,375.04	JANITORIAL SERVICES	CORPORATE SERVICES
T5185	HOUSING AUTHORITY COUNTY OF KERN	34,700.00	HOUSING AUTHORITY GRANT	UM
T4696	ZNALYTICS, LLC	34,560.00	PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE MANAGEMENT
T2955	DELTA ELECTRIC INC.	34,110.00	BUILDING MAINTENANCE	CORPORATE SERVICES
T5132	TIME WARNER CABLE LLC	33,124.69	INTERNET SERVICES	MIS INFRASTRUCTURE
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	32,512.00	2020 ANNUAL DUES & CONFERENCE REGISTRATION	VARIOUS
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	30,248.95	PROFESSIONAL SERVICES	VARIOUS
T4389	EXACT STAFF, INC.	28,661.72	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
T1272	COFFEY COMMUNICATIONS INC.	21,315.61	MEMBER NEWSLETTER/ WEBSITE IMPLEMENTATION	HEALTH EDUCATION/ MIS INFRASTRUCTURE
T3449	CDW GOVERNMENT	24,209.40	HARDWARE& COMPUTER SUPPLIES	VARIOUS
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	24,000.00	2019 AUDIT FEES	ADMINISTRATION
T1022	UNUM LIFE INSURANCE CO.****	23,623.20	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T2413	TREK IMAGING INC	22,660.48	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T2232	DLT SOLUTIONS, LLC	22,499.80	SQL LICENSES	MIS INFRASTRUCTURE
T4546	LEVEL 3 COMMUNICATIONS, LLC	21,169.97	DISASTER RECOVERY, INTERNET, LONG DISTANCE CALLS	MIS INFRASTRUCTURE
T4503	VISION SERVICE PLAN	21,154.70	EMPLOYEE HEALTH BENEFITS	VARIOUS
T5121	TPx COMMUNICATIONS	20,896.67	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T1180	LANGUAGE LINE SERVICES INC.	19,741.63	INTERPRETATION SERVICES	MEMBER SERVICES
T4873	L5 HEALTHCARE SOLUTIONS, INC.	19,414.47	LICENSE AND SUPPORT FEES - CLAIMS AUDIT TOOL	MIS INFRASTRUCTURE
T1128	HALL LETTER SHOP, INC.****	18,050.26	NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, CLINICAL CARE MANUAL FOR HH, NEW MEMBER PKT.	VARIOUS
T5240	ACE EYECARE INC	18,000.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year- to-Date	Description	Department
T4652	BAKERSFIELD SYMPHONY ORCHESTRA****	16,600.00	COMMUNITY SPONSORSHIP	ADMINISTRATION
T4521	PAYSCALE, INC.	16,000.00	COMPENSATION STUDY AND SALARY ANALYTICS	HUMAN RESOURCES
T3084	KERN COUNTY-COUNTY COUNSEL****	15,662.11	LEGAL FEES	ADMINISTRATION
T5236	BEST BEST & KRIEGER LLP	15,065.24	LEGAL FEES	ADMINISTRATION
T1183	MILLIMAN USA****	14,756.25	CY2018/2019 RDT & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T4466	SMOOTH MOVE USA****	14,290.87	MOVING SERVICES	CORPORATE SERVICES
T2562	CACTUS SOFTWARE LLC	14,131.31	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T4228	THE SSI GROUP, LLC.****	14,025.80	EDI CLAIM PROCESSING	CLAIMS / MIS
T2441	LAURA J. BREZINSKI	14,025.00	MARKETING MATERIALS	MARKETING
T4563	SPH ANALYTICS	13,782.00	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T3986	JACQUELYN S. JANS****	13,575.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T2446	AT&T MOBILITY****	13,489.44	CELLULAR PHONE / INTERNET USAGE	MIS
T4731	LOGMEIN USA, INC.****	12,701.00	INTERNET SERVICES	MIS INFRASTRUCTURE
T2961	SOLUTION BENCH, LLC****	12,600.00	M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE
T4052	RAHUL SHARMA****	12,184.40	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5246	ACCELEBRATE, INC.****	12,120.15	ASP.NET CORE 3 DEVELOPMENT TRAINING	BUSINESS INTELLIGENCE
T2941	KERN PRINT SERVICES INC.****	12,061.92	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year- to-Date	Description	Department
T5226	SAN MICHAEL PEDIATRICS INC.****	11,928.71	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5258	GOOD SAMARITAN HOSPITAL, LLC****	11,605.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T2933	SIERRA PRINTERS, INC.****	11,534.75	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T2686	ALLIANT INSURANCE SERVICES INC.	11,183.88	PROPERTY AND LIABILITY COVERAGE UPDATES	ADMINISTRATION
T4182	THE LAMAR COMPANIES****	11,160.00	OUTDOOR ADVERTISEMENT-BILLBOARDS	ADVERTISING
T4683	CLAUDIA M. BACA PROJECT MANAGEMENT CONSULTIN****	11,000.00	PROJECT MANAGEMENT CONSULTING SERVICES	PROJECT MANAGEMENT
T4216	NEXSTAR BROADCASTING INC****	10,497.50	ADVERTISEMENT - MEDIA	MARKETING
T4781	EDRINGTON HEALTH CONSULTING, LLC**	10,412.50	CONSULTING SERVICES	ADMINISTRATION
T2840	ATALASOFT, INC.	10,254.00	DOT IMAGING RENEWAL	MIS INFRASTRUCTURE
		10,995,369.30		
	TOTAL VENDORS OVER $10,000	10,995,369.30		
	TOTAL VENDORS UNDER $10,000	430,214.69		
	TOTAL VENDOR EXPENSES- MARCH	11,425,583.99		

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

KERN·HEALTH SYSTEMS

April AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	427,734.96	873,726.92	NOV. & DEC. 2019 HEALTH HOME GRANT	COMMUNITY GRANT
T4350	COMPUTER ENTERPRISE INC.	276,173.36	807,880.91	FEB. & MAR.2020 PROFESSIONAL SERVICES	CAPITAL PROJECTS IN PROCESS/MIS
T4391	OMNI FAMILY HEALTH	210,133.80	1,393,371.33	DEC. 2019 & JAN. 2020 HEALTH HOME GRANT	COMMUNITY GRANT
T5269	KERN COMMUNITY FOUNDATION****	150,000.00	150,000.00	KERN COUNTY COVID-19 RELIEF FUND DONATION & ANNUAL COMMUNITY BANK CONTRIBUTION	VARIOUS
T4982	NGC US, LLC	140,000.00	461,510.99	MAR. 2020 PREFUND HEALTH HOME & HEALTH ED. INCENTIVES	HEALTH HOMES/ HEALTH ED.
T2726	DST PHARMACY SOLUTIONS, INC.	127,943.41	512,706.09	MAR. 2020 PHARMACY CLAIMS	PHARMACY
T4483	INFUSION AND CLINICAL SERVICES, INC.	106,950.15	276,940.30	JAN. & FEB. 2020 HEALTH HOME GRANT	COMMUNITY GRANT
T5111	ENTISYS 360	99,945.63	355,345.81	MAR. 2020-2021 NUTANIX LEAP CLOUD SUBSCRIPTION	CAPITAL PROJECT
T5005	CRAYON SOFTWARE EXPERTS LLC	79,313.05	400,743.60	2019 MICROSOFT AZURE CLOUD HOSTING OVERAGE	MIS INFRASTRUCTURE
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	64,174.12	254,543.82	APRIL 2020 VOLUNTARY LIFE, AD&D, DENTAL INSURANCE PREMIUM	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC.	62,684.70	462,561.19	MAR.& APR. 2020 PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	VARIOUS
T1272	COFFEY COMMUNICATIONS INC.	53,332.45	74,648.06	JAN.- APR. 2020 MODULE SUBSCRIPTION, SPRING '20 ADD. POSTAGE & ISSUE	HEALTH EDUCATION
T4582	HEALTHX, INC.	40,376.00	161,504.00	APR. 2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

April AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T2584	UNITED STATES POSTAL SVC.-HASLER	30,000.00	100,000.00	2020 3RD POSTAGE (METER) FUND	CORPORATE SERVICES
T4657	DAPONDE SIMPSON ROWE PC	29,520.00	72,427.50	MAR. 2020 LEGAL SERVICES	PROVIDER RELATIONS/ ADMIN
T4193	STRIA LLC	28,880.86	155,669.84	MAR. & APR. 2020 OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T5109	RAND EMPLOYMENT SOLUTIONS	26,060.12	123,937.86	MAR. & APR. 2020 TEMP SERVICES- 5 MS, 1 HED	VARIOUS
T3454	DEPARTMENT OF MANAGED HEALTH CARE****	25,000.00	25,000.00	ENFORCEMENT MATTER# 19-479 & #18-936	ADMINISTRATION
T4460	PAYSPAN, INC	24,995.40	77,154.61	MAR. 2020 ELECTRIC CLAIMS/PAYMENTS	FINANCE
T4792	KP LLC*****	24,044.03	27,344.03	PROVIDER DIRECTORIES & FEB. & MAR. FORMULARYSUPPORT/MAINT	PROVIDER RELATIONS/PHARMACY
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	23,503.17	103,549.92	MAR. 2020 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T5185	HOUSING AUTHORITY COUNTY OF KERN*****	18,600.00	53,300.00	JAN. 2020 HOUSING AUTHORITY GRANT	COMMUNITY GRANT
T4501	ALLIED UNIVERSAL SECURITY SERVICES	18,364.29	80,466.58	MAR. & APR. 2020 ONSITE SECURITY	CORPORATE SERVICES
T3011	OFFICE ALLY, INC.	17,915.75	66,584.25	MAR. 2020 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	16,800.00	33,400.00	APR. & MAY 2020 YOUTH EDUCATION SPONSORHIP	COMMUNITY ACTIVITIES

KERN·HEALTH SYSTEMS

April AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T3449	CDW GOVERNMENT	16,792.74	41,002.14	HARDWARE & COMPUTER SUPPLIES - 15 HEADSETS, 100 AXIOM DVI-D, 10 IVR CISCO LICENSESW/SUPPORT, 50 TRIP 6FT VGA CABLES, 50 HDMI CABLES, 90 CISCO UNIFIED LICENSES	VARIOUS
T4733	UNITED STAFFING ASSOCIATES	16,377.20	96,142.34	MAR. & APR. 2020 TEMPORARY HELP - 3 MS, 1 HR, 1 CS, 1 PR	VARIOUS
T2167	PG&E	16,113.28	93,249.86	3/18/20-4/16/20 USAGE/UTILITIES	CORPORATE SERVICES
T4967	ADMINISTRATIVE SOLUTIONS, INC.	15,559.15	67,130.70	APRIL 2020 FSA EMPLOYEE PREMIUM	VARIOUS
T4696	ZNALYTICS, LLC	15,120.00	49,680.00	MARCH 2020 PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE
T4731	LOGMEIN USA, INC.*****	13,778.00	26,479.00	MAR.- MAY. 2020 INTERNET SERVICES	MIS INFRASTRUCTURE
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	12,979.26	65,262.03	MAR.& APR. 2020 TEMP SERVICES- 1 MIS	MIS INFRASTRUCTURE
T5201	JAC SERVICES, INC.*****	12,929.00	13,732.00	SPRING 2020 AC MAINTENANCE	CORPORATE SERVICES
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	12,847.40	50,287.48	MAR. 2020 ACCIDENT & CRITICAL ILLNESS EMPLOYEE PREMIUM	VARIOUS
T4785	COMMGAP	12,455.00	75,605.00	MAR. 2020 INTERPRETATION SERVICES	HEALTH EDUCATION
T2938	SAP AMERICA, INC****	12,308.32	12,308.32	SAP BUSINESS OBJECTS SOFTWARE ANNUAL MAINTENANCE FEE	BUSINESS INTELLIGENCE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.*****	11,673.00	41,921.95	MAR. 2020 QNXT SOFTWARE SUBSCRIPTION	MIS INFRASTRUCTURE

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April AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.*****	11,143.75	15,182.50	MAR. 2020 CONSULTING SERVICES	ADMINISTRATION
T1128	HALL LETTER SHOP, INC.*****	10,710.80	28,761.06	MAR. & APR. 2020 NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, EMPLOYEE PIZZA COUPONS, COVID-19 LETTER	VARIOUS
T2918	STINSON'S	10,659.07	99,477.80	MAR. 2020 OFFICE SUPPLIES & CLEANING SUPPLIES	VARIOUS
T5262	YOUTH CONNECTION, INC.****	10,000.00	10,000.00	COMMUNITY SPONSORSHIP	COMMUNITY ACTIVITIES
		2,333,891.22			
	TOTAL VENDORS OVER $10,000	2,333,891.22			
	TOTAL VENDORS UNDER $10,000	206,889.40			
	TOTAL VENDOR EXPENSES- APRIL	**$ 2,540,780.62**			

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

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	1,804,460.48	HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T4290	S.C. ANDERSON, INC.	1,555,742.74	NEW BUILDING RETAINER	CAPITAL PROJECT - NEW BUILDING
T4391	OMNI FAMILY HEALTH	1,393,371.33	HEALTH HOMES AND PROVIDER QUAILITY CARE GRANT	COMMUNITY GRANTS
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	873,726.92	HEALTH HOMES GRANT	COMMUNITY GRANTS
T4350	COMPUTER ENTERPRISE INC.	807,880.91	PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	CAPITAL PROJECTS IN PROCESS/ MIS
T2726	DST PHARMACY SOLUTIONS, INC.	512,706.09	PHARMACY CLAIMS	PHARMACY
T4237	FLUIDEDGE CONSULTING, INC.	462,561.19	PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	VARIOUS
T4982	NGC US, LLC	461,510.99	PREFUND HEALTH HOMES INCENTIVES & HE MEMBER INCENTIVES	VARIOUS
T5005	CRAYON SOFTWARE EXPERTS LLC	400,743.60	2019 TRUE UP MAINTENANCE & 2020 ESD ANNUAL SUPPORT	MIS INFRASTRUCTURE
T5111	ENTISYS 360	355,345.81	HARDWARE- 2 NUTANIX PLATFORM WITH SUPPORT	CAPITAL PROJECT
T4483	INFUSION AND CLINICAL SERVICES, INC.	276,940.30	HEALTH HOMES GRANT	COMMUNITY GRANT
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	254,543.82	VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC.	235,758.22	NEW BUILDING FURNITURE (LIVE STREAM VIA IP)	CAPITAL PROJECT - NEW BUILDING
T4582	HEALTHX, INC.	161,504.00	2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5217	AMERICAN TILE & BRICK VENEER, INC.	157,500.00	FINAL PAYMENT FOR BRICK WALL	BUILDING IMPROVEMENT
T4193	STRIA LLC	155,669.84	OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5269	KERN COMMUNITY FOUNDATION****	150,000.00	HEALTH HOME GRANT	COMMUNITY GRANT
T5109	RAND EMPLOYMENT SOLUTIONS	123,937.86	TEMPORARY HELP	VARIOUS
T2458	HEALTHCARE FINANCIAL, INC.	122,000.00	PROFESSIONAL SERVICES	ADMINISTRATION
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	103,549.92	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T2584	UNITED STATES POSTAL SVC.-HASLER	100,000.00	TEMPORARY HELP	VARIOUS
T2918	STINSON'S	99,477.80	2020 OFFICE SUPPLIES, CONFERENCE TABLES, OFFICE FURNITURE, CABINET FOR TRAINING & DEVELOPMENT ROOM	VARIOUS
T4733	UNITED STAFFING ASSOCIATES	96,142.34	TEMPORARY HELP	VARIOUS
T2167	PG&E	93,249.86	USAGE/UTILITIES	CORPORATE SERVICES
T4165	SHI INTERNATIONAL CO.	80,987.94	STANDING WORKING STATIONS & LICENSES FEES	VARIOUS
T1272	COFFEY COMMUNICATIONS INC.	74,648.06	MEMBER NEWSLETTER/ WEBSITE IMPLEMENTATION	HEALTH EDUCATION/ MIS INFRASTRUCTURE
T4501	ALLIED UNIVERSAL SECURITY SERVICES	80,466.58	ONSITE SECURITY	CORPORATE SERVICES
T4460	PAYSPAN, INC	77,154.61	ELECTRONIC CLAIMS/PAYMENTS & PPD REIMBURSEMENTS	FINANCE
T4785	COMMGAP	75,605.00	INTERPRETATION SERVICES	HEALTH EDUCATION
T5015	SENTINEL ENGINEERING	74,963.34	JUNIPER NETWORKS - FIBER OPTICS	MIS INFRASTRUCTURE
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	73,500.00	2020 ANNUAL DUES, 2019 SALARY SURVEY, & LEADERSHIP FEES	VARIOUS
T1408	DELL MARKETING L.P.	72,442.53	HARDWARE & CUMPUTER EQUIPMENT	MIS INFRASTRUCTURE
T4657	DAPONDE SIMPSON ROWE PC	72,427.50	LEGAL SERVICES	PROVIDER RELATIONS

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4038	POLYCLINIC MEDICAL CENTER, INC	68,658.81	HEALTH HOME AND PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4967	ADMINISTRATIVE SOLUTIONS, INC.	67,130.70	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T3011	OFFICE ALLY, INC.	66,584.25	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	65,262.03	TEMPORARY HELP	VARIOUS
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	59,020.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T4699	ZeOMEGA, INC.	54,646.52	PROFESSIONAL SERVICES AND TRAVEL EXP.	UM
T5185	HOUSING AUTHORITY COUNTY OF KERN	53,300.00	HOUSING AUTHORITY GRANT	UM
T4265	SIERRA SCHOOL EQUIPMENT COMPANY	52,428.83	NEW FURNITURE & OFFICE CHAIRS FOR EMOPLYEES	CORPORATE SERVICES
T4963	LINKEDIN CORPORATION	52,000.00	ONLINE TRAINING FOR EMPLOYEES	HUMAN RESOURCES
T4396	KAISER FOUNDATION HEALTH-DHMO	51,100.24	EMPLOYEE HEALTH BENEFITS - DHMO	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	50,733.63	EDI CLAIM PROCESSING	CLAIMS / MIS
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	50,287.48	EMPLOYEE PREMIUM - ACCIDENT & CRITICAL ILLNESS	VARIOUS
T4696	ZNALYTICS, LLC	49,680.00	PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE MANAGEMENT
T5026	TEL-TEC SECURITY SYSTEMS	48,081.94	ADDITIONAL SECURITY SYSTEM & LABOR	CORPORATE SERVICES
T3001	MERCER	47,500.00	CONSULTING SERVICES	HUMAN RESOURCES
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, IN	41,921.95	PROFESSIONAL SERVICES	VARIOUS
T2955	DELTA ELECTRIC INC.	41,710.00	BUILDING 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
T1861	CERIDIAN HCM, INC.	41,041.36	MONTHLY SUBSCRIPTION FEES,PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT IMPLEMENTATION & AMENDMENTS	HUMAN RESOURCES
T3449	CDW GOVERNMENT	41,002.14	HARDWARE& COMPUTER SUPPLIES	VARIOUS
T5227	RIDGECREST MEDICAL TRANSPORTATION	40,932.81	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T2969	AMERICAN BUSINESS MACHINES INC	40,202.77	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T5132	TIME WARNER CABLE LLC	39,545.88	INTERNET SERVICES	MIS INFRASTRUCTURE
T5145	CCS ENGINEERING FRESNO INC.,	36,675.04	JANITORIAL SERVICES	CORPORATE SERVICES
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	33,400.00	COMMUNITY SPONSORSHIP	ADMINISTRATION
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	32,512.00	2020 ANNUAL DUES & CONFERENCE REGISTRATION	VARIOUS
T2413	TREK IMAGING INC	32,034.90	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T4389	EXACT STAFF, INC.	31,736.64	TEMPORARY HELP	VARIOUS
T1128	HALL LETTER SHOP, INC.	28,761.06	NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, CLINICAL CARE MANUAL FOR HH, NEW MEMBER PACKETS	VARIOUS
T4792	KP LLC****	27,344.03	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PROVIDER RELATIONS/PHARMACY
T5121	TPx COMMUNICATIONS	27,013.97	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T4731	LOGMEIN USA, INC.	26,479.00	INTERNET SERVICES	MIS INFRASTRUCTURE
T1180	LANGUAGE LINE SERVICES INC.	25,132.19	INTERPRETATION SERVICES	MEMBER SERVICES

KERN • HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2232	DLT SOLUTIONS, LLC	25,022.27	SQL LICENSES	MIS INFRASTRUCTURE
T3454	DEPARTMENT OF MANAGED HEALTH CARE	25,000.00	ENFORCEMENT MATTERS	ADMINISTRATION
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	24,000.00	2019 AUDIT FEES	ADMINISTRATION
T1022	UNUM LIFE INSURANCE CO.	23,623.20	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T4546	LEVEL 3 COMMUNICATIONS, LLC	21,169.97	DISASTER RECOVERY, INTERNET, LONG DISTANCE CALLS	MIS INFRASTRUCTURE
T4503	VISION SERVICE PLAN	21,154.70	EMPLOYEE HEALTH BENEFITS	VARIOUS
T4873	L5 HEALTHCARE SOLUTIONS, INC.	19,414.47	LICENSE AND SUPPORT FEES - CLAIMS AUDIT TOOL	MIS INFRASTRUCTURE
T3986	JACQUELYN S. JANS	18,175.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T2446	AT&T MOBILITY	18,078.73	CELLULAR PHONE / INTERNET USAGE	MIS INFRASTRUCTURE
T5240	ACE EYECARE INC	18,000.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4216	NEXSTAR BROADCASTING INC	17,850.00	ADVERTISEMENT - MEDIA	MARKETING
T2441	LAURA J. BREZINSKI	17,425.00	MARKETING MATERIALS	MARKETING
T2941	KERN PRINT SERVICES INC.	17,191.13	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T4228	THE SSI GROUP, LLC.	16,284.60	EDI CLAIM PROCESSING	CLAIMS / MIS
T4466	SMOOTH MOVE USA	16,165.87	MOVING SERVICES	CORPORATE SERVICES
T4960	ZELIS CLAIMS INTEGRITY, LLC****	16,024.26	POST EDITING SYSTEMS FOR CLAIMS PROCESSING	CLAIMS
T4521	PAYSCALE, INC.	16,000.00	COMPENSATION STUDY AND SALARY ANALYTICS	HUMAN RESOURCES
T3084	KERN COUNTY-COUNTY COUNSEL	15,662.11	LEGAL FEES	ADMINISTRATION
T5236	BEST BEST & KRIEGER LLP	15,389.24	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
T5226	SAN MICHAEL PEDIATRICS INC.	15,305.66	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.****	15,182.50	CONSULTING SERVICES	ADMINISTRATION
T1183	MILLIMAN USA	14,756.25	CY2018/2019 RDT & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T2562	CACTUS SOFTWARE LLC	14,131.31	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T4182	THE LAMAR COMPANIES	13,950.00	OUTDOOR ADVERTISEMENT-BILLBOARDS	ADVERTISING
T4563	SPH ANALYTICS	13,782.00	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T5201	JAC SERVICES, INC.****	13,732.00	SPRING 2020 AC MAINTENANCE	CORPORATE SERVICES
T2961	SOLUTION BENCH, LLC	12,600.00	M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE
T2938	SAP AMERICA, INC****	12,308.32	SAP BUSINESS OBJECTS SOFTWARE ANNUAL MAINTENANCE FEE	BUSINESS INTELLIGENCE
T4544	BARNES WEALTH MANAGEMENT GROUP****	12,250.00	RETIREMENT PLAN CONSULTANTS	ADMINISTRATION
T4052	RAHUL SHARMA	12,184.40	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5246	ACCELEBRATE, INC.	12,120.15	ASP.NET CORE 3 DEVELOPMENT TRAINING	BUSINESS INTELLIGENCE
T2933	SIERRA PRINTERS, INC.	11,969.87	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T4239	COAST TO COAST COMPUTER PRODUCTS****	11,762.55	COMPUTER PRODUCTS & SUPPLIES	CORPORATE SERVICES
T5258	GOOD SAMARITAN HOSPITAL, LLC	11,605.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T2686	ALLIANT INSURANCE SERVICES INC.	11,183.88	PROPERTY AND LIABILITY COVERAGE UPDATES	ADMINISTRATION
T4683	CLAUDIA M. BACA PROJECT MANAGEMENT C(	11,000.00	PROJECT MANAGEMENT CONSULTING SERVICES	PROJECT MANAGEMENT

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4781	EDRINGTON HEALTH CONSULTING, LLC	10,412.50	CONSULTING SERVICES	ADMINISTRATION
T2840	ATALASOFT, INC.****	10,254.00	DOT IMAGING RENEWAL	MIS INFRASTRUCTURE
T5262	YOUTH CONNECTION, INC.****	10,000.00	COMMUNITY SPONSORSHIP	COMMUNITY ACTIVITIES
		13,476,500.69		

TOTAL VENDORS OVER $10,000	13,476,500.69
TOTAL VENDORS UNDER $10,000	489,863.92
TOTAL VENDOR EXPENSES- APRIL	$ 13,966,364.61

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

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
January							
LinkedIn	$52,000.00	Yes	HR	Anita Martin	Online training for managed learners	1/1/2020	12/31/2020
Poppyrock Designs	$40,800.00	Yes	MRK	Louie Iturriria	Graphic Design Consultant of KHS/KFHC marketing materials	1/1/2020	12/31/2020
Jacquelyn S. Jans	$55,200.00	Yes	MRK	Louie Iturriria	Marketing and corporate image consultant	1/1/2020	12/31/2020
February							
Lifesigns	$45,000.00	Yes	HE	Isabel Silva	ASL Interpreting services for members	2/23/2020	2/22/2021
March							
Stria	$68,118.00	Yes	HR	Anita Martin	Document Management & Workflow services for HR	3/1/2020	2/28/2021
Entisys	$99,945.63	Yes	IT	Richard Pruitt	Nutanix Xi Leap Cloud Service	3/23/2020	3/22/2021
Bynum Inc	$42,500.00	Yes	PR	Emily Duran	Post construction consulting services	3/23/2020	3/22/2021

2020 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	*Enterprise Logging*	*EXP*	$18,480	$0	$550	$0											$550	$17,930
2	*BizTalk Upgrade*	*EXP*	$14,705	$5,100	$4,590	$4,845											$14,535	$170
3	*2D - Clinical Engagement*	CAP	$15,660	$0	$4,118	$5,400											$9,518	$6,143
4	*QNXT Upgrade with NetworX and CES KB Update*	*EXP*	$20,760	$0	$0	$468											$468	$20,292
5	*Hospital Directed Payments (HDP)/Encounters*	*EXP*	$14,705	$0	$0	$0											$0	$14,705
6	*HHP 2020 - CSV Health Homes*	*CA*	$135,903	$28,448	$10,918	$9,303											$48,669	$87,234
7	*HHP - Member Engagement*	*CA*	$50,988	$0	$1,442	$7,501											$8,943	$42,045
8	*Enterprise Data Warehouse*	*CA*	$738,400	$58,640	$53,835	$62,480											$174,955	$563,445
9	*HHP 2020 - Distributive Model*	*CA*	$149,771	$0	$412	$6,956											$7,368	$142,403
10	*Disaster Recovery and Business Continuity Test*	*CA*	$338,975	$56,200	$37,300	$37,940											$131,440	$207,535
11	*Rx PBM Transition*	*EXP*	$9,860														$0	$9,860
12	*Auto Adjudication Enhancements*	*EXP*	$416,640														$0	$416,640
13	*MCAS Member Engagement*	*EXP*	$48,580														$0	$48,580
14	*Specialty Med Mgnt.*	*CA*	$56,321			$945											$945	$55,376
15	*Interoperability*	*CA*	$32,620														$0	$32,620
16	*Automated Member Display*	*CA*	$45,188														$0	$45,188
17	*Staff Augmentation*	EXP	$1,781,009	$137,881	$139,976	$153,234											$431,091	$1,349,918
	Totals:	**Totals**	**$3,888,565**	**$286,269**	**$253,141**	**$289,072**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$828,482**	**$3,060,083**	

*Note: State's projects being re-organized due to mid-year changes.

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
June 11, 2020

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 05/06/2020				
Kimberly Dixon, MD Corporation dba: The Childrens Clinic of Bakersfield	PCP / Pediatrics	1700 A Street Bakesfield CA 93301	Provider Already Credentialed / Individual Contract for Private Office	6/1/2020
Michelle L. Remmes, MD	PCP / Internal Medicine	2021 22nd Street Bakesfield CA 93301		6/1/2020
Kern Surgery Center, LLC	Ambulatory Surgery Center	2323 16th Street Ste 507 Bakersfield CA 93301		6/1/2020
PharMedQuest Pharmacy Services	Pharmacy	PharMedQuest Pharmacy Services dba #1: CSV PMQ Wible Pharmacy 2400 Wible Rd Rm 1 dba #2CSV PMQ Bakersfield Pharmacy 2000 Phys Blvd Rm B Bakersfield CA	**Notes:** Pharmacy vendor for Clinica Sierra Vista Locations / Locum status approved 04/13/2020 due to COVID19 emergency request.	Retro-Eff 4/13/2020
NextGen Laboratories, Inc	Laboratory	2020 20th Street Bakersfield CA 93301		6/1/2020
Hemant Dhingra, MD CEO The Nephrology Group, Inc	Nephrology	3933 Coffee Road Ste. B Bakersfield CA 93308 *Multiple Locations	Aquired existing group Advanced Kidney and providers (McCauley, Joshi & Kazmi) are already credentialed.	Retro-Eff 4/1/2020
BASS Medical Group Canyon Oaks Foot and Ankle	Podiatry	Omni Clinic (Location) 210 N Chester Ave Bakersfield CA 93308	Existing provider (Terry Nelson DPM) requesting indiv contract for surgeries / Pre & Post op done at Omni Clinics	6/1/2020
CHA Medical Group PC	Ophthalmology	8150 Brimhall Rd Ste 401 Bakersfield CA 93312	Existing Providers (Jacob & Alena Reznik) at Fritch Eye Care already Credentialed.	6/1/2020

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
June 11, 2020

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 06/03/2020				
Spine and Pain Treatment Medical Center of Santa Barbara Inc. Dba: LAGS Surgery Center Bakersfield	Surgery Center	3550 Q Street Suite 103 Bakersfield CA 93301		7/1/2020
Bright Heart Health Medical Group	Mental Health & Pain Management	2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Telehealth Providers	7/1/2020
Compassionate Care Home Health Agency, LLC	Home Health	5201 California Ave Ste. 255 Bakersfield CA 93309		7/1/2020
James E Holland Jr	Mental Health	4646 Wilson Road Ste. 101A Bakersfield CA 93309	Existing provider already credentialed.	7/1/2020
JoAnna Morse, LMFT dba: AV Family Connections	Mental Health	44709 Date Avenue Lancaster CA 93534		7/1/2020
Phast Pharmacy	Pharmacy/DME Sterile Compunding / Home Infusion / TPNs / Enteral Feeding	1121 W Columbus Street Bakersfield CA 93301		7/1/2020
Ramneet Mangat, MD Inc	OB/GYN	3838 San Dimas Street Ste. B231 Bakersfield CA 93301		7/1/2020
Resource Anesthesiology Associates of California, A Medical Corporation	Anesthesiology	2215 Truxtun Ave 400 Old River Road Bakersfield CA	Hospital Based Anesthesiology Services Non-Cred Providers	7/1/2020
Telemedicine Group PC dba: TeleMed2U	Multi-Specialty	3400 Douglas Blvd, Ste. 225 Roseville CA 95661	Telehealth Providers	7/1/2020
Victor N. Onuaguluchi dba: On Call Anesthesia	Anesthesiology	901 Olive Drive Bakersfield CA 93308	Hospital Based Anesthesiology Services Non-Cred Providers	7/1/2020
VIPMD Corp	PCP	2901 Sillect Ave Ste. 201 Bakersfield CA 93308	Existing provider already credentialed.	7/1/2020

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
June 11, 2020

Legal Name DBA	Specialty	Address	Comments	Effective Date
Bakersfield Foot & Ankle Surgeons	Podiatry	500 Old River Road Ste. 185 Bakersfield CA	Per term letter, most everthing they submit we deny.	5/10/2020
CEP American California	Emergency Med	2100 Powell Street Ste. 900 Emeryville CA	They no longer have sites in Kern County	4/1/2020
Advanced Kidney Medical Group	Nephrology	3933 Coffee Road Ste. B Bakersfield CA	Change of Ownership	3/1/2020
California Institute of Behavior Analysis, Inc.	ABA	13440 Ventura Blvd Ste. 200 Sherman Oaks CA	Non-Resp to Recred	3/5/2020
Hoffmann Homecare Inc.	Pharmacy / IV Infusion	2225 E Street Ste. 200 Bakersfield CA	Business Dissolved	3/1/2020
Leah Jarvis	ABA	9808 Margery Avenue California City CA	Non-Resp to Recred	4/30/2020

KERN HEALTH SYSTEMS

To: KHS Board of Directors

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

Date: June 11, 2020

Re: CMO BOARD REPORT

Medical Cost and Utilization Trend Analyses: (Attachment A)

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

Per capita cost of physician services by all AID category is down in April 2020. This is possibly due to stay at home order from the Governor in order to reduce exposure to the COVID-19 virus.

Cost of professional services for the SPDs continue to trend higher than budget but is stable. During this time we have followed the State guidance and encouraged our providers to provide services to their patients via telemedicine as appropriate. The implementation of some of our disease specific programs are still on hold because of the need for social distancing due to the COVID-19 pandemic. We are hoping to implement these programs for our most costly diagnosis such as diabetes and COPD when it is safe for our members, providers and staff.

The most frequent outpatient diagnosis for physician services for all Aid categories in April was chronic kidney disease with diabetes coming a close second. General well child exam was third and essential hypertension was fourth.

Pharmacy

Pharmacy utilization did not see the same reduction as noted with professional services. Since the public was encouraged to stay at home and reduce travel, KHS modified the number of days between prescription refills for routine medications. Members could now receive a 90-day supply instead of a 60-day supply of medication. The pharmacies in the network also provided delivery services for our members. The monthly cost and utilization per enrollee for all AID categories remained stable at or just below budget.

Inpatient Services

The overall PMPM cost, cost per bed-day, admissions incurred and average length of stay in the acute hospital for all aide codes has been falling over the past couple of months. There was a big drop in inpatient services for the SPDs. This is understandable since this group has more members considered high risk for COVID-19. Absent elective procedures, you would expect a decrease in admissions. With resuming of selected elective procedures, gradually, hospital admissions are beginning to increase for the 1st time in a few months. We are following this trend very closely and analyzing available data to determine what our new norm for inpatient hospital utilization will be following the pandemic.

We have identified alternative facilities for our members who test positive for COVID-19, do not need to be hospitalized but cannot safely self-quarantine in their place of residence. With the high number of positive COVID cases in the SNFs, many SNFs are not accepting members recuperating from COVID. We have also identified recuperative alternative facilities for our members to recuperate safely after hospitalization for COVID-19.

Most of the in-patient activity continues to be at Bakersfield Memorial Hospital **(Attachment B).**

The C/Section rate is 14 % which continues to be below the State average for low–risk, first birth deliveries. **(Attachment C).**

Hospital Outpatient

Hospital outpatient utilization was low in April with a big drop in the SPD Aid category. Similar with inpatient services, we will continue to monitor hospital outpatient services as well. The same pattern should follow as more elective procedures are approved and patients are contacted about scheduling appointments for treatment.

Emergency Room (ER)

The PMPM cost and number of ER visits dropped in April 2020 due to the COVID-19 pandemic. The most frequent diagnosis for all combined AID codes in the ER was disorders of the urinary tract and acute upper respiratory infections came second.

Most of the ER visits are occurring at Bakersfield Memorial Hospital **(Attachment D).**

Managed Care Accountability Set (Attachment E)

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. Just like with HEDIS, 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 receiving the 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, MCPs and providers are under increased pressure to coordinate their quality programming and metrics.

2019 Measured Year:

We have completed abstraction of medical records and submitted our final number for measuring year 2019 to the State. Due the COVID-19 pandemic and the stay at home orders we were not able to get all the eligible medical records from the provider offices. This will have a negative impact on our performance in the hybrid measures. We hope to have our results from the State by the next Board meeting.

2020 Measured Year:

Attachment E is tracking our performance for the 2020 measuring year compared to the 2019 measuring year. The boxes in green show measures where our performance has improved over last year. We are doing better than 2019 in 12 of the 25 MCAS measures. We have plans ready for implementation to improve our performance in most of the areas where were now not performing as good as the previous year as soon as it is safe for our members, providers and staff. We are continuing to work with our providers and encouraging them to provide routine care via telemedicine as possible during the pandemic. Unfortunately, the longer the "stay at home order" remains the less likely patients will receive services that count toward each measure resulting in KHS not achieving its goal. DHCS recognizes this challenge. Although this will not change their performance expectations, health plans will not likely be sanctioned either in 2020. It is expected DHCS will consider the pandemic's impact to the MCAS quality scores when evaluating health plan performance for the 2020 measuring year.

KERN HEALTH SYSTEMS

Governed Reporting System

Attachment A

Kern Health Systems

KHS Medical Management Performance Dashboard (Critical Performance Measurements)

KERN HEALTH SYSTEMS

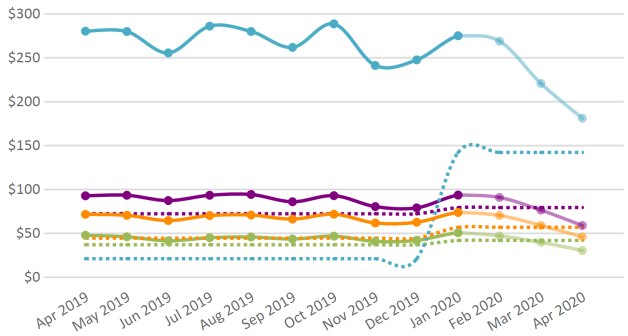
Governed Reporting System

Physician Services

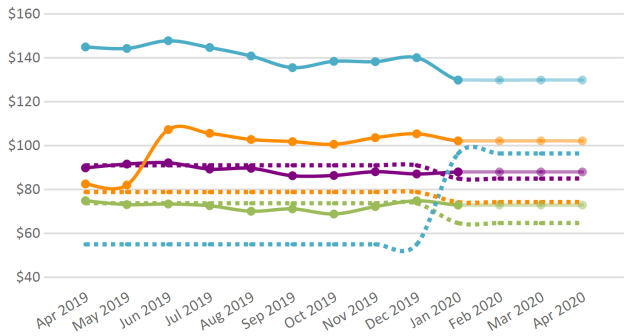
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

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

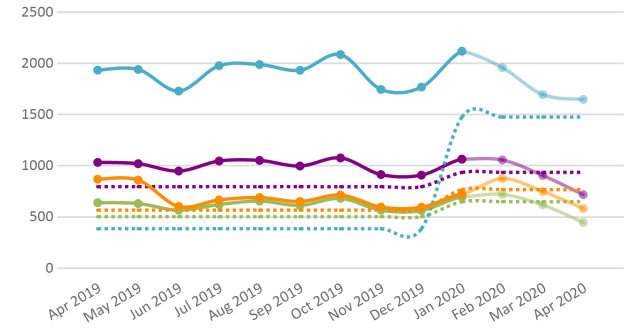
Professional Services Incurred by Aid Group PMPM



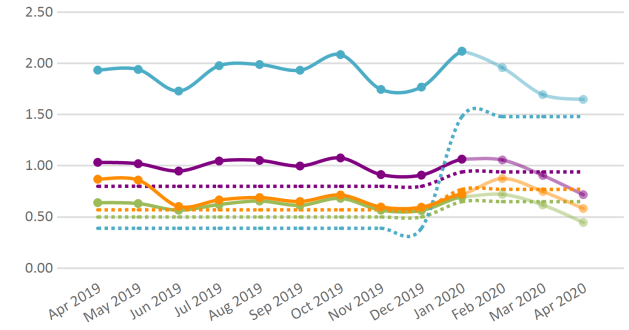
Cost per Professional Service Visit by Aid Group



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



Professional Service Visits per Member per Month by Aid Group

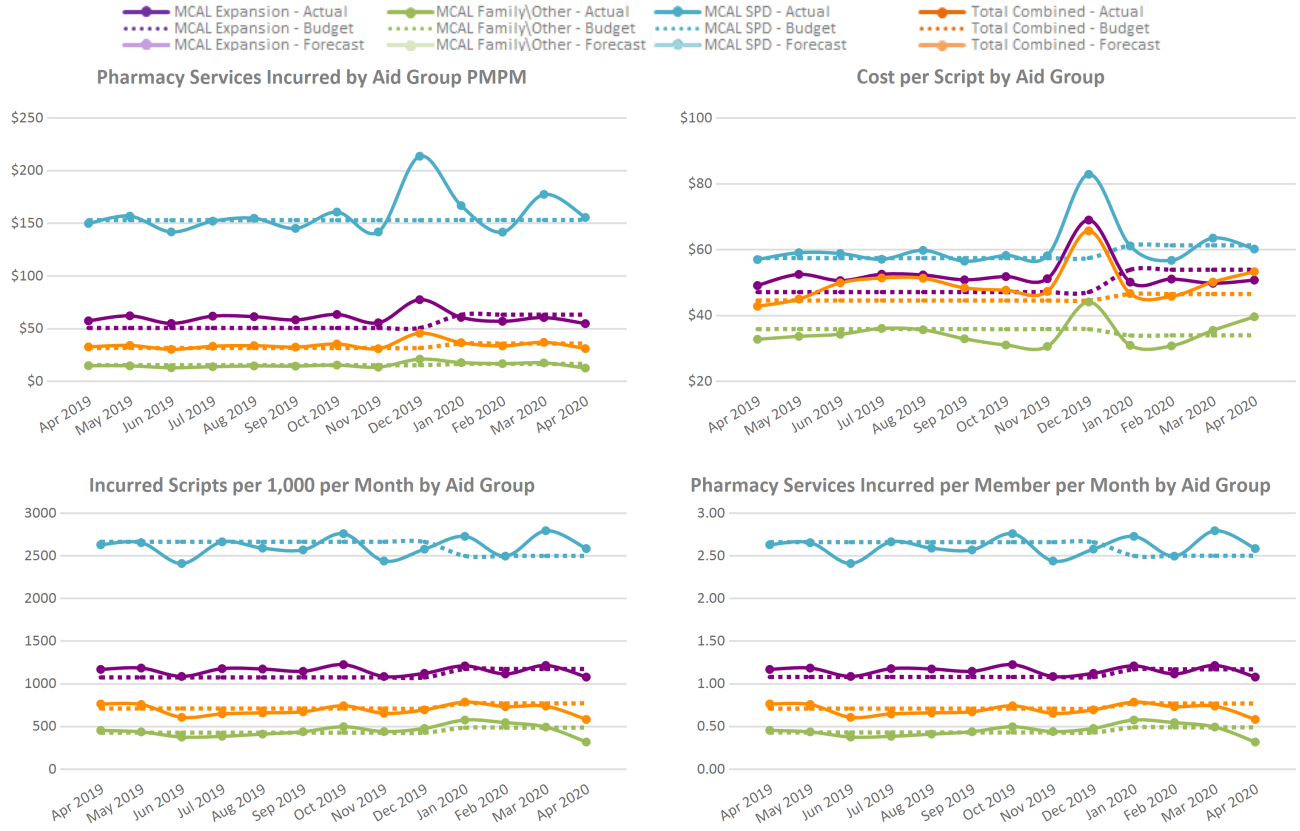


KERN HEALTH SYSTEMS

Governed Reporting System

Pharmacy

(Includes: Claims paid by PBM)



KERN HEALTH SYSTEMS

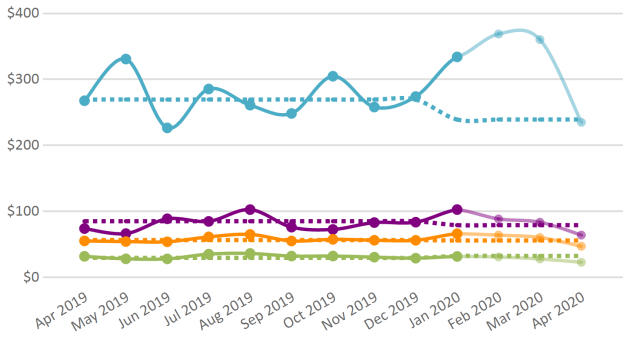
Governed Reporting System

Inpatient

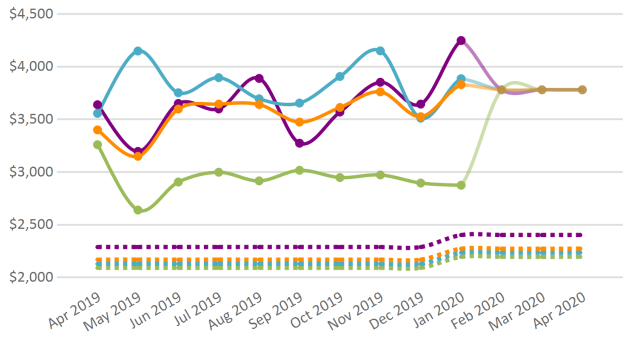
(Includes: Inpatient Hospital Claims)

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

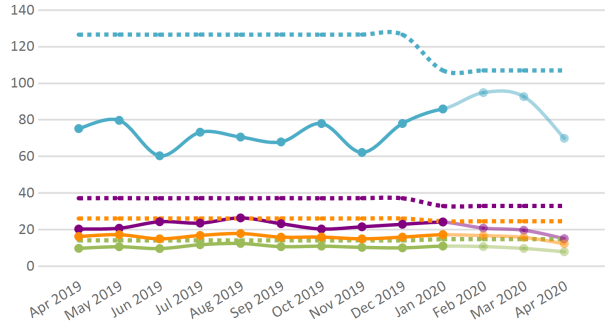
Inpatient Services Incurred by Aid Group PMPM



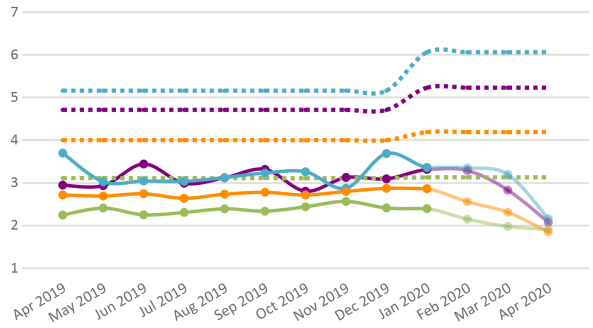
Cost Per Bed Day by Aid Group



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



Average Length of Stay in Days by Aid Group

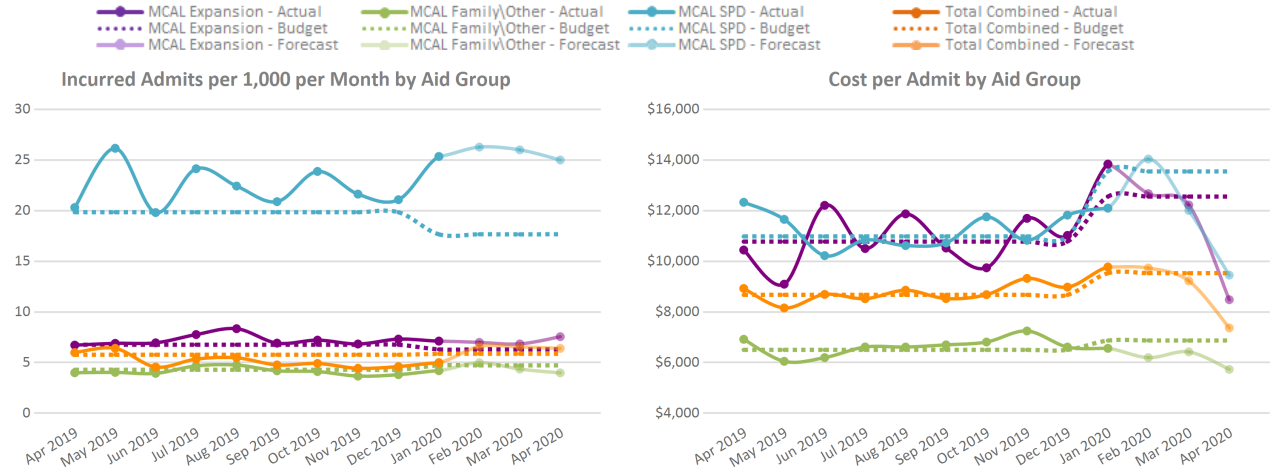


KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient

(Includes: Inpatient Hospital Claims)



KERN HEALTH SYSTEMS

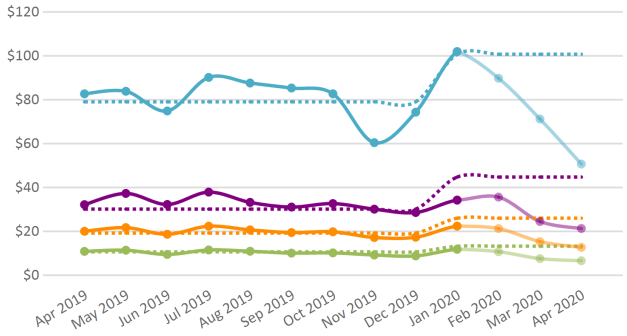
Governed Reporting System

Outpatient Hospital

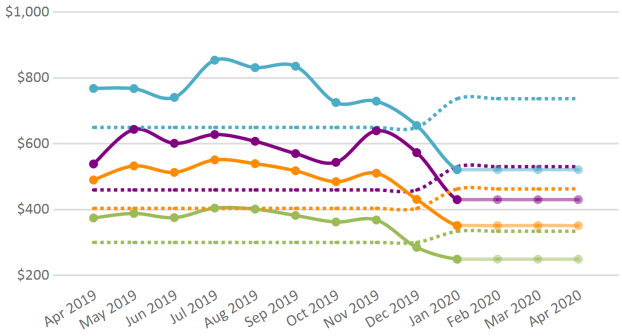
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

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

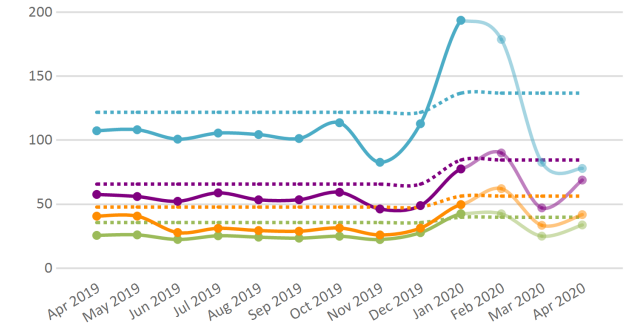
Outpatient Services Incurred by Aid Group PMPM



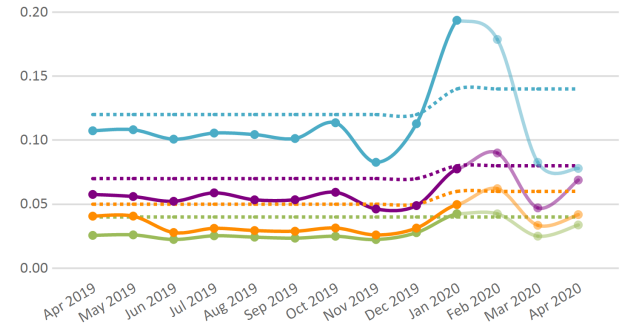
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



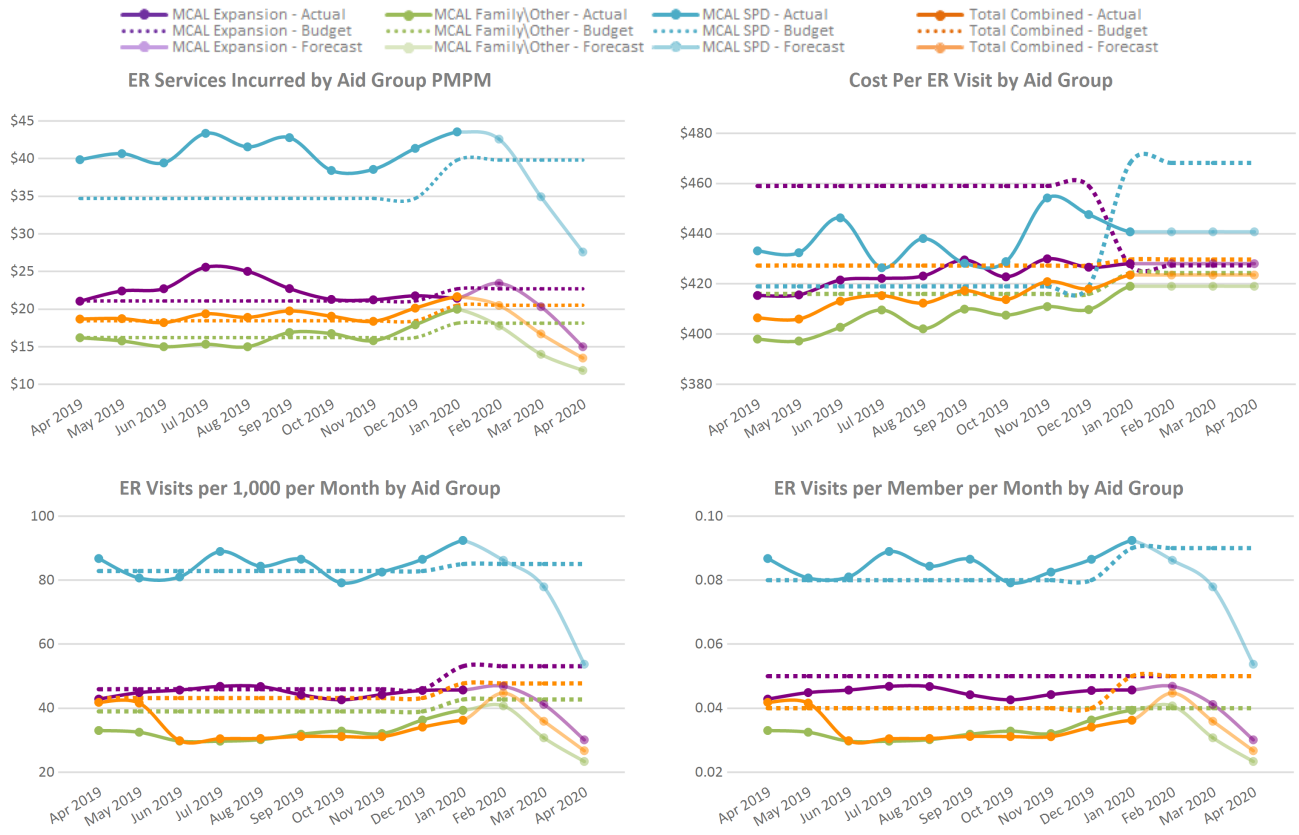
Outpatient Visits per Member per Month by Aid Group



KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Room

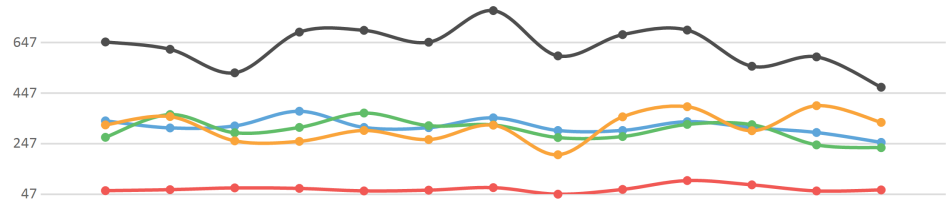


KERN HEALTH SYSTEMS

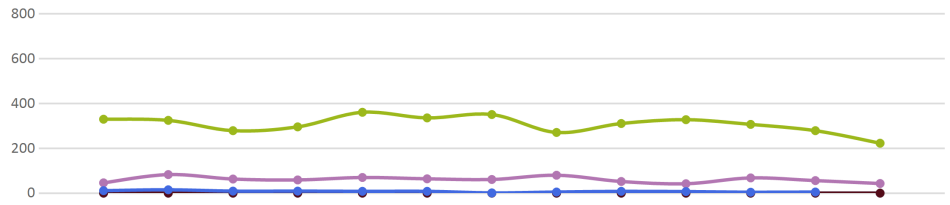
Governed Reporting System

Attachment B

Inpatient Admits by Hospital



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
BAKERSFIELD MEMORIAL	649	620	527	688	695	648	773	594	678	696	553	590	470
KERN MEDICAL	321	354	258	256	299	263	320	203	353	393	298	397	331
MERCY HOSPITAL	272	362	290	311	368	318	321	271	275	323	322	242	231
ADVENTIST HEALTH	337	309	317	375	311	310	349	299	299	334	310	291	252
GOOD SAMARITAN HOSPITAL	61	65	72	70	60	63	73	47	66	101	84	60	64



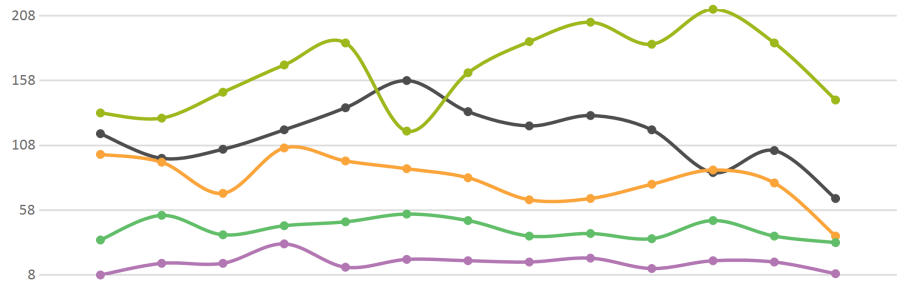
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
DELANO REGIONAL HOSPITAL	46	83	63	59	70	64	61	80	52	42	68	56	43
OUT OF AREA	330	325	279	296	361	336	351	271	311	328	307	279	223
BAKERSFIELD HEART HOSP	45	37	43	46	60	59	50	61	50	51	60	61	44
KERN VLY HLTHCRE HOSP	11	15	9	9	8	8	1	5	8	7	4	5	0

KERN HEALTH SYSTEMS

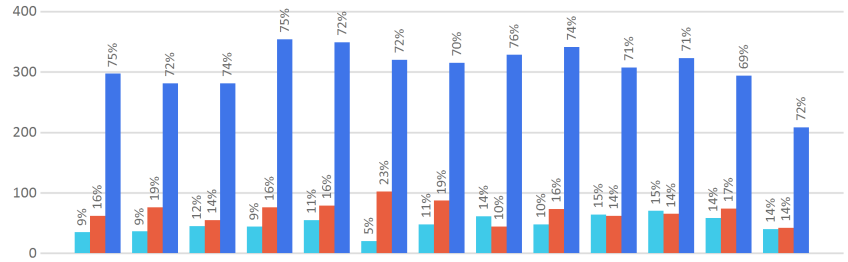
Governed Reporting System

Attachment C

Obstetrics Metrics



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
BAKERSFIELD MEMORIAL	117	98	105	120	137	158	134	123	131	120	87	104	67
KERN MEDICAL	101	95	71	106	96	90	83	66	67	78	89	79	38
OTHER	133	129	149	170	187	119	164	188	203	186	213	187	143
MERCY HOSPITAL	35	54	39	46	49	55	50	38	40	36	50	38	33
DELANO REGIONAL HOSPITAL	8	17	17	32	14	20	19	18	21	13	19	18	9



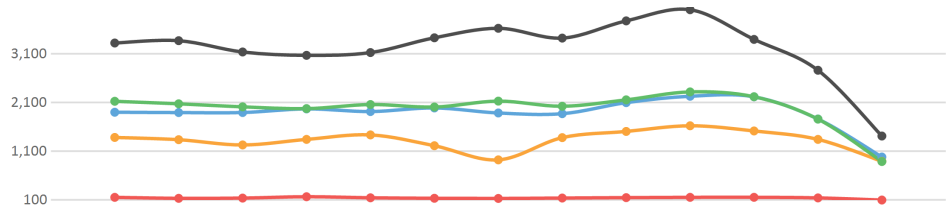
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
VAGINAL DELIVERY	297	281	281	354	349	320	315	328	341	307	323	294	208
C-SECTION DELIVERY	62	76	55	76	79	102	87	44	73	62	65	74	42
PREVIOUS C-SECTION DELIVERY	35	36	45	44	55	20	48	61	48	64	70	58	40

Attachment D

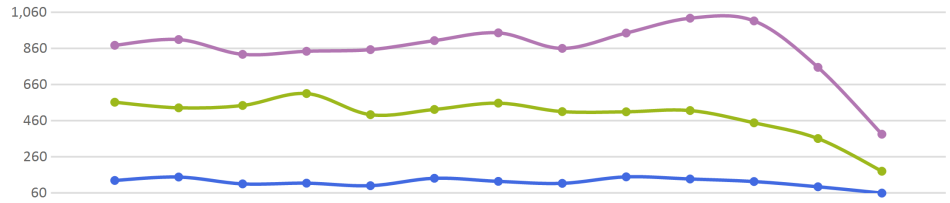
KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Visits by Hospital



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
BAKERSFIELD MEMORIAL	3,321	3,369	3,137	3,068	3,125	3,428	3,623	3,422	3,775	4,004	3,395	2,762	1,413
MERCY HOSPITAL	2,126	2,074	2,012	1,975	2,059	2,008	2,129	2,024	2,155	2,318	2,219	1,760	890
ADVENTIST HEALTH	1,901	1,894	1,895	1,970	1,915	1,989	1,886	1,871	2,098	2,229	2,218	1,762	982
KERN MEDICAL	1,384	1,338	1,230	1,344	1,436	1,214	924	1,380	1,507	1,623	1,517	1,344	894
BAKERSFIELD HEART HOSP	155	135	140	168	146	136	133	141	149	155	156	144	100



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
DELANO REGIONAL HOSPITAL	878	910	828	845	854	904	947	861	946	1,028	1,013	756	386
OUT OF AREA	563	532	545	611	494	523	558	511	510	517	449	362	181
KERN VLY HLTHCRE HOSP	130	149	111	115	101	142	125	114	150	138	124	95	60

KERN HEALTH SYSTEMS *Governed Reporting System*

Attachment E

MCAS Performance Trending Metrics

ABA - 18-19	ABA - 20-74	ABA	AMM - Acute	AMM - Cont
4.95 %	27.92 %	27.64 %	53.30 %	30.36 %
Prior Year 3.36%	Prior Year 17.47%	Prior Year 17.29%	Prior Year 53.09%	Prior Year 33.89%
% Change 47.32%	% Change 59.82%	% Change 59.86%	% Change 0.40%	% Change -10.42%

AMR	APM - Cholesterol	APM - Glucose	APM - Glucose Cholesterol	AWC
63.71 %	8.33 %	33.33 %	8.33 %	11.04 %
Prior Year 51.42%	Prior Year 34.94%	Prior Year 98.30%	Prior Year 33.24%	Prior Year 13.11%
% Change 23.90%	% Change -76.16%	% Change -66.09%	% Change -74.94%	% Change -15.79%

BCS	CBP	CCS	CDC - BP	CDC - Eye Exam
45.82 %	2.74 %	44.10 %	2.90 %	48.67 %
Prior Year 37.20%	Prior Year 2.68%	Prior Year 41.62%	Prior Year 2.38%	Prior Year 30.37%
% Change 23.17%	% Change 2.24%	% Change 5.96%	% Change 21.85%	% Change 60.26%

KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

CDC - HBA1C <7%	CDC - HBA1C <8%	CDC - HBA1C >9%	CDC - HBa1C Test	CDC - Nephropathy
2.52 %	4.07 %	3.04 %	57.81 %	75.82 %
Prior Year 4.01%	Prior Year 7.15%	Prior Year 5.07%	Prior Year 66.34%	Prior Year 83.63%
% Change -37.16%	% Change -43.08%	% Change -40.04%	% Change -12.86%	% Change -9.34%

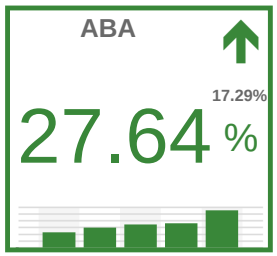
CHL - Adults	CHL	CHL - Peds	CIS - Combo 10	IMA - Combo 2
45.75 %	41.73 %	36.79 %	14.08 %	37.59 %
Prior Year 50.15%	Prior Year 44.59%	Prior Year 37.34%	Prior Year 8.14%	Prior Year 30.45%
% Change -8.77%	% Change -6.41%	% Change -1.47%	% Change 72.97%	% Change 23.45%

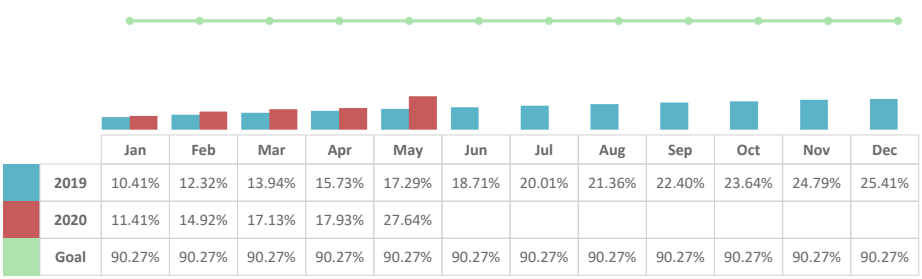
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Adult BMI Assessment

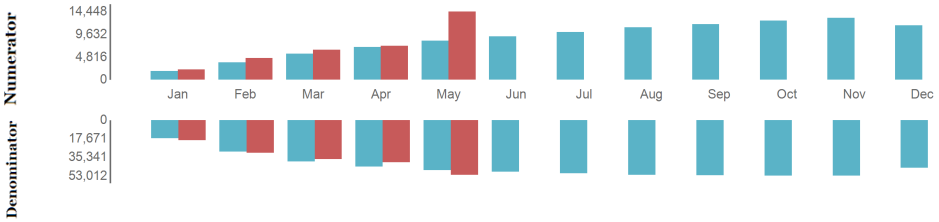
The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	10.41%	12.32%	13.94%	15.73%	17.29%	18.71%	20.01%	21.36%	22.40%	23.64%	24.79%	25.41%
2020	11.41%	14.92%	17.13%	17.93%	27.64%							
Goal	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%

14,448
52,280

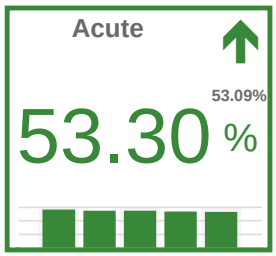


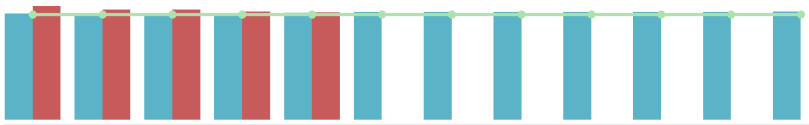
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Antidepressant Medication Management

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	52.74%	52.92%	52.67%	52.78%	53.09%	53.47%	53.48%	53.51%	53.47%	53.47%	53.49%	53.70%
2020	56.39%	54.77%	54.73%	53.74%	53.30%							
Goal	52.33%	52.33%	52.33%	52.33%	52.33%	52.33%	52.33%	52.33%	52.33%	52.33%	52.33%	52.33%

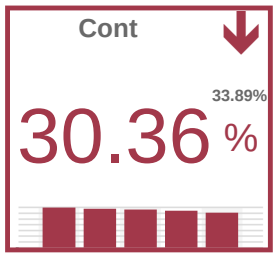
760
1,426

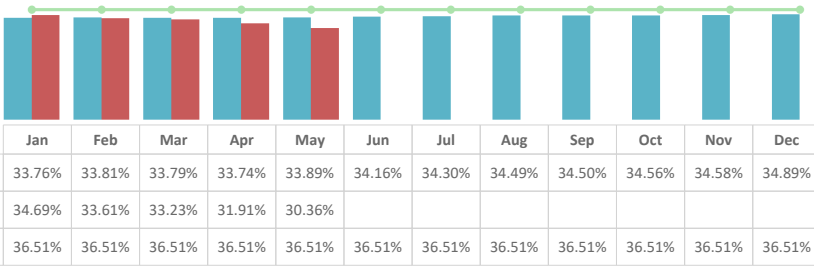
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Antidepressant Medication Management

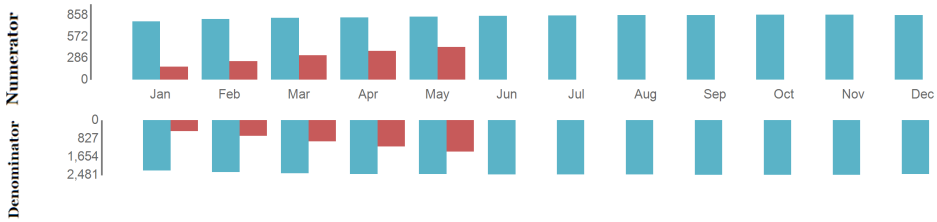
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 180 days.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	33.76%	33.81%	33.79%	33.74%	33.89%	34.16%	34.30%	34.49%	34.50%	34.56%	34.58%	34.89%
2020	34.69%	33.61%	33.23%	31.91%	30.36%							
Goal	36.51%	36.51%	36.51%	36.51%	36.51%	36.51%	36.51%	36.51%	36.51%	36.51%	36.51%	36.51%

433
1,426

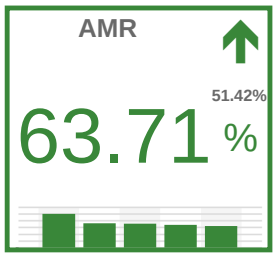


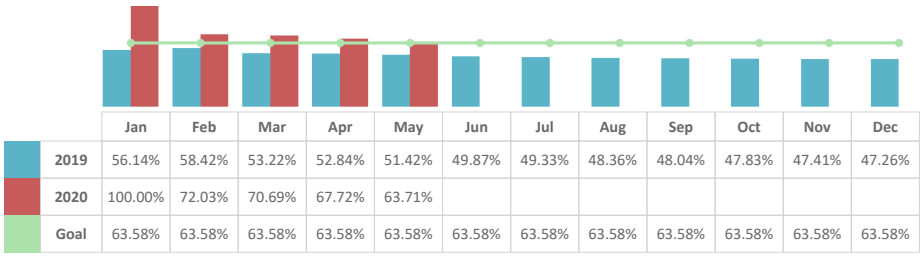
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Asthma Medication Ratio

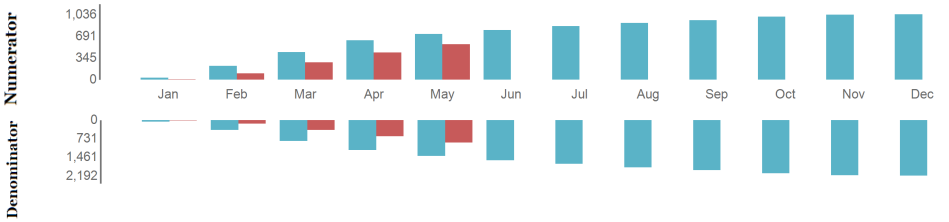
The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	56.14%	58.42%	53.22%	52.84%	51.42%	49.87%	49.33%	48.36%	48.04%	47.83%	47.41%	47.26%
2020	100.00%	72.03%	70.69%	67.72%	63.71%							
Goal	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%

560
879

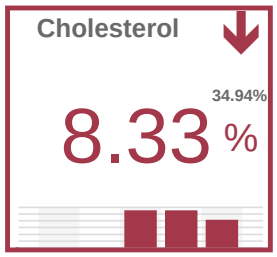


KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

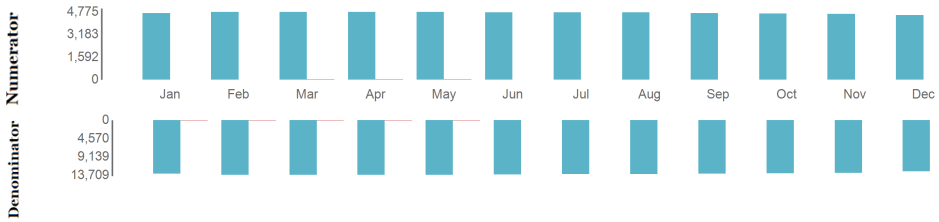
Metabolic Monitoring for Children and Adolescents on Antipsychotics

The percentage of children and adolescents on antipsychotics 1–17 years who received cholesterol testing.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	34.90%	34.81%	34.82%	34.96%	34.94%	34.93%	34.99%	35.08%	35.12%	35.11%	35.09%	35.40%
2020	0.00%	0.00%	11.11%	11.11%	8.33%							
Goal	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%

1
12

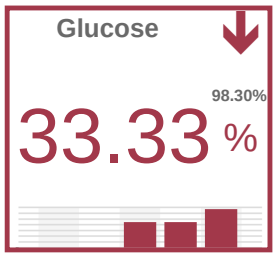


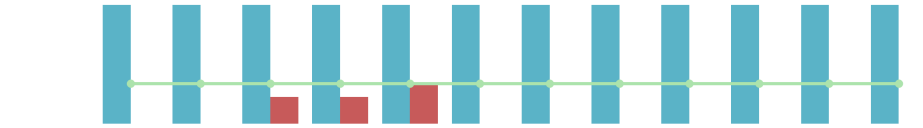
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Metabolic Monitoring for Children and Adolescents on Antipsychotics

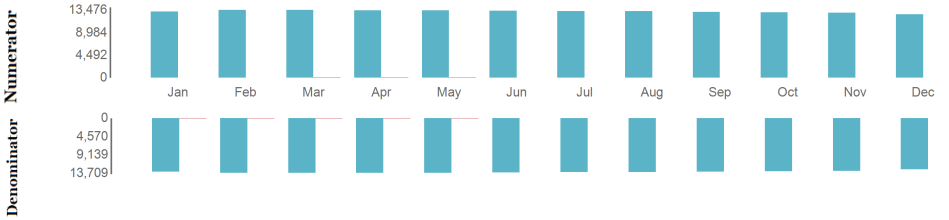
The percentage of children and adolescents 1–17 years on antipsychotics who received blood glucose testing.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	98.34%	98.32%	98.30%	98.30%	98.30%	98.31%	98.30%	98.29%	98.29%	98.29%	98.28%	98.25%
2020	0.00%	0.00%	22.22%	22.22%	33.33%							
Goal	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%

4
12

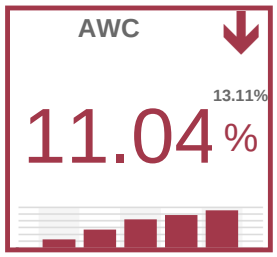


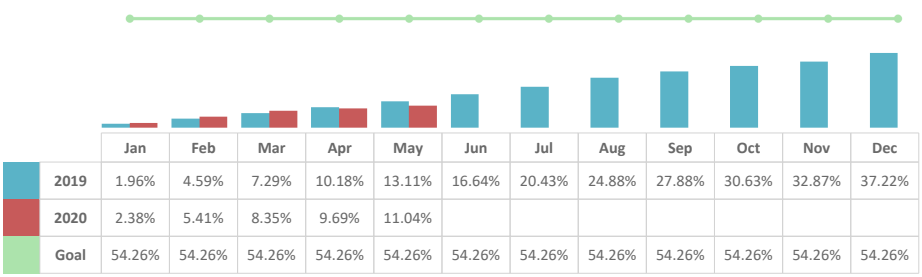
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Adolescent Well-Care Visits

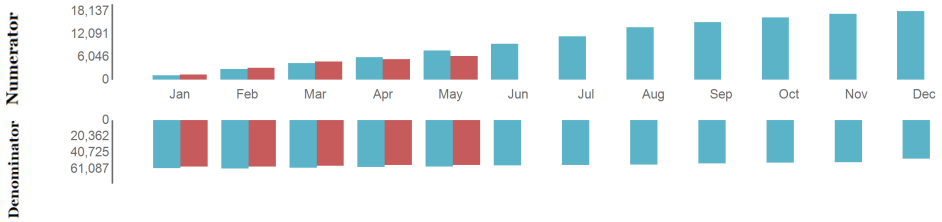
The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	1.96%	4.59%	7.29%	10.18%	13.11%	16.64%	20.43%	24.88%	27.88%	30.63%	32.87%	37.22%
2020	2.38%	5.41%	8.35%	9.69%	11.04%							
Goal	54.26%	54.26%	54.26%	54.26%	54.26%	54.26%	54.26%	54.26%	54.26%	54.26%	54.26%	54.26%

6,233
56,440

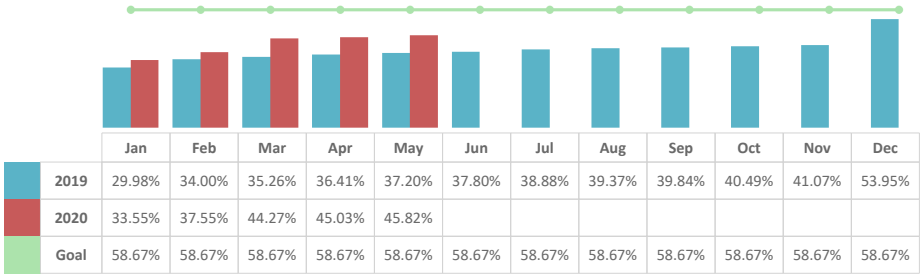


KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

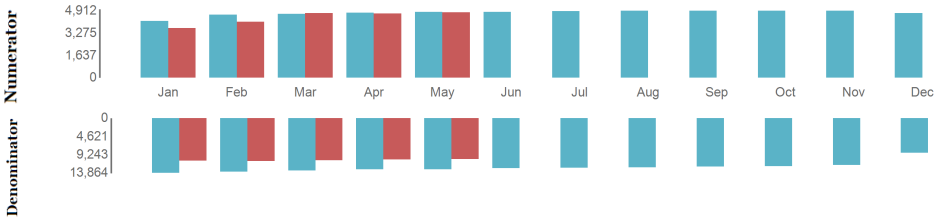
Breast Cancer Screening

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
2019	29.98%	34.00%	35.26%	36.41%	37.20%	37.80%	38.88%	39.37%	39.84%	40.49%	41.07%	53.95%
2020	33.55%	37.55%	44.27%	45.03%	45.82%							
Goal	58.67%	58.67%	58.67%	58.67%	58.67%	58.67%	58.67%	58.67%	58.67%	58.67%	58.67%	58.67%

4,770
10,411

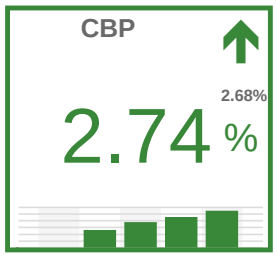


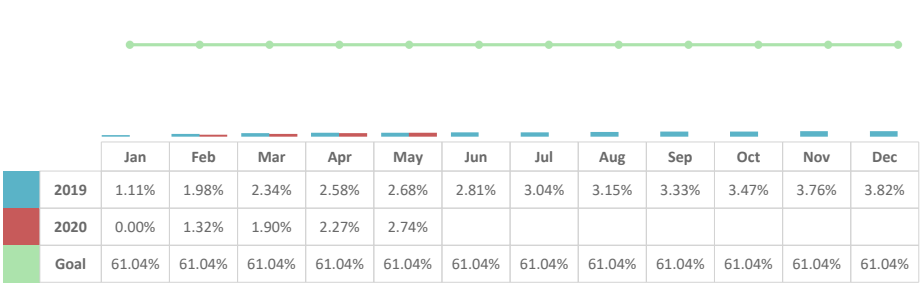
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

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
2019	1.11%	1.98%	2.34%	2.58%	2.68%	2.81%	3.04%	3.15%	3.33%	3.47%	3.76%	3.82%
2020	0.00%	1.32%	1.90%	2.27%	2.74%							
Goal	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%

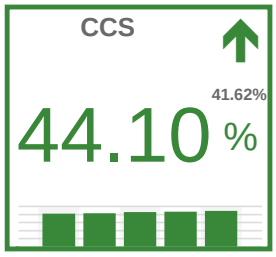
433
15,829

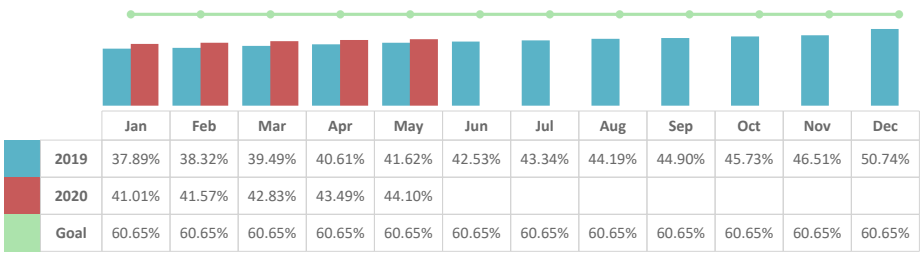
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Cervical Cancer Screening

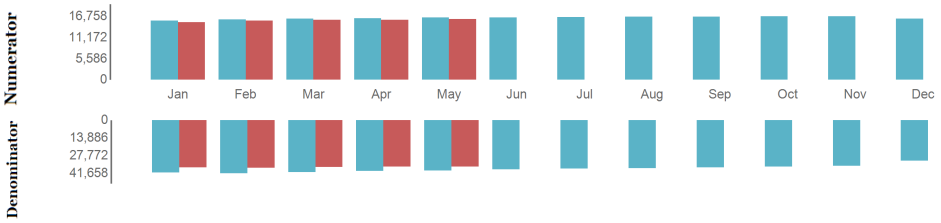
The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
• Women 21–64 years of age who had cervical cytology performed within the last 3 years.
• Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed 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
2019	37.89%	38.32%	39.49%	40.61%	41.62%	42.53%	43.34%	44.19%	44.90%	45.73%	46.51%	50.74%
2020	41.01%	41.57%	42.83%	43.49%	44.10%							
Goal	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%

16,067
36,435

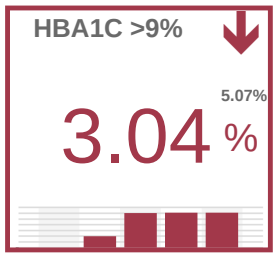


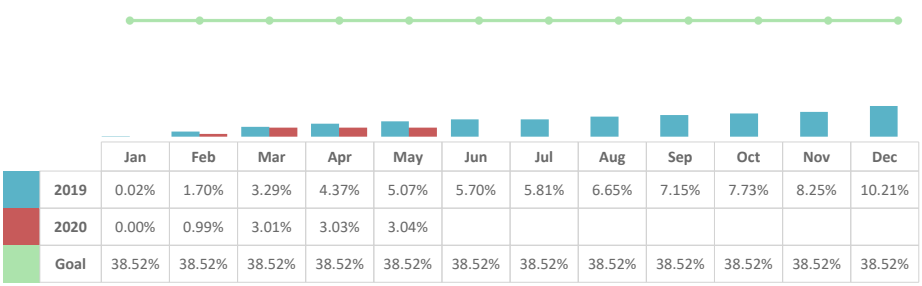
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Comprehensive Diabetes Care

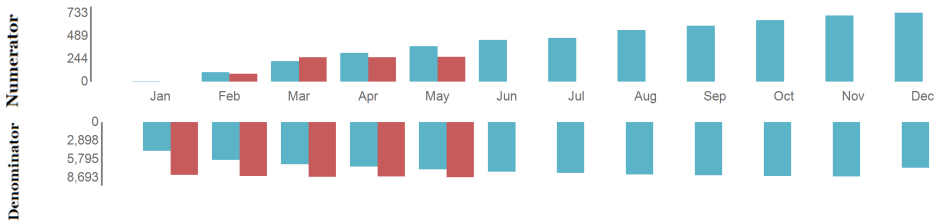
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had recent HBA1C Test Result > 9 %.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	0.02%	1.70%	3.29%	4.37%	5.07%	5.70%	5.81%	6.65%	7.15%	7.73%	8.25%	10.21%
2020	0.00%	0.99%	3.01%	3.03%	3.04%							
Goal	38.52%	38.52%	38.52%	38.52%	38.52%	38.52%	38.52%	38.52%	38.52%	38.52%	38.52%	38.52%

264
8,693

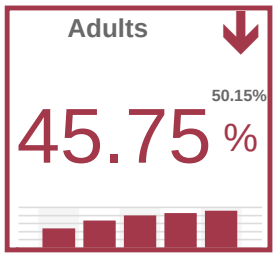


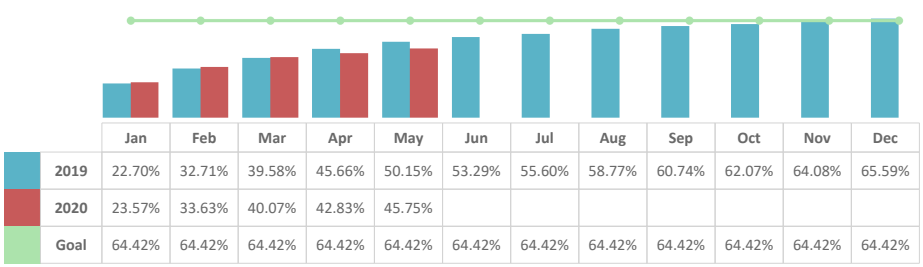
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Chlamydia Screening in Women

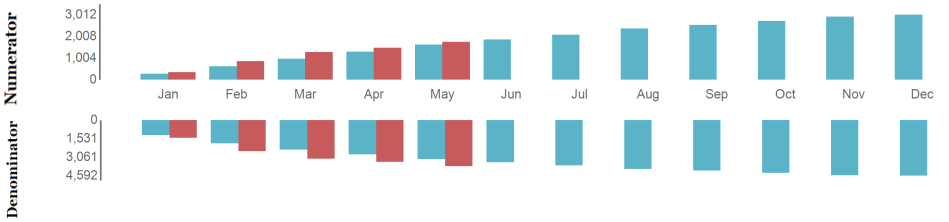
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	22.70%	32.71%	39.58%	45.66%	50.15%	53.29%	55.60%	58.77%	60.74%	62.07%	64.08%	65.59%
2020	23.57%	33.63%	40.07%	42.83%	45.75%							
Goal	64.42%	64.42%	64.42%	64.42%	64.42%	64.42%	64.42%	64.42%	64.42%	64.42%	64.42%	64.42%

1,743
3,810

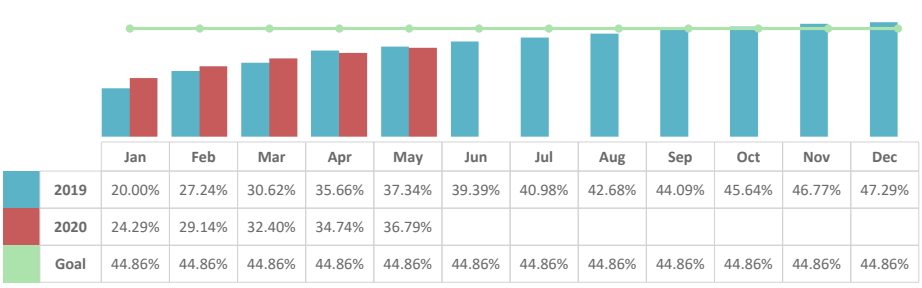


KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

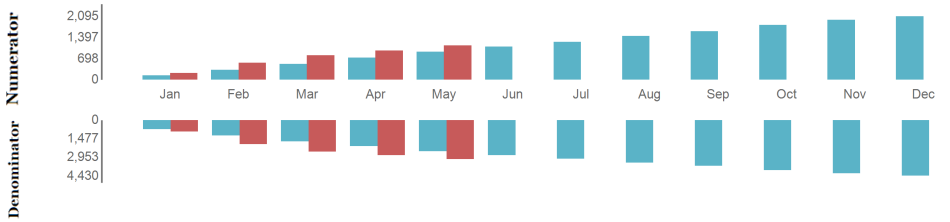
Chlamydia Screening in Women

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.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	20.00%	27.24%	30.62%	35.66%	37.34%	39.39%	40.98%	42.68%	44.09%	45.64%	46.77%	47.29%
2020	24.29%	29.14%	32.40%	34.74%	36.79%							
Goal	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%

1,140
3,099

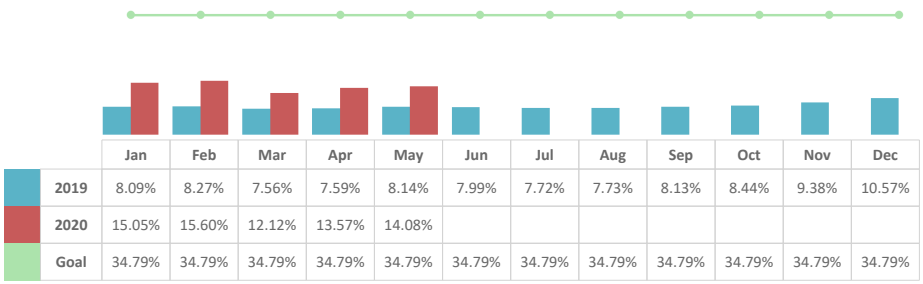


KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Childhood Immunization Status

The percentage of members who turned 15 months old during the measurement year and who had the at least 6 well-child visits with a PCP during their first 15 months of life.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	8.09%	8.27%	7.56%	7.59%	8.14%	7.99%	7.72%	7.73%	8.13%	8.44%	9.38%	10.57%
2020	15.05%	15.60%	12.12%	13.57%	14.08%							
Goal	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%

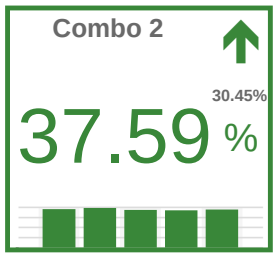
724
5,141

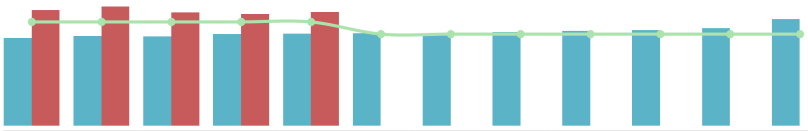
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Immunizations for Adolescents

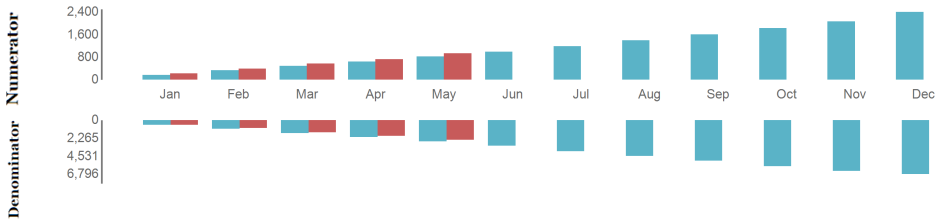
The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and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





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	29.10%	29.69%	29.62%	30.39%	30.45%	30.65%	30.56%	30.94%	31.36%	31.65%	32.31%	35.31%
2020	38.22%	39.42%	37.52%	37.04%	37.59%							
Goal	34.43%	34.43%	34.43%	34.43%	34.43%	30.39%	30.39%	30.39%	30.39%	30.39%	30.39%	30.39%

933
2,482



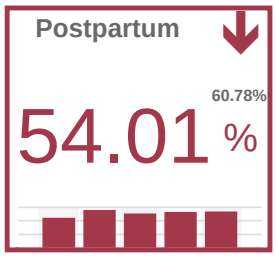
KERN HEALTH SYSTEMS

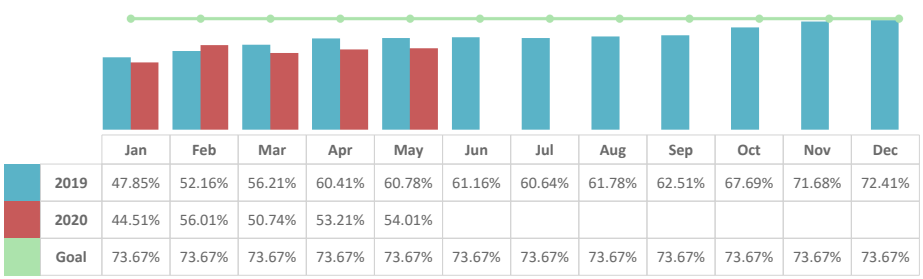
Governed Reporting System

MCAS Performance Trending Metrics

Postpartum Care

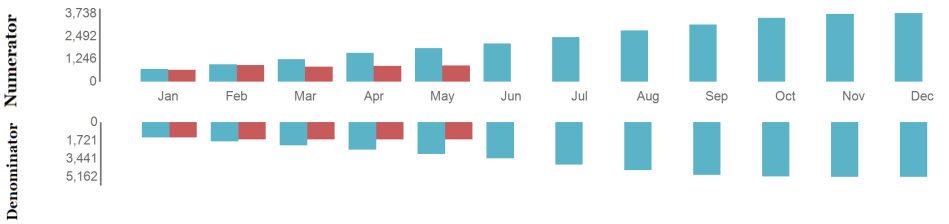
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	47.85%	52.16%	56.21%	60.41%	60.78%	61.16%	60.64%	61.78%	62.51%	67.69%	71.68%	72.41%
2020	44.51%	56.01%	50.74%	53.21%	54.01%							
Goal	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%

876
1,622

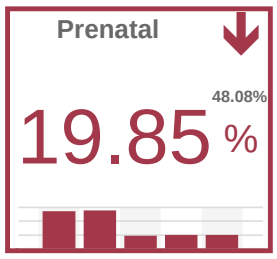


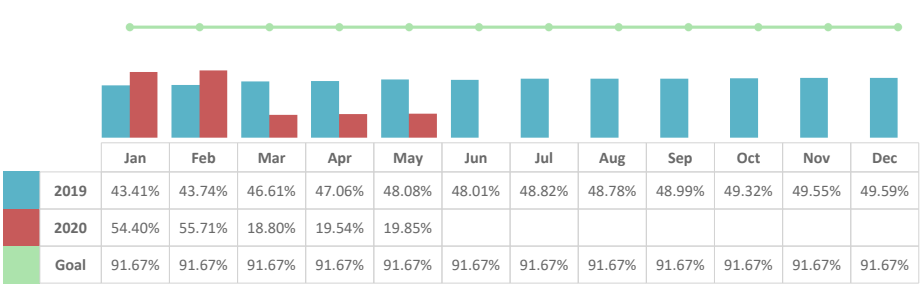
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

Prenatal Care

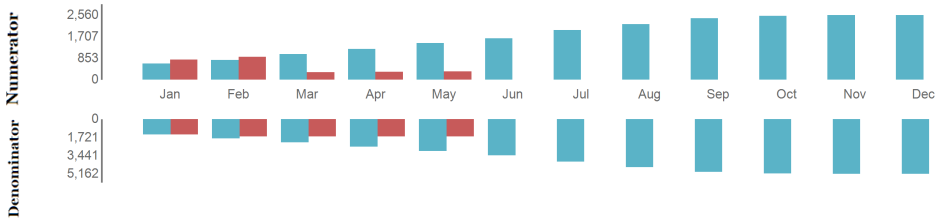
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.
Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start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





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	43.41%	43.74%	46.61%	47.06%	48.08%	48.01%	48.82%	48.78%	48.99%	49.32%	49.55%	49.59%
2020	54.40%	55.71%	18.80%	19.54%	19.85%							
Goal	91.67%	91.67%	91.67%	91.67%	91.67%	91.67%	91.67%	91.67%	91.67%	91.67%	91.67%	91.67%

322
1,622

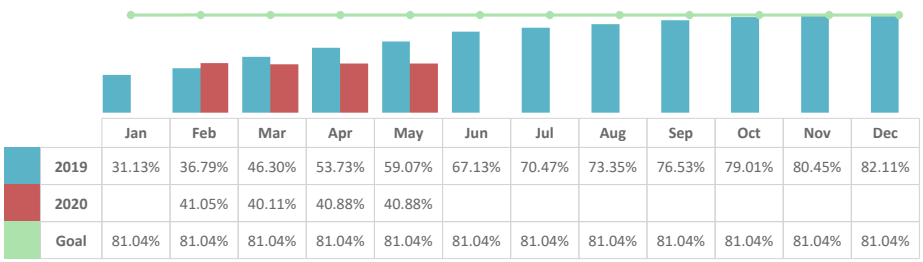


KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

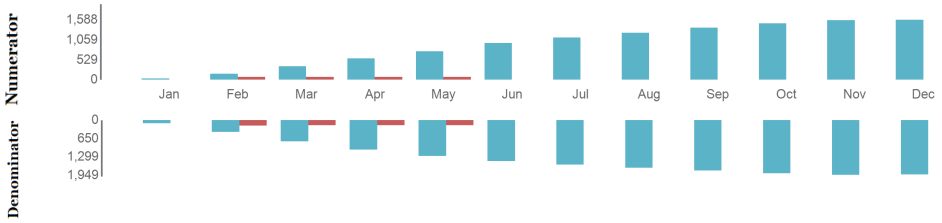
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	31.13%	36.79%	46.30%	53.73%	59.07%	67.13%	70.47%	73.35%	76.53%	79.01%	80.45%	82.11%
2020		41.05%	40.11%	40.88%	40.88%							
Goal	81.04%	81.04%	81.04%	81.04%	81.04%	81.04%	81.04%	81.04%	81.04%	81.04%	81.04%	81.04%

74
181



KERN HEALTH SYSTEMS *Governed Reporting System*

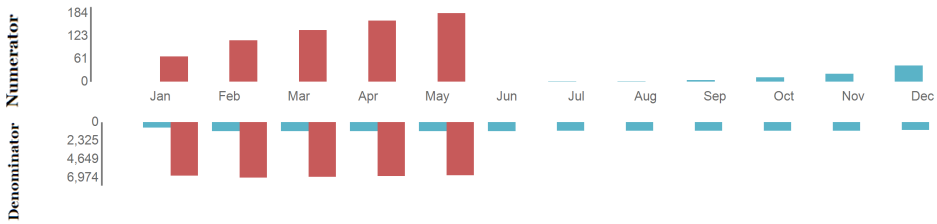
MCAS Performance Trending Metrics

Well-Child Visits in the First 15 Months of Life

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.09%	0.09%	0.37%	1.11%	1.96%	4.31%
2020	1.01%	1.59%	2.00%	2.40%	2.75%							
Goal	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%

184
6,699



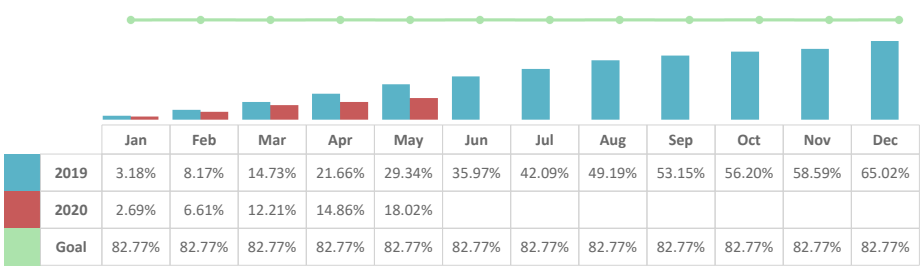
KERN HEALTH SYSTEMS

Governed Reporting System

MCAS Performance Trending Metrics

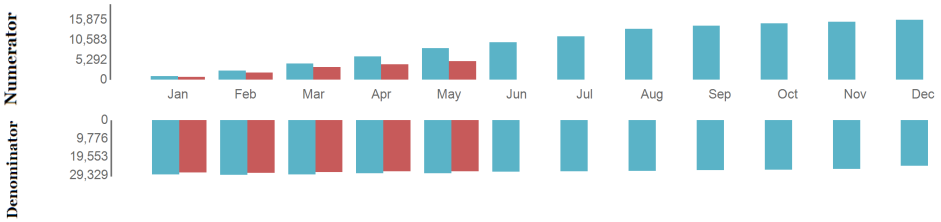
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	3.18%	8.17%	14.73%	21.66%	29.34%	35.97%	42.09%	49.19%	53.15%	56.20%	58.59%	65.02%
2020	2.69%	6.61%	12.21%	14.86%	18.02%							
Goal	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%

4,931
27,360

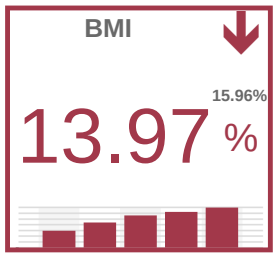


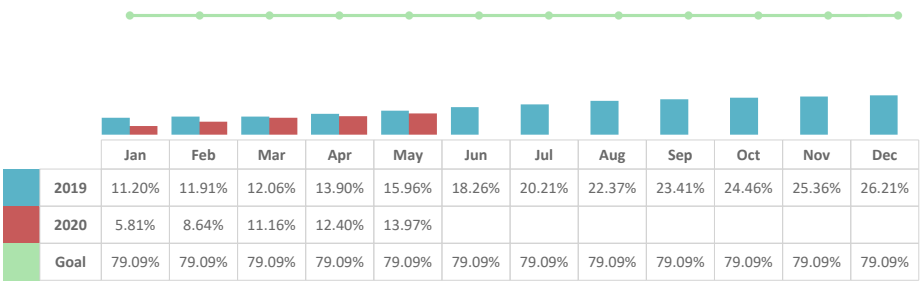
KERN HEALTH SYSTEMS *Governed Reporting System*

MCAS Performance Trending Metrics

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

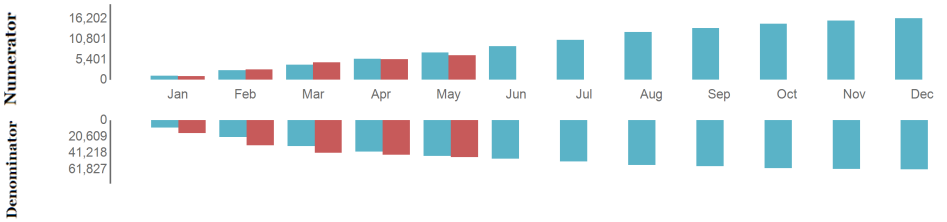
The percentage of members 3-17 years of age who had BMI Percentile documented during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	11.20%	11.91%	12.06%	13.90%	15.96%	18.26%	20.21%	22.37%	23.41%	24.46%	25.36%	26.21%
2020	5.81%	8.64%	11.16%	12.40%	13.97%							
Goal	79.09%	79.09%	79.09%	79.09%	79.09%	79.09%	79.09%	79.09%	79.09%	79.09%	79.09%	79.09%

6,481
46,377



KERN HEALTH SYSTEMS
CHIEF EXECUTIVE OFFICER'S REPORT
June 11, 2020
BOARD OF DIRECTORS MEETING

COVID-19 IMPACT TO OPERATIONS

Remote Work Environment

In March KHS moved swiftly to respond to the emerging COVID-19 pandemic and resulting stay-at-home order. This included several measures taken in support of our members, providers, employees, and the community. Currently around 95% of KHS staff continue to work remotely. KHS Management continues to meet regularly to discuss the status of operations, policy, and regulations. This period of rapid change has necessitated operational agility and required new tools to manage oversight of the organization and its constituents. A significant impact to operations was the transitioning of nearly all staff to remote working. Currently MIS and Management continue to monitor and improve the remote working conditions for staff. The MIS and Corporate Services departments are resolving staff requests quickly and are generally reporting few open issues.

Performance Monitoring

Additionally, Management has been utilizing operational reporting metrics and other tools to ensure the core operations of KHS continues as expected. These operational reports are reviewed daily with the goal of identifying and addressing any anomalies. Generally, the anomalies found have been related to reduced volume of elective services which impacts calls, authorizations, and claims.

Government Requirements

Another area of impact comes from Government legislation, policy and regulation. The pandemic has resulted in numerous regulatory and operational changes that must be monitored and implemented. Government Relations staff has monitored and advocated on draft legislative and policy proposals while the Compliance team coordinates implementation of operational changes required by All-Plan-Letters or similar regulatory guidance. To-date our regulators have issued over 25 All-Plan-Letters or other guidance related to COVID-19. These have resulted in changes to MCAL benefits, medical services requirements, utilization management protocols, network

provider participation qualifications, member outreach responsibilities, member enrollment criteria, provider payment arrangements, etc. Items are tracked and communicated to Management throughout the process of policy development and implementation.

Provider Network Impact

Supporting and monitoring KHS' Provider Network is of critical importance during this time. The Provider Network Management (PNM) team has communicated to our providers about new regulatory and operational guidance including the use of telehealth services and the 24/7 COVID hotline. Additionally, the team is monitoring for provider office closures, reductions in hours, re-openings, etc. Any impacts are communicated to internal teams to minimize member disruption as well as being reported to our regulators. PNM has also overseen our Provider Financial Relief Program which has provided no-interest payment advances to roughly 50 providers to-date.

Return to Work Planning

Finally, Management has convened an internal task force to plan for the eventual return to KHS' offices. This committee is reviewing guidance from local, state, and federal public health and other governmental entities to help inform preparations that must be made in advance of returning staff to the office. This will include a variety of facility and policy changes necessary to meet regulatory requirements. Thankfully KHS operations continue to be stable which allows for a thoughtful and measured approach to returning to the office. Employees have been notified that this committee is in the early stages of developing their policies and a return to the offices is not currently imminent. KHS Management will continue to keep the Board of Directors updated throughout this pandemic.

COMPLIANCE AND REGULATORY ACTIVITIES

Compliance and Regulatory Affairs Report

Attachment A- D are included in the update on regulatory and compliance activities impacting KHS. The length and scope of the Report continues to point to the effect COVID -19 is having on health plans (see Attachment C to the report).

PROGRAM DEVELOPMENT ACTIVITIES

CalAIM

The COVID-19 pandemic and resulting projected budget deficits have necessitated a delay in DHCS' CalAIM efforts. DHCS reiterated their long-term commitment to CalAIM but estimates the programs will be delayed at least one year. DHCS is currently negotiating with CMS to extend existing waiver programs through 12/31/21 to ensure there aren't gaps in services.

Long Term Care and Transplants Carve-In

KHS was notified in May of DHCS' intentions to delay the carve-in of Long Term Care and Major Organ Transplant services. Originally scheduled to transition 1/1/21, the State has not committed to a new effective date. DHCS will continue to keep Health Plans informed when transition planning resumes.

Health Homes Program

Staff continue efforts to implement additional Health Home Sites with Clinica Sierra Vista and implementation of a "distributive model" to serve eligible members identified in community PCP offices. These members will stay with their PCP and receive the enhanced services offered through the HHP via the distributive care team. DHCS had intended to make changes to HHP services under CalAIM, but those changes are on-hold with the rest of the CalAIM initiatives.

Interoperability of Health Information Rule

CMS recently finalized their "Interoperability" rule which requires health plans to provide member data to 3rd parties upon receiving consent from the member. These 3rd parties could be other healthcare providers, health plans, or apps the member would like to share their data with. Plans have until 7/1/21 to come into compliance with the rules. KHS is currently awaiting DHCS guidance but is working toward implementation internally.

LEGISLATIVE SUMMARY UPDATE

Federal Update

In mid-May the House of Representatives passed the HEROES Act, which would be the next phase of coronavirus relief legislation. The $3+ trillion proposal would provide additional funding to states and localities to offset bleak budget projections and provide more financial support to the health care system in fighting the virus, among other major provisions. The bill also includes several smaller notable provisions including: a bump in the federal matching dollars for Medicaid, automatic extensions for expiring 1115 waivers, and a suspension of the proposed Medicaid fiscal accountability rule (MFAR). Attention now turns to the Senate to determine whether this or other legislation will advance. KHS staff continues to work with our federal trade association (ACAP) to advocate for the healthcare related provisions.

State Legislative

The State Legislature reconvened in early May with a condensed schedule and a large projected budget deficit. Many of the bills proposed early in the year have stalled as the legislature pares down the initiatives for consideration in this session. The deadline for bills to advance out of their committee of origin has passed and appropriations hearings are scheduled for early June. Included under Attachment E is a list of active bills being tracked by staff.

Additionally, the State Budget process has been upended due to the COVID-19 pandemic. The Governor released his May revision to the budget which projected a $54 billion deficit. In order to balance the upcoming budget, the Governor's Administration recommended numerous programmatic cuts including several to the Medi-Cal program. Some of the significant proposals included: retro-active and prospective Medi-Cal Managed Care rate cuts, elimination of many Medi-Cal "optional benefits", the elimination of supplemental provider payments via Prop 56, and a delay in the DHCS CalAIM initiatives. Under the Governor's proposal, some of these cuts would be reversed upon receipt of additional federal funding.

Upon release of the May revised budget, the Legislature's Budget Committees are tasked with reviewing and revising the Administration's proposal and then ultimately passing a final budget. In early June the Assembly and Senate released a joint budget agreement. The joint legislative budget plan rejects most of the Governor's proposed Medi-Cal program cuts and assumes additional Federal funding will be received. If Federal funding is not received by September, the joint legislative budget would then trigger a set of alternative revenue generating proposals. Of

note, both the Governor's and Legislature's budget proposals include Managed Care Plan rate cuts, delays in CalAIM, and the continuation of the Pharmacy Carve-Out. KHS staff is working with our Trade Associations to advocate on relevant budget items. The deadline to pass a final budget is mid-June.

DHCS Director's Departure

Dr. Bradley Gilbert recently announced he will retire from his role as Director of DHCS effective June 12th. At this time no replacement has been identified, which leaves Jacey Cooper, Medi-Cal Director and Chief Deputy Director of Health Care Services as the primary liaison with Health Plans.

KHS JUNE 2020 ENROLLMENT:

Medi-Cal Family Enrollment

As of June 1, 2020, Medi-Cal enrollment is 179,480, which represents an increase of 1.0% from May enrollment.

Seniors and Persons with Disabilities (SPDs)

As of June 1, 2020, SPD enrollment is 14,189, which represents a decrease of 0.1% from May enrollment.

Expanded Eligible Enrollment

As of June 1, 2020, Expansion enrollment is 63,921, which represents an increase of 2.2% from May enrollment

Kaiser Permanente (KP)

As of June 1, 2020, Kaiser enrollment is 9,579 which represents an increase of 1.1% from May enrollment.

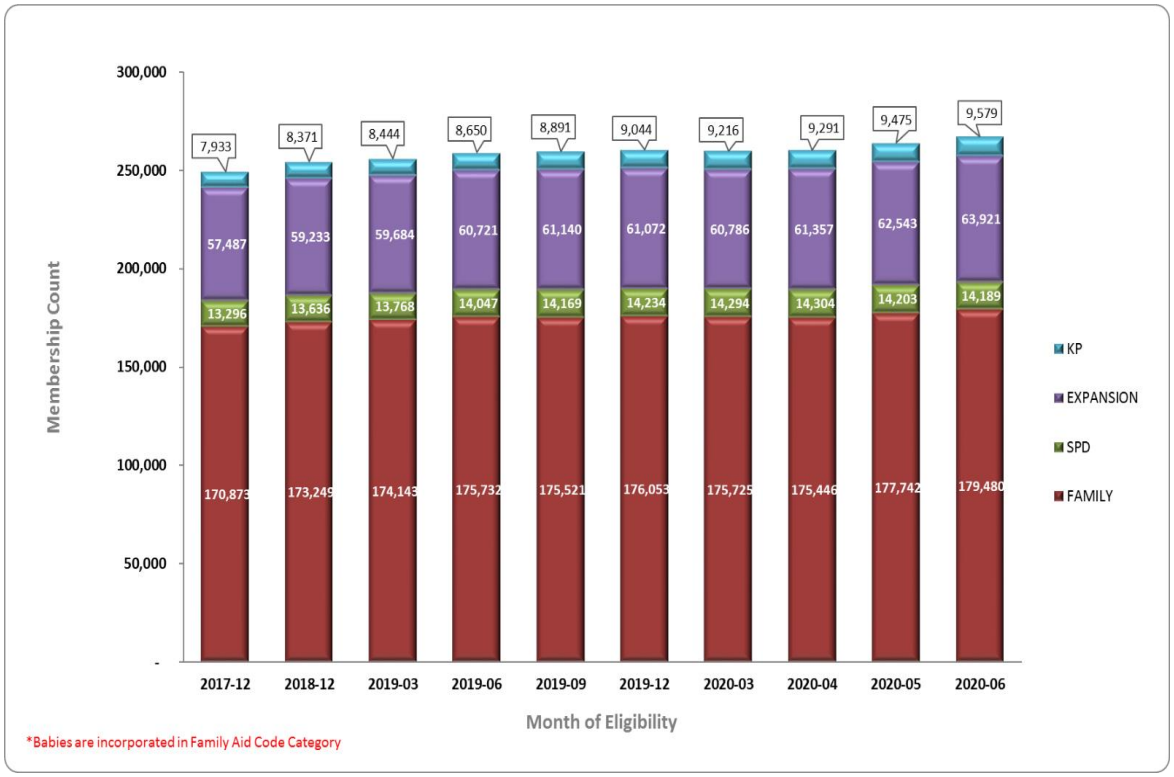
Total KHS Medi-Cal Managed Care Enrollment

As of June 1, 2020, total Medi-Cal enrollment is 267,169, which represents an increase of 1.2% from May enrollment.

Membership as of Month of Eligibility	FAMILY	SPD	EXPANSION	KP	BABIES	Monthly/ Member Months Total
2017-12	170,426	13,296	57,487	7,933	447	249,589
2018-12	172,772	13,636	59,233	8,371	477	254,489
2019-03	173,744	13,768	59,684	8,444	399	256,039
2019-06	175,315	14,047	60,721	8,650	417	259,150
2019-09	175,009	14,169	61,140	8,891	512	259,721
2019-12	175,626	14,234	61,072	9,044	427	260,403
2020-03	175,300	14,294	60,786	9,216	425	260,021
2020-04	175,049	14,304	61,357	9,291	397	260,398
2020-05	177,356	14,203	62,543	9,475	386	263,963
2020-06	179,112	14,189	63,921	9,579	368	267,169

COVID -19 Enrollment Impact

The Kern County Department of Human Services confirmed they are not continuing their "automated discontinuance process" for Medi-Cal Redeterminations through at least the end of August due to the pandemic. As you recall, in January Kern DHS began a new automated discontinuance process when Medi-Cal beneficiaries do not complete the Annual Eligibility Redetermination process. The Department of Health Care Services (DHCS) said the State is still working on a plan to reprocess these cases no sooner than September 2020 via a phased in approach rather than all at once. Kern DHS continues working new Medi-Cal applications, reenrollments, successful renewals, additions, etc. (anything with a positive outcome). DHCS said they expect to see a gradual increase in Medi-Cal applications statewide beginning in July. Locally, Kern DHS said the county has seen a 10% decrease in Medi-Cal applications in 2020.



KHS ADMINISTRATIVE INITIATIVES

Provider Relations Credentialing

Type	May	June
Initials	33	20
Re-credentialing	80	30
New Vendors	5	4

Provider Portal Utilization

Encouraging provider office staff to conduct inquires, track claims, review reports and submit information using the Provider Portal results in faster response times for providers. Below is the utilization summary for the most recent three months of data.

Portal Activity	March 2020	April 2020	May 2020
Total HealthX User Accounts	4,660	5,047	4,445
Total New HealthX User Accounts	446	546	119
Page Views	702,620	517,122	717,361
Unique Page Views	278,335	217,063	290,787
Avg. Time of Page	3:19	3:16	2:38

Provider Contracting (most recent month)

Provider contracts and amendments highlighted this month are as follows:

1. **Hospital contracts in negotiation: complete or in process:**

    - San Joaquin Community Hospital – in negotiation, final stages
    - Valley Children's Hospital – in negotiation, final stages
    - Dignity Health (Bakersfield Memorial and Mercy Hospitals) – negotiations discussions in progress
    - Antelope Valley Hospital – in process
    - Amending hospital contracts to include language pertaining to Hospital Directed Payment (HDP) – in process

2. **Network changes: in process: complete or in process:**

    - Pharmacy network for AB1114 – in review to determine who may be eligible to provide services under the law.
    - Skilled Nursing Facility and Congregate Living Health Facility networks under review for updating
    - NEMT Services – amended a NEMT provider vendor agreements to gain access to gurney services

Provider Contracts Summary (Status)

Open	Inquiries	Waiting signature
76	228	88

Marketing/Public Relations

Community Sponsorships: KHS will share sponsorship in the following events in June and July:

- KHS supported the 5th District Drive-Thru COVID-19 Testing Site at The Prado Senior Center by providing the drive-thru tent, portable air coolers, handwashing sinks, a janitor and lunch, beverages and snacks each day for 25 team members. The site was available from May 4th – June 3rd and it was operational 6 days a week from 8a-2p. The contributions totaled over $26,000.

- KHS is supporting the Oildale COVID-19 County Testing Site at Good Samaritan Hospital by providing small tents, portable air coolers, handwashing sinks, and lunch and beverages each day for 20 team members. The site was opened on May 15th and it will be operational for 1 month, 6 days a week, from 8a-8p (8a-12p on Saturdays). The contributions totaled about $15,000.

- KHS is supporting the Kern River Valley COVID-19 County Testing Site at Kern Valley Hospital by providing the drive-thru tent, portable air coolers, handwashing sinks, and lunch and beverages each day for 5 team members. The site was opened on May 27th and

it will be operational for 2 months, 3 days a week, from 7a-2p. The contributions totaled over $19,000.

- KHS donated $1,000 to the Bakersfield Memorial Hospital Foundation President's Circle.

- KHS supported Bakersfield East Rotary in their fundraising drive to support several local beneficiaries (Valley Fever Americas Foundation, Ronald McDonald House of Bakersfield and Bakersfield East Rotary Foundation) by donating $1,000.

No community events are scheduled in June or July due to the Governor's order disallowing large gatherings.

2020 KFHC Community Grant Program

In recognition of the essential role that community organizations have in our health care delivery system, our Community Grant Program financially aids and encourages innovative efforts to bring beneficial services to our community. Community organizations that serve Medi-Cal beneficiaries and low-income populations are eligible to apply for funding, grant awards range from $500-$2,000.

This year marks the 5th Anniversary of our Community Grant Program. We received a total of 56 applications, four more than last year. The number of applications received grows each year. To date, we've approved 50 of the grant applications totaling $95,350. Funded programs serve the Bakersfield area as well as outlying communities. Below are some of the programs we are proudly supporting.

- **Independent Living Center** - *Mattress Project 2* - This project will help ILCKC's Housing Resources & Services Program fund beds for 17-20 individuals with disabilities that are transitioning into permanent housing.

- **The Salvation Army** - *Bakersfield Adult Rehabilitation Center's Tuberculosis Prevention & Testing* - This project allows the center to provide TB testing to their clients in their one-stop shop where they assess health care needs and ensure access to medical services for prevention and treatment. They serve homeless, hungry and jobless individuals who are at high risk for being infected with TB.

- **California Farmworker Foundation** - *Diabetes Prevention Campaign* - This project will engage farm-working crews in Kern County with a diabetes prevention campaign. CFF, in collaboration with local health care partners, will provide diabetes training and resources to Farmworkers.

- **Catholic Charities** - *Feeding Kern County* - This project will help feed at least 4,000 families in Kern County. Funds will be used to purchase food (peanut butter, milk, cereal, canned fruit and canned vegetables) to make food boxes and distribute them to families in need.

- **Blessing Box Foundation** - *Fighting Food Insecurity During the COVID Crisis* - This project will help provide food assistance to families in need due to COVID-19. This grant will provide some of the most difficult to acquire nonperishable foods for their COVID Emergency Food Bags.

- **Bakersfield Homeless Center** - *Refrigerators to End Homelessness* - This project will help fund 10 refrigerators for 10 families or individuals transitioning from the Bakersfield Homeless Center to permanent housing. Without refrigerators, these individuals/families would not be able to be placed into permanent housing.

- **Alliance Against Family Violence and Sexual Assault** – *Delano Domestic Violence Center Wellness Project* - This grant will help purchase over-the-counter medications such as aspirin and cold and flu medications, first aid supplies and hygiene items such as diapers, feminine hygiene products and deodorant, for about 60 clients at the Delano Domestic Violence Center.

KFHC Advertising Campaign Update

As per the 2020 Marketing Plan, we would utilize our most recent advertising campaign in Q1 and Q2. While we develop our new advertising campaign for 2021 and 2022, we will only utilize billboards in Q3 and Q4 of this year to preserve our permanent billboard location by the Kern County Department of Human Services in Bakersfield. Due to COVID-19, we developed a message to thank our Providers for serving our community that will be displayed on billboards for

the remainder of 2020. We also created a similar message for television to utilize in May and June. Please click on the link below to see a presentation of our Provider Thank You campaign.

https://my.visme.co/projects/010oq7jr-kfhc-thank-you-providers-2020-campaign

Employee Newsletter

The May 2020 Employee Newsletter can be seen by clicking the following link:

https://us20.campaign-archive.com/?u=f1b2565c17b55547feeb94aeb&id=717629a3f0

ADMINISTRATIVE PERFORMANCE REPORTS

Dashboard Presentation

- The Dashboard Reports showing KHS critical performance measurements are located under Attachment F.

KERN HEALTH SYSTEMS

Attachment A

Compliance and Regulatory Affairs Update

Board of Directors Meeting

June 11, 2020

STATE REGULATORY AFFAIRS

Since the April 16, 2020 Board meeting:

- The Department of Health Care Services ("DHCS") issued six All Plan Letters ("APLs"). *See Attachment B for APLs 20-008 – 20-013* that provide guidance for Managed Care Plan's (MCP). All six APLs apply to the Plan and are on track for appropriate implementation as required by the APLs.

- The DHCS issued 25 COVID-19 APLs and Guidance. *See Attachment C for the COVID-19 APL and Guidance*. All 25 APLs apply to the Plan and are on track for appropriate implementation as required by the APL and Guidance.

- The Department of Managed Health Care ("DMHC") issued eight APLs. *See Attachment D for APLs 20-013 – 20-020* that provide guidance for MCPs. Four out of the eight APLs do not apply to the Plan's Medi-Cal business; four are on track for appropriate implementation as required by the APLs.

Number of Regulatory Reports Sent to Government Agencies for April and May 2020:

REGULATORY AGENCY	APRIL 2020	MAY 2020
DHCS	15	17
DMHC	6	5

COMPLIANCE

DMHC Office of Enforcement

On April 16, 2020, the DMHC Office of Enforcement concluded their investigation into

enforcement matter number 18-936. The Department conducted an onsite portion of the survey from August 29, 2016, through September 1, 2016. The Preliminary Report of the Routine Survey was issued to the Plan on January 9, 2017. The Department issued the Final Report of the Routine Survey on March 16, 2017. In the Final Report, the Department identified one corrected deficiency and five uncorrected deficiencies. On December 21, 2017, the Department notified the Plan that the Follow-Up Survey had commenced, and requested the Plan submit information regarding its uncorrected deficiencies as cited in the Final Report. The Department conducted its Follow-Up Survey and found three of the previous outstanding deficiencies corrected while two remained uncorrected. The Department issued the Routine Survey Follow-Up Report on August 30, 2018. The two uncorrected deficiencies were as follows:

- The Plan's Board of Directors did not periodically review the written record of grievances, and document its review.
- The Plan fails to ensure it satisfies required physician-to-enrollee ratios.

The Plan acknowledged the areas of violation and wrote a corrective action plan ("CAP"). The Office of Enforcement accepted the CAP and an administrative penalty of $5K.

DMHC Notice of Nonroutine Survey of Kern Health Systems

On May 18, 2020, the Plan was notified by the DMHC of the intent to conduct a nonroutine survey. The nonroutine survey will evaluate the Plan's utilization management ("UM") operations and its clinical criteria and guidelines between June 1, 2016 through May 31, 2020. The nonroutine survey will include the examination of how the Plan develops and maintains its clinical criteria and guidelines, the Plan's utilization review practices, UM decision making practices, including the Plan's practices pertaining to the treatment of varicose veins, and other related operations. The nonroutine survey is scheduled to commence on October 5, 2020.

Per the DMHC, "based on a provider complaint concerning the Plan's UM operations and various documentation obtained from the Plan, the Department is concerned and has reason to believe the Plan is no longer meeting standards set forth in Articles 4 and 5 of the Knox-Keene Act, including Sections 1363.5, 1367, and 1367.01." The Plan will be working with outside counsel to provide legal advice, help prepare for the survey, and assist in responding to the Department's report.

Summary of Alleged Fraud Investigations for April and May 2020

The Plan coordinates and communicates information and evidence of alleged fraud to appropriate state and federal officials. The Compliance Department maintains communications with state and federal agencies and cooperates with their related requests. Information gathered during an investigation is forwarded to the appropriate state and federal agencies as needed.

State Medi-Cal Program Integrity Unit Requests for Information April & May 2020

Provider

In the months of April and May 2020, the Plan received three requests for information from the State Medi-Cal Program Integrity Unit related to alleged provider fraud, waste, or abuse. The Plan has completed one investigation and the data was forwarded to the DHCS. The Plan currently has two investigations pending analytics for the Department. The Plan does not know the outcome of the Department's investigation pertaining to the completed case.

Member

The Plan received one request for information from the State Medi-Cal Program Integrity Unit related to a Plan Member. Data reports were provided by the Plan's Business Intelligence team and forwarded to the DHCS. The Plan does not know the outcome of the Department's investigation pertaining to the case.

Summary of Potential Protected Health Information ("PHI") Disclosures for April & May 2020

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 April and May 2020, the Compliance Department investigated and reported three individual alleged privacy concerns to the DHCS. Two of the reported cases were closed. One case is still in review. DHCS determined the closed cases to be a non-breach due to the corrective action and mitigation steps taken by the Plan, and the low level of risk involved in each case.

Summary of Alleged Fraud Investigations for April and May 2020

The Plan coordinates and communicates information and evidence of alleged fraud cases to appropriate state and federal officials. The Plan cooperates with the related requests. Information gathered during an investigation is forwarded to the appropriate state and federal agencies as required.

Member

During the months of April and May 2020, the Compliance Department received nine reports of alleged fraud, waste, or abuse by the Plan's Members. The cases are still under review.

Provider

During the months of April and May 2020, the Plan received three allegations of fraud, waste, and abuse involving participating providers. Two of the reported allegations were found to be unsubstantiated. One allegation is currently being reviewed by the Compliance Department.

Compliance Education and Presence

The Compliance Department has initiated its first monthly newsletter to relay various Compliance topics to all staff. The first Compliance Capsule released in May is titled “HIPAA Outside of the Office”.

Compliance Capsule – May 2020

HIPAA Outside of the Office

Q: Do the Same Privacy and Security Standards Apply When Working Remotely?

A: Yes!

During the COVID-19 pandemic, the same privacy and security standards apply when working remotely. It is important to keep Personally Identifiable Information ("PII") and Protected Health Information ("PHI") private.

While some may work from the home office, the kitchen table, or simply stepping outside to have a quiet space on a conference call, family or friends could possibly oversee your work or overhear your conversation. Here are a few ways that you can help protect PII and PHI of Members while working outside of Kern Health Systems ("KHS") premises:

- Do not let anyone use your work laptop or work phone. Having an extra device around the house when everyone is at home would be helpful, but it is against KHS policy and puts the privacy of KHS Members at risk when others use your work device.
- Shield your screens when working and lock your device's screen when you are away. While you may think people in the home are uninterested in what is on your screen, it would still be a violation of the Health Insurance Portability and Accountability Act ("HIPAA") if a family member or other person was able to see any PHI.
- Do not have conversations about PII or PHI in front of other family members or friends. If you are on a work-related call, do not allow others the ability to overhear the PHI of Members.

If you have any questions about how to protect PII or PHI while working outside of the office, contact the Compliance Department at Compliance@khs-net.com or the Director of Compliance and Regulatory Affairs at 661.664.5016.

Ethics Hotline is available 24/7 - All calls are Strictly Confidential: 800.500.0333

KERN HEALTH SYSTEMS

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
April May 2020 Attachment B

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-001	2020-2021 Medi-Cal Managed Care Health Plan Meds/834 Cutoff And Processing Schedule	IT Compliance	The purpose of this APL is to provide Plans with the 2020-2021 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.	1/4/2020	1. Schedule sent to IT for review. 2. Complete	
APL20-002	Non-Contract Ground Emergency Medical Transport Payment Obligations	Claims IT Finance Compliance	The purpose of this APL is to provide Plans with pertinent information concerning enhanced reimbursement obligations ground emergency medical transport (GEMT) service.	2/20/2020	1. Stakeholders updated GEMT reports. 2. Complete	
APL20-003	Network Certification Requirements	Provider Network Management Compliance	The ANC provides a prospective look at the Plan's network for the upcoming contract year (CY). Plans are required to annually submit documentation to the Department of Health Care Services (DHCS) to demonstrate the adequacy of their networks.	2/27/2020	1. APL sent to Stakeholders 2. Due date extended until April 20, 2020.	
APL20-004	Emergency Guidance for Medi-Cal Managed Care Health Plans	Member Services PNM Health Services Claims Compliance	Highlights the flexibilities included in the approved 1135 Wavier, including, State Fair Hearings, Provider Enrollment, Prior Authorization, Reimbursement of COVID-19 Testing, and Provision of Care in Alternate Settings.	3/26/2020	1. Sent to all Stakeholders on 3/30/20 2. Meeting scheduled for 4/7/2020 3. Complete	
APL20-005	Extension of the Adult Expansion Risk Corridor for State Fiscal Year 2017-2018	Finance Compliance	The APL notifies Plans that DHCS will extend the Adult Expansion Risk Corridor for SFY 2017-2018	3/26/2020	1. Sent to all Stakeholders on 3/30/2020 2. Stakeholder meeting scheduled for 4/7/2020 3. Complete	

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
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APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-006	Site Reviews: Facility Site Reviews and Medical Record Review	Health Services Quality Improvement Compliance	The APL informs MCPs of updates to the DHCS site review process, which includes Facility Site Review and Medical Record Review policies.	4/8/2020	1. 4/8/2020 sent to Stakeholders 2. 4/21/20 Small Stakeholder meeting scheduled	
APL20-007	APL20-007 Policy Guidance for Community-based Adult Services in Response to COVID-19 Public Health Emergency	Pharmacy PNM Health Services Compliance	The APL discusses the expansion of health care delivery via telehealth and methods to reduce the need for in-person Pharmacy visits.	3/30/2020	1. 3/30/20 APL sent to Stakeholders 2. 4/3/20 Meeting scheduled to review the APL 3. Complete	
APL20-008	APL20-008 Mitigating Health Impacts of Secondary Stress due to COVID-19 Emergency	Marketing PNM Member Services Health Services Compliance	The purpose of this All Plan Letter is to offer recommendations to Medi-Cal managed care health plans on mitigating negative health outcomes to members due to the COVID-19 emergency.	4/10/2020	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholder meeting schedule	
APL20-009	APL 20-009 Older/At-Risk Individuals – Guidelines to Reduce Isolation and Promote Health While Sheltering at Home	Member Services Health Services PNM Compliance	During California's stay-at-home order, older members and other at-risk members – especially those living alone – will likely need their MCPs, as well as family, friends, neighbors and community, to help them maintain basic needs like groceries and prescriptions, and much-needed social interaction and connection.	4/18/2020	1. 4/18/20 Sent to Stakeholders 2. 4/27/20 Stakeholders met and shared resource information and identified efforts to reach at risk individuals. 3. Complete	

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
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APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-010	APL20-010 Cost Avoidance	Claims IT Finance Compliance PMO	The APL provides updated clarification and guidance to MCPs with respect to the requirements for cost avoidance and post-payment recovery when an MCP member has other health coverage (OHC).	5/12/2020	1. 5/12/20 Small Stakeholder meeting 2. 5/27/30 Unplanned Project Stakeholder Meeting.	
APL20-011	APL20-011 Governor's Executive Order N-55-20 in response to COVID-19	Claims Health Services PNM Member Services Pharmacy Compliance	This Executive Order provides for various flexibilities in relation to state statutes and regulations, thereby allowing DHCS to take appropriate actions to mitigate the effects of the COVID-19 pandemic.	4/24/2020	1. 4/25/20 Sent to Stakeholders 2. 5/8/20 Stakeholder meeting. Stakeholder reviewed documents. Follow-up meeting for IHA completion scheduled. 3. Complete	
APL20-012	APL20-011 Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21	Health Services Quality Improvement Compliance	The APL clarifies MCPs obligations related to the provision of case management services for Private Duty Nursing (PDN) services that have been approved for members under the age of 21pursuant to the EPSDT benefit.	5/15/2020	1. 5/21/20 APL and attachments sent to Stakeholders 2. 5/29/20 Small Stakeholder meeting scheduled.	
APL20-013	APL 20-013 Proposition 56 Directed Payments for family Planning Services.	Claims PNM Finance IT Member Services Compliance	The APL provides MCPs with guidance on directed payments, Proposition 56, for the provision of specified family planning services with dates of service on or after July 1, 2019.	5/14/2020	1. 5/13/20 Sent to Stakeholders. 2. 5/20/20 Potentially eliminated in May 2020 Governor's Budget. Compliance is monitoring.	

KEY	
	Compliance - YES
	Compliance - NO
	Outcome Pending

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APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
			N/A - informational document			

KHS COVID-19 Tracking Log
April May 2020 Attachment C

State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	5/20/2020	Link	Associate Clinical Social Worker and Associate Marriage and Family Therapist Services for Federally Qualified Health Centers and Rural Health Clinics	PNM Health Services QI Claims	1. 5/26/20 Sent to Stakeholders 2. 6/4/20 Stakeholder meeting scheduled.	Pursuant to the federally approved State Plan Amendment (SPA) 20-0024, a FQHC or RHC can be reimbursed at the Prospective Payment System (PPS) rate for a visit between a FQHC or RHC patient and an ACSW or AMFT. The visit may be conducted as a face to face encounter or meet the requirements of a face to visit provided via telehealth.
DHCS	5/13/2020	Link	Email: Member Notification Flexibilities Update	Member Services Marketing Compliance	1. 5/13/20 Sent to Stakeholders **2. Complete**	DHCS is not able to allow MCPs flexibility to provide non-public member notices electronically, as several California state laws, for which DHCS does not have Executive Order authority to waive, require MCPs to specifically mail such written notices to members. MCPs to specifically mail such written notices to members. As a result, MCPs must continue to follow all current written noticing requirements for non-public member notices, such as those used for Grievances and Appeals, and ensure that members are properly informed of their rights regarding MCP actions.
DHCS	4/30/2020	Link	APL19-017 Supplement Quality and Performance Improvement Adjustments Due to COVID-19	Health Services Quality Improvement Provider Relations Compliance	1. 4/30/20 Sent to Stakeholders 2. 5/19/20 Stakeholders reviewed the APL and QI stated that they were currently meeting the requirements. **3. Complete**	On March 13, 2020, NCQA released guidance on reporting year (RY) 2020 Healthcare Effectiveness Data Information Set (HEDIS) reporting. This included an adjustment for RY 2020 reporting on measures utilizing the hybrid methodology given the limitations on medical record collection imposed by COVID-19 due to travel restrictions, quarantines, and risk to staff.
DHCS	4/27/2020	Link	APL20-004rev Emergency Guidance for Medi-Cal Managed Care Health Plans in Response to COVID-19	Pharmacy Member Services Claims Health Services Health Homes Program IT Compliance	1. 4/27/20 Sent to Stakeholders 2. 5/11/20 Stakeholders met and reviewed updated requirements. **3. Complete**	The purpose of this APL revision is to provide information to Medi-Cal managed plans on temporary changes to federal requirements as a result of the ongoing global Novel Coronavirus Disease (COVID-19) pandemic. The APL covers the approved 1135 Waiver and other guidance provided by DHCS in response to the public health crisis.

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State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DMHC	4/29/2020	Link	APL20-018 COVID-19 (OPM) Modification of Timely Access Provider Appointment Availability Surveys (PAAS) Timeframes	PNM Claims	1. 4/29/20 Sent to Stakeholders 2. Complete	Health and Safety Code section 1367.03(f)(3) and page 11 of the PAAS Methodology require health plans to complete the administration of the PAAS between April 1 and December 31. For MY 2020, health plans shall begin administration of the PAAS no earlier than August 1, 2020.
DHCS	4/27/2020	Link	Information on Closures/Changes March 11 through April 24, 2020	PNM Health Services Member Services Compliance	1. 4/27/20 Sent to Stakeholders 2. 4/28/20 Stakeholder meeting held 3. 4/29/20 Questions raised about the template on All Plan Call 4. 5/4/20 Template due to DHCS (Plans may submit sooner) 5. 5/11/20 PNM submits weekly report. **6. Complete**	The Department of DHCS needs to ensure that members assigned to your managed care plans are not experiencing access to care issues as a result of closures/changes (including but not limited to provider offices, clinics, medical offices, etc.) related to COVID-19. Therefore, the DHCS is requiring that MCPs report to the DHCS via the attached Excel template
DHCS	4/25/2020	Link	Waiver of Requirement for Patient Signature On-File for Mailed or Delivered Prescriptions	Pharmacy PNM Member Services Health Services Compliance	1. 4/25/20 Sent to Bruce Wearda for clarification 2. 4/29/20 Sent to all Stakeholders 3. 5/4/20 Per Bruce, this is FFS, not Medi-Cal **4. Complete**	Effective immediately the Department of Health Care Services (DHCS) will allow any form of delivery service tracking or electronically documented proof of delivery to suffice as proof of receipt of a drug or device by the Medi-Cal and Family PACT beneficiary or authorized representative.
DHCS	4/24/2020	Link	APL20-011 Governor's Executive Order N-55-20 in response to COVID-19	Quality Improvement Health Services Member Services PNM Compliance	1. 4/25/20 Sent to Stakeholders 2. 5/8/20 Stakeholder meeting. Stakeholder reviewed documents. Follow-up meeting for IHA completion scheduled. **3. Complete**	This Executive Order provides for various flexibilities in relation to state statutes and regulations, thereby allowing DHCS to take appropriate actions to mitigate the effects of the COVID-19 pandemic - specifically as it applies to MCP Site Reviews and Subcontractor Monitoring, Annual Medical Audits, and Health Risk Assessments.

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State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	4/24/2020	Link	Well-Child Visits During Coronavirus (COVID-19) Pandemic	PNM Health Services Member Services Compliance	1. 4/25/20 Sent to Stakeholders 2. 5/4/20 Stakeholder meeting scheduled. 3. 6/4/20 Additional Stakeholder meeting scheduled to discuss telehealth options.	Where community circumstances require pediatricians to limit in-person visits, this guidance encourages clinicians to prioritize in-person newborn care, and well visits and immunizations of infants and young children (through 24 months of age) whenever possible.
DHCS	4/22/2020	Link	Information about Novel Coronavirus for Medi-Cal Transportation Providers	Member Services PNM Compliance	1. 4/23/20 Sent to Stakeholders 2. 4/23/20 **Complete**	The DHCS continues to closely monitor the emerging 2019 COVID-19 situation, and is providing information to all nonemergency medical transportation NEMT and nonmedical transportation (NMT) providers as a reminder of federal Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH)-recommended safety procedures and protocols to help prevent spread of COVID-19.
DHCS	4/17/2020	Link	Medication Assisted Treatment and Telehealth - COVID-19 FAQ - for FFS	Member Services PNM Health Services Compliance	1. 4/18/20 Sent to Stakeholders - Bruce verified that is was related to FFS 2. **Complete**	Telehealth FAQ for FFS updated April 7, 2020
DHCS	4/17/2020	Link	Breast and Cervical Cancer Treatment Program (BCCTP) Presumptive Eligibility Flexibilities due to COVID-19	Member Services Health Services PNM Compliance	1. 4/18/20 Sent to Stakeholders 2. 5/1/20 Stakeholder Meeting scheduled	DHCS is approving immediate flexibilities for Every Woman Counts (EWC) and Family Planning, Access, Care, and Treatment (FPACT) program Qualified Providers that are enrolling individuals into the Breast and Cervical Cancer Treatment Program (BCCTP) to limit potential exposure to COVID-19.
DHCS	4/17/2020	Link	APL 20-009 Older/At-Risk Individuals – Guidelines to Reduce Isolation and Promote Health While Sheltering at Home	Member Services Health Services PNM Compliance	1. 4/18/20 Sent to Stakeholders 2. 4/27/20 Stakeholders met and shared resource information and identified efforts to reach at risk individuals. 3. Complete	During California's stay-at-home order, older members and other at-risk members – especially those living alone – will likely need their MCPs, as well as family, friends, neighbors and community, to help them maintain basic needs like groceries and prescriptions, and much-needed social interaction and connection.

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State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	4/16/2020	Link	Email: E-Mail File and Use	Marketing Member Services Health Services Compliance	1. 4/16/20 Sent to Stakeholders 2. **Complete**	MCPs are approved to utilize a "file and use" approach for COVID-19 related emails with the agreement and understanding that the information being shared by the MCPs is in alignment with information or guidance already shared and approved regarding COVID-19 from DHCS, CDPH or the Centers for Disease Control and Prevention.
DMHC	4/16/2020	Link	DMHC APL20-016 Assistance to Seniors	Health Services PNM Claims Configuration Compliance	1. 4/16/20 Sent to Stakeholders 2. 4/27/20 Stakeholders met and shared resource information and identified efforts to reach at risk individuals. **3. Complete**	The purpose of this All Plan Letter is to offer reminders and resources to help health care service plans serve enrollees who are aged 60+ or have high-risk health conditions during the COVID-19 emergency response stay home, stay healthy, and stay connected.
DHCS	4/15/2020	Link	DHCS APL20-007rev Policy Guidance for Community-Based Adult Services response to COVID-19 Public Health Emergency	Health Services PNM Claims Configuration Compliance	1. 4/16/20 Sent to Stakeholders 2. 4/23/20 Meeting Scheduled with Stakeholders 3. CBAS Centers have completed the applications and submitted them to DHCS. **4. Complete**	APL 20-007rev provides Plans with policy guidance regarding the temporary authorization of Community-Based Adult Services (CBAS) provided telephonically, in members' homes, and individually in centers, in lieu of congregate services provided at CBAS centers, during the period of this current public health emergency. **This revision includes updates from the California Department on Aging and requirements related to alternative services provided during the COVID-19 health emergency.
DMHC	4/13/2020	Link	DMHC APL20-015 Temporary Extension of Plan Deadlines	Health Services PNM Member Services Claims Compliance	1. 4/14/20 Sent to Stakeholders 2**. Complete**	COVID-19 Temporary Extension of Plan Deadlines In light of the COVID-19 State of Emergency, the Director has determined that select deadlines and requirements may be temporarily extended to give health plans additional time to comply.

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State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	4/13/2020	Link	Follow-up Guidance to MEDIL I 20-07	Member Services Compliance Config	1. 4/13/20 Sent to Stakeholders 2. 4/13/20 Complete	The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to provide additional information and clarification for counties and the Statewide Automated Welfare System (SAWS) regarding the instructions found in MEDIL I 20-07. MEDIL I 20-07 directs counties to delay processing of Medi-Cal annual renewals, and defer discontinuances and negative actions based on the declared State and National Emergency due to the COVID-19 public health crisis.
DHCS	4/3/2020	Link	Every Woman Counts (EWC) Primary Care Provider (PCP) Information Notice Program	PNM Health Services Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/10/20 Stakeholders reviewed analytics 3. 4/24/20 Stakeholder meeting scheduled	It is critical that EWC providers assess their office policies and follow recommended safety procedures and protocols from the federal Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) to help prevent the spread of the virus. The Guidance provides information on enrollment and re-certification.
DHCS	4/10/2020	Link	Update Provision of Care in Alternative Settings, Hospital Capacity, and Blanket Section 1135 Waiver Flexibilities for Medicare and Medicaid Enrolled Providers Relative to COVID-19	Member Services Provider Relations Claims Health Services Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholder meeting scheduled	This revised notice is to inform providers of the additional waivers flexibilities applicable to Medi-Cal providers enrolled in Medicare and Medicaid Programs. These waivers are in effect, with a retroactive effective date of March 1, 2020, through the end of the PHE. Where these flexibilities affect Medi-Cal billing or prior approval policies, DHCS has included additional billing guidance, where warranted, at the end of the flexibility, and added applicable website links to the additional CMS fact sheets
DHCS	4/9/2020	Link	"File and Use" Approach for Robocall and Phone Call Campaigns, Printed Mailer Communications	Marketing Member Services C&L Health Services	1. 4/9/20 Sent to Stakeholders 2. Complete	DHCS is approving the "file and use" approach for robocall and phone call campaigns and printed mailer communications in response to COVID-19. MCPs are approved to utilize a "file and use" approach for these COVID-19 related robocalls, phone call campaigns and printed mailer communications in response to COVID-19 with the agreement and understanding that the information being shared by the MCPs is in alignment with the Plans' already approved Emergency Call Scripts
DHCS	4/8/2020	Link	Coverage of Emergency COVID-19 Inpatient or Outpatient Services	Member Services Provider Relations Claims Health Services Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/14/20 Stakeholder meeting scheduled	The guidance states that all enrolled Medi-Cal beneficiaries, regardless of their scope of coverage under Medi-Cal or documentation status, are entitled to all inpatient and outpatient services necessary for the testing and treatment of COVID-19 as certified by the attending physician. The guidance also provides billing information.

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State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DMHC	4/7/2020	Link	APL 20-014 Mitigating Negative Health Outcomes due to COVID-19	Marketing PNM Member Services Health Services Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholder meeting scheduled	The purpose of this All Plan Letter is to offer reminders and resources to help health care service plans serve enrollees and mitigate negative health outcomes to members due to the COVID-19 emergency.
DHCS	4/7/2020	Link	APL20-008 Mitigating Health Impacts of Secondary Stress due to COVID-19 Emergency	Marketing PNM Member Services Health Services Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholder meeting schedule	The purpose of this All Plan Letter is to offer recommendations to Medi-Cal managed care health plans on mitigating negative health outcomes to members due to the COVID-19 emergency.
DHCS	4/7/2020	Link	Telehealth Services Guidance email	PNM Claims Configuration Member Services Health Services Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/13/20 Stakeholder meeting scheduled.	Although the DHCS' Section 1135 Waiver has not yet been approved, DHCS has instructed all Medi-Cal providers, including for FQHCs, RHCs, and IHS clinics, to implement the guidance relative to telehealth and virtual/telephonic communication modalities immediately in light of COVID-19.
DHCS	4/3/2020	Link	1135 Waiver (4/3/20)	ONM Claims Configuration Member Services Health Services	1. 4/7/20 Sent to Stakeholders 2. **Complete**	1135 Waiver (4/3/20) request that will provide the State with greater flexibility in managing the COVID-19 health crisis. Included in the Waiver is language that clarifies the parameters for telehealth and telephonic services provided by RHCs and FQHCs.
DHCS	4/1/2020	Link	Use of Telehealth During COVID-19 Emergency	PNM Health Services Claims Compliance	1. 4/1/20 Sent to Stakeholders. 2. **Complete**	An email from DHCS reminding Plans of the changes to telehealth services, including; communication methods, HIPAA issues, and the use of telehealth by FQHCs and RHCs.

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State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	3/30/2020	Link	DHCS Releases Guidance Related to "File and Use" of Texting Campaign Requests Related to COVID-19	Marketing C&L Member Services Health Services	1. 3/30/20 Sent documents to Stakeholders 2. 4/1/20 Meeting scheduled to discuss DHCS comments. 3. 4/6/20 KHS has documents that require approval by DHCS prior to moving forward. Compliance will ask DHCS to approve documents that were submitted in December 2019. 4. In-progress	For Plans that have any prior approved texting campaigns on file with DHCS (as of June 18, 2019, forward) to submit a new request related to COVID-19 for "file and use." For those MCPs that do not have an approved texting campaign on file with the DHCS, DHCS indicates it cannot approve "file and use" but will make every effort to expedite review of the submission once received.
DHCS	3/30/2020	Link	APL20-007 Policy Guidance for Community-based Adult Services in Response to COVID-19 Public Health Emergency	Health Services PNM Claims Configuration Compliance	1. 3/30 /20 APL sent to Stakeholders 2. 4/3/20 Meeting scheduled to review the APL 3. **Complete**	APL 20-007 provides Plans with policy guidance regarding the temporary authorization of Community-Based Adult Services (CBAS) provided telephonically, in members' homes, and individually in centers, in lieu of congregate services provided at CBAS centers, during the period of this current public health emergency. The APL outlines mechanisms by which CBAS centers may continue to provide services to CBAS members now remaining at home. The APL also addresses reimbursement for these temporary services, as well as reporting requirements for CBAS centers
DHCS	3/30/2020	Link	Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 (COVID-19)	PNM Member Services Health Services Compliance	1. 3/30/20 Sent to Stakeholders 2. 4/3/20 Heather met with Melissa, Robin DM, and discussed language for Provider Bulletin. 3. 4/9/20 Compliance is drafting and updated Provider Bulletin to include additional topics.	DHCS reminds providers that no person, on the basis of mental, developmental, intellectual, or physical disability or a perceived disability, may be unlawfully denied full and equal access to the benefits of Medi-Cal services, including the receipt of COVID-19 treatment, in the event of limited hospital or other health care facility resources and/or capacity.

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State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	3/28/2020	Link	Provision of Care in Alternative Settings, Hospital Capacity, and Blanket 1135 Waiver Flexibilities - Mar 27, 2020	Health Services PNM Configuration	1. 3/30/20 Sent to all Stakeholders 2. 4/3/20 Stakeholders reviewed requirements and found no impediments to implementation 3. **Complete.**	The 1135 Waiver relaxes several rules, including: reimbursement to unlicensed facilities under certain conditions, removes restrictions from Critical Access Hospitals, and address the requirement for qualifying hospital stay prior to SNF authorization.
DMHC	3/27/2020	Link	APL20-012 Health Plan Actions to Reach Vulnerable Populations	Health Services Member Services Compliance	1. 3/30/20 Carmen working with Stakeholders to complete required submission on 3/31/20 2**. Complete**	Health Plans should be actively engaging with vulnerable populations. By March 31, 2020, each health plan to which this All Plan Letter applies shall file with the Department of Managed Health Care (DMHC): A description of the steps the health plan has taken or is taking to contact (1) enrollees over age 65 and approximately how many enrollees the Health Plan has contacted in each category provided by the DMHC.
DHCS	3/27/2020	Link	APL 20-004 Emergency Guidance for Medi-Cal Managed Care Health Plans - Mar 27, 2020	All	1. Sent to all Stakeholders on 3/30/20 2. 4/7/20 Stakeholders met and reviewed the APL. There were no impediments to implementation. 3. **Complete**	Highlights the flexibilities included in the approved 1135 Wavier, including: State Fair Hearings, Provider Enrollment, Prior Authorization, Reimbursement of COVID-19 Testing, and Provision of Care in Alternate Settings.
DHCS	3/27/2020	Link	Guidance for Emergency Medi-Cal Provider Enrollment	PNM Compliance	1. 3/26/20 Sent to Stakeholders 2. 3/27/20 Compliance met with Stakeholders - The Plan is ready to follow the guidance if needed. Will potentially be used for telehealth. 3. **Complete**	DHCS is establishing requirements and procedures to suspend certain provider enrollment requirements in order to facilitate greater beneficiary access to care. After the crisis the Providers will have to go back and enroll through the normal process.

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April May 2020 Attachment C

State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	3/26/2020	Link	State Fair Hearing Timeframe Change - Managed Care - Mar 26, 2020 - Supplement to All Plan Letter 17-006	Member Services Compliance Config	1. 3/26/20 Sent to Stakeholders 2. 3/27/20 Compliance met with Stakeholders 3. 4/1/20 Compliance met with stakeholders. 4. 04/8/2020 DHCS approved letter language. Stakeholders implementing guidance. 5. **Complete**	The March 23, 2020, Section 1135 Waiver approval temporarily extends the timeframe and allows beneficiaries to have more than 90 days, up to an additional 120 days, for an eligibility or FFS appeal to request a State Fair Hearing. Specifically, individuals for whom the 90-day deadline would have occurred between March 1, 2020, through the end of the COVID-19 public health emergency, are now allowed up to an additional 120 days to request a State Fair Hearing (i.e. initial 90 day timeframe plus an additional 120 days, for a total of up to 210 days). All other existing State Fair Hearing processes remain unchanged.
DHCS	3/19/2020	Link	COVID-19 Lab Tests are New Medi-Cal Benefits	Claims Configuration	1. 3/27/20 Sent to Claims - Robin sent an IR when the codes were first announced. Config has updated. 2**. Complete**	From the Medi-Cal website, provides testing codes for COVID-19
DMHC	3/18/2020	Link	APL20-008 Provision of Health Care Services During Self Isolation Orders	Member Services Health Services PNM Compliance	1. 4/2/20 Sent to Stakeholders 2. 4/6/20 Stakeholder reviewed APL and are working to implement the requirements. **3. Complete**	Plans were provided guidance for the provision of Health Care Services During Self Isolation Orders.

KHS COVID-19 Tracking Log
April May 2020 Attachment C

State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	3/18/2020	Link	Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19) v.3	PNM Health Services Member Services Compliance	1. Sent 3/19/20 Sent to Stakeholders 2. 3/20/20 Met with Stakeholders 3. 3/23/20 Met with Stakeholders - Action Items include an updated Provider Bulletin, implementation of new codes and rates. 4. 3/30/20 Robin DM put in IR for codes. **5. Complete**	The Bulletin provides new codes and rates for telehealth/telephonic encounters. Additionally, it addresses the potential relaxing of the telehealth requirements for FQHCs and RHCs.
DMHC	3/18/2020	Link	APL 20-009 (OPL) - Reimbursement for Telehealth Services	PNM Health Services Claims Member Services Compliance	1. 3/18/20 Compliance reviewed the APL and conferred with PNM and concluded that current KHS P&Ps support the APLs requirements and does impede the implementation of APL. 2. **Complete**	Effective immediately, Plans must comply with the following: shall reimburse providers at the same rate or services provided via telehealth, a health plan may not subject enrollees to cost-sharing greater than the same cost-sharing if the service were provided in person, and Plans shall provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the enrollee.
DHCS	3/18/2020	Link	Medi-Cal Payment for Medical Services Related to the 2019-Novel Coronavirus (COVID-19) - Supplemental to APL19-006	PNM Health Services Claims Member Services Compliance	1. Sent 3/19/20 Sent to Stakeholders 2. 3/20/20 Met with Stakeholders 3. 3/23/20 Met with Stakeholders - Action items completed including; Configuration and creation of a Provider Bulletin. 4. **Complete**	Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery and Plan MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video.

KHS COVID-19 Tracking Log
April May 2020 Attachment C

State Agency	Release Date	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	3/17/2020	Link	MEDIL I 20-07 Access to Care During Public Health Crisis or Disaster	Member Services Config	1. Sent to Stakeholders on 3/30/20 2. **Complete**	Directive to County Agencies to continue to provide benefits beyond the certification period, as needed, to provide additional time to submit renewals or verifications, and Modify eligibility requirements at application or renewal to allow for self-attest
DHCS	3/16/2020	Link	Medi-Cal Payment for Medical Services Related to the 2019-Novel Coronavirus (COVID-19)	Health Services PNM Configuration	1. 3/30/20 Sent to Stakeholders 2. **Complete**	Provides guidance for Medi-Cal providers of existing state and federal laws requiring Medi-Cal providers to ensure their patients do not experience barriers. Discusses telehealth as it relates to providing services timely.
DHCS	3/14/2020	Link	COVID-19 Guidance for NEMT and NMT Providers	Member Services Marketing Compliance	1. Sent to Stakeholders on 4/1/20 2. **Complete**	Provides information to all non-emergency medical transportation (NEMT) and non-medical transportation (NMT) providers as regarding recommended safety procedures and protocols to help prevent spread of COVID-19.
DMHC	3/12/2020	Link	APL 20-007 (OPL) "Social Distancing" Measures in Response to COVID-19	Pharmacy PNM Health Services Compliance	1. 3/16/20 APL sent to Stakeholders 2. Stakeholders reviewed APL and implemented requirements on 3/18/20 3. **Complete**	Describes how health plans can assist with medically appropriate social distancing in the delivery of health care services for the duration of the state of emergency proclaimed by the Governor
DHCS	3/12/2020	Link	MEDIL I 20-06 Public Health Crisis or Disaster Reminders for Medi-Cal	Member Services Config	1. Sent to Stakeholders on 3/30/20 2. **Complete**	Directive to County Agencies to continue to provide benefits beyond the certification period, as needed, to provide additional time to submit renewals or verifications, and Modify eligibility requirements at application or renewal to allow for self-attestation
DMHC	3/6/2020	Link	APL20-006 COVID-19 Screening and Testing	Marketing C&L Member Services Health Services	1. Sent to Stakeholders on 3/6/20 2. Stakeholders met and reviewed the APL's requirements. 3. **Complete**	The APL reminds Plans to provide timely access to services during the emergency. Specifically, Covering all medically necessary emergency care without prior authorization, whether that care is provided by an in-network or out-of-network provider.

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
April May Attachment D

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-001	Newly Enacted Statutes Impacting Health Plans	Claims Health Services Marketing Pharmacy PNM	The APL outlines several newly enacted statutory legislative requirements for health Plans. KHS response to the DMHC is due by March 6, 2020, unless otherwise noted.	1/15/2020	1. Multiple meetings were held with Stakeholders. 2. DMHC filing completed timely on 3/6/30. 3. Complete	
APL20-002	Enrollment Data Reporting	Finance Compliance	The APL Provides Plans with direction for completing and filing the Report of Plan Enrollment.	1/21/2020	1. The Plan filed timely by February 15, 2020. 2. Complete	
APL20-003	Provider Directory Annual Filings 2020	PNM Marketing Compliance	Provides guidance and instructions to Plans regarding the Annual Filing of the Provider Directory.	1/24/2020	1. Stakeholders met on 3/4/20 and drafted a response to the E-1 filing. 2. Final documents due 4/15/2020.	
APL20-004	Federal SBC Template Filing	N/A	N/A	N/A	N/A	
APL20-005	Plan Year 2021 QHP and QDP Filing Requirements	N/A	N/A	N/A	N/A	
APL20-006	COVID-19 Screening and Testing	Marketing C&L Member Services Health Services	The APL reminds Plans to provide timely access to services during the emergency. Specifically, Covering all medically necessary emergency care without prior authorization, whether that care is provided by an in-network or out-of-network provider.	3/10/2020	1. 3/6/20 APL sent to Stakeholders 2. Stakeholders met and reviewed the APL's requirements. 3. Complete	
APL20-007	"Social Distancing" Measures in Response to COVID-19	Pharmacy PNM Health Services Compliance	Describes how health plans can assist with medically appropriate social distancing in the delivery of health care services for the duration of the state of emergency proclaimed by the Governor	3/12/2020	1. 3/16/20 APL sent to Stakeholders 2. Stakeholders reviewed APL and implemented requirements on 3/18/20 3. Complete	

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
April May Attachment D

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-008	Provision of Health Care Services During Self Isolation Orders	Member Services Health Services PNM Compliance	Plans were provided guidance for the provision of Health Care Services During Self Isolation Orders.	3/18/2020	1. 4/2/20 APL sent to Stakeholders 2. 4/6/20 Stakeholder meeting scheduled. 3. Stakeholders are working on Action Items from the meeting.	
APL20-009	Reimbursement for Telehealth Services	PNM Health Services Claims Member Services Compliance	The APL provides requirements related the provision of telehealth and telephonic services by Providers	3/18/2020	1. 3/18/20 Compliance reviewed the APL and conferred with PNM and concluded that current KHS P&Ps support the APLs requirements and does impede the implementation of APL. 2. Complete	
APL20-010	Special Enrollment Period and Coverage Effective Dates	N/A	N/A	N/A	N/A	
APL20-011	2020 Annual Assessment Letter	Finance Compliance	Provides Plans with direction for filing the Report of Plan Enrollment by May 15, 2020.	3/26/2020	1. 4/3/20 APL sent to Stakeholders. 2. Compliance to monitor progress of completion.	
APL20-012	Health Plan Actions to Reach Vulnerable Populations	Health Services Member Services Compliance	Health Plans should be actively engaging with vulnerable populations. By March 31, 2020, each health plan to which this All Plan Letter applies shall file with the Department of Managed Health Care (DMHC)	3/27/2020	1. 3/31/20 The Plan filed timely. 2. Complete	
APL20-013	Billing for Telehealth Services; Telehealth for the Delivery of Services	N/A	N/A	N/A	N/A	

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
April May Attachment D

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-014	Mitigating Negative Health Outcomes due to COVID-19	Marketing PNM Member Services Health Services Compliance	The purpose of this All Plan Letter is to offer reminders and resources to help health care service plans serve enrollees and mitigate negative health outcomes to members due to the COVID-19 emergency.	4/16/2020	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholder meeting scheduled 3. 4/16/20 Complete	
APL20-015	COVID-19 Temporary Extension of Plan Deadlines	Health Services PNM Member Services Claims Compliance	In light of the COVID-19 State of Emergency, the Director has determined that select deadlines and requirements may be temporarily extended to give health plans additional time to comply.	5/27/2020	1. 4/14/20 Sent to Stakeholders 2. 5/27/20 In process	
APL20-016	Assistance to Seniors	Health Services PNM Claims Configuration Compliance	The purpose of this All Plan Letter is to offer reminders and resources to help health care service plans serve enrollees who are aged 60+ or have high-risk health conditions during the COVID-19 emergency response stay home, stay healthy, and stay connected.	4/27/2020	1. 4/16/20 Sent to Stakeholders 2. 4/27/20 Stakeholders met and shared resource information and identified efforts to reach at risk individuals. 3. Complete	
APL20-017	Guidance Regarding DMHC General Licensure Regulation	N/A	N/A	N/A	N/A	
APL20-018	COVID-19 (OPM) Modification of Timely Access Provider Appointment Availability Surveys (PAAS) Timeframes	PNM Claims	Health and Safety Code section 1367.03(f)(3) and page 11 of the PAAS Methodology require health plans to complete the administration of the PAAS between April 1 and December 31. For MY 2020, health plans shall begin administration of the PAAS no earlier than August 1, 2020.	4/29/2020	1. 4/29/20 Sent to Stakeholders 2. 4/29/20 Complete	
APL20-019	Association Health Plans: Extension of "Phase-Out" Period	N/A	N/A	N/A	N/A	

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
April May Attachment D

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-020	Ensuring Continued Network Adequacy and Removing Unnecessary Burdens on Providers	N/A	N/A	N/A	N/A	

KEY	
	Compliance - YES
	Compliance - NO
	Outcome Pending
	N/A - informational document

Attachment E

State Legislative Summary – June 2020

Bill Tracking Matrix:

Title	Description	Status
AB 648 (Nazarian)	This bill would prohibit health care service plans and insurers from sharing any personal information or data collected through a wellness program, and would prohibit health care service plans or insurers from taking any adverse action, if the action of the health care service plans or insurers is in response to a matter related to a wellness program, such as an individual's election to not participate in a wellness program. The bill would establish and impose upon health care service plans and insurers various requirements related to a wellness programs, such as requiring a health care service plan or insurer to provide an individual information concerning its policies and practices pertaining to wellness programs, as specified. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB648	CAHP Oppose (2019) 1/27/2020 - Read third time. Passed. Ordered to the Senate.
AB 683 (Carrillo)	Requires the department to disregard specified assets and resources, such as motor vehicles and life insurance policies, in determining the Medi-Cal eligibility for an applicant or beneficiary whose eligibility is not determined using MAGI, subject to federal approval and federal financial participation. The bill would require the department to adopt regulations by July 1, 2020. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB683	01/30/20 In Senate. Read first time. To Com. on RLS. for assignment.
AB 890 (Wood)	Authorizes a nurse practitioner to practice without the supervision of a physician and surgeon if the nurse practitioner meets specified requirements. Authorizes the nurse practitioner to perform specified functions including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB890	1/27/2020 - Read third time. Passed. Ordered to the Senate.

AB 910 (Wood)	Would require a county mental health plan and Medi-Cal managed care plan that are unable to resolve a dispute to submit a request for resolution to the State Department of Health Care Services. The bill would require the department to issue a written decision to the plans within 30 calendar days from receipt of the request by either the county mental health plan or the Medi-Cal plan. The bill would also prohibit the dispute from delaying the provision of medically necessary services, as specified. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB910	1/30/2020 - In Senate. Read first time. To Com. on RLS. for assignment.
AB 2100 (Wood)	This bill would require the department to establish the Independent Prescription Drug Medical Review System (IPDMRS), commencing on January 1, 2021. The bill would provide that any Medi-Cal beneficiary grievance involving a disputed health care service is eligible for review under the IPDMRS. The bill would require the department to permit a Medi-Cal beneficiary to continue use of a drug that was covered by a Medi-Cal managed care plan and is part of a prescribed therapy in effect for the beneficiary immediately before the date of receipt of coverage through the department, irrespective of whether the drug is on the Medi-Cal contract drug list, for a prescribed period of time. This bill would revise the definition of “specialty drug” to mean any drug determined by the department that generally meets specified criteria, including that the drug has limited product availability and distribution or requires specialized nursing facility services. The bill would require the department to contract, by March 1, 2021, with a vendor to perform specified duties, including surveying specialty drug price information. The bill would require the department to provide a disease management payment to a pharmacy for the costs and activities that are associated with dispensing any specialty drug in an amount determined by the survey completed by the vendor. This bill would require the department to include specified information in the Medi-Cal program assumptions and estimates, such as the percentage of pharmacies actively billing the Medi-Cal program, and the average expenditure and net expenditure for outpatient prescription drugs per Medi-Cal beneficiary. This bill would repeal copay requirements and the 6 prescription limits that currently exist in FFS Rx. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB2100	5/19/2020 - From committee: Do pass and re-refer to Com. on APPR.

AB 2157 (Wood)	Current law requires the Department of Managed Health Care and the Department of Insurance to establish an independent dispute resolution process to resolve a claim dispute between a health care service plan or health insurer, as appropriate, and a non-contracting individual health professional, and sets forth requirements and guidelines for that process, including contracting with an independent organization for the purpose of conducting the review process. Existing law requires the independent organization, in deciding the dispute, to base its decision regarding the appropriate reimbursement on all relevant information. This bill would require the procedures established by each department to include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2157	5/19/2020 - From committee: Do pass and re-refer to Com. on APPR.
AB 2276 (Reyes)	This bill would require the department to ensure that a Medi-Cal beneficiary who is a child receives blood lead screening tests at specified ages consistent with state regulatory standards, and would require a contract between the department and a Medi-Cal managed care plan to ensure that the Medi-Cal managed care plan and its contracting health care providers who are responsible for performing a periodic health assessment of a child meet specified standard of care requirements relating to blood lead testing. The bill would require the department to report its progress toward blood lead screening tests for Medi-Cal beneficiaries who are children, as specified, annually on its internet website. The bill would require each Medi-Cal managed care plan to establish a monitoring system related to blood lead screening tests, to require its contracting health care providers who are responsible for performing a periodic health assessment of a child to test each child pursuant to specified standards of care for lead testing, to inform a child's parent, parents, guardian, or other person charged with their support and maintenance with specified information, including the risks and effects of lead exposure, and to notify a child's health care provider when that child has missed a required blood lead screening test. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2276	5/19/2020 - From committee: Do pass and re-refer to Com. on APPR.

AB 2277 (Salas)	This bill would require any contract between the department and a Medi-Cal managed care plan to impose requirements on the Medi-Cal managed care plan to identify every enrollee who does not have a record of completing those tests at 12 and 24 months of age, and to remind the contracting health care provider who is responsible for performing a periodic health assessment of a child of the need to perform those tests. The bill would require the department to develop and implement procedures, and take enforcement action, as prescribed, to ensure that a Medi-Cal managed care plan performs those duties. If a Medi-Cal managed care plan enrollee who is a child misses a required blood lead screening test at 12 and 24 months of age, the bill would require the Medi-Cal managed care plan to notify specified individuals responsible for that child, including the parent or guardian, about those missed blood lead screening tests, and would require that notification to be included as part of an annual notification on preventive services. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2277	5/21/2020 - Re-referred to Com. on APPR.
AB 2279 (Garcia)	This bill would add several risk factors to be considered as part of the standard of care specified for lead screening, including a child's residency in or visit to a foreign country, or their residency in a high-risk ZIP Code, and would require the department to develop, by January 1, 2021, the regulations on the additional risk factors, in consultation with the specified individuals. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2279	05/19/20 From committee: Do pass and re-refer to Com. on APPR.
AB 2360 (Maienschein)	This bill would require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require the consultation to be done by telephone or telehealth video, and would authorize the consultation to include guidance on providing triage services and referrals to evidence based treatment options, including psychotherapy. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. The bill would require health care service plans and health insurers to maintain records and data pertaining to the utilization of the program and the availability of psychiatrists in order to facilitate ongoing changes and improvements, as necessary. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2360	CAHP Oppose 5/19/2020 - From committee: Do pass and re-refer to Com. on APPR

AB 2830 (Wood)	This bill would delete those provisions relative to the Health Care Cost Transparency Database and would instead require the office to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System, which would include health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multiemployer-insured plans, and other specified mandatory submitters. The bill would require the Department of Managed Health care and the Department of Insurance to take appropriate action to bring a plan or insurer into compliance if the office notifies the appropriate department of a plan or insurer's failure to submit required data, and would specify that the failure of a health care service plan to submit required data is a violation of Knox-Keene. This bill would require the office to use the above-described data to produce publicly available information, including data products, summaries, analyses, studies, and other reports, to support goals that include improving public health, reducing disparities, and reducing health care costs. The bill would protect the confidentiality of personally identifiable data submitted to the system and would exempt it from disclosure, but would authorize controlled access to that nonpublic data by outside data analysts, researchers, and other qualified applicants if the data and requesters meet specified criteria. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2830	CAHP Opposed Unless Amended 5/21/2020 - Re-referred to Com. on APPR.
SB 803 (Beall)	This bill would establish a peer support specialist certification program administered by the department. Would require the department to conduct specified activities relating to the certification of peer support specialists, including establishing a certifying body to provide for a statewide certification for peer support specialists and determining curriculum and core competencies, as specified, required for certification of an individual as a peer support specialist. The bill would require the department to amend the Medicaid state plan to include a certified peer support specialist as a provider type for purposes of the Medi-Cal program and to include peer support specialist services as a distinct service type under the Medi-Cal program. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB803	5/26/2020 - Set for hearing June 1.

SB 852 (Pan)	This bill would establish the Office of Drug Contracting and Manufacturing within the California Health and Human Services Agency to, among other things, increase patient access to affordable drugs. The bill would require the office, on or before January 1, 2022, to contract or partner with at least one drug company or generic drug manufacturer to produce at least 10 generic prescription drugs, as determined by the office, and insulin at a price that results in savings. The bill would require the office prepare and submit a report to the Legislature on or before January 1, 2022, that, among other things, assesses the feasibility of the office to directly manufacture generic prescription drugs and includes an estimate of the cost of building or acquiring manufacturing capacity. The bill would also require the office to prepare and submit a report to the Legislature on or before January 1, 2023, that assesses the major problems faced by patients in accessing affordable generic prescription drugs, describes the status of the drugs targeted for manufacture under the office's contracts or partnerships, and analyzes how the office's activities have impacted competition, access, and costs for those drugs.s. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB852	CAHP Support in concept 05/19/20 Read second time and amended. Re-referred to Com. on APPR.
SB 1237 (Dodd)	The bill would delete the condition that a certified nurse-midwife practice under the supervision of a physician and surgeon and would instead authorize a certified nurse-midwife to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including gynecologic and family-planning services, inter-conception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the board. The bill would delete the above-described provisions defining the practice of nurse-midwifery, and instead would provide that the practice of nurse-midwifery includes consultation, co-management, or referral, as those terms are defined by the bill, as indicated by the health status of the patient and the resources and medical personnel available in the setting of care, subject to specified conditions, including that a patient is required to be transferred from the primary management responsibility of the nurse-midwife to that of a physician and surgeon for the management of a problem or aspect of the patient's care that is outside the scope of the certified nurse-midwife's education, training, and experience. The bill would authorize a certified nurse-midwife to attend pregnancy and childbirth in an out-of-hospital setting if specified conditions are met, including that the gestational age of the fetus is within a specified range. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB1237	5/26/2020 - Set for hearing June 1.

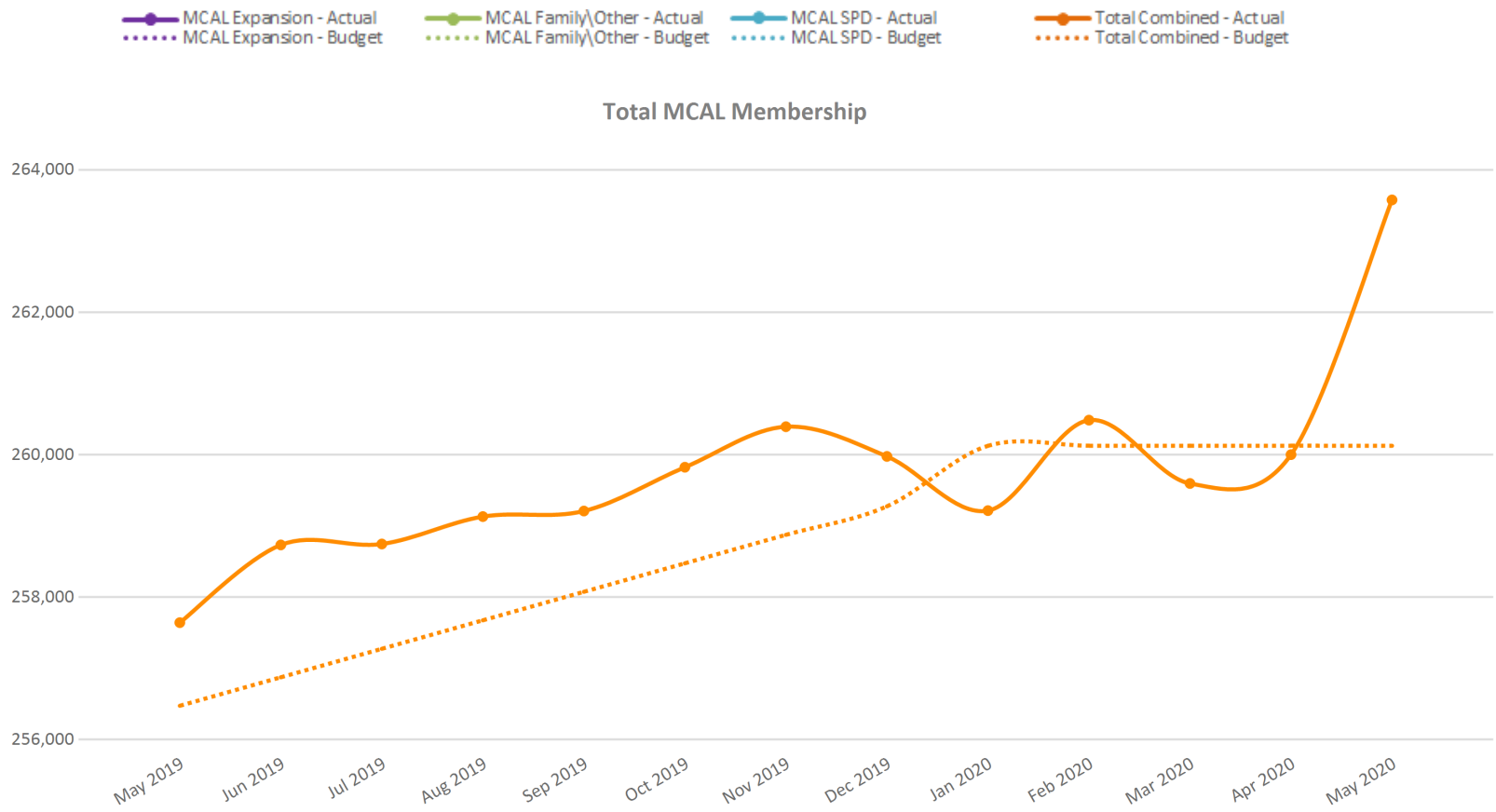
Kern Health Systems
Attachment F

KHS Dashboard Performance Reports
(Critical Performance Measurements)

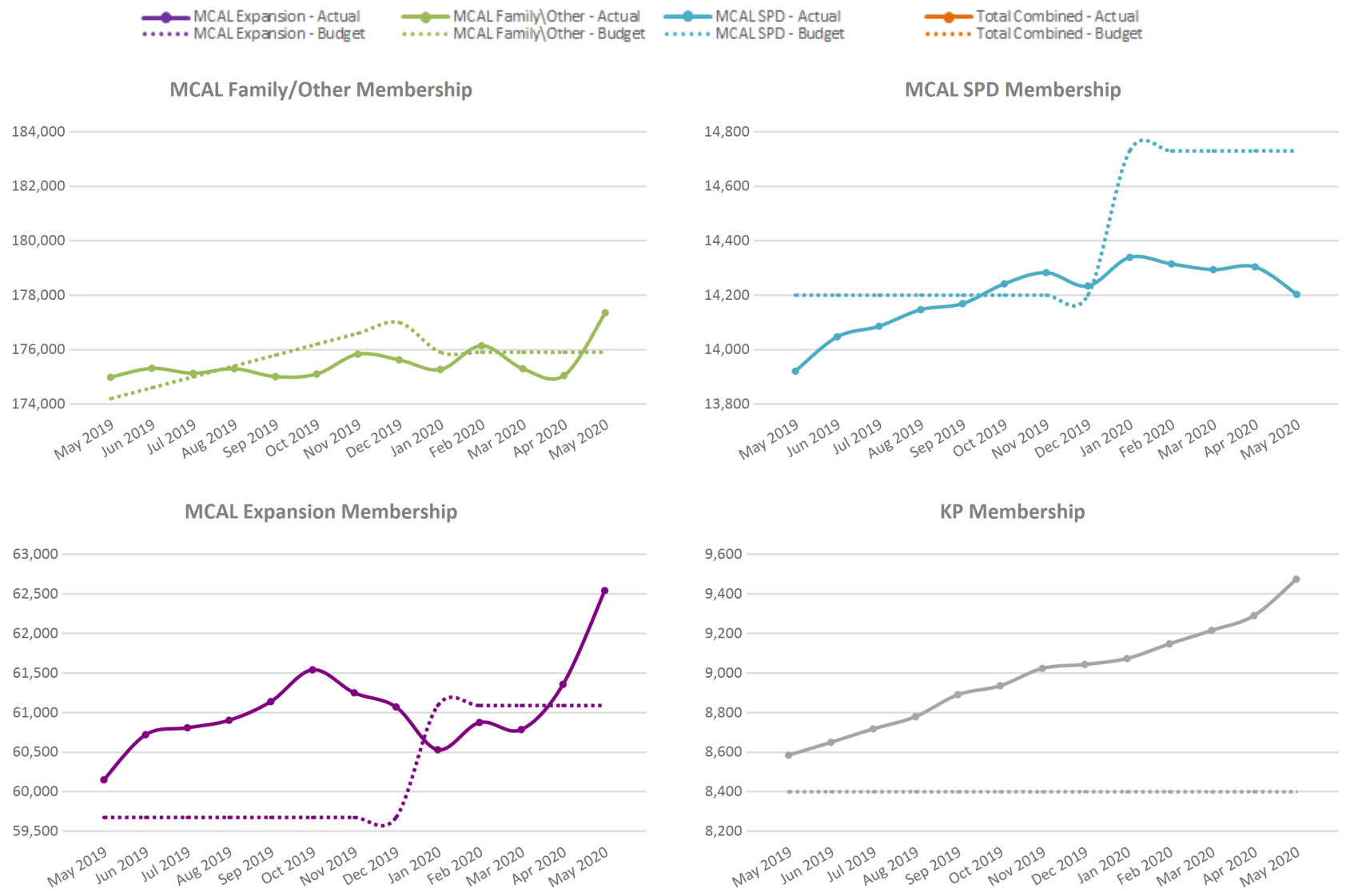
KERN HEALTH SYSTEMS

Governed Reporting System

Membership



Membership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May 2019
Jun 2019
Jul 2019
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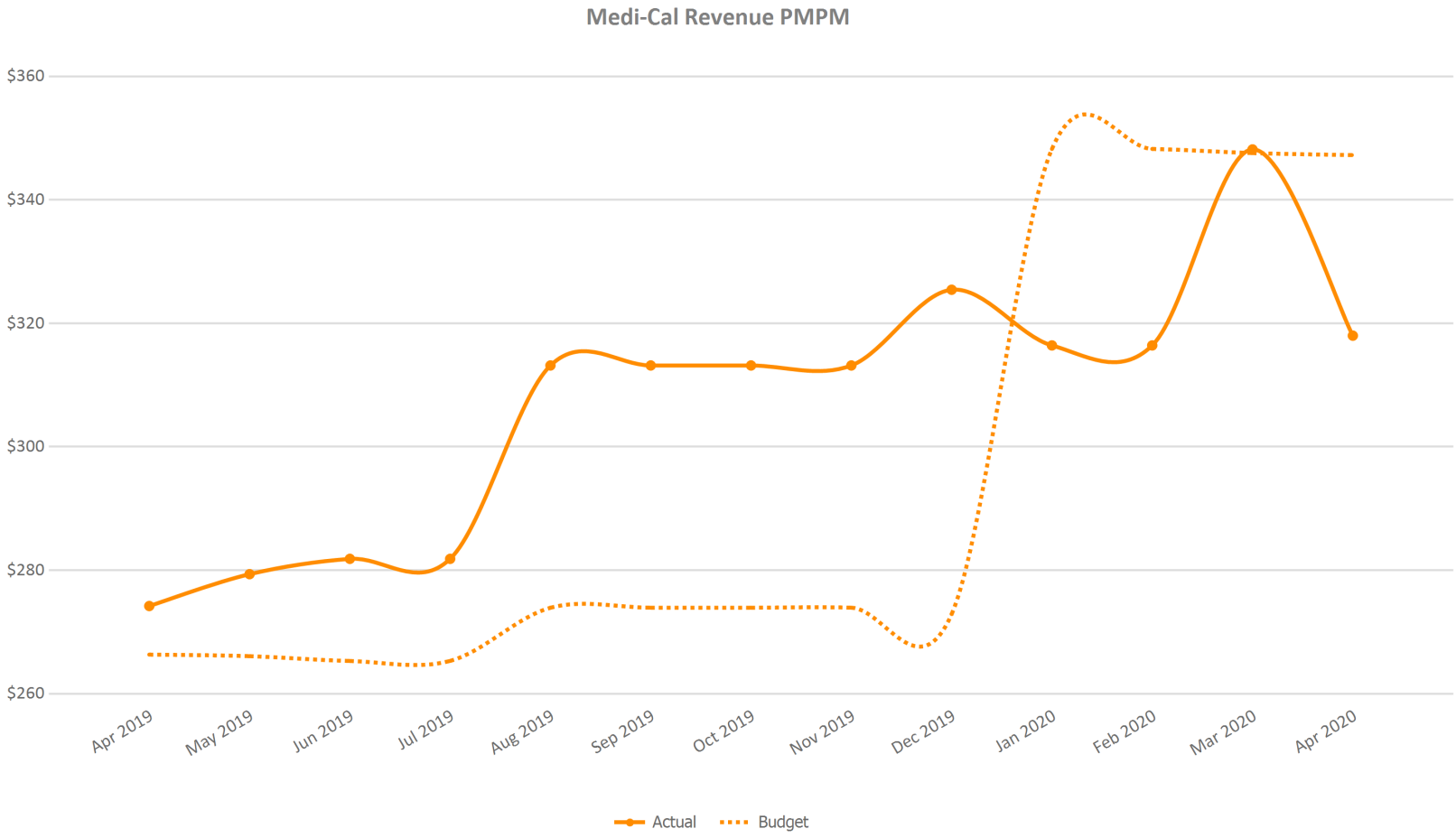
Feb 2020
Mar 2020
Apr 2020
May 2020

KERN HEALTH SYSTEMS

Governed Reporting System

Revenue



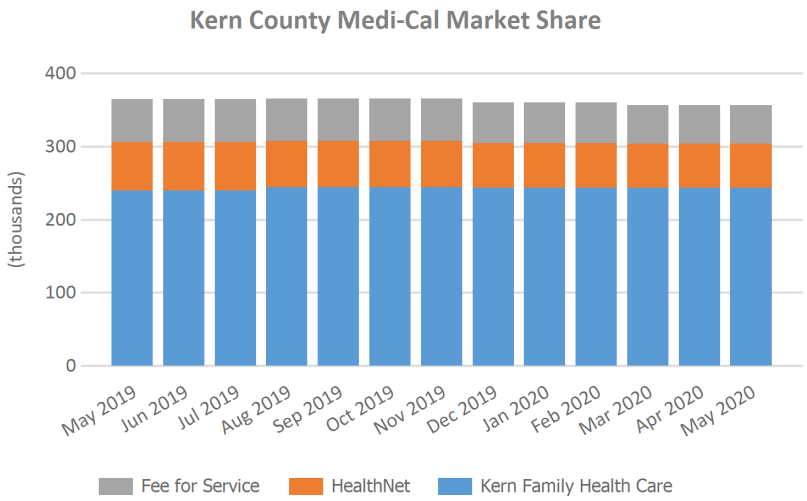
Kern Health Systems

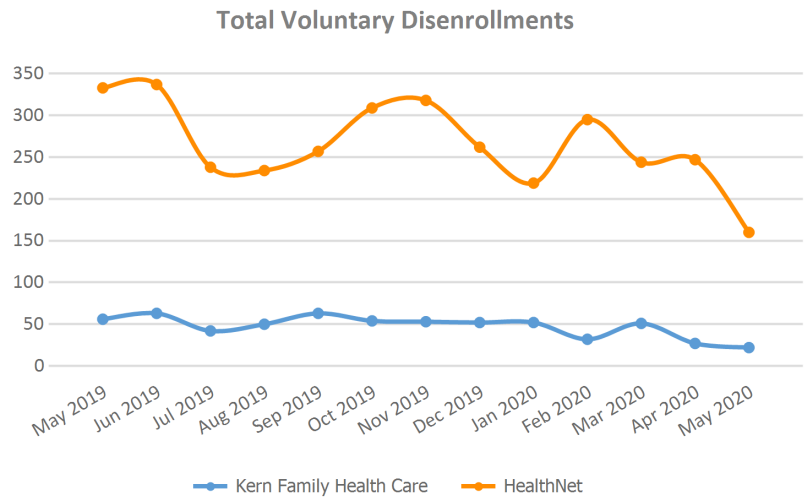
Performance Reports
Operations Metrics

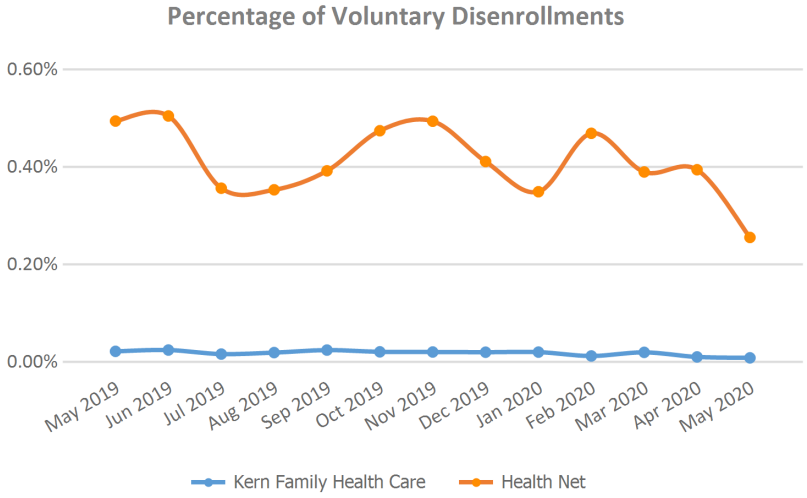
KERN HEALTH SYSTEMS

Governed Reporting System

Enrollment - Market Share





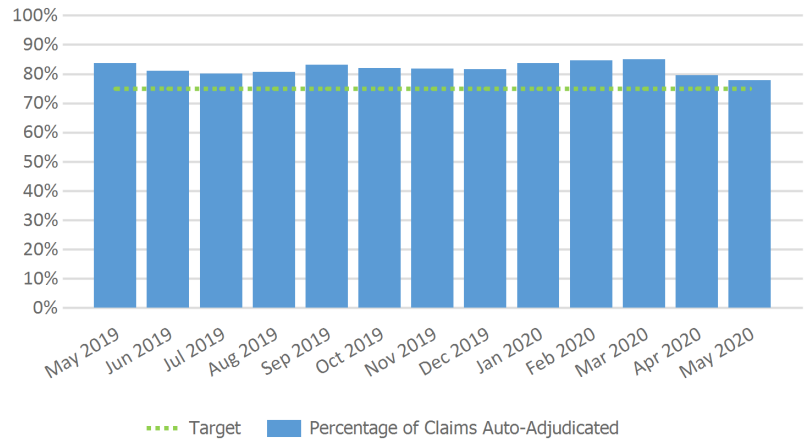


KERN HEALTH SYSTEMS

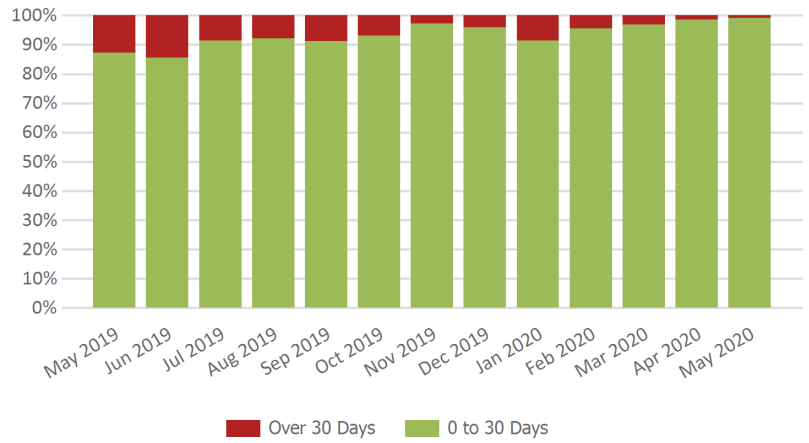
Governed Reporting System

Claims Efficiency and Quality

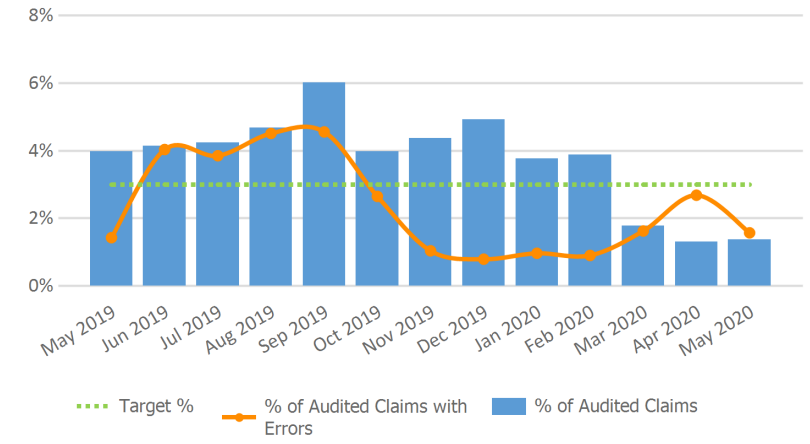
Claims Auto-Adjudication Rates



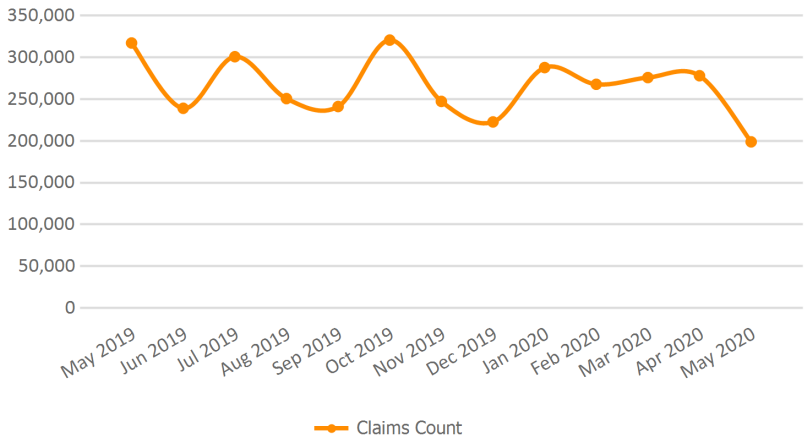
Claims Turnaround Days



Claims Audit Percentage and Accuracy



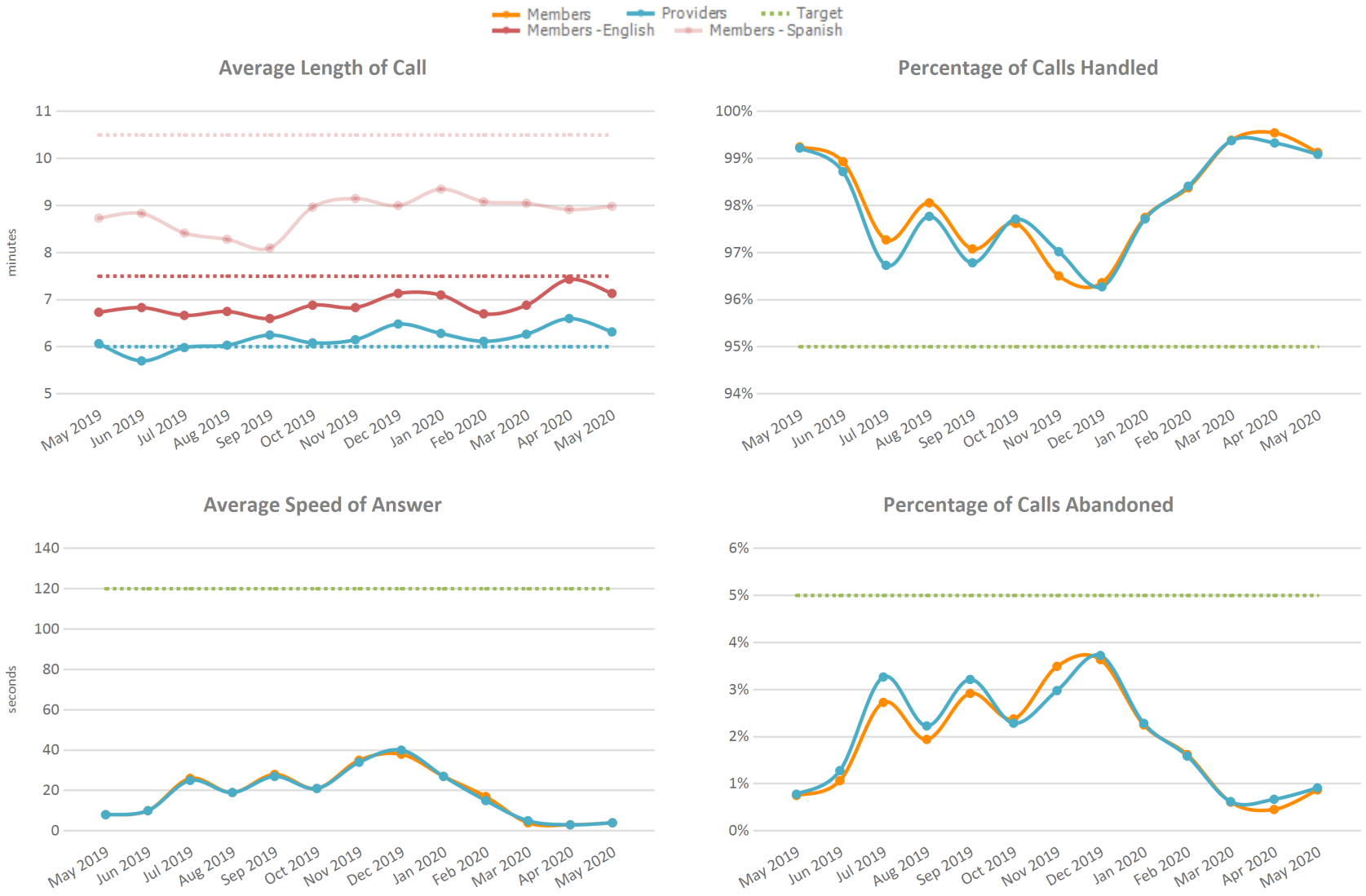
Claims Processed



KERN HEALTH SYSTEMS

Governed Reporting System

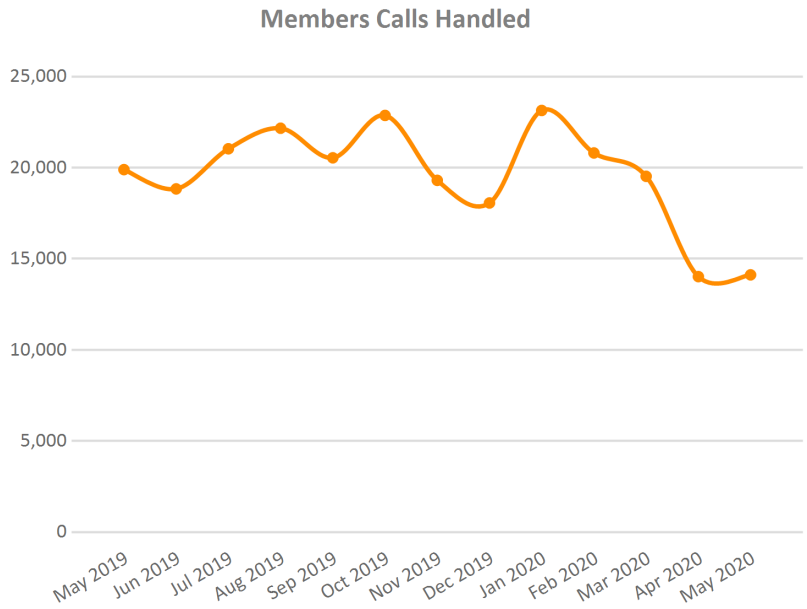
Member Services

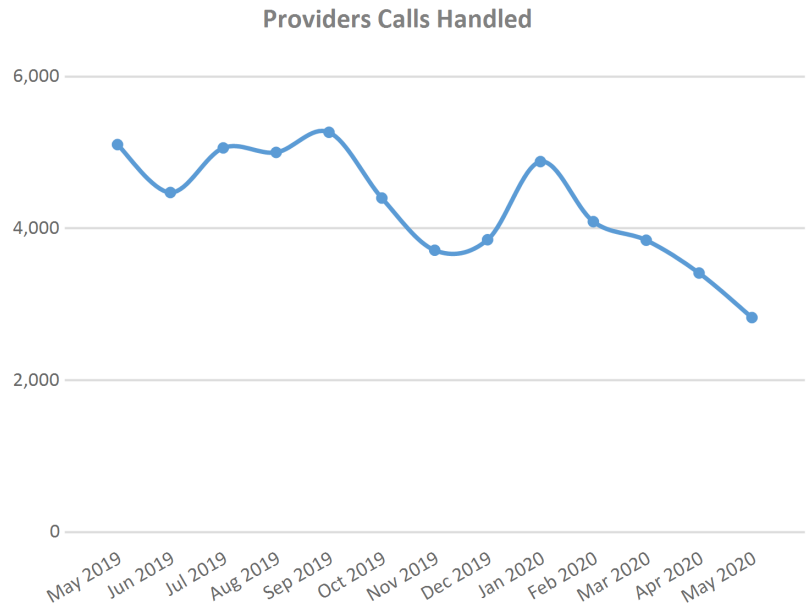


KERN HEALTH SYSTEMS

Governed Reporting System

Member Services Calls Handled





KERN HEALTH SYSTEMS

Governed Reporting System

Provider Network and Terminations