REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, August 13, 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, August 13, 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, Deats, Flores, Garcia, Hoffmann, Jones, Martinez, Melendez, Nilon, Patel, Patrick, Peters, Rhoades, Watson

ADJOURN TO CLOSED SESSION

CLOSED SESSION

1) 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

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. THE MEETING FACILATATOR WILL INDICATE WHEN THERE IS 15 SECONDS REMAINING TO YOUR PRESENTATION TIME!

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))

CA-4) Minutes for Kern Health Systems Board of Directors regular meeting on June 11, 2020 (Fiscal Impact: None) –
APPROVE

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

6) Appreciation recognition of Linda Hinojosa for 8 years of dedicated service as a member of the Kern Health Systems Board of Directors (Fiscal Impact: None) –
RECEIVE AND FILE

7) Proposed election to appoint a board member for the Board of Directors role of Treasurer (Fiscal Impact: None) –
APPOINT TREASURER

CA-8) Report on Kern Health Systems investment portfolio for the second quarter ending June 30, 2020 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-9) Report on Kern Health Systems Strategic Plan for second quarter ending June 30, 2020 (Fiscal Impact: None) –
RECEIVE AND FILE

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

11) 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

12) Proposed appointments to the Kern Health Systems Public Policy/Community Advisory Committee (Fiscal Impact: None) –
MAKE APPOINTMENTS

CA-13) Proposed Agreement with Cotiviti, Inc., for Healthcare Effectiveness Data and Information Set (HEDIS) software that is required to report annual health quality metrics to the State of California, from September 8, 2020 through September 7, 2022 (Fiscal Impact: $300,625; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-14) Request to Authorize approval of contracts associated with the procurement of Fast Healthcare Interoperability Resources (FHIR) System and Professional Services with one of the three vendors (upon completion of contracting) in the amount not to exceed $850,000 over five (5) years in capital expenses to complete the Interoperability corporate project (Fiscal Impact: $850,000;Budgeted) -
APPROVE

CA-15) Proposed Agreement with Commercial Cleaning Systems, Inc., Proposed Agreement with Commercial Cleaning Systems, Inc., for commercial janitorial services for 2900 Buck Owens Blvd., from September 6, 2020 through September 5, 2021 (Fiscal Impact: $170,000 annually; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

16) Report on Kern Health Systems financial statements for May 2020 and June 2020 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-17) Report on Accounts Payable Vendor Report, Administrative Contracts between $30,000 and $100,000 for May 2020 and June 2020 IT Technology Consulting Resources for the period ending May 31, 2020 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-18) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

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

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

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

CA-22 Miscellaneous Documents –
RECEIVE AND FILE

A) Minutes for KHS Finance Committee meeting on June 5, 2020

ADJOURN TO OCTOBER 8, 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, June 11, 2020

8:00 A.M.

BOARD RECONVENED

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

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
Patrick

CLOSED SESSION

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

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

8:20 A.M.

BOARD RECONVENED AT 8:20 A.M.

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 1 concerning PUBLIC EMPLOYEE PERFORMANCE EVALUATION - Title: Chief Executive Officer (Government Code Section 54957) – HEARD, NO REPORTABLE ACTION TAKEN

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING** **MAY 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 JUDD ABSTAINED FROM VOTING ON KERN SURGERY CENTER LLC, LOEB, CHAVEZ, FATEHCHEHR, SALVADOR; DIRECTOR STEWART ABSTAINED FROM VOTING ON MENDOZA; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON PHARMEDQUEST PHARMACY SERVICES, MARQUEZ
Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING** **MAY 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 GAREWAL, HETHUMUNI; DIRECTOR JUDD ABSTAINED FROM VOTING ON DAKAK, BOREN, NGUYEN; DIRECTOR STEWART ABSTAINED FROM VOTING ON HENEIN, SYED, BEAL, BIBAY, CANADAY, CATILLO, COMELLI, GARCIA, GONZALEZ, LEE, LEE, MERILL, METTER, PADILLA, REBER; DIRECTOR PATEL ABSTAINED FROM VOTING ON BANSAL; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON BAKERSFIELD COMMUNITY HOSPICE, INC., DO VALLE, GAREWAL
Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING** **JUNE 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 JUDD ABSTAINED FROM VOTING ON LOEB, LAWRENCE, SMITH, VASQUEZ; DIRECTOR STEWART ABSTAINED FROM VOTING ON GARRETT, PAL; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON VALENZUELA
Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING** **JUNE 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 BUXTON, FINSTAD; DIRECTOR JUDD ABSTAINED FROM VOTING ON KHURANA, WEINSTEIN; DIRECTOR STEWART ABSTAINED FROM VOTING ON NGUYEN; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON EMPIRE SURGERY CENTER, INC.,

PUBLIC PRESENTATIONS

3) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THE MEETING FACILATATOR WILL INDICATE WHEN THERE IS 15 SECONDS REMAINING TO YOUR PRESENTATION TIME!
NO ONE HEARD

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on April 16, 2020 (Fiscal Impact: None) –
APPROVED
Rhoades-Patrick: All Ayes

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) –
APPROVED; RECOMMENDED TO KERN COUNTY BOARD OF SUPERVISORS FOR REAPPOINTMENT
Deats-Rhoades: 7 Ayes; 3 Abstention - McGlew, Hinojosa, Patel
Deats-Rhoades: All Ayes for slate to BOS

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) –
MOVED TO THE AUGUST 2020 BOARD MEETING

CA-8) Report on Kern Health Systems 2019 Utilization Management (UM) Program Evaluation and the 2020 UM Program Description (Fiscal Impact: None) –
MOVED TO THE AUGUST 2020 BOARD MEETING

CA-9) Report on Kern Health Systems investment portfolio for the first quarter ending March 31, 2020 (Fiscal Impact: None) –
RECEIVED AND FILED
Rhoades-Patrick: All Ayes

CA-10) Proposed Amendments to the Kern Health Systems Investment Policy (Fiscal Impact: None) –
APPROVED
Rhoades-Patrick: All Ayes

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) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Deats-Stewart: All Ayes

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) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Rhoades-Patrick: All Ayes

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) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Rhoades-Patrick: All Ayes

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) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Rhoades-Patrick: All Ayes

15) Report on Kern Health Systems financial statements for February 2020, March 2020 and April 2020 (Fiscal Impact: None) –
RECEIVED AND FILED
Deats-Rhoades: All Ayes

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) –
RECEIVED AND FILED
Rhoades-Patrick: All Ayes

CA-17) 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-Patrick: All Ayes

CA-18) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Rhoades-Patrick: All Ayes

19) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Rhoades-Patrick: All Ayes

ADJOURN TO THURSDAY, AUGUST 13, 2020 AT 8:00 A.M.
Patel

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

To: KHS Board of Directors

From: Tim McGlew, Chairman

Date: August 13, 2020

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

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Background

In July 2020, the Kern County Board of Supervisors reappointed the following members to Kern Health Systems Board of Directors:

- Tim McGlew, Rural Hospital Representative
- Vijaykumar B. Patel, M.D., Rural PCP Representative

Also, in July 2020, seven new members were appointed to the Kern Health Systems Board of Directors including:

- Jeff Flores – 3rd District Community Representative
- John Nilon – 2nd District Community Representative
- Todd Jones - 2nd District Community Representative
- Elsa Martinez - 1st District Community Representative
- Phillip Peters - 1st District Community Representative
- Alex Garcia - 5th District Community Representative
- Kristen Beall Watson - 5th District Community Representative

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

Requested Action

Receive and file.

BOARD OF DIRECTORS

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

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

1st District Community Representatives
1) Elsa Martinez, Sr. CAO Manager, County of Kern
2) Phillip Peters, District Director, County of Kern

Urban PCP Representative
Philipp Melendez, M.D.
Obstetrics & Gynecology Medical, Owner

2nd District Community Representatives
1) Todd Jones, Sr. Vice President Agriculture, Grimmway Farms
2) John Nilon, Retired

Safety Net Provider Representative
Cindy Stewart, LVN, ***Secretary***
Director of Managed Care
Omni Family Health

3rd District Community Representatives
1) Jeff Flores, Chief of Staff, County of Kern
2) Larry Rhoades, Retired

Kern Medical Representative
Russell Judd, ***Vice Chairman***
Chief Executive Officer,
Kern Medical

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

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

5th District Community Representatives
1) Alex Garcia, Councilmember, City of Wasco
2) Kristen Beall Watson, President & CEO, Kern Community Foundation

Rev. 7/23/2020
By: S.Woods

To: KHS Board of Directors

From: Tim McGlew, Chairman

Date: August 13, 2020

Re: Linda Hinojosa Service Recognition on KHS Board of Directors

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Background

Linda Hinojosa served eight years as a member of the Kern Health Systems Board of Directors. Appointed to the Board from District 1, Linda contributed in many ways during her tenure, most notable as a founding member of our KHS Wellness Committee and most recently as Treasurer of Kern Health Systems.

Recognition

Declaration acknowledging Ms. Hinojosa's contribution to Kern Health Systems as a member of its Board of Directors:

> *On behalf of the Kern Health Systems Board of Directors and the KHS Executive team, please know how much we appreciated your participation and input on Kern Health Systems Board of Directors. Your unique perspective of combining public education with health care proved invaluable in helping the Board navigate the many challenges facing Kern Health Systems during your years of service. Your contribution and insight will be missed.*

To: KHS Board of Directors

From: Tim McGlew, Chairman

Date: August 13, 2020

Re: Officer Vacancy

Background

The position of Treasurer of Kern Health Systems is currently vacant and will need to be filled.

As stated in the Kern Health System Bylaws:

> *"the Treasurer shall keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the properties and business transactions of KHS. The books of account shall at all times be open to inspection by any Director. The Treasurer shall maintain a bond in an amount to be determined by the Board of Directors with the surety or sureties specified by the Board of Directors for faithful performance of the duties of the office and for restoration to KHS of all of its books, papers, vouchers, money and other property of every kind in the possession or under the control of the Treasurer on his or her death, resignation, retirement, or removal from office.*
>
> *The Treasurer shall deposit or cause to be deposited all moneys and other valuables in the name and to the credit of KHS with such depositories as may be designated by the Board of Directors. The Treasurer shall disburse or cause to be disbursed the funds of KHS as may be ordered by the Board of Directors, shall render to the Directors and the Chief Executive Officer, whenever they request it, an account of all transactions and of the financial condition of KHS, and shall have such other powers and perform such other duties as may be prescribed by the Board of Directors".*

Election of Treasurer

The Treasurer is elected by majority vote of the Directors then sitting on the Board of Directors and shall serve a term of not more than three (3) years at the pleasure of the Board of Directors. Any current Board members who may be interested in serving as Treasurer should notify the Chair. Should more than one member of the Board wish to serve, the Chair will convene the Nominating Committee to review candidates and nominate one to serve as Treasurer. The nominee will be presented at the next scheduled Board meeting for approval by the Board of Directors.

Requested Action

Approve Election of Treasurer selection process for recommendation to the Kern Health Systems Board at its meeting in October 2020.

To: KHS Board of Directors

From: Robert Landis, CFO

Date: August 13, 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
June 30, 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)	$ 700,000	0.32%	100%	0.16%	1 Day	None
JP Morgan Money Market	(A)	(1)	$ 50,100,000	22.69%	40%	0.04%	1 Day	None
Local Agency Investment Fund (LAIF)	(B)	(2)	$ 70,300,000	31.84%	50%	1.41%	2 Days	None
US T-Bills at Wells Fargo		(1)	$ 20,000,000	9.06%	100%	0.11%	1 Day	Subject to Interest Rate Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)	(1)	$ 28,500,000	12.91%		0.65%	3 Days	Subject to Interest Rate Fluctuations
Sub-Total			$ 169,600,000	76.81%		0.72%		

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.

Description			Dollar Amount	% of Portfolio	Maximum Allowed Per Policy	Approximate Current Yield	Liquidity	Principal Fluctuation
UBS Managed Portfolio	(D)		$ 51,200,000	23.19%		0.90%	3 Days	Subject to Interest Rate and Credit Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)		$ -	0.00%		0.00%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 51,200,000	23.19%		0.90%		
Total Portfolio			$ 220,800,000	100.00%		0.76%		

Yield Curve	Treasuries	Yield Curve AA Corporate Bonds	A Corporate Bonds	CD's
I year	0.14%	0.30%	0.40%	0.10%
2 year	0.16%	0.40%	0.50%	0.10%
3 year	0.19%	0.50%	0.70%	0.30%
5 year	0.30%	0.75%	1.00%	0.65%

(A) $118.0 Billion money market fund managed by JP Morgan comprised of US Treasury Obligations.

(B) LAIF is part of a $101 Billion Pooled Money Investment Account managed by the State Treasurer of CA. Majority of portfolio is comprised of Treasuries, CD's, Time Deposits and Commercial Paper.

(C) High quality diversified portfolio comprising commercial paper, corporate bonds and notes.

(D) High quality diversified portfolio comprising certificate of deposits, corporate bonds and notes, municipal securities and US Treasury Securities. Includes investments maturing in less than 1 year that will be re-invested for over 1 year at maturity.

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

(2) Funds are primarily utilized to fund various Grant Programs and 2020 capital projects.

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

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

UBS Client Review

as of June 30, 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

Portfolio review. 2
Asset allocation by account. 5
Asset allocation review. 6
Bond summary. 7
Bond holdings. 8
Additional information about your portfolio. 13
Important information about this report. 14

UBS

Portfolio review

as of June 30, 2020

EX XX120 • BOND PORTFOLIO • Portfolio Management Program

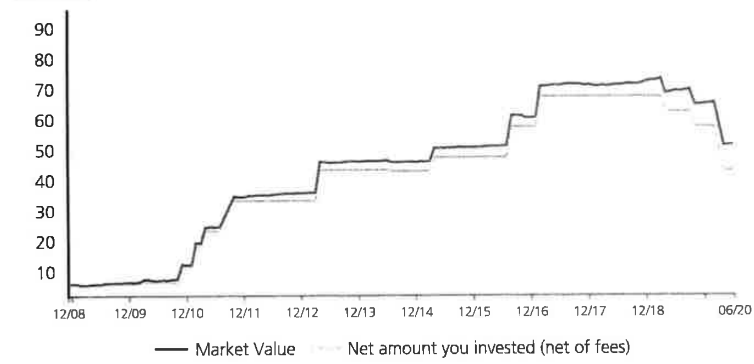
Prepared for	**Kern Health Systems**
Risk profile:	Conservative
Return Objective:	Current Income

Asset allocation review

	Value on 06/30/2020 ($)	% of Portfolio
A Cash	**99,743.34**	**0.19**
Cash	99,743.34	0.19
US	99,743.34	0.19
B Fixed Income	**51,092,076.88**	**99.81**
US	51,092,076.88	99.81
US Fixed Income	201,785.70	0.40
Government	17,889,843.44	34.95
Municipals	2,510,547.13	4.90
Corporate IG Credit	30,489,900.61	59.56
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	**$51,191,820.22**	**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 03/31/2020 to 06/30/2020	YTD 12/31/2019 to 06/30/2020	YTD 12/31/2019 to 06/30/2020
Opening value	**64,774,148.39**	**58,129,797.38**	**64,774,148.39**	**64,774,148.39**
Net deposits/withdrawals	-7,028,930.59	-7,427,147.10	-14,456,077.69	-14,456,077.69
Div./interest income	344,471.43	276,248.55	620,719.98	620,719.98
Change in accr. interest	-54,177.38	-51,281.07	-105,458.46	-105,458.46
Change in value	94,285.53	264,202.47	358,488.00	358,488.00
Closing value	**58,129,797.38**	**51,191,820.22**	**51,191,820.22**	**51,191,820.22**
Net Time-weighted ROR	0.64	0.90	1.54	1.54

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	**23,407.79**	**115,561.90**	**138,969.69**
Taxable	23,407.79	115,561.90	138,969.69
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.

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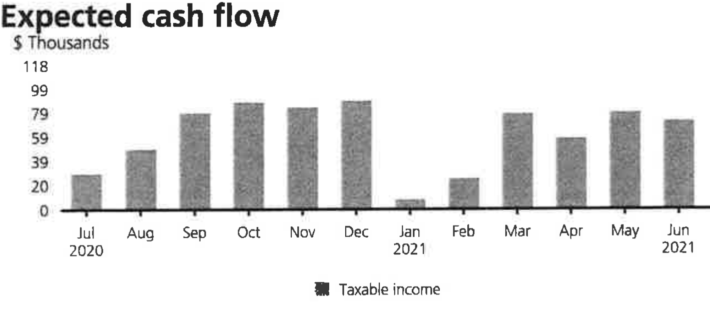
EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for: **Kern Health Systems**
Risk profile: Conservative
Return Objective: Current Income

Portfolio review - as of June 30, 2020 (continued)

Expected cash flow



Total taxable income: $752,051.88
Total expected cash flow: $752,051.88
Cash flows displayed account for known events such as maturities and mandatory puts.

Bond maturity schedule

$ Millions

20
15
10
5
0

17.8% 35.1% 35.1% 11.7% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0%

2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2031 + Other

Effective maturity schedule

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

Equity sector analysis

Compared to S&P 500 index

	Value on 06/30/2020 ($)	Actual (%)	Model (%)	Gap (%)
Communication Services	0.00	0.00	11.19	-11.19
Consumer Discretionary	0.00	0.00	11.62	-11.62
Consumer Staples	0.00	0.00	7.78	-7.78
Energy	0.00	0.00	2.58	-2.58
Financials	0.00	0.00	9.68	-9.68
Health Care	0.00	0.00	14.28	-14.28
Industrials	0.00	0.00	7.34	-7.34
Information Technology	0.00	0.00	26.60	-26.60
Materials	0.00	0.00	2.61	-2.61
Real Estate	0.00	0.00	2.68	-2.68
Utilities	0.00	0.00	3.03	-3.03
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: July 20, 2020

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

Portfolio review - as of June 30, 2020 (continued)

Summary of performance by account

	Performance start date	Value on 06/30/2020 ($)	% of portfolio		Performance returns (annualized > 1 year): For the period of 12/31/2019 to 03/31/2020	For the period of 03/31/2020 to 06/30/2020	YTD 12/31/2019 to 06/30/2020	YTD 12/31/2019 to 06/30/2020
EX XX120 BOND PORTFOLIO•PMP•The Cohen Group Fixed Income - PIV Risk profile: Conservative Return objective: Current Income	Dec 08, 2008	51,191,820.22	100.00%	Net time-weighted	0.64%	0.90%	1.54%	1.54%
Total Portfolio	**Dec 08, 2008**	**$51,191,820.22**	**100%**	**Net time-weighted**	**0.64%**	**0.90%**	**1.54%**	**1.54%**

Benchmarks - Annualized time-weighted returns	For the period of 12/31/2019 to 03/31/2020	For the period of 03/31/2020 to 06/30/2020	YTD 12/31/2019 to 06/30/2020	YTD 12/31/2019 to 06/30/2020
Blended Index	0.24%	2.47%	2.71%	2.71%
US Treasury Bill - 3 Mos	0.47%	0.02%	0.49%	0.49%
Barclays US Agg 1-3Y	1.79%	0.88%	2.68%	2.68%
S&P 500	-19.60%	20.54%	-3.08%	-3.08%

Blended Index:11/04/2019 - Current: 45% Barclays Corp 1-3Y; 55% Barclays Govt/Credit 1-3Y
Past performance does not guarantee future results and current performance may be lower/higher than past data presented.

Report created on: July 20, 2020

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Asset allocation by account

as of June 30, 2020

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

	Cash ($/%)	Equities ($/%) U.S.	Equities Global	Equities International	Fixed Income ($/%) U.S.	Fixed Income Global	Fixed Income International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	Total
	99,743.34	**0.00**	**0.00**	**0.00**	**51,092,076.88**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$51,191,820.22**
Total Portfolio	**0.19**	**0.00**	**0.00**	**0.00**	**99.81**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**
	99,743.34	0.00	0.00	0.00	51,092,076.88	0.00	0.00	0.00	0.00	0.00	**$51,191,820.22**
	0.19	0.00	0.00	0.00	99.81	0.00	0.00	0.00	0.00	0.00	**100.00%**

EX XX120 . BOND PORTFOLIO . BSA PMP

Risk profile: Conservative
Return objective: Current Income

	Cash ($/%)	Equities ($/%) U.S.	Equities Global	Equities International	Fixed Income ($/%) U.S.	Fixed Income Global	Fixed Income International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	Total
	99,743.34	**0.00**	**0.00**	**0.00**	**51,092,076.88**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$51,191,820.22**
Total Portfolio	**0.19**	**0.00**	**0.00**	**0.00**	**99.81**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**

Balanced mutual funds are allocated in the 'Other' category

UBS

Asset allocation review

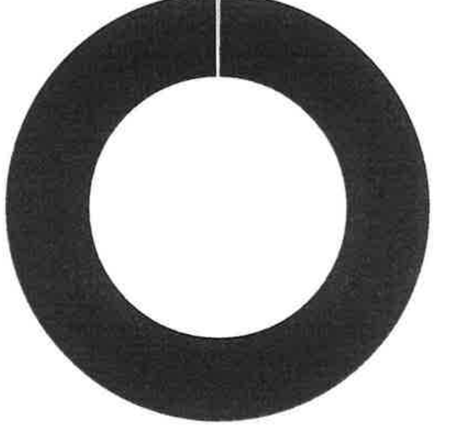
as of June 30, 2020

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	**99,743.34**	**0.19**
Cash	**99,743.34**	**0.19**
US	99,743.34	0.19
Fixed Income	**51,092,076.88**	**99.81**
US	**51,092,076.88**	**99.81**
US Fixed Income	201,785.70	0.40
Government	17,889,843.44	34.95
Municipals	2,510,547.13	4.90
Corporate IG Credit	30,489,900.61	59.56
Equity	**0.00**	**0.00**
Commodities	**0.00**	**0.00**
Non-Traditional	**0.00**	**0.00**
Other	**0.00**	**0.00**
Total Portfolio	**$51,191,820.22**	**100%**

Balanced mutual funds are allocated in the 'Other' category



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Bond summary

as of June 30, 2020

EX XX120 • BOND PORTFOLIO • Portfolio Management Program

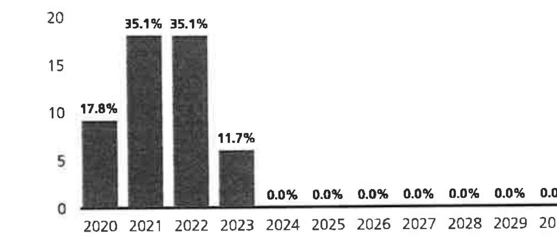
Prepared for	**Kern Health Systems**
Risk profile:	Conservative
Return Objective:	Current Income

Bond overview

Total quantity	50,397,000
Total market value	$50,913,180.82
Total accrued interest	$178,896.06
Total market value plus accrued interest	$51,092,076.88
Total estimated annual bond interest	$848,266.25
Average coupon	1.69%
Average current yield	1.67%
Average yield to maturity	0.61%
Average yield to worst	0.45%
Average modified duration	1.06
Average effective maturity	1.49

Credit quality of bond holdings

	Effective credit rating	Issues	Value on 06/30/2020 ($)	% of port.
A	Aaa/AAA/AAA	10	17,889,843.44	35.09
B	Aa/AA/AA	4	5,044,817.68	9.87
C	A/A/A	17	25,948,690.06	50.72
D	Baa/BBB/BBB	1	2,006,940.00	3.93
E	Non-investment grade	0	0.00	0.00
F	Certificate of deposit	1	201,785.70	0.40
G	Not rated	0	0.00	0.00
Total		**33**	**$51,092,076.88**	**100%**



Investment type allocation

Investment type	Taxable ($)	Tax-exempt / deferred ($)	Total ($)	% of bond port.
Certificates of deposit	201,785.70	0.00	201,785.70	0.39
Municipals	2,510,547.13	0.00	2,510,547.13	4.91
U.S. corporates	30,489,900.62	0.00	30,489,900.62	59.68
U.S. federal agencies	17,889,843.44	0.00	17,889,843.44	35.01
Total	**$51,092,076.89**	**$0.00**	**$51,092,076.89**	**100%**

Bond maturity schedule

$ Millions

20
15
10
5
0

17.8% 35.1% 35.1% 11.7% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0%

2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2031 + Other

■ Effective maturity schedule

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

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

Report created on: July 20, 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 June 30, 2020

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	6	9,070,000	189,715.00	2.09%	0.72 %	0.57 %	0.20	8,975,216	121,758.50	9,144,464.29	17.87%
2021	13	17,588,000	424,658.75	2.37%	0.54 %	0.43 %	0.95	17,656,621.7	253,273.05	17,993,624.79	35.18%
2022	11	17,739,000	205,142.50	1.15%	0.67 %	0.41 %	1.54	17,744,950.83	162,340.74	17,952,791.42	35.17%
2023	3	6,000,000	28,750.00	0.48%	0.48 %	0.48 %	1.21	6,000,000	-980.00	6,001,196.39	11.78%
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	**33**	**50,397,000**	**$848,266.25**	**1.67%**	**0.61 %**	**0.45 %**	**1.06**	**$50,376,788.53**	**$536,392.29**	**$51,092,076.88**	

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: July 20, 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 June 30, 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		**50,397,000**	**1.69%**	**12/28/2021**	**NA**	**$848,266.25** **1.67%**	**0.61%** **0.45%**	**1.06**	**$50,376,788.5** **$536,392.29**	**NA**	**$50,913,180.82** **$178,896.06** **$51,092,076.88**	**100%**

	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												
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%	0.40% 0.40%	0.08	1,734,110.00 18,777.50	100.165	1,752,887.50 17,983.68	3.44%
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%	0.22% 0.22%	0.14	2,479,925.00 26,025.00	100.238	2,505,950.00 17,020.83	4.92%
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 2.54%	1.00% 0.48%	0.24	994,430.00 10,670.00	100.510	1,005,100.00 4,320.83	1.97%
BOEING CO B/E 01.650% 103020 DTD102915 FC043016 CALL@MW+10BP	Baa2/BBB/BBB- NR/NR/NR	2,000,000	1.65%	10/30/2020	09/30/2020 100.00	33,000.00 1.65%	1.43% 1.36%	0.24	1,969,800.00 31,640.00	100.072	2,001,440.00 5,500.00	3.93%
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 2.44%	0.90% 0.42%	0.26	316,736.00 4,976.00	100.535	321,712.00 1,197.78	0.63%
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%	0.75% 0.43%	0.37	1,480,215.00 29,670.00	100.659	1,509,885.00 1,466.67	2.97%
Total 2020		**9,070,000**	**2.09%**	**10/01/2020**		**$189,715.00** **2.09%**	**0.72%** **0.57%**	**0.20**	**$8,975,216.00** **$121,758.50**		**$9,096,974.50** **$47,489.79**	**17.87%**

	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%	0.14% 0.14%	0.53	199,800.00 1,832.00	100.816	201,632.00 153.70	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 2.52%	0.68% 0.41%	0.57	1,006,080.37 6,409.63	101.249	1,012,490.00 8,429.17	1.99%

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 June 30, 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												
BANK OF AMER CORP 02.625% 041921 DTD041916 FC101916 CALL@MW+25BP	A2/A+/A- NR/NR/NR	3,143,000	2.63%	04/19/2021		82,503.75 2.58%	0.41% 0.41%	0.79	3,188,810.31 9,820.79	101.770	3,198,631.10 16,271.57	6.28%
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 2.93%**	**0.32% 0.32%**	**0.85**	**994,790.00 28,300.00**	102.309	**1,023,090.00 4,083.33**	**2.01%**
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 4.00%	1.44% 0.47%	0.65	1,014,973.36 9,256.64	102.423	1,024,230.00 3,302.78	2.01%
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 1.92%**	**0.25% 0.25%**	**0.91**	**1,065,645.10 21,121.80**	101.567	**1,086,766.90 1,564.88**	**2.13%**
LAM RESEARCH CORP NTS 2.800% 061521 DTD060716 FC121516 CALL@MW+25BP	A3/NR/A- NR/NR/NR	2,000,000	2.80%	06/15/2021	05/15/2021 100.00	56,000.00 2.74%	0.45% 0.24%	0.86	2,034,092.08 10,707.92	102.240	2,044,800.00 2,333.33	4.02%
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 1.68%**	**0.44% 0.44%**	**1.09**	**1,984,080.00 43,640.00**	101.386	**2,027,720.00 13,316.67**	**3.98%**
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 2.11%	0.44% 0.44%	1.15	994,250.00 25,640.00	101.989	1,019,890.00 7,106.94	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 1.87%**	**0.48% 0.38%**	**1.10**	**1,399,934.25 49,419.00**	101.709	**1,449,353.25 7,896.88**	**2.85%**
NVIDIA CORP NTS B/E 2.200% 091621 DTD091616 FC031617 CALL@MW+15BP	A3/A/A- NR/NR/NR	1,300,000	2.20%	09/16/2021	08/16/2021 100.00	28,600.00 2.16%	0.55% 0.43%	1.10	1,324,646.83 1,184.17	101.987	1,325,831.00 8,262.22	2.60%
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 1.82%**	**0.39% 0.29%**	**1.12**	**993,660.00 24,120.00**	101.778	**1,017,780.00 5,138.89**	**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 2.42%	1.03% 1.03%	1.31	1,455,859.40 21,821.10	101.909	1,477,680.50 5,869.68	2.90%
Total 2021		**17,588,000**	**2.42%**	**07/06/2021**		**$424,658.75 2.37%**	**0.54% 0.43%**	**0.95**	**$17,656,621.7 $253,273.05**		**$17,909,894.75 $83,730.04**	**35.18%**

	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%	1.15% 0.37%	0.53	1,099,175.00 7,975.00	100.650	1,107,150.00 8,062.39	2.17%

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: July 20, 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 June 30, 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 2022												
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 2.18%**	**0.44% 0.36%**	**1.72**	**1,087,301.16 37,777.41**	**103.313**	**1,125,078.57 3,947.63**	**2.21%**
CATERPILLAR FINL SERVICE 00.950% 051322 DTD051520 FC111320 CALL@MW+15BP	A3/A/A NR/NR/NR	1,500,000	0.95%	05/13/2022		14,250.00 0.94%	0.27% 0.27%	1.85	1,507,067.25 11,907.75	101.265	1,518,975.00 1,781.25	2.98%
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 2.87%**	**0.60% 0.60%**	**1.84**	**1,011,543.04 33,396.96**	**104.494**	**1,044,940.00 3,333.33**	**2.05%**
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 1.60%	1.55% 0.58%	0.09	1,149,655.00 1,449.00	100.096	1,151,104.00 7,462.22	2.26%
FHLMC MED TERM NTS 00.310 % DUE 081922 DTD 051920 FC 11192020	**Aaa/AAA/NR NR/NR/NR**	**2,000,000**	**0.31%**	**08/19/2022**	**05/19/2021 100.00**	**6,200.00 0.31%**	**0.31% 0.31%**	**0.88**	**1,999,500.00 520.00**	**100.001**	**2,000,020.00 706.11**	**3.93%**
FHLMC MED TERM NTS 00.340 % DUE 090122 DTD 060120 FC 12012020	Aaa/AAA/NR NR/NR/NR	2,400,000	0.34%	09/01/2022	12/01/2020 100.00	8,160.00 0.34%	0.38% 0.38%	2.15	2,400,000.00 -1,992.00	99.917	2,398,008.00 657.33	4.71%
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 1.61%**	**0.57% 0.57%**	**2.12**	**2,290,501.00 63,043.00**	**102.328**	**2,353,544.00 12,544.58**	**4.62%**
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%	1.58% 0.30%	0.32	2,000,708.38 9,091.62	100.490	2,009,800.00 6,200.00	3.95%
FHLMC MED TERM NTS 00.375 % DUE 112322 DTD 052220 FC 11232020	**Aaa/AAA/NR NR/NR/NR**	**2,000,000**	**0.38%**	**11/23/2022**	**11/23/2020 100.00**	**7,500.00 0.38%**	**0.39% 0.39%**	**2.38**	**1,999,500.00 -120.00**	**99.969**	**1,999,380.00 791.67**	**3.93%**
FHLMC NTS 00.400 % DUE 122922 DTD 062920 FC 12292020	Aaa/NR/NR NR/NR/NR	1,200,000	0.40%	12/29/2022	12/29/2020 100.00	4,800.00 0.40%	0.42% 0.42%	2.48	1,200,000.00 -708.00	99.941	1,199,292.00 13.33	2.36%
Total 2022		**17,739,000**	**1.17%**	**08/15/2022**		**$205,142.50 1.15%**	**0.67% 0.41%**	**1.54**	**$17,744,950.8 $162,340.74**		**$17,907,291.57 $45,499.85**	**35.17%**

	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												
FNMA NTS 00.500 % DUE 052523 DTD 052220 FC 11252020	NR/AAA/AA+ NR/NR/NR	2,500,000	0.50%	05/25/2023	11/25/2020 100.00	12,500.00 0.50%	0.50% 0.49%	0.40	2,500,000.00 75.00	100.003	2,500,075.00 1,319.45	4.91%
FNMA NTS 00.450 % DUE 060223 DTD 060420 FC 12022020	**NR/AAA/AA+ NR/NR/NR**	**1,500,000**	**0.45%**	**06/02/2023**	**12/02/2020 100.00**	**6,750.00 0.45%**	**0.48% 0.48%**	**2.89**	**1,500,000.00 -1,395.00**	**99.907**	**1,498,605.00 487.50**	**2.94%**
FNMA NTS 00.475 % DUE 061623 DTD 061620 FC 12162020	NR/AAA/AA+ NR/NR/NR	2,000,000	0.47%	06/16/2023	06/16/2021 100.00	9,500.00 0.47%	0.47% 0.46%	0.95	2,000,000.00 340.00	100.017	2,000,340.00 369.44	3.93%
Total 2023		**6,000,000**	**0.48%**	**06/04/2023**		**$28,750.00 0.48%**	**0.48% 0.48%**	**1.21**	**$6,000,000.00 $-980.00**		**$5,999,020.00 $2,176.39**	**11.78%**

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: July 20, 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 June 30, 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.
Total Bond Portfolio		**50,397,000**	**1.69%**	**12/28/2021**	**NA**	**$848,266.25** **1.67%**	**0.61%** **0.45%**	**1.06**	**$50,376,788.5** **$536,392.29**	**NA**	**$50,913,180.82** **$178,896.06** **$51,092,076.88**	**100%**

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

UBS

Additional information about your portfolio

as of June 30, 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

Disclosures applicable to accounts at UBS Financial Services Inc.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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/interest rates per share and multiplying by the quantity of shares held in the selected account(s) as of the End Date of Report.For savings product & sweep funds this value is not calculated and is displayed as 0.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Bond sensitivity analysis: This analysis uses Modified Duration which approximates the percentage price change of a security for a given change in yield. The higher the modified duration of a security, the higher its risk. 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.

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.

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UBS

Kern Health Systems

Account Number: EBXXX20

Your Financial Advisor
THE COHEN GROUP
Phone: 661-663-3200/800-523-8022

Filtered by: Entry Date 04/01/2020-06/30/2020, Call/Redemption

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
06/29/20	06/29/20	CALL REDEMPTION	WELLS FARGO BK NA SD US RT 02.8000% MAT 06/29/20	N79483	-50,000.000	REDEMPTION	50,000.00
06/24/20	06/24/20	CALL REDEMPTION	FHLB BOND 01.020 % DUE 062422	FE9P38	-1,700,000.000	REDEMPTION	1,700,000.00
06/19/20	06/19/20	CALL REDEMPTION	SYNCHRONY BANK UT US RT 02.1500% MAT 06/19/20	N360W7	-99,000.000	REDEMPTION	99,000.00
06/15/20	06/15/20	CALL REDEMPTION	JPMORGAN CHASE BK OH US RT 01.6500% MAT 12/13/20 AS OF 06/13/20	ZBAOM-N419C	-100,000.000	REDEMPTION	100,000.00
06/11/20	06/11/20	CALL REDEMPTION	FFCB BOND 01.000 % DUE 031122	FE9P89	-2,000,000.000	REDEMPTION	2,000,000.00
05/26/20	05/26/20	CALL REDEMPTION	FHLMC MED TERM NTS 01.875 % DUE 052623	FD9473	-320,000.000	REDEMPTION	320,000.00
05/26/20	05/26/20	CALL REDEMPTION	FNMA NTS 01.350 % DUE 082420 AS OF 05/24/20	F06ZL6	-3,500,000.000	REDEMPTION	3,500,000.00
05/20/20	05/20/20	CALL REDEMPTION	QUALCOMM INC NTS B/E 02.250% 052020 DTD052015	8372Q8	-2,879,000.000	REDEMPTION	2,879,000.00
05/12/20	05/12/20	CALL REDEMPTION	CITIBANK NA NTS B/E 02.100% 061220 DTD061217	677J24	-550,000.000	REDEMPTION	550,000.00
05/08/20	05/08/20	CALL REDEMPTION	FFCB BOND 01.630 % DUE 080522	FE6V93	-800,000.000	REDEMPTION	800,000.00
04/29/20	04/29/20	CALL REDEMPTION	FFCB BOND 01.625 % DUE 042922	FE6F23	-2,000,000.000	REDEMPTION	2,000,000.00
04/28/20	04/28/20	CALL REDEMPTION	FNMA NTS 01.530 % DUE 072821	F06U72	-3,750,000.000	REDEMPTION	3,750,000.00
04/27/20	04/27/20	CALL REDEMPTION	AMERICAN EXPRESS CRD 2.375% 052620 DTD052615	659L71	-900,000.000	REDEMPTION	900,000.00
04/21/20	04/21/20	CALL REDEMPTION	BK OF AMER CORP NTS B/E 02.250% 042120 DTD042115	658QB1	-750,000.000	REDEMPTION	750,000.00

Filtered by: Entry Date 04/01/2020-06/30/2020, Bought

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
06/25/20	06/29/20	BOUGHT	FHLMC NTS 00.400 % DUE 122922 Trade#:34356 Blot:08	FG12D0	1,200,000.000	$100.000	-1,200,000.00
06/25/20	06/26/20	BOUGHT	FNMA NTS 00.450 % DUE 060223 Trade#:34387 Blot:08	FG12E8	1,500,000.000	$100.000	-1,500,412.50
06/12/20	06/16/20	BOUGHT	FNMA NTS 00.475 % DUE 061623 Trade#:43258 Blot:08	FG06E1	2,000,000.000	$100.000	-2,000,000.00
06/01/20	06/02/20	BOUGHT	FHLMC MED TERM NTS 00.340 % DUE 090122 Trade#:06760 Blot:08	FF9ZX1	2,400,000.000	$100.000	-2,400,022.67
05/28/20	05/29/20	BOUGHT	FNMA NTS 00.500 % DUE 052523 Trade#:31800 Blot:08	FF9S29	2,500,000.000	$100.000	-2,500,243.06
05/22/20	05/22/20	BOUGHT	FHLMC MED TERM NTS 00.375 % DUE 112322 TRADE DATE: 05/21/2020 Trade#:42123 Blot:0	FF9B70	2,000,000.000	$99.975	-1,999,500.00
05/21/20	05/26/20	BOUGHT	NVIDIA CORP NTS B/E 2.200% 091621 DTD091616 Trade#:34191 Blot:97	810LY0	1,300,000.000	$102.065	-1,332,406.11
05/20/20	05/22/20	BOUGHT	CATERPILLAR FINL SERVICE 00.950% 051322 DTD051520 Trade#:22528 Blot:97	690783	1,500,000.000	$100.499	-1,507,762.08
05/20/20	05/21/20	BOUGHT	FHLMC MED TERM NTS 00.310 % DUE 081922 Trade#:22263 Blot:08	FF8RT1	2,000,000.000	$99.975	-1,999,534.44
05/19/20	05/21/20	BOUGHT	BANK OF AMER CORP 02.625% 041921 DTD041916 Trade#:14631 Blot:97	665QX8	1,143,000.000	$101.862	-1,166,949.66
05/14/20	05/14/20	BOUGHT	UBS SELECT PRIME INSTITUTIONAL FUND Trade#:00194 Blot:37	MFIRSA-3A0FP1	6,745,952.429	$1.001	-6,750,000.00
05/01/20	05/05/20	BOUGHT	BANK OF AMER CORP 02.625% 041921 DTD041916 Trade#:42997 Blot:97	665QX8	2,000,000.000	$101.635	-2,035,033.33
04/30/20	05/04/20	BOUGHT	LAM RESEARCH CORP NTS 2.800% 061521 DTD060716 Trade#:32886 Blot:97	7516L4	2,000,000.000	$102.000	-2,061,622.22

This report is provided for informational purposes with your consent. Your UBS Financial Services Inc. ("UBSFS") accounts statements and confirmations are the official record of your holdings, balances, transactions and security values. UBSFS does not provide tax or legal advice. You should consult with your attorney or tax advisor regarding your personal circumstances. Rely only on year-end tax forms when preparing your tax return. Past performance does not guarantee future results and current performance may be lower or higher than past performance

data presented. Past performance for periods greater than one year are presented on an annualized basis. UBS official reports are available upon request.

As a firm providing wealth management services to clients, UBS Financial Services Inc. offers both investment advisory services and brokerage services. Investment advisory services and brokerage services are separate and distinct, differ in material ways and are governed by different laws and separate arrangements. It is important that clients understand the ways in which we conduct business and that they carefully read the agreements and disclosures that we provide to them about the products or services we offer. For more information visit our website at ubs.com/workingwithus.

The information is based upon the market value of your account(s) as of the close of business on ***June 30, 2020***, *is subject to daily market fluctuation and in some cases may be rounded for convenience.*

Your UBS account statements and trade confirmation are the official records of your accounts at UBS. We assign index benchmarks to our asset allocations, strategies in our separately managed accounts and discretionary programs based on our understanding of the allocation, strategy, the investment style and our research. The benchmarks included in this report can differ from those assigned through our research process. As a result, you may find that the performance comparisons may differ, sometimes significantly, from that presented in performance reports and other materials that are prepared and delivered centrally by the Firm. Depending upon the composition of your portfolio and your investment objectives, the indexes used in this report may not be an appropriate measure for comparison purposes, and as such, are represented for illustration only. Your portfolio holdings and performance may vary significantly from the index.

Your financial advisor can provide additional information about how benchmarks within this report were selected.

You have discussed the receipt of this individually customized report with your Financial Advisor and understand that it is being provided for informational purposes only.

If you would like to revoke such consent, and no longer receive this report, please notify your Financial Advisor and/or Branch Manager.

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
06/01/2020 - 06/30/2020

KERN HEALTH SYSTEMS
2900 BUCK OWENS BOULEVARD

Account Number

Account Value Summary *USD*

	Amount Last Statement Period	Amount This Statement Period	% Portfolio
Cash	$ 0.00	$ **0.00**	0%
Money Market Mutual Funds	35,020,762.49	**50,067,515.97**	51%
Bonds	59,549,828.97	**48,516,789.23**	49%
Stocks	0.00	**0.00**	0%
Total Account Value	**$ 94,570,591.46**	**$ 98,584,305.20**	**100%**
Value Change Since Last Statement Period		**$ 4,013,713.74**	
Percent Increase Since Last Statement Period		**4%**	
Value Last Year-End		**$ 72,702,342.87**	
Percent Increase Since Last Year-End		**36%**	

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

Income Summary *USD*

	This Period	Year-To-Date
Interest	$ 102,496.14	$ 342,701.89
Dividends/Capital Gains	0.00	0.00
Money Market Mutual Funds Dividends	4,285.66	128,376.97
Other	0.00	0.00
Income Total	**$ 106,781.80**	**$ 471,078.86**

Interest Charged *USD*

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

Money Market Mutual Funds Summary *USD*

Description	Amount
Opening Balance	**$ 35,020,762.49**
Deposits and Other Additions	195,593,073.62
Distributions and Other Subtractions	(180,550,605.80)
Dividends Reinvested	4,285.66
Change in Value	0.00
Closing Balance	**$ 50,067,515.97**

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.

KERN HEALTH SYSTEMS | **Statement Ending: June 30, 2020**
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*								
23102UG63	CUMMINS INC 4(2) DISCOUNTED COMMERCIAL PAPER	07/06/20	0.000%	3,000,000.000	99.9985	2,999,955.00		
62479LG66	MUFG BANK LTD/NY DISCOUNTED COMMERCIAL PAPER	07/06/20	0.000%	3,000,000.000	99.9981	2,999,943.00		
9127963D9	US TREASURY BILL	07/14/20	0.000%	20,000,000.000	99.9960	19,999,205.60		
68389XAK1	ORACLE CORP	07/15/20	3.875%	3,005,000.000	100.1293	3,008,884.05		N
808513AD7	CHARLES SCHWAB CORP	07/22/20	4.450%	3,466,000.000	100.2202	3,473,633.55		N
94974BGN4	WELLS FARGO & COMPANY	07/22/20	1.978%	4,100,000.000	100.0438	4,101,796.99		
55279HAN0	MANUF & TRADERS TRUST CO	08/17/20	2.050%	3,000,000.000	100.0606	3,001,819.44		Y
375558BB8	GILEAD SCIENCES INC	09/01/20	2.550%	1,065,000.000	100.3610	1,068,844.93		N
48306AJ32	KAISER FOUNDATION HOSP DISCOUNTED COMMERCIAL PAPER	09/03/20	0.000%	3,000,000.000	99.9350	2,998,050.00		
0258M0DX4	AMERICAN EXPRESS CREDIT	09/14/20	2.600%	3,305,000.000	100.2560	3,313,460.80		Y
20030NCV1	COMCAST CORP	10/01/20	1.763%	1,550,000.000	100.0772	1,551,195.87		N
				48,491,000.000		48,516,789.23	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*									
06/04/20	06/04/20	Security Receipt	912796TZ2	UNITED STATES TREASURY BILL	20,000,000.00	99.9986390	(19,999,727.78)	0.00	(19,999,727.78)
06/04/20	06/04/20	Security Receipt	912796TZ2	UNITED STATES TREASURY BILL	50,000,000.00	99.9986390	(49,999,319.44)	0.00	(49,999,319.44)
06/03/20	06/05/20	Security Receipt	06367TYL8	BANK OF MONTREAL	3,500,000.00	100.0540000	(3,501,890.00)	(34,708.33)	(3,536,598.33)
06/04/20	06/05/20	Security Receipt	06367TYL8	BANK OF MONTREAL	2,000,000.00	100.0540000	(2,001,080.00)	(19,833.33)	(2,020,913.33)
06/10/20	06/11/20	Security Receipt	9127962X6	UNITED STATES TREASURY BILL	25,000,000.00	99.9947220	(24,998,680.55)	0.00	(24,998,680.55)
06/16/20	06/16/20	Security Receipt	9127963D9	US TREASURY BILL	20,000,000.00	99.9918330	(19,998,366.67)	0.00	(19,998,366.67)
06/17/20	06/17/20	Security Receipt	9127962X6	UNITED STATES TREASURY BILL	20,000,000.00	99.9971110	(19,999,422.22)	0.00	(19,999,422.22)
Income / Payment Activity *USD*									
06/01/20	06/01/20	Matured	50000DF19	KOCH INDUSTRIES INC DISCOUNTED			3,000,000.00		3,000,000.00

036205 1311777 0013 2C027 UN#3196374-00009743 74267-00 0 55481 07/01/20 P

Safekeeping

KERN HEALTH SYSTEMS
Account Number: [redacted]

Statement Ending: **June 30, 2020**

Daily Account Activity (Continued)

Your investment transactions during this statement period.

Income / Payment Activity *USD*

Transaction / Trade Date	Settlement / Effective Date	Activity	Security ID	Description	Par / Quantity	Price	Principal Amount	Income Amount	Debit / Credit Amount
06/02/20	06/02/20	Matured	9127962P3	UNITED STATES TREASURY BILL			10,000,000.00		10,000,000.00
06/03/20	06/03/20	Matured	90328AF32	USAA CAPITAL CORP DISCOUNTED			3,000,000.00		3,000,000.00
06/04/20	06/04/20	Matured	50000DF43	KOCH INDUSTRIES INC DISCOUNTED			2,000,000.00		2,000,000.00
06/05/20	06/05/20	Matured	437076BR2	HOME DEPOT INC			1,000,000.00		1,000,000.00
06/05/20	06/05/20	Interest	437076BR2	HOME DEPOT INC				3,741.97	3,741.97
06/11/20	06/11/20	Matured	912796TZ2	UNITED STATES TREASURY BILL			70,000,000.00		70,000,000.00
06/15/20	06/15/20	Matured	06367TYL8	BANK OF MONTREAL			5,500,000.00		5,500,000.00
06/15/20	06/15/20	Interest	06367TYL8	BANK OF MONTREAL				57,750.00	57,750.00
06/19/20	06/19/20	Matured	14913Q2Y4	CATERPILLAR FINL SERVICE			3,993,000.00		3,993,000.00
06/19/20	06/19/20	Interest	14913Q2Y4	CATERPILLAR FINL SERVICE				11,754.17	11,754.17
06/22/20	06/22/20	Matured	24422ETS8	JOHN DEERE CAPITAL CORP			3,000,000.00		3,000,000.00
06/22/20	06/22/20	Interest	24422ETS8	JOHN DEERE CAPITAL CORP				29,250.00	29,250.00
06/30/20	06/30/20	Matured	86564YFW7	SUMITOMO MIT/SINGAPORE 4(2)			5,000,000.00		5,000,000.00
06/30/20	06/30/20	Matured	9127962X6	UNITED STATES TREASURY BILL			45,000,000.00		45,000,000.00

Cash Activity *USD*

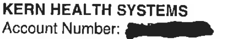
Transaction / Trade Date	Settlement / Eff. Date	Activity	Description	Debit Amount / Disbursements	Credit Amount / Receipts
06/02/20	06/02/20	ACH/DDA Transaction	DESIGNATED DDA	10,000,000.00	
06/04/20	06/04/20	ACH/DDA Transaction	DESIGNATED DDA		70,000,000.00
06/09/20	06/09/20	ACH/DDA Transaction	DESIGNATED DDA	13,000,000.00	
06/12/20	06/12/20	ACH/DDA Transaction	DESIGNATED DDA	5,000,000.00	
06/16/20	06/16/20	ACH/DDA Transaction	DESIGNATED DDA	11,000,000.00	
06/17/20	06/17/20	ACH/DDA Transaction	DESIGNATED DDA	5,000,000.00	
06/23/20	06/23/20	ACH/DDA Transaction	DESIGNATED DDA	20,000,000.00	
06/29/20	06/29/20	ACH/DDA Transaction	DESIGNATED DDA	2,000,000.00	

Money Market Fund Activity

Morgan Stan TreasSvc 8314	Dividend paid this period	7 day* simple yield	30 day* simple yield
*As of June 30, 2020			
USD	0.49	0.010%	0.010%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**35,987.01**		**35,987.01000**
06/01/20	Reinvest	0.49000			0.49	35,987.50000

KERN HEALTH SYSTEMS **Statement Ending: June 30, 2020**

Account Number: 

Money Market Fund Activity (Continued)

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Ending Balance		**1.0000**	**35,987.50**		**35,987.50000**

JPMorgan 100%UST Ins 199 *As of June 30, 2020 *USD*	Dividend paid this period	7 day* simple yield	30 day* simple yield
	4,285.17	0.040%	0.040%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**34,984,775.48**		**34,984,775.48000**
06/01/20	Purchase	3,000,000.00000		3,000,000.00		37,984,775.48000
06/01/20	Reinvest	4,285.17000			4,285.17	37,989,060.65000
06/02/20	Purchase	10,000,000.00000		10,000,000.00		47,989,060.65000
06/02/20	Redemption	(10,000,000.00000)		(10,000,000.00)		37,989,060.65000
06/03/20	Purchase	3,000,000.00000		3,000,000.00		40,989,060.65000
06/04/20	Purchase	2,000,000.00000		2,000,000.00		42,989,060.65000
06/04/20	Purchase	70,000,000.00000		70,000,000.00		112,989,060.65000
06/04/20	Redemption	(69,999,047.22000)		(69,999,047.22)		42,990,013.43000
06/05/20	Redemption	(4,553,769.69000)		(4,553,769.69)		38,436,243.74000
06/09/20	Redemption	(13,000,000.00000)		(13,000,000.00)		25,436,243.74000
06/11/20	Purchase	45,001,319.45000		45,001,319.45		70,437,563.19000
06/12/20	Redemption	(5,000,000.00000)		(5,000,000.00)		65,437,563.19000
06/15/20	Purchase	5,500,000.00000		5,500,000.00		70,937,563.19000
06/15/20	Purchase	57,750.00000		57,750.00		70,995,313.19000
06/16/20	Redemption	(11,000,000.00000)		(11,000,000.00)		59,995,313.19000
06/16/20	Redemption	(19,998,366.67000)		(19,998,366.67)		39,996,946.52000
06/17/20	Redemption	(5,000,000.00000)		(5,000,000.00)		34,996,946.52000
06/17/20	Redemption	(19,999,422.22000)		(19,999,422.22)		14,997,524.30000
06/19/20	Purchase	3,993,000.00000		3,993,000.00		18,990,524.30000
06/22/20	Purchase	3,041,004.17000		3,041,004.17		22,031,528.47000
06/23/20	Redemption	(20,000,000.00000)		(20,000,000.00)		2,031,528.47000
06/29/20	Redemption	(2,000,000.00000)		(2,000,000.00)		31,528.47000
06/30/20	Purchase	50,000,000.00000		50,000,000.00		50,031,528.47000
	Ending Balance		**1.0000**	**50,031,528.47**		**50,031,528.47000**

Safekeeping

PMIA/LAIF Performance Report as of 07/15/20

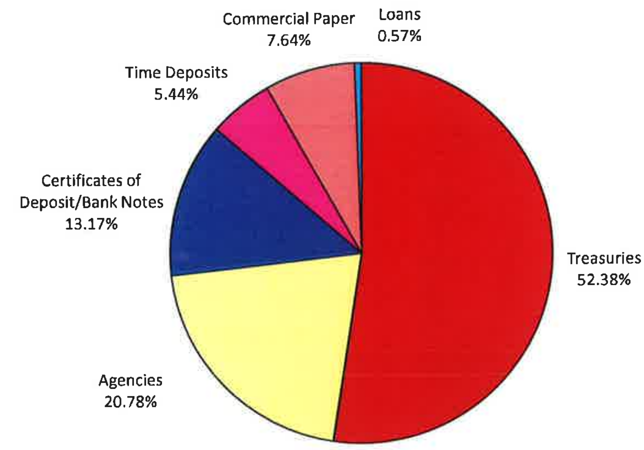
PMIA Average Monthly Effective Yields(1)

Jun	**1.217**
May	1.363
Apr	1.648

Quarterly Performance Quarter Ended 06/30/20

LAIF Apportionment Rate(2):	1.36
LAIF Earnings Ratio(2):	0.000037106682614
LAIF Fair Value Factor(1):	1.004912795
PMIA Daily(1):	1.08%
PMIA Quarter to Date(1):	1.41%
PMIA Average Life(1):	191

Pooled Money Investment Account Monthly Portfolio Composition (1) 06/30/20 $101.0 billion



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

To: KHS Board of Directors

From: Douglas Hayward, CEO

Date: August 13, 2020

Re: Update on KHS Strategic Plan

Background

After the close of each quarter Management updates the Board on KHS' Strategic Plan progress. With the conclusion of Q2 2020 of the 2018-2020 Strategic Plan, staff has included a presentation showing the current status. KHS is currently on track for items that were targeted for completion in the 2nd quarter 2020.

In the presentation, items highlighted in green indicate an item is on track, items in gray have been completed and items in white have not started.

There are 3 items recently moved to "yellow" status related to DHCS' CalAIM initiatives. These items were originally scheduled to be implemented beginning 1/1/21 but have since been delayed by DHCS due to COVID-19 and the subsequent State budget deficits. Implementation dates on these items are now TBD and KHS is awaiting further guidance from DHCS.

Requested Action

Receive and file.

Q2 2020 Strategic Plan Update

August 13, 2020

Background

- In November 2017 a Board and Executive strategy meeting was held to begin shaping the 2018-2020 KHS strategic plan. This was followed by an internal work effort to further define key initiatives, action items, and projects directly supporting the newly defined Strategic Plan. In February 2018 the KHS Board of Directors approved the 2018-2020 Strategic Plan.

- With Q2 2020 coming to an end, management has prepared a status update on the key initiatives currently in progress within the Strategic Plan.

- **Green** = On Track, **White** = Not Started, **Gray** = Completed, **Yellow** = Behind Schedule, **Red** = Incomplete/Canceled

Goal 1 – Align Compensation and Network Configuration to improve service quality and value in the health care delivery system

Task Name	Start Date	Due Date	% Complete	Assigned To
Align Compensation and Network Configuration to improve service quality and value in the health care delivery system				
Look to ways to compensate providers through value based purchasing using cost –effective, quality driven Alternative Reimbursement Arrangements.				**Emily Duran**
Define clinical activities where Value Based Purchasing applies	1/1/2018	3/31/2018	100.00%	
Establish priority list of clinical services and treatment modalities for consideration.	1/1/2018	3/31/2018	100.00%	
Custom design payment strategies unique to specific care delivery systems	4/1/2018	8/1/2019	100.00%	
Determine desired outcome(s) for each	4/1/2018	12/31/2018	100.00%	
Determine impact to KHS internal operations for 2018 priorities	4/1/2018	7/1/2019	100.00%	
Develop provider specific proposals for 2018 priorities	1/1/2018	8/1/2019	100.00%	
For 2018 priorities Initiate provider contract revisions to change or enhance compensation	4/1/2018	8/1/2019	100.00%	
For 2018 priorities, begin monitoring to determine if targeted outcomes are achieved	1/1/2019	8/1/2019	100.00%	
Determine impact to KHS internal operations for 2019 priorities	1/1/2019	8/1/2019	100.00%	
Develop provider specific proposals for 2019 priorities	1/1/2019	12/31/2019	100.00%	
For 2019 priorities Initiate provider contract revisions to change or enhance compensation	1/1/2019	9/30/2019	100.00%	
For 2019 priorities, begin monitoring to determine if targeted outcomes are achieved	1/1/2019	10/31/2019	100.00%	
Design data tracking/reporting to determine achievement of the desired outcome	1/1/2020	6/30/2020	100.00%	
Detrmine impact to KHS internal operations for 2020 priorities	1/1/2020	9/30/2020	95.00%	
Begin monitoring to determine if targeted outcomes are achieved	1/1/2020	9/30/2020	85.00%	

Goal 1 – Align Compensation and Network Configuration to improve service quality and value in the health care delivery system

Task Name	Start Date	Due Date	% Complete	Assigned To
Align Compensation and Network Configuration to improve service quality and value in the health care delivery system				
Focus on internal departmental restructuring, fostering partnership, and utilization of new technologies.				**Deborah Murr**
Reorganize UM, DM, CM Depts. to more effectively implement and monitor the Triple Aim	1/1/2018	3/31/2018	100.00%	
Revise the Prior Authorization list to ensure appropriate care for treatment requested	1/1/2018	3/31/2018	100.00%	
Augment referral network using telehealth alternatives	1/1/2018	5/31/2018	100.00%	
Identify vendor platforms for Medical Necessity Determination	1/1/2018	6/30/2018	100.00%	
Incorporate risk stratification methodology to identify future risk populations for early intervention to prevent or stabilize medical condition(s) and reduce cost through early intervention.	1/1/2018	7/31/2018	100.00%	
Develop a provider network configuration strategy designed to achieve optimum health care system performance around the Triple Aim of "Right Care, Right Time, and Right Setting".				**Emily Duran Deborah Murr**
Review network configuration to address Physical, Behavioral and Social Determinants	1/1/2018	11/30/2018	100.00%	
Adjust network configuration for changing population need and/or medical complexity	4/1/2018	11/30/2018	100.00%	
Using evidence based medicine as the standard, identify network gaps or limitations	4/1/2018	12/31/2018	100.00%	
Develop delivery system model to address needs at all levels using existing provider network, County Mental Health, County Human Services and Community Based Organizations	4/1/2018	12/31/2018	100.00%	
Develop clinical algorithms for Provider education to promote consistent management of member condition	4/1/2018	7/31/2019	100.00%	Deborah Murr
Establish provider compensation arrangements to support structure and performance goals, monitor expected outcomes	4/1/2018	10/31/2018	100.00%	
Ensure systems in place to communicate and coordinate patient care across the physical and mental health divide.	4/1/2018	11/15/2019	100.00%	Deborah Murr
Determine internal and external (Provider) operational needs to support concept	4/1/2018	11/15/2019	100.00%	Deborah Murr
Determine internal and external capital requirements where necessary to support concept	4/1/2018	11/15/2019	100.00%	Deborah Murr
Implementation	4/1/2018	12/31/2019	100.00%	Deborah Murr

Goal 2 – Prepare for New Benefits / Programs /Coverage Populations/ Regulations

Task Name	Start Date	Due Date	% Complete	Assigned To
Prepare for New Benefits / Programs /Coverage Populations/ Regulations				
Prepare for new or modified benefits, expanded coverage, or changes to the tracking and reporting requirements as required by government agencies				**Jeremy McGuire**
Determine the impact of changes to benefits or population coverage categories, or monitoring and reporting requirements on KHS and provider network	1/1/2018	12/31/2020	85.00%	Jeremy McGuire
BHT Expansion	1/1/2018	7/31/2018	100.00%	Deborah Murr
Diabetes Prevention Program	1/1/2018	12/31/2018	100.00%	Deborah Murr
DHCS Sanctions	3/1/2019	6/30/2019	100.00%	Jeremy McGuire
2019 State Budget Items	1/1/2019	7/30/2019	100.00%	Jeremy McGuire
DHCS Rx Carve-Out	1/1/2019	6/30/2020	100.00%	Bruce Wearda
DHCS LTC and Transplant Carve-In	9/1/2019	TBD	60.00%	Deborah Murr
CalAIM	11/1/2019	TBD	60.00%	Jeremy McGuire
ECM / ILOS	11/1/2019	TBD	60.00%	Deb Murr
LTC @ Home	6/1/2020	12/31/2020	20.00%	Martha Tasinga
Establish a project plan for instituting new benefits, coverage expansion, or tracking and reporting requirements	1/1/2018	12/31/2020	75.00%	Jeremy McGuire
Palliative Care	1/1/2018	3/31/2018	100.00%	Deborah Murr
Health Homes	1/1/2018	12/31/2019	100.00%	Julie Worthing
Diabetes Prevention Program	11/1/2018	4/26/2019	100.00%	Martha Tasinga
DHCS Sanctions Projects	6/1/2019	6/30/2020	100.00%	Deborah Murr
Rx Carve-Out	4/30/2020	12/31/2020	50.00%	Deb Murr
LTC @ Home	9/1/2020	7/1/2021	0.00%	Martha Tasinga
Determine the impact of Managed Care Final Rule (MCFR) to KHS, its policy, procedures, protocols and tracking and reporting functions.	1/1/2018	12/31/2020	85.00%	Jeremy McGuire
Establish a project plan for adopting MCFR requirements instituting new benefits, coverage expansion, or tracking and reporting requirements	1/1/2018	12/31/2020	85.00%	Jeremy McGuire
Hospital Directed Payments	7/30/2018	9/30/2020	95.00%	Jeremy McGuire
COBA	1/1/2018	2/28/2019	100.00%	Jeremy McGuire
Post implementation, audit each activity to ensure installation and performance meets KHS and government agencies expectations.	1/1/2018	12/31/2020	85.00%	Carmen Dobry

Goal 3 – Increase Member Engagement in their Health Care

Task Name	Start Date	Due Date	% Complete	Assigned To
Increase Member Engagement in their Health Care				
Identify ways to engage members more in their health care through education, navigation, coordination, promotion and access to services designed to address their specific needs.				**Alan Avery**
Based on member's medical need, establish what programs and measures members can take to improve health outcomes.	1/1/2018	6/29/2018	100.00%	Martha Tasinga Deborah Murr
Gather information to determine ways to engage members more in maintaining health.	1/1/2018	3/29/2019	100.00%	Martha Tasinga
Develop a member engagement program with a goal to improve access to care in ways that will improve health status.	9/3/2018	6/28/2019	100.00%	Martha Tasinga Deborah Murr
Develop performance standards, data tracking system and reporting structure for the member engagement program.	3/1/2019	6/28/2019	100.00%	Richard Pruitt Martha Tasinga
In collaboration with providers, identify ways to reduce appointment no shows, sharing health information, establishing member accountability, emphasizing prevention and compliance	6/1/2018	12/31/2018	100.00%	Emily Duran
Leverage technology to enhance communication and improve service (administrative and clinical) to members	1/1/2018	6/28/2019	100.00%	Louie Iturriria Martha Tasinga
Explore ways to report health metrics to members to begin tracking what works and outcomes	9/3/2018	6/28/2019	100.00%	Deborah Murr
Survey membership to gauge satisfaction with member engagement program	1/1/2018	6/28/2019	100.00%	
SPH Analytics conducts annual Provider and Member Satisfaction Survey	1/1/2018	9/30/2018	100.00%	Emily Duran
Conduct Member focused surveys to members who participate in Complex Case Management, Health Homes, Disease Management and Member Portal Users	1/1/2018	12/28/2018	100.00%	Deborah Murr Julie Worthing

Goal 4 – Assure Kern Health Systems' Long Term Viability

Task Name	Start Date	Due Date	% Complete	Assigned To
Assure Kern Health Systems Long Term Viability				
Maintain a Financially viable organization capable of meeting its obligations to its members, providers, and government agencies.				**Robert Landis**
Annually develop an operating budget enabling KHS to achieve its annual goals	6/1/2020	12/10/2020	20.00%	Robert Landis
Annually develop capital budget to support new programs, member growth and benefits	9/1/2020	10/2/2020	0.00%	Robert Landis
Determine Capital Budget And Estimated Depreciation Expense	9/1/2020	10/2/2020	0.00%	
Prepare 2021 Capital Budget	9/1/2020	10/2/2020	0.00%	
Executive Review And Discussion - Executives to Review Capital Budget	10/5/2020	10/16/2020	0.00%	
Draft Capital Presented To Finance Committee	10/19/2020	11/13/2020	0.00%	
Final Capital Presented To Finance Committee - December Meeting	11/16/2020	12/4/2020	0.00%	
Final Capital Presented To KHS Board For Approval - December Meeting	12/4/2020	12/10/2020	0.00%	
Retain sufficient reserves to protect KHS from unexpected events to include but not limited to: unforeseen underwriting risks (adverse selection), actuarially unsound rates, un-financed or under financed required benefits, payment delays, future growth	1/1/2020	12/31/2020	60.00%	Robert Landis
Maintain an on-going dialogue with DHCS over reimbursement for any current or proposed, programs, benefits, aid categories or services KHS is required to provide by the State or Federal governments.	1/1/2020	12/31/2020	60.00%	Robert Landis
Relocate KHS offices to its new facility which is convenient to members and able to house all functions in one location.				**Emily Duran, MSA**
Issue Notice to Proceed with Phase II to S.C. Anderson	1/1/2018	1/31/2018	100.00%	
Obtain Grading Permits	1/1/2018	2/28/2018	100.00%	
Complete Phase III – Notice Inviting Bids	5/30/2018	1/31/2019	100.00%	
Novate all Contracts to S.C. Anderson	6/1/2017	1/31/2019	100.00%	
Commence Construction	12/1/2017	2/2/2018	100.00%	
Obtain appropriate property / earthquake insurance	1/1/2018	9/30/2018	100.00%	
Monitoring of Owner Controlled Insurance Program	1/1/2019	12/31/2019	100.00%	
Monitor On-Going Construction	1/1/2019	12/31/2019	100.00%	
Monitor Construction Budget	1/1/2019	12/31/2019	100.00%	
Compliance Oversight GC	1/1/2019	12/31/2019	100.00%	
Coordinate Move	9/30/2018	9/15/2019	100.00%	
Occupancy	7/1/2019	9/15/2019	100.00%	

Goal 4 – Assure Kern Health Systems' Long Term Viability

Task Name	Start Date	Due Date	% Complete	Assigned To
Assure Kern Health Systems Long Term Viability				
Consider opportunities to expand KHS business suitable to the mission and business model.				**Jeremy McGuire**
Monitor key regulatory areas of MC Waiver, SUDS, APM/CP3 FQHC payment reform and CCI	1/1/2018	12/31/2020	85.00%	Jeremy McGuire
Monitor Medi-Cal marketplace trends e.g. Continuation of the two-plan model, entrance of new commercial managed care plans and public plan option in the ACA	1/1/2018	12/31/2020	85.00%	Jeremy McGuire
Continue expanding HHP model to additional qualified contracted provider's sites sufficient to meet the requirements as determined by DHCS.	1/1/2018	12/31/2020	85.00%	Julie Worthing Emily Duran
Continue participation in implementation of Whole Person Care	1/1/2018	2/28/2018	100.00%	Emily Duran,
Monitor internal capacity and regulatory landscape for initiating: CCI (Duals),MH Expansion (S and P population),SUD, LTC and IHSS	1/1/2018	12/31/2020	85.00%	Jeremy McGuire
Consider future Medicare SNP expansion	1/1/2020	6/30/2020	100.00%	Jeremy McGuire
Ensure achievement of the annual Medical Loss Ratio as determined in KHS's annual budget				**Deborah Murr**
Review utilization and cost trends by aid category and medical service category over the past 12 months. Internal Reallocation of resources to address inefficiency or duplication of services in the Provider Network.	1/1/2018	12/31/2020	75.00%	
Review applicable changes in treatment modalities or best practices impacting respective medical service categories.	1/1/2018	12/31/2020	75.00%	
Identify potential medical service areas for impact and determine intervention strategies(s) required to achieve desired results	1/1/2018	12/31/2020	75.00%	
Develop reporting and monitoring system	1/1/2018	12/31/2020	75.00%	

Goal 5 – Optimize the use of technology to improve service to constituency and increase administrative / operations economies of scale

Task Name	Start Date	Due Date	% Complete	Assigned To
Optimize the use of technology to improve service to constituency and increase administrative / operations economies of scale.				
Continue to maximize utility of the new UM, CM, DM and QI operating system to integrate medical management responsibilities using a single platform (JIVA).				**Deborah Murr**
Refine JIVA Phase 1 application components to meet production and performance requirements: UM Workflows,Ops Systems Platform Integration,Data Reporting and Analytics Config,JIVA Training	1/1/2018	3/31/2018	100.00%	
Implement JIVA Phase 2 components: CM/DM/HE/ Appeals, MCG Point of Service (POS),JIVA / QNXT interphase	1/1/2018	6/30/2020	100.00%	
Implement JIVA Phase 3 to integrate HHP and QI Programs	1/1/2018	7/1/2019	100.00%	
Include prospects in annual project planning	1/1/2018	12/31/2020	65.00%	
Develop project budgets along with ROI and/or cost-benefit analysis	1/1/2018	12/31/2020	65.00%	
Continuously monitor and control for operational effectiveness	1/1/2018	12/31/2020	65.00%	
Increase data sharing between and among providers and KHS to reduce health care cost and/or enhance the patient care experience				**Richard Pruitt**
Identify opportunities for sharing information (e.g. Health Homes Program, telehealth, EDI)	1/1/2018	12/31/2019	100.00%	
Educate applicable providers about the importance of data sharing to reduce health care costs and/or enhance the patient care experience.	1/1/2018	12/31/2019	100.00%	
Develop approaches KHS can implement with providers to achieve a level of data sharing	1/1/2018	12/31/2019	100.00%	
Analyze and evaluate products or methods for effectiveness and compatibility with the health plan and provider community	1/1/2018	12/31/2019	100.00%	
Complete a cost benefit analysis of the data sharing program	1/1/2018	12/31/2018	100.00%	
Present to Board of Directors	1/1/2018	12/31/2018	100.00%	
Create plan for implementation	1/1/2018	12/31/2018	100.00%	
Implement regulatory interoperability requirements	3/1/2020	3/31/2021	35.00%	
Review and analyze requirements	3/1/2020	7/17/2020	100.00%	
Procure/build solution	5/1/2020	9/1/2020	40.00%	
Market/train constituents	7/1/2020	3/31/2021	0.00%	
Available for utilization	12/31/2020	3/31/2021	0.00%	

Goal 5 – Optimize the use of technology to improve service to constituency and increase administrative / operations economies of scale

Task Name	Start Date	Due Date	% Complete	Assigned To
Optimize the use of technology to improve service to constituency and increase administrative / operations economies of scale.				
Continuously identify and promote organizational efficiencies and process improvement through Business Process Reengineering (BPR).				**Richard Pruitt**
Identify and analyze efficiencies and improvement opportunities	1/1/2020	12/31/2020	50.00%	
Establish projects into annual project and budget planning	1/1/2020	12/31/2020	50.00%	
Align these initiatives with annual departmental goals and objectives	1/1/2020	12/31/2020	50.00%	
Continuously monitor and control for operational effectiveness	1/1/2020	12/31/2020	50.00%	
Create and execute project plans	1/1/2020	12/31/2020	50.00%	
Review and Update Disaster Recovery and Business Continuity Plans to minimize risk of operational downtime				**Richard Pruitt Alan Avery**
Update Disaster Recovery Plan	1/1/2020	8/30/2020	75.00%	
Procure and Install Disaster Recovery Software	1/1/2020	8/30/2020	75.00%	
Disaster Recovery testing	8/15/2020	9/30/2020	0.00%	
Report to Board of Directors	10/1/2020	12/31/2020	0.00%	

Goal 6 – Develop central business unit devoted to support metrics driven mgmt. at all levels in KHS.

Task Name	Start Date	Due Date	% Complete	Assigned To
Develop business intelligence unit devoted to support metrics driven performance and management at all organizational levels				
Create a KHS Business Intelligence Department with clearly defined roles and responsibilities.				**Richard Pruitt**
Identify personnel from multiple departments that are capable of contributing towards BI	1/1/2018	3/30/2018	100.00%	
Collaborate with management to migrate new BI personnel and transition to BI	1/1/2018	3/30/2018	100.00%	
Create a dedicated cost center and budget that is cost neutral.	1/1/2018	4/30/2018	100.00%	
Establish employee job descriptions, standards, roles and responsibilities, expectations	1/1/2018	3/30/2018	100.00%	
Centralize resources in a geographical location to locally manage.	1/1/2018	3/30/2018	100.00%	
Define employee work models and productivity metrics.	1/1/2018	3/30/2018	100.00%	
Develop Business Intelligence Department processes and procedures to create an effective and efficient team that will support KHS.				**Richard Pruitt**
Create a business analytic intake process that identifies needs, problems, actions, outcomes	1/1/2018	3/31/2018	100.00%	
Establish new data analytics procedure that optimizes full potential outcome and benefits	1/1/2018	6/30/2018	100.00%	
Create process analytics procedure that can identify areas of opportunity for process improvement or continuous improvement.	1/1/2018	6/30/2018	100.00%	
Implement corporate KPI Census reporting process that communicates the measure and performance of established KPIs	1/1/2018	6/30/2019	100.00%	
Establish Audit/QA process to ensure that the department produces quality work products.	1/1/2018	12/31/2019	100.00%	
Establish regular monitoring of department processes/KPI/Data Governance to identify anomalies, unacceptable variance, or issues.	1/1/2018	12/31/2019	100.00%	
Provide business visibility of services contributed by BI efforts	1/1/2018	12/31/2019	100.00%	
Manage Inventory Process	1/1/2018	12/31/2018	100.00%	
Create Corporate Policies to support the new Business Intelligence processes/procedures	1/1/2018	12/31/2019	100.00%	

Goal 6 – Develop central business unit devoted to support metrics driven mgmt. at all levels in KHS.

Task Name	Start Date	Due Date	% Complete	Assigned To
Develop business intelligence unit devoted to support metrics driven performance and management at all organizational levels				
Provide centralized standard operational reporting and analytics for the company.				**Richard Pruitt**
Provide Dept.'s data analysis and routine or adhoc reporting support.	1/1/2018	12/31/2020	100.00%	
Provide Depts. with tools and training to perform routine data analysis and reporting				**Richard Pruitt**
Empowering Depts. with the ability to perform self-service reporting capabilities and basic analytics for routine or simple analysis	1/1/2018	12/31/2020	50.00%	
Create quality control protocol to monitor dept reports for consistency and accuracy	1/1/2018	3/31/2020	100.00%	
Evaluate Depts. data and information requirements	1/1/2018	12/31/2018	100.00%	
Continue to develop and refine a metrics-driven performance culture within the organizations administrative and medical disciplines to enhance operations.				**Richard Pruitt**
Analyze and establish metric oriented baselines for measurement:Finance ,Health Services,Physician Peer Profiles,HHP,Pharmacy,KHS/Statewide (DHCS) Benchmarks	1/1/2018	12/31/2019	100.00%	
Create presentation model(s) to ensure transparent and fluid communication with endpoint	1/1/2018	12/31/2019	100.00%	
Continuously monitor and affirm metrics and performance for effectiveness	1/1/2018	12/31/2019	100.00%	
Provide support for the annual Corporate Project Portfolio through Business Intelligence	1/1/2020	12/31/2020	50.00%	Angela Ahsan
Verify and Validate Return on Investment (ROI) Project Calculation prior to Project	1/1/2020	12/31/2020	50.00%	
Identify and create 2020 Project metrics	1/1/2020	12/31/2020	50.00%	
Measure Factors that are critical to the success of each Project	1/1/2020	12/31/2020	50.00%	

To: KHS Board of Directors

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

Date: August 13, 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 UM Program Evaluation and 2020 UM Program Description

August 13, 2020

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

Agenda

- Overview/Purpose
- 2019 Program Evaluation
- 2020 Program Description

Overview

DHCS contract requirement

- Title 22 CCR 53860 Quality of Care
- Health and Safety Code 1363.50 Utilization Management
- DHCS and DMHC audit

- Annual review
  - QI/UM Committee
  - KHS Governing body

2019 UM Program Evaluation Overview

- Evaluate effectiveness of UM Program
- Changes incorporated into the subsequent annual UM Program Description based on goal achievement or barriers

2019 UM Program Evaluation Results

Goals Met

- Training
- Auditing
  - DMHC/DHCS CAP
- Committee reporting
- Transitions of Care
- Projects

Goals Not Met

- Policy updates-*partial*
- Timeliness and notifications-*partial*
- Inpatient LOS

2020 Program Description Overview

- Overview of the comprehensive health care and applicable processes and resources
- Scope of the program is defined and integrated throughout all the departments in the organization

2020 UM Program Description Contents

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

Questions

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

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

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
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.
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. UM - Referral Notification Compliance 120.0% 100.0% 80.0% 60.0% 40.0% 20.0% 0.0% (4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19) Member Notification: 93.0%, 92.0%, 95.0%, 96.0%, 96.0% Provider Notification: 100.0%, 100.0%, 100.0%, 100.0%, 100.0% Criteria Included: 98.0%, 96.0%, 95.0%, 95.0%, 75.0% MD Signature Included: 97.0%, 99.0%, 99.0%, 100.0%, 97.0%	□ 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

Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
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
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

<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>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.</td><td>☐ Goal Met</td></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>
</table>

<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>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>
<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 **UM - Timeliness of Decision** 4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19 Urgent %: 93.1%, 92.3%, 90.3%, 85.9%, 90.6% Routine %: 92.7%, 92.7%, 94.0%, 89.4%, 96.3% 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	**UM - Referral Notification Compliance** 4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19 Member Notification: 93.0%, 92.0%, 95.0%, 96.0%, 96.0% Provider Notification: 100.0%, 100.0%, 100.0%, 100.0%, 100.0% Criteria Included: 98.0%, 96.0%, 95.0%, 95.0%, 75.0% MD Signature Included: 97.0%, 99.0%, 99.0%, 100.0%, 97.0%	□ 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	**Total Referrals Received** 4Q/2018, 1Q/2019, 2Q/2019, 3Q/2019, 4Q/2019 Total Referrals: 46552, 50266, 52397, 54210, 50595	□ Goal Met
UM	Denial % - Adults	Met/Not Met	Year End 2019	**OUTPT-Adult Referral Denial** 4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19 Denial %: 5%, 6%, 7%, 6%, 6%	□ Goal Met- goal is to remain below 10% overall denial rate

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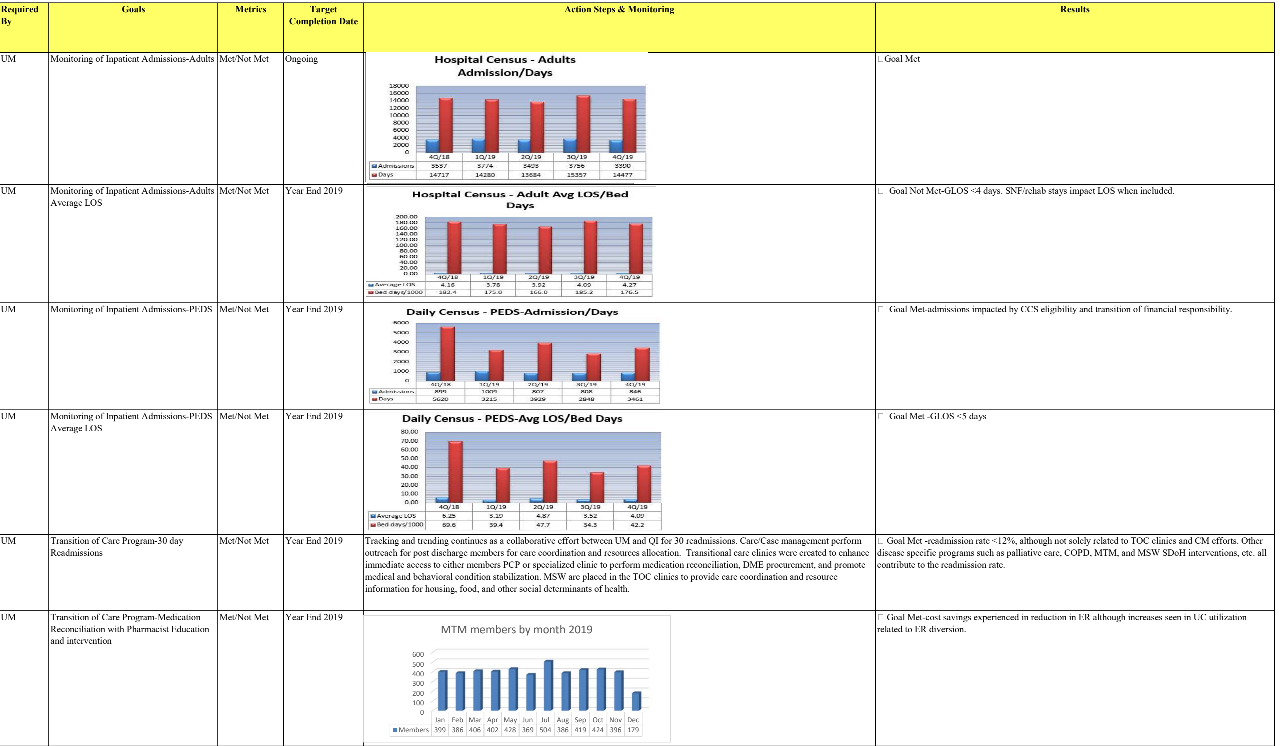
<table>
<tr><th>Required By</th><th>Goals</th><th>Metrics</th><th>Target Completion Date</th><th>Action Steps & Monitoring</th><th>Results</th></tr>
<tr><td>UM</td><td>Approved/Denied Adult Referral Count</td><td>Met/Not Met</td><td>Year End 2019</td><td>OUTPT-Adult Approved/Denied
<table><tr><th></th><th>4Q/18</th><th>1Q/19</th><th>2Q/19</th><th>3Q/19</th><th>4Q/19</th></tr><tr><td>Approved</td><td>33034</td><td>34150</td><td>36747</td><td>38542</td><td>35041</td></tr><tr><td>Denied</td><td>1981</td><td>2219</td><td>2383</td><td>2105</td><td>2035</td></tr></table></td><td>☐Goal Met</td></tr>
<tr><td>UM</td><td>Denial % - Peds</td><td>Met/Not Met</td><td>Year End 2019</td><td>OUTPT - Denied Peds
<table><tr><th></th><th>4Q/18</th><th>1Q/19</th><th>2Q/19</th><th>3Q/19</th><th>4Q/19</th></tr><tr><td>Denied</td><td>726</td><td>807</td><td>760</td><td>733</td><td>724</td></tr><tr><td>CCS Denied</td><td>444</td><td>490</td><td>467</td><td>397</td><td>367</td></tr><tr><td>Denial %</td><td>8%</td><td>8%</td><td>7%</td><td>7%</td><td>7%</td></tr></table></td><td>☐ Goal Met- majority of denials related to carved out services; i.e. CCS, Kern Regional Center- not under KHS benefit</td></tr>
<tr><td>UM</td><td>Approved/Denied Peds Referral Count</td><td>Met/Not Met</td><td>Year End 2019</td><td>OUTPT- Peds Approved-Denied
<table><tr><th></th><th>4Q/18</th><th>1Q/19</th><th>2Q/19</th><th>3Q/19</th><th>4Q/19</th></tr><tr><td>Approved</td><td>8144</td><td>8893</td><td>9511</td><td>10280</td><td>9746</td></tr><tr><td>Denied</td><td>726</td><td>807</td><td>760</td><td>733</td><td>724</td></tr></table></td><td>☐ Goal Met</td></tr>
<tr><td>UM</td><td>Monitoring of Emergency Services - -Health Dialog</td><td>Met/Not Met</td><td>Year End 2019</td><td>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.

Redirection Rates - Inbound Symptom Check Calls (Rolling Twelve Months)
<table><tr><th></th><th></th><th colspan="3">Downward Redirection</th><th colspan="3">Upward & Downward Redirection</th></tr><tr><th>Member's Initial Intended Treatment Plan or Setting</th><th>Number of Symptom Check Calls</th><th>DENOMINATOR</th><th>NUMERATOR</th><th>PERCENT</th><th>DENOMINATOR</th><th>NUMERATOR</th><th>PERCENT</th></tr><tr><td>Call 911</td><td>47</td><td>37</td><td>19</td><td>51.4%</td><td>37</td><td>19</td><td>51.4%</td></tr><tr><td>Emergency Room</td><td>877</td><td>372</td><td>260</td><td>69.9%</td><td>484</td><td>299</td><td>61.8%</td></tr><tr><td>Urgent Care</td><td>395</td><td>99</td><td>77</td><td>77.8%</td><td>115</td><td>89</td><td>77.4%</td></tr><tr><td>Call Provider or Office Visit</td><td>368</td><td>61</td><td>34</td><td>55.7%</td><td>205</td><td>110</td><td>53.7%</td></tr><tr><td>Home Treatment</td><td>464</td><td>N/A</td><td>N/A</td><td>N/A</td><td>365</td><td>251</td><td>68.8%</td></tr><tr><td>None</td><td>459</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr></table></td><td>☐Goal Met</td></tr>
<tr><td>UM</td><td>Monitoring of Inpatient Admissions</td><td>Met/Not Met</td><td>Ongoing</td><td>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.</td><td>☐ Goal Not Met- ALOS not met for overall goal of 3.5 days or less for acute setting</td></tr>
</table>



Required By	Goals	Metrics	Target Completion Date	Action Steps & Monitoring	Results
UM	Monitoring of Inpatient Admissions-Adults	Met/Not Met	Ongoing	**Hospital Census - Adults Admission/Days** 4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19 Admissions: 3537, 3774, 3493, 3756, 3390 Days: 14717, 14280, 13684, 15357, 14477	Goal Met
UM	Monitoring of Inpatient Admissions-Adults Average LOS	Met/Not Met	Year End 2019	**Hospital Census - Adult Avg LOS/Bed Days** 4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19 Average LOS: 4.16, 3.78, 3.92, 4.09, 4.27 Bed days/1000: 182.4, 175.0, 166.0, 185.2, 176.5	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	**Daily Census - PEDS-Admission/Days** 4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19 Admissions: 899, 1009, 807, 808, 846 Days: 5620, 3215, 3929, 2848, 3461	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	**Daily Census - PEDS-Avg LOS/Bed Days** 4Q/18, 1Q/19, 2Q/19, 3Q/19, 4Q/19 Average LOS: 6.25, 3.19, 4.87, 3.52, 4.09 Bed days/1000: 69.6, 39.4, 47.7, 34.3, 42.2	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	**MTM members by month 2019** Jan, Feb, Mar, Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec Members: 399, 386, 406, 402, 428, 369, 504, 386, 419, 424, 396, 179	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 Health Home Program team in place and expansion beyond current models with expansion of additional HHP with FQHC and other community/individual partners.
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.
UM	Community Housing Support	Met/Not Met	Year End 2019	The Permanent Supportive Housing Case Management Program in collaboration with the Kern County Housing Authority will afford KHS patients an opportunity to exit homelessness and receive decent, safe, and affordable housing. These case management services will be matched with a housing resource that already exists in our community, such as, short term rental assistance, housing choice vouchers, and low income public housing. By providing case management services to these housing options it now allows homeless persons to access them and to thrive.	□Goal Met -Housing contract finalized in November 2019. Enrolled has surpassed more than 150 members. Ongoing monitoring anticipate through 2020.
UM	COPD Program	Met/Not Met	Year End 2019	Establish a home COPD management program which includes four components: (1) assess and monitor disease; (2) reduce risk factors; (3) manage stable COPD; (4) manage exacerbations. Strategic Goals include: • Improve health status and quality of life • Improve overall quality of care in the management of members with COPD • Prevent disease progression • Decrease ER/urgent care utilization • Decrease hospitalizations/readmissions and length of stay • Decrease overall COPD related costs by 20%	□ Goal Met-November 2019 implementation
UM	Medical Loss Ratio	Met/Not Met	Year End 2019	The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). Medical loss ratio is defined as a measure of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus administrative costs. KHS's annual goal is maintain an overall MLR of 92% or less.	□ Goal Met -Medical Loss Ratio ongoing strategies for improvement ER Utilization Reduction-GOAL 4% 1-2 Day Inpt Stay Reduction-GOAL 2% 30 Day Readmission Reduction-GOAL 2% Potentially Preventable Admissions-GOAL 2% SNF/LTC LOS reduction -GOAL 10% Tertiary LOS Reduction-GOAL 1% Tertiary Utilization/Redirection-GOAL 1% UCLA Redirection-GOAL 1% Urgent Care Utilization Reduction-GOAL 1%

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.

<u>Structure</u>

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.

<u>Meeting Schedule</u>
The PAC meets monthly or more frequently if necessary.

<u>Reporting Relationship</u>

- 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.

<u>Pharmacy and Therapeutics Committee (P&T)</u>

<u>Key Responsibilities</u>

- 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.

<u>Membership</u>

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

<u>Meeting Schedule</u>
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 through the Quality Improvement and Utilization Management Committee.

Appointed members include:

1 Ex-officio Non-Voting Member: KHS Director of Marketing and Public Affairs (Chairperson)
1 Member of the KHS Board of Directors
7 KHS Members
2 Community Representatives
1 Participating Health Care Practitioner
1 Kern County Department of Public Health Representative
1 Kern County Department of Human Services Representative

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

<u>Pre-authorization</u>

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

To: KHS Board of Directors

From: Jane Daughenbaugh, Director of Quality Improvement

Date: August 13, 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

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

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

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.

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

Requested Action

Review and approve the 2018 QI Program Evaluation, 2019 QI Program Description, and the 2019 QI Program Work Plan.

Quality Improvement Program Annual Review

Presentation to Board of Directors

August 13, 2020

By

Jane Daughenbaugh, RN, PHN, CCM,BSN, MA - Director of Quality Improvement

Contents

- Quality Improvement Program Background
- Quality Improvement Program Evaluation & Key Outcomes – 2019
- Quality Improvement Program Description – 2020
- Quality Improvement Program Work Plan – 2020
- COVID-19 Impact

Quality Improvement Program Background

- Medi-Cal Managed Care Plan QI Programs defined by 3 documents
- Each is developed annually
- Opportunities from QI Program Evaluation influence next year's Program Description & Work Plan

Quality Improvement Program Evaluation – 2019

- Program evaluation reflects outcomes of the primary QI program activities

- Key Outcomes for 2019
  - MCAS results
    - All measures met minimum performance level except Well Child Visits (ages 3-6 yrs) & Asthma Medication Ratio

Quality Improvement Program Evaluation – 2019, Key Outcomes, Continued

- Two New Performance Improvement Projects (PIPs) initiated
- Consumer Assessment of Healthcare Providers & System (CAHPS) survey completed – results in 2020
- DHCS annual audit – two findings
  - Information regarding member rights not included in new provider training – Corrected
  - Incorrect classification of some grievances - Corrected

Quality Improvement Program Evaluation – 2019, Key Outcomes, Continued

- DMHC annual audit – two findings
  - Public Policy Committee not meeting membership criteria – Plan Contested Finding
  - KHS governing body has not consistently reviewed & approved QI Program documents - Corrected

Quality Improvement Program Description – 2020

- Overview of QI Program goals, objectives & functions
- Defines program scope & integration throughout organization
- Defines lines of authority
- Identifies BOD role (pg. 4) as well as the role of the CMO and the other sub-committees
- Identifies primary program activities

Quality Improvement Program Work Plan – 2020

- Identifies program's primary activities throughout current year
- Activities ongoing, recurring, or may be special projects or improvement plans
- Work Plan outcomes feed into Program Evaluation

Primary Impacts of COVID-19

- Stopped Site Review activity
- Limited volume of medical records retrieved for MCAS/HEDIS audit
- Limited & eventually stopped Performance Improvement Projects for Asthma & Well Child Visits that were underway

Questions

Contact
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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

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
Member Incentive	Met	12/31/2019	The following is a summary of member incentives that were made available to members and managed by the Health Education Department. (see table below) *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	Complete for 2019
Committees				
Quality Improvement/Utilization Management Committee (QI/UMC)	Met	Quarterly - ongoing	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	Complete for 2019

Member Incentive Program (MIP)	Total Members who received incentive
1. Health Homes MIP	2,480
2. Asthma Class MIP	118
3. Healthy Eating, Active Lifestyle MIP	469
4. Asthma Impact Model Pilot MIP	25
5. Member Portal MIP	11,881
6. IHA MIP	8,157
7. 1 Year Well Baby MIP	5,775
8. Prenatal Care MIP	422
9. Postpartum Care MIP	2,710
10. Diabetes Prevention MIP	*see note below
11. Perinatal Survey MIP	400

QI Program Evaluation
2019

Goal	Metrics	Target Completion	Action Steps and Monitoring	Results
			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:	
	Met	12/31/2019	1. Practitioner attendance and participation in the QI/UM Committee or subcommittees is required.	Complete for 2019

QI/UM Committee Members	Attended
CMO	4 meetings
Family Practitioner	4 meetings
Family Practitioner	Open Position
1st Specialist (ENT)	4 meetings
2nd Specialist (OB-GYN)	3 meetings
FQHC Provider	4 meetings
Pharmacy Provider	4 meetings
Public Health Department	3 meetings
Home Health/Hospice Provider	1 meeting
DME Provider	4 meetings

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>

			3. The committee meets every four months and provides recommendations and reports findings to the Board of Directors.	
	Met	12/31/2019	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:	Complete for 2019
Regulatory Compliance				
DHCS audit	Partially Met	8/6/2019 – 8/9/2019	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	Complete for 2019

Public Policy Committee Members	Attended
Chair	4
KHS Member	4
KHS Member	2
KHS Member	0
Community Representative	4
Community Representative	1
Kern County Department of Public Health	4
Kern County Department of Human Services	3

			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.
			  ○ 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.
			  ○ 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.

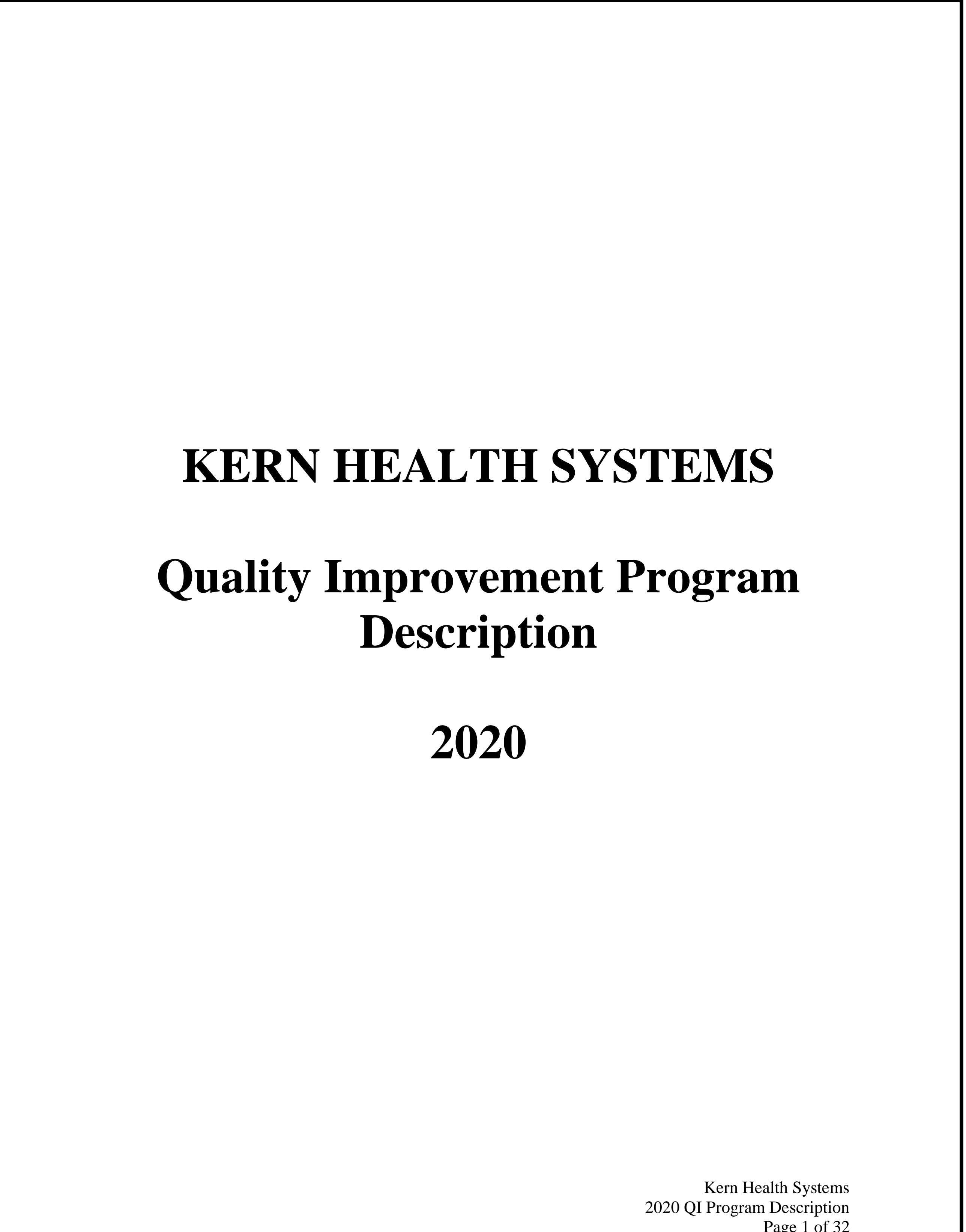
QI Program Evaluation
2019

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

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 Kern Family Health Care (KFHC) Public Policy/Community Advisory Committee (PP/CAC) provides participation of members in the establishment of public policy of KFHC. Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.[1]

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

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

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

Appointed members include:

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

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

5. Grievance Review Team (GRT)

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

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

#	MEASURE Total Number of Measures = 36 (14 Hybrid and 22 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
15	Prenatal and Postpartum Care: Postpartum Care	PPC-Pst	Hybrid	Yes
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.

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KHS Board of Directors (Chair) Date

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Chief Executive Officer Date

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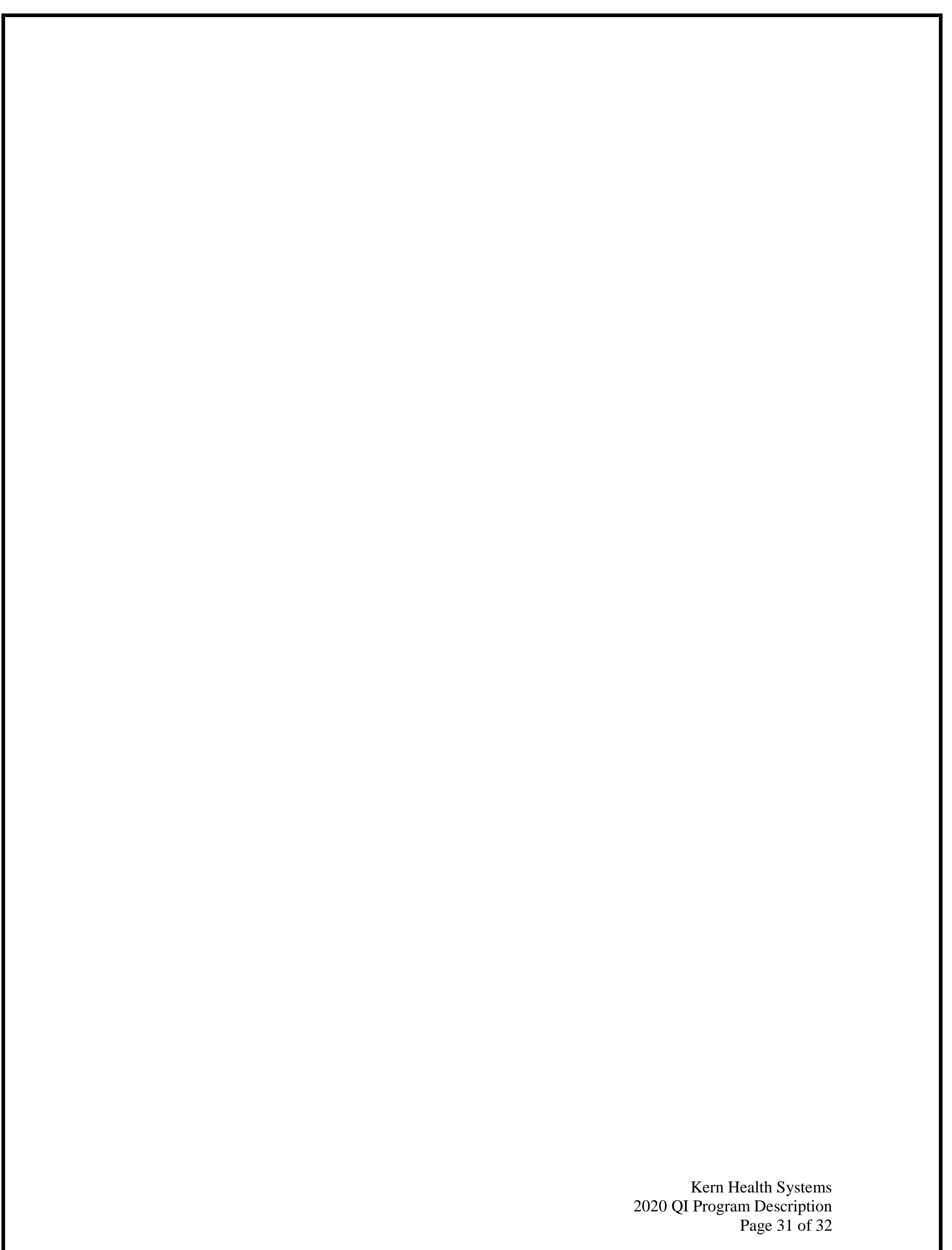
Chairman QI/UM COMMITTEE Date


Kern Health Systems
2020 QI Program Description
Page 31 of 32

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).

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
2020 QUALITY IMPROVEMENT WORK PLAN

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

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

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

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

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
N. MCAS Member Engagement & Incentive Program	A program for using Interactive Voice Recognition to contact members with Gaps in Care related to the MCAS measures either providing health education or reminders about preventive health measures. The program includes establishing specific member incentives for completion of health care activities that resolve their care gaps.	12/31/202	Chief Health Services Officer/QI Director/Health Education Director		Started May 2020 and ongoing.
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

KERN HEALTH SYSTEMS
2020 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
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
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

To: KHS Board of Directors

From: Douglas A. Hayward, CEO

Date: August 13, 2020

Re: Appointments to the KHS Public Policy/Community Advisory Committee

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Background

The Public Policy/Community Advisory Committee (PP/CAC) provides a mechanism for structured input from KFHC 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 PP/CAC is delegated by the KHS Board of Directors to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the KHS Quality Improvement/Utilization Management Committee, which reports to the KHS Board of Directors. The PP/CAC meets quarterly.

Enclosed is an overview of the KHS Public Policy/Community Advisory Committee including: the benefits of the committee, committee structure, existing committee members and new committee member recommendations.

The presentation will be given by Louis Iturriria, Director, Marketing & Public Relations

Requested Action

The following applicants are being submitted for appointment to the KHS Public Policy/Community Advisory Committee (PP/CAC) to fill all current vacancies:

- KFHC members:
  - Michelle Darlene Bravo
  - Caitlin Criswell
  - Yadira Ramirez
  - Jose Sanchez
  - Tammy Maxine Torres
- KHS Board Member Alex Garcia
- KHS Participating Provider - Quon Louey, Exec. Dir. of Telehealthdocs
  (KHS provider offering telemedicine services to members)

Approve Appointments to the KHS Public Policy/Community Advisory Committee

Louis Iturriria

Director, Marketing & Public Relations

What is the KHS Public Policy/Community Advisory Committee?

- Provides:
  - Member feedback to KHS on delivery of care and administration of benefits
  - Link KHS to community through community representation on the Comm.
  - Link KHS to other sister agencies serving same constituents (DPH and DHS)
  - Sounding board for new initiatives, programs and activities planned for implementation
  - Input on:
    - where KHS may improve its service to members
    - Best sources for communication and information dissemination
    - helpful health topics/benefit information to include in KFHC Member Newsletters
    - marketing materials and advertising campaigns
  - Advice on cultural & linguistic issues
  - Community collaboration and partnerships

Committee Structure

- Ex-officio Non-Voting Member: KHS Director of Marketing and Public Relations (Chairperson)
- 7 KFHC Members (51% of committee members are plan enrollees)
- 1 Member of the KHS Board of Directors
- 1 Participating Health Care Provider
- 1 Kern County Department of Human Services Representative
- 1 Kern County Department of Public Health Representative
- 2 Community Representatives

Coordinated by Maritza Jimenez, Marketing/Public Affairs Representative

Executive Leadership Representative: Chief Operating Officer

Current Committee members

KFHC Member Representatives

- **Cecilia Hernandez-Colin** – Mother of KFHC members who's served on the committee for 12 years.
- **Beatriz Basulto** – KFHC member who's served on the committee for 6 years.

Community Representatives

- **Jan Hefner** – Exec. Dir. of The Center for Sexuality & Gender Diversity. Jan has served for 12 years.
- **Jennifer Wood Lancaster** – Program Director of the Lamont Family Resource Center. Jennifer has served for 13 years.

Kern County Government Representatives

- **Valerie Rangel** – Program Director, Department of Human Services Representative: Valerie has served for 1 year.
- **Jasmine Ochoa** – Senior Health Educator/Project Director, Dept. of Public Health : Jasmine has served for 1 year.

New appointees who want to serve on PP/CAC

KFHC Member Appointments

- **Michelle Darlene Bravo** –
  - She stated, “I like to give feedback to help others”. Michelle participated in the Diabetes Prevention Program and was recommended by Disease Management.
- **Caitlin Criswell** -
  - She stated, “As the parent of a KFHC Member, I feel I can bring valuable representation to the committee”.
- **Yadira Ramirez** -
  - She stated, “I am interested because I like to be the voice for my son that has autism. As a mom, I know what my son’s health needs are and what my plan needs to do to help keep him healthy.” Yadira was recommended by the Richardson Center.
- **Jose Sanchez** -
  - He stated, “I am interested in joining the group to share my thoughts and concerns I see as a member. I feel that since I am an older adult I’ll be able to provide a different opinion to the group.”
- **Tammy Maxine Torres** -
  - She stated, “I would like to share what the health plan is doing right or wrong based on my membership experience. I would like to be the voice for other members.”

New appointees who want to serve on PP/CAC

KHS Board Member and Provider Appointments

- **KHS Board Member Alex Garcia -**
  - He stated, “For nearly 4 years now, I've represented thousands of low-income working families. I have walked in their shoes and understand the difficulties these folks go through daily. I can bring a unique perspective to the committee in understanding the underserved communities I frequently work with.”
- **KHS Participating Provider Quon Louey -**
  - As a provider, Quon Louey offers a unique perspective on members as patients and the way they interact with providers.

Requested KHS Board Action

Appoint the following individuals to fill current vacancies on the Public Policy/Community Advisory Committee committee:

- ***5 KFHC Members:***
  - *Michelle Darlene Bravo,*
  - *Caitlin Criswell*
  - *Yadira Ramirez*
  - *Jose Sanchez*
  - *Tammy Maxine Torres*
- ***1 KHS Board Member:***
  - *Alex Garcia*
- ***1 KHS Participating Provider:***
  - *Quon Louey*

To: KHS Board of Directors

From: Jane Daughenbaugh, Director of Quality Improvement

Date: August 13, 2020

Re: Cotiviti Agreement Renewal

Background

Kern Health Systems is required under its contract with DHCS and requirements for Knox-Keene licensure to perform an annual data audit of its managed care operations. This audit is mandated by the State. We are required to use Managed Care Accountability Set (MCAS) metrics reporting software that has been certified by the National Committee for Quality Assurance (NCQA) and DHCS' designated External Quality Review Organization (EQRO). These healthcare metrics are complex algorithms that are used to identify the rate of compliance for health care measures designated by DHCS. Kern Health Systems has used the software manufactured by Cotiviti, for the last 10 years.

Discussion

Cotiviti, Inc., will provide KHS with a NCQA-certified software solution that performs MCAS calculations on a monthly and annual basis. The platform provides a software system for data collection, full access to the underlying databases, member correspondence, analytic and reporting interfaces and reporting formats that meet DHCS requirements to report MCAS results. This contract will provide KHS with software licensing, support and maintenance for Cotiviti's software.

Financial Impact

Cost for two years term will not exceed $300,625.00 per two years.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

MCAS/HEDIS Software

August 13, 2020

Jane Daughenbaugh, RN, PHN, CCM, BSN, MA
Director of Quality Improvement

Agenda

- MCAS/HEDIS Software Purpose
- Software Functionality
- Software Deliverables
- Board Request

HEDIS Software Purpose

- Managed Care Accountability Set (MCAS): Set of health care measures required by DHCS to report plan outcomes annually.
- Include measures from the National Committee for Quality Assurance (NCQA) & the Centers for Medicaid & Medicare (CMS) to measure health outcomes
- DHCS conducts an annual audit of the data used for measurement outcomes reporting that:
  - Evaluate provider performance in preventative care
  - Identify opportunities for health care improvement
  - Serve as basis for auto assignment of new membership in Kern County
- KHS is mandated to utilize software certified by NCQA and the State's External Quality Review Organization (EQRO)

Software Functionality

- The software provides:
  - Monthly/Annual MCAS Data Abstraction & Rate Calculations
  - Quality Improvement initiative identification
- KHS has used current vendor, Cotiviti, for 10 years
- Request: Two year contract extension
  - Current cost in line with other vendors
  - Allows time for additional cost & system analysis for a major conversion
  - We will undertake a competitive bid process for a RFP over the next 18 months

Software Deliverables

- Software certified by NCQA
- Includes MCAS measures for Measurement Year 2020 / Reporting Year 2021
- Configuration of data sets for rate compliance reporting
- Staff training by Cotiviti for use of their software
- Ongoing software support to ensure timely & accurate data & reports submission

Board Request

- Authorize CEO to sign budgeted contract associated with the MCAS Software solution from Cotiviti, Inc., in an amount not to exceed **$300,625** for two (2) years.

Questions

Jane Daughenbaugh, RN, PHN, CCM, BSN, MA
661-664-5080
Jane.daughenbaugh@khs-net.com

Proposed Administrative contract over $100,000, August 13, 2020

1. Operational Agreement with Cotiviti, Inc.
   a. Recommended Action
      Approve; Authorize Chief Executive Officer to Sign
   b. Contact
      Jane Daughenbaugh, Director of Quality Improvement
   c. Background
      MCAS is an annual regulatory event required by DHCS. It serves as the basis of auto member assignment, financial penalties for non-compliance, corrective action plans (CAPs) issued for non-compliance and for identifying opportunities for improvement. DHCS mandates that MCPs use software certified by the National Committee for Quality Assurance (NCQA) to complete this deliverable. The software uses our membership, claims and encounter data, and manually entered clinical data to identify a selected population and measure performance of preventive care performed. KHS has used Cotiviti Inc.'s software for the past 10 years for HEDIS and MCAS audits and rate submission.
   d. Discussion
      Cotiviti, Inc. will provide a software tool and platform for data upload, report generation and clinical review abstractions for MCAS audit and rate submissions required by DHCS. This submission influences membership assignment to KHS and financial penalties and CAPs for non-compliant measures.
   e. Fiscal Impact
      Total amount not to exceed $300,625.00 for two years.
   f. Risk Assessment
      Performing an annual data audit of KHS's managed care operations is a regulatory requirement under its DHCS contract and Knox-Keene license. Failure to perform the audit would place KHS into a non-compliant status.
   g. Attachments
      An Agreement at a Glance form is attached.
   h. Reviewed by Chief Compliance Officer and/or Legal Counsel
      This agreement has been approved by legal counsel.

AGREEMENT AT A GLANCE

Department Name: Quality Improvement   Department Head: Jane Daughenbaugh

Vendor Name: Cotiviti, Inc.

Contact name & e-mail: Cayla Johnson, Cayla.johnson@cotiviti.com

What services will this vendor provide to KHS? Cotiviti, Inc. will provide a NCQA certified software program for data upload, reporting and clinical record abstractions for the MCAS audit and data submission.

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☐ New agreement ☒ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background: MCAS is an annual regulatory event required by DHCS. It serves as the basis of auto member assignment, financial penalties for non-compliance, corrective action plans (CAPs) issued for non-compliance and for identifying opportunities for improvement. DHCS mandates that MCPs use software certified by the National Committee for Quality Assurance (NCQA) to complete this deliverable. The software uses our membership, claims and encounter data, and manually entered clinical data to identify a selected population and measure performance of preventive care performed. KHS has used Cotiviti Inc.'s software for the past 10 years for HEDIS and MCAS audits and rate submission. During the RFP process, Cotiviti, Inc. produced the lowest bid for services. Brief Explanation: Cotiviti Inc. will provide a software tool and platform for data upload, report generation and clinical review abstractions for MCAS audit and rate submissions required by DHCS. This submission influences membership assignment to KHS and financial penalties and CAPs for non-compliant measures.

☐ 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.

Brief reason for sole source: This has been our vendor for the past 10 years and the system is known and understood by IT and QI.

☐ Conflict of Interest Form is required for this Contract

☐ HIPAA Business Associate Agreement is required for this Contract

Form updated 11/21/19

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 311 GL# 5645

Maximum cost of this agreement not to exceed: $300,625.00 per two-years

Notes: Price includes $128,308 for licenses per year (will include 3% increase for year 2), and $20,080 for Medi-Cal Medicaid Measures per year.

Contract Terms and Conditions

Effective date: 9/8/2020 Termination date: 9/7/2022

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:**
Approved per J. Daughenbaugh	Approved per. Alonso Hurtado 7/30/20
Department Head	Director of Procurement and Facilities
7/30/20	7/30/20
Date	Date
Reviewed as to Budget:	**Recommended by the Executive Committee:**
Robert Landis	[signature]
Chief Financial Officer or Controller	Chief Operating Officer
7/30/20	7/30/2020
Date	Date
IT Approval:	**Chief Executive Officer Approval:**
Chief Information Officer or IT Director	Chief Executive Officer
Date	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

To: KHS Board of Directors

From: Richard M. Pruitt, Chief Information Officer

Date: August 13, 2020

Re: Fast Healthcare Interoperability Resources (FHIR) System

Background

CMS and the State of California have regulated the Interoperability and Patient Access Rule (CMS-9115-F) to *"deliver on the Administration's promise to put patients first, giving them access to their health information when they need it most and in a way they can best use it."* The goal is to break down information silos for patients leading to better care and improved outcomes. This secure data link between 3rd parties, payors, providers, and patients and is intended to improve care coordination and reduce cost through data exchange and technological innovations. This purchase is a major component to ensure that Kern Health Systems meets the regulatory statute to be completed by June 2021.

The attached presentation outlines the procurement process; vendor responses; and Board of Directors request.

Requested Action

Authorize the CEO to approve contracts associated with the procurement of Fast Healthcare Interoperability Resources (FHIR) System and Professional Services with Citius Tech in the amount not to exceed $850,000 over five (5) years in capital expenses to complete the Interoperability corporate project.

Fast Healthcare Interoperability Resources (FHIR) System

August 13, 2020

Richard M. Pruitt
Chief Information Officer

1

Agenda

- General Overview
- Operational Impact
- Selection Process
- Selection Criteria
- Board of Directors Request

General Overview

CMS and the State of California have regulated the Interoperability and Patient Access Rule (CMS-9115-F) to *"deliver on the Administration's promise to put patients first, giving them access to their health information when they need it most and in a way they can best use it."* The goal is to break down information silos for patients leading to better care and improved outcomes. This secure data link between 3rd parties, payors, providers, and patients and is intended to improve care coordination and reduce cost through data exchange and technological innovations. This purchase is a major component to ensure that Kern Health Systems meets the regulatory statute to be completed by June 2021.

Operational Impact

Immediate

- Limited Personal Health Record
  - Claims History
  - Pharmacy Data
  - Immunizations
- Laboratory Test Results
- Decision Support
  - Drug Interactions
  - Missed Diagnosis Data
- Provider Directory

Selection Process

- Prior Year Allocated Budget and Project Proposal
- Performed Research and Analysis for Requirements
- Collaborated with Local Health Plans of California (LHPC)
- Published Request for Proposal/Request for Quote (RFP/RFQ)
- Performed Selection Process
- Create recommendation for the Board of Directors.

5

Selection Criteria

VENDOR	TECHNOLOGY	COMPANY	EXPERIENCE	SERVICES	PRICE	SCORE
CITIUS TECH	4	4	3	5	4	4
VENDOR 2	5	4	3	5	2	3.8
VENDOR 3	4	2	3	5	3	3.4

Board of Directors Request

Authorize the CEO to approve contracts associated with the procurement of Fast Healthcare Interoperability Resources (FHIR) System and Professional Services with Citius Tech in the amount not to exceed $850,000 over five (5) years in capital expenses to complete the Interoperability corporate project.

Questions

Please contact:

Richard M. Pruitt
Chief Information Officer
661-664-5078
richard.pruitt@khs-net.com

8

To: KHS Board of Directors

From: Alonso Hurtado, Director of Procurement and Facilities

Date: August 13, 2020

Re: Commercial Cleaning Systems, Inc. Agreement

Background

In 2018, Kern Health Systems embarked on building a new facility located at 2900 Buck Owens Boulevard to accommodate the current and future growth of the business. KHS will leverage Commercial Cleaning Systems, Inc., to provide commercial janitorial services for this facility.

Discussion

In June 2019, KHS posted an RFP for commercial janitorial services for its new facility. CCS was selected as the vendor for these services based on experience, price, and references. CCS will provide commercial janitorial services for its new facility five days a week to include two janitors that will provide sanitization services during regular business hours. Per KHS contracting policy, KHS is authorized to execute a one-time renewal contract with a vendor that was selected as a result of an RFP.

These services include the cleaning services for KHS four story 110,000 SqFt facility which houses 18 conference rooms, 48 private offices, 380 cubicles and a break area for 250 employees. The annual cost does not include cleaning supplies.

Financial Impact

Cost for a one year term will not exceed $170,000.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

Commercial Janitorial Services

August, 2020

Alonso Hurtado

Director of Procurement and Facilities

1

Agenda

- Background
- Scope of services
- RFP process and renewal option
- COVID-19 Preventive cleaning
- Recommendation
- Questions

Background

- In 2018, KHS embarked on building a new facility, located at 2900 Buck Owens Blvd, to accommodate the current and future growth of the business.

3

Scope of Services

- Daily janitorial services for KHS four story 110,000 square feet facility
  - 18 conference rooms
  - 48 private offices
  - 380 cubicles
  - 3 common areas (board room, break room and training room)
- Two additional daily janitors from 10 am – 2 pm

Request for Proposal

- In June 2019, KHS posted an RFP for commercial janitorial services for its new facility. CCS was selected as the vendor for these services based on experience, price, and references. CCS will provide commercial janitorial services for its new facility five days a week. Per KHS' contracting policy, KHS is authorized to execute a one-time renewal contract with a vendor that was selected as a result of an RFP.

- Monthly cost is $13,120 (does not include cleaning supplies)

- Additional funding allocated for exterior cleaning, floor waxing, carpet cleaning and emergency cleaning services.

COVID-19 Preventive cleaning

- Two day-porters
- Identified/marked high-traffic areas
- Cleaning of IT equipment
- Disinfect with EPA registered hospital grade products
- Increase air circulation in our AC/System
- Installed body temperature reader

6

Recommendation

- Request the Board of Directors authorize the CEO to approve a one year contract with Commercial Cleaning Systems Inc., in the amount not to exceed $170,000 for commercial janitorial services.

7

Questions

For additional information, please contact:

Alonso Hurtado
Director of Procurement and Facilities
661-664-5541

8

Proposed administrative contract over $100,000, August 13, 2020

1. Operational Agreement with Commercial Cleaning Systems, Inc.
    a. Recommended Action

       Approve; Authorize Chief Executive Officer to Sign
    b. Contact

       Alonso Hurtado; Director of Procurement and Facilities
    c. Background

       In 2018, KHS embarked on building a new facility, located at 2900 Buck Owens Blvd, to accommodate the current and future growth of the business. KHS will leverage CCS to provide commercial janitorial services for this facility.
    d. Discussion

       In June 2019, KHS posted an RFP for commercial janitorial services for its new facility. CCS was selected as the vendor for these services based on experience, price, and references. CCS will provide commercial janitorial services for its new facility five days a week to include two janitors that will provide sanitization services during regular business hours. Per KHS contracting policy, KHS is authorized to execute a one-time renewal contract with a vendor that was selected as a result of an RFP.
    e. Fiscal Impact

       Not to exceed $170,000 for one year.
    f. Risk Assessment

       Janitorial services are required in order to maintain a suitable work environment for KHS employees and members.
    g. Attachments

       An Agreement at a Glance form is attached.
    h. Reviewed by Chief Compliance Officer and/or Legal Counsel

       This contract has been approved by Legal.

AGREEMENT AT A GLANCE

Department Name: CS Department Head: Alonso Hurtado

Vendor Name: Commercial Cleaning Systems, Inc. Contact name & e-mail: Jaime Jacobo, jjacobo@ccsbts.com

What services will this vendor provide to KHS? Janitorial services five days a week for 2900 Buck Owens Blvd.

Description of Contract	
Type of Agreement: Professional Services ☒ Contract ☐ Purchase ☐ New agreement ☐ Continuation of Agreement ☐ Addendum ☒ Amendment No. 1 ☐ Retroactive Agreement	Background: In 2018, KHS embarked on building a new facility, located at 2900 Buck Owens Blvd, to accommodate the current and future growth of the business. KHS will leverage CCS to provide commercial janitorial services for this facility. Brief Explanation: In June 2019, KHS posted an RFP for commercial janitorial services for its new facility. CCS was selected as the vendor for these services based on experience, price, and references. CCS will provide commercial janitorial services for its new facility five days a week.

☒ 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: Commercial Cleaning Systems was selected as the vendor based on company experience, price and references.

☐ Sole source – no competitive process can be performed.

Brief reason for sole source: _____

☐ Conflict of Interest Form is required for this Contract

☐ HIPAA Business Associate Agreement is required for this Contract

Fiscal Impact		
KHS Governing Board previously approved this expense in KHS' FY 2020 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☒ NO	☐ YES
Capital project	☒ NO	☐ YES
Project type: _____		
Budgeted Cost Center 340 GL# 5510		

Form updated 11/21/19

Maximum cost of this agreement not to exceed: $170,000.00 per one year

Notes: Termination clause of thirty (30) days' notice per PSA.

Contract Terms and Conditions

Effective date: 9/06/20 Termination date: 9/05/21

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:** [signature]
Department Head	Director of Procurement and Facilities
Date	6/24/20 Date
Reviewed as to Budget: Robert [signature]	**Recommended by the Executive Committee:** [signature]
Chief Financial Officer or Controller	Chief Operating Officer
7/6/20 Date	7-6-2020 Date
IT Approval:	**Chief Executive Officer Approval:**
Chief Information Officer or IT Director	Chief Executive Officer
Date	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

AMENDMENT NO. 1
TO
PROFESSIONAL SERVICES AGREEMENT

(Kern Health Systems – Commercial Cleaning Systems, Inc.)

AMENDMENT NO. 1 TO AGREEMENT, effective this ___ day of _____, 2020, is between the Kern Health Systems, a County Health Authority (hereinafter "KHS") and Commercial Cleaning Systems, Inc. (hereinafter "CONTRACTOR").

WITNESSETH:

WHEREAS:

A. KHS and CONTRACTOR entered into an Agreement, dated September 6, 2019, for the term of September 6, 2019 through September 5, 2020 for the provision of janitorial services to KHS; and

B. KHS and CONTRACTOR desire to amend the term to cover thru September 5, 2021 for the provision of janitorial services to KHS; and

C. KHS and CONTRACTOR desire to amend the not to exceed amount to cover the additional cost of $170,000.00 for janitorial services for the additional year

NOW, THEREFORE, KHS and CONTRACTOR do mutually agree as follows:

1. The Term of Agreement, identified in Paragraph 1 of the Agreement, shall be amended to be from September 6, 2019 to September 5, 2021.
2. The maximum compensation payable to CONTRACTOR by KHS, identified in Paragraph 3.2 of the Agreement shall be increased from one hundred forty thousand dollars ($140,000.00) to three hundred ten thousand dollars ($310,000.00).
3. The Janitorial Contract Pricing attached hereto as "Exhibit "B-1" Schedule of Fees is incorporated and made a part of the Agreement by this reference.
4. Except as expressly amended herein, all provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, this Amendment No. 1 to the Agreement has been executed as of the date indicated above.

Kern Health Systems	Commercial Cleaning Systems, Inc.
By_______________________	By_______________________
Chief Executive Officer	
Date: _____________________	Date: _____________________

APPROVED AS TO FORM:
Office of the County Counsel
Gurujodha S. Khalsa
Deputy County Counsel for Kern Health Systems

Exhibit "B-1"
Schedule of Fees

Service	Pricing
Nighttime janitorial Monday – Friday, 5 nights per week	$11,130.00 per month
Day porter Services 4 hours per day (Monday – Friday)	$2,010.00 per month
Total monthly billing:	$13,140.00 per month

To: KHS Board of Directors

From: Robert Landis, CFO

Date: August 13, 2020

Re: May 2020 Financial Results

The May results reflect a $2,244,361 Net Increase in Net Position which is a $2,937,153 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $.3 million unfavorable variance primarily due to:

   A) $1.3 million favorable variance primarily due to higher than expected budgeted membership.

   B) $.9 million unfavorable variance due to a 1 ½% rate reduction required under the Governor's budget.

   C) $.9 million unfavorable variance in BHT Kick Premiums from lower than expected utilization due to Covid-19 offset against lower expenses included in 2B below.

   D) $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 programs that became effective January 1, 2020 offset against amounts included in 2F below.

   E) $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.

2) Total Medical Costs reflect a $1.0 million favorable variance primarily due to:

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

   B) $1.1 million favorable variance in Other Professional Services primarily due to lower than expected utilization of Behavioral Health Treatment offset against lower revenue included 1C above.

   C) $.9 million favorable variance in Emergency Room due to lower than expected utilization.

   D) $.9 million unfavorable variance in Inpatient due to higher than expected utilization for SPD members.

E) $1.4 million favorable variance in Outpatient Hospital due to lower than expected utilization.

F) $3.9 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 that became effective January 1, 2020 offset against revenue included in 1D above ($1.6 million) and Covid-19 provider relief expenses ($2.8 million).

G) $1.1 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 beginning in March.

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 1E above.

The May Medical Loss Ratio is 89.1% which is favorable to the 93.2% budgeted amount. The May Administrative Expense Ratio is 6.7% which is slightly unfavorable to the 6.6% budgeted amount primarily due to the unfavorable rate reduction mentioned in 1B above (Administrative Expense Ratio would have been 6.5% without this adjustment).

The results for the 5 months ended May 31, 2020 reflect a Net Increase in Net Position of $4,636,670. This is a $7,768,201 favorable variance to budget and includes approximately $6.4 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 91.6% which is favorable to the 93.1% budgeted amount. The year-to-date Administrative Expense Ratio is 6.2% which is favorable to the 6.6% budgeted amount.

Kern Health Systems
Financial Packet
May 2020

KHS – Medi-Cal Line of Business

Comparative Statement of Net Position Page 1

Statement of Revenue, Expenses, and Changes in Net Position Page 2

Statement of Revenue, Expenses, and Changes in Net Position - PMPM Page 3

Statement of Revenue, Expenses, and Changes in Net Position by Month Page 4

Statement of Revenue, Expenses, and Changes in Net Position by Month - PMPM Page 5

Schedule of Revenues Page 6

Schedule of Medical Costs Page 7

Schedule of Medical Costs - PMPM Page 8

Schedule of Medical Costs by Month Page 9

Schedule of Medical Costs by Month – PMPM Page 10

Schedule of Administrative Expenses by Department Page 11

Schedule of Administrative Expenses by Department by Month Page 12

KHS Group Health Plan – Healthy Families Line of Business

Comparative Statement of Net Position Page 13

Statement of Revenue, Expenses, and Changes in Net Position Page 14

KHS Administrative Analysis and Other Reporting

Monthly Member Count Page 15

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF NET POSITION AS OF MAY 31, 2020						
ASSETS	**MAY 2020**		**APRIL 2020**		**INC(DEC)**	
CURRENT ASSETS:						
Cash and Cash Equivalents	$	104,728,141	$	107,152,379	$	(2,424,238)
Short-Term Investments		111,709,814		100,271,133		11,438,681
Premiums Receivable - Net		112,708,379		106,636,509		6,071,870
Premiums Receivable - Hospital Direct Payments		261,068,716		249,417,529		11,651,187
Interest Receivable		372,583		186,300		186,283
Provider Advance Payment		3,283,252		1,445,781		1,837,471
Other Receivables		1,322,729		1,171,172		151,557
Prepaid Expenses & Other Current Assets		1,771,285		1,791,315		(20,030)
Total Current Assets	$	596,964,899	$	568,072,118	$	28,892,781
CAPITAL ASSETS - NET OF ACCUM DEPRE:						
Land		4,090,706		4,090,706		-
Furniture and Equipment - Net		2,392,952		2,414,411		(21,459)
Computer Hardware and Software - Net		16,713,240		17,523,898		(810,658)
Building and Building Improvements - Net		35,878,118		35,952,529		(74,411)
Capital Projects in Progress		9,647,465		9,590,631		56,834
Total Capital Assets	$	68,722,481	$	69,572,175	$	(849,694)
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	$	669,619,879	$	641,576,792	$	28,043,087
LIABILITIES AND NET POSITION						
CURRENT LIABILITIES:						
Accrued Salaries and Employee Benefits	$	3,247,048	$	3,254,546		(7,498)
Accrued Other Operating Expenses		1,369,676		1,375,721		(6,045)
Accrued Taxes and Licenses		39,398,078		31,483,081		7,914,997
Claims Payable (Reported)		16,816,653		13,909,456		2,907,197
IBNR - Inpatient Claims		26,539,826		28,462,611		(1,922,785)
IBNR - Physician Claims		14,851,477		17,651,340		(2,799,863)
IBNR - Accrued Other Medical		19,425,332		22,567,072		(3,141,740)
Risk Pool and Withholds Payable		2,514,541		2,146,369		368,172
Statutory Allowance for Claims Processing Expense		2,278,463		2,278,463		-
Other Liabilities		55,322,123		44,487,019		10,835,104
Accrued Hospital Directed Payments		261,068,716		249,417,529		11,651,187
Total Current Liabilities	$	442,831,933	$	417,033,207	$	25,798,726
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		4,636,670		2,392,309		2,244,361
Total Net Position	$	219,329,049	$	217,084,688	$	2,244,361
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$	669,619,879	$	641,576,792	$	28,043,087

KHS7/28/2020
Management Use Only

CURRENT MONTH MEMBERS			KERN HEALTH SYSTEMS MEDI-CAL - ALL COA STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION	YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE	FOR THE MONTH ENDED MAY 31, 2020	ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
170,641	169,100	1,541	Family Members	841,171	841,500	(329)
62,535	61,090	1,445	Expansion Members	305,011	305,450	(439)
15,946	14,730	1,216	SPD Members	78,786	73,650	5,136
7,012	6,205	807	Other Members	34,315	31,025	3,290
9,475	8,660	815	Kaiser Members	46,023	43,300	2,723
265,609	259,785	5,824	Total Members - MCAL	1,305,306	1,294,925	10,381
			REVENUES			
28,170,470	27,488,620	681,850	Title XIX - Medicaid - Family and Other	140,575,530	137,087,550	3,487,980
23,386,527	23,145,509	241,018	Title XIX - Medicaid - Expansion Members	116,169,651	115,727,546	442,105
14,967,019	14,884,621	82,398	Title XIX - Medicaid - SPD Members	75,262,334	74,423,106	839,228
7,915,091	10,045,000	(2,129,909)	Premium - MCO Tax	39,576,033	50,065,000	(10,488,967)
11,614,663	11,083,892	530,771	Premium - Hospital Directed Payments	57,392,764	55,376,622	2,016,142
323,827	399,047	(75,220)	Investment Earnings And Other Income	1,505,573	1,988,877	(483,304)
-	72,826	(72,826)	Reinsurance Recoveries	-	362,971	(362,971)
36,524	-	36,524	Rate Adjustments - Hospital Directed Payments	294,775	-	294,775
444,891	-	444,891	Rate/Income Adjustments	(1,838,734)	-	(1,838,734)
86,859,012	87,119,515	(260,503)	TOTAL REVENUES	428,937,926	435,031,672	(6,093,746)
			EXPENSES			
			Medical Costs:			
12,429,908	14,373,104	1,943,196	Physician Services	67,830,860	71,696,760	3,865,900
3,489,408	4,630,562	1,141,154	Other Professional Services	19,724,397	23,078,019	3,353,622
4,212,272	5,151,709	939,437	Emergency Room	23,881,973	25,686,016	1,804,043
14,410,696	13,503,461	(907,235)	Inpatient	73,955,351	67,389,737	(6,565,614)
69,310	72,826	3,516	Reinsurance Expense	363,183	362,971	(212)
5,199,240	6,550,380	1,351,140	Outpatient Hospital	30,975,151	32,698,739	1,723,588
10,860,308	7,006,045	(3,854,263)	Other Medical	46,028,608	34,961,665	(11,066,943)
8,616,291	9,712,686	1,096,395	Pharmacy	46,813,984	48,492,269	1,678,285
508,354	502,250	(6,104)	Pay for Performance Quality Incentive	2,518,566	2,503,250	(15,316)
-	-	-	Risk Corridor Expense	-	-	-
11,614,663	11,083,892	(530,771)	Hospital Directed Payments	57,392,764	55,376,622	(2,016,142)
36,524	-	(36,524)	Hospital Directed Payment Adjustment	294,775	-	(294,775)
167,936	-	(167,936)	Non-Claims Expense Adjustment	(1,124,849)	-	1,124,849
11,543	-	(11,543)	IBNR, Incentive, Paid Claims Adjustment	(7,089,990)	-	7,089,990
71,626,453	72,586,915	960,462	Total Medical Costs	361,564,773	362,246,048	681,275
15,232,559	14,532,600	699,959	GROSS MARGIN	67,373,153	72,785,624	(5,412,471)
			Administrative:			
2,375,693	2,680,857	305,164	Compensation	12,486,636	13,324,256	837,620
941,269	859,881	(81,388)	Purchased Services	4,262,667	4,303,863	41,196
21,318	119,190	97,872	Supplies	259,996	596,114	336,118
924,253	332,375	(591,878)	Depreciation	2,099,815	1,654,875	(444,940)
223,548	346,997	123,449	Other Administrative Expenses	1,300,340	1,767,586	467,246
-	-	-	Administrative Expense Adjustment	-	-	-
4,486,081	4,339,300	(146,781)	Total Administrative Expenses	20,409,454	21,646,695	1,237,241
76,112,534	76,926,215	813,681	TOTAL EXPENSES	381,974,227	383,892,743	1,918,516
10,746,478	10,193,300	553,178	OPERATING INCOME (LOSS) BEFORE TAX	46,963,699	51,138,929	(4,175,230)
7,914,997	10,045,000	2,130,003	MCO TAX	39,575,970	50,065,000	10,489,030
2,831,481	148,300	2,683,181	OPERATING INCOME (LOSS) NET OF TAX	7,387,729	1,073,929	6,313,800
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
(329,620)	(333,333)	3,713	Provider Recruitment and Retention Grants	(1,879,116)	(1,666,665)	(212,451)
(257,500)	(507,759)	250,259	Health Home	(871,943)	(2,538,795)	1,666,852
(587,120)	(841,092)	253,972	TOTAL NONOPERATING REVENUE (EXPENSE)	(2,751,059)	(4,205,460)	1,454,401
2,244,361	(692,792)	2,937,153	NET INCREASE (DECREASE) IN NET POSITION	4,636,670	(3,131,531)	7,768,201
89.1%	93.2%	4.1%	MEDICAL LOSS RATIO	91.6%	93.1%	1.5%
6.7%	6.6%	-0.1%	ADMINISTRATIVE EXPENSE RATIO	6.2%	6.6%	0.4%

KHS7/28/2020
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CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE	FOR THE MONTH ENDED MAY 31, 2020	ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
170,641	169,100	1,541	Family Members	841,171	841,500	(329)
62,535	61,090	1,445	Expansion Members	305,011	305,450	(439)
15,946	14,730	1,216	SPD Members	78,786	73,650	5,136
7,012	6,205	807	Other Members	34,315	31,025	3,290
9,475	8,660	815	Kaiser Members	46,023	43,300	2,723
265,609	259,785	5,824	Total Members - MCAL	1,305,306	1,294,925	10,381
			REVENUES			
158.57	156.80	1.77	Title XIX - Medicaid - Family and Other	160.57	157.12	3.45
373.98	378.88	(4.90)	Title XIX - Medicaid - Expansion Members	380.87	378.88	1.99
938.61	1,010.50	(71.89)	Title XIX - Medicaid - SPD Members	955.28	1,010.50	(55.22)
30.90	40.00	(9.10)	Premium - MCO Tax	31.43	40.00	(8.57)
45.35	44.14	1.21	Premium - Hospital Directed Payments	45.58	44.24	1.33
1.26	1.59	(0.32)	Investment Earnings And Other Income	1.20	1.59	(0.39)
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	0.23	0.00	0.23
1.74	0.00	1.74	Rate/Income Adjustments	(1.46)	0.00	(1.46)
339.12	346.92	(7.80)	TOTAL REVENUES	340.62	347.57	(6.95)
			EXPENSES			
			Medical Costs:			
48.53	57.23	8.71	Physician Services	53.86	57.28	3.42
13.62	18.44	4.82	Other Professional Services	15.66	18.44	2.78
16.45	20.51	4.07	Emergency Room	18.96	20.52	1.56
56.26	53.77	(2.49)	Inpatient	58.73	53.84	(4.89)
0.27	0.29	0.02	Reinsurance Expense	0.29	0.29	0.00
20.30	26.08	5.79	Outpatient Hospital	24.60	26.13	1.53
42.40	27.90	(14.50)	Other Medical	36.55	27.93	(8.62)
33.64	38.68	5.04	Pharmacy	37.18	38.74	1.57
1.98	2.00	0.02	Pay for Performance Quality Incentive	2.00	2.00	0.00
0.00	0.00	0.00	Risk Corridor Expense	0.00	0.00	0.00
45.35	44.14	(1.21)	Hospital Directed Payments	45.58	44.24	(1.33)
0.14	0.00	(0.14)	Hospital Directed Payment Adjustment	0.23	0.00	(0.23)
0.66	0.00	(0.66)	Non-Claims Expense Adjustment	(0.89)	0.00	0.89
0.05	0.00	(0.05)	IBNR, Incentive, Paid Claims Adjustment	(5.63)	0.00	5.63
279.64	289.05	9.40	Total Medical Costs	287.12	289.42	2.30
59.47	57.87	1.60	GROSS MARGIN	53.50	58.15	(4.65)
			Administrative:			
9.28	10.68	1.40	Compensation	9.92	10.65	0.73
3.67	3.42	(0.25)	Purchased Services	3.38	3.44	0.05
0.08	0.47	0.39	Supplies	0.21	0.48	0.27
3.61	1.32	(2.28)	Depreciation	1.67	1.32	(0.35)
0.87	1.38	0.51	Other Administrative Expenses	1.03	1.41	0.38
0.00	0.00	0.00	Administrative Expense Adjustment	0.00	0.00	0.00
17.51	17.28	(0.24)	Total Administrative Expenses	16.21	17.29	1.09
297.16	306.33	9.17	TOTAL EXPENSES	303.33	306.72	3.39
41.96	40.59	1.37	OPERATING INCOME (LOSS) BEFORE TAX	37.29	40.86	(3.56)
30.90	40.00	9.10	MCO TAX	31.43	40.00	8.57
11.05	0.59	10.46	OPERATING INCOME (LOSS) NET OF TAX	5.87	0.86	5.01
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
(1.29)	(1.33)	0.04	Reserve Fund Projects/Community Grants	(1.49)	(1.33)	(0.16)
(1.01)	(2.02)	1.02	Health Home	(0.69)	(2.03)	1.34
(2.29)	(3.35)	1.06	TOTAL NONOPERATING REVENUE (EXPENSE)	(2.18)	(3.36)	1.18
8.76	(2.76)	11.52	NET INCREASE (DECREASE) IN NET POSITION	3.68	(2.50)	6.18
89.1%	93.2%	4.1%	MEDICAL LOSS RATIO	91.6%	93.1%	1.5%
6.7%	6.6%	-0.1%	ADMINISTRATIVE EXPENSE RATIO	6.2%	6.6%	0.4%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH MAY 31, 2020	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	248,640	250,007	251,552	252,950	256,134	3,259,530
REVENUES														
Title XIX - Medicaid - Family and Other	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	28,170,470	362,847,411
Title XIX - Medicaid - Expansion Members	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	23,386,527	303,467,646
Title XIX - Medicaid - SPD Members	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	14,967,019	193,017,743
Premium - MCO Tax	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	7,915,091	55,851,926
Premium - Hospital Directed Payments	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	11,614,664	11,614,663	193,556,230
Investment Earnings And Other Income	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	323,827	5,777,275
Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	-	-	-	-	62,733,334	-	-	101,394,310	118,333	60,959	42,436	36,523	36,524	164,422,419
Rate/Income Adjustments	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)	444,891	(1,875,619)
TOTAL REVENUES	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	86,859,012	1,277,065,030
EXPENSES														
Medical Costs:														
Physician Services	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	12,429,908	178,494,916
Other Professional Services	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	3,489,408	52,063,428
Emergency Room	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	4,212,272	63,739,881
Inpatient	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	14,410,696	188,720,218
Reinsurance Expense	126,609	126,658	126,658	129,256	126,290	127,228	129,075	128,012	72,320	144,425	(213)	77,341	69,310	1,382,969
Outpatient Hospital	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	5,199,240	79,597,400
Other Medical	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	10,860,308	109,432,818
Pharmacy	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	8,616,291	121,033,247
Pay for Performance Quality Incentive	496,698	501,792	498,760	498,932	502,552	502,078	500,918	498,762	497,280	500,014	503,104	509,814	508,354	6,519,058
Risk Corridor Expense	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hospital Directed Payments	-	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	11,614,664	11,614,663	193,556,230
Hospital Directed Payment Adjustment	-	-	-	-	62,605,426	-	-	101,154,229	118,333	60,959	42,436	36,523	36,524	164,054,430
Non-Claims Expense Adjustment	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	167,936	(306,358)
IBNR, Incentive, Paid Claims Adjustment	(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)	11,543	(9,935,658)
Total Medical Costs	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	71,626,453	1,148,352,579
GROSS MARGIN	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	15,232,559	128,712,451
Administrative:														
Compensation	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	2,375,693	31,377,431
Purchased Services	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	941,269	10,838,545
Supplies	15,577	59,549	47,853	49,290	76,514	203,279	58,830	(7,208)	35,806	43,182	99,552	60,138	21,318	763,680
Depreciation	179,516	179,516	151,640	151,655	151,656	355,208	280,129	304,894	287,390	287,536	300,318	300,318	924,253	3,854,029
Other Administrative Expenses	239,380	412,596	338,545	489,494	523,591	519,786	270,201	344,959	353,414	181,493	387,179	154,706	223,548	4,438,892
Administrative Expense Adjustment	-	-	-	-	-	-	-	1,325,136	-	-	-	-	-	1,325,136
Total Administrative Expenses	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	4,486,081	52,597,713
TOTAL EXPENSES	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	76,112,534	1,200,950,292
OPERATING INCOME (LOSS) BEFORE TAX	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	10,746,478	76,114,738
MCO TAX	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	7,914,997	55,625,721
OPERATING INCOME (LOSS) NET OF TAX	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	2,831,481	20,489,017
TOTAL NONOPERATING REVENUE (EXPENSE)	(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	(587,120)	(4,204,162)
NET INCREASE (DECREASE) IN NET POSITION	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	2,244,361	16,284,855
MEDICAL LOSS RATIO	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%	89.1%	91.6%
ADMINISTRATIVE EXPENSE RATIO	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.8%	6.7%	6.1%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH MAY 31, 2020	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	248,349	250,896	249,380	249,466	251,277	251,039	250,459	249,381	248,640	250,007	251,552	252,950	256,134	3,259,530
REVENUES														
Title XIX - Medicaid - Family and Other	140.92	147.25	155.06	157.80	157.10	157.23	199.08	162.50	162.42	161.68	163.16	157.08	158.57	159.99
Title XIX - Medicaid - Expansion Members	386.02	383.23	360.65	374.91	377.23	373.38	419.77	410.96	386.25	387.18	388.37	369.04	373.98	383.85
Title XIX - Medicaid - SPD Members	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	938.61	960.56
Premium - MCO Tax	32.59	32.58	32.59	49.38	40.52	40.08	46.35	(209.68)	0.00	64.63	30.16	31.29	30.90	17.13
Premium - Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.35	45.56	45.70	45.92	45.35	59.38
Investment Earnings And Other Income	1.54	4.42	1.42	1.53	2.82	1.35	1.06	2.93	0.76	1.21	1.69	1.05	1.26	1.77
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	249.66	0.00	0.00	406.58	0.48	0.24	0.17	0.14	0.14	50.44
Rate/Income Adjustments	0.72	(2.80)	0.53	1.32	0.41	1.27	(0.01)	(1.57)	3.30	3.24	2.45	(17.91)	1.74	(0.58)
TOTAL REVENUES	279.36	281.84	287.58	313.16	554.56	305.87	352.21	1,017.92	316.41	381.55	348.16	317.99	339.12	391.79
EXPENSES														
Medical Costs:														
Physician Services	56.59	53.68	55.79	54.18	49.64	52.92	57.48	62.38	59.35	55.49	57.05	49.10	48.53	54.76
Other Professional Services	15.95	17.49	15.44	15.13	15.57	17.86	14.36	17.53	17.43	15.87	16.00	15.45	13.62	15.97
Emergency Room	20.56	18.73	20.78	18.62	18.69	22.20	20.87	18.97	21.02	21.03	21.35	15.08	16.45	19.55
Inpatient	49.05	57.36	53.46	61.08	61.94	59.56	58.52	57.94	59.97	55.57	58.61	63.24	56.26	57.90
Reinsurance Expense	0.51	0.50	0.51	0.52	0.50	0.51	0.52	0.51	0.29	0.58	(0.00)	0.31	0.27	0.42
Outpatient Hospital	25.80	23.57	26.50	26.15	24.40	24.41	24.52	19.12	27.08	24.82	26.10	24.79	20.30	24.42
Other Medical	28.93	25.34	26.93	25.81	30.13	23.23	66.50	26.66	22.77	40.08	42.35	34.92	42.40	33.57
Pharmacy	38.89	33.91	36.83	37.43	36.40	39.18	37.06	37.16	40.10	36.98	40.99	34.27	33.64	37.13
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	2.02	1.98	2.00
Risk Corridor Expense	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
Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.35	45.56	45.70	45.92	45.35	59.38
Hospital Directed Payment Adjustment	0.00	0.00	0.00	0.00	249.15	0.00	0.00	405.62	0.48	0.24	0.17	0.14	0.14	50.33
Non-Claims Expense Adjustment	0.16	3.02	0.08	0.05	0.05	(0.02)	(0.07)	0.02	0.23	0.93	(6.30)	0.01	0.66	(0.09)
IBNR, Incentive, Paid Claims Adjustment	(8.40)	(2.81)	(1.41)	0.81	1.49	0.08	(0.16)	(1.04)	0.00	(0.03)	(10.53)	(17.57)	0.05	(3.05)
Total Medical Costs	230.04	232.78	236.90	241.79	489.96	241.92	281.60	1,192.88	296.10	299.13	293.50	267.65	279.64	352.31
GROSS MARGIN	49.31	49.06	50.68	71.38	64.61	63.94	70.61	(174.96)	20.32	82.43	54.66	50.34	59.47	39.49
Administrative:														
Compensation	9.41	8.59	9.21	9.04	9.33	10.00	9.60	10.38	10.37	9.63	9.73	10.59	9.28	9.63
Purchased Services	3.55	1.79	3.23	2.43	3.33	3.31	3.21	5.45	3.24	3.34	2.98	3.68	3.67	3.33
Supplies	0.06	0.24	0.19	0.20	0.30	0.81	0.23	(0.03)	0.14	0.17	0.40	0.24	0.08	0.23
Depreciation	0.72	0.72	0.61	0.61	0.60	1.41	1.12	1.22	1.16	1.15	1.19	1.19	3.61	1.18
Other Administrative Expenses	0.96	1.64	1.36	1.96	2.08	2.07	1.08	1.38	1.42	0.73	1.54	0.61	0.87	1.36
Administrative Expense Adjustment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.31	0.00	0.00	0.00	0.00	0.00	0.41
Total Administrative Expenses	14.71	12.98	14.60	14.23	15.65	17.61	15.24	23.72	16.33	15.01	15.84	16.31	17.51	16.14
TOTAL EXPENSES	244.75	245.76	251.51	256.02	505.61	259.53	296.84	1,216.60	312.43	314.14	309.34	283.96	297.16	368.44
OPERATING INCOME (LOSS) BEFORE TAX	34.60	36.08	36.07	57.14	48.96	46.34	55.37	(198.68)	3.99	67.41	38.82	34.03	41.96	23.35
MCO TAX	32.57	32.24	32.28	49.22	40.45	40.06	49.04	(212.37)	0.00	64.63	30.16	31.29	30.90	17.07
OPERATING INCOME (LOSS) NET OF TAX	2.03	3.85	3.79	7.92	8.50	6.27	6.32	13.69	3.99	2.78	8.66	2.73	11.05	6.29
TOTAL NONOPERATING REVENUE (EXPENSE)	(1.45)	5.15	(1.23)	(0.61)	(1.51)	(0.94)	(3.54)	(1.71)	(3.79)	(2.28)	(4.28)	1.68	(2.29)	(1.29)
NET INCREASE (DECREASE) IN NET POSITION	0.59	9.00	2.56	7.31	6.99	5.33	2.79	11.98	0.20	0.50	4.38	4.41	8.76	5.00
MEDICAL LOSS RATIO	93.2%	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%	89.1%	91.6%
ADMINISTRATIVE EXPENSE RATIO	6.0%	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.8%	6.7%	6.1%

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF REVENUES - ALL COA FOR THE MONTH ENDED MAY 31, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
22,110,502	22,176,300	(65,798)	Premium - Medi-Cal	109,584,238	110,590,059	(1,005,821)
2,097,909	2,375,503	(277,594)	Premium - Maternity Kick	10,942,096	11,877,515	(935,419)
94,151	72,979	21,172	Premium - Hep C Kick	230,148	363,231	(133,083)
243,779	597,892	(354,113)	Premium - BHT Kick	1,804,308	2,975,816	(1,171,508)
161,798	313,787	(151,989)	Premium - Health Home Kick	845,519	1,561,775	(716,256)
3,182,804	1,701,175	1,481,629	Premium - Provider Enhancement	15,927,825	8,466,875	7,460,950
157,114	156,925	189	Premium - Ground Emergency Medical Transportation	779,066	782,345	(3,279)
122,413	94,059	28,354	Other	462,330	469,935	(7,605)
28,170,470	27,488,620	681,850	Total Title XIX - Medicaid - Family & Other	140,575,530	137,087,551	3,487,979
			Title XIX - Medicaid - Expansion Members			
21,136,477	21,183,611	(47,134)	Premium - Medi-Cal	104,406,939	105,918,055	(1,511,116)
258,969	214,189	44,780	Premium - Maternity Kick	1,476,124	1,070,945	405,179
237,994	303,377	(65,383)	Premium - Hep C Kick	1,399,196	1,516,885	(117,689)
313,427	519,998	(206,571)	Premium - Health Home Kick	1,777,380	2,599,990	(822,610)
1,246,635	742,244	504,392	Premium - Provider Enhancement	6,193,802	3,711,218	2,482,585
156,817	152,964	3,853	Premium - Ground Emergency Medical Transportation	774,622	764,820	9,802
36,208	29,126	7,082	Other	141,588	145,630	(4,042)
23,386,527	23,145,509	241,018	Total Title XIX - Medicaid - Expansion Members	116,169,651	115,727,543	442,108
			Title XIX - Medicaid - SPD Members			
13,649,185	13,148,587	500,598	Premium - Medi-Cal	67,321,059	65,742,935	1,578,124
62,768	94,152	(31,384)	Premium - Hep C Kick	653,830	470,760	183,070
318,897	818,847	(499,950)	Premium - BHT Kick	2,618,046	4,094,235	(1,476,189)
335,589	416,635	(81,046)	Premium - Health Home Kick	1,707,057	2,083,175	(376,118)
461,880	282,521	179,359	Premium - Provider Enhancement	2,278,236	1,420,605	857,631
138,700	123,879	14,821	Premium - Ground Emergency Medical Transportation	684,106	619,395	64,711
14,967,019	14,884,621	82,398	Total Title XIX - Medicaid - SPD Members	75,262,334	74,431,105	831,229

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS - ALL COA FOR THE MONTH ENDED MAY 31, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
2,417,265	2,868,230	450,965	Primary Care Physician Services	14,305,551	14,297,168	(8,383)
8,955,919	10,071,538	1,115,619	Referral Specialty Services	46,666,521	50,257,163	3,590,642
1,047,424	1,424,036	376,612	Urgent Care & After Hours Advise	6,813,188	7,095,928	282,740
9,300	9,300	-	Hospital Admitting Team	45,600	46,500	900
12,429,908	14,373,104	1,943,196	TOTAL PHYSICIAN SERVICES	67,830,860	71,696,760	3,865,900
			OTHER PROFESSIONAL SERVICES			
267,033	270,585	3,552	Vision Service Capitation	1,352,608	1,350,340	(2,268)
195,184	212,779	17,595	221 - Business Intelligence	1,028,910	1,063,895	34,985
541,633	556,462	14,829	310 - Health Services - Utilization Management - UM Allocation *	2,702,474	2,753,547	51,073
144,487	169,504	25,017	311 - Health Services - Quality Improvement - UM Allocation *	715,443	847,518	132,075
114,199	127,991	13,792	312 - Health Services - Education - UM Allocation *	558,524	639,951	81,427
76,014	94,630	18,616	313 - Health Services - Pharmacy - UM Allocation *	412,616	473,152	60,536
101,323	135,159	33,836	314 - Health Homes - UM Allocation *	514,081	657,378	143,297
251,817	258,856	7,039	315 - Case Management - UM Allocation *	1,310,419	1,294,281	(16,138)
56,199	61,775	5,576	616 - Disease Management - UM Allocation *	293,661	308,874	15,213
670,273	1,416,739	746,466	Behavior Health Treatment	4,780,166	7,070,051	2,289,885
112,306	170,701	58,395	Mental Health Services	796,225	852,337	56,112
958,940	1,155,380	196,440	Other Professional Services	5,259,270	5,766,695	507,425
3,489,408	4,630,562	1,141,154	TOTAL OTHER PROFESSIONAL SERVICES	19,724,397	23,078,019	3,353,622
4,212,272	5,151,709	939,437	EMERGENCY ROOM	23,881,973	25,686,016	1,804,043
14,410,696	13,503,461	(907,235)	INPATIENT HOSPITAL	73,955,351	67,389,737	(6,565,614)
69,310	72,826	3,516	REINSURANCE EXPENSE PREMIUM	363,183	362,971	(212)
5,199,240	6,550,380	1,351,140	OUTPATIENT HOSPITAL SERVICES	30,975,151	32,698,739	1,723,588
			OTHER MEDICAL			
1,090,342	1,545,683	455,341	Ambulance and NEMT	6,302,885	7,713,235	1,410,350
492,779	389,277	(103,502)	Home Health Services & CBAS	1,928,817	1,943,688	14,871
95,995	488,855	392,860	Utilization and Quality Review Expenses	1,127,007	2,442,775	1,315,768
1,452,690	939,026	(513,664)	Long Term/SNF/Hospice	6,792,305	4,691,114	(2,101,191)
330,205	483,662	153,457	Health Home Capitation & Incentive	1,010,040	2,415,542	1,405,502
4,373,154	2,725,773	(1,647,381)	Provider Enhancement Expense - Prop. 56	23,570,349	13,588,752	(9,981,597)
258,923	433,768	174,845	Provider Enhancement Expense - GEMT	1,969,885	2,166,560	196,675
2,766,220	-	(2,766,220)	Provider COVID-19 Expenes	3,327,320	-	(3,327,320)
10,860,308	7,006,045	(3,854,263)	TOTAL OTHER MEDICAL	46,028,608	34,961,665	(11,066,943)
			PHARMACY SERVICES			
7,771,494	8,698,645	927,151	RX - Drugs & OTC	42,384,451	43,428,460	1,044,009
292,610	470,508	177,898	RX - HEP-C	1,731,156	2,350,874	619,718
687,187	689,326	2,139	Rx - DME	3,273,377	3,441,626	168,249
(135,000)	(145,793)	(10,793)	RX - Pharmacy Rebates	(575,000)	(728,691)	(153,691)
8,616,291	9,712,686	1,096,395	TOTAL PHARMACY SERVICES	46,813,984	48,492,269	1,678,285
508,354	502,250	(6,104)	PAY FOR PERFORMANCE QUALITY INCENTIVE	2,518,566	2,503,250	(15,316)
-	-	-	RISK CORRIDOR EXPENSE	-	-	-
11,614,663	11,083,892	(530,771)	HOSPITAL DIRECTED PAYMENTS	57,392,764	55,376,622	(2,016,142)
36,524	-	(36,524)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	294,775	-	(294,775)
167,936	-	(167,936)	NON-CLAIMS EXPENSE ADJUSTMENT	(1,124,849)	-	1,124,849
11,543	-	(11,543)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(7,089,990)	-	7,089,990
71,626,453	72,586,915	960,462	Total Medical Costs	361,564,773	362,246,048	681,275

* Medical costs per DMHC regulations

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM FOR THE MONTH ENDED MAY 31, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
9.44	11.42	1.98	Primary Care Physician Services	11.36	11.42	0.06
34.97	40.11	5.14	Referral Specialty Services	37.06	40.15	3.10
4.09	5.67	1.58	Urgent Care & After Hours Advise	5.41	5.67	0.26
0.04	0.04	0.00	Hospital Admitting Team	0.04	0.04	0.00
48.53	57.23	8.71	TOTAL PHYSICIAN SERVICES	53.86	57.28	3.42
			OTHER PROFESSIONAL SERVICES			
1.04	1.08	0.03	Vision Service Capitation	1.07	1.08	0.00
0.76	0.85	0.09	221 - Business Intelligence	0.82	0.85	0.03
2.11	2.22	0.10	310 - Health Services - Utilization Management - UM Allocation *	2.15	2.20	0.05
0.56	0.67	0.11	311 - Health Services - Quality Improvement - UM Allocation *	0.57	0.68	0.11
0.45	0.51	0.06	312 - Health Services - Education - UM Allocation *	0.44	0.51	0.07
0.30	0.38	0.08	313 - Health Services - Pharmacy - UM Allocation *	0.33	0.38	0.05
0.40	0.54	0.14	314 - Health Homes - UM Allocation *	0.41	0.53	0.12
0.98	1.03	0.05	315 - Case Management - UM Allocation *	1.04	1.03	(0.01)
0.22	0.25	0.03	616 - Disease Management - UM Allocation *	0.23	0.25	0.01
2.62	5.64	3.02	Behavior Health Treatment	3.80	5.65	1.85
0.44	0.68	0.24	Mental Health Services	0.63	0.68	0.05
3.74	4.60	0.86	Other Professional Services	4.18	4.61	0.43
13.62	18.44	4.82	TOTAL OTHER PROFESSIONAL SERVICES	15.66	18.44	2.78
16.45	20.51	4.07	EMERGENCY ROOM	18.96	20.52	1.56
56.26	53.77	(2.49)	INPATIENT HOSPITAL	58.73	53.84	(4.89)
0.27	0.29	0.02	REINSURANCE EXPENSE PREMIUM	0.29	0.29	0.00
20.30	26.08	5.79	OUTPATIENT HOSPITAL SERVICES	24.60	26.13	1.53
			OTHER MEDICAL			
4.26	6.16	1.90	Ambulance and NEMT	5.01	6.16	1.16
1.92	1.55	(0.37)	Home Health Services & CBAS	1.53	1.55	0.02
0.37	1.95	1.57	Utilization and Quality Review Expenses	0.89	1.95	1.06
5.67	3.74	(1.93)	Long Term/SNF/Hospice	5.39	3.75	(1.65)
1.29	1.93	0.64	Health Home Capitation & Incentive	0.80	1.93	1.13
17.07	10.85	(6.22)	Provider Enhancement Expense - Prop. 56	18.72	10.86	(7.86)
1.01	1.73	0.72	Provider Enhancement Expense - GEMT	1.56	1.73	0.17
10.80	0.00	(10.80)	Provider COVID-19 Expenes	2.64	0.00	(2.64)
42.40	27.90	(14.50)	TOTAL OTHER MEDICAL	36.55	27.93	(8.62)
			PHARMACY SERVICES			
30.34	34.64	4.30	RX - Drugs & OTC	33.66	34.70	1.04
1.14	1.87	0.73	RX - HEP-C	1.37	1.88	0.50
2.68	2.74	0.06	Rx - DME	2.60	2.75	0.15
(0.53)	(0.58)	(0.05)	RX - Pharmacy Rebates	(0.46)	(0.58)	(0.13)
33.64	38.68	5.04	TOTAL PHARMACY SERVICES	37.18	38.74	1.57
1.98	2.00	0.02	PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	0.00
0.00	0.00	0.00	RISK CORRIDOR EXPENSE	0.00	0.00	0.00
45.35	44.14	(1.21)	HOSPITAL DIRECTED PAYMENTS	45.58	44.24	(1.33)
0.14	0.00	(0.14)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.23	0.00	(0.23)
0.66	0.00	(0.66)	NON-CLAIMS EXPENSE ADJUSTMENT	(0.89)	0.00	0.89
0.05	0.00	(0.05)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(5.63)	0.00	5.63
279.64	289.05	9.40	Total Medical Costs	287.12	289.42	2.30

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH MAY 31, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES						
Primary Care Physician Services	2,908,272	3,164,601	2,861,899	2,953,514	2,417,265	14,305,551
Referral Specialty Services	10,425,085	8,803,273	10,044,984	8,437,260	8,955,919	46,666,521
Urgent Care & After Hours Advise	1,414,889	1,896,664	1,435,097	1,019,114	1,047,424	6,813,188
Hospital Admitting Team	9,300	8,700	9,300	9,000	9,300	45,600
TOTAL PHYSICIAN SERVICES	14,757,546	13,873,238	14,351,280	12,418,888	12,429,908	67,830,860
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	299,489	261,072	261,072	263,942	267,033	1,352,608
221 - Business Intelligence	199,939	204,745	195,081	233,961	195,184	1,028,910
310 - Health Services - Utilization Management - UM Allocation *	550,905	482,617	507,782	619,537	541,633	2,702,474
311 - Health Services - Quality Improvement - UM Allocation *	130,719	131,973	135,845	172,419	144,487	715,443
312 - Health Services - Education - UM Allocation *	111,799	102,037	108,402	122,087	114,199	558,524
313 - Health Services - Pharmacy - UM Allocation *	88,153	80,696	81,505	86,248	76,014	412,616
314 - Health Homes - UM Allocation *	91,425	88,868	104,710	127,755	101,323	514,081
315 - Case Management - UM Allocation *	267,758	241,370	244,642	304,832	251,817	1,310,419
616 - Disease Management - UM Allocation *	56,335	54,217	57,384	69,526	56,199	293,661
Behavior Health Treatment	980,035	935,456	999,720	1,194,682	670,273	4,780,166
Mental Health Services	330,842	217,343	131,506	4,228	112,306	796,225
Other Professional Services	1,227,554	1,166,121	1,197,113	709,542	958,940	5,259,270
TOTAL OTHER PROFESSIONAL SERVICES	4,334,953	3,966,515	4,024,762	3,908,759	3,489,408	19,724,397
EMERGENCY ROOM	5,226,947	5,258,084	5,370,795	3,813,875	4,212,272	23,881,973
INPATIENT HOSPITAL	14,911,677	13,893,706	14,743,904	15,995,368	14,410,696	73,955,351
REINSURANCE EXPENSE PREMIUM	72,320	144,425	(213)	77,341	69,310	363,183
OUTPATIENT HOSPITAL SERVICES	6,734,395	6,204,610	6,566,090	6,270,816	5,199,240	30,975,151
OTHER MEDICAL						
Ambulance and NEMT	1,599,375	1,498,607	1,444,299	670,262	1,090,342	6,302,885
Home Health Services & CBAS	392,407	393,491	349,594	300,546	492,779	1,928,817
Utilization and Quality Review Expenses	308,250	229,353	247,983	245,426	95,995	1,127,007
Long Term/SNF/Hospice	1,052,766	1,197,702	1,539,187	1,549,960	1,452,690	6,792,305
Health Home Capitation & Incentive	166,060	137,300	112,910	263,565	330,205	1,010,040
Provider Enhancement Expense - Prop. 56	1,820,309	5,971,496	6,564,136	4,841,254	4,373,154	23,570,349
Provider Enhancement Expense - GEMT	322,617	593,064	395,321	399,960	258,923	1,969,885
Provider COVID-19 Expenes	-	-	-	561,100	2,766,220	3,327,320
TOTAL OTHER MEDICAL	5,661,784	10,021,013	10,653,430	8,832,073	10,860,308	46,028,608
PHARMACY SERVICES						
RX - Drugs & OTC	9,137,997	8,470,785	9,200,496	7,803,679	7,771,494	42,384,451
RX - HEP-C	271,776	331,788	470,380	364,602	292,610	1,731,156
Rx - DME	696,914	578,635	675,997	634,644	687,187	3,273,377
RX - Pharmacy Rebates	(135,000)	(135,000)	(35,000)	(135,000)	(135,000)	(575,000)
TOTAL PHARMACY SERVICES	9,971,687	9,246,208	10,311,873	8,667,925	8,616,291	46,813,984
PAY FOR PERFORMANCE QUALITY INCENTIVE	497,280	500,014	503,104	509,814	508,354	2,518,566
RISK CORRIDOR EXPENSE	-	-	-	-	-	-
HOSPITAL DIRECTED PAYMENTS	11,276,584	11,391,396	11,495,457	11,614,664	11,614,663	57,392,764
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	118,333	60,959	42,436	36,523	36,524	294,775
NON-CLAIMS EXPENSE ADJUSTMENT	57,172	232,393	(1,583,770)	1,420	167,936	(1,124,849)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	816	(8,559)	(2,649,204)	(4,444,586)	11,543	(7,089,990)
Total Medical Costs	73,621,494	74,784,002	73,829,944	67,702,880	71,626,453	361,564,773

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH MAY 31, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES						
Primary Care Physician Services	11.70	12.66	11.38	11.68	9.44	11.36
Referral Specialty Services	41.93	35.21	39.93	33.36	34.97	37.06
Urgent Care & After Hours Advise	5.69	7.59	5.70	4.03	4.09	5.41
Hospital Admitting Team	0.04	0.03	0.04	0.04	0.04	0.04
TOTAL PHYSICIAN SERVICES	59.35	55.49	57.05	49.10	48.53	53.86
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	1.20	1.04	1.04	1.04	1.04	1.07
221 - Business Intelligence	0.80	0.82	0.78	0.92	0.76	0.82
310 - Health Services - Utilization Management - UM Allocation *	2.22	1.93	2.02	2.45	2.11	2.15
311 - Health Services - Quality Improvement - UM Allocation *	0.53	0.53	0.54	0.68	0.56	0.57
312 - Health Services - Education - UM Allocation *	0.45	0.41	0.43	0.48	0.45	0.44
313 - Health Services - Pharmacy - UM Allocation *	0.35	0.32	0.32	0.34	0.30	0.33
314 - Health Homes - UM Allocation *	0.37	0.36	0.42	0.51	0.40	0.41
315 - Case Management - UM Allocation *	1.08	0.97	0.97	1.21	0.98	1.04
616 - Disease Management - UM Allocation *	0.23	0.22	0.23	0.27	0.22	0.23
Behavior Health Treatment	3.94	3.74	3.97	4.72	2.62	3.80
Mental Health Services	1.33	0.87	0.52	0.02	0.44	0.63
Other Professional Services	4.94	4.66	4.76	2.81	3.74	4.18
TOTAL OTHER PROFESSIONAL SERVICES	17.43	15.87	16.00	15.45	13.62	15.66
EMERGENCY ROOM	21.02	21.03	21.35	15.08	16.45	18.96
INPATIENT HOSPITAL	59.97	55.57	58.61	63.24	56.26	58.73
REINSURANCE EXPENSE PREMIUM	0.29	0.58	0.00	0.31	0.27	0.29
OUTPATIENT HOSPITAL SERVICES	27.08	24.82	26.10	24.79	20.30	24.60
OTHER MEDICAL						
Ambulance and NEMT	6.43	5.99	5.74	2.65	4.26	5.01
Home Health Services & CBAS	1.58	1.57	1.39	1.19	1.92	1.53
Utilization and Quality Review Expenses	1.24	0.92	0.99	0.97	0.37	0.89
Long Term/SNF/Hospice	4.23	4.79	6.12	6.13	5.67	5.39
Health Home Capitation & Incentive	0.67	0.55	0.45	1.04	1.29	0.80
Provider Enhancement Expense - Prop. 56	7.32	23.89	26.09	19.14	17.07	18.72
Provider Enhancement Expense - GEMT	1.30	2.37	1.57	1.58	1.01	1.56
Provider COVID-19 Expenes	0.00	0.00	0.00	2.22	10.80	2.64
TOTAL OTHER MEDICAL	22.77	40.08	42.35	34.92	42.40	36.55
PHARMACY SERVICES						
RX - Drugs & OTC	36.75	33.88	36.57	30.85	30.34	33.66
RX - HEP-C	1.09	1.33	1.87	1.44	1.14	1.37
Rx - DME	2.80	2.31	2.69	2.51	2.68	2.60
RX - Pharmacy Rebates	(0.54)	(0.54)	(0.14)	(0.53)	(0.53)	(0.46)
TOTAL PHARMACY SERVICES	40.10	36.98	40.99	34.27	33.64	37.18
PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	2.00	2.02	1.98	2.00
RISK CORRIDOR EXPENSE	0.00	0.00	0.00	0.00	0.00	0.00
HOSPITAL DIRECTED PAYMENTS	45.35	45.56	45.70	45.92	45.35	45.58
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.48	0.24	0.17	0.14	0.14	0.23
NON-CLAIMS EXPENSE ADJUSTMENT	0.23	0.93	(6.30)	0.01	0.66	(0.89)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(0.03)	(10.53)	(17.57)	0.05	(5.63)
Total Medical Costs	296.10	299.13	293.50	267.65	279.64	287.12

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT FOR THE MONTH ENDED MAY 31, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
259,748	333,252	73,504	110 - Executive	1,657,202	1,591,309	(65,894)
174,058	198,810	24,752	210 - Accounting	884,853	992,076	107,223
375,885	273,114	(102,771)	220 - Management Information Systems	1,554,305	1,365,576	(188,729)
15,303	13,051	(2,252)	221 - Business Intelligence	70,420	65,267	(5,153)
213,893	281,948	68,055	222 - Enterprise Development	1,206,023	1,409,749	203,726
428,168	415,722	(12,446)	225 - Infrastructure	1,611,559	2,078,617	467,058
485,601	557,269	71,668	230 - Claims	2,577,258	2,788,817	211,559
102,586	114,151	11,565	240 - Project Management	471,113	570,755	99,642
93,694	99,615	5,921	310 - Health Services - Utilization Management	508,331	494,497	(13,834)
45,627	55,141	9,514	311 - Health Services - Quality Improvement	195,786	275,505	79,719
-	67	67	312 - Health Services - Education	121	483	362
123,386	141,883	18,497	313- Pharmacy	718,641	717,238	(1,403)
-	-	-	314 - Health Homes	659	-	(659)
16,074	16,573	499	315 - Case Management	84,158	82,864	(1,294)
20,786	23,131	2,345	616 - Disease Management	108,662	115,656	6,994
269,465	313,552	44,087	320 - Provider Network Management	1,378,518	1,567,760	189,242
484,348	563,882	79,534	330 - Member Services	2,560,298	2,819,394	259,096
1,070,946	528,116	(542,830)	340 - Corporate Services	2,930,284	2,633,580	(296,704)
60,510	67,176	6,666	360 - Audit & Investigative Services	372,854	335,880	(36,974)
29,053	54,315	25,262	410 - Advertising Media	259,144	271,575	12,431
55,996	68,457	12,461	420 - Sales/Marketing/Public Relations	215,302	342,285	126,983
160,954	220,076	59,122	510 - Human Resourses	1,043,963	1,127,812	83,849
4,486,081	4,339,300	(146,781)	Total Administrative Expenses	20,409,454	21,646,695	1,237,241

KHS7/28/2020
Management Use Only

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED MAY 31, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	YEAR TO DATE 2020
110 - Executive	339,242	293,820	365,045	399,347	259,748	1,657,202
210 - Accounting	173,904	178,919	174,836	183,136	174,058	884,853
220 - Management Information Systems (MIS)	381,511	295,419	338,903	162,587	375,885	1,554,305
221 - Business Intelligence	-	11,648	20,702	22,767	15,303	70,420
222 - Enterprise Development	211,299	225,855	262,079	292,897	213,893	1,206,023
225 - Infrastructure	359,015	241,507	308,323	274,546	428,168	1,611,559
230 - Claims	556,280	498,960	493,312	543,105	485,601	2,577,258
240 - Project Management	85,191	84,709	97,954	100,673	102,586	471,113
310 - Health Services - Utilization Management	98,529	107,809	95,426	112,873	93,694	508,331
311 - Health Services - Quality Improvement	10,824	41,860	43,027	54,448	45,627	195,786
312 - Health Services - Education	-	60	-	61	-	121
313- Pharmacy	156,947	147,980	148,599	141,729	123,386	718,641
314 - Health Homes	222	15,046	98	(14,707)	-	659
315 - Case Management	17,349	15,664	15,615	19,456	16,074	84,158
616 - Disease Management	20,836	20,068	21,223	25,749	20,786	108,662
320 - Provider Network Management	256,860	252,748	291,995	307,450	269,465	1,378,518
330 - Member Services	530,714	484,954	496,790	563,492	484,348	2,560,298
340 - Corporate Services	439,804	482,885	487,474	449,175	1,070,946	2,930,284
360 - Audit & Investigative Services	81,923	83,979	59,288	87,154	60,510	372,854
410 - Advertising Media	9,439	47,590	38,083	134,979	29,053	259,144
420 - Sales/Marketing/Public Relations	44,020	35,104	43,800	36,382	55,996	215,302
510 - Human Resourses	285,952	186,648	181,915	228,494	160,954	1,043,963
Total Department Expenses	4,059,861	3,753,232	3,984,487	4,125,793	4,486,081	20,409,454
ADMINISTRATIVE EXPENSE ADJUSTMENT	-	-	-	-	-	-
Total Administrative Expenses	4,059,861	3,753,232	3,984,487	4,125,793	4,486,081	20,409,454

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

ASSETS	MAY 2020	APRIL 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,127,540	$ 1,127,540	-
Interest Receivable	3,600	1,800	1,800
Prepaid Expenses & Other Current Assets	834	1,667	(833)
TOTAL CURRENT ASSETS	$ 1,131,974	$ 1,131,007	$ 967
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	3,089	2,122	967
Total Net Position	$ 1,131,974	$ 1,131,007	$ 967
TOTAL LIABILITIES AND NET POSITION	$ 1,131,974	$ 1,131,007	$ 967

CURRENT MONTH			KERN HEALTH SYSTEMS GROUP HEALTH PLAN - HFAM STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE	FOR THE MONTH ENDED MAY 31, 2020	ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
1,800	-	1,800	Interest	9,216	-	9,216
-	-	-	Other Investment Income	(1,961)	-	(1,961)
1,800	-	1,800	TOTAL REVENUES	7,255	-	7,255
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
1,800	-	1,800	GROSS MARGIN	7,255	-	7,255
			Administrative			
833	-	(833)	Management Fee Expense and Other Admin Exp	4,166	-	(4,166)
833	-	(833)	Total Administrative Expenses	4,166	-	(4,166)
833	-	(833)	TOTAL EXPENSES	4,166	-	(4,166)
967	-	967	OPERATING INCOME (LOSS)	3,089	-	3,089
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
967	-	967	NET INCREASE (DECREASE) IN NET POSITION	3,089	-	3,089
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
46%	0%	-46%	ADMINISTRATIVE EXPENSE RATIO	57%	0%	-57%

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	221,549	43,519	43,767	44,480	44,402	45,381	0	0	0	0	0	0	0
CHILD	617,365	122,496	123,040	123,357	123,687	124,785	0	0	0	0	0	0	0
SUB-TOTAL ADULT & FAMILY	**838,914**	**166,015**	**166,807**	**167,837**	**168,089**	**170,166**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
OTHER MEMBERS													
BCCTP-TOBACCO SETTLEMENT	132	26	28	26	25	27	0	0	0	0	0	0	0
DUALS													
PARTIAL DUALS - FAMILY	2,252	432	432	453	461	474	0	0	0	0	0	0	0
PARTIAL DUALS - CHILD	5	1	1	1	1	1	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	8	1	1	2	2	2	0	0	0	0	0	0	0
SPD FULL DUALS	34,175	6,599	6,759	6,911	6,923	6,983	0	0	0	0	0	0	0
SUB-TOTAL DUALS	**36,440**	**7,033**	**7,193**	**7,367**	**7,387**	**7,460**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FAMILY & OTHER	**875,486**	**173,074**	**174,028**	**175,230**	**175,501**	**177,653**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SPD													
SPD (AGED AND DISABLED)	78,786	15,667	15,493	15,688	15,992	15,946	0	0	0	0	0	0	0
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	303,483	59,583	60,197	60,360	61,164	62,179	0	0	0	0	0	0	0
ACA Expansion Duals	1,528	316	289	274	293	356	0	0	0	0	0	0	0
SUB-TOTAL MED-CAL EXPANSION	**305,011**	**59,899**	**60,486**	**60,634**	**61,457**	**62,535**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL KAISER	**46,023**	**8,992**	**9,125**	**9,169**	**9,262**	**9,475**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL MEDI-CAL MEMBERS	**1,305,306**	**257,632**	**259,132**	**260,721**	**262,212**	**265,609**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

To: KHS Board of Directors

From: Robert Landis, CFO

Date: August 13, 2020

Re: June 2020 Financial Results

The June results reflect a $2,339,288 Net Increase in Net Position which is a $3,079,493 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $4.4 million favorable variance primarily due to:

    A) $4.5 million favorable variance primarily due to higher than expected budgeted membership.

    B) $.9 million unfavorable variance due to a 1 ½% rate reduction required under the Governor's budget.

    C) $.6 million unfavorable variance in BHT Kick Premiums from lower than expected utilization due to Covid-19 offset against lower expenses included in 2B below.

    D) $2.5 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 programs that became effective January 1, 2020 offset against amounts included in 2E below.

    E) $2.0 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.

    F) $1.1 million favorable variance in Premium-Hospital Directed Payments due to higher than expected membership and rates offset against amounts included in 2H below.

2) Total Medical Costs reflect a $3.6 million favorable variance primarily due to:

    A) $2.6 million favorable variance in Physician Services due to lower than expected utilization of PCP, Specialty and Urgent Care services.

    B) $1.2 million favorable variance in Other Professional Services primarily due to lower than expected utilization of Behavioral Health Treatment offset against lower revenue included 1C above.

    C) $1.8 million favorable variance in Emergency Room due to lower than expected utilization.

D) $3.6 million unfavorable variance in Inpatient due to higher than expected utilization for SPD and Expansion members.

E) $2.2 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 that became effective January 1, 2020 offset against revenue included in 1D above.

F) $1.4 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 beginning in March.

G) $4.7 million unfavorable variance due to a new requirement under the Governor's budget imposing surplus and deficit limitations on health plans from COVID-19 impact on overall medical cost and/or utilization of health care services. May be used to offset future medical cost increases for members incurring service previously deferred or delayed during the pandemic.

H) $1.1 million unfavorable variance in Hospital Directed Payments due to higher than expected membership and rates offset against amounts included in 1F above.

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 1E above.

The June Medical Loss Ratio is 89.8% which is favorable to the 93.3% budgeted amount. The June Administrative Expense Ratio is 6.4% which is favorable to the 6.6% budgeted amount.

The results for the 6 months ended June 30, 2020 reflect a Net Increase in Net Position of $6,975,958. This is a $10,847,694 favorable variance to budget and includes approximately $7.8 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 91.3% which is favorable to the 93.1% budgeted amount. The year-to-date Administrative Expense Ratio is 6.2% which is favorable to the 6.6% budgeted amount.

Kern Health Systems
Financial Packet
June 2020

KHS – Medi-Cal Line of Business

Comparative Statement of Net Position Page 1

Statement of Revenue, Expenses, and Changes in Net Position Page 2

Statement of Revenue, Expenses, and Changes in Net Position - PMPM Page 3

Statement of Revenue, Expenses, and Changes in Net Position by Month Page 4

Statement of Revenue, Expenses, and Changes in Net Position by Month - PMPM Page 5

Schedule of Revenues Page 6

Schedule of Medical Costs Page 7

Schedule of Medical Costs - PMPM Page 8

Schedule of Medical Costs by Month Page 9

Schedule of Medical Costs by Month – PMPM Page 10

Schedule of Administrative Expenses by Department Page 11

Schedule of Administrative Expenses by Department by Month Page 12

KHS Group Health Plan – Healthy Families Line of Business

Comparative Statement of Net Position Page 13

Statement of Revenue, Expenses, and Changes in Net Position Page 14

KHS Administrative Analysis and Other Reporting

Monthly Member Count Page 15

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF NET POSITION AS OF JUNE 30, 2020			
ASSETS	**JUNE 2020**	**MAY 2020**	**INC(DEC)**
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 121,095,261	$ 104,728,141	$ 16,367,120
Short-Term Investments	99,708,610	111,709,814	(12,001,204)
Premiums Receivable - Net	123,207,997	112,708,379	10,499,618
Premiums Receivable - Hospital Direct Payments	273,207,660	261,068,716	12,138,944
Interest Receivable	222,273	372,583	(150,310)
Provider Advance Payment	4,954,766	3,283,252	1,671,514
Other Receivables	1,323,300	1,322,729	571
Prepaid Expenses & Other Current Assets	2,380,655	1,771,285	609,370
Total Current Assets	$ 626,100,522	$ 596,964,899	$ 29,135,623
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	2,370,584	2,392,952	(22,368)
Computer Hardware and Software - Net	16,416,972	16,713,240	(296,268)
Building and Building Improvements - Net	35,802,446	35,878,118	(75,672)
Capital Projects in Progress	9,984,253	9,647,465	336,788
Total Capital Assets	$ 68,664,961	$ 68,722,481	$ (57,520)
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,504,221	743,320	760,901
Total Long Term Assets	$ 1,804,221	$ 1,043,320	$ 760,901
DEFERRED OUTFLOWS OF RESOURCES	$ 2,889,179	$ 2,889,179	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 699,458,883	$ 669,619,879	$ 29,839,004
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 2,959,374	$ 3,247,048	(287,674)
Accrued Other Operating Expenses	1,568,523	1,369,676	198,847
Accrued Taxes and Licenses	47,313,321	39,398,078	7,915,243
Claims Payable (Reported)	24,900,754	16,816,653	8,084,101
IBNR - Inpatient Claims	27,598,105	26,539,826	1,058,279
IBNR - Physician Claims	15,098,135	14,851,477	246,658
IBNR - Accrued Other Medical	14,230,576	19,425,332	(5,194,756)
Risk Pool and Withholds Payable	3,033,725	2,514,541	519,184
Statutory Allowance for Claims Processing Expense	2,066,234	2,278,463	(212,229)
Other Liabilities	58,355,242	55,322,123	3,033,119
Accrued Hospital Directed Payments	273,207,660	261,068,716	12,138,944
Total Current Liabilities	$ 470,331,649	$ 442,831,933	$ 27,499,716
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	6,975,958	4,636,670	2,339,288
Total Net Position	$ 221,668,337	$ 219,329,049	$ 2,339,288
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 699,458,883	$ 669,619,879	$ 29,839,004

KHS7/28/2020
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CURRENT MONTH MEMBERS			KERN HEALTH SYSTEMS MEDI-CAL - ALL COA STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION	YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE	FOR THE MONTH ENDED JUNE 30, 2020	ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
173,040	169,500	3,540	Family Members	1,014,211	1,011,000	3,211
63,779	61,090	2,689	Expansion Members	368,790	366,540	2,250
15,803	14,730	1,073	SPD Members	94,589	88,380	6,209
6,970	6,205	765	Other Members	41,285	37,230	4,055
9,594	8,660	934	Kaiser Members	55,617	51,960	3,657
269,186	260,185	9,001	Total Members - MCAL	1,574,492	1,555,110	19,382
			REVENUES			
30,522,053	27,524,174	2,997,879	Title XIX - Medicaid - Family and Other	171,097,583	164,611,725	6,485,858
24,776,875	23,145,509	1,631,366	Title XIX - Medicaid - Expansion Members	140,946,526	138,873,055	2,073,471
15,603,750	14,884,621	719,129	Title XIX - Medicaid - SPD Members	90,866,084	89,307,727	1,558,357
8,023,287	10,061,000	(2,037,713)	Premium - MCO Tax	47,599,320	60,126,000	(12,526,680)
12,149,677	11,088,176	1,061,501	Premium - Hospital Directed Payments	69,542,441	66,464,798	3,077,643
62,534	399,682	(337,148)	Investment Earnings And Other Income	1,568,107	2,388,559	(820,452)
-	72,942	(72,942)	Reinsurance Recoveries	-	435,914	(435,914)
(10,733)	-	(10,733)	Rate Adjustments - Hospital Directed Payments	284,042	-	284,042
476,588	-	476,588	Rate/Income Adjustments	(1,362,146)	-	(1,362,146)
91,604,031	87,176,105	4,427,926	TOTAL REVENUES	520,541,957	522,207,778	(1,665,821)
			EXPENSES			
			Medical Costs:			
11,806,601	14,389,979	2,583,378	Physician Services	79,637,461	86,086,739	6,449,278
3,385,134	4,633,322	1,248,188	Other Professional Services	23,109,531	27,711,341	4,601,810
3,363,172	5,158,962	1,795,790	Emergency Room	27,245,145	30,844,978	3,599,833
17,115,732	13,516,218	(3,599,514)	Inpatient	91,071,083	80,905,955	(10,165,128)
73,356	72,942	(414)	Reinsurance Expense	436,539	435,914	(626)
6,447,664	6,555,696	108,032	Outpatient Hospital	37,422,815	39,254,435	1,831,620
9,199,742	7,035,760	(2,163,982)	Other Medical	55,228,350	41,997,426	(13,230,924)
8,313,457	9,719,803	1,406,346	Pharmacy	55,127,441	58,212,072	3,084,631
519,184	503,050	(16,134)	Pay for Performance Quality Incentive	3,037,750	3,006,300	(31,450)
4,700,000	-	(4,700,000)	Risk Corridor Expense	4,700,000	-	(4,700,000)
12,149,677	11,088,176	(1,061,501)	Hospital Directed Payments	69,542,441	66,464,798	(3,077,643)
(10,733)	-	10,733	Hospital Directed Payment Adjustment	284,042	-	(284,042)
(325,027)	-	325,027	Non-Claims Expense Adjustment	(1,449,876)	-	1,449,876
(426,819)	-	426,819	IBNR, Incentive, Paid Claims Adjustment	(7,516,809)	-	7,516,809
76,311,140	72,673,909	(3,637,231)	Total Medical Costs	437,875,913	434,919,957	(2,955,956)
15,292,891	14,502,196	790,695	GROSS MARGIN	82,666,044	87,287,820	(4,621,776)
			Administrative:			
2,835,739	2,680,857	(154,882)	Compensation	15,322,375	16,005,113	682,738
1,295,571	859,881	(435,690)	Purchased Services	5,558,238	5,163,744	(394,494)
29,774	119,200	89,426	Supplies	289,770	715,315	425,545
418,036	332,375	(85,661)	Depreciation	2,517,851	1,987,250	(530,601)
192,449	347,996	155,547	Other Administrative Expenses	1,492,789	2,115,583	622,794
(212,229)	-	212,229	Administrative Expense Adjustment	(212,229)	-	212,229
4,559,340	4,340,309	(219,031)	Total Administrative Expenses	24,968,794	25,987,004	1,018,210
80,870,480	77,014,218	(3,856,262)	TOTAL EXPENSES	462,844,707	460,906,961	(1,937,746)
10,733,551	10,161,887	571,664	OPERATING INCOME (LOSS) BEFORE TAX	57,697,250	61,300,816	(3,603,566)
7,915,244	10,061,000	2,145,756	MCO TAX	47,491,214	60,126,000	12,634,786
2,818,307	100,887	2,717,420	OPERATING INCOME (LOSS) NET OF TAX	10,206,036	1,174,816	9,031,220
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
(420,915)	(333,333)	(87,582)	Provider Recruitment and Retention Grants	(2,300,031)	(1,999,998)	(300,033)
(58,104)	(507,759)	449,655	Health Home	(930,047)	(3,046,554)	2,116,507
(479,019)	(841,092)	362,073	TOTAL NONOPERATING REVENUE (EXPENSE)	(3,230,078)	(5,046,552)	1,816,474
2,339,288	(740,205)	3,079,493	NET INCREASE (DECREASE) IN NET POSITION	6,975,958	(3,871,736)	10,847,694
89.8%	93.3%	3.4%	MEDICAL LOSS RATIO	91.3%	93.1%	1.8%
6.4%	6.6%	0.2%	ADMINISTRATIVE EXPENSE RATIO	6.2%	6.6%	0.4%

KHS7/28/2020
Management Use Only

CURRENT MONTH ACTUAL	CURRENT MONTH BUDGET	CURRENT MONTH VARIANCE	KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM FOR THE MONTH ENDED JUNE 30, 2020	YEAR-TO-DATE ACTUAL	YEAR-TO-DATE BUDGET	YEAR-TO-DATE VARIANCE
			ENROLLMENT			
173,040	169,500	3,540	Family Members	1,014,211	1,011,000	3,211
63,779	61,090	2,689	Expansion Members	368,790	366,540	2,250
15,803	14,730	1,073	SPD Members	94,589	88,380	6,209
6,970	6,205	765	Other Members	41,285	37,230	4,055
9,594	8,660	934	Kaiser Members	55,617	51,960	3,657
269,186	260,185	9,001	Total Members - MCAL	1,574,492	1,555,110	19,382
			REVENUES			
169.56	156.65	12.91	Title XIX - Medicaid - Family and Other	162.10	157.04	5.06
388.48	378.88	9.60	Title XIX - Medicaid - Expansion Members	382.19	378.88	3.31
987.39	1,010.50	(23.11)	Title XIX - Medicaid - SPD Members	960.64	1,010.50	(49.86)
30.91	40.00	(9.09)	Premium - MCO Tax	31.34	40.00	(8.66)
46.80	44.08	2.72	Premium - Hospital Directed Payments	45.79	44.22	1.57
0.24	1.59	(1.35)	Investment Earnings And Other Income	1.03	1.59	(0.56)
0.00	0.29	(0.29)	Reinsurance Recoveries	0.00	0.29	(0.29)
(0.04)	0.00	(0.04)	Rate Adjustments - Hospital Directed Payments	0.19	0.00	0.19
1.84	0.00	1.84	Rate/Income Adjustments	(0.90)	0.00	(0.90)
352.88	346.59	6.29	TOTAL REVENUES	342.72	347.41	(4.69)
			EXPENSES			
			Medical Costs:			
45.48	57.21	11.73	Physician Services	52.43	57.27	4.84
13.04	18.42	5.38	Other Professional Services	15.21	18.44	3.22
12.96	20.51	7.56	Emergency Room	17.94	20.52	2.58
65.93	53.74	(12.20)	Inpatient	59.96	53.82	(6.14)
0.28	0.29	0.01	Reinsurance Expense	0.29	0.29	0.00
24.84	26.06	1.23	Outpatient Hospital	24.64	26.11	1.48
35.44	27.97	(7.47)	Other Medical	36.36	27.94	(8.42)
32.03	38.64	6.62	Pharmacy	36.29	38.73	2.43
2.00	2.00	0.00	Pay for Performance Quality Incentive	2.00	2.00	0.00
18.11	0.00	(18.11)	Risk Corridor Expense	3.09	0.00	(3.09)
46.80	44.08	(2.72)	Hospital Directed Payments	45.79	44.22	(1.57)
(0.04)	0.00	0.04	Hospital Directed Payment Adjustment	0.19	0.00	(0.19)
(1.25)	0.00	1.25	Non-Claims Expense Adjustment	(0.95)	0.00	0.95
(1.64)	0.00	1.64	IBNR, Incentive, Paid Claims Adjustment	(4.95)	0.00	4.95
293.97	288.93	(5.03)	Total Medical Costs	288.29	289.34	1.05
58.91	57.66	1.25	GROSS MARGIN	54.43	58.07	(3.64)
			Administrative:			
10.92	10.66	(0.27)	Compensation	10.09	10.65	0.56
4.99	3.42	(1.57)	Purchased Services	3.66	3.44	(0.22)
0.11	0.47	0.36	Supplies	0.19	0.48	0.29
1.61	1.32	(0.29)	Depreciation	1.66	1.32	(0.34)
0.74	1.38	0.64	Other Administrative Expenses	0.98	1.41	0.42
(0.82)	0.00	0.82	Administrative Expense Adjustment	(0.14)	0.00	0.14
17.56	17.26	(0.31)	Total Administrative Expenses	16.44	17.29	0.85
311.53	306.19	(5.34)	TOTAL EXPENSES	304.73	306.63	1.90
41.35	40.40	0.95	OPERATING INCOME (LOSS) BEFORE TAX	37.99	40.78	(2.79)
30.49	40.00	9.51	MCO TAX	31.27	40.00	8.73
10.86	0.40	10.46	OPERATING INCOME (LOSS) NET OF TAX	6.72	0.78	5.94
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
(1.62)	(1.33)	(0.30)	Reserve Fund Projects/Community Grants	(1.51)	(1.33)	(0.18)
(0.22)	(2.02)	1.79	Health Home	(0.61)	(2.03)	1.41
(1.85)	(3.34)	1.50	TOTAL NONOPERATING REVENUE (EXPENSE)	(2.13)	(3.36)	1.23
9.01	(2.94)	11.95	NET INCREASE (DECREASE) IN NET POSITION	4.59	(2.58)	7.17
89.8%	93.3%	3.4%	MEDICAL LOSS RATIO	91.3%	93.1%	1.8%
6.4%	6.6%	0.2%	ADMINISTRATIVE EXPENSE RATIO	6.2%	6.6%	0.4%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH JUNE 30, 2020	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	JUNE 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	250,896	249,380	249,466	251,277	251,039	250,459	249,381	248,640	250,007	251,552	252,950	256,134	259,592	3,270,773
REVENUES														
Title XIX - Medicaid - Family and Other	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	28,170,470	30,522,053	368,925,192
Title XIX - Medicaid - Expansion Members	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	23,386,527	24,776,875	305,111,328
Title XIX - Medicaid - SPD Members	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	14,967,019	15,603,750	195,474,027
Premium - MCO Tax	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	7,915,091	8,023,287	55,782,672
Premium - Hospital Directed Payments	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	11,614,664	11,614,663	12,149,677	205,705,907
Investment Earnings And Other Income	1,108,727	354,349	382,033	708,869	338,986	265,233	731,395	190,131	301,265	424,094	266,256	323,827	62,534	5,457,699
Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	-	-	-	62,733,334	-	-	101,394,310	118,333	60,959	42,436	36,523	36,524	(10,733)	164,411,686
Rate/Income Adjustments	(703,658)	132,080	329,476	103,418	318,771	(3,664)	(391,644)	819,618	809,261	616,798	(4,529,302)	444,891	476,588	(1,577,367)
TOTAL REVENUES	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	86,859,012	91,604,031	1,299,291,143
EXPENSES														
Medical Costs:														
Physician Services	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	12,429,908	11,806,601	176,247,134
Other Professional Services	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	3,489,408	3,385,134	51,487,610
Emergency Room	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	4,212,272	3,363,172	61,996,257
Inpatient	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	14,410,696	17,115,732	193,654,440
Reinsurance Expense	126,658	126,658	129,256	126,290	127,228	129,075	128,012	72,320	144,425	(213)	77,341	69,310	73,356	1,329,716
Outpatient Hospital	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	5,199,240	6,447,664	79,636,760
Other Medical	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	10,860,308	9,199,742	111,448,844
Pharmacy	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	8,616,291	8,313,457	119,687,431
Pay for Performance Quality Incentive	501,792	498,760	498,932	502,552	502,078	500,918	498,762	497,280	500,014	503,104	509,814	508,354	519,184	6,541,544
Risk Corridor Expense	-	-	-	-	-	-	-	-	-	-	-	-	4,700,000	4,700,000
Hospital Directed Payments	-	-	-	-	-	-	136,163,466	11,276,584	11,391,396	11,495,457	11,614,664	11,614,663	12,149,677	205,705,907
Hospital Directed Payment Adjustment	-	-	-	62,605,426	-	-	101,154,229	118,333	60,959	42,436	36,523	36,524	(10,733)	164,043,697
Non-Claims Expense Adjustment	756,640	19,252	11,717	11,329	(5,919)	(18,762)	4,624	57,172	232,393	(1,583,770)	1,420	167,936	(325,027)	(670,995)
IBNR, Incentive, Paid Claims Adjustment	(704,885)	(350,851)	202,480	374,161	20,741	(40,346)	(259,737)	816	(8,559)	(2,649,204)	(4,444,586)	11,543	(426,819)	(8,275,246)
Total Medical Costs	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	71,626,453	76,311,140	1,167,533,099
GROSS MARGIN	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	15,232,559	15,292,891	131,758,044
Administrative:														
Compensation	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	2,375,693	2,835,739	31,876,485
Purchased Services	449,468	805,910	605,801	836,783	831,542	805,047	1,358,494	805,903	833,909	749,771	931,815	941,269	1,295,571	11,251,283
Supplies	59,549	47,853	49,290	76,514	203,279	58,830	(7,208)	35,806	43,182	99,552	60,138	21,318	29,774	777,877
Depreciation	179,516	151,640	151,655	151,656	355,208	280,129	304,894	287,390	287,536	300,318	300,318	924,253	418,036	4,092,549
Other Administrative Expenses	412,596	338,545	489,494	523,591	519,786	270,201	344,959	353,414	181,493	387,179	154,706	223,548	192,449	4,391,961
Administrative Expense Adjustment	-	-	-	-	-	-	1,325,136	-	-	-	-	-	(212,229)	1,112,907
Total Administrative Expenses	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	4,486,081	4,559,340	53,503,062
TOTAL EXPENSES	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	76,112,534	80,870,480	1,221,036,161
OPERATING INCOME (LOSS) BEFORE TAX	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	10,746,478	10,733,551	78,254,982
MCO TAX	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	7,914,997	7,915,244	47,537,803
OPERATING INCOME (LOSS) NET OF TAX	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	2,831,481	2,818,307	30,717,179
TOTAL NONOPERATING REVENUE (EXPENSE)	1,293,258	(306,804)	(151,504)	(380,606)	(236,574)	(885,928)	(425,785)	(942,282)	(569,882)	(1,076,457)	424,682	(587,120)	(479,019)	(3,845,002)
NET INCREASE (DECREASE) IN NET POSITION	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	2,244,361	2,339,288	26,872,177
MEDICAL LOSS RATIO	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%	89.1%	89.8%	91.3%
ADMINISTRATIVE EXPENSE RATIO	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.8%	6.7%	6.4%	6.1%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH JUNE 30, 2020	JUNE 2019	JULY 2019	AUGUST 2019	SEPTEMBER 2019	OCTOBER 2019	NOVEMBER 2019	DECEMBER 2019	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	JUNE 2020	13 MONTH TOTAL
ENROLLMENT														
Members - MCAL	250,896	249,380	249,466	251,277	251,039	250,459	249,381	248,640	250,007	251,552	252,950	256,134	259,592	3,270,773
REVENUES														
Title XIX - Medicaid - Family and Other	147.25	155.06	157.80	157.10	157.23	199.08	162.50	162.42	161.68	163.16	157.08	158.57	169.56	162.20
Title XIX - Medicaid - Expansion Members	383.23	360.65	374.91	377.23	373.38	419.77	410.96	386.25	387.18	388.37	369.04	373.98	388.48	384.06
Title XIX - Medicaid - SPD Members	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	938.61	987.39	968.71
Premium - MCO Tax	32.58	32.59	49.38	40.52	40.08	46.35	(209.68)	0.00	64.63	30.16	31.29	30.90	30.91	17.05
Premium - Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.35	45.56	45.70	45.92	45.35	46.80	62.89
Investment Earnings And Other Income	4.42	1.42	1.53	2.82	1.35	1.06	2.93	0.76	1.21	1.69	1.05	1.26	0.24	1.67
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	249.66	0.00	0.00	406.58	0.48	0.24	0.17	0.14	0.14	(0.04)	50.27
Rate/Income Adjustments	(2.80)	0.53	1.32	0.41	1.27	(0.01)	(1.57)	3.30	3.24	2.45	(17.91)	1.74	1.84	(0.48)
TOTAL REVENUES	281.84	287.58	313.16	554.56	305.87	352.21	1,017.92	316.41	381.55	348.16	317.99	339.12	352.88	397.24
EXPENSES														
Medical Costs:														
Physician Services	53.68	55.79	54.18	49.64	52.92	57.48	62.38	59.35	55.49	57.05	49.10	48.53	45.48	53.89
Other Professional Services	17.49	15.44	15.13	15.57	17.86	14.36	17.53	17.43	15.87	16.00	15.45	13.62	13.04	15.74
Emergency Room	18.73	20.78	18.62	18.69	22.20	20.87	18.97	21.02	21.03	21.35	15.08	16.45	12.96	18.95
Inpatient	57.36	53.46	61.08	61.94	59.56	58.52	57.94	59.97	55.57	58.61	63.24	56.26	65.93	59.21
Reinsurance Expense	0.50	0.51	0.52	0.50	0.51	0.52	0.51	0.29	0.58	(0.00)	0.31	0.27	0.28	0.41
Outpatient Hospital	23.57	26.50	26.15	24.40	24.41	24.52	19.12	27.08	24.82	26.10	24.79	20.30	24.84	24.35
Other Medical	25.34	26.93	25.81	30.13	23.23	66.50	26.66	22.77	40.08	42.35	34.92	42.40	35.44	34.07
Pharmacy	33.91	36.83	37.43	36.40	39.18	37.06	37.16	40.10	36.98	40.99	34.27	33.64	32.03	36.59
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	2.02	1.98	2.00	2.00
Risk Corridor Expense	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	18.11	1.44
Hospital Directed Payments	0.00	0.00	0.00	0.00	0.00	0.00	546.01	45.35	45.56	45.70	45.92	45.35	46.80	62.89
Hospital Directed Payment Adjustment	0.00	0.00	0.00	249.15	0.00	0.00	405.62	0.48	0.24	0.17	0.14	0.14	(0.04)	50.15
Non-Claims Expense Adjustment	3.02	0.08	0.05	0.05	(0.02)	(0.07)	0.02	0.23	0.93	(6.30)	0.01	0.66	(1.25)	(0.21)
IBNR, Incentive, Paid Claims Adjustment	(2.81)	(1.41)	0.81	1.49	0.08	(0.16)	(1.04)	0.00	(0.03)	(10.53)	(17.57)	0.05	(1.64)	(2.53)
Total Medical Costs	232.78	236.90	241.79	489.96	241.92	281.60	1,192.88	296.10	299.13	293.50	267.65	279.64	293.97	356.96
GROSS MARGIN	49.06	50.68	71.38	64.61	63.94	70.61	(174.96)	20.32	82.43	54.66	50.34	59.47	58.91	40.28
Administrative:														
Compensation	8.59	9.21	9.04	9.33	10.00	9.60	10.38	10.37	9.63	9.73	10.59	9.28	10.92	9.75
Purchased Services	1.79	3.23	2.43	3.33	3.31	3.21	5.45	3.24	3.34	2.98	3.68	3.67	4.99	3.44
Supplies	0.24	0.19	0.20	0.30	0.81	0.23	(0.03)	0.14	0.17	0.40	0.24	0.08	0.11	0.24
Depreciation	0.72	0.61	0.61	0.60	1.41	1.12	1.22	1.16	1.15	1.19	1.19	3.61	1.61	1.25
Other Administrative Expenses	1.64	1.36	1.96	2.08	2.07	1.08	1.38	1.42	0.73	1.54	0.61	0.87	0.74	1.34
Administrative Expense Adjustment	0.00	0.00	0.00	0.00	0.00	0.00	5.31	0.00	0.00	0.00	0.00	0.00	(0.82)	0.34
Total Administrative Expenses	12.98	14.60	14.23	15.65	17.61	15.24	23.72	16.33	15.01	15.84	16.31	17.51	17.56	16.36
TOTAL EXPENSES	245.76	251.51	256.02	505.61	259.53	296.84	1,216.60	312.43	314.14	309.34	283.96	297.16	311.53	373.32
OPERATING INCOME (LOSS) BEFORE TAX	36.08	36.07	57.14	48.96	46.34	55.37	(198.68)	3.99	67.41	38.82	34.03	41.96	41.35	23.93
MCO TAX	32.24	32.28	49.22	40.45	40.06	49.04	(212.37)	0.00	64.63	30.16	31.29	30.90	30.49	14.53
OPERATING INCOME (LOSS) NET OF TAX	3.85	3.79	7.92	8.50	6.27	6.32	13.69	3.99	2.78	8.66	2.73	11.05	10.86	9.39
TOTAL NONOPERATING REVENUE (EXPENSE)	5.15	(1.23)	(0.61)	(1.51)	(0.94)	(3.54)	(1.71)	(3.79)	(2.28)	(4.28)	1.68	(2.29)	(1.85)	(1.18)
NET INCREASE (DECREASE) IN NET POSITION	9.00	2.56	7.31	6.99	5.33	2.79	11.98	0.20	0.50	4.38	4.41	8.76	9.01	8.22
MEDICAL LOSS RATIO	93.4%	92.9%	91.7%	91.1%	91.0%	92.1%	87.7%	92.5%	93.4%	91.0%	92.1%	89.1%	89.8%	91.3%
ADMINISTRATIVE EXPENSE RATIO	5.2%	5.7%	5.4%	5.9%	6.6%	5.0%	8.6%	6.0%	5.5%	5.8%	6.8%	6.7%	6.4%	6.1%

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF REVENUES - ALL COA FOR THE MONTH ENDED JUNE 30, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			R E V E N U E S			
			Title XIX - Medicaid - Family & Other			
23,675,261	22,205,444	1,469,817	Premium - Medi-Cal	133,259,499	132,795,503	463,996
2,382,646	2,375,503	7,143	Premium - Maternity Kick	13,324,742	14,253,018	(928,276)
107,228	73,146	34,082	Premium - Hep C Kick	337,376	436,377	(99,001)
359,872	599,256	(239,384)	Premium - BHT Kick	2,164,180	3,575,072	(1,410,892)
249,010	314,503	(65,493)	Premium - Health Home Kick	1,094,529	1,876,278	(781,749)
3,482,521	1,705,075	1,777,446	Premium - Provider Enhancement	19,410,346	10,171,950	9,238,396
165,708	157,153	8,555	Premium - Ground Emergency Medical Transportation	944,774	939,498	5,276
99,807	94,095	5,712	Other	562,137	564,030	(1,893)
30,522,053	27,524,174	2,997,879	Total Title XIX - Medicaid - Family & Other	171,097,583	164,611,725	6,485,858
			Title XIX - Medicaid - Expansion Members			
22,505,883	21,183,611	1,322,272	Premium - Medi-Cal	126,912,822	127,101,666	(188,844)
187,753	214,189	(26,436)	Premium - Maternity Kick	1,663,877	1,285,134	378,743
151,689	303,377	(151,688)	Premium - Hep C Kick	1,550,885	1,820,262	(269,377)
479,759	519,998	(40,239)	Premium - Health Home Kick	2,257,139	3,119,988	(862,849)
1,256,773	742,244	514,530	Premium - Provider Enhancement	7,450,575	4,453,462	2,997,114
164,805	152,964	11,841	Premium - Ground Emergency Medical Transportation	939,427	917,784	21,643
30,213	29,126	1,087	Other	171,801	174,756	(2,955)
24,776,875	23,145,509	1,631,366	Total Title XIX - Medicaid - Expansion Members	140,946,526	138,873,052	2,073,474
			Title XIX - Medicaid - SPD Members			
13,948,994	13,148,587	800,407	Premium - Medi-Cal	81,270,053	78,891,522	2,378,531
94,152	94,152	0	Premium - Hep C Kick	747,982	564,912	183,070
453,733	818,847	(365,114)	Premium - BHT Kick	3,071,779	4,913,082	(1,841,303)
498,619	416,635	81,984	Premium - Health Home Kick	2,205,676	2,499,810	(294,134)
467,729	282,521	185,208	Premium - Provider Enhancement	2,745,965	1,703,126	1,042,839
140,523	123,879	16,644	Premium - Ground Emergency Medical Transportation	824,629	743,274	81,355
15,603,750	14,884,621	719,129	Total Title XIX - Medicaid - SPD Members	90,866,084	89,315,726	1,550,358

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

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
2,336,317	2,872,628	536,311	Primary Care Physician Services	16,641,868	17,169,796	527,928
8,510,414	10,081,590	1,571,176	Referral Specialty Services	55,176,935	60,338,754	5,161,819
950,870	1,426,761	475,891	Urgent Care & After Hours Advise	7,764,058	8,522,689	758,631
9,000	9,000	-	Hospital Admitting Team	54,600	55,500	900
11,806,601	14,389,979	2,583,378	TOTAL PHYSICIAN SERVICES	79,637,461	86,086,739	6,449,278
			OTHER PROFESSIONAL SERVICES			
265,598	270,844	5,246	Vision Service Capitation	1,618,206	1,621,184	2,978
234,246	212,779	(21,467)	221 - Business Intelligence	1,263,156	1,276,674	13,518
584,598	556,462	(28,136)	310 - Health Services - Utilization Management - UM Allocation *	3,287,072	3,310,009	22,937
144,162	169,504	25,342	311 - Health Services - Quality Improvement - UM Allocation *	859,605	1,017,021	157,416
123,705	127,991	4,286	312 - Health Services - Education - UM Allocation *	682,229	767,942	85,713
89,969	94,630	4,661	313 - Health Services - Pharmacy - UM Allocation *	502,585	567,782	65,197
104,978	135,159	30,181	314 - Health Homes - UM Allocation *	619,059	792,537	173,478
270,106	258,856	(11,250)	315 - Case Management - UM Allocation *	1,580,525	1,553,138	(27,387)
58,667	61,775	3,108	616 - Disease Management - UM Allocation *	352,328	370,649	18,321
685,282	1,418,103	732,821	Behavior Health Treatment	5,465,448	8,488,154	3,022,706
55,987	170,818	114,831	Mental Health Services	852,212	1,023,155	170,943
767,836	1,156,401	388,565	Other Professional Services	6,027,106	6,923,096	895,990
3,385,134	4,633,322	1,248,188	TOTAL OTHER PROFESSIONAL SERVICES	23,109,531	27,711,341	4,601,810
3,363,172	5,158,962	1,795,790	EMERGENCY ROOM	27,245,145	30,844,978	3,599,833
17,115,732	13,516,218	(3,599,514)	INPATIENT HOSPITAL	91,071,083	80,905,955	(10,165,128)
73,356	72,942	(414)	REINSURANCE EXPENSE PREMIUM	436,539	435,914	(626)
6,447,664	6,555,696	108,032	OUTPATIENT HOSPITAL SERVICES	37,422,815	39,254,435	1,831,620
			OTHER MEDICAL			
366,750	1,547,202	1,180,452	Ambulance and NEMT	6,669,635	9,260,436	2,590,801
171,601	389,547	217,946	Home Health Services & CBAS	2,100,418	2,333,235	232,817
243,906	511,865	267,959	Utilization and Quality Review Expenses	1,370,913	2,954,640	1,583,727
697,808	939,428	241,620	Long Term/SNF/Hospice	7,490,113	5,630,542	(1,859,571)
249,665	483,939	234,274	Health Home Capitation & Incentive	1,259,705	2,899,481	1,639,776
5,297,431	2,729,784	(2,567,647)	Provider Enhancement Expense - Prop. 56	28,867,780	16,318,536	(12,549,244)
425,341	433,996	8,655	Provider Enhancement Expense - GEMT	2,395,226	2,600,556	205,330
1,747,240	-	(1,747,240)	Provider COVID-19 Expenes	5,074,560	-	(5,074,560)
9,199,742	7,035,760	(2,163,982)	TOTAL OTHER MEDICAL	55,228,350	41,997,426	(13,230,924)
			PHARMACY SERVICES			
7,983,954	8,705,122	721,168	RX - Drugs & OTC	50,368,405	52,133,582	1,765,177
298,687	470,674	171,987	RX - HEP-C	2,029,843	2,821,548	791,705
109,695	689,826	580,131	Rx - DME	3,383,072	4,131,452	748,380
(78,879)	(145,820)	(66,941)	RX - Pharmacy Rebates	(653,879)	(874,510)	(220,631)
8,313,457	9,719,803	1,406,346	TOTAL PHARMACY SERVICES	55,127,441	58,212,072	3,084,631
519,184	503,050	(16,134)	PAY FOR PERFORMANCE QUALITY INCENTIVE	3,037,750	3,006,300	(31,450)
4,700,000	-	(4,700,000)	RISK CORRIDOR EXPENSE	4,700,000	-	(4,700,000)
12,149,677	11,088,176	(1,061,501)	HOSPITAL DIRECTED PAYMENTS	69,542,441	66,464,798	(3,077,643)
(10,733)	-	10,733	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	284,042	-	(284,042)
(325,027)	-	325,027	NON-CLAIMS EXPENSE ADJUSTMENT	(1,449,876)	-	1,449,876
(426,819)	-	426,819	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(7,516,809)	-	7,516,809
76,311,140	72,673,909	(3,637,231)	Total Medical Costs	437,875,913	434,919,957	(2,955,956)

* Medical costs per DMHC regulations

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM FOR THE MONTH ENDED JUNE 30, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
9.00	11.42	2.42	Primary Care Physician Services	10.96	11.42	0.47
32.78	40.08	7.30	Referral Specialty Services	36.33	40.14	3.81
3.66	5.67	2.01	Urgent Care & After Hours Advise	5.11	5.67	0.56
0.03	0.04	0.00	Hospital Admitting Team	0.04	0.04	0.00
45.48	57.21	11.73	TOTAL PHYSICIAN SERVICES	52.43	57.27	4.84
			OTHER PROFESSIONAL SERVICES			
1.02	1.08	0.05	Vision Service Capitation	1.07	1.08	0.01
0.90	0.85	(0.06)	221 - Business Intelligence	0.83	0.85	0.02
2.25	2.21	(0.04)	310 - Health Services - Utilization Management - UM Allocation *	2.16	2.20	0.04
0.56	0.67	0.12	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 *	0.45	0.51	0.06
0.35	0.38	0.03	313 - Health Services - Pharmacy - UM Allocation *	0.33	0.38	0.05
0.40	0.54	0.13	314 - Health Homes - UM Allocation *	0.41	0.53	0.12
1.04	1.03	(0.01)	315 - Case Management - UM Allocation *	1.04	1.03	(0.01)
0.23	0.25	0.02	616 - Disease Management - UM Allocation *	0.23	0.25	0.01
2.64	5.64	3.00	Behavior Health Treatment	3.60	5.65	2.05
0.22	0.68	0.46	Mental Health Services	0.56	0.68	0.12
2.96	4.60	1.64	Other Professional Services	3.97	4.61	0.64
13.04	18.42	5.38	TOTAL OTHER PROFESSIONAL SERVICES	15.21	18.44	3.22
12.96	20.51	7.56	EMERGENCY ROOM	17.94	20.52	2.58
65.93	53.74	(12.20)	INPATIENT HOSPITAL	59.96	53.82	(6.14)
0.28	0.29	0.01	REINSURANCE EXPENSE PREMIUM	0.29	0.29	0.00
24.84	26.06	1.23	OUTPATIENT HOSPITAL SERVICES	24.64	26.11	1.48
			OTHER MEDICAL			
1.41	6.15	4.74	Ambulance and NEMT	4.39	6.16	1.77
0.66	1.55	0.89	Home Health Services & CBAS	1.38	1.55	0.17
0.94	2.04	1.10	Utilization and Quality Review Expenses	0.90	1.97	1.06
2.69	3.73	1.05	Long Term/SNF/Hospice	4.93	3.75	(1.19)
0.96	1.92	0.96	Health Home Capitation & Incentive	0.83	1.93	1.10
20.41	10.85	(9.55)	Provider Enhancement Expense - Prop. 56	19.01	10.86	(8.15)
1.64	1.73	0.09	Provider Enhancement Expense - GEMT	1.58	1.73	0.15
6.73	0.00	(6.73)	Provider COVID-19 Expenes	3.34	0.00	(3.34)
35.44	27.97	(7.47)	TOTAL OTHER MEDICAL	36.36	27.94	(8.42)
			PHARMACY SERVICES			
30.76	34.61	3.85	RX - Drugs & OTC	33.16	34.68	1.52
1.15	1.87	0.72	RX - HEP-C	1.34	1.88	0.54
0.42	2.74	2.32	Rx - DME	2.23	2.75	0.52
(0.30)	(0.58)	(0.28)	RX - Pharmacy Rebates	(0.43)	(0.58)	(0.15)
32.03	38.64	6.62	TOTAL PHARMACY SERVICES	36.29	38.73	2.43
2.00	2.00	0.00	PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	0.00
18.11	0.00	(18.11)	RISK CORRIDOR EXPENSE	3.09	0.00	(3.09)
46.80	44.08	(2.72)	HOSPITAL DIRECTED PAYMENTS	45.79	44.22	(1.57)
-0.04	0.00	0.04	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.19	0.00	(0.19)
(1.25)	0.00	1.25	NON-CLAIMS EXPENSE ADJUSTMENT	(0.95)	0.00	0.95
(1.64)	0.00	1.64	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(4.95)	0.00	4.95
293.97	288.93	(5.03)	Total Medical Costs	288.29	289.34	1.05

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH JUNE 30, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	JUNE 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES							
Primary Care Physician Services	2,908,272	3,164,601	2,861,899	2,953,514	2,417,265	2,336,317	16,641,868
Referral Specialty Services	10,425,085	8,803,273	10,044,984	8,437,260	8,955,919	8,510,414	55,176,935
Urgent Care & After Hours Advise	1,414,889	1,896,664	1,435,097	1,019,114	1,047,424	950,870	7,764,058
Hospital Admitting Team	9,300	8,700	9,300	9,000	9,300	9,000	54,600
TOTAL PHYSICIAN SERVICES	14,757,546	13,873,238	14,351,280	12,418,888	12,429,908	11,806,601	79,637,461
OTHER PROFESSIONAL SERVICES							
Vision Service Capitation	299,489	261,072	261,072	263,942	267,033	265,598	1,618,206
221 - Business Intelligence	199,939	204,745	195,081	233,961	195,184	234,246	1,263,156
310 - Health Services - Utilization Management - UM Allocation *	550,905	482,617	507,782	619,537	541,633	584,598	3,287,072
311 - Health Services - Quality Improvement - UM Allocation *	130,719	131,973	135,845	172,419	144,487	144,162	859,605
312 - Health Services - Education - UM Allocation *	111,799	102,037	108,402	122,087	114,199	123,705	682,229
313 - Health Services - Pharmacy - UM Allocation *	88,153	80,696	81,505	86,248	76,014	89,969	502,585
314 - Health Homes - UM Allocation *	91,425	88,868	104,710	127,755	101,323	104,978	619,059
315 - Case Management - UM Allocation *	267,758	241,370	244,642	304,832	251,817	270,106	1,580,525
616 - Disease Management - UM Allocation *	56,335	54,217	57,384	69,526	56,199	58,667	352,328
Behavior Health Treatment	980,035	935,456	999,720	1,194,682	670,273	685,282	5,465,448
Mental Health Services	330,842	217,343	131,506	4,228	112,306	55,987	852,212
Other Professional Services	1,227,554	1,166,121	1,197,113	709,542	958,940	767,836	6,027,106
TOTAL OTHER PROFESSIONAL SERVICES	4,334,953	3,966,515	4,024,762	3,908,759	3,489,408	3,385,134	23,109,531
EMERGENCY ROOM	5,226,947	5,258,084	5,370,795	3,813,875	4,212,272	3,363,172	27,245,145
INPATIENT HOSPITAL	14,911,677	13,893,706	14,743,904	15,995,368	14,410,696	17,115,732	91,071,083
REINSURANCE EXPENSE PREMIUM	72,320	144,425	(213)	77,341	69,310	73,356	436,539
OUTPATIENT HOSPITAL SERVICES	6,734,395	6,204,610	6,566,090	6,270,816	5,199,240	6,447,664	37,422,815
OTHER MEDICAL							
Ambulance and NEMT	1,599,375	1,498,607	1,444,299	670,262	1,090,342	366,750	6,669,635
Home Health Services & CBAS	392,407	393,491	349,594	300,546	492,779	171,601	2,100,418
Utilization and Quality Review Expenses	308,250	229,353	247,983	245,426	95,995	243,906	1,370,913
Long Term/SNF/Hospice	1,052,766	1,197,702	1,539,187	1,549,960	1,452,690	697,808	7,490,113
Health Home Capitation & Incentive	166,060	137,300	112,910	263,565	330,205	249,665	1,259,705
Provider Enhancement Expense - Prop. 56	1,820,309	5,971,496	6,564,136	4,841,254	4,373,154	5,297,431	28,867,780
Provider Enhancement Expense - GEMT	322,617	593,064	395,321	399,960	258,923	425,341	2,395,226
Provider COVID-19 Expenes	-	-	-	561,100	2,766,220	1,747,240	5,074,560
TOTAL OTHER MEDICAL	5,661,784	10,021,013	10,653,430	8,832,073	10,860,308	9,199,742	55,228,350
PHARMACY SERVICES							
RX - Drugs & OTC	9,137,997	8,470,785	9,200,496	7,803,679	7,771,494	7,983,954	50,368,405
RX - HEP-C	271,776	331,788	470,380	364,602	292,610	298,687	2,029,843
Rx - DME	696,914	578,635	675,997	634,644	687,187	109,695	3,383,072
RX - Pharmacy Rebates	(135,000)	(135,000)	(35,000)	(135,000)	(135,000)	(78,879)	(653,879)
TOTAL PHARMACY SERVICES	9,971,687	9,246,208	10,311,873	8,667,925	8,616,291	8,313,457	55,127,441
PAY FOR PERFORMANCE QUALITY INCENTIVE	497,280	500,014	503,104	509,814	508,354	519,184	3,037,750
RISK CORRIDOR EXPENSE	-	-	-	-	-	4,700,000.00	4,700,000.00
HOSPITAL DIRECTED PAYMENTS	11,276,584	11,391,396	11,495,457	11,614,664	11,614,663	12,149,677	69,542,441
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	118,333	60,959	42,436	36,523	36,524	(10,733)	284,042
NON-CLAIMS EXPENSE ADJUSTMENT	57,172	232,393	(1,583,770)	1,420	167,936	(325,027)	(1,449,876)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	816	(8,559)	(2,649,204)	(4,444,586)	11,543	(426,819)	(7,516,809)
Total Medical Costs	73,621,494	74,784,002	73,829,944	67,702,880	71,626,453	76,311,140	437,875,913

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH JUNE 30, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	JUNE 2020	YEAR TO DATE 2020
PHYSICIAN SERVICES							
Primary Care Physician Services	11.70	12.66	11.38	11.68	9.44	9.00	10.96
Referral Specialty Services	41.93	35.21	39.93	33.36	34.97	32.78	36.33
Urgent Care & After Hours Advise	5.69	7.59	5.70	4.03	4.09	3.66	5.11
Hospital Admitting Team	0.04	0.03	0.04	0.04	0.04	0.03	0.04
TOTAL PHYSICIAN SERVICES	59.35	55.49	57.05	49.10	48.53	45.48	52.43
OTHER PROFESSIONAL SERVICES							
Vision Service Capitation	1.20	1.04	1.04	1.04	1.04	1.02	1.07
221 - Business Intelligence	0.80	0.82	0.78	0.92	0.76	0.90	0.83
310 - Health Services - Utilization Management - UM Allocation *	2.22	1.93	2.02	2.45	2.11	2.25	2.16
311 - Health Services - Quality Improvement - UM Allocation *	0.53	0.53	0.54	0.68	0.56	0.56	0.57
312 - Health Services - Education - UM Allocation *	0.45	0.41	0.43	0.48	0.45	0.48	0.45
313 - Health Services - Pharmacy - UM Allocation *	0.35	0.32	0.32	0.34	0.30	0.35	0.33
314 - Health Homes - UM Allocation *	0.37	0.36	0.42	0.51	0.40	0.40	0.41
315 - Case Management - UM Allocation *	1.08	0.97	0.97	1.21	0.98	1.04	1.04
616 - Disease Management - UM Allocation *	0.23	0.22	0.23	0.27	0.22	0.23	0.23
Behavior Health Treatment	3.94	3.74	3.97	4.72	2.62	2.64	3.60
Mental Health Services	1.33	0.87	0.52	0.02	0.44	0.22	0.56
Other Professional Services	4.94	4.66	4.76	2.81	3.74	2.96	3.97
TOTAL OTHER PROFESSIONAL SERVICES	17.43	15.87	16.00	15.45	13.62	13.04	15.21
EMERGENCY ROOM	21.02	21.03	21.35	15.08	16.45	12.96	17.94
INPATIENT HOSPITAL	59.97	55.57	58.61	63.24	56.26	65.93	59.96
REINSURANCE EXPENSE PREMIUM	0.29	0.58	0.00	0.31	0.27	0.28	0.29
OUTPATIENT HOSPITAL SERVICES	27.08	24.82	26.10	24.79	20.30	24.84	24.64
OTHER MEDICAL							
Ambulance and NEMT	6.43	5.99	5.74	2.65	4.26	1.41	4.39
Home Health Services & CBAS	1.58	1.57	1.39	1.19	1.92	0.66	1.38
Utilization and Quality Review Expenses	1.24	0.92	0.99	0.97	0.37	0.94	0.90
Long Term/SNF/Hospice	4.23	4.79	6.12	6.13	5.67	2.69	4.93
Health Home Capitation & Incentive	0.67	0.55	0.45	1.04	1.29	0.96	0.83
Provider Enhancement Expense - Prop. 56	7.32	23.89	26.09	19.14	17.07	20.41	19.01
Provider Enhancement Expense - GEMT	1.30	2.37	1.57	1.58	1.01	1.64	1.58
Provider COVID-19 Expenes	0.00	0.00	0.00	2.22	10.80	6.73	3.34
TOTAL OTHER MEDICAL	22.77	40.08	42.35	34.92	42.40	35.44	36.36
PHARMACY SERVICES							
RX - Drugs & OTC	36.75	33.88	36.57	30.85	30.34	30.76	33.16
RX - HEP-C	1.09	1.33	1.87	1.44	1.14	1.15	1.34
Rx - DME	2.80	2.31	2.69	2.51	2.68	0.42	2.23
RX - Pharmacy Rebates	(0.54)	(0.54)	(0.14)	(0.53)	(0.53)	(0.30)	(0.43)
TOTAL PHARMACY SERVICES	40.10	36.98	40.99	34.27	33.64	32.03	36.29
PAY FOR PERFORMANCE QUALITY INCENTIVE	2.00	2.00	2.00	2.02	1.98	2.00	2.00
RISK CORRIDOR EXPENSE	0.00	0.00	0.00	0.00	0.00	18.11	3.09
HOSPITAL DIRECTED PAYMENTS	45.35	45.56	45.70	45.92	45.35	46.80	45.79
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.48	0.24	0.17	0.14	0.14	(0.04)	0.19
NON-CLAIMS EXPENSE ADJUSTMENT	0.23	0.93	(6.30)	0.01	0.66	(1.25)	(0.95)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(0.03)	(10.53)	(17.57)	0.05	(1.64)	(4.95)
Total Medical Costs	296.10	299.13	293.50	267.65	279.64	293.97	288.29

CURRENT MONTH			KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT FOR THE MONTH ENDED JUNE 30, 2020	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
372,155	333,252	(38,903)	110 - Executive	2,029,357	1,924,561	(104,797)
235,051	198,810	(36,241)	210 - Accounting	1,119,904	1,190,886	70,982
409,177	273,114	(136,063)	220 - Management Information Systems	1,963,482	1,638,690	(324,792)
14,750	13,051	(1,699)	221 - Business Intelligence	85,170	78,318	(6,852)
299,686	281,947	(17,739)	222 - Enterprise Development	1,505,709	1,691,696	185,987
431,419	415,722	(15,697)	225 - Infrastructure	2,042,978	2,494,339	451,361
531,975	559,279	27,304	230 - Claims	3,109,233	3,348,096	238,863
121,862	114,151	(7,711)	240 - Project Management	592,975	684,906	91,931
127,289	99,615	(27,674)	310 - Health Services - Utilization Management	635,620	594,112	(41,508)
46,653	55,141	8,488	311 - Health Services - Quality Improvement	242,439	330,646	88,207
-	67	67	312 - Health Services - Education	121	550	429
126,485	140,883	14,398	313- Pharmacy	845,126	858,121	12,995
76	-	(76)	314 - Health Homes	735	-	(735)
17,240	16,573	(667)	315 - Case Management	101,398	99,436	(1,962)
21,699	23,131	1,432	616 - Disease Management	130,361	138,787	8,426
313,902	313,552	(350)	320 - Provider Network Management	1,692,420	1,881,312	188,892
547,629	563,882	16,253	330 - Member Services	3,107,927	3,383,276	275,349
640,485	528,116	(112,369)	340 - Corporate Services	3,570,769	3,161,696	(409,073)
76,957	67,176	(9,781)	360 - Audit & Investigative Services	449,811	403,056	(46,755)
138,348	54,315	(84,033)	410 - Advertising Media	397,492	325,890	(71,602)
54,859	68,457	13,598	420 - Sales/Marketing/Public Relations	270,161	410,742	140,581
243,872	220,076	(23,796)	510 - Human Resourses	1,287,835	1,347,888	60,053
(212,229)	-	212,229	Budgeted Administrative Vacancy and Timing Factor	(212,229)	-	212,229
4,559,340	4,340,309	(219,031)	Total Administrative Expenses	24,968,794	25,987,004	1,018,210

KHS7/28/2020
Management Use Only

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED JUNE 30, 2020	JANUARY 2020	FEBRUARY 2020	MARCH 2020	APRIL 2020	MAY 2020	JUNE 2020	YEAR TO DATE 2020
110 - Executive	339,242	293,820	365,045	399,347	259,748	372,155	2,029,357
210 - Accounting	173,904	178,919	174,836	183,136	174,058	235,051	1,119,904
220 - Management Information Systems (MIS)	381,511	295,419	338,903	162,587	375,885	409,177	1,963,482
221 - Business Intelligence	-	11,648	20,702	22,767	15,303	14,750	85,170
222 - Enterprise Development	211,299	225,855	262,079	292,897	213,893	299,686	1,505,709
225 - Infrastructure	359,015	241,507	308,323	274,546	428,168	431,419	2,042,978
230 - Claims	556,280	498,960	493,312	543,105	485,601	531,975	3,109,233
240 - Project Management	85,191	84,709	97,954	100,673	102,586	121,862	592,975
310 - Health Services - Utilization Management	98,529	107,809	95,426	112,873	93,694	127,289	635,620
311 - Health Services - Quality Improvement	10,824	41,860	43,027	54,448	45,627	46,653	242,439
312 - Health Services - Education	-	60	-	61	-	-	121
313- Pharmacy	156,947	147,980	148,599	141,729	123,386	126,485	845,126
314 - Health Homes	222	15,046	98	(14,707)	-	76	735
315 - Case Management	17,349	15,664	15,615	19,456	16,074	17,240	101,398
616 - Disease Management	20,836	20,068	21,223	25,749	20,786	21,699	130,361
320 - Provider Network Management	256,860	252,748	291,995	307,450	269,465	313,902	1,692,420
330 - Member Services	530,714	484,954	496,790	563,492	484,348	547,629	3,107,927
340 - Corporate Services	439,804	482,885	487,474	449,175	1,070,946	640,485	3,570,769
360 - Audit & Investigative Services	81,923	83,979	59,288	87,154	60,510	76,957	449,811
410 - Advertising Media	9,439	47,590	38,083	134,979	29,053	138,348	397,492
420 - Sales/Marketing/Public Relations	44,020	35,104	43,800	36,382	55,996	54,859	270,161
510 - Human Resourses	285,952	186,648	181,915	228,494	160,954	243,872	1,287,835
Total Department Expenses	4,059,861	3,753,232	3,984,487	4,125,793	4,486,081	4,771,569	25,181,023
ADMINISTRATIVE EXPENSE ADJUSTMENT	-	-	-	-	-	(212,229)	(212,229)
Total Administrative Expenses	4,059,861	3,753,232	3,984,487	4,125,793	4,486,081	4,559,340	24,968,794

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

ASSETS	JUNE 2020	MAY 2020	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,127,540	$ 1,127,540	-
Interest Receivable	3,786	3,600	186
Prepaid Expenses & Other Current Assets	-	834	(834)
TOTAL CURRENT ASSETS	$ 1,131,326	$ 1,131,974	$ (648)

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	2,441	3,089	(648)
Total Net Position	$ 1,131,326	$ 1,131,974	$ (648)
TOTAL LIABILITIES AND NET POSITION	$ 1,131,326	$ 1,131,974	$ (648)

CURRENT MONTH			KERN HEALTH SYSTEMS GROUP HEALTH PLAN - HFAM STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION	YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE	FOR THE MONTH ENDED JUNE 30, 2020	ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
186	-	186	Interest	9,402	-	9,402
-	-	-	Other Investment Income	(1,961)	-	(1,961)
186	-	186	TOTAL REVENUES	7,441	-	7,441
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
186	-	186	GROSS MARGIN	7,441	-	7,441
			Administrative			
834	-	(834)	Management Fee Expense and Other Admin Exp	5,000	-	(5,000)
834	-	(834)	Total Administrative Expenses	5,000	-	(5,000)
834	-	(834)	TOTAL EXPENSES	5,000	-	(5,000)
(648)	-	(648)	OPERATING INCOME (LOSS)	2,441	-	2,441
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
(648)	-	(648)	NET INCREASE (DECREASE) IN NET POSITION	2,441	-	2,441
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
448%	0%	-448%	ADMINISTRATIVE EXPENSE RATIO	67%	0%	-67%

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	268,107	43,519	43,767	44,480	44,402	45,381	46,558	0	0	0	0	0	0
CHILD	743,396	122,496	123,040	123,357	123,687	124,785	126,031	0	0	0	0	0	0
SUB-TOTAL ADULT & FAMILY	1,011,503	166,015	166,807	167,837	168,089	170,166	172,589	0	0	0	0	0	0
OTHER MEMBERS													
BCCTP-TOBACCO SETTLEMENT	159	26	28	26	25	27	27	0	0	0	0	0	0
DUALS													
PARTIAL DUALS - FAMILY	2,702	432	432	453	461	474	450	0	0	0	0	0	0
PARTIAL DUALS - CHILD	6	1	1	1	1	1	1	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	10	1	1	2	2	2	2	0	0	0	0	0	0
SPD FULL DUALS	41,116	6,599	6,759	6,911	6,923	6,983	6,941	0	0	0	0	0	0
SUB-TOTAL DUALS	43,834	7,033	7,193	7,367	7,387	7,460	7,394	0	0	0	0	0	0
TOTAL FAMILY & OTHER	1,055,496	173,074	174,028	175,230	175,501	177,653	180,010	0	0	0	0	0	0
SPD													
SPD (AGED AND DISABLED)	94,589	15,667	15,493	15,688	15,992	15,946	15,803	0	0	0	0	0	0
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	366,856	59,583	60,197	60,360	61,164	62,179	63,373	0	0	0	0	0	0
ACA Expansion Duals	1,934	316	289	274	293	356	406	0	0	0	0	0	0
SUB-TOTAL MED-CAL EXPANSION	368,790	59,899	60,486	60,634	61,457	62,535	63,779	0	0	0	0	0	0
TOTAL KAISER	55,617	8,992	9,125	9,169	9,262	9,475	9,594	0	0	0	0	0	0
TOTAL MEDI-CAL MEMBERS	1,574,492	257,632	259,132	260,721	262,212	265,609	269,186	0	0	0	0	0	0

KERN·HEALTH SYSTEMS

May AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO*****	457,452.70	2,261,913.18	MAY 2020 HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T3130	OPTUMINSIGHT, INC.****	399,294.00	399,294.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T4391	OMNI FAMILY HEALTH	118,474.43	1,511,845.76	FEBRUARY 2020 HEALTH HOME GRANT (OILDALE & SHAFTER)	COMMUNITY GRANT
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	126,131.82	999,858.74	JANUARY - MARCH 2020 HEALTH HOME GRANT	COMMUNITY GRANT
T2726	DST PHARMACY SOLUTIONS, INC.	104,382.62	617,088.71	APRIL 2020 PHARMACY CLAIMS	PHARMACY
T4237	FLUIDEDGE CONSULTING, INC.	90,316.98	552,878.17	APR. & MAY 2020 PROFESSIONAL SERVICES/ CONSULTING SERVICES & 2019	VARIOUS
T4165	SHI INTERNATIONAL CO.*****	78,362.15	159,350.09	(40) LAPTOP DOCKING STATIONS, SMARTNET ANNAUL LICENSE RENEWAL, CISCO UNITY ESD LICENSE	MIS INFRASTRUCTURE
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	65,057.53	319,601.35	MAY 2020 VOLUNTARY LIFE, AD&D, DENTAL INSURANCE PREMIUM	VARIOUS
T4483	INFUSION AND CLINICAL SERVICES, INC.	51,748.55	328,688.85	MARCH 2020 HEALTH HOME GRANT	COMMUNITY GRANT
T4634	EXECUTIVE STAFFING SOLUTIONS****	49,999.00	49,999.00	RECRUITMENT FEE -DIRECTOR OF	HUMAN RESOURCES
T4582	HEALTHX, INC.	40,376.00	201,880.00	MAY 2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T2458	HEALTHCARE FINANCIAL, INC.*****	33,000.00	155,000.00	MARCH & APRIL 2020 PROFESSIONAL SERVICES	ADMINISTRATION
T4657	DAPONDE SIMPSON ROWE PC	32,184.50	104,612.00	APRIL 2020 LEGAL SERVICES	PROVIDER RELATIONS/ ADMIN
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK******	31,135.00	55,135.00	2019 AUDIT FEES	ADMINISTRATION

KERN·HEALTH SYSTEMS

May AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T1861	CERIDIAN HCM, INC.*****	27,619.35	68,660.71	APRIL & MAY 2020 MONTHLY SUBSCRIPTION FEES,PROFESSIONAL SERVICES/ FEBRUARY- MARCH 2020 DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4193	STRIA LLC	27,402.51	183,072.35	APRIL 2020 OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T5109	RAND EMPLOYMENT SOLUTIONS	25,142.70	149,080.56	APRIL - MAY 2020 TEMP SERVICES- 5 MS, 1	VARIOUS
T1128	HALL LETTER SHOP, INC.	22,888.79	51,649.85	(500) PIZZA COUPONS & COVID 19 LETTERS	ADMINISTRATION / MS
T4733	UNITED STAFFING ASSOCIATES	21,295.29	117,437.63	APRIL - MAY 2020 TEMPORARY HELP -1 HH, 1HE, 3 MS	VARIOUS
T4654	DELAWIE****	20,325.93	20,325.93	1ST QTR 2020 ARCHITECTURAL SERVICES	CAPITAL PROJECT - NEW BUILDING
T4609	GREGORY D. BYNUM AND ASSOCIATES, INC.****	20,000.00	20,000.00	CONSTRUCTION CLOSE OUT (SERVICES COMPLETED DURING 2019)	ADMINISTRATION
T5026	TEL-TEC SECURITY SYSTEMS*****	18,456.31	66,538.25	(3) ADDITIONAL SECURITY CAMERAS	CAPITAL PROJECT
T4501	ALLIED UNIVERSAL SECURITY SERVICES	18,265.38	98,731.96	MARCH & APRIL 2020 ONSITE SECURITY	CORPORATE SERVICES
T2167	PG&E	17,811.96	111,061.82	4/17/20-5/17/20 USAGE/UTILITIES	CORPORATE SERVICES
T4460	PAYSPAN, INC	17,559.68	94,714.29	APRIL 2020 ELECTRIC CLAIMS/PAYMENTS	FINANCE
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	16,295.29	119,845.21	APRIL 2020 EDI CLAIM PROCESSING	CLAIMS
T4696	ZNALYTICS, LLC	15,840.00	65,520.00	APRIL 2020 PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE MANAGEMENT
T4967	ADMINISTRATIVE SOLUTIONS, INC.	14,807.50	81,938.20	MAY 2020 FSA EMPLOYEE PREMIUM	VARIOUS
T4781	EDRINGTON HEALTH CONSULTING, LLC*****	14,606.25	25,018.75	MARCH - APRIL 2020 CONSULTING SERVICES	ADMINISTRATION

KERN·HEALTH SYSTEMS

May AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T3011	OFFICE ALLY, INC.	14,352.75	80,937.00	MAY 2020 EDI CLAIM PROCESSING	CLAIMS
T5260	HD DYNAMICS*****	14,283.75	19,353.75	APRIL- MAY 2020 SYSTEM CONFIGURATION, CUSTOMIZATION, &	PROVIDER RELATIONS
T5145	CCS ENGINEERING FRESNO INC.,	13,831.68	50,506.72	APRIL 2020 JANITORIAL SERVICES & PORTER FEES	CORPORATE SERVICES
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	13,098.36	63,831.99	MARCH 2020 EDI PROCESSING	CLAIMS
T4396	KAISER FOUNDATION HEALTH-DHMO*****	12,775.06	63,875.30	MAY 2020 DHMO EMPLOYEE HEALTH BENEFITS	HUMAN RESOURCES
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	12,543.28	62,830.76	APRIL 2020 ACCIDENT & CRITICAL ILLNESS EMPLOYEE PREMIUM	VARIOUS
T5185	HOUSING AUTHORITY COUNTY OF KERN	12,500.00	65,800.00	DECEMBER 2019 HOUSING AUTHORITY GRANT	COMMUNITY GRANT
T5251	PREVALENT, INC.****	11,412.25	11,412.25	ANNUAL SAAS SUBSCRIPTION	MIS INFRASTRUCTURE
T5279	GOOD SAMARITAN HEALTH FOUNDATION****	10,000.00	10,000.00	COVID-19 TESTING SITE SUPPORT-SPONSORSHIP	COMMUNITY ACTIVITIES
		2,091,029.35			
	TOTAL VENDORS OVER $10,000	2,091,029.35			
	TOTAL VENDORS UNDER $10,000	220,054.05			
	TOTAL VENDOR EXPENSES- MAY	$ 2,311,083.40			

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

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	2,261,913.18	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	1,511,845.76	HEALTH HOMES AND PROVIDER QUAILITY CARE GRANT	COMMUNITY GRANTS
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	999,858.74	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.	617,088.71	PHARMACY CLAIMS	PHARMACY
T4237	FLUIDEDGE CONSULTING, INC.	552,878.17	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
T3130	OPTUMINSIGHT, INC.****	399,294.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T5111	ENTISYS 360	355,345.81	HARDWARE- 2 NUTANIX PLATFORM WITH SUPPORT	CAPITAL PROJECT
T4483	INFUSION AND CLINICAL SERVICES, INC.	328,688.85	HEALTH HOMES GRANT	COMMUNITY GRANT
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	319,601.35	VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO	235,758.22	NEW BUILDING FURNITURE (LIVE STREAM VIA IP)	CAPITAL PROJECT - NEW BUILDING
T4582	HEALTHX, INC.	201,880.00	2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T4193	STRIA LLC	183,072.35	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
T4165	SHI INTERNATIONAL CO.	159,350.09	STANDING WORKING STATIONS & LICENSES FEES	VARIOUS
T5217	AMERICAN TILE & BRICK VENEER, INC.	157,500.00	FINAL PAYMENT FOR BRICK WALL	BUILDING IMPROVEMENT
T2458	HEALTHCARE FINANCIAL, INC.	155,000.00	PROFESSIONAL SERVICES	ADMINISTRATION
T5269	KERN COMMUNITY FOUNDATION	150,000.00	HEALTH HOME GRANT	COMMUNITY GRANT
T5109	RAND EMPLOYMENT SOLUTIONS	149,080.56	TEMPORARY HELP	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	119,845.21	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4733	UNITED STAFFING ASSOCIATES	117,437.63	TEMPORARY HELP	VARIOUS
T2167	PG&E	111,061.82	USAGE/UTILITIES	CORPORATE SERVICES
T4657	DAPONDE SIMPSON ROWE PC	104,612.00	LEGAL SERVICES	PROVIDER RELATIONS
T2918	STINSON'S	102,867.50	2020 OFFICE SUPPLIES, CONFERENCE TABLES, OFFICE FURNITURE, CABINET FOR TRAINING & DEVELOPMENT ROOM	VARIOUS
T2584	UNITED STATES POSTAL SVC.-HASLER	100,000.00	TEMPORARY HELP	VARIOUS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	98,731.96	ONSITE SECURITY	CORPORATE SERVICES
T4460	PAYSPAN, INC	94,714.29	ELECTRONIC CLAIMS/PAYMENTS & PPD REIMBURSEMENTS	FINANCE
T4967	ADMINISTRATIVE SOLUTIONS, INC.	81,938.20	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T4785	COMMGAP	81,095.00	INTERPRETATION SERVICES	HEALTH EDUCATION
T3011	OFFICE ALLY, INC.	80,937.00	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T1272	COFFEY COMMUNICATIONS INC.	78,344.43	MEMBER NEWSLETTER/ WEBSITE IMPLEMENTATION	HEALTH EDUCATION/ MIS INFRASTRUCTURE

Year to Date AP Vendor Report
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
T4038	POLYCLINIC MEDICAL CENTER, INC	73,560.19	HEALTH HOME AND PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
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
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	70,012.63	TEMPORARY HELP	VARIOUS
T1861	CERIDIAN HCM, INC.	68,660.71	MONTHLY SUBSCRIPTION FEES,PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT IMPLEMENTATION & AMENDMENTS	HUMAN RESOURCES
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	67,600.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T5026	TEL-TEC SECURITY SYSTEMS	66,538.25	ADDITIONAL SECURITY SYSTEM & LABOR	CORPORATE SERVICES
T5185	HOUSING AUTHORITY COUNTY OF KERN	65,800.00	HOUSING AUTHORITY GRANT	UM
T4696	ZNALYTICS, LLC	65,520.00	PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE MANAGEMENT
T4396	KAISER FOUNDATION HEALTH-DHMO	63,875.30	EMPLOYEE HEALTH BENEFITS - DHMO	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	63,831.99	EDI CLAIM PROCESSING	CLAIMS / MIS
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	62,830.76	EMPLOYEE PREMIUM - ACCIDENT & CRITICAL ILLNESS	VARIOUS
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	55,135.00	2019 AUDIT FEES	ADMINISTRATION
T4699	ZeOMEGA, INC.	54,846.52	PROFESSIONAL SERVICES AND TRAVEL EXP.	UM
T4265	SIERRA SCHOOL EQUIPMENT COMPANY	52,428.83	NEW FURNITURE & OFFICE CHAIRS FOR EMOPLYEES	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
T4963	LINKEDIN CORPORATION	52,000.00	JUNIPER NETWORKS - FIBER OPTICS	MIS INFRASTRUCTURE
T1128	HALL LETTER SHOP, INC.	51,649.85	NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, CLINICAL CARE MANUAL FOR HH, NEW MEMBER PACKETS	VARIOUS
T5145	CCS ENGINEERING FRESNO INC.,	50,506.72	JANITORIAL SERVICES	CORPORATE SERVICES
T4634	EXECUTIVE STAFFING SOLUTIONS****	49,999.00	RECRUITMENT FEES	HUMAN RESOURCES
T5227	RIDGECREST MEDICAL TRANSPORTATION	48,380.33	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T3001	MERCER	47,500.00	CONSULTING SERVICES	HUMAN RESOURCES
T3449	CDW GOVERNMENT	46,392.63	HARDWARE& COMPUTER SUPPLIES	VARIOUS
T2969	AMERICAN BUSINESS MACHINES INC	42,793.22	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T5132	TIME WARNER CABLE LLC	42,493.88	INTERNET SERVICES	MIS INFRASTRUCTURE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	41,921.95	PROFESSIONAL SERVICES	VARIOUS
T2955	DELTA ELECTRIC INC.	41,710.00	BUILDING MAINTENANCE	CORPORATE SERVICES
T4389	EXACT STAFF, INC.	37,874.68	TEMPORARY HELP	VARIOUS
T5121	TPx COMMUNICATIONS	35,380.54	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	33,400.00	COMMUNITY SPONSORSHIP	ADMINISTRATION
T2413	TREK IMAGING INC	33,373.19	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	32,512.00	2020 ANNUAL DUES & CONFERENCE REGISTRATION	VARIOUS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4731	LOGMEIN USA, INC.	32,367.00	INTERNET SERVICES	MIS INFRASTRUCTURE
T4792	KP LLC	27,944.03	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PROVIDER RELATIONS/PHARMACY
T2446	AT&T MOBILITY	27,080.80	CELLULAR PHONE / INTERNET USAGE	MIS INFRASTRUCTURE
T4503	VISION SERVICE PLAN	26,558.01	EMPLOYEE HEALTH BENEFITS	VARIOUS
T1180	LANGUAGE LINE SERVICES INC.	25,132.19	INTERPRETATION SERVICES	MEMBER SERVICES
T2232	DLT SOLUTIONS, LLC	25,022.27	SQL LICENSES	MIS INFRASTRUCTURE
T4781	EDRINGTON HEALTH CONSULTING, LLC	25,018.75	CONSULTING SERVICES	ADMINISTRATION
T3454	DEPARTMENT OF MANAGED HEALTH CARE	25,000.00	ENFORCEMENT MATTERS	ADMINISTRATION
T1022	UNUM LIFE INSURANCE CO.	23,623.20	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T3986	JACQUELYN S. JANS	22,775.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T3084	KERN COUNTY-COUNTY COUNSEL	22,042.11	LEGAL FEES	ADMINISTRATION
T4546	LEVEL 3 COMMUNICATIONS, LLC	21,169.97	DISASTER RECOVERY, INTERNET, LONG DISTANCE CALLS	MIS INFRASTRUCTURE
T4960	ZELIS CLAIMS INTEGRITY, LLC	20,345.73	POST EDITING SYSTEMS FOR CLAIMS PROCESSING	CLAIMS
T4654	DELAWIE****	20,325.93	1ST QTR 2020 ARCHITECTURAL SERVICES	CAPITAL PROJECT
T4609	GREGORY D. BYNUM AND ASSOCIATES, INC.****	20,000.00	CONSTRUCTION CLOSE OUT (SERVICES COMPLETED DURING 2019)	CAPITAL PROJECT/ NEW BUILDING
T4873	L5 HEALTHCARE SOLUTIONS, INC.	19,414.47	LICENSE AND SUPPORT FEES - CLAIMS AUDIT TOOL	MIS INFRASTRUCTURE
T5260	HD DYNAMICS	19,353.75	2020 SYSTEM CONFIGURATION, CUSTOMIZATION, & PROJECT MANAGEMENT	PROVIDER RELATIONS
T4466	SMOOTH MOVE USA	18,643.87	MOVING SERVICES	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
T5226	SAN MICHAEL PEDIATRICS INC.	18,525.30	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5240	ACE EYECARE INC	18,000.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4216	NEXSTAR BROADCASTING INC	17,850.00	ADVERTISEMENT - MEDIA	MARKETING
T4239	COAST TO COAST COMPUTER PRODUCTS	17,615.71	COMPUTER PRODUCTS & SUPPLIES	CORPORATE SERVICES
T4228	THE SSI GROUP, LLC.	17,546.00	EDI CLAIM PROCESSING	CLAIMS / MIS
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	17,490.00	CONSULTING SERVICES	ADMINISTRATION
T2441	LAURA J. BREZINSKI	17,425.00	MARKETING MATERIALS	MARKETING
T2941	KERN PRINT SERVICES INC.	17,191.13	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T4182	THE LAMAR COMPANIES	16,740.00	OUTDOOR ADVERTISEMENT-BILLBOARDS	ADVERTISING
T4521	PAYSCALE, INC.	16,000.00	COMPENSATION STUDY AND SALARY ANALYTICS	HUMAN RESOURCES
T5236	BEST BEST & KRIEGER LLP	15,389.24	LEGAL FEES	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
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
T2933	SIERRA PRINTERS, INC.	12,581.48	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
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

KERN•HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
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
T5258	GOOD SAMARITAN HOSPITAL, LLC	11,605.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5251	PREVALENT, INC.****	11,412.25	ANNUAL SAAS SUBSCRIPTION	MIS INFRASTRUCTURE
T2686	ALLIANT INSURANCE SERVICES INC.	11,183.88	PROPERTY AND LIABILITY COVERAGE UPDATES	ADMINISTRATION
T4683	CLAUDIA M. BACA PROJECT MANAGEMENT CONSULTING	11,000.00	PROJECT MANAGEMENT CONSULTING SERVICES	PROJECT MANAGEMENT
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO., INC.****	10,795.50	2020 BUILDING MAINTENANCE	CORPORATE SERVICE
T2840	ATALASOFT, INC.	10,254.00	DOT IMAGING RENEWAL	MIS INFRASTRUCTURE
T5262	YOUTH CONNECTION, INC.	10,000.00	COMMUNITY SPONSORSHIP	COMMUNITY ACTIVITIES
T5279	GOOD SAMARITAN HEALTH FOUNDATION****	10,000.00	COVID-19 TESTING SITE SUPPORT-SPONSORSHIP	COMMUNITY ACTIVITIES
		15,703,339.11		
	TOTAL VENDORS OVER $10,000	15,703,339.11		
	TOTAL VENDORS UNDER $10,000	574,108.90		
	TOTAL VENDOR EXPENSES- May	**$ 16,277,448.01**		

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

KERN • HEALTH SYSTEMS

June AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	915,468.86	3,177,382.04	JUNE & JULY 2020 HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T2686	ALLIANT INSURANCE SERVICES INC.****	487,271.03	498,454.91	2020 -2021 ANNUAL INSURANCE & ACIP CRIME PREMIUM	ADMINISTRATION
T4350	COMPUTER ENTERPRISE INC.****	388,845.44	1,196,726.35	APRIL & MAY PROFESSIONAL SERVICES / CONSULTING SERVICES	CAPITAL PROJECTS IN PROCESS/ MIS
T2726	DST PHARMACY SOLUTIONS, INC.	103,992.55	721,081.26	MAY 2020 PHARMACY CLAIMS	PHARMACY
T4391	OMNI FAMILY HEALTH	96,523.24	1,608,369.00	MARCH 2020 HEALTH HOME GRANT (OILDALE & SHAFTER)	COMMUNITY GRANT
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	89,907.81	1,089,766.55	APRIL 2020 HEALTH HOME GRANT	COMMUNITY GRANT
T4237	FLUIDEDGE CONSULTING, INC.	87,440.00	640,318.17	MAY - JUNE 2020 PROFESSIONAL SERVICES/ CONSULTING SERVICES & 2019 TRAVEL EXP.	VARIOUS
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.****	66,782.03	108,703.98	APRIL & MAY 2020 PROFESSIONAL SERVICES, MAY 2020 QNXT MAINT.	VARIOUS
T4982	NGC US, LLC****	60,000.00	521,510.99	PREFUND HEALTH HOMES INCENTIVES	HEALTH HOMES
T3130	OPTUMINSIGHT, INC.	54,270.00	453,564.00	2019 - 2020 CES FACILITY LICENSE-INCREMENTAL	MIS INFRASTRUCTURE
T4634	EXECUTIVE STAFFING SOLUTIONS	49,999.00	99,998.00	FINAL PAYMENT - DIRECTOR OF COMPLIANCE RECRUITMENT FEE	HUMAN RESOURCES
T5005	CRAYON SOFTWARE EXPERTS LLC****	48,760.26	449,503.86	JANUARY- APRIL 2020 AZURE OVERAGE ESD	MIS INFRASTRUCTURE

KERN • HEALTH SYSTEMS

June AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T1408	DELL MARKETING L.P.****	41,196.13	113,638.66	(2) 4-CELL BATTERY, (20) RAM FOR DESKTOPS, & (6) VMWARE LICENSES	MIS INFRASTRUCTURE, CAPITAL PROJECT
T4582	HEALTHX, INC.	40,376.00	242,256.00	JUNE 2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T2584	UNITED STATES POSTAL SVC.-HASLER****	40,000.00	140,000.00	4TH POSTAGE (METER) FUND	CORPORATE SERVICES
T3449	CDW GOVERNMENT	37,526.70	83,919.33	(15) CISCO PHONE, CIO EQUIPMENT, ADOBE INDESIGN LICENSE, (90)	MIS INFRASTRUCTURE
T5145	CCS ENGINEERING FRESNO INC.,	22,148.91	72,655.63	MAY & JUNE 2020 JANITORIAL SERVICES & PORTER FEES	CORPORATE SERVICES
T4165	SHI INTERNATIONAL CO.	32,834.31	192,184.40	(450) PROOFPOINT LICENSES, FORTIGATE VIRTUAL APPLIANCE LICENSES, & (20) WEBCAMS	MIS INFRASTRUCTURE
T4193	STRIA LLC	28,303.66	211,376.01	MAY & JUNE 2020 OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T5132	TIME WARNER CABLE LLC****	26,716.74	69,210.62	MAY & JUNE 2020 INTERNET SERVICES	MIS INFRASTRUCTURE
T2458	HEALTHCARE FINANCIAL, INC.	26,000.00	181,000.00	MAY 2020 PROFESSIONAL SERVICES	ADMINISTRATION
T4396	KAISER FOUNDATION HEALTH-DHMO	25,550.12	89,425.42	JUNE & JULY 2020 DHMO EMPLOYEE HEALTH BENEFITS	HUMAN RESOURCES
T2167	PG&E	24,035.40	135,097.22	5/18/20-6/16/20 USAGE/UTILITIES	CORPORATE SERVICES
T5026	TEL-TEC SECURITY SYSTEMS	23,728.63	90,266.88	EQUIPMENT - (2) STAND ALONG TEMP CAMERAS	CORPORATE SERVICES
T1022	UNUM LIFE INSURANCE CO.****	20,921.20	44,544.40	MAY, JUN, & JUL 2020 EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	19,616.08	83,448.07	APRIL 2020 EDI PROCESSING	CLAIMS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	19,155.57	117,887.53	MAY & JUNE 2020 ONSITE SECURITY	CORPORATE SERVICES

KERN•HEALTH SYSTEMS

June AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T5185	HOUSING AUTHORITY COUNTY OF KERN	18,700.00	84,500.00	FEBRUARY 2020 HOUSING AUTHORITY GRANT	COMMUNITY GRANT
T4967	ADMINISTRATIVE SOLUTIONS, INC.	17,232.50	99,170.70	JUNE 2020 FSA EMPLOYEE PREMIUM & MARCH, APRIL, MAY SECTION 125	VARIOUS
T1861	CERIDIAN HCM, INC.	16,782.25	85,442.96	MAY & JUN 2020 MONTHLY SUBSCRIPTION FEES,PROFESSIONAL SERVICES	HUMAN RESOURCES
T4963	LINKEDIN CORPORATION****	16,775.00	68,775.00	ANNUAL SUBSCRIPTION -CORPORATE	HUMAN RESOURCES
T4563	SPH ANALYTICS	16,561.80	30,343.80	2020 CAHPS SIMUATION SURVEY - FINAL PAYMENT	PROVIDER RELATIONS
T4696	ZNALYTICS, LLC	15,200.00	80,720.00	MAY 2020 PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	14,522.58	134,367.79	MAY 2020 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T2787	SAGE SOFTWARE, INC****	14,381.75	14,381.75	2020 - 2021 SAGE300 ERP SILVER BUSINESS CARE & (1) ADDITIONAL USERS	FINANCE
T3011	OFFICE ALLY, INC.	13,675.50	94,612.50	MAY 2020 EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM F	12,673.26	75,504.02	MAY 2020 ACCIDENT & CRITICAL ILLNESS EMPLOYEE PREMIUM	VARIOUS
T4460	PAYSPAN, INC	12,655.99	107,370.28	MAY 2020 ELECTRIC CLAIMS/PAYMENTS	FINANCE
T4733	UNITED STAFFING ASSOCIATES	12,557.86	129,995.49	MAY - JUNE 2020 TEMPORARY HELP -1 HH, 1HE, 1 MS	VARIOUS
T5109	RAND EMPLOYMENT SOLUTIONS	12,317.77	161,398.33	MAY - JUNE 2020 TEMP SERVICES- 4 MS, 1 HED	VARIOUS

KERN • HEALTH SYSTEMS

June AP Vendor Report
Amounts over $10,000.00

Vendor No.	Vendor Name	Current Month	Year-to- Date	Description	Department
T4699	ZeOMEGA, INC.****	12,000.00	66,846.52	APRIL - MAY PROFESSIONAL SERVICES	UM
T1189	APPLE ONE INC, EMPLOYMENT SERVICES****	11,720.63	81,733.26	MAY - JUNE 2020 TEMP SERVICES- 1 MIS	MIS INFRASTRUCTURE
		3,095,126.56			
	TOTAL VENDORS OVER $10,000	3,095,126.56			
	TOTAL VENDORS UNDER $10,000	307,529.27			
	TOTAL VENDOR EXPENSES- JUNE	**3,402,655.83**			

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

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	3,177,382.04	HMO EMPLOYEE HEALTH BENEFITS	VARIOUS
T4391	OMNI FAMILY HEALTH	1,608,369.00	HEALTH HOMES AND PROVIDER QUAILITY CARE GRANT	COMMUNITY GRANTS
T4290	S.C. ANDERSON, INC.	1,555,742.74	NEW BUILDING RETAINER	CAPITAL PROJECT - NEW BUILDING
T4350	COMPUTER ENTERPRISE INC.	1,196,726.35	PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	CAPITAL PROJECTS IN PROCESS/ MIS
T5229	DIGNITY HEALTH MEDICAL GROUP - BAKERSFIELD	1,089,766.55	HEALTH HOMES GRANT	COMMUNITY GRANTS
T2726	DST PHARMACY SOLUTIONS, INC.	721,081.26	PHARMACY CLAIMS	PHARMACY
T4237	FLUIDEDGE CONSULTING, INC.	640,318.17	PROFESSIONAL SERVICES / CONSULTING SERVICES & TRAVEL EXP.	VARIOUS
T4982	NGC US, LLC	521,510.99	PREFUND HEALTH HOMES INCENTIVES & HE MEMBER INCENTIVES	VARIOUS
T2686	ALLIANT INSURANCE SERVICES INC.	498,454.91	ANNUAL INSURANCE & ACIP CRIME PREMIUMS	ADMINISTRATION
T3130	OPTUMINSIGHT, INC.	453,564.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T5005	CRAYON SOFTWARE EXPERTS LLC	449,503.86	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.	328,688.85	HEALTH HOMES GRANT	COMMUNITY GRANT
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	319,601.35	VOLUNTARY LIFE, AD&D, DENTAL INSURANCE	VARIOUS
T4582	HEALTHX, INC.	242,256.00	2020 MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC.	235,758.22	NEW BUILDING FURNITURE (LIVE STREAM VIA IP)	CAPITAL PROJECT - NEW BUILDING

KERN • HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4193	STRIA LLC	211,376.01	OCR SERVICES AND PROFESSIONAL SERVICES	CLAIMS
T4165	SHI INTERNATIONAL CO.	192,184.40	STANDING WORKING STATIONS & LICENSES FEES	VARIOUS
T2458	HEALTHCARE FINANCIAL, INC.	181,000.00	PROFESSIONAL SERVICES	ADMINISTRATION
T5109	RAND EMPLOYMENT SOLUTIONS	161,398.33	TEMPORARY HELP	VARIOUS
T5217	AMERICAN TILE & BRICK VENEER, INC.	157,500.00	FINAL PAYMENT FOR BRICK WALL	BUILDING IMPROVEMENT
T5269	KERN COMMUNITY FOUNDATION	150,000.00	HEALTH HOME GRANT	COMMUNITY GRANT
T2584	UNITED STATES POSTAL SVC.-HASLER	140,000.00	TEMPORARY HELP	VARIOUS
T2167	PG&E	135,097.22	USAGE/UTILITIES	CORPORATE SERVICES
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	134,367.79	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4733	UNITED STAFFING ASSOCIATES	129,995.49	TEMPORARY HELP	VARIOUS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	117,887.53	ONSITE SECURITY	CORPORATE SERVICES
T1408	DELL MARKETING L.P.	113,638.66	HARDWARE & CUMPUTER EQUIPMENT	MIS INFRASTRUCTURE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	108,703.98	PROFESSIONAL SERVICES	VARIOUS
T4460	PAYSPAN, INC	107,370.28	ELECTRONIC CLAIMS/PAYMENTS & PPD REIMBURSEMENTS	FINANCE
T4657	DAPONDE SIMPSON ROWE PC	104,612.00	LEGAL SERVICES	PROVIDER RELATIONS
T2918	STINSON'S	103,576.83	2020 OFFICE SUPPLIES, CONFERENCE TABLES, OFFICE FURNITURE, CABINET FOR TRAINING & DEVELOPMENT ROOM	VARIOUS

KERN • HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4634	EXECUTIVE STAFFING SOLUTIONS	99,998.00	RECRUITMENT FEES	HUMAN RESOURCES
T4967	ADMINISTRATIVE SOLUTIONS, INC.	99,170.70	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T3011	OFFICE ALLY, INC.	94,612.50	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T5026	TEL-TEC SECURITY SYSTEMS	90,266.88	ADDITIONAL SECURITY SYSTEM & LABOR	CORPORATE SERVICES
T4396	KAISER FOUNDATION HEALTH-DHMO	89,425.42	EMPLOYEE HEALTH BENEFITS - DHMO	VARIOUS
T1861	CERIDIAN HCM, INC.	85,442.96	MONTHLY SUBSCRIPTION FEES,PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT IMPLEMENTATION & AMENDMENTS	HUMAN RESOURCES
T4785	COMMGAP	85,360.00	INTERPRETATION SERVICES	HEALTH EDUCATION
T5185	HOUSING AUTHORITY COUNTY OF KERN	84,500.00	HOUSING AUTHORITY GRANT	UM
T3449	CDW GOVERNMENT	83,919.33	HARDWARE & COMPUTER SUPPLIES	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	83,448.07	EDI CLAIM PROCESSING	CLAIMS / MIS
T1272	COFFEY COMMUNICATIONS INC.	82,311.52	MEMBER NEWSLETTER/ WEBSITE IMPLEMENTATION	HEALTH EDUCATION/ MIS INFRASTRUCTURE
T1189	APPLE ONE INC, EMPLOYMENT SERVICES	81,733.26	TEMPORARY HELP	VARIOUS
T4038	POLYCLINIC MEDICAL CENTER, INC	81,418.51	HEALTH HOME AND PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4696	ZNALYTICS, LLC	80,720.00	PROFESSIONAL SERVICES	CAPITAL PROJECT-CASE MANAGEMENT/DISEASE MANAGEMENT
T1005	COLONIAL LIFE & ACCIDENT ATTN PREMIUM PROCESSING	75,504.02	EMPLOYEE PREMIUM - ACCIDENT & CRITICAL ILLNESS	VARIOUS
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	75,500.00	2020 ANNUAL DUES, 2019 SALARY SURVEY, & LEADERSHIP FEES	VARIOUS

KERN • HEALTH SYSTEMS

Year to Date AP Vendor Report
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
T5145	CCS ENGINEERING FRESNO INC.,	72,655.63	JANITORIAL SERVICES	CORPORATE SERVICES
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	70,720.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T5132	TIME WARNER CABLE LLC	69,210.62	INTERNET SERVICES	MIS INFRASTRUCTURE
T4963	LINKEDIN CORPORATION	68,775.00	JUNIPER NETWORKS - FIBER OPTICS	MIS INFRASTRUCTURE
T4699	ZeOMEGA, INC.	66,846.52	PROFESSIONAL SERVICES AND TRAVEL EXP.	UM
T1128	HALL LETTER SHOP, INC.	57,026.89	NEW MEMBER LETTER/ENVELOPES, MEMBER HANDBOOKS, CLINICAL CARE MANUAL FOR HH, NEW MEMBER PACKETS	VARIOUS
T5227	RIDGECREST MEDICAL TRANSPORTATION	56,065.49	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	55,135.00	2019 AUDIT FEES	ADMINISTRATION
T4265	SIERRA SCHOOL EQUIPMENT COMPANY	52,428.83	NEW FURNITURE & OFFICE CHAIRS FOR EMPLOYEES	CORPORATE SERVICES
T3001	MERCER	47,500.00	CONSULTING SERVICES	HUMAN RESOURCES
T1022	UNUM LIFE INSURANCE CO.	44,544.40	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T2969	AMERICAN BUSINESS MACHINES INC	44,403.11	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T5121	TPx COMMUNICATIONS	42,480.43	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T2955	DELTA ELECTRIC INC.	41,710.00	BUILDING MAINTENANCE	CORPORATE SERVICES
T4389	EXACT STAFF, INC.	37,874.68	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
T2446	AT&T MOBILITY	34,988.34	CELLULAR PHONE / INTERNET USAGE	MIS INFRASTRUCTURE
T4731	LOGMEIN USA, INC.	33,690.00	INTERNET SERVICES	MIS INFRASTRUCTURE
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	33,400.00	COMMUNITY SPONSORSHIP	ADMINISTRATION
T2413	TREK IMAGING INC	33,373.19	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	32,512.00	2020 ANNUAL DUES & CONFERENCE REGISTRATION	VARIOUS
T4503	VISION SERVICE PLAN	31,974.60	EMPLOYEE HEALTH BENEFITS	VARIOUS
T4792	KP LLC	30,749.67	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PROVIDER RELATIONS/PHARMACY
T1180	LANGUAGE LINE SERVICES INC.	30,699.02	INTERPRETATION SERVICES	MEMBER SERVICES
T4563	SPH ANALYTICS	30,343.80	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T5260	HD DYNAMICS	27,611.25	2020 SYSTEM CONFIGURATION, CUSTOMIZATION, & PROJECT MANAGEMENT	PROVIDER RELATIONS
T3986	JACQUELYN S. JANS	27,375.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T3084	KERN COUNTY-COUNTY COUNSEL	26,682.11	LEGAL FEES	ADMINISTRATION
T2232	DLT SOLUTIONS, LLC	25,733.63	SQL LICENSES	MIS INFRASTRUCTURE
T4781	EDRINGTON HEALTH CONSULTING, LLC	25,018.75	CONSULTING SERVICES	ADMINISTRATION
T3454	DEPARTMENT OF MANAGED HEALTH CARE	25,000.00	ENFORCEMENT MATTERS	ADMINISTRATION
T2441	LAURA J. BREZINSKI	24,225.00	MARKETING MATERIALS	MARKETING
T5226	SAN MICHAEL PEDIATRICS INC.	22,971.86	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4960	ZELIS CLAIMS INTEGRITY, LLC	22,547.20	POST EDITING SYSTEMS FOR CLAIMS PROCESSING	CLAIMS

KERN • HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2941	KERN PRINT SERVICES INC.	21,776.06	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T4546	LEVEL 3 COMMUNICATIONS, LLC	21,169.97	DISASTER RECOVERY, INTERNET, LONG DISTANCE CALLS	MIS INFRASTRUCTURE
T4216	NEXSTAR BROADCASTING INC	20,782.50	ADVERTISEMENT - MEDIA	MARKETING
T4654	DELAWIE	20,325.93	1ST QTR 2020 ARCHITECTURAL SERVICES	CAPITAL PROJECT
T4609	GREGORY D. BYNUM AND ASSOCIATES, INC.	20,000.00	CONSTRUCTION CLOSE OUT (SERVICES COMPLETED DURING 2019)	CAPITAL PROJECT/ NEW BUILDING
T4873	L5 HEALTHCARE SOLUTIONS, INC.	19,414.47	LICENSE AND SUPPORT FEES - CLAIMS AUDIT TOOL	MIS INFRASTRUCTURE
T4228	THE SSI GROUP, LLC.	19,085.20	EDI CLAIM PROCESSING	CLAIMS / MIS
T4466	SMOOTH MOVE USA	19,033.87	MOVING SERVICES	CORPORATE SERVICES
T2933	SIERRA PRINTERS, INC.	18,282.83	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T5240	ACE EYECARE INC	18,000.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T4239	COAST TO COAST COMPUTER PRODUCTS	17,615.71	COMPUTER PRODUCTS & SUPPLIES	CORPORATE SERVICES
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	17,490.00	CONSULTING SERVICES	ADMINISTRATION
T4182	THE LAMAR COMPANIES	16,740.00	OUTDOOR ADVERTISEMENT-BILLBOARDS	ADVERTISING
T4521	PAYSCALE, INC.	16,000.00	COMPENSATION STUDY AND SALARY ANALYTICS	HUMAN RESOURCES
T5236	BEST BEST & KRIEGER LLP	15,389.24	LEGAL FEES	ADMINISTRATION
T1183	MILLIMAN USA	14,756.25	CY2018/2019 RDT & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T5201	JAC SERVICES, INC.	14,535.00	SPRING 2020 AC MAINTENANCE & SERVICE	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
T2787	SAGE SOFTWARE, INC****	14,381.75	2019-20 SAGE300 ERP SILVER BUSINESS ANNUAL LICENSE	FINANCE
T2562	CACTUS SOFTWARE LLC	14,131.31	SOFTWARE LICENSE	MIS INFRASTRUCTURE
T5155	A-C ELECTRIC COMPANY****	13,939.58	BUILDING MAINTENANCE	CORPORATE SERVICES
T1650	UNIVISION TELEVISION GROUP****	12,877.50	ADVERTISEMENT - TELEVISION	MARKETING
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
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO., INC.	12,302.50	2020 BUILDING MAINTENANCE	CORPORATE SERVICE
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA****	12,259.25	EMPLOYEE PREMIUM	ADMINISTRATION
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
T5258	GOOD SAMARITAN HOSPITAL, LP	11,605.00	PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5251	PREVALENT, INC.	11,412.25	ANNUAL SAAS SUBSCRIPTION	MIS INFRASTRUCTURE
T3092	LINKS FOR LIFE****	11,000.00	COMMUNITY ACTIVITIES-SPONSORSHIP	MARKETING
T4683	CLAUDIA M. BACA PROJECT MANAGEMENT CONSULTING	11,000.00	PROJECT MANAGEMENT CONSULTING SERVICES	PROJECT MANAGEMENT
T5159	AT&T CORP****	10,739.10	INTERNET SERVICES	MIS INFRASTRUCTURE
T4195	SCRIPPS MEDIA, INC. DBA KERO-TV****	10,515.00	ADVERTISEMENT - TELEVISION	MARKETING
T2840	ATALASOFT, INC.	10,254.00	DOT IMAGING RENEWAL	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

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

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5262	YOUTH CONNECTION, INC.	10,000.00	COMMUNITY SPONSORSHIP	COMMUNITY ACTIVITIES
T5270	ENFORCE, LLC****	10,000.00	DAYFORCE OPTIMIZATION & CONSULTING SERVICES	HUMAN RESOURCES
T5279	GOOD SAMARITAN HEALTH FOUNDATION	10,000.00	COVID-19 TESTING SITE SUPPORT-SPONSORSHIP	COMMUNITY ACTIVITIES
		18,995,622.29		
	TOTAL VENDORS OVER $10,000	18,995,622.29		
	TOTAL VENDORS UNDER $10,000	684,481.55		
	TOTAL VENDOR EXPENSES- June	**$ 19,680,103.84**		

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

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
April							
CDW-G	$44,942.40	Yes	IT	Richard Pruitt	Ninety (90) new IVR Cisco Unified licenses with support	4/6/2020	4/5/2021
Hall Letter Shop	$47,921.92	Yes	MS	Nate Scott	Print and mail COVID19 letters to KHS households	4/6/2020	4/30/2020
Agility Recovery	$30,000.00	Yes	IT	Richard Pruitt	Rental of Laptops	4/30/2020	8/1/2020
SHI	$64,913.60	Yes	IT	Richard Pruitt	Cisco Smartnet co-term and 70 new licenses	4/23/2020	4/22/2021
May							
Dell	$40,258.32	Yes	IT	Richard Pruitt	Six (6) new VMware licenses with maintenance and support	5/1/2020	4/30/2025
June							
Milliman	$50,000.00	Yes	ACCT	Robin Plumb	Actuarial Services (IBNP, ACA OE MLR, CMS ACA OE Audit)	6/1/2020	5/31/2021
MCG	$51,277.31	Yes	UM	Deborah Murr	Medical Care Clinical Guidelines (one month extension)	6/4/2020	7/4/2020
Edrington Health Consulting	$95,000.00	Yes	ACCT	Robin Plumb	Actuarial Services (RDT, SDRs & Rate Analysis)	6/1/2020	5/31/2021
Entisys360	$57,162.37	Yes	IT	Richard Pruitt	Nutanix AOS Single Node	6/24/2020	6/23/2023

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	$0	$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	$2,633									$12,150	$3,510
4	*QNXT Upgrade with NetworX and CES KB Update*	*EXP*	$20,760	$0	$0	$468	$0									$468	$20,292
5	*Hospital Directed Payments (HDP)/Encounters*	*EXP*	$14,705	$0	$0	$0	$0	$0								$0	$14,705
6	*HHP 2020 - CSV Health Homes*	*CA*	$135,903	$28,448	$10,918	$9,303	$6,695	$2,833								$58,197	$77,706
7	*HHP - Member Engagement*	*CA*	$50,988	$0	$1,442	$7,501	$824	$4,928								$14,695	$36,294
8	*Enterprise Data Warehouse*	*CA*	$738,400	$58,640	$53,835	$62,480	$62,355	$56,800								$294,110	$444,290
9	*HHP 2020 - Distributive Model*	*CA*	$149,771	$0	$412	$6,956	$14,983	$15,726								$38,077	$111,695
10	*Disaster Recovery and Business Continuity Test*	*CA*	$338,975	$56,200	$37,300	$37,940	$34,160	$23,520								$189,120	$149,855
11	*Rx PBM Transition*	*EXP*	$9,860					$0								$0	$9,860
12	*Auto Adjudication Enhancements*	*EXP*	$416,640				$13,990	$40,332								$54,322	$362,319
13	*MCAS Member Engagement*	*EXP*	$48,580				$5,880	$18,970								$24,850	$23,730
14	*Specialty Med Mgnt.*	*CA*	$56,321			$945	$9,450	$0								$10,395	$45,926
15	*Interoperability*	*CA*	$32,620					$0								$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	$150,779	$141,734								$723,603	$1,057,406
	Totals:	**Totals**	**$3,888,565**	**$286,269**	**$253,141**	**$289,072**	**$301,748**	**$304,841**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,435,071**	**$2,453,494**

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

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
August 13, 2020

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 08/05/2020				
Advanced Cardiology Medical Associates, Inc	Cardiovascular Disease / Interv. Cardiology	2601 16th Street Bakersfield CA 93301	New Ownership	9/1/2020
Adventist Health Physician Network	Multi-Specialty	2701 Chester Ave #202 Bakersfield CA 93301	Existing Credentialed Provider	9/1/2020
Autism Behavior Services, Inc.	ABA	4900 California Ave Tower B 2nd Flr Bakersfield CA 93309	Telehealth providers only	9/1/2020
Centric Health	PCP	4531 Buena Vista Rd #100 Bakersfield CA 93311	Existing Credentialed Provider	9/1/2020
Desert Sky Transit	Transportation	1601 Et Palmdale Blvd Ste. B Palmdale CA 93550		9/1/2020
Divinity Hospice	Hospice	3545 San Dimas Street Bakersfield CA 93301		9/1/2020
DV Therapy Inc.	Speech Therapy	1601 New Stine Rd #100 Bakersfield CA 93309		9/1/2020
Greater Bakersfield Dialysis Center LLC dba: Central Bakersfield Dialysis	Dialysis Center	5101 White Lane Ste A Bakersfield CA 93309		9/1/2020
Imad Abumeri, MD Inc. dba: Comprehensive Neurosurgery & Spine Institute	Neurological Surgery	2701 Chester Ave #102 Bakersfield CA 93301	New Individual Contract	9/1/2020
James E Holland	Clinical Social Worker	4646 Wilson Rd #101A Bakersfield CA 93309	Existing Credentialed Provider	9/1/2020
Kern County Regional Dialysis Center, LLC dba: North Bakersfield Dialysis	Dialysis Center	2661 Oswell Street Ste B Bakersfield CA 93306		9/1/2020
Lincare Inc.	DME	4300 Stine Road Ste. 603 Bakersfield CA 93313		9/1/2020
Link Medical Transport, LLC	Transportation	2540 F Street Suite A Bakersfield CA 93301		**Retro- Eff 8/1/20**
Marsinah Ramirez Buchan LMFT dba: Therapy Trec	Marriage & Family Therapy	6200 Lake Ming Avenue Unit 4-Ste A Bakersfield CA 93306		9/1/2020
Natera Inc	Laboratory	201 Industrial Rd #410 San Carlos CA 94070		9/1/2020

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
August 13, 2020

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
Pediatric For All Inc.	PCP	2700 F Street Ste. 210 Bakersfield CA 93301	New Tax ID - Existing Credentialed Provider	9/1/2020
STAT MD Urgent Care Inc	Walk-In PCP	5701 Young St Ste. C201 Bakersfield CA 93313	Existing Credentialed Provider	9/1/2020
Theodore Richard LCSW	Clinical Social Worker	930 Truxtun Ave Ste. 202 Bakersfield CA 93301	Existing Credentialed Provider	9/1/2020
Ultimate Family Orthopedics (UFO), Inc.	Orthopedic Surgery	8307 Brimhall Rd #1706 Bakersfield CA 93312		9/1/2020
VIPMD Corp (Specialist)	Multi-Specialty	2901 Sillect Ave Ste 201 Bakersfield CA 93308	Existing Credentialed Provider	9/1/2020
Wellbeing Rx Inc. dba: Rosecare Pharmacy	Pharmacy	1415 W. Rosamond Blvd Ste. 22 Rosamond CA 93560		9/1/2020
West Side Health Care District	Chiropractic	100 E North Street Taft CA 93268	Specialty contract adding Chiro services	9/1/2020

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
August 13, 2020

Legal Name DBA	Specialty	Address	Comments	Effective Date
Kern PM&R Associates Inc.	Physical Medicine and Rehabilitation	5001 Commerce Drive Bakersfield CA 93309	Provider moved out of Kern County	5/31/2020
Central California Medical Group, Inc.	General Surgery	432 Lexington St Ste. A Delano CA 93215	Business Dissolved	4/30/2020
Luke W. Deitz, MD	Ophthalmology	520 S San Vicente Blvd Los Angeles CA 90048	Termed Contract	6/1/2020
Metro Physicians Medical Group	Nephrology	2828 H Street Ste. F Bakersfield CA 93301	Termed Contract - Did not reapply	5/31/2020

TO: KHS Board of Directors

FROM: Alan Avery, COO

DATE: August 13, 2020

RE: 2nd Quarter 2020 Operations Report

I am pleased to report the KHS operational departments have continued to meet or exceed all regulatory and performance goals during the 2nd Quarter of 2020. This is remarkable considering all functions are being performed in 400+ remote locations as a result of the COVID-19 pandemic. We continue to meet all operational goals and regulatory requirements along with providing excellent customer service to our members and providers as we deal with the effects of COVID-19 challenges on our employees and their extended families.

Claims

Incoming claims receipts for the 2nd Quarter were down 20% due to the decreased hospital and physician billings for an overall claims volume of 667,768 for the quarter. During the month of July, we have seen the weekly claims volume picking up slightly due to provider offices expanding visits including telehealth visits. The Claims Management and Provider Network Management Teams continue to work with providers who are still submitting paper claims, offering training and hardware resources to encourage electronic billing submission. As a result of their ongoing focused efforts, we continue to experience a low percentage of claims being submitted on paper. The claims department continues to meet and often exceeds all regulatory payment requirements for the quarter-including claims processing timeliness and inventory measures. However, we slightly missed achieving our auto adjudication target, only reaching 80% for the quarter instead of the 82% goal. The claims department is working closely with the configuration, information technology and provider network management to increase this rate along with improving our overall quality and efficiency.

Member Services

Like the reduction in claim receipts in the 2nd Quarter, the Member Services Department experienced 57,207 incoming calls, a 26% reduction in the total number of member and provider calls during the 2nd Quarter. Outbound calls by the Member Service Representatives did not

decrease at the same level—as we only experienced a 16% reduction in outbound calls. This could be attributed to increased difficulty reaching provider offices, many who are closed or have reduced their hours. The top five reasons for members calling Member Services continues to remain the same: (1) New Member questions (2) PCP changes, (3) Demographic updates/changes (4) ID Card replacement requests and (5) authorization referral status. All these top five reasons for incoming calls could easily be handled by the member via the Member Portal, therefore, we continue to encourage members to sign onto the portal and use the self-service tools. During the 2nd quarter, Member Services received 2,500 new member portal account enrollments, for a total of 26,758 member accounts. This equates to 10.3% of our members with online accounts compared to industry standard of 4%. Member Service Representatives continue to encourage members to sign up for a member portal account whenever they call. With the closure of the office due to the COVID-19 pandemic, no in person member visits were allowed during the 2nd Quarter.

Provider Relations

Both the Primary Care Network and the Specialty Network met our targets for the 2nd quarter, remaining relatively flat. Provider terminations were minimal—similar to previous quarters with only a 2% reduction. Appointment availability for primary care providers barely met the regulatory standards @ 9.8 days for PCP visits however specialty providers visit availability was clearly compliant @ 5.4 days.

Human Resources

During the 2nd Quarter, the Human Resources Department continued to support the departments in meeting their staffing needs. During the quarter staffing reached 423 employees compared to a budget of 442. Employee turnover continued to be extremely positive with only 5.28% year to date. In addition to their regular talent acquisition, learning and development, employee wellness benefit, and payroll activities, Human Resources was also leading the development of our return to work plan.

Grievance Report

The total number of formal grievances for the 2nd Quarter decreased by 14% primarily in the Access to Care and Potential Inappropriate Care categories. The biggest drop was Exempt Grievances, a 38% decrease over the 1st quarter Exempt Grievances. Exempt grievances are primarily simple service-related complaints often addressed during the member call or the same day. Never-the-less, the State asks health plans to report these as well along with formal complaints. These include such things as PCP changes or complaints about the physical nature of the office or staff. The Grievance Department tracks and trends these by provider and results are reviewed by the KHS Physicians Advisory Committee as part of the recredentialing process.

Part two of the Grievance Report that I am required to report to the Board is the disposition of the Formal grievances. This report indicates what decision was made by the KHS Grievance Committee regarding the Formal grievances. Recently, another step was added sending all quality of care issues (Potential Inappropriate Care) to KHS's Quality Improvement (QI)

Department for further review, investigation and resolution. The QI Department will engage the appropriate health care provider(s) in discussion in order to come up with a suitable resolution.

Of the remaining 298 (505-207) grievances being reviewed by the Grievances Department, 63% of the original decision were upheld by the Grievance Committee, 5% were still under review and 32% were overturned and agreed with the members position. The primary reason for overturning the original decision of the grievance occurs when we receive additional supporting documentation from the member or the provider.

Transportation Update

Due to the pandemic, transportation activity during the 2nd quarter significantly decreased by 45% overall, with the largest decrease in the ride share (UBER) category @ 57%. NEMT or medical van transportation decreased by 10% during the quarter. Again, the major contributing factor for this decrease ridership was decreased patient demand caused by COVID concerns. In addition, UBER driver availability also decreased initially during the quarter as they too were concerned with potentially being exposed to COVID within their vehicles. After implementing mandatory mask wearing for both drivers and riders, driver availability has improved. KHS has also identified a transportation vendor who will transport COVID positive patients to appointments.

In order to increase the availability of NEMT medical van vehicles along with expanding the ride share capacity, KHS and Golden Empire Transit have entered a partnership arrangement to add new wheelchair accessible vans to our current bus only service. These attractive vans will provide exclusive service to KHS members as of August 1st. We project these new vans will increase access to our members along with providing a positive ride experience while supporting our local public transportation agency.

2020 2nd Quarter Operational Report

1

2nd Quarter 2020 Claims Department Indicators

Activity	Goal	2nd Quarter	Status	1st Quarter	4th Quarter 2019	3rd Quarter	2nd Quarter
Claims Received		**667,768**		843,576	785,806	788,199	764,979
Electronic	85%	**94%**		95%	93%	93%	92%
Paper	15%	**6%**		5%	7%	7%	8%
Claims Processed Within 30 days	90%	**96%**		93%	93%	92%	89%
Claims Processed within 45 days	95%	**99%**		99%	95%	98%	96%
Claims Processed within 90 days	99%	**99%**		99%	99%	99%	99%
Claims Inventory-Under 30 days	96%	**98%**		98%	97%	95%	96%
31-45 days	<3%	**1%**		1%	2%	4%	3%
Over 45 days	<1%	**1%**		1%	1%	1%	1%
Auto Adjudication	82%	**80%**		82%	82%	81%	81%
Audited Claims with Errors	<3%	**2%**		2%	2%	2%	2%
Claims Disputes	<5%	**1%**		1%	1%	1%	1%

2nd Quarter 2020 Member Service Indicators

Activity	Goal	2nd Quarter	Status	1st Quarter	4th Quarter	3rd Quarter	2nd Quarter
Incoming Calls		**57,207**		77,452	74,441	81,107	75,201
Abandonment Rate	<5%	**1.0%**		1.6%	3.2%	2.6%	1.2%
Avg. Answer Speed	<2:00	**:05**		:19	:34	:28	:12
Average Talk Time	<8:00	**7:38**		7:26	7:24	7:00	7:05
Top Reasons for Member Calls	Trend	**1. New Member 2. PCP Change 3. Demographic 4. Referrals 5. ID Card**		Same	Same	Same	Same
Outbound Calls	Trend	**86,206**		103,634	97,467	97,172	96,819
# of Walk Ins	Trend	**0**		545	436	381	372
Member Portal Accounts-Q/Total	4%	**2500 (Q2) 26,758 (10.3%)**		2778 24,257 (9.75%)	2864 21,480	3625 18,544	3424 14,905

Provider Network Indicators

Activity	Goal	2nd Quarter	Status	1st Quarter	4th Quarter	3rd Quarter	2nd Quarter
# of PCPs	Maintain	.75%		3.35%	0%	0%	1.03%
# of Specialists	>1% growth	<.68%>		6.16%	4.4%	1.1%	.31%
% Provider Terminations	<5% term	2.05%		1.97%	2.23%	.94%	1.4%
Termination Reasons		76% left group 8%-Term 6% Site Closed 4% resigned 2% retired 2% illness 2% no reason given		71%-Left Group 13%-Site Closed 6%-term 4%-Resigned 2%-Death 4%-Retirement	43%-Left Group 40%-Site Closed 8%-term 3%-Resigned 2%-Death 2%-Practice Sold 2%-Retirement	71%-Left Group 14%-Term 5%-Retired 5%-Resigned 5%-Practice sold	65%-left group 15% term 8% site closed 8%-Retired 8%-practice sold
Appointment Survey	Average wait time						
PCP	< 10 days	9.8 Days		4.4 Days	3.14 Days	3.7 Days	4.4 Days
Specialty	< 15 days	5.4 Days		3.1 Days	5.33 Days	5.7 Days	11.5 Days

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4

Human Resources Indicators

Activity	Budget	2nd Quarter	Status	1st Quarter	4th Quarter	3rd Quarter	2nd Quarter
Staffing Count	442	**423**		418	406	397	391
Employee Turnover	12%	**5.28%**		6.71%	8.90%	11.36%	10.77%
Turnover Reasons	Voluntary Involuntary Retired	**72.8%** **18.1%** **8.1%**		85.7% 14.3% 0%	82.9% 17.1% 0%	81% 19% 0%	86% 14% 0%

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2nd Quarter 2020 Grievance Report

Category	Q2 2020	Status	Issue	Q1 2020	Q4 2019	Q3 2019	Q2 2019
Access to Care	33		Appointment Availability	53	56	34	32
Coverage Dispute	0		Authorizations and Pharmacy	0	0	3	9
Medical Necessity	246		Questioning denial of service	225	187	214	244
Other Issues	11		Miscellaneous	36	14	16	13
Potential Inappropriate Care	207		Questioning services provided. All cases forwarded to Quality Dept.	273	323	65	26
Quality of Service	8		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	2	0	0	1
Total Formal Grievances	505			589	580	332	325
Exempt**	989		Exempt Grievances-	1620	1140	1515	1321
Total Grievances (Formal & Exempt)	1494			2209	1720	1847	1646

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6

Additional Insights-Formal Grievance Detail

Issue	2nd Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	29	20	0	9	0
Coverage Dispute	0	0	0	0	0
Specialist Access	4	3	0	1	0
Medical Necessity	246	150	0	80	16
Other Issues	11	8	0	3	0
Potential Inappropriate Care	207	0	207	0	0
Quality of Service	8	7	0	1	0
Total	505	188	207	94	16

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2nd Quarter 2020 Transportation Update

Operational Statistics	Q2 2020	Q1 2020	Q4 2019	Q3 2019	Q2 2019
ALC Calls	**73,726**	128,968	134,982	157,239	123,448
One Way Rides Scheduled	**70,522**	127,434	135,394	148,731	129,084
NMT	**40,956**	95,530	100,840	113,649	95,526
Bus Passes Distributed	**1,055**	3,101	2,575	3,678	2,679
Ride Share Rides	**39,901**	92,429	97,422	109,971	91,847
No Shows	**3,613**	6,537	6,292	6,738	6,006
NEMT	**29,566**	33,191	34,554	35,082	33,558
Van Rides Scheduled	**28,981**	32,484	33,958	34,442	33,028
Gurney Rides Scheduled	**585**	707	596	640	530
Member Reimbursement	**1,752**	4,011	1,762	1,419	1,878
ALC Admin Expense	**$414,731**	$753,478	$775,838	$812,661	$750,070

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Member Transportation Expansion

- KHS has expanded it's partnership with Golden Empire Transit (GET) adding vans to the current bus only services.
- GET will provide curb to curb non-medical transportation wheel chair accessible vans exclusively for KHS members
- Benefit to KHS
  - Improve NEMT (vans) and NMT (Uber) access
  - Partnering with local public transportation agency
  - Improve member & provider satisfaction

KHS/GET Partnership

To: KHS Board of Directors

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

Date: August 13, 2020

Re: CMO BOARD REPORT

Medical Cost and Utilization Trend Analyses: (Attachment A)

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

The PMPM capitated cost of physician services in all AID codes is down in June 2020. This is due to STATE's stay at home order and delaying elective procedures to reduce the spread of the COVID-19 pandemic. 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. We have been in communication with our network providers to assist to help them start seeing members in the offices now that the Governor's order has been lifted. We are also reaching out to our members directly to encourage them to get the care they need. On August 3, 2020 we launched an outreach campaign targeting members 0 to 2 years to encourage parents to take them to see doctors for routing services such as immunizations. The next targeted group will be children 2 to 6 years of age. Since April 2020, KHS staff has made over 21,000 calls to our vulnerable members to see to it their medical and psychosocial needs are being met during the stressful times of the pandemic and give them information on available community resources. The implementation of some of our disease specific programs are still on hold because of the need for social distancing recommendations due to the COVID-19 pandemic. We hope to restart these programs for Diabetes and COPD diagnosed members when it is safe for our members, providers and our staff to reconvene.

The most frequent diagnosis for physician services for all Aid categories in June 2020 is routine encounter for child health and close second was contact with or exposure to a communicable disease.

Pharmacy

Pharmacy utilization did not see the same reduction as we noted for the professional services. Early in the pandemic, KHS modified the number of days between medication refills from 60 days' supply to 90 days to reduce frequency of members needing to go out to pick up medications. The pharmacies in the network also provide delivery services for our members. The monthly cost and utilization per enrollee for all AID categories remained stable at or just below budget which we are happy to see since it represents patients are filling prescriptions and taking their medication as they historically have done.

Inpatient Services

The overall utilization of inpatient services has been lower than expected since March, 2020 for all aide categories. The cost per bed-day, bed-days incurred and average length of stay in the acute hospital for all aide codes is at or below budget. There was a big drop in inpatient services PMPM for the SPDs. This is understandable with elective procedures being halted until recently. Now that this has been lifted, we see a gradual increase in members admitted for elective procedures.

With the pandemic continuing, we are following COVID- 19 admissions closely to determine what our new normal for inpatient hospital utilization will be for the different eligibility categories. In June and July, we have seen an increase in the number of members admitted to the hospital and those in ICU beds. Since the beginning of the pandemic, we have had a total of 330 members in the hospital at different levels. We are running between 35 and 40 members in the hospitals daily. We have had a total of 14 deaths. 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 our In-patient activity continues to be at BMH.

The C/Section rate is 11 % which continues to be below State average for low–risk, first birth deliveries. There seems to be a drop in the numbers of deliveries. This is most probably due to delays in claims submission. **(Attachment C).**

Hospital Outpatient

We see a significant increase in hospital outpatient utilization in May and June for all AID categories. This could be due to the return of outpatient procedures. We will be analyzing the data to see if this is a trend that we need to watch carefully or not.

Emergency Room (ER)

The PMPM cost and number of ER visits per month and per member per month is below our benchmarks for all Aide groups. This trend has been present since March 2020 but we have started

to see some light increase in June, 2020. This too is attributed to the Governor's stay at home order. So that patient's may access physician services when necessary, KHS set up a 24/7 physician hotline and began reimbursing physicians for telephone consults with their patients. It's not unusual to see that the most frequent diagnosis for ER visits in June 2020 is COVID-19 acute respiratory disease. Most of the ER visits are occurring at BMH **(Attachment D).**

Managed Care Accountability Set (MCAS)

This is a set of performances measures that DHCS selects for annual reporting by Medi-Cal managed care health plans (MCPs). The updated Managed Care Accountability Set (MCAS) for 2020 measuring year prescribes a set of 33 quality measures, with 21 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.

Recently, DHCS changed the MPL benchmark from 25% to 50% doubling the performance standard Medi-Cal health plans must achieve. As a result of this change, health plans and providers are under increased pressure to coordinate their efforts to see to it patients see their physician and receive procedures and services included in the metrics. The report attached 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 13 of the 25 MCAS measures. The boxes in red show where our performance is significantly lower than the previous year. The yellow boxes show we have lower performance, but it is not significant.

As the pandemic continues, patients are slow to return to their doctor for routine care. Although we have plans ready for implementation to improve the areas in red as soon as it is safe for our members and providers, it is unlikely to expect KHS will recover if the pandemic continues. We are continuing to work with our providers and encouraging them to provide routine care via telemedicine as possible during the pandemic. The longer patients stay away from the doctors' offices, the less likely they are to complete these services most of which require an office visit. This could have a negative impact on the patient's health and KHS will not be able to meet the State MPL. DHCS recognizes this challenge. Although, this will not change DHCS performance expectations, the department does not plan sanctioned health plans in 2020 for not meeting MPL. We do not know yet what will happen in 2021.

KERN HEALTH SYSTEMS

Attachment A

Governed Reporting System

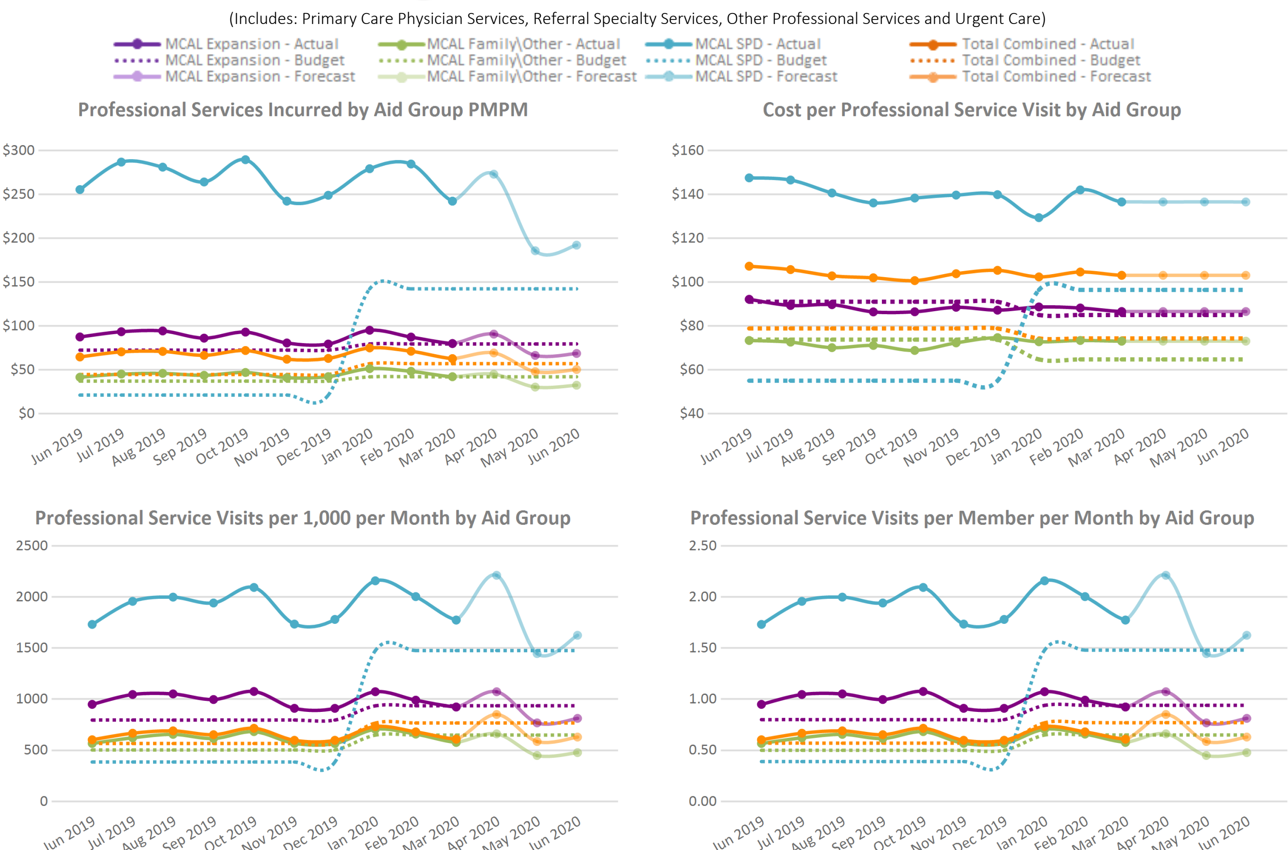
Kern Health Systems

KHS Medical Management Performance Dashboard (Critical Performance Measurements)

Governed Reporting System

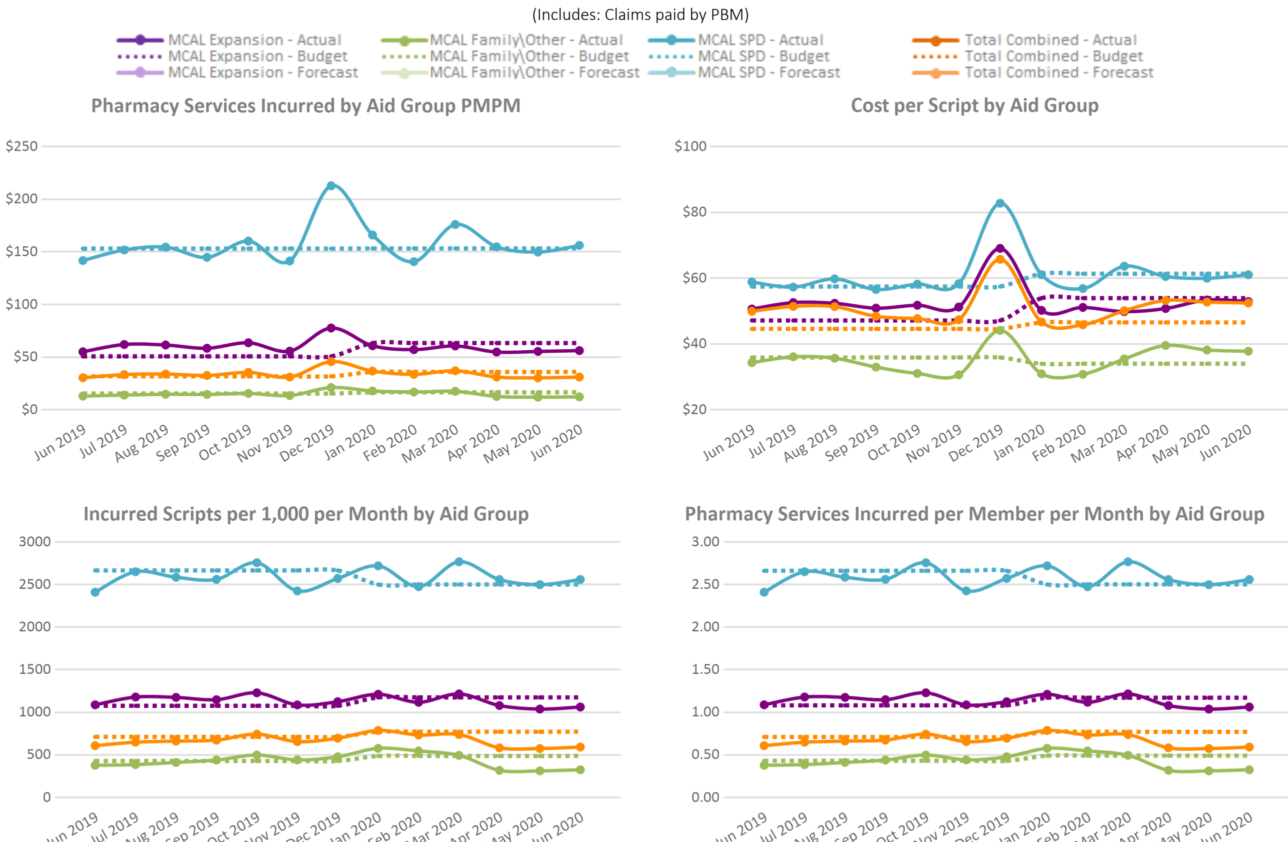
Physician Services

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



Governed Reporting System

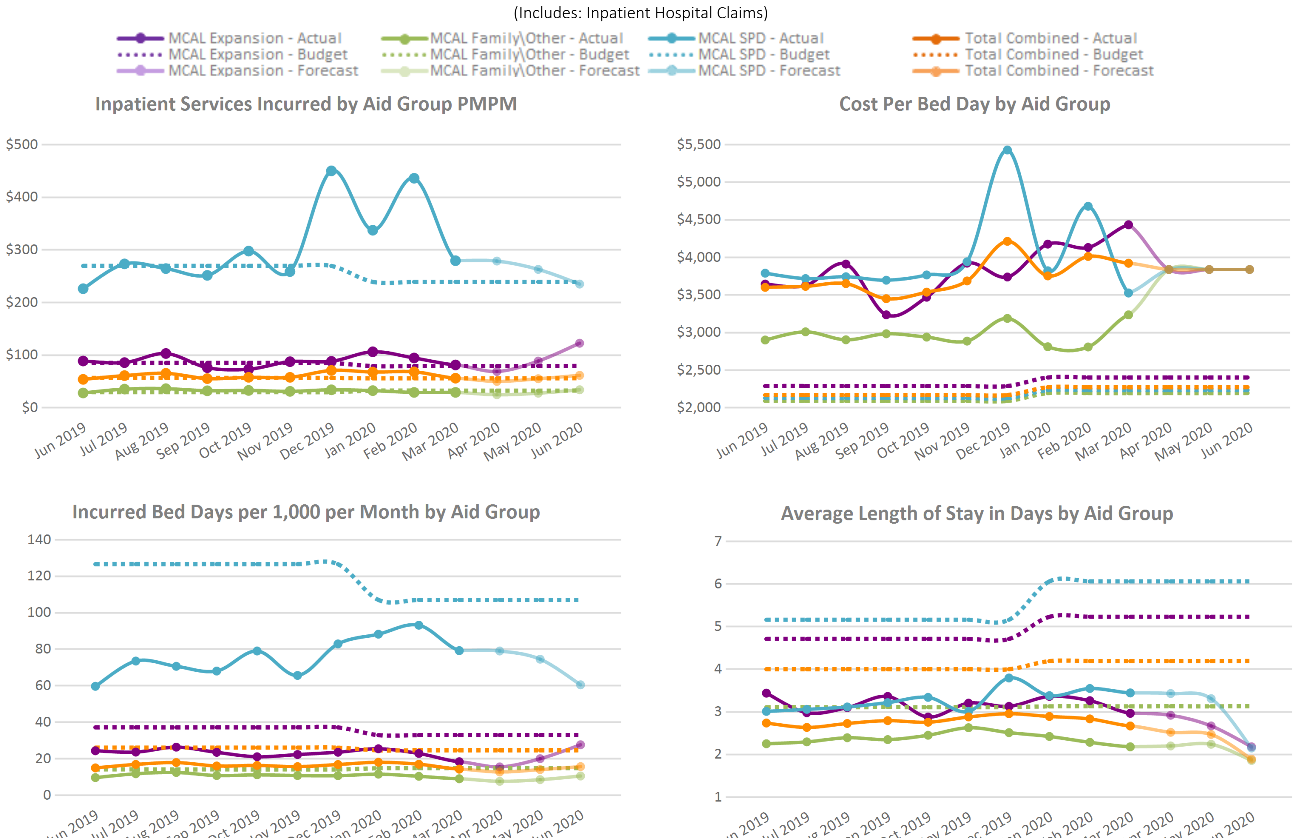
(Includes: Claims paid by PBM)



Governed Reporting System

Inpatient

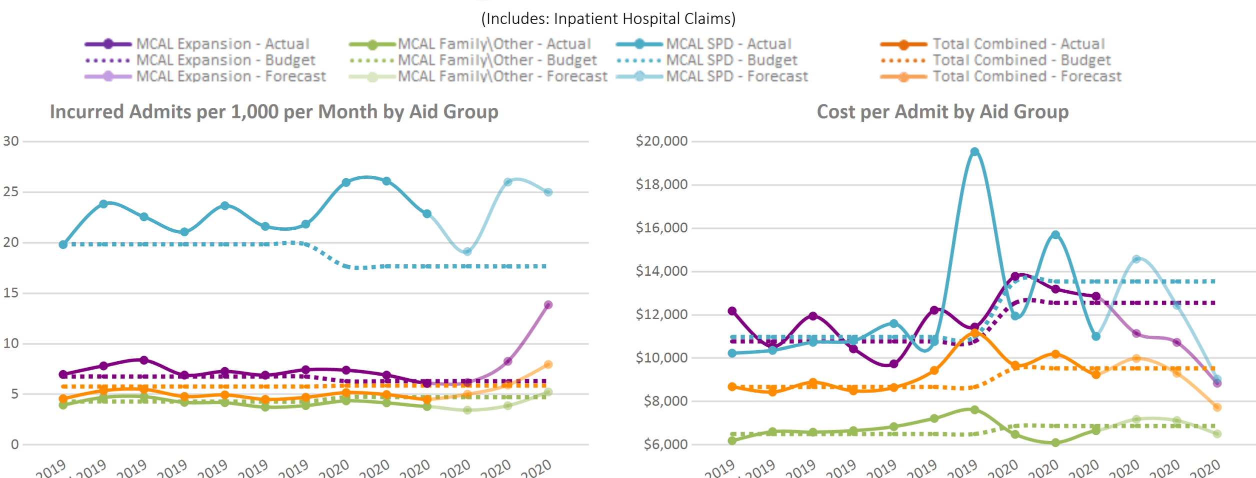
(Includes: Inpatient Hospital Claims)



Governed Reporting System

Inpatient

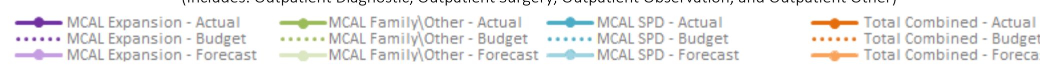
(Includes: Inpatient Hospital Claims)

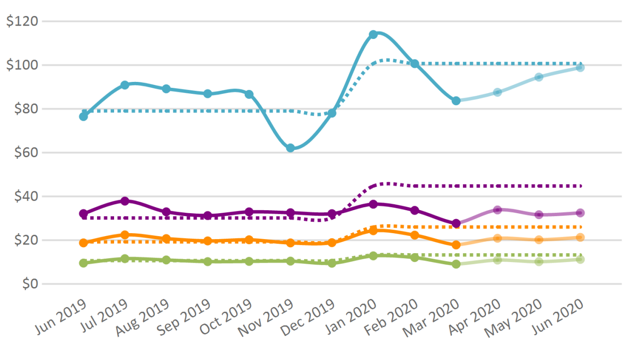


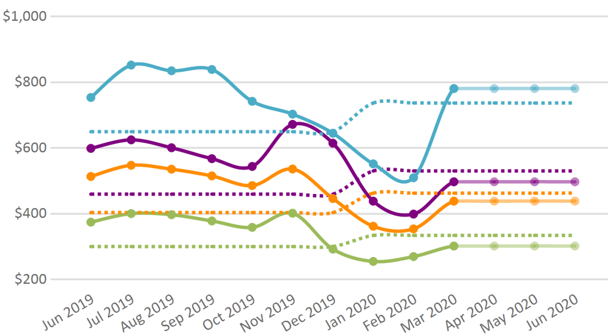
Governed Reporting System

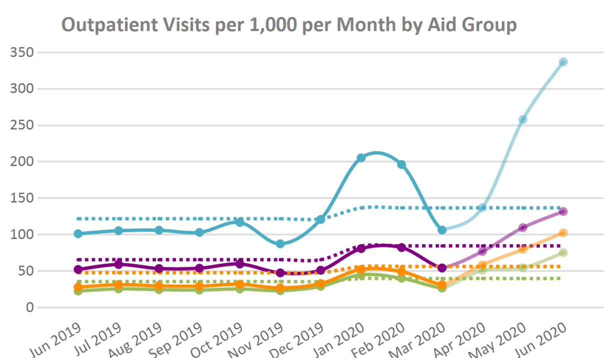
Outpatient Hospital

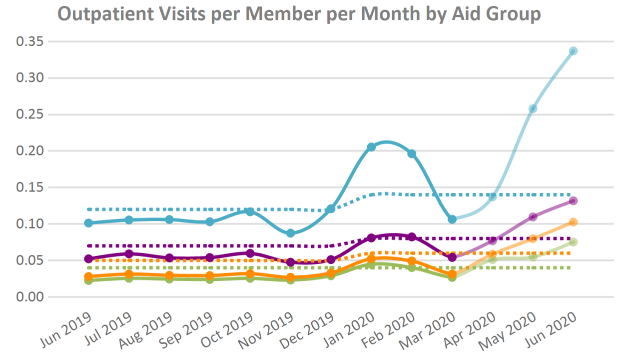
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)





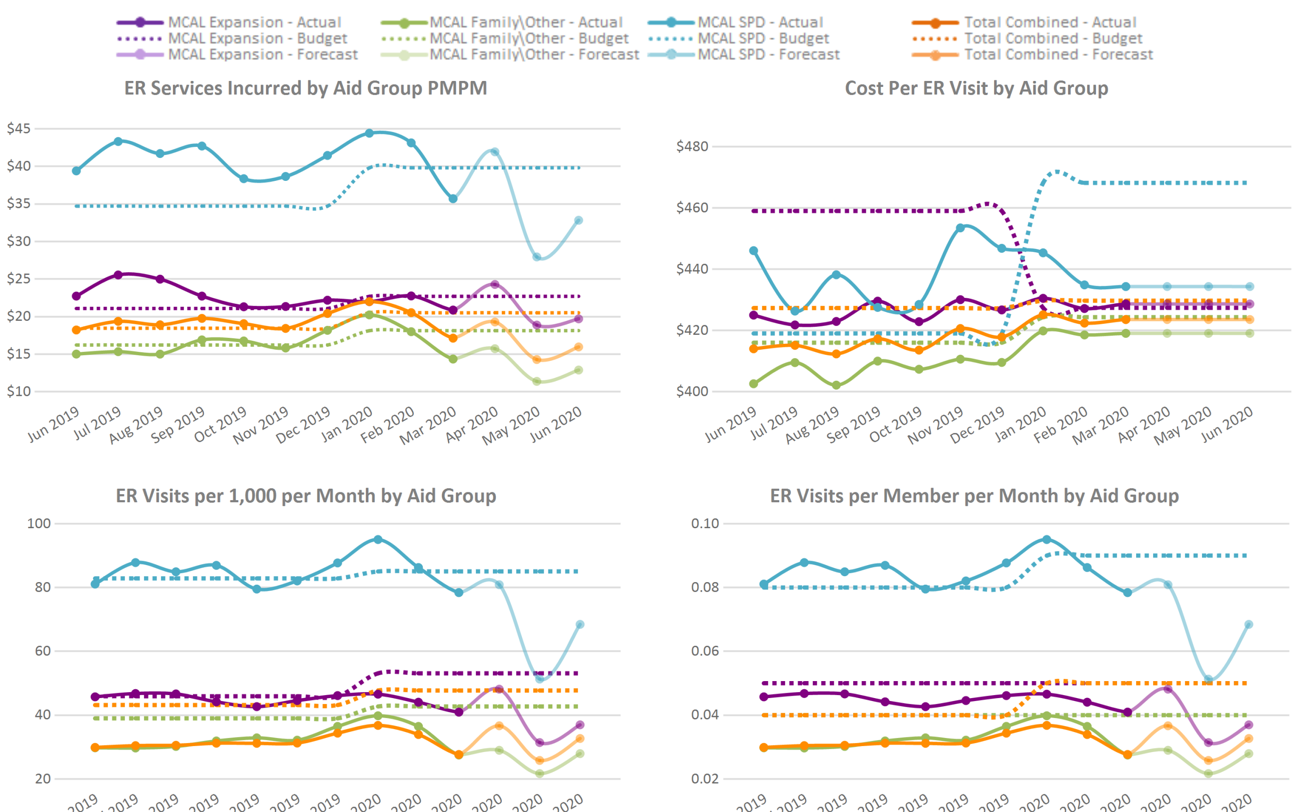






Governed Reporting System

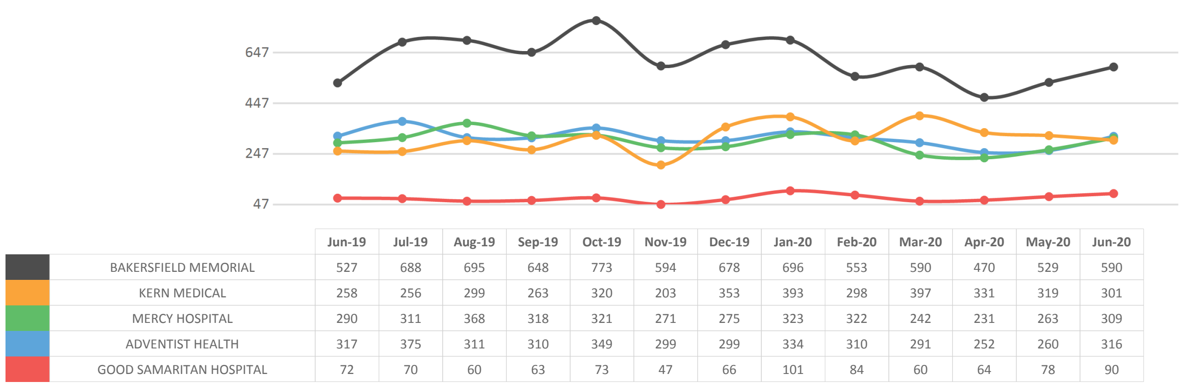
Emergency Room



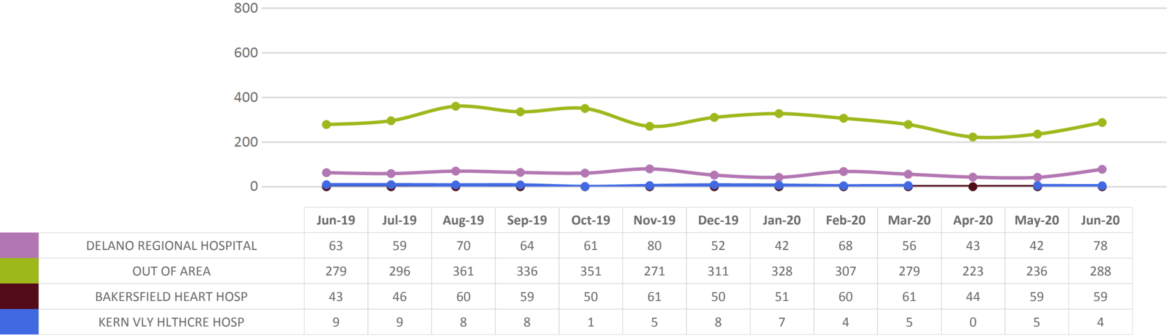
Attachment B

Governed Reporting System

Inpatient Admits by Hospital



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
BAKERSFIELD MEMORIAL	527	688	695	648	773	594	678	696	553	590	470	529	590
KERN MEDICAL	258	256	299	263	320	203	353	393	298	397	331	319	301
MERCY HOSPITAL	290	311	368	318	321	271	275	323	322	242	231	263	309
ADVENTIST HEALTH	317	375	311	310	349	299	299	334	310	291	252	260	316
GOOD SAMARITAN HOSPITAL	72	70	60	63	73	47	66	101	84	60	64	78	90

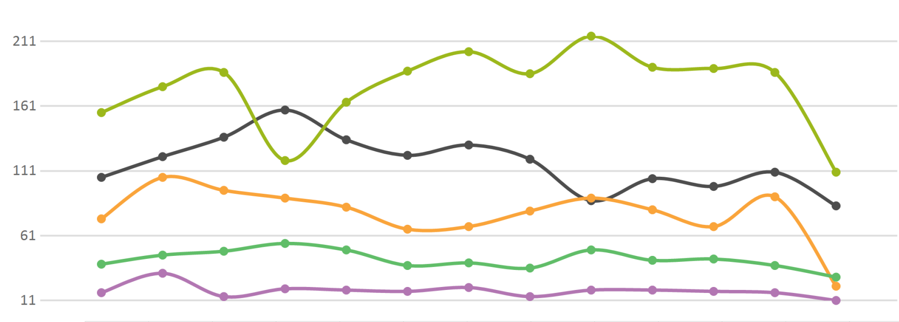


	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
DELANO REGIONAL HOSPITAL	63	59	70	64	61	80	52	42	68	56	43	42	78
OUT OF AREA	279	296	361	336	351	271	311	328	307	279	223	236	288
BAKERSFIELD HEART HOSP	43	46	60	59	50	61	50	51	60	61	44	59	59
KERN VLY HLTHCRE HOSP	9	9	8	8	1	5	8	7	4	5	0	5	4

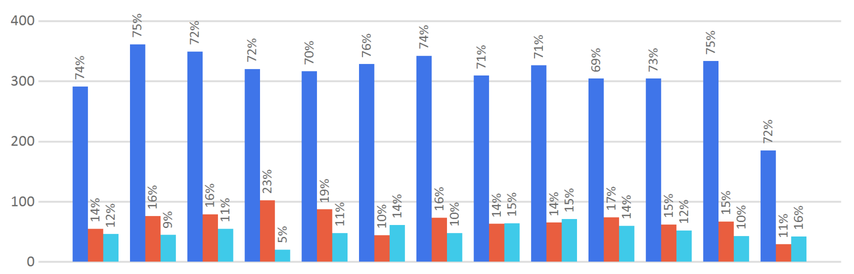
Attachment C

Governed Reporting System

Obstetrics Metrics



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
BAKERSFIELD MEMORIAL	106	122	137	158	135	123	131	120	88	105	99	110	84
KERN MEDICAL	74	106	96	90	83	66	68	80	90	81	68	91	22
OTHER	156	176	187	119	164	188	203	186	215	191	190	187	110
MERCY HOSPITAL	39	46	49	55	50	38	40	36	50	42	43	38	29
DELANO REGIONAL HOSPITAL	17	32	14	20	19	18	21	14	19	19	18	17	11

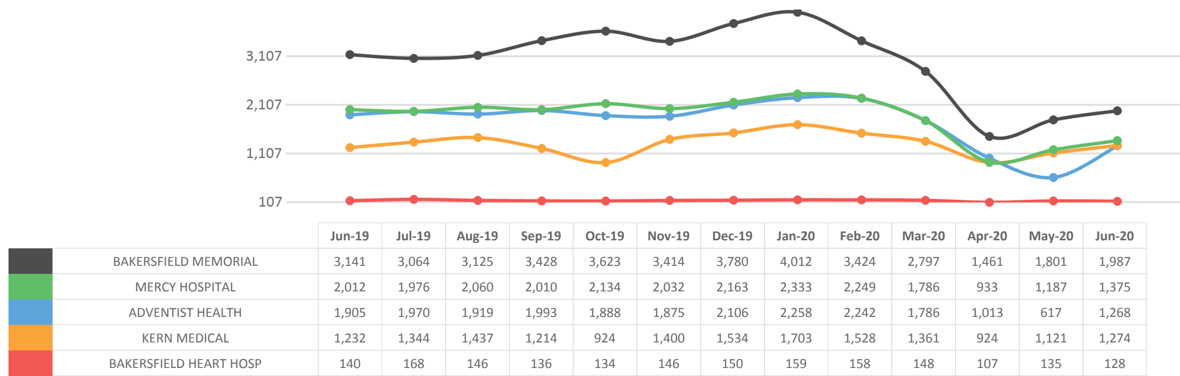


	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
VAGINAL DELIVERY	291	361	349	320	316	328	342	309	326	304	304	333	185
C-SECTION DELIVERY	55	76	79	102	87	44	73	63	65	74	62	67	29
PREVIOUS C-SECTION DELIVERY	46	45	55	20	48	61	48	64	71	60	52	43	42

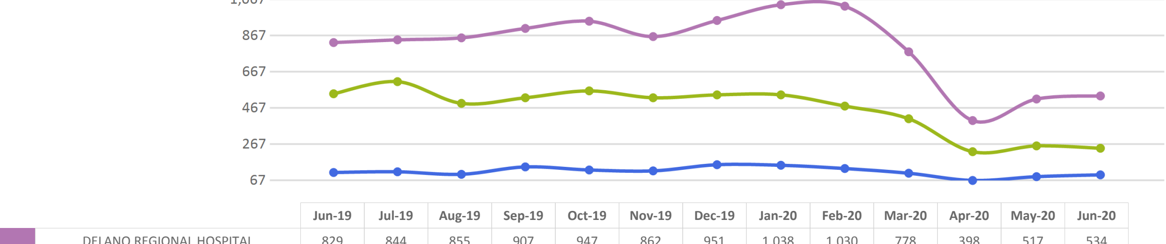
Attachment D

Governed Reporting System

Emergency Visits by Hospital



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
BAKERSFIELD MEMORIAL	3,141	3,064	3,125	3,428	3,623	3,414	3,780	4,012	3,424	2,797	1,461	1,801	1,987
MERCY HOSPITAL	2,012	1,976	2,060	2,010	2,134	2,032	2,163	2,333	2,249	1,786	933	1,187	1,375
ADVENTIST HEALTH	1,905	1,970	1,919	1,993	1,888	1,875	2,106	2,258	2,242	1,786	1,013	617	1,268
KERN MEDICAL	1,232	1,344	1,437	1,214	924	1,400	1,534	1,703	1,528	1,361	924	1,121	1,274
BAKERSFIELD HEART HOSP	140	168	146	136	134	146	150	159	158	148	107	135	128



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
DELANO REGIONAL HOSPITAL	829	844	855	907	947	862	951	1,038	1,030	778	398	517	534
OUT OF AREA	546	613	493	524	562	524	540	540	478	408	226	258	245
KERN VLY HLTHCRE HOSP	111	115	101	142	125	120	154	151	133	107	67	88	98

Governed Reporting System

Attachment E

MCAS Performance Trending Metrics

Metric	Value	Prior Year	% Change
ABA - 18-19	5.86 %	Prior Year 9.60%	% Change -38.96%
ABA - 20-74	21.25 %	Prior Year 29.58%	% Change -28.16%
ABA	21.00 %	Prior Year 29.18%	% Change -28.03%
AMM - Acute	51.82 %	Prior Year 53.48%	% Change -3.10%
AMM - Cont	30.93 %	Prior Year 34.30%	% Change -9.83%
AMR	55.06 %	Prior Year 49.33%	% Change 11.62%
APM - Cholesterol	7.14 %	Prior Year 34.99%	% Change -79.59%
APM - Glucose	28.57 %	Prior Year 98.30%	% Change -70.94%
APM - Glucose Cholesterol	7.14 %	Prior Year 33.30%	% Change -78.56%
AWC	15.66 %	Prior Year 19.53%	% Change -19.82%
BCS	47.36 %	Prior Year 38.88%	% Change 21.81%
CBP	3.30 %	Prior Year 3.02%	% Change 9.27%
CCS	45.46 %	Prior Year 43.34%	% Change 4.89%
CDC - BP	3.05 %	Prior Year 2.65%	% Change 15.09%
CDC - Eye Exam	50.42 %	Prior Year 36.32%	% Change 38.82%

Governed Reporting System

MCAS Performance Trending Metrics

Metric	Value	Prior Year	% Change
CDC - HBA1C <7%	10.98 %	Prior Year 5.53%	% Change 98.55%
CDC - HBA1C <8%	18.24 %	Prior Year 9.57%	% Change 90.60%
CDC - HBA1C >9%	75.43 %	Prior Year 5.81%	% Change 1,198.28%
CDC - HBa1C Test	68.12 %	Prior Year 76.04%	% Change -10.42%
CDC - Nephropathy	81.20 %	Prior Year 87.71%	% Change -7.42%
CHL - Adults	51.53 %	Prior Year 55.60%	% Change -7.32%
CHL	46.70 %	Prior Year 49.02%	% Change -4.73%
CHL - Peds	40.99 %	Prior Year 40.98%	% Change 0.02%
CIS - Combo 10	15.48 %	Prior Year 0.13%	% Change 11,807.69%
IMA - Combo 2	31.75 %	Prior Year 1.39%	% Change 2,184.17%
PPC - Postpartum	55.73 %	Prior Year 60.71%	% Change -8.20%
PPC - Prenatal	11.27 %	Prior Year 48.89%	% Change -76.95%
SSD	41.11 %	Prior Year 70.47%	% Change -41.66%
W15	3.52 %	Prior Year 4.33%	% Change -18.71%
W34	27.35 %	Prior Year 38.16%	% Change -28.33%

Governed Reporting System

MCAS Performance Trending Metrics

WCC - BMI	WCC - NC	WCC - PAC
17.67 %	7.84 %	6.64 %
Prior Year 20.21%	Prior Year 10.35%	Prior Year 5.78%
% Change -12.57%	% Change -24.25%	% Change 14.88%

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.

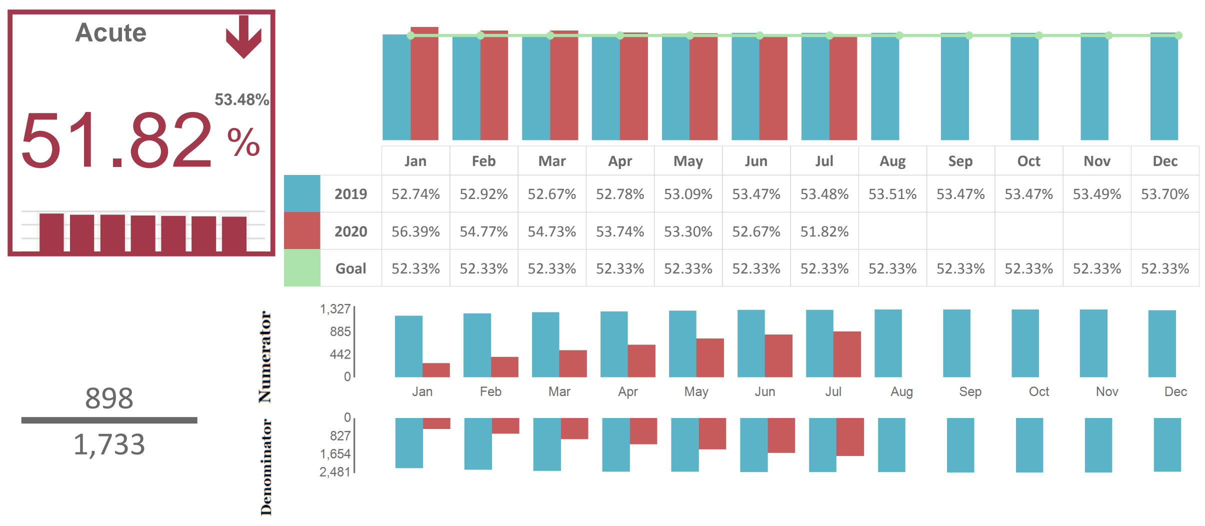
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	24.65%	25.42%	26.23%	26.97%	27.70%	28.43%	29.18%	29.99%	30.76%	31.65%	32.46%	33.14%
2020	25.84%	27.06%	28.10%	28.61%	29.23%	20.27%	21.00%					
Goal	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%	90.27%

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%	52.67%	51.82%					
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%

898

1,733

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%	31.15%	30.93%					
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%

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.

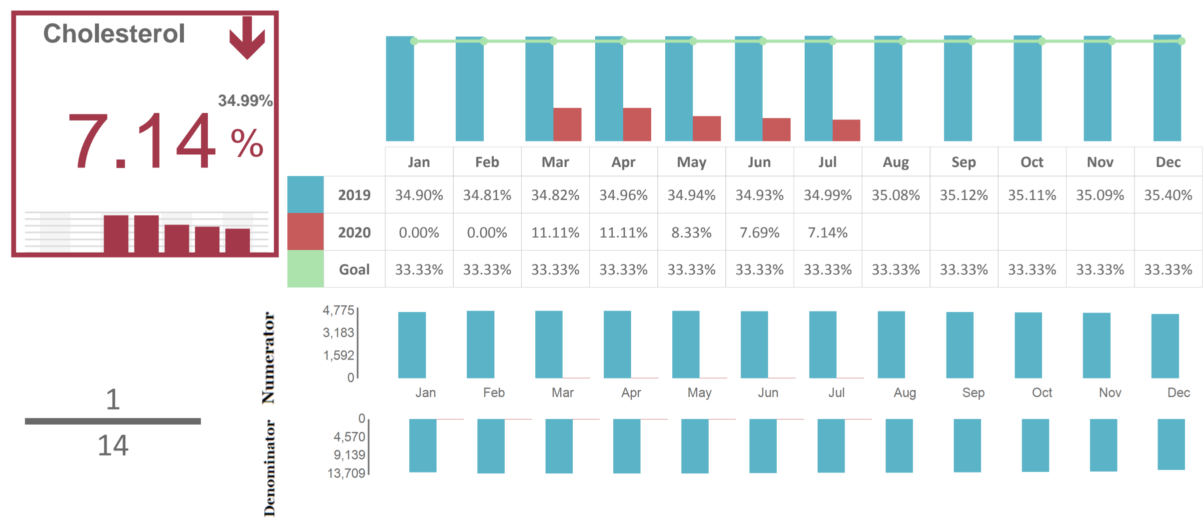
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	56.14%	58.42%	53.22%	52.84%	51.42%	49.87%	49.33%	48.36%	48.04%	47.83%	47.41%	47.69%
2020	40.00%	60.96%	58.63%	56.31%	55.73%	55.13%	55.06%					
Goal	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%	63.58%

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.



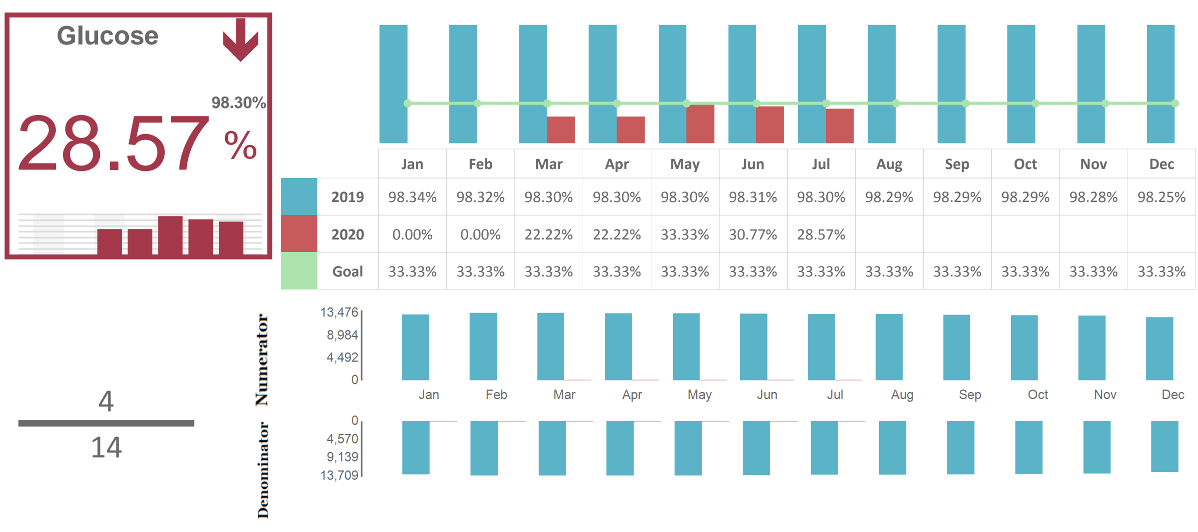
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	34.90%	34.81%	34.82%	34.96%	34.94%	34.93%	34.99%	35.08%	35.12%	35.11%	35.09%	35.40%
2020	0.00%	0.00%	11.11%	11.11%	8.33%	7.69%	7.14%					
Goal	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%	33.33%

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%	30.77%	28.57%					
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%

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	1.90%	4.41%	6.97%	9.73%	12.57%	15.91%	19.53%	23.79%	26.73%	29.37%	31.57%	35.76%
2020	2.38%	5.41%	8.35%	9.69%	11.04%	13.57%	15.66%					
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%

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%	46.57%	47.36%					
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%

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.

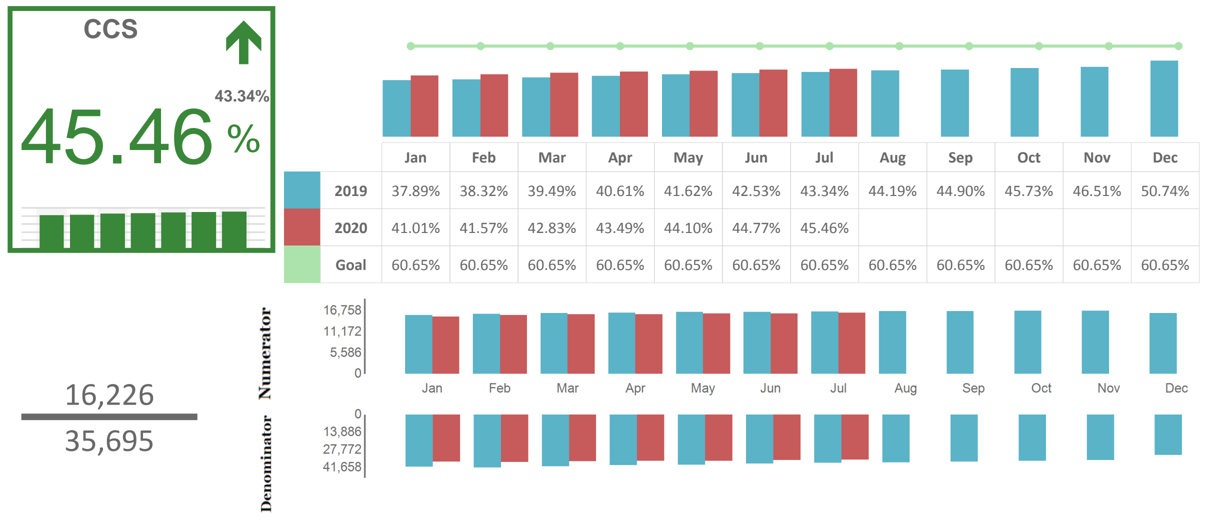
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	1.12%	1.98%	2.34%	2.58%	2.68%	2.81%	3.02%	3.15%	3.32%	3.46%	3.75%	3.78%
2020	0.85%	2.06%	2.53%	2.87%	3.11%	3.21%	3.30%					
Goal	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%	61.04%

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.



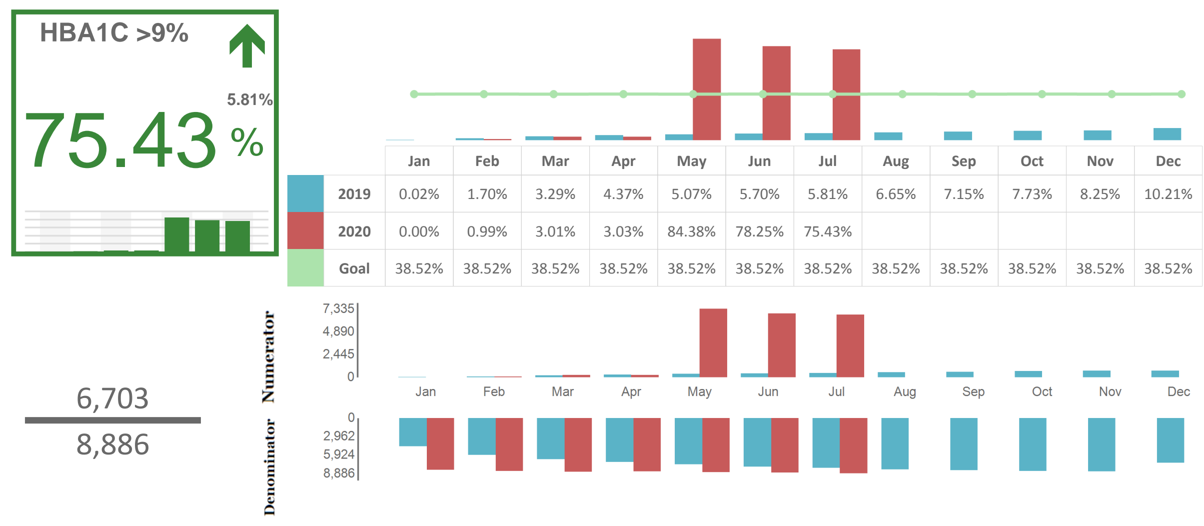
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	37.89%	38.32%	39.49%	40.61%	41.62%	42.53%	43.34%	44.19%	44.90%	45.73%	46.51%	50.74%
2020	41.01%	41.57%	42.83%	43.49%	44.10%	44.77%	45.46%					
Goal	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%	60.65%

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%	84.38%	78.25%	75.43%					
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%

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%	48.90%	51.53%					
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%

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.

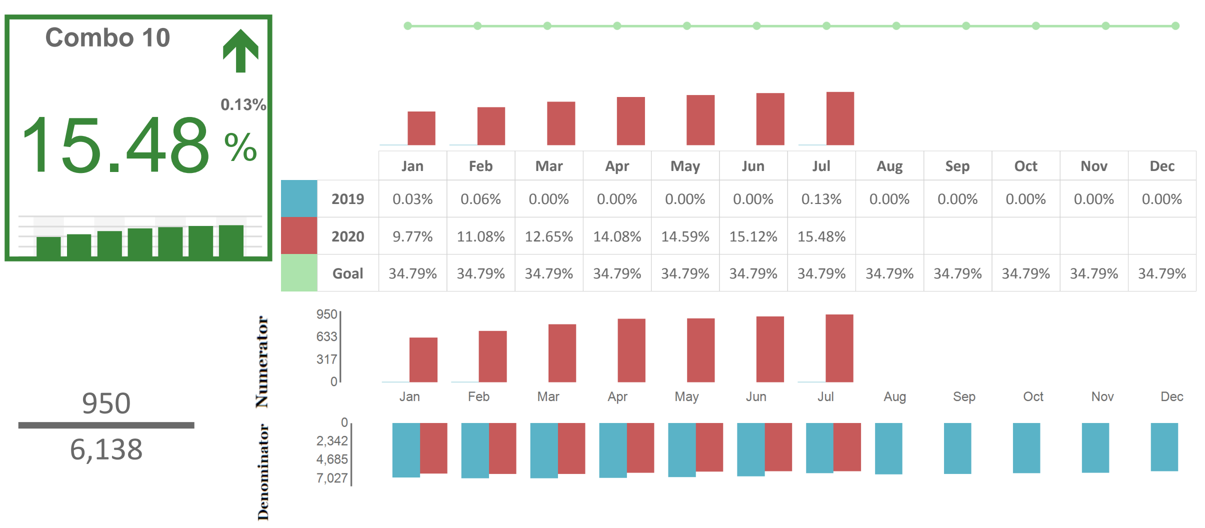
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	20.00%	27.24%	30.62%	35.66%	37.34%	39.39%	40.98%	42.68%	44.09%	45.64%	46.77%	47.29%
2020	24.29%	29.14%	32.40%	34.74%	36.79%	38.41%	40.99%					
Goal	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%	44.86%

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	0.03%	0.06%	0.00%	0.00%	0.00%	0.00%	0.13%	0.00%	0.00%	0.00%	0.00%	0.00%
2020	9.77%	11.08%	12.65%	14.08%	14.59%	15.12%	15.48%					
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%

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%	0.71%	0.83%	0.98%	1.12%	1.30%	1.39%	1.60%	1.70%	1.86%	0.91%	2.06%
2020	24.84%	26.21%	27.74%	5.07%	30.06%	31.09%	31.75%					
Goal	34.43%	34.43%	34.43%	34.43%	34.43%	34.43%	34.43%	30.39%	30.39%	30.39%	30.39%	30.39%

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.

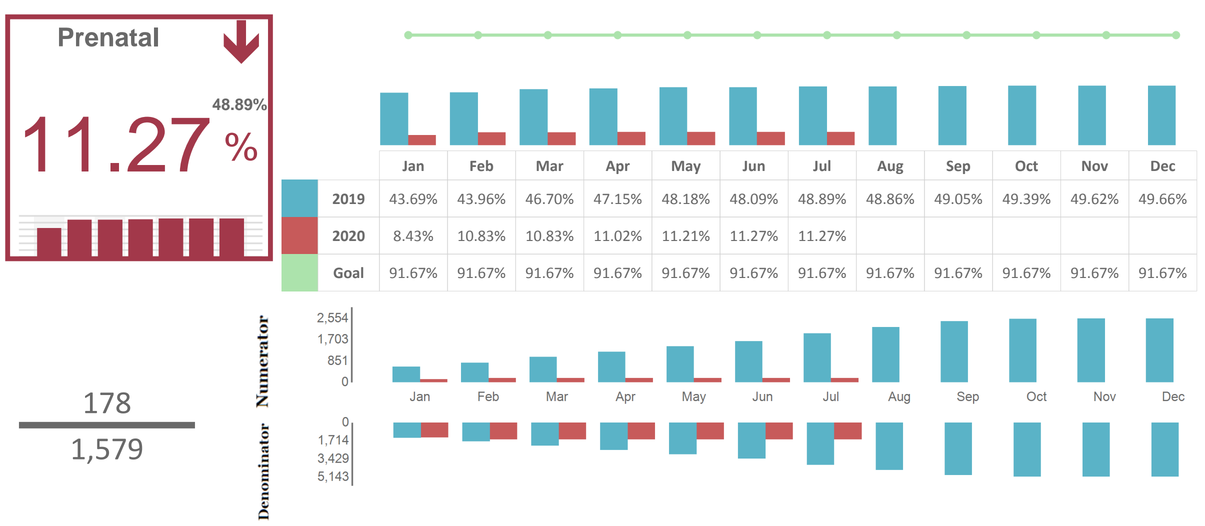
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	48.17%	52.40%	56.32%	60.51%	60.89%	61.24%	60.71%	61.86%	62.59%	67.79%	71.79%	72.53%
2020	24.93%	39.77%	50.73%	53.39%	54.53%	55.22%	55.73%					
Goal	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%	73.67%

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	43.69%	43.96%	46.70%	47.15%	48.18%	48.09%	48.89%	48.86%	49.05%	49.39%	49.62%	49.66%
2020	8.43%	10.83%	10.83%	11.02%	11.21%	11.27%	11.27%					
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%

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%	41.11%	41.11%					
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%

Governed Reporting System

MCAS Performance Trending Metrics

Well-Child Visits in the First 15 Months of Life

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life.

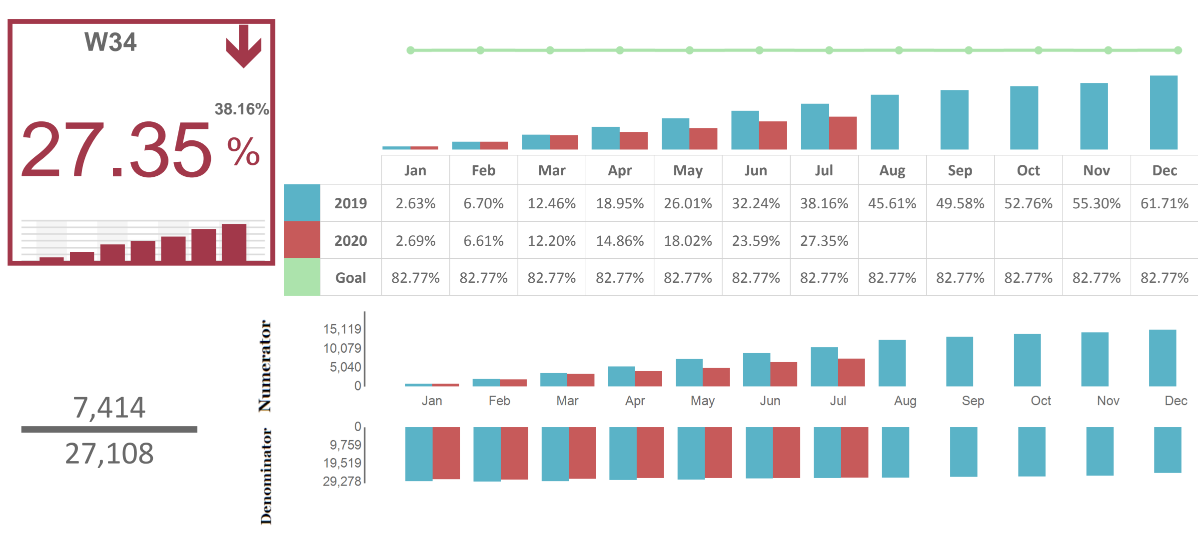
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	0.86%	1.56%	2.21%	2.56%	3.15%	3.64%	4.33%	5.08%	5.59%	5.89%	6.12%	6.39%
2020	0.69%	1.54%	1.62%	2.04%	2.41%	2.77%	3.52%					
Goal	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%

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.



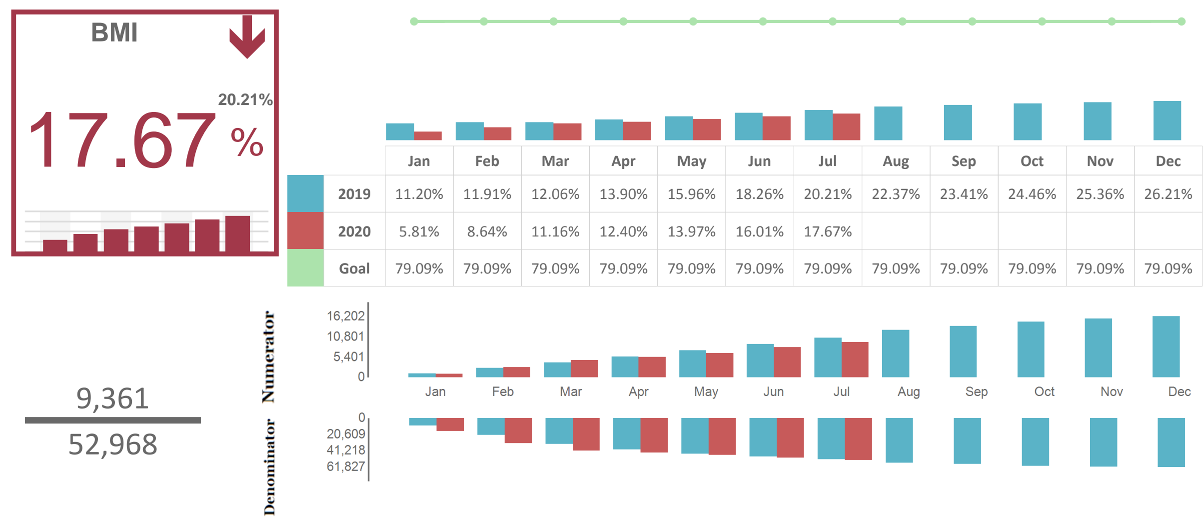
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	2.63%	6.70%	12.46%	18.95%	26.01%	32.24%	38.16%	45.61%	49.58%	52.76%	55.30%	61.71%
2020	2.69%	6.61%	12.20%	14.86%	18.02%	23.59%	27.35%					
Goal	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%	82.77%

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%	16.01%	17.67%					
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%

9,361

52,968

KERN HEALTH SYSTEMS
CHIEF EXECUTIVE OFFICER'S REPORT
August 13th, 2020
BOARD OF DIRECTORS MEETING

COMPLIANCE AND REGULATORY ACTIVITIES

Compliance and Regulatory Affairs Report

Attachments A through D are included in the update on regulatory and compliance activities impacting KHS.

COVID-19 IMPACT TO OPERATIONS

Remote Work Environment

As KHS enter its 6th month of adjusting to the COVID-19 pandemic, Kern County continues to see increases in cases, positivity rates and deaths attributed to the disease. Statewide, July recorded the highest month in new deaths indicating the disease has yet to plateau. Still being several months or longer from a vaccine, it would be risky to return employees to the office particularly those who are of higher risk of contracting the disease. Following CDC guidelines, this population represents about 40% of Kern Health Systems workforce. Another consideration is employees with children K-8 who will be distance learning. This population represents approximately 24% of the workforce. A survey of Kern County school districts indicates most will continue distance learning until there is a change in the trajectory of the disease and safe for students to return to class. 95% of our 433 KHS employees currently work remote. Performance reports show the quality and quantity of work has not suffered. Targets and standards continue to be met across all departments. This is a tribute to staff's dedication to KHS and their commitment to their respective jobs.

Return to Work Plan

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. With the knowledge that the work is getting done, quality is being maintained, and performance targets met (erroring on the side of caution) KHS will continue to work remote for the remainder of 2020. Our return to the office work schedule will begin with volunteers coming back to the office January 4th, 2021.

COVID -19 Member Impact

Since the County doesn't distinguish those afflicted with the virus by their medical coverage, it's not possible to accurately determine the % of the infected population who are KFHC members. However, since approximately a third of Kern County residents are enrolled with Kern Family Health Care, it suspected a similar % of those infected to be our members. Given the disproportionate number of cases afflicting low income adults and minorities, its likely, with our demographic, we would insure a significant number of these cases.

Since discovering the first COVID -19 case in Kern County, KHS has been monitoring its impact on our members particularly those hospitalized since March. Daily inpatient utilization is tracked across all hospitals by diagnosis. Attachment E shows the cumulative impact COVID-19 has had on KFHC. For these services it's estimated the cumulative liability to approximate $8 million for inpatient services alone. Since cases are increasing, inpatient utilization will likely follow and KHS should expect a corresponding surge in cost over the next few months.

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 physician 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. This represents one of several ongoing provider support initiatives. A complete list of activities to which KHS has provided staff and /or financial support is found under Attachment F.

PROGRAM DEVELOPMENT ACTIVITIES

Long Term Care at Home

In late June DHCS released a draft design paper for a "Long Term Care at Home" benefit for implementation in 2021. The goal of this program is to offer certain services in the home in lieu of skilled institutions. DHCS currently envisions Provider Organizations offering a range of medical, personal care, and social worker services as part of this benefit. KHS staff are engaged with DHCS and our Trade Associations in the development of this benefit.

RX Carve-Out

DHCS continues to move forward on the Governor's Executive order to Carve-Out Pharmacy services from Managed Care Plans effective 1/1/21. KHS staff are working closely with DHCS, DMHC, and our Trade Associations in preparation for the transition. A few policy issues related to continuity of care, grievances and appeals, member outreach, and future drug coverage are being worked through. Internally staff are working on systems and workflows, policies and procedures, and data sharing updates that will need to be made to support the transition.

Interoperability of Health Information Rule

In March 2020 CMS 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. This includes work on data sharing, member/provider portal updates, and internal policies and procedures.

LEGISLATIVE SUMMARY UPDATE

Federal Update

Senate Republicans in late July released their latest proposal for COVID relief funding. Known as the HEALS Act, this bill is a counter proposal to the HEROES Act which was passed by the House

of Representatives in mid-May. Notable to KHS, the HEALS Act did not include additional funding to state and local governments to help offset budget deficits, nor did it include a bump in federal matching dollars for Medicaid. These provisions were included in the HEROES Act and were advocated for by several groups. Congressional negotiations are underway and a final package is expected to be agreed upon by mid-August. KHS staff continues to work with our federal trade association (ACAP) on relevant healthcare-related provisions.

State Legislative

The State Legislature reconvened from summer recess on 7/27 and has until the end of August to finalize their session. The number of bills being considered is fewer than normal due to budget implications and the condensed schedule of the legislature. However, there are still several bills being tracked and advocated for shown in Attachment G.

Additionally, the State Budget process was upended due to the COVID-19 pandemic. In May the Governor released his revision to the budget which projected a $54 billion deficit. In order to balance the deficit, the Governor's Administration recommended numerous programmatic cuts including several to the Medi-Cal program. The legislature quickly responded with their own proposal that rejected many of the cuts proposed by the Governor. By the end of June, the Governor and Legislature had come to agreement on a budget solution. Notable items impacting KHS include retro-active and prospective Medi-Cal Managed Care rate cuts, a delay in the DHCS CalAIM initiatives, and the continuation of the Pharmacy Carve-Out. KHS staff worked with our Trade Associations to advocate on relevant budget items throughout the negotiation process.

New Department of Health Care Services Director

On June 15, 2020, Governor Gavin Newsom appointed Will Lightbourne to serve as DHCS Director. Lightbourne returned to state service after leading the California Department of Social Services (CDSS) as Director from 2011 through 2018. He sees his new role as a chance to continue serving the people of California and pursuing social justice at a critical moment. He recently said in a published interview that he believes we must now insist that our publicly financed health care system partner with the state's public health network and social safety net system to address community and population health, with emphasis on reducing health disparities, addressing structural inequities in how health care is delivered, and promoting social justice.

KHS AUGUST 2020 ENROLLMENT:

Enrollment Update

The U.S. Department of Health & Human Services again extended the public health emergency order. As a result, the Department of Health Care Services extended the freeze on redeterminations until about October 24, 2020. Thus, the Kern County Department of Human Services' suspension of their "automated discontinuance process" for Medi-Cal Redeterminations continues. The automated discontinuance process was in place locally prior to the public health emergency order when Medi-Cal beneficiaries did not complete the Annual Eligibility Redetermination process. However, Kern DHS continues working new Medi-Cal applications, reenrollments, successful renewals, additions, etc. (anything with a positive outcome).

Medi-Cal Enrollment

As of August 1, 2020, Medi-Cal enrollment is 184,132, which represents an increase of 1.3% from July enrollment.

Seniors and Persons with Disabilities (SPDs)

As of August 1, 2020, SPD enrollment is 14,054, which represents a decrease of 0.3% from July enrollment.

Expanded Eligible Enrollment

As of August 1, 2020, Expansion enrollment is 66,694, which represents an increase of 2.5% from July enrollment.

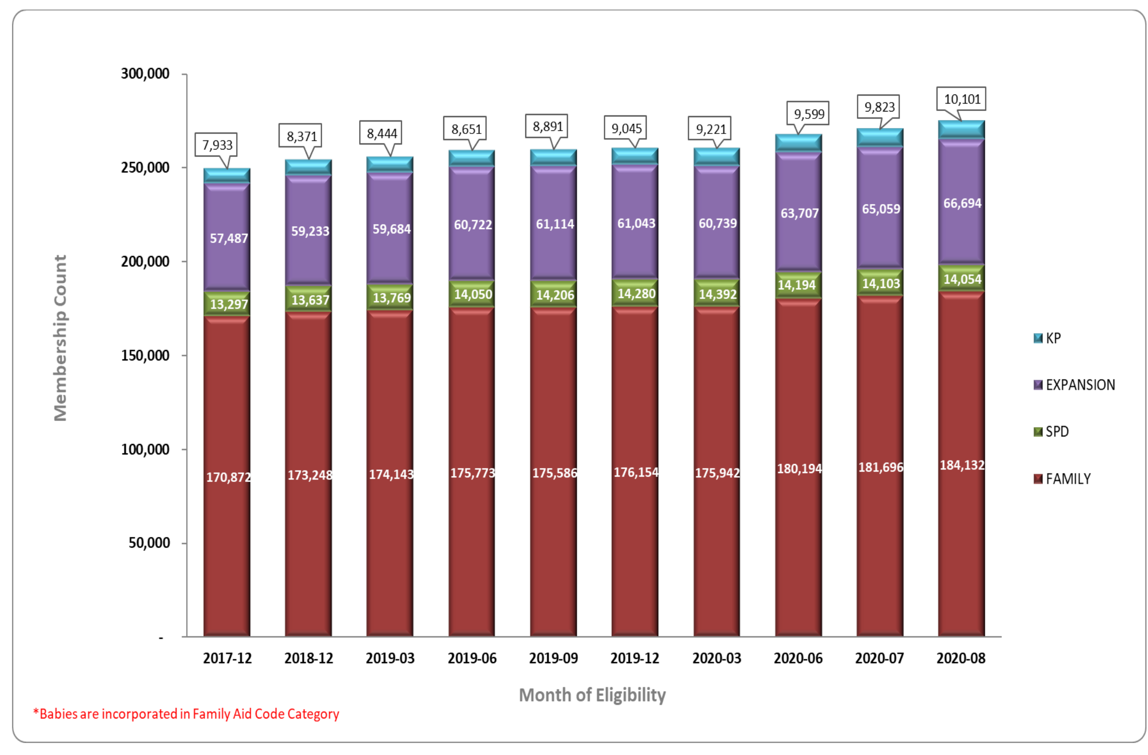
Kaiser Permanente (KP)

As of August 1, 2020, Kaiser enrollment is 10,101 which represents an increase of 2.8% from July enrollment.

Total KHS Medi-Cal Managed Care Enrollment

As of August 1, 2020, total Medi-Cal enrollment is 274,981, which represents an increase of 1.6% from July enrollment.

Membership as of Month of Eligibility	FAMILY	SPD	EXPANSION	KP	BABIES	Member Total
2017-12	170,425	13,297	57,487	7,933	447	249,589
2018-12	172,771	13,637	59,233	8,371	477	254,489
2019-03	173,743	13,769	59,684	8,444	400	256,040
2019-06	175,356	14,050	60,722	8,651	417	259,196
2019-09	175,074	14,206	61,114	8,891	512	259,797
2019-12	175,727	14,280	61,043	9,045	427	260,522
2020-03	175,515	14,392	60,739	9,221	427	260,294
2020-06	179,774	14,194	63,707	9,599	420	267,694
2020-07	181,272	14,103	65,059	9,823	424	270,681
2020-08	183,718	14,054	66,694	10,101	414	274,981



KHS ADMINISTRATIVE INITIATIVES

Provider Relations Credentialing

Type	July	August
Initial	No Mtg	72
Re-credentialing	No Mtg	37
New Vendors	No Mtg	18

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	May 2020	June 2020	July 2020
Total HealthX User Accounts	4,445	4,844	4,589
Total New HealthX User Accounts	119	216	162
Page Views	717,361	783,106	786,576
Unique Page Views	290,787	314,369	321,798
Avg. Time of Page	2:38	2:57	3:01

Provider Contracting

New or Modified Provider Agreements (may be completed or in negotiation):

- Dignity Health (Bakersfield Memorial and Mercy Hospitals)
- Antelope Valley Hospital
- Cedars Sanai (Los Angeles)
- Imad Abumeri, MD Inc., Neurological Surgery, eff 9/1/2020
- Desert Sky Transit, NEMT Transportation, eff 9/1/2020
- DV Therapy Inc., Speech therapy, eff 9/1/2020
- Greater Bakersfield Dialysis Center LLC, dialysis, eff 9/1/2020
- Advanced Cardiology Medical Associates, Inc, Cardiovascular Disease/Inter. Cardiology, eff 9/1/2020
- Kern County Regional Dialysis Center, LLC, dialysis, eff 9/1/2020
- Lincare Inc., DME, eff 9/1/2020
- Link Medical Transport, LLC, NEMT Transportation, eff 8/1/2020
- Marsinah Ramirez Buchan LMFT, MFT, eff 9/1/2020
- Wellbeing Rx Inc. (Angie), Pharmacy, eff 9/1/2020
- Autism Behavior Services, Inc. (Alex), ABA, eff 9/1/2020
- Adventist Health Physician Network, Multi-Specialty, eff 9/1/2020
- Centric Health, PCP, eff 9/1/2020
- Theodore Richard LCSW, eff 9/1/2020
- STAT MD Inc, walk-in, eff 9/1/2020
- Natera Inc, Laboratory, eff 9/1/2020
- Pediatric For All Inc., PCP, eff 9/1/2020
- West Side Health Care District, Chiropractic, eff 9/1/2020
- James E Holland, CSW, eff 9/1/2020

Provider Contracts Summary (Status)

The following summarizes current status of provider contracting activity for July. Open represents contracts or amendments still in negotiation. Inquiries represent either providers inquiring about becoming a participating provider or questions concerning their existing contract should they already participate in the KHS network. Waiting signature represents contracts or amendments that have been agreed to but not signed.

Open	Inquiries	Waiting signature
48	381	84

Marketing/Public Relations

KHS will share sponsorship in the following events in August and September:

- KHS supported the Kern County District 5 COVID-19 Testing Site at the Kern County Fairgrounds by providing 2-3 Medical Assistants per day through one of our staffing agencies. The site was available from June 22nd – July 27th. The contribution totaled around $15,000.
- KHS continues to support the Oildale COVID-19 County Testing Site at Good Samaritan Hospital by providing portable air coolers and handwashing sinks. The site was opened on May 15th and it's scheduled to continue operating through August. The contributions totaled about $30,000.
- KHS continues to support the Kern River Valley COVID-19 County Testing Site at Kern Valley Hospital by providing the drive-thru tent, portable air coolers and handwashing sinks. The site was opened on May 27th and it's scheduled to continue operating through September. The contributions totaled over $38,000.
- KHS is supporting a project being operationalized by Good Samaritan Hospital, along with partners Kern County District 4 and the California Farmworker Foundation, to provide mobile COVID-19 testing to underserved farmworkers at their worksites in agricultural communities of Kern County. Good Samaritan Hospital provides the supplies and medical professionals to conduct the COVID-19 testing at the mobile testing clinic. The daily cost of the mobile testing clinic is $5,000 and KHS was proud to donate $25,000 to the Good Samaritan Health Foundation in support of this project.
- KHS donated $5,000 to the Kern Valley Hospital Foundation to sponsor the River Rhythms concert series happening every Friday night in August in Kernville and the End of Summer Crabfest on September 13th.

No community events are scheduled in August or September due to the Governor's order disallowing large gatherings.

Employee Newsletters

The June and July 2020 Employee Newsletters can be seen by clicking the following links:

https://us20.campaign-archive.com/?u=f1b2565c17b55547feeb94aeb&id=9472703c48

https://us20.campaign-archive.com/?u=f1b2565c17b55547feeb94aeb&id=93c036e5b3

ADMINISTRATIVE PERFORMANCE REPORTS

Dashboard Presentation

- The Dashboard Reports showing KHS critical performance measurements are located under Attachment H.

Attachment A

Compliance and Regulatory Affairs Update

Board of Directors Meeting

August 13, 2020

STATE REGULATORY AFFAIRS

State Regulatory Affairs

Since the June 11, 2020 Board meeting:

- The Department of Health Care Services ("DHCS") issued three All Plan Letters ("APLs"). *See Attachment B for APLs 20-014 – 20-015* that provide guidance for Managed Care Plan's (MCP). Additionally, the DHCS revised APL20-004 in June 2020. All three APLs apply to the Plan and are on track for appropriate implementation as required by the APLs.

- The DHCS issued 5 COVID-19 APLs and Guidance Letters. *See Attachment C for the COVID- 19 APL and Guidance*. All five releases 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 nine APLs. *See Attachment D for APLs 20-021 – 20-029* that provide guidance for MCPs. Seven out of the nine 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 June and July 2020:

REGULATORY AGENCY	JUNE 2020	JULY 2020
DHCS	7	12
DMHC	0	1

COMPLIANCE

Summary of Alleged Fraud Investigations for June and July 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 June & July 2020

Provider

- For the months of June and July 2020, the Plan received five requests for information from the State Medi-Cal Program Integrity Unit ("Department") related to potential provider fraud, waste, or abuse.
- The Plan has recently completed a thorough investigation of one provider, including a claims audit. The Plan found the allegations to be unsubstantiated.
- Two other requests were for the same provider and for the same incident. In review of both requests, it was determined that it was a quality issue and not a case of fraud, which was referred to the Quality Department.
- The Plan currently has two investigations pending final analytics for the Department. The Plan does not know the outcome of the Department's investigation pertaining to the completed case.

Member

For the months of June and July 2020, the Plan did not receive any requests for information from the State Medi-Cal Program Integrity Unit related to potential Plan Member fraud, waste, or abuse.

Summary of Potential Protected Health Information ("PHI") Disclosures for June and July 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 June and July 2020, the Compliance Department investigated and reported six individual alleged privacy concerns to the DHCS.
- Three of the reported cases were closed. 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.
- Three cases are still pending final review.

Summary of Alleged Fraud Investigations for June and July 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 June and July 2020, the Compliance Department received two reports of alleged fraud, waste, or abuse by the Plan's Members. One case regards eligibility and will be submitted to the DHCS' Fraud Hotline. The other allegation is under review.

Provider

During the months of June and July 2020, the Plan received five allegations of fraud, waste, and abuse involving participating providers. Four 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 produces monthly newsletters to relay various Compliance topics to all staff. The June topic was "Suspicious Emails" and July was "Work-from-Home Photos Expose Security Risks". The newsletters are on the following pages.

Training and Education

Training and education are considered an important line of defense for a compliance program. The Plan conducts annual training and education in two areas: Health Insurance Portability and Accountability Act ("HIPAA") and Fraud, Waste, and Abuse.

To date 99% of all employees have completed their annual HIPAA training.

To date 96% of all employees have completed their annual fraud, waste, and abuse training.

Conflict of Interest Form 700

Per the Plan's Conflict of Interest Policy and Procedure #10.02-I "It is the policy of Kern Health Systems (KHS) to provide for a process for the disclosure and management of conflicts of interest which may exist for persons with positions of trust and responsibility in the governance and management of KHS, and to assure that state law provisions relating to such conflicts are followed. In order to safeguard independent judgment and action in business decisions, each person entrusted

with a key position of responsibility in KHS has a duty to disclose actual or potential conflicts of interest, to avoid acting out of any actual or apparent conflict of interest which may arise from personal financial interests in entities which may conflict with KHS' best interests."

100% for both Board Member and Executive personnel completed the Form 700 as per policy.

Compliance Capsule – June 2020

Suspicious Emails

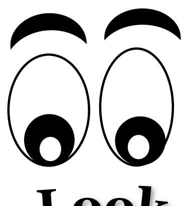
Q: What should you do if you get a suspicious email?

A: Stop, Look, and Act

Kern Health Systems ("KHS") continues to serve Members remotely with the highest standards to secure Member's Personally Identifiable Information ("PII") and Protected Health Information ("PHI"). In efforts to comply with State and Federal Regulations, the KHS Team shall notify and mitigate any potential network threats, which includes suspicious emails. The following Stop, Look, and Act steps can help prevent, protect, and secure the network from unwanted visitors.

When receiving a Suspecious Email:

1. Do not reply, reply all, or forward the email.
2. Do not open any attachments.
3. Do not open any links.



Read and Examine the Suspicious Email:

1. Who is the Sender? Do you...
   - ✓ Know the Sender?
   - ✓ Expect email from this Sender?
   - ✓ Notice that the content and signature match the Sender?

"No" ...

2. What is the Content? Does the email...
   - ✓ Contain misspellings or poor grammar?
   - ✓ Contain attachment or links?
   - ✓ Advertise? Ex: Offer expiring, products, or entice to win a prize
   - ✓ Request Information? Ex: Passwords, Logging In, or Credit Card Information
   - ✓ Have a suspicious deadline or urgency?

"Yes" ...

Next Steps to Take Action:

1. Contact the IT Help Desk at 661.664.5002.
2. Properly Delete the Suspicious Email.
   - ✓ Select Inbox Email - Right Click>Select **Delete,**
   - ✓ Deleted Items Folder - Select Email >Right Click>Select **Delete** (Permanently Delete Message) Click **Yes** > Remain_on the Deleted Items Folder,
   - ✓ Recover Deleted Items from Server (Left top corner, recycle can) - Select Email> Select **Purge Selected Items** > Click **Ok** (Message of permanent deletion pops-up)> Click **Ok.**

"Deleted!"

If you have any further questions on a Suspicious Email, contact the Compliance Department at Compliance@khs-net.com or the Director, Compliance and Regulatory Affairs at 661.664.5016.
Ethics Hotline is available 24/7 - All calls are Strictly Confidential: 800.500.0333

Compliance Capsule – July 2020

Work-from-Home Photos Expose Security Risks

Q: Can taking photos at home and posting them on social media expose security risks?

A: Yes!

As employees from many organizations continue to work from home, more people are sharing pictures of their remote-working set-ups. If you are on social media, chances are you've seen several photos with hashtags such as #wfh, #WFHSELFIE, #homeoffice, #quarantine, #stayathome, #socialdistancing, #workfromhomelife, #WFHwithKids, #remotework, or #covid. These and other similar tags are some of the most popular hashtags trending on the internet, but they can also be putting Member Protected Health Information ("PHI") or your own Personally Identifiable Information ("PII") at risk. Some items to be aware of before posting on social media:

- Photos showing screensavers with pictures of pets, family, favorite hobbies, trophies, books, and posters can provide personal clues about yourself to help cybercrooks guess your passwords.
- Images displaying details about your laptop, computer, and software such as Microsoft Windows or Office can expose you to several cyber risks.
- Sharing photos of virtual meetings and home office set-ups make it easy for cybercrooks to focus on your personal information and Member PHI.
- Photos showing your badge credentials (i.e., your photo, name, title) can be copied and used by hackers.
- Do not keep username & passwords visible.
- Be aware that envelopes and packages (i.e., Amazon), in the background can display your physical address.

Think Before You Post!

All Kern Health Systems employees are responsible for protecting Member's PHI and PII. If you have any questions about how to protect PHI or PII while working outside of the office, contact the Compliance Department at Compliance@khs-net.com or the Director, Compliance and Regulatory Affairs at 661.664.5016, carmen.dobry@khs-net.com. Ethics Hotline is available 24/7 - All calls are Strictly Confidential: 800.500.0333

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
June and July 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.	4/20/2020	1. APL sent to Stakeholders 2. Due date extended until April 20, 2020. 3. Complete	
APL20-004(rev)	Emergency Guidance for Medi-Cal Managed Care Health Plans	Member Services Provider Network Management 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.	4/7/2020	1. 3/30/20 Sent to APL to all Stakeholders 2. 4/7/20 Stakeholders met and discussed the requirements of the APL 3. 6/8/20 Revised APL sent to Stakeholders 4. 6/1820 Stakeholders met and reviewed updated requirements. 4. 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	
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. 4/24/20 Stakeholders reviewed APL 3. Complete	
APL20-007	APL20-007 Policy Guidance for Community-based Adult Services in Response to COVID-19 Public Health Emergency	Pharmacy Provider Network Management 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 Stakeholders reviewed the APL 3. 4/27/20 APL updated by DHCS and Stakeholders reviewed updates 4. 6/18/2020 APL updated by DHCS and Stakeholders reviewed updates 4. Complete	
APL20-008	APL20-008 Mitigating Health Impacts of Secondary Stress due to COVID-19 Emergency	Marketing Provider Network Management 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. 4/20/20 Stakeholders met and reviewed the APL 3. Complete	

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
June and July 2020 Attachment B

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-009	APL 20-009 Older/At-Risk Individuals – Guidelines to Reduce Isolation and Promote Health While Sheltering at Home	Member Services Health Services Provider Network Management 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	
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 Stakeholders reviewed the APL - Agreed to escalate to the PMO for implementation. 2. 5/27/30 Unplanned Project Stakeholder Meeting. 3. 5/28/20 Compliance will monitor the implementation of the Project by the PMO.	
APL20-011	APL20-011 Governor's Executive Order N-55-20 in response to COVID-19	Claims Health Services Provider Network Management 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.	5/8/2020	1. 4/25/20 Sent to Stakeholders 2. 5/8/20 Stakeholders reviewed documents. Follow-up meeting for IHA completion held. 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 held. 3. 6/17/20 UM to send letters to Members and will notify Member Services when the letters are sent. 4. 7/31/20 Updated P&P to be submitted by 8/7/2020	
APL20-013	APL 20-013 Proposition 56 Directed Payments for family Planning Services.	Claims Provider Network Management 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 APL sent to Stakeholders. 2. 5/20/20 Potentially eliminated in May 2020 Governor's Budget. Compliance is monitoring 3. 8/2/20 Payments sent the week of the 8/4/20 4. Complete	
APL20-014	APL20-014 Proposition 56 Value Based Payment Program Directed Payments	Claims Provider Network Management Finance IT Member Services Compliance	The APL provides MCPs with guidance on enhancement payments for Providers for the provision of specified for services with dates of service on or after July 1, 2019.	5/15/2020	1. 5/29/20 Sent draft to Stakeholders 2. 6/15/20 Redline Guidance document sent to stakeholders 3. 6/19/20 Stakeholders reviewed updated APL 4. 8/2/20 Payments to be sent the week of 8/4/20 5. Complete	

Kern Health Systems
2020 DHCS All Plan Letters and Status Updates
June and July 2020 Attachment B

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-015	APL 20-015: State Non-Discrimination and Language Assistance Requirements	Health Edu Cultural Linguistics Svs Marketing Member Services Compliance	The purpose of the APL is to remind Medi-Cal MCP Plans of continued nondiscrimination prohibitions and language assistance requirements pursuant to state law in light of recent federal rule changes.	6/24/2020	1. 6/25/20 APL sent to Stakeholders. 2. Complete	(green)

KEY	
(green)	Compliance - YES
(red)	Compliance - NO
(white)	Outcome Pending
(gray)	N/A - informational document

Attachment C
KHS COVID-19 Regulatory Guidance Tracking Log
8/2/2020

State Agency	Date Received by Plan	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	7/12/2020	Link	DHCS Suicide Prevention Letter for Providers	Provider Network Mgmt. Health Services Compliance	1. 7/13/20 Letter sent to Stakeholders - Provider Network Management posted the information on the website and sent out a Provider Bulletin . 2. **Complete**	DHCS requests that all Plans send to Providers a letter regarding suicide prevention
DHCS	6/23/2020	Link	Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19) (June Revision)	Provider Network Mgmt. Claims Configuration Member Services Health Services Compliance	1. 6/29/2020 sent to Stakeholders 2. **Complete**	Comprehensive update of Telehealth/Virtual Telephonic communication requirements. In light of both the federal Health and Human Services Secretary's January 31, 2020, public health emergency declaration, as well as the President's March 13, 2020, national emergency declaration relative to COVID-19, the Department of Health Care Services (DHCS) is issuing additional guidance to enrolled Medi-Cal providers, including, but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists – as well as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal 638 Clinics
DHCS	6/12/2020	Link	APL20-011 Governor's Executive Order (June Rev)	Quality Improvement Health Services Member Services Provider Network Mgmt. Compliance	1. 6/18/20 Sent to Stakeholders 2. 6/26/20 Stakeholders met reviewed updated requirements. 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
DHCS	6/9/2020	Link	APL20-004rev (June Rev.) 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. 6/12/20 Revised (2x) APL sent to Stakeholders 2. 6/18/20 Stakeholders reviewed the updated guidance. 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.
DHCS	6/3/2020	Link	Provision of Care in Alternative Settings, Hospital Capacity, State Plan and Blanket Section 1135 Waiver Flexibilities for Medicare and Medicaid Enrolled Providers Relative to COVID-19	Health Services Provider Network Mgmt. Member Services Claims Compliance	1. 6/8/20 Redline version created and sent to Stakeholders. 2. 6/11/20 Stakeholder met discussed options, requested follow-up questions with DHCS, and an additional meeting to discuss follow-up Face-to-face encounters. 3. 6/17/20 Stakeholders discussed the Providers ability to bill for a follow-up face-to-face visit after a telehealth Encounter. 4. **Complete**	Updates 4/22/20 guidance (Locations, Ambulance Services, Laboratories, etc.)- 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	5/29/2020	Link	MedIL I 20-14 Extension of Delaying Annual Redeterminations, Discontinuances, and Negative Actions Due to COVICE-19 PHE	Member Services Health Services Provider Network Mgmt. Compliance	1.6/1/20 Sent to Stakeholders 2. **Complete**	The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to instruct counties to extend the delay of processing Medi-Cal annual redeterminations and delay discontinuances and negative actions for Medi-Cal, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and County Children's Health Initiative Program (CCHIP) through the end of the Public Health Emergency (PHE).
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	Provider Network Mgmt. Health Services QI Claims	1. 5/26/20 Sent to Stakeholders 2. 6/18/20 Stakeholder met and discussed the requirements of the mandate. 3. **Complete**	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 Network Mgmt. 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.

Attachment C
KHS COVID-19 Regulatory Guidance Tracking Log
8/2/2020

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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.
DMHC	4/29/2020	Link	APL20-018 COVID-19 (OPM) Modification of Timely Access Provider Appointment Availability Surveys (PAAS) Timeframes	Provider Network Mgmt. 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	Provider Network Mgmt. 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 Provider Network Mgmt. 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 Provider Network Mgmt. 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 Provider Network Mgmt. 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.
DHCS	4/24/2020	Link	Well-Child Visits During Coronavirus (COVID-19) Pandemic	Provider Network Mgmt. Health Services Member Services Compliance	1. 4/25/20 Sent to Stakeholders 2. 5/4/20 Stakeholder meeting scheduled. 3. 6/4/20 Stakeholders met and discuss telehealth options. 4. **Complete**	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 Provider Network Mgmt. Compliance	1. 4/23/20 Sent to Stakeholders 2. **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 Provider Network Mgmt. 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 Provider Network Mgmt. Compliance	1. 4/18/20 Sent to Stakeholders 2. 5/1/20 Stakeholder met and discussed impacts. 3. **Complete**	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 Provider Network Mgmt. 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.
DHCS	4/16/2020	Link	Email: E-Mail File and Use	Member Services Health Services Provider Network Mgmt. 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.

Attachment C
KHS COVID-19 Regulatory Guidance Tracking Log
8/2/2020

State Agency	Date Received by Plan	URL/ Link	Title	Department Impacted	Status	Summary
DMHC	4/16/2020	Link	DMHC APL20-016 Assistance to Seniors	Member Services Health Services Provider Network Mgmt. 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	Member Services Health Services Provider Network Mgmt. 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	Member Services Health Services Provider Network Mgmt. 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.
DHCS	4/13/2020	Link	Follow-up Guidance to MEDIL I 20-07	Member Services Health Services Provider Network Mgmt. Compliance	1. 4/13/20 Sent to Stakeholders 2**. 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	Member Services Health Services Provider Network Mgmt. Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/10/20 Stakeholders reviewed analytics 3. 4/24/20 Stakeholder reviewed the Guidance in meeting. 4. **Complete**	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 Health Services Provider Network Mgmt. Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholder reviewed the updated guidance and made changes as needed. **3. Complete**	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	Member Services Health Services Provider Network Mgmt. Compliance	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 Health Services Provider Network Mgmt. Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/14/20 Stakeholders met and discussed limits of some Medi-Cal programs and implementation of Guidance. **3. Complete**	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.
DMHC	4/7/2020	Link	APL 20-014 Mitigating Negative Health Outcomes due to COVID-19	Member Services Health Services Provider Network Mgmt. Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholders met and discussed the Plan's approach to mitigating negative health outcomes. 3. **Complete**	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	Member Services Health Services Provider Network Mgmt. Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/15/20 Stakeholders met and discussed the Plan's approach to mitigating negative health outcomes. 3. **Complete**	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.

Attachment C
KHS COVID-19 Regulatory Guidance Tracking Log
8/2/2020

State Agency	Date Received by Plan	URL/ Link	Title	Department Impacted	Status	Summary
DHCS	4/7/2020	Link	Telehealth Services Guidance email	Member Services Health Services Provider Network Mgmt. Compliance	1. 4/10/20 Sent to Stakeholders 2. 4/13/20 Stakeholders met and discussed the Provider Bulletin and Provider Network Mgmt.'s outreach to FQHCs/RHCs 3. Complete	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)	Member Services Health Services Provider Network Mgmt. Compliance	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	Member Services Health Services Provider Network Mgmt. 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.
DHCS	3/30/2020	Link	DHCS Releases Guidance Related to "File and Use" of Texting Campaign Requests Related to COVID-19	Member Services Health Services Provider Network Mgmt. Compliance	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. Complete**	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	Member Services Health Services Provider Network Mgmt. 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)	Member Services Health Services Provider Network Mgmt. 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 updating potential language for Provider Network Mgmt.'s Provider Bulletin . 4. Complete	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.
DHCS	3/28/2020	Link	Provision of Care in Alternative Settings, Hospital Capacity, and Blanket 1135 Waiver Flexibilities - Mar 27, 2020	Member Services Health Services Provider Network Mgmt. Compliance	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	Member Services Health Services Provider Network Mgmt. 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	Member Services Health Services Provider Network Mgmt. Compliance	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.

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8/2/2020

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DHCS	3/27/2020	Link	Guidance for Emergency Medi-Cal Provider Enrollment	Member Services Health Services Provider Network Mgmt. 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.
DHCS	3/26/2020	Link	State Fair Hearing Timeframe Change - Managed Care - Mar 26, 2020 - Supplement to All Plan Letter 17-006	Member Services Health Services Provider Network Mgmt. Compliance	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	Member Services Health Services Provider Network Mgmt. Compliance	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 Provider Network Mgmt. 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.
DHCS	3/18/2020	Link	Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19) v.3	Member Services Health Services Provider Network Mgmt. 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	Member Services Health Services Provider Network Mgmt. Compliance	1. 3/18/20 Compliance reviewed the APL and conferred with Provider Network Mgmt. 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	Member Services Health Services Provider Network Mgmt. 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.
DHCS	3/17/2020	Link	MEDIL I 20-07 Access to Care During Public Health Crisis or Disaster	Member Services Health Services Provider Network Mgmt. Compliance	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)	Member Services Health Services Provider Network Mgmt. Compliance	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 Health Services Provider Network Mgmt. 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.

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KHS COVID-19 Regulatory Guidance Tracking Log
8/2/2020

State Agency	Date Received by Plan	URL/ Link	Title	Department Impacted	Status	Summary
DMHC	3/12/2020	Link	APL 20-007 (OPL) "Social Distancing" Measures in Response to COVID-19	Member Services Health Services Provider Network Mgmt. 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 Health Services Provider Network Mgmt. Compliance	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	Member Services Health Services Provider Network Mgmt. Compliance	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
DMHC All Plan Letters and Status Updates
June and July 2020 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 Provider Network Management	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	Provider Network Management 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. 3. Complete	
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 Provider Network Management 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	
APL20-008	Provision of Health Care Services During Self Isolation Orders	Member Services Health Services Provider Network Management 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 implementing APL 4. Complete	
APL20-009	Reimbursement for Telehealth Services	Provider Network Management 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 Provider Network Management 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.	5/15/2020	1. 4/3/20 APL sent to Stakeholders. 2. Complete	

Kern Health Systems
DMHC All Plan Letters and Status Updates
June and July 2020 Attachment D

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
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 the required documents timely. 2. Complete	
APL20-013	Billing for Telehealth Services; Telehealth for the Delivery of Services	N/A	N/A	N/A	N/A	
APL20-014	Mitigating Negative Health Outcomes due to COVID-19	Marketing Provider Network Management 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 APL was sent to Stakeholders 2. 4/15/20 Stakeholder met and reviewed the requirements of the APL. Stakeholders have implemented the requirements. 3. 4/16/20 Complete	
APL20-015	COVID-19 Temporary Extension of Plan Deadlines	Health Services Provider Network Management 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 APL was sent to Stakeholders 2. 5/27/20 Complete	
APL20-016	Assistance to Seniors	Health Services Provider Network Management 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 APL was 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	Provider Network Management 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	
APL20-020	Ensuring Continued Network Adequacy and Removing Unnecessary Burdens on Providers	N/A	N/A	N/A	N/A	
APL20-021	Governor's State of Emergency in Los Angeles County	N/A	N/A	N/A	N/A	

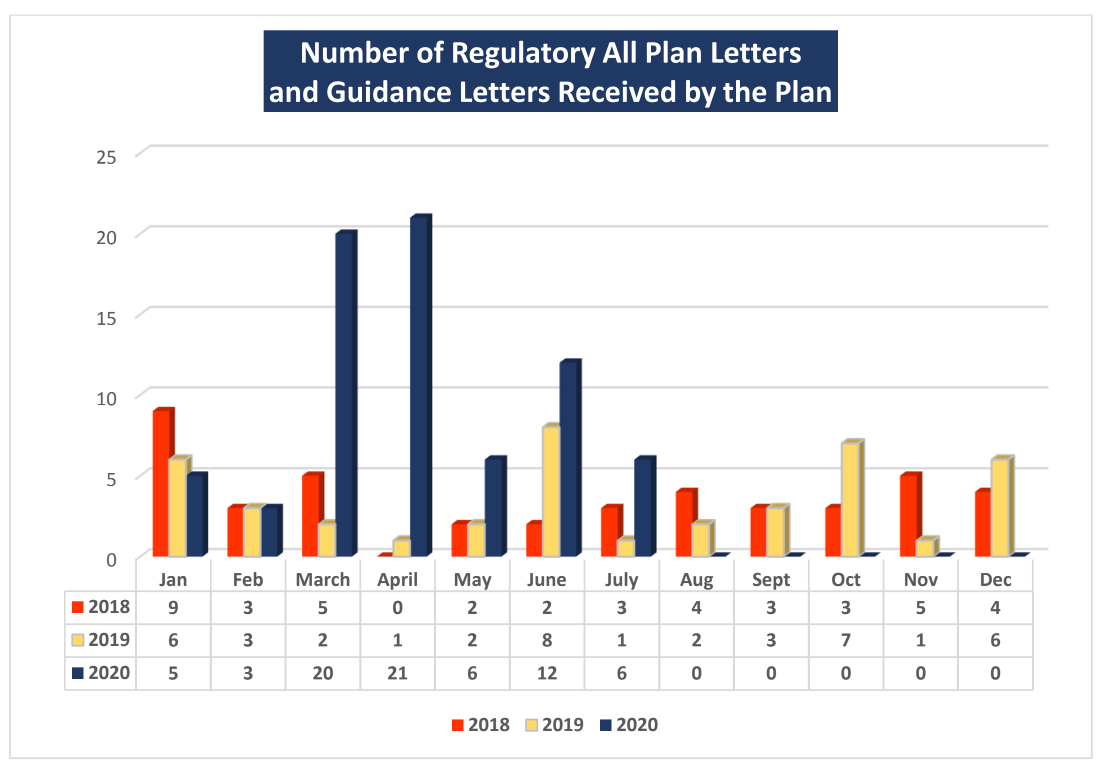
Kern Health Systems
DMHC All Plan Letters and Status Updates
June and July 2020 Attachment D

APL Number	Description	Impacted Department(s)	Impacted Functions	Plan Compliance Review Date	Status/Comment	Compliance Status
APL20-022	Compliance with California nondiscrimination requirements	Health Services Claims Provider Network Management Marketing Member Services Compliance	The DMHC affirms in the APL that it remains committed to protecting the health care rights of all Californians, regardless of their gender identity, sexual orientation, or English proficiency.	6/15/2020	1. 6/17/2020 APL sent to Stakeholders 2. Complete	
APL20-023	Extension of Special Enrollment Period in APL 20-010	N/A	N/A	N/A	N/A	
APL20-024	AB 315 Reporting Requirements	N/A	N/A	N/A	N/A	
APL20-025	Guidance Regarding New or Innovative Benefits	N/A	N/A	N/A	N/A	
APL20-026	Preventive Health Services Coverage for HIV Preexposure Prophylaxis	Pharmacy Provider Network Management Health Services Compliance	Per the APL, all plans must cover preventive health services for HIV PrEP to any individual who is determined to be at high risk of contracting HIV by the attending health care provider, and must do so without cost sharing.	7/27/2020	1. 7/8/20 APL sent to Stakeholders 2. 7/27/20 Stakeholders met and reviewed the APL. The P&P is being circulated for signatures. 3. 8/7/20 Compliance will file an E-1 document with the DMHC by 8/7/2020.	
APL20-027	Guidance Regarding Assembly Bill (AB) 731	N/A	N/A	N/A	N/A	
APL20-028	Emergency Regulation Regarding COVID-19 Diagnostic Testing	N/A	N/A	N/A	N/A	
APL20-029	Extension of Special Enrollment Period to August 31, 2020	N/A	N/A	N/A	N/A	

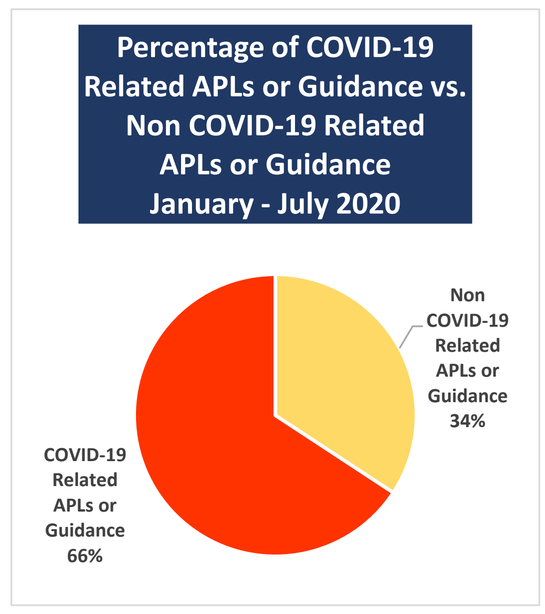
KEY	
(green)	Compliance - YES
(red)	Compliance - NO
(white)	Outcome Pending
(gray)	N/A - informational document

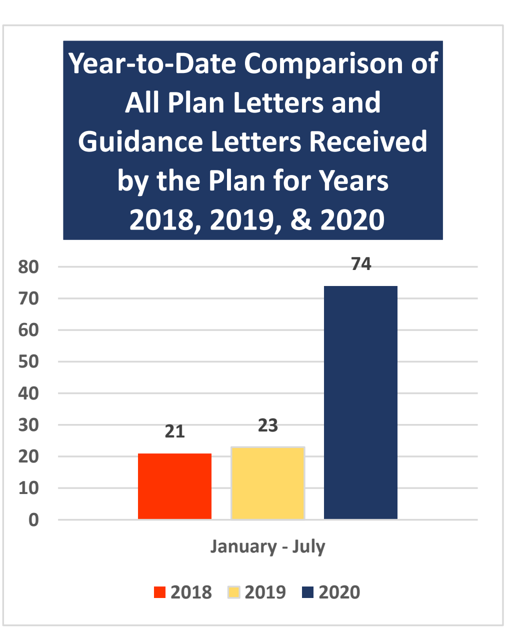
3 of 3

Attachment E
Compliance and Regulatory Affairs Department
All Plan Letters and Regulatory Guidance
Reviews: January to July 2020



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2018	9	3	5	0	2	2	3	4	3	3	5	4
2019	6	3	2	1	2	8	1	2	3	7	1	6
2020	5	3	20	21	6	12	6	0	0	0	0	0



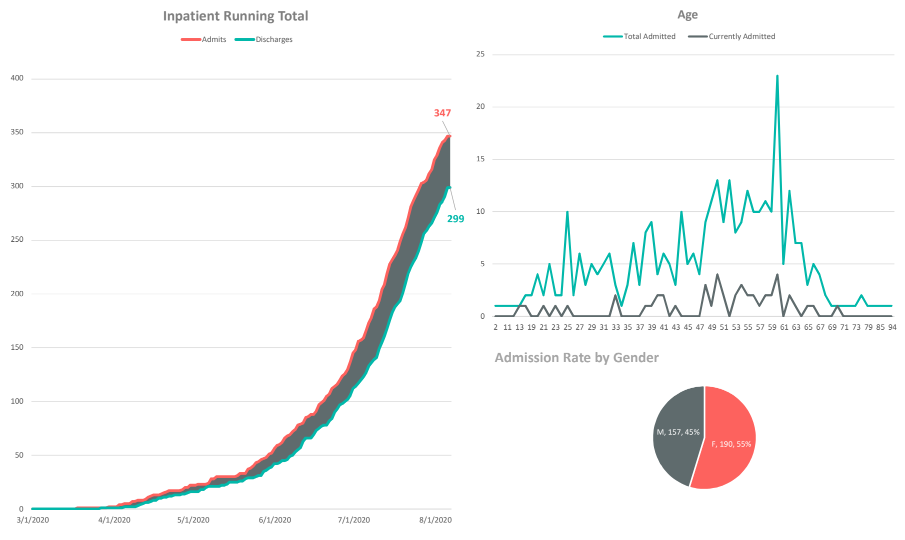


KERN HEALTH SYSTEMS

Attachment E

Positive COVID Testing - Inpatient

through Aug 7, 2020



Facility	Positive Tests	Currently Admitted
ADVENTIST HEALTH BAKERSFIELD SAN JOAQUIN HOSP	86	14
MERCY HOSPITAL	85	10
BAKERSFIELD MEMORIAL HOSPITAL	77	7
KERN COUNTY MEDICAL AUTHORITY HOSPITAL	35	5
DELANO REGIONAL MEDICAL CENTER	21	2
GOOD SAMARITAN HOSPITAL	12	4
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF BAKERSFIELD	5	1
WHITE MEMORIAL MEDICAL CENTER	3	0
ADVENTIST MEDICAL CENTER HANFORD COMMUNITY HOSPITAL	2	0
PACIFICA HOSPITAL OF THE VALLEY	2	2
FRESNO COMMUNITY HOSPITAL AND MEDICAL CENTER	2	1
ADVENTIST HEALTH MEDICAL CENTER TEHACHAPI HOSPITAL	2	0
BAKERSFIELD HEART HOSPITAL	1	0
LONG BEACH MEMORIAL MEDICAL CENTER MILLER CHILDRENS HOSPITAL	1	0
BUTTAR MUHAMMAD	1	0
GLENDALE ADVENTIST MEDICAL GROUP	1	0
THE REHABILITATION CENTER OF BAKERSFIELD	1	1
ANTELOPE VALLEY HOSPITAL	1	0
UCLA MEDICAL CENTER RONALD REAGAN	1	1
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	1	0
CALIFORNIA HOSPITAL MEDICAL CENTER LOS ANGELES	1	0
SCRIPPS MERCY (CHULA VISTA)	1	0
KAWEAH DELTA MEDICAL CENTER	1	0
SOUTHERN CALIFORNIA HOSPITAL	1	0
ERLANGER MEDICAL CENTER	1	0
UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA	1	0
REGIONAL MEDICAL CENTER	1	0
Grand Total	**347**	**48**

ETHNICITY	KHS	COVID +
HISPANIC	63%	76%
CAUCASIAN	17%	10%
NO VALID DATA	8%	3%
AFRICAN AMERICAN	7%	6%
ASIAN INDIAN	1%	1%
FILIPINO	1%	1%
UNKNOWN	1%	1%
ASIAN/PACIFIC	1%	1%

ATTACHMENT F

Kern Health Systems
COVID-19 Pandemic Programs

Kern Health Systems (KHS) has been closely monitoring the unprecedented events resulting from the COVID-19 pandemic. One key component we are tracking daily is access to care for our members. In an effort to support and maintain a strong network of providers to ensure network adequacy, KHS has developed several programs to address the emergency needs of providers. in meeting their office obligations during these challenging times. Further, KHS understands the stress and anxiety our members are experiencing with the rising concern this pandemic is causing, therefore we implemented a 24/7 COVID-19 call center which will assist our members to consult with an on-call physician 24/7 regarding any symptoms or questions they may have about COVID-19.

The COVID-19 Provider Relief Program:

KHS continues to provide emergency provider financial relief program which offered advance payments to providers that meet certain requirements. KHS already provided payment advancements to 63 different provider offices to assist them during these challenging times where they experienced a financial impact due to the pandemic. The total advance payment will be up to 50% of the average monthly claim's revenue paid by KHS. Each advance payment will be paid on a monthly basis for up to three (3) months.

Omni Family Health - COVID19 Alternate Payment Program:

Kern Health Systems (KHS) established a program for COVID-19 specific services with an FQHC using performance incentives to encourage patients to return to care. Below are the performance outcome measures for this project:

Measure 1: Physician shall maintain a minimum of two (2) COVID-19 screening and testing sites. These sites will be equipped with COVID-19 specific testing kits and triage equipment.

Measure 2: Physician will create a telehealth structure and provide access to care at 22 locations. The telehealth programs will be open to all Kern Family Health Care members.

Measure 3: Physician will provide COVID-19 education and outreach to a minimum of 10,000 Kern Family Health Care members. Education and outreach will be available in English and Spanish.

Measure 4: Physician will create and maintain a COVID-19 hotline offered to all Family Health Care members. The hotline will be incorporated into Kern Health Systems overall on-call physician availability.

Measure 5: Physician will create and maintain a COVID-19 pre-screening process at 22 clinic locations. Prescreening process will include but not be limited to temperature screenings, symptom evaluation and isolation prior to doctor visit, if needed.

Hospital COVID Relief Fund:

Kern Health Systems (KHS) is creating a COVID -19 Hospital Relief Fund to address revenue shortfall Hospitals are experiencing from a reduction in hospital outpatient visits when patients don't seek routine services or defer elective procedures during the Pandemic.

24/7 COVID-19 Call Center:

Kern Health Systems set up a 24/7 COVID-19 call center for our members to have access to speak to an on-call physician at any time. This program contains the spread of COVID-19 by providing telemedicine or telephonic medical care for KFHC members that have questions specific to COVID-19 AND to provide telemedicine or telephonic medical care to the stable patients at home. For members who are recommended to see additional COVID-19 care, the appropriate isolation, testing and treating sites will be made readily available. The program has Bilingual staff available to assist our members (Spanish, Punjabi & Hindi). The program is made up of 2 providers, 2 receptionist and 2 RNs for 24-hour coverage.

COVID-19 Recuperative Care Beds (COVID-19 and Non-COVID 19):

Kern Health Systems has created a system to facilitate hospital discharges for COVID-19 positive members that continue to require lower level medical services. The two post discharge placement options that will be coordinated between the KHS discharge planning nurse and Recuperative Care Facility. KHS has a guaranteed 10 bed-hold for individuals that are COVID-19+ and cannot safely return to their homes and 10 additional bed-hold for recuperative care of non COVID-19+ members.

COVID-19 Telephonic and Telehealth Providers:

Kern Health Systems expanded its telehealth providers to address a shortage in the traditional face to face visits with members. Also, telephonic visits, as approved by DHCS, were incorporated and promoted within our provider network.

COVID-19 Member Resources Guide:

Kern Health Systems is aware that not only does COVID-19 impact member's medical needs, it affects their social and economic needs as well. KHS staff created and continues to maintain a community resource guide that is available for Member Services and utilization management staff. This guide providers the most up-to date resources available for our members in all Kern County communities.

Kern Community Foundation Kern County COVID-19 Relief Fund Donation

KHS donated to the Kern Community Foundation's "Kern County COVID-19 Relief Fund" to support local nonprofits serving vulnerable populations with basic needs. Nine local organizations benefitted from this funding.

KHS Supports COVID-19 Testing Sites in Kern County

- 5th District Drive-Thru COVID-19 Testing Site at The Prado Senior Center in East Bakersfield. It was the first COVID-19 testing site that was operational for one month.

- 5th District Drive-Thru COVID-19 Testing Site at the Kern County Fairgrounds. It was operational for a month and a half.

- Kern River Valley COVID-19 County Testing Site at Kern Valley Hospital. The site was opened on May 27th and it will be operational through September.

- Oildale COVID-19 County Testing Site at Good Samaritan Hospital. The site was opened on May 15th and it will be operational through August.

- 4th District - Rural Mobile Testing Site for Farmworkers in rural Kern County. This program will continue for the fall.

Attachment G

Legislative/Policy Summary – August 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) 06/23/20 Referred to Com. on HEALTH.
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	6/23/2020 - Referred to Com. on HEALTH.
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	LHPC Support 7/23/2020 - Read second time, amended, and re-referred to Com. on B., P. & E.D.

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	6/23/2020 - Referred to Com. on HEALTH.
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 also authorize the department to enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's duties, as specified. 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 require the department to contract, by January 1, 2024, 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 pursuant to a contract with the department for the costs and activities that are associated with dispensing any specialty drug in an amount necessary to ensure beneficiary access, as determined by the department based on the results of 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. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB2100	8/1/2020 - 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	8/1/2020 - From committee: Do pass and re-refer to Com. on APPR.
AB 2164 (Rivas)	This bill would provide that an FQHC or RHC "visit" includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous interaction or asynchronous store and forward. The bill would specify that an FQHC or RHC is not precluded from establishing a patient who is located within the FQHC's or RHC's federal designated service area through synchronous interaction or asynchronous store and forward as of the date of service if specified requirements are met. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2164	LHPC Support 08/01/20 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. The bill would require each Medi-Cal managed care plan to establish a monitoring system related to blood lead screening tests that includes standard reporting requirements, as specified, 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 and parent, parents, guardian, or other person charged with their support and maintenance when that child has missed a required blood lead screening test. The bill would provide that it is the goal of the state that children at risk of lead exposure receive blood lead screening tests. 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. This bill would add several risk factors to be considered as part of the standard of care specified in regulations, including a child's residency in or visit to a foreign country, and would require the department to develop, by January 1, 2021, the regulations on the additional risk factors, in consultation with medical experts, environmental experts, appropriate professional organizations, the public, and others as determined by the department. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2276	8/1/2020 - VOTE: Do pass as amended, but first amend, and re-refer to the Committee on [Appropriations]
AB 2360 (Maienschein)	This bill would require health care service plans and health insurers, by July 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and certain postpartum persons with access to a psychiatric consultation program. The bill would require the consultation to be conducted by telephone or telehealth video, and to include guidance on the range of 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 monitor data pertaining to the utilization of the program to facilitate ongoing quality improvements, as necessary. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2360	CAHP Oppose, LHPC Oppose Unless Amended 8/1/2020 - VOTE: Do pass as amended, but first amend, and re-refer to the Committee on [Appropriations]

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 seek any federal waivers or other state plan amendments to achieve specified objectives, such as including 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	LHPC Support 7/27/2020 - Read second time and amended. Re-referred to Com. on HEALTH.
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. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB852	CAHP Support in concept 6/29/2020 - Referred to Com. on HEALTH.

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 low-risk pregnancy, as defined, and childbirth and to provide prenatal, intrapartum, and postpartum care, including gynecologic and family-planning services, interconception 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 authorize a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient's care, signed by both the certified nurse-midwife and a physician and surgeon to provide a patient with specified services. The bill would require the patient to be transferred to the care of a physician and surgeon to provide those services if the nurse-midwife does not have those mutually agreed-upon policies and protocols in place, and would authorize the return of that patient to the care of the nurse-midwife after the physician and surgeon has determined that the condition or circumstance that required, or would require, the transfer is resolved. The bill would authorize a certified nurse-midwife to attend pregnancy and childbirth in an out-of-hospital setting if consistent with the above-described provisions. http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB1237	7/27/2020 - Read second time and amended. Re-referred to Com. on B. & P. July 27 hearing postponed by committee.

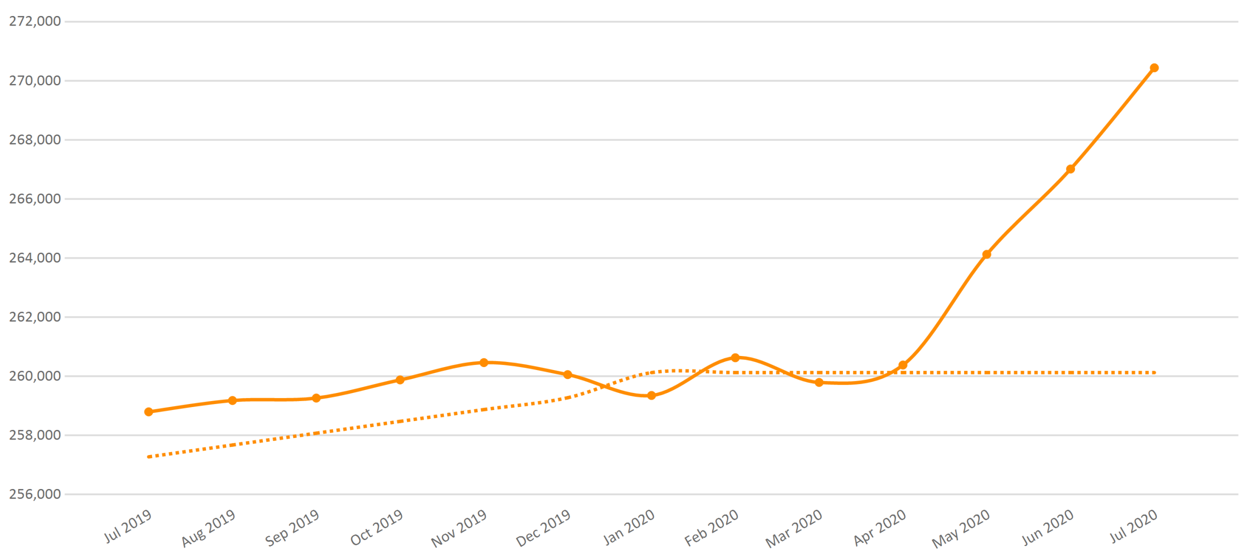
Governed Reporting System

Kern Health Systems
Attachment H

KHS Dashboard Performance Reports
(Critical Performance Measurements)

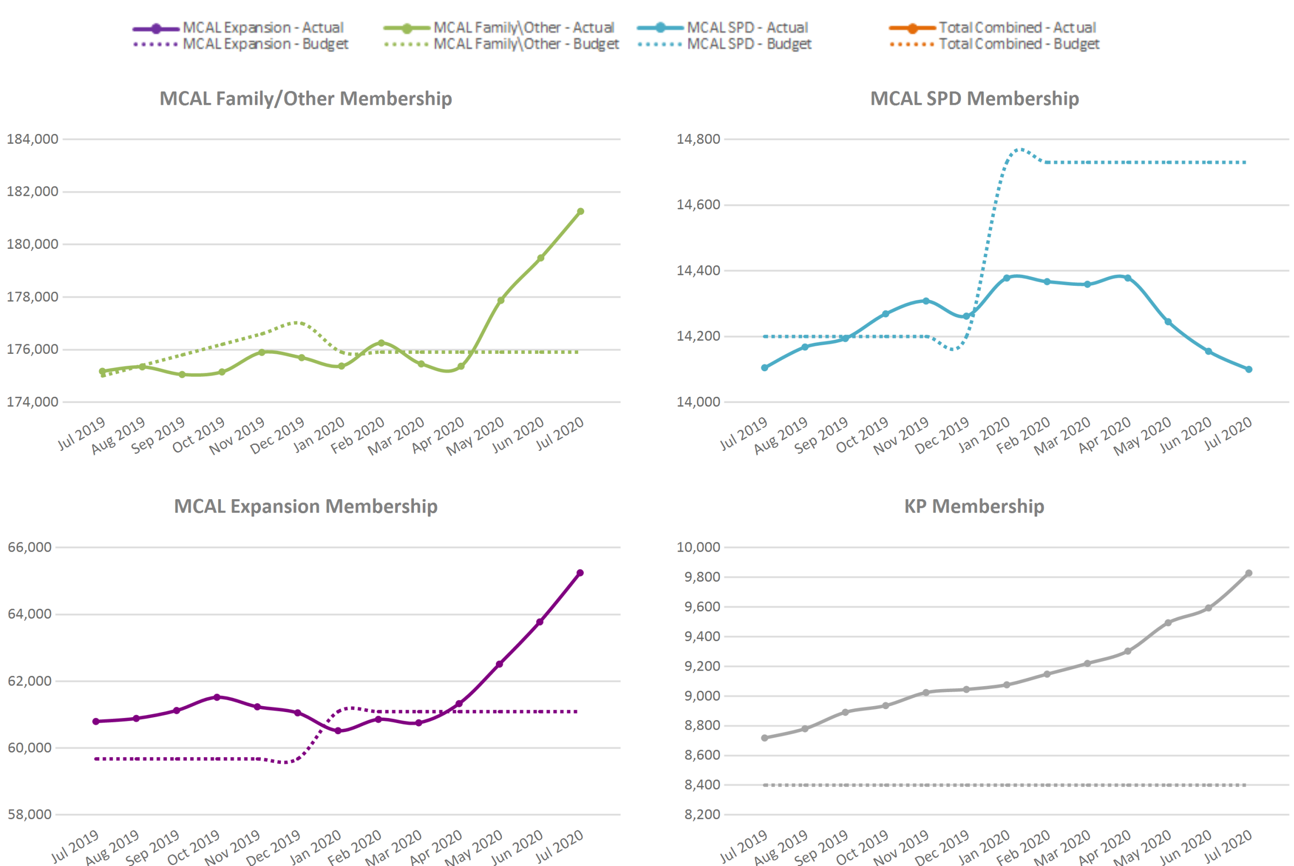
Governed Reporting System

Membership



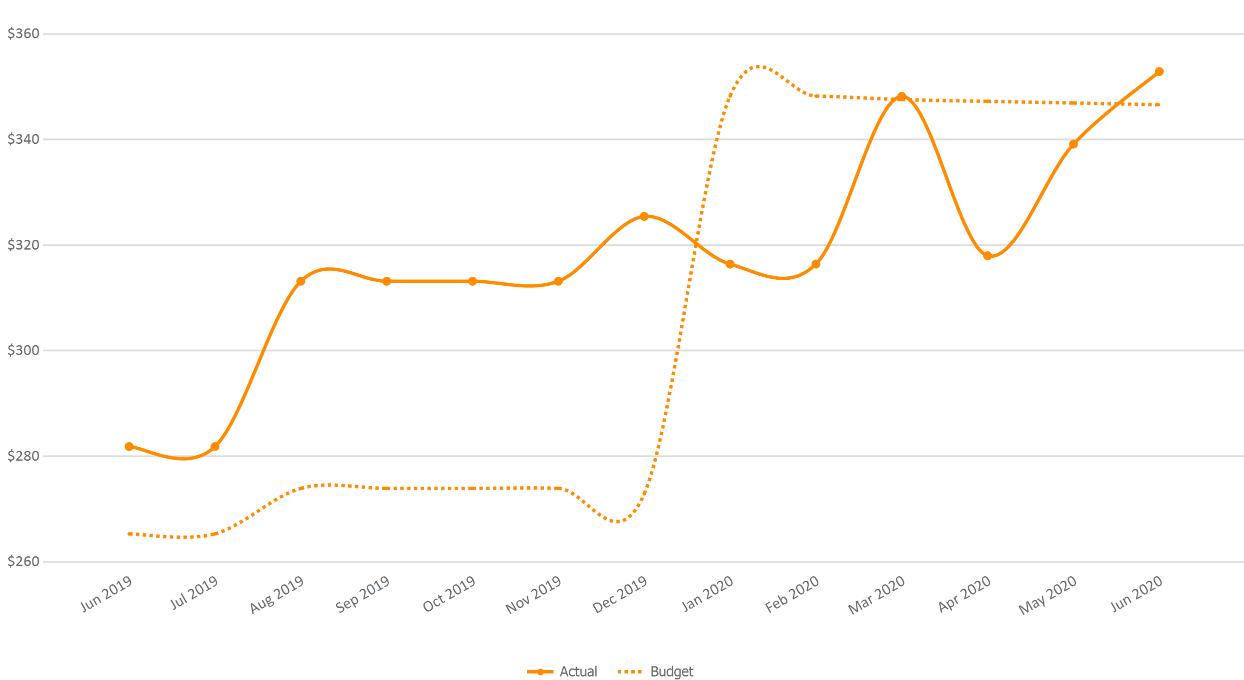
Governed Reporting System

Membership



Governed Reporting System

Revenue



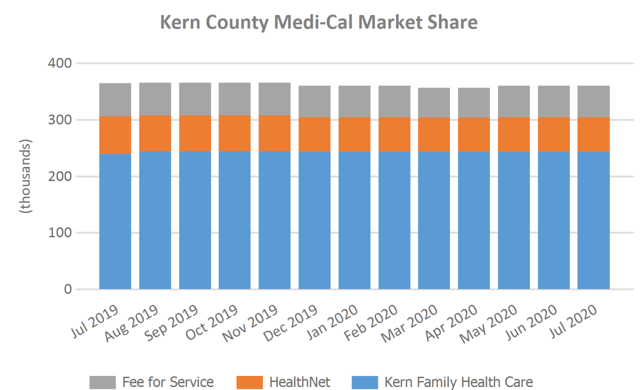
Governed Reporting System

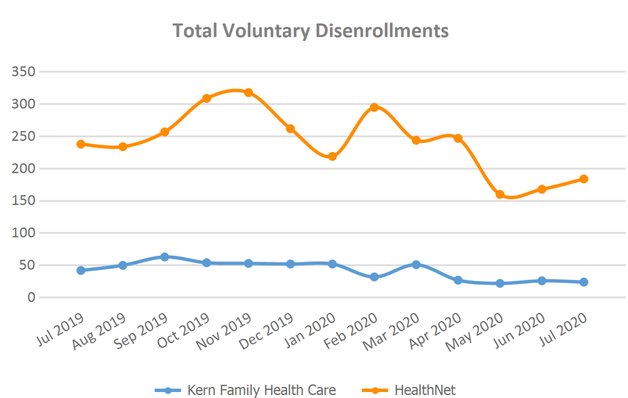
Kern Health Systems

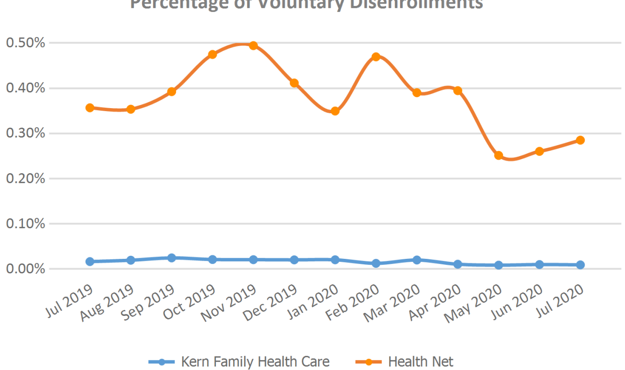
Performance Reports
Operations Metrics

Governed Reporting System

Enrollment - Market Share

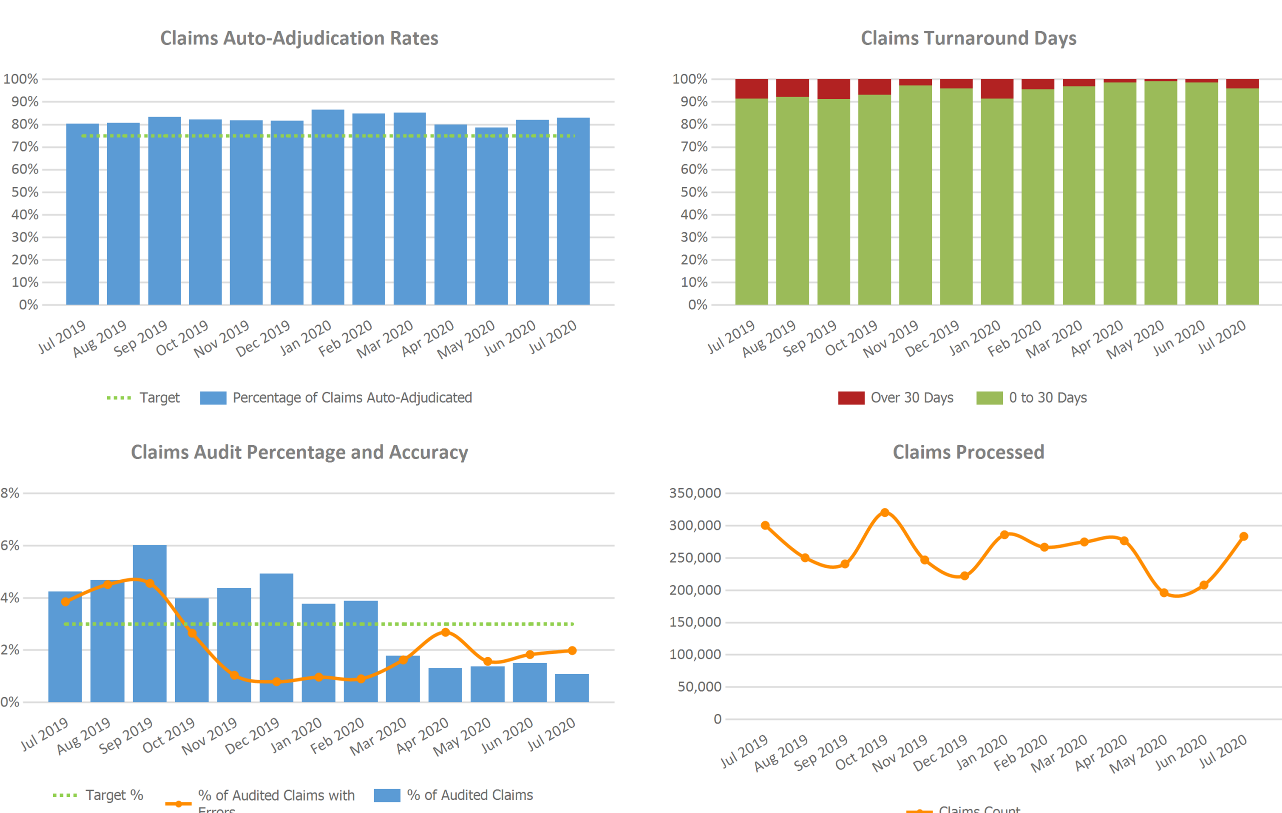






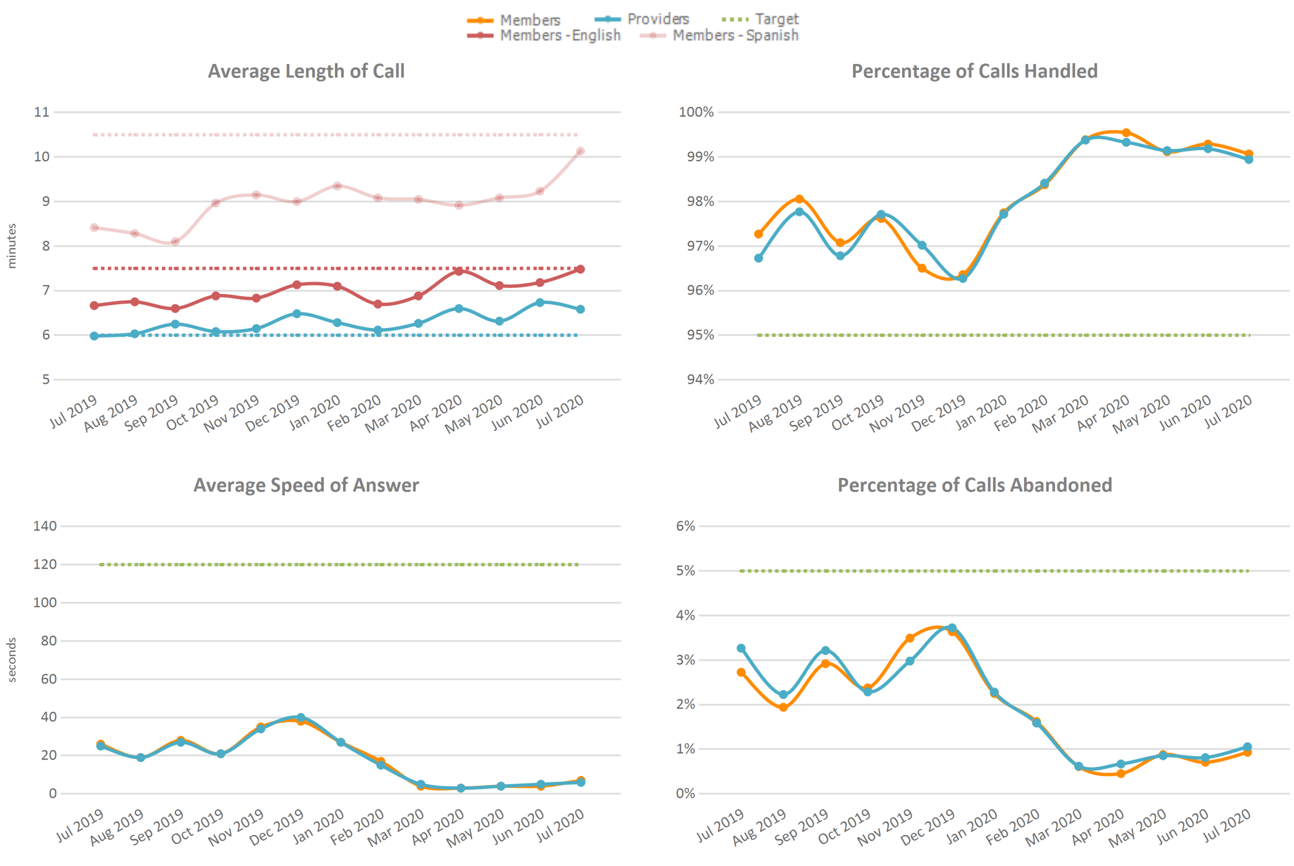
Governed Reporting System

Claims Efficiency and Quality



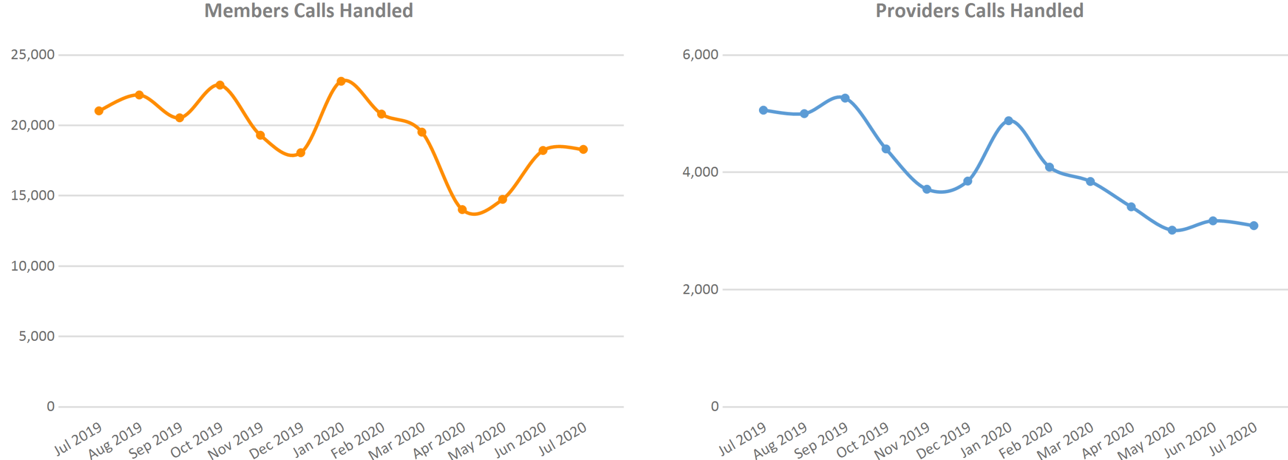
Governed Reporting System

Member Services



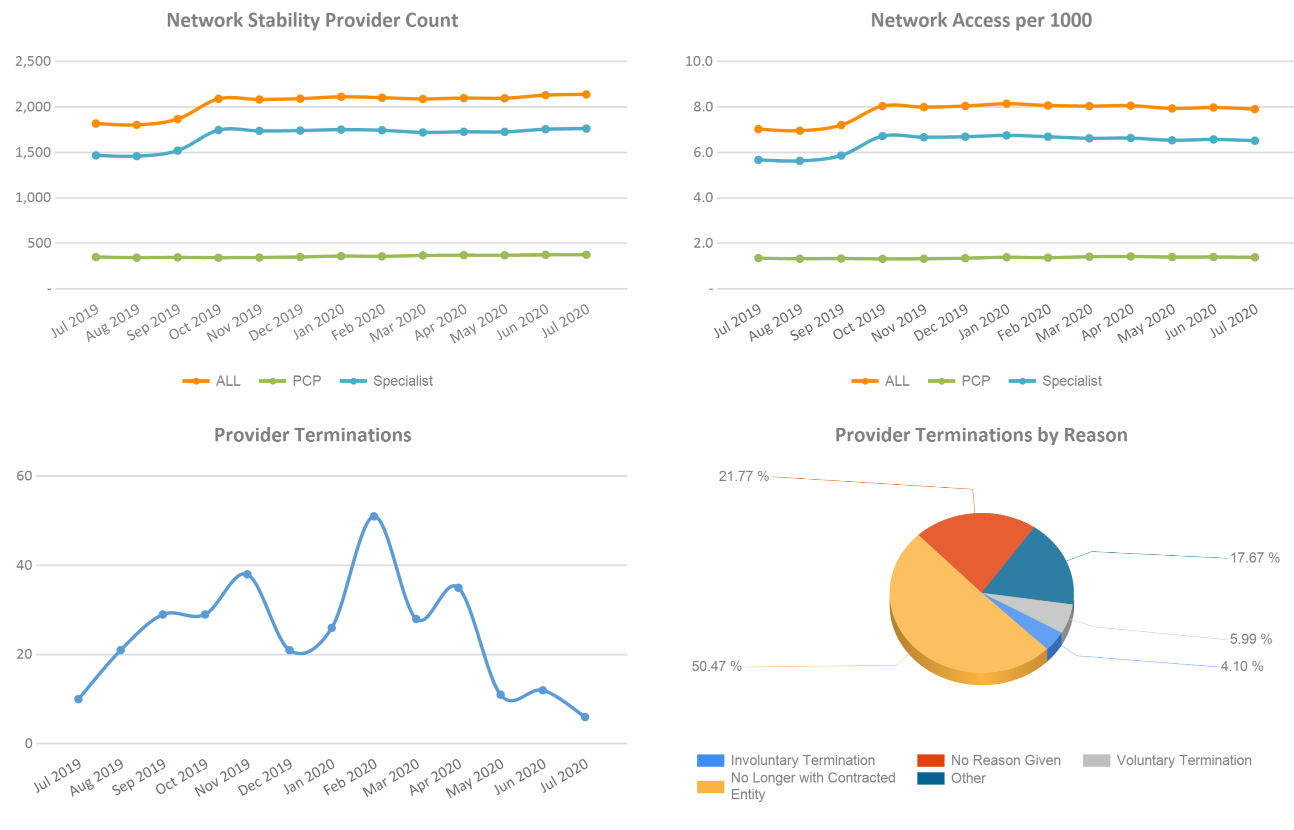
Governed Reporting System

Member Services Calls Handled



Governed Reporting System

Provider Network and Terminations



SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, June 5, 2020

8:00 A.M.

COMMITTEE RECONVENED

Members present: Deats, McGlew, Rhoades

Members absent: Hinojosa, Melendez

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

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

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

3) Report on Kern Health Systems investment portfolio for the first quarter ending March 31, 2020 (Fiscal Impact: None) – IRA COHEN, UBS FINANCIAL SERVICES, INC., HEARD;
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Rhoades: 3 Ayes; 2 Absent – Hinojosa, Melendez

4) Proposed Amendments to Kern Health Systems Investment Policy (Fiscal Impact: None) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Rhoades: 3 Ayes; 2 Absent – Hinojosa, Melendez

5) 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) – MONIQUE EUBANKS, MICHAEL MOORE, MORTENSEN INSURANCE/INSURICA, HEARD;
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Rhoades: 3 Ayes; 2 Absent – Hinojosa, Melendez

6) 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) – CHRIS TOBIN, ALLIANT INSURANCE, HEARD;
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Rhoades-McGlew: 3 Ayes; 2 Absent – Hinojosa, Melendez

7) 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) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Rhoades-McGlew: 3 Ayes; 2 Absent – Hinojosa, Melendez

8) 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) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Rhoades: 3 Ayes; 2 Absent – Hinojosa, Melendez

9) Report on Kern Health Systems financial statements for February 2020, March 2020 and April 2020 (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Deats-Rhoades: 3 Ayes; 2 Absent – Hinojosa, Melendez

10) 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 ended March 31, 2020 (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Rhoades: 3 Ayes; 2 Absent – Hinojosa, Melendez

ADJOURN TO FRIDAY, AUGUST 7, 2020 AT 8:00 A.M.
Rhoades