KERN HEALTH SYSTEMS

REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, February 16, 2023
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, February 16, 2023

8:00 A.M.

All agenda item supporting documentation is available for public review on the Kern Health Systems website: https://www.kernfamilyhealthcare.com/about-us/governing-board/
Following the posting of the agenda, any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available on the KHS website.

PLEASE SILENT CELL PHONES AND OTHER ELECTRONIC DEVICES DURING THE MEETING

BOARD TO RECONVENE

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

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

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

8:15 A.M.

BOARD TO RECONVENE

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO MEMBER OF THE BOARD OR AUDIENCE WISHES TO COMMENT OR ASK QUESTIONS. IF COMMENT OR DISCUSSION IS DESIRED BY ANYONE, THE ITEM WILL BE REMOVED FROM THE CONSENT AGENDA AND WILL BE CONSIDERED IN LISTED SEQUENCE WITH AN OPPORTUNITY FOR ANY MEMBER OF THE PUBLIC TO ADDRESS THE BOARD CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

3) This portion of the meeting is reserved for persons to address the Board on any matter not on this agenda but under the jurisdiction of the Board. Board members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Board at a later meeting. Also, the Board may take action to direct the staff to place a matter of business on a future agenda. SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THE MEETING FACILATATOR WILL INDICATE WHEN THERE IS 15 SECONDS REMAINING TO YOUR PRESENTATION TIME!

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

4) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on December 15, 2022 (Fiscal Impact: None) –
APPROVE

6) Appreciation recognition of Wayne Deats for 11 + years of dedicated service as a member of the Kern Health Systems Board of Directors (Fiscal Impact: None) – RECEIVE AND FILE

7) Appreciation recognition of Jeff Flores for his tenure of dedicated service as a member of the Kern Health Systems Board of Directors (Fiscal Impact: None) – RECEIVE AND FILE

CA-8) Report on Kern Health Systems 2023 Utilization Management Program Work Plan and the Quality Improvement 2023 Work Plan (Fiscal Impact: None) – APPROVE

9) Report on Kern Health Systems Managed Care Accountability Set (MCAS) Action Plan (Fiscal Impact: None) – APPROVE

10) Review of Kern Health Systems Cyber Insurance Policy (Fiscal Impact: None) – RECEIVE AND FILE

CA-11) Report on Kern Health Systems 2022 Corporate Goals and Objectives Final Report (Fiscal Impact: None) – RECEIVE AND FILE

CA-12) Proposed revisions to Policy 4.01-P, Credentialing (Fiscal Impact: None) – APPROVE

CA-13) Proposed revisions to Policy 4.47-P, Clinical Laboratory Improvements Amendments (Fiscal Impact: None) – APPROVE

14) Report on Kern Health Systems 2023-2025 Strategic Plan (Fiscal Impact: None) – RECEIVE AND FILE

CA-15) Report on Kern Health Systems 2023 Marketing and Community Outreach Campaign Plan (Fiscal Impact: None) – RECEIVE AND FILE

CA-16) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2022 (Fiscal Impact: None) – RECEIVE AND FILE

CA-17) Report on 2022 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) – RECEIVE AND FILE

CA-18) Request to change the previously approved 2023 reinsurance carrier from HM Life Insurance back to the current 2022 carrier IOA Re (2023 Fiscal Impact: $1,122,917; $914,969 Budgeted; $207,948 Not Budgeted) –
APPROVE

CA-19) Report on 2022 Annual Travel Report (Fiscal Impact: None) –
RECEIVE AND FILE

CA-20) Report on 2022 Annual Report of Disposed Assets (Fiscal Impact: None) –
RECEIVE AND FILE

CA-21) Review of 2022 Budgeted Capital Projects scheduled to be completed in 2023 (Fiscal Impact: None) –
APPROVE

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

CA-23) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2022 and IT Technology Consulting Resources for the period ended November 30, 2022 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-24) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-25) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) –
RECEIVE AND FILE

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

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

CA-28) Miscellaneous Documents –
RECEIVE AND FILE

A) Minutes for Kern Health Systems QI / UM Committee meeting on Feb. 24, 2022
B) Minutes for Kern Health Systems QI / UM Committee meeting on May 26, 2022
C) Minutes for Kern Health Systems QI / UM Committee meeting on July 28, 2022
D) Minutes for Kern Health Systems QI / UM Committee meeting on Nov. 10, 2022
E) Minutes for Kern Health Systems Finance Committee meeting on Dec. 9, 2022

ADJOURN TO APRIL 13, 2023 AT 8:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 2900 Buck Owens Boulevard, Bakersfield, California 93308 or by calling (661) 664-5010. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: February 16, 2023

Re: AB 361 Remote Meeting Resolution

Background

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

Recommended Action

The Board adopt the resolution and continue with remote meetings during the month of February 2023 or until the state of emergency is lifted.

KERN HEALTH SYSTEMS

RESOLUTION

In the matter of:

A RESOLUTION OF THE BOARD OF DIRECTORS OF KERN HEALTH SYSTEMS PROCLAIMING A LOCAL EMERGENCY, RATIFYING THE PROCLAMATION OF A STATE OF EMERGENCY, AND AUTHORIZING REMOTE TELECONFERENCE MEETINGS FOR THE MONTH OF FEBRUARY 2023

Section 1. WHEREAS

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Effective Date of Resolution. This Resolution shall take effect on February 16, 2023 and shall be effective until the earlier of March 15, 2023, or such time the Board of Directors adopts a subsequent resolution in accordance with Government Code section 54953(e)(3) to extend the time during which Kern Health Systems may continue to teleconference without compliance with paragraph (3) of subdivision (b) of section 54953.

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

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

Office of Kern County Counsel

Kern Health Systems

I, Sheilah Woods, Clerk of the Board of Directors of Kern Health Systems, hereby certify that the following resolution, on motion of Director _____, seconded by Director _____, was duly and regularly adopted by the Board of Directors of Kern Health Systems at an official meeting thereof on the 16TH day of February 2023, by the following vote and that a copy of the resolution has been delivered to the Chairman of the Board of Directors.

AYES:

NOES:

ABSENT:

_____
Sheilah Woods, Clerk
Board of Directors
Kern Health Systems

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, December 15, 2022

8:00 A.M.

BOARD RECONVENED

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

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

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

BOARD ACTION SHOWN IN CAPS

1) Board Resolution to Allow Virtual Board Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) -
APPROVED
Patrick-Thygerson: 11 Ayes; 4 Absent – Flores, Garcia, Hoffmann, Singh

ADJOURNED TO CLOSED SESSION
Patrick

CLOSED SESSION

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

NOTE: DIRECTOR HOFFMANN ARRIVED AT 8:04 AM DURING CLOSED SESSION

NOTE: DIRECTOR FLORES ARRIVED AT 8:08 AM DURING CLOSED SESSION

NOTE: DIRECTOR SINGH JOINED THE MEETING AT 8:13 AM DURING CLOSED SESSION

NOTE: DIRECTOR GARCIA JOINED THE MEETING AT 8:14 DURING CLOSED SESSION

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING NOVEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON AHMAD, CLARKE, DAQUIOAG, ELROD, PETERSEN, YALAMANCHILI; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON FERNANDEZ, HER, OUMA, TRAN, VUE; DIRECTOR MEAVE ABSTAINED FROM VOTING ON FERNANDEZ, HER, OUMA, TRAN, VUE

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING DECEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON DORSCH, GARG, GUARNEROS, IGNACIO, MADZIARSKI, PASCUAL, SAMRA; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON BAKERSFIELD RECOVERY STATION, MING & H DRUGS, GILL, JOHNSON, MADZIARSKI, ONYIA, VIAMONTES; DIRECTOR MCGLEW ABSTAINED FROM VOTING ON KERN VALLEY HEALTHCARE DISTRICT D/P SNF; DIRECTOR MEAVE ABSTAINED FROM VOTING ON GILL, JOHNSON, ONYIA, VIAMONTES

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING NOVEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON BEKAREV, BHANDOHAL, HUNTER, LEE, PALISPIS, RAMZAN, RIVERA; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON KOMOTO MEDICAL PHARMACY, PANSAWIRA, SANTOS; DIRECTOR MCGLEW ABSTAINED FROM VOTING ON FELIZARTA, MONGAR, PANSAWIRA, SANTOS, SPOHN-GROSS; DIRECTOR MEAVE ABSTAINED FROM VOTING ON DIXON

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING DECEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON LOPEZ, MACK, YANG; DIRECTOR BOWERS ABSTAINED FROM VOTING ON DUGGAL; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON AYALA-RODRIGUEZ, CHASE, MARTINEZ DUENAS, MCDERMOTT, ORNELAZ; DIRECTOR MCGLEW ABSTAINED FROM VOTING ON GUTZMAN; DIRECTOR MEAVE ABSTAINED FROM VOTING ON FONG BALART, AYALA-RODRIGUEZ, CHASE, MARTINEZ DUENAS, MCDERMOTT, ORNELAZ

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

4) On their own initiative, Board members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code section 54954.2(a)(2))

DIRECTOR NILON REPORTED ON THE COMPENSATION COMMITTEE MEETING AND INFORMED THE BOARD OF THE INFLATION STIPEND PAYMENT THAT WAS DISBURSED TO ALL KHS FULL TIME AND PART TIME EMPLOYEES

CHAIRMAN WATSON REMINDED THE BOARD THAT WE ARE HERE TO SERVE THE MEMBERS AND THAT THERE ARE SEVERAL ITEMS ON THE AGENDA AND THAT WE ARE LOOKING FORWARD TO A CONSTRUCTIVE MEETING

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

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

7) Welcome New Board Member to the Kern Health Systems Board of Directors (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Patel: All Ayes

8) Report from Local Health Plans of California, overview (Fiscal Impact: None) – LINNEA KOOPMANS, CHIEF EXECUTIVE OFFICER, LOCAL HEALTH PLANS OF CALIFORNIA, HEARD; RECEIVED AND FILED
Nilon-Patel: All Ayes

CA-9) Proposed amended Conflict of Interest Code for Kern Health Systems (Fiscal Impact: None) – APPROVED; REFERRED TO KERN COUNTY BOARD OF SUPERVISORS
McGlew-Patrick: All Ayes

CA-10) Report on Kern Health Systems investment portfolio for the third quarter ending September 30, 2022 (Fiscal Impact: None) – RECEIVED AND FILED
McGlew-Patrick: All Ayes

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

12) Proposed Kern Health Systems 2023 Operating and Capital Budgets (Fiscal Impact: None) – APPROVED
Abernathy-Nilon: All Ayes

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

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

CA-15) Report on COVID-19 Kern Health Systems Final Report (Fiscal Impact: None) – RECEIVED AND FILED
McGlew-Patrick: All Ayes

16) Report on Kern Health Systems Quality Improvement (QI) 2021 Program Evaluation, 2022 QI Program Description and the 2022 QI Program Work Plan (Fiscal Impact: None) – APPROVED
Nilon-Patel: All Ayes

17) Report on Kern Health Systems 2021 Utilization Management (UM) Program Evaluation and the 2022 UM Program Description (Fiscal Impact: None) – APPROVED
Patrick-Bowers: All Ayes

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

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

CA-20) Report on 2022 State Legislation and Budget Overview (Fiscal Impact: None) – RECEIVED AND FILED
McGlew-Patrick: All Ayes

CA-21) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
McGlew-Patrick: All Ayes

22) Report on Kern Health Systems financial statements for September 2022 and October 2022 (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Bowers: All Ayes

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

24) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) – RECEIVED AND FILED
Patel-Nilon: All Ayes

25) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Meave-Garcia: All Ayes

26) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) – RECEIVE AND FILE
Abernathy-Garcia: All Ayes

CA-27) Miscellaneous Documents –
RECEIVED AND FILED
Turnipseed-Patrick: All Ayes

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

ADJOURN TO FEBRUARY 16, 2023
Patel

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

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Kristen Beall Watson, Chairman

Date: February 16, 2023

Re: Service Recognition for KHS Board of Director

Background

Wayne Deats, Jr. served as a member of the Kern Health Systems Board of Directors as the Fourth District Community Representative since May 10, 2011.

During his tenure, Wayne served as Board Treasurer *(June 2014 – October 2019* ***and*** *August 2020 – June 2022)*. In addition, he was a member of Board Committees including Finance Committee Chairman, Nominating Committee and Compensation Committee where we relied on Wayne's keen insight and guidance. For this, KHS is eternally grateful.

Wayne's unique perspective on the role of public service was invaluable in helping the Board navigate the many challenges facing Kern Health Systems during his years of service.

On behalf of the Kern Health Systems Board of Directors, please know how much we appreciate Director Deats participation on Kern Health Systems Board of Directors for 11+ years

Recognition

The Board of Directors will recognize Board Member Deats' contribution with a service recognition award to commemorate his years of service.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Kristen Beall Watson, Chairman

Date: February 16, 2023

Re: Service Recognition for KHS Board of Director

Background

Jeff Flores served as a member of the Kern Health Systems Board of Directors as the Third District Community Representative since June 16, 2020.

During Member Flores' tenure Kern Health System governing body had to adapt to the COVID-19 Pandemic by providing Board members a virtual meeting alternative to onsite participation. Despite its challenges, Jeff remained committed to his duty and contributed to Board deliberation during a time of profound change to the organization.

On behalf of the Kern Health Systems Board of Directors, thank you for your service and best of luck to you in your new role as Supervisor 3rd District and Chairman of the Board of Supervisors.

Recognition

The Board of Directors will recognize Board Member Flores' contribution with a service recognition award to commemorate his years of service.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

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

Date: February 16, 2023

Re: KHS Utilization Management & Quality Improvement Program Work Plan

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Background

The KHS Utilization Management (UM) & Quality Improvement (QI) Programs are defined by the following documents:

- The UM & QI Program Description,
- The UM & QI Program Evaluation, and
- The UM & QI 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 as defined under our contract with the Department of Health Care Services (DHCS). Opportunities identified in the previous year's Program Evaluation are considered in development of the following year's Program Work Plan

Program Work Plan

2023 UM Work Plan: The goal of the utilization management department is to ensure members we serve receive high quality care in the right setting at the right time.

The UM Program Workplan identifies the primary activities that will occur throughout the current year. KHS strategic initiatives, corporate goals and State requirements in combination with outcomes of the previous year UM program evaluation are used to develop the work plan for 2023.

2023 QI Work Plan (Attachment C): The QI Program Workplan identifies the primary activities that will occur throughout the current year. KHS strategic initiatives, corporate goals and State requirements in combination with outcomes of the previous year QI program evaluation are used to develop the work plan for 2023.

The workplan is a dynamic document that is updated throughout the year based on outcomes realized and priority shifts. Outcomes of this workplan are assessed during the annual UM & QI program evaluation.

Requested Action

Review and approve the KHS 2023 Utilization Management Program Work Plan.
Review and approve the KHS 2023 Quality Improvement Program Work Plan.

KERN HEALTH SYSTEMS

Utilization Management Workplan 2023

INTRODUCTION:	**The goal of the utilization management department is to ensure members we serve receive high quality care in the right setting at the right time. To ensure this goal is met, the utilization management department proposes the following interventions.**

GOAL 1:	**Ensure that qualified, licensed healthcare professionals assess clinical information used for clinical decision making.**

INTERVENTIONS:	GOAL:	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Ensure high quality new hire orientation training is provided to all new clinical staff. 2. Provide annual continuing education opportunities for the clinical staff. 3. Review and revise staff orientation materials, manuals and processes 4. Implement verification process to validate continuing education completion and verification of certifications.	100% compliance with maintaining records of professional licenses and credentialing for staff that support clinical decision making.	Utilization Review Manager	Ongoing

GOAL 2:	**Compliance with hierarchy of decision making, ensuring consistent application of medical determination criteria.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Quarterly completion of Milliman Care guidelines Inter Rater Reliability)(MCG IRR) 2. MCG training annual and as needed based on changes to the guidelines. 3. Annual review of Medi-Cal guideline training and for hires	Interrater-reliability pass rate of 100%	Utilization Review Manager	Ongoing
GOAL 3:	**Ensure compliance with legislative and regulatory directives.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Participate in all appropriate legislative and regulatory workgroups and/or activities that may impact the UM department. 2. Update department policies and procedures to reflect these changes. 3. Implement a policy and procedure review plan to ensure directives are operationalized. 4. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	All new APLs will be reviewed and policies updated to comply with new APL directives and other Federal and State regulations.	Utilization Management Director	Ongoing with Quarterly Review

GOAL 4:	**Ensure separation of medical decisions from fiscal considerations.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness. KHS does not compensate physicians or nurse reviewers for denials. KHS does not offer incentives to encourage denials of coverage or service". 2. Ensure this education is provided to all Utilizaiton Managment staff.	100% compliance with distribution and reciept of completion of affirmative statement about financial incentives.	Utilization Management Mananger	Annually
GOAL 5:	**Ensure compliance with regulatory standards.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. File reviews to validate regulatory standards are met. 2.Education, both ongoing and remedial will be provided to staff on any issues revealed during the file review process.	Documented use of guidelines in medical determinations will be in compliance with State, Federal and other regulatory requirements >/= 95%.	Utilization Review Manager and Supervisor	Quarterly

GOAL 6:	**Monitoring of the utilization managment review process.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1.Utilize business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process. 2.Assess staffing requirements to complete the prior authorization process timely and ensure an adequate budget is allocated to meet the staffing needs.	Track and trend authorization activity on a monthly basis including: Number of prior authorization requests submitted, approved, deferred, denied, modified as well as denials appealed and overturned.	Utilization Management Director and Manager	Monthly

GOAL 7:	Compliance with timeliness of processing. (Turn Around Times =TAT)		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Monitoring of the Turn Around Time (TAT) by type on a routine basis using business intelligence reporting tools. 2.Weekly evaluation to identify barriers to meeting utilization management timeline standards. 3.Develop action plans to address deficiencies. 4.Ongoing focus on meeting TAT requirements. 5.Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. 6. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining process.	Compliance with DHCS turn-around timeframes >/= 95% by type of request.	Utilization Review Manager and Supervisor	Daily

GOAL 8:	**Consistency with which criteria are applied in UM decision-making and opportunities for improvement are acted upon.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1.Conduct quarterly Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making.	Physician and nonphysician UM reviewers achieving passing score on MCG IRR Tool.	Clinical Supervisor	Quarterly
GOAL 9:	**Appeals and dispute management compliance.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1.Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times. 2.Analyze the UM appeal review to identify trends. 3.Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned. 4.Ensure appeals are processed by specialty-matched physicians.	Ensure >/= 90% accuracy of all determinations while complying with regulatory turn-around times	Utilization Review Manager and Supervisor	Monthly

GOAL 10:	**Monitoring of over and under utilization.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1.Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of acute care stays, ER visits/thousand, all-cause readmissions, readmissions within 30 days, C-Section rate. 2.Aggregate specialty referral review assessment on a biannual basis.	5% improvement of current statistical baseline.	Medical Director	Monthly
GOAL 11:	**Consistent referral of members for specialty program consideration originating from utilization management.**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1.Assessment of each member with an inpatient encounter with the purpose of identifying a condition that would warrant additional specialty care management and refer for consideration prior to encounter closure. 2.Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer.	25% increase of referrals over current baseline each quarter until >/= 90% of eligible members are referred for specialty program consideration.	Utilization Review Manager and Supervisor	Ongoing

GOAL 12:	Coordination of care with California Children's Services (CCS).		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1.Daily inpatient census will be reviewed ad any eligible member will be referred to CCS for service authorization request. 2.Weekly review of CCS business intelligence report to validate member's ambulatory referrals are authorized and encounters processed appropriately 3.Quarterly review of reports to identify CCS eligible members that are near age out and referral to Case Management to facilitate smooth transition of provisions of care.	100% of eligible cases will be identified care will be coordinated with CCS as appropriate.	Utilization Review Manager and Supervisor	Quarterly

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

Kern Health Systems
2023 Quality Improvement Program Work plan

	On Track
	In Jeopardy
	Barrier

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	COMMENTS
I. QUALITY MANAGEMENT AND IMPROVEMENTS						
A. Annual Review/Approval of QI Program (QIP) Documents						
1. Approval QI Evaluation	Approval of 2022 QI Program Evaluation	5/31/2023	Chief Medical Officer (CMO) / QI Director	None	On Track	In progress - Board of Directors Meeting April 2023
2. Review/Update and Approval of QI Program Description	Approval of 2023 QI Program Description	5/31/2023	Chief Medical Officer (CMO) / QI Director	None	On Track	In progress - Board of Directors Meeting April 2023
3. Review/Update and Approval of QI Work Plan	Approval of 2023 QI Work Plan	9/2/2022	Chief Medical Officer (CMO) / QI Director	None	On Track	Board of Directors Meeting Agenda February 2023
B. Clinical - Focused Studies						
1. State Required				None	On Track	
1.a Asthma Medication Ratio PIP - Improving Asthma Medication Ratio Compliance in Children 5-21 years of age	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with the Asthma Disease Management Program and Asthma Mitigation Project to increase correct medication usage by asthmatic members	06/30/2023	Chief Medical Officer (CMO) / QI Director	None	On Track	Final summary module in process for delivery to State-Appointed External Quality Review Organization (EQRO) in April 2023
1.b. Improving the Health and Well Being of low income children, ages 3- 21 years, through Well Child Visits (WCV)	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with increasing the number of children ages 3 - 21 years old with completing an annual well care visit.	06/30/2023	Chief Medical Officer (CMO) / QI Director	None	On Track	Final summary module in process for delivery to State-Appointed External Quality Review Organization (EQRO) in April 2023
C. MCAS Quality Measurements Monitoring & Support						
1. MCAS Audit and Rate Submission MY2022/RY2023	Report to State via NCQA and EQRO Auditor, HSAG	7/31/2023	Director of QI Director of Business Intelligence (BI)	None	On Track	Audit and rate development started November 2022. Medical Record Retrievals and Abstraction Reviews to begin February 2023 with submission of final rates no later than June 1, 2023. Audit completed by mid July 2023.
2 Configure MCAS/HEDIS software for new measures (Cotiviti) MY2022/RY2023	Vendor, Cotiviti, to have all new measure configured, tested and changes approved by NCQA	3/31/2023	QI Director/ BI Director	None	On Track	On track for completion no later than end of March 2023
3 Configure KHS data and reports for new measures	KHS to modify data receipt, storage and reports to meet new DHCS MCAS specifications	3/31/2023	QI Director/ BI Director	None	On Track	Request for data and report updates submitted and BI Dept on track for completion by end of March 2023
4. Educate KHS Staff on MY2023 measures	KHS to educate internal staff on new requirements for MCAS	3/31/2023	Chief Medical Officer (CMO)/ QI Director	None	On Track	In process and on track for completing by end of April 2023
5. Educate providers on MY2023 measures	KHS to educate providers on new requirements for MCAS	3/31/2023	Chief Medical Officer (CMO)/ QI Director/ PNM Director	None	On Track	In process and on track for completing by April 2023
6. Meet MCAS Compliance Rates for MY2023	Monitor progress in meeting Minimum Performance Level (MPL) of each MCAS measure for 2023 monthly. This will be used to evaluate improvement activities toward meeting all MCAS MPLs.	12/31/2023	Chief Medical Officer (CMO) / QI Director	None	On Track	On-going monitoring and trending on track with completion of updating MCAS data and reports to align with MY2023 measures.
Behavioral Health Domain 6.a Depression Remission or Response for Adolescents and Adults (DRR-E) 6.b Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) 6.c Follow-Up After ED Visit for Mental Illness – 30 days (FUM) 6.d Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	Meet MPLs DRR-E MPL rate not yet provided by DHCS DSF-E MPL rate not yet provided by DHCS FUM 54.51 FUA 21.24				On Track	Monitoring initiated

KERN HEALTH SYSTEMS
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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	COMMENTS
Childhood Health Domain 6.e Child and Adolescent Well – Care Visits (WCV) 6.f Childhood Immunization Status – Combination 10 (CIS-10) 6.g Developmental Screening in the First Three Years of Life (DEV) 6.h Immunizations for Adolescents – Combination 2 (IMA-2) 6.i Lead Screening in Children (LSC) 6.j Topical Fluoride for Children (TFL-CH) 6.k Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits (W30-6+) 6.l Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits (W30-2+)	Meet MPLs WCV 48.93 CIS-10 34.79 DEV MPL rate not yet provided by DHCS IMA-2 35.04 LSC 63.99 TFL-CH MPL rate not yet provided by DHCS W30-+6 55.72 W30-+2) 65.83				On Track	Monitoring initiated
Chronic Disease Management Domain 6.m Asthma Medication Ratio (AMR) 6.n Controlling High Blood Pressure (CBP) 6.o Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%) (HBD)	Meet MPLs AMR 64.26 CBP 59.85 HBD 39.9				On Track	Monitoring initiated
Reproductive Health Domain 6.p Chlamydia Screening in Women (CHL) 6.q Prenatal and Postpartum Care: Postpartum Care (PPC-Pst) 6.r Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	Meet MPLs CHL 55.32 PPC-Pst 77.37 PPC-Pre 85.4				On Track	Monitoring initiated
Cancer Prevention Domain 6.s Breast Cancer Screening (BCS) 6.t Cervical Cancer Screening (CCS)	Meet MPLs BCS 50.95 CCS 57.64				On Track	Monitoring initiated
7. MCAS Improvement Activities	Meet MPL for each MY 2023 MCAS measure	12/31/2023	Chief Medical Officer	None	On Track	In progress
7.a Health Information Exchange	Establish HIE to support clinical information data sharing that allows timely and accurate data capture for MCAS compliance monitoring	12/31/2023	Business Intelligence Director	None	On Track	In progress
7.b Provider Electronic Clinical Data Upload	Establish process to upload electronic medical record data upload from providers to support clinical information data access and timely and accurate data capture for MCAS compliance monitoring	12/31/2023	Business Intelligence Director	None	On Track	EMR data from Clinical Sierra Vista in place
7c. Clinical Assessments in Community Settings	Establish process for KHS Population Health Management and Community & Social Services staff to conduct assessments such as - Health Risk Assessments - Depression Screening - Substances Use Screening in community settings such as homeless shelters, Department of Motor Vehicle offices, Social Security Office, etc. to support identification of member health care needs.	12/31/2023	Population Health Management Director; Director of Community & Social Services	None	On Track	In process
7.d. Member Engagement & Rewards Program	Establish year-round, member outreach program focused on members with gaps in care. Redesign MCAS member rewards program to increase motivation for compliance with obtaining preventive health services and follow through with chronic condition self-care.	12/31/2023	Director of Member Engagement; Chief Medical Officer	None	On Track	In process
7.e. Mobile Preventive Health Services Program	Establish network of providers to provide mobile health care services that will allow KHS to increase access to preventive health services in rural areas of Kern County and in ad hoc community events	6/1/2023	Senior Director of Provider Network; Deputy Director of Provider Contracting	None	On Track	In process

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	COMMENTS
7.f. Urgent Care Utilization to Close Gaps in Care	Establish agreements with select urgent care providers to deliver services to close member gaps in care at their center	7/1/2023	Senior Director of Provider Network; Deputy Director of Provider Contracting	None	On Track	Initiated in Q4 or 2022 and is in development as an ongoing service
7.g Provider Collaboration Meetings	Conduct monthly meetings with higher volume providers to review MCAS measure compliance and establish practice interventions to improve rates	6/1/2023	Chief Medical Officer; Director of Quality Improvement; Senior Director of Provider Network	None	On Track	In process
7.g. Red Tier Action: Establish process for timely, complete, & accurate MCAS data	Develop process for timely, complete, & accurate data to measure MCAS compliance for strategy development and outcomes analysis	6/1/2023	Director of Business Intelligence; Director of Quality Improvement	None	On Track	In process
7.h. Red Tier Action: Develop a Quality education program	Develop a quality education program to enable KHS staff & providers to develop & implement effective MCAS improvement strategies	6/1/2022	Director of Quality Improvement; Chief Medical Officer; Senior Director of Provider Network	None	On Track	In process
7.i Red Tier Action: Communication process for organization-wide MCAS information sharing	Establish a communication process that supports strategic thought partnership, transparency, & decision-making for MCAS compliance throughout all levels of the organization	6/1/2023	Executive Leadership Team	None	On Track	In process
D. Other On-going Monitoring						
1. 30 day re-admissions	Conduct audit quarterly of 50 30-day hospital readmissions to identify trending related to quality of care and readmission prevention	Quarterly	Chief Medical Officer (CMO) / QI Director	None	On Track	First audit for 2023 will take place in 2nd quarter
2. Potential Quality of Care Issues (PQI)	Complete investigation of all PQIs and any corrective action plans issued	Annually	Chief Medical Officer (CMO) / QI Director	None	On Track	Ongoing 2023
2.a. Grievances	Review all grievances for Quality of Care issues and refer those identified to QI Dept as a PQI	Annually	Chief Medical Officer (CMO) / QI Director	None	On Track	Ongoing 2023
3. Facility Site Reviews (FSR)	Provider review of physical offices to ensure DHCS site safety and other requirements are met.	Quarterly	Chief Medical Officer (CMO)/ Director QI	None	On Track	Ongoing and on track for 2023
3.a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly		None	On Track	
3.b. Initial Health Appointment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly		None	On Track	
3.c. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly		None	On Track	
3.d. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None	On Track	
3.e. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None	On Track	
3.f. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None	On Track	
3.g. Safety of Care - Autoclave - Bio-hazardous waste - Infection Control	Physician Site Monitoring / Quarterly reporting	Quarterly		None	On Track	
3.h. Bi-annual repot to DHCS of FSRs completed	Generate and submit report of all site and medical record reviews (both initial, periodic and focus) to DHCS for January through June and July through December in accordance with DHCS report requirements	January 31st July 31st	Chief Medical Officer (CMO) / QI Director	None	On Track	January report submitted to DHCS on time
F. Provider Availability						
1. Primary Care Practitioners				None	On Track	
1.a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2. Specialty Practitioners					On Track	
2.a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2.b. Geographic Standard - Network Capacity Report	Measure and Report	Annually	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023

KERN HEALTH SYSTEMS
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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	COMMENTS
G. Provider Access						
1. Primary Care Appointments					On Track	
1.a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
1.b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
1.c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
1.d. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2. Telephone access to Member Services			Senior Director of Provider Network, Chief Compliance Officer		On Track	
2.a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2.b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
3. Mental Health Appointment	Quarterly MOU Meetings/Grievances	As necessary	Director of UM; Director of Population Health Management	None	On Track	Ongoing 2023
2.a Life-threatening Emergency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2.b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2.c Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2.d Routine office visit Standard (visit within 10 working days)	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
2.e Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Chief Compliance Officer	None	On Track	Ongoing 2023
- Caller reaches non-recorded voice						
- Abandonment rate						
H. Encounters, Complaints, Grievances and Appeals Data Analysis	Report aggregate data quarterly to QI/UM Committee	Quarterly	Director of Member Services	None	On Track	Ongoing 2023
I. CAHPS Survey	State administered survey every 2 years - Survey being administered for 2022 in Q1 of 2023 by DHCS/HSAG	9/30/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	On Track	On track
1. Member data provided to EQRO for 2022	Provide 2022 member data per EQRO specifications	Jan-23	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	On Track	Completed
2. Results reported to QI/UM Committee	Present summary of report to QI/UM Committee for review and identification of improvement actions	12/31/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	On Track	Survey in process - timing of presentation to QI/UM Committee dependent on receipt from DHCS/HSAG
3. Results reported to practitioners and providers	Report to Physician Advisory Committee	12/31/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None	On Track	Survey in process - timing of presentation to QI/UM Committee dependent on receipt from DHCS/HSAG
J. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		On Track	Ongoing 2023
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None	On Track	Ongoing 2023
2. PCP & Mental Health	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None	On Track	Ongoing 2023
3. Specialist	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None	On Track	Ongoing 2023
K. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes evaluation of QI program activities delegated through quarterly and annual report monitoring	12/31/2022	QI Director	None	On Track	Ongoing 2023
L. Annual Review of QI Policies and Procedures	Submit to QI/UM Committee and DHCS	Annually and as necessary	Chief Medical Officer (CMO) / QI Director/Director Compliance	None	On Track	Ongoing 2023
M. QI/UM Committee					On Track	

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	COMMENTS
1. Reports and agenda items	Gathered from pertinent departments	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	On Track	Ongoing 2023
2. Minutes	Attached to next meetings agenda and sent to Board of Directors	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	On Track	Ongoing 2023
3. Form 700 (Statement of Economic Interests)	Send to all committee members yearly	Initial / Yearly December	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	On Track	Ongoing 2023
4. PO's and Check Requests	Fill out for each member attending meeting	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	On Track	Ongoing 2023
N. MCAS Member Engagement & Incentive Program	Conduct at least 3 campaigns using Interactive Voice Recognition, Text messaging and Mailers to contact members with Gaps in Care related to the MCAS measures. Outreach is focused on providing health education or reminders about preventive health measures and incentivizing them with a reward for closing a care gap.	Campaign 1 within 1st quarter Campaign 2 within 2nd quarter Campaign 3 within 3rd quarter	Chief Health Services Officer/QI Director/Health Education Director	None	On Track	First campaign on track for completion in 1st quarter
O. MCAS Committee	Multi-department committee focused on providing strategic direction and oversight of KHS' level of compliance with the MCAS measures. Committee meets at least quarterly	12/31/2023	Chief Medical Officer	None	On Track	Ongoing
1. Update and disseminate MCAS Provider Guide and MCAS Coding Card for MY2022 MCAS Measures	Update the KHS MCAS Provider Guide to reflect measures for MY2022. The guide provides a definition and specifications for each measure, diagnosis and service codes as applicable and tips for achieving compliance. The guide is made available to all KHS providers accountable to meet these measures. The coding card lists the most commonly used service and diagnosis codes for documenting completion of MCAS measures.	3/31/2022	Director of Quality Improvement/Provider Network Management/Provider Relations Manager	None	On Track	Completed
II. UTILIZATION MANAGEMENT - See UM Work Plan						
A. Annual Review/Approval of UM Program Documents by KHS QI/UMC and Board of Directors.	Program Description 2023	4/30/2023	Chief Medical Officer (CMO) / UM Director	None	On Track	In process
	Program Evaluation 2022	4/30/2023	Chief Medical Officer (CMO) / UM Director	None	On Track	In Process
III. CREDENTIALING AND RECREDENTIALING						
A. Initial Credentialing Site Visit & Medical Record	Site and Medical Record Reviews done to validate new provider's compliance with DHCS regulatory requirements. Both reviews must be passed before a provider can be added to the KHS Provider Network.	Ongoing	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	On Track	Ongoing 2023
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/Compliance/MS for any opportunities for improvement identified. QI Department performs review of readmissions within 30 days of discharge and member deaths notifications for potential inappropriate care issues	Quarterly	Chief Medical Officer (CMO) / Chief Health Services Officer/QI Director	None	On Track	Ongoing 2023
1. Hospitals	Tracking grievances, PIC referrals, Deaths Notifications with potential Quality issues, and a sampling of readmissions within 30 days of discharge for possible quality issues related to readmission	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
2. SNF's	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
3. Home Health Agencies	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
4. Free-Standing Surgery Centers	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
5. Impatient MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
6. Residential MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	COMMENTS
7. Ambulatory MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
C. Ongoing Monitoring of Sanctions and Complaints	Ongoing; time sensitive; sanctions; grievance process	Ongoing	Senior Director of Provider Network Management/Compliance	None	On Track	Ongoing 2023
D. Credentialing / Recredentialing File Audit	Ongoing KHS/Compliance random audits	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is TJC accredited	Annually / as necessary	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
F. Annual Review of Credentialing/Recredentialing Policies and Proc	Ongoing	Annually / as necessary	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
IV. MEMBER RIGHTS AND RESPONSIBILITIES						
A. Statement of Members' Rights and Responsibilities	Review, annually / revise as necessary	Annually / as necessary	Director of Member Services	None	On Track	Ongoing 2023
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services	None	On Track	Ongoing 2023
C. Complaints and Appeals	Aggregate/analyze/report to QI/UM Committee Quarterly	Quarterly	Director of Member Services	None	On Track	Ongoing 2023
D. Grievance Report (HFP)	Report number and types of benefit grievances for previous calendar year - geographic region, ethnicity, gender and primary language	Quarterly	Director of Member Services	None	On Track	Ongoing 2023
				None	On Track	Ongoing 2023
				None	On Track	Ongoing 2023
E. Annual Analysis of Privacy and Confidentiality Policies	Review annually / Revise as needed	Ongoing	Director Compliance	None	On Track	Ongoing 2023
F. Delegation of Members' Rights and Responsibilities Activities	Non-delegated. Grievance committee	N/A	Grievance Committee	None	On Track	Ongoing 2023
G. Annual Review of Member Rights Policies and Procedures	Non-delegated	N/A	Grievance Committee	None	On Track	Ongoing 2023
VI. MEDICAL RECORDS						
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2022	Chief Medical Officer (CMO) / Director QI	None	On Track	Ongoing 2023
B. Distribution of Standards to New Providers	Ongoing / as necessary	Ongoing	Senior Director of Provider Network Management	None	On Track	Ongoing 2023
C. Audit of Medical Records Documentation	Refer to Credentialing/Recredentialing	Ongoing	Chief Medical Officer (CMO) / Director QI / Senior Director of Provider Network Management	None	On Track	Ongoing 2023
D. Annual Review of Policies and Procedures	Annually and as necessary	Ongoing	Chief Medical Officer (CMO) / QI Director	None	On Track	Ongoing 2023

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: February 16, 2023

Re: MCAS Action Plan

Background

Annually, the Department of Health Care Services develops a set of preventative care measures known as the Managed Care Accountability Set (MCAS) for Medi-Cal plans. The measures focus on specific domains of preventative health such as children's health, women's health, chronic disease management, and cancer prevention.

In December 2022, DHCS published the 2021 Health Plan Quality Ranking that ranked all Medi-Cal plans. Additionally, DHCS issued a monetary sanction to KHS in the amount of $188,000 for not meeting the minimum performance level in 10 of the 15 MCAS measures. Unfortunately, KHS' plan performance will not demonstrate improvement for measurement year 2022.

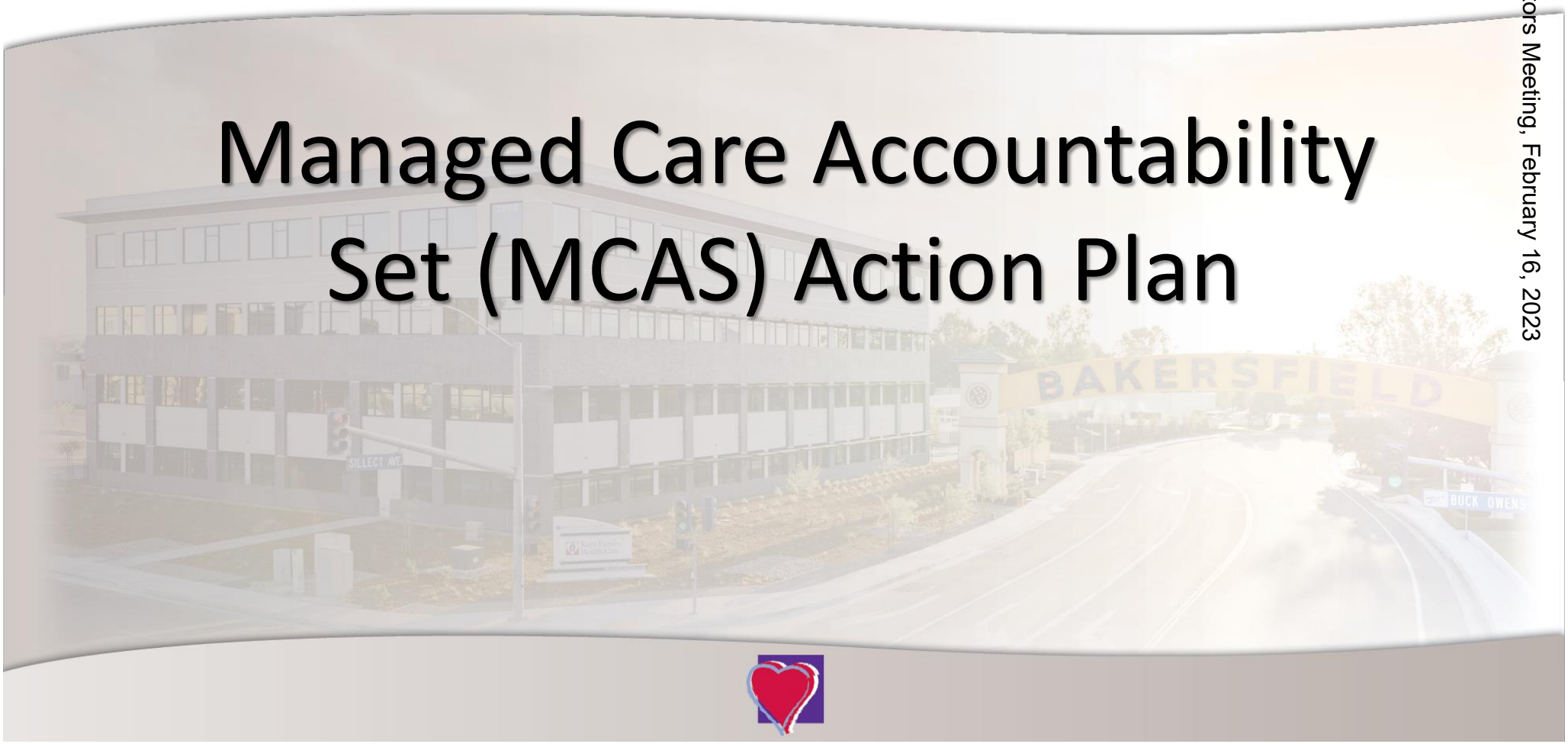
KHS' mission includes providing access to quality care service to our members. The MCAS Quality Program is in the process of a full reconfiguration and our goal is to make significant performance improvements in measurement year 2023 and beyond. Creating and establishing programs, infrastructure, and best practices that can be implemented immediately to increase performance in the near term is the first step. Establishing high performance practice habits and member engagement to support KHS' mission of increasing the health status of our members is always the driving force behind such efforts.

Jake Hall, Deputy Director of Provider Contracting will present an overview of the 2023 MCAS Action Plan.

Requested Action

Receive and File.

Managed Care Accountability Set (MCAS) Action Plan



Topics for Discussion

- MCAS Overview
- KHS Population
- 2023 MCAS Measures
- KHS MCAS Action Plan

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MCAS Overview

The Managed Care Accountability Sets (MCAS) is a set of performances measures that DHCS selects for annual reporting by Medi-Cal managed care health plans (MCPs).

Many of the measures are NCQA HEDIS measures and some are from other sources such as the Centers for Medicare & Medicaid (CMS).

Each measure has an acronym and corresponding definition. Example: AMR = Asthma Medication Ratio.

MCAS has two measurement time frames. These time frames are also used for HEDIS measures.

- Measurement Year (MY) refers to the year that the measurements are applicable.
- Report Year (RY) refers to the year that a report of outcomes for each measure is calculated
- Example: MCAS measure outcomes for MY2022 are reported the following year, RY2023.

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MCAS Performance

	MY2017	MY2018	MY2019		MY2020		MY2021		MY2022	
KHS Membership	242,265	246,564	251,280		277,616		299,864		334,078	
	MPL 25th Percentile	MPL 25th Percentile	MPL 50th Percentile	MPL 25th Percentile	MPL 50th Percentile	MPL 25th Percentile	MPL 50th Percentile	MPL 25th Percentile	MPL 50th Percentile	MPL 25th Percentile
Total Measures Held to MPL	21	20	18	18	19	19	15	15	15	15
Met MPL	19	18	3	9	2	6	5	9	1	3
Did not meet MPL	1	2	15	9	17	13	10	6	14	12

- Minimum Performance Level (MPL) requirement increased from 25th percentile to 50th Percentile for MY2019.
- Increase of KHS Membership year over year
- COVID-19 shut down all in-person activities

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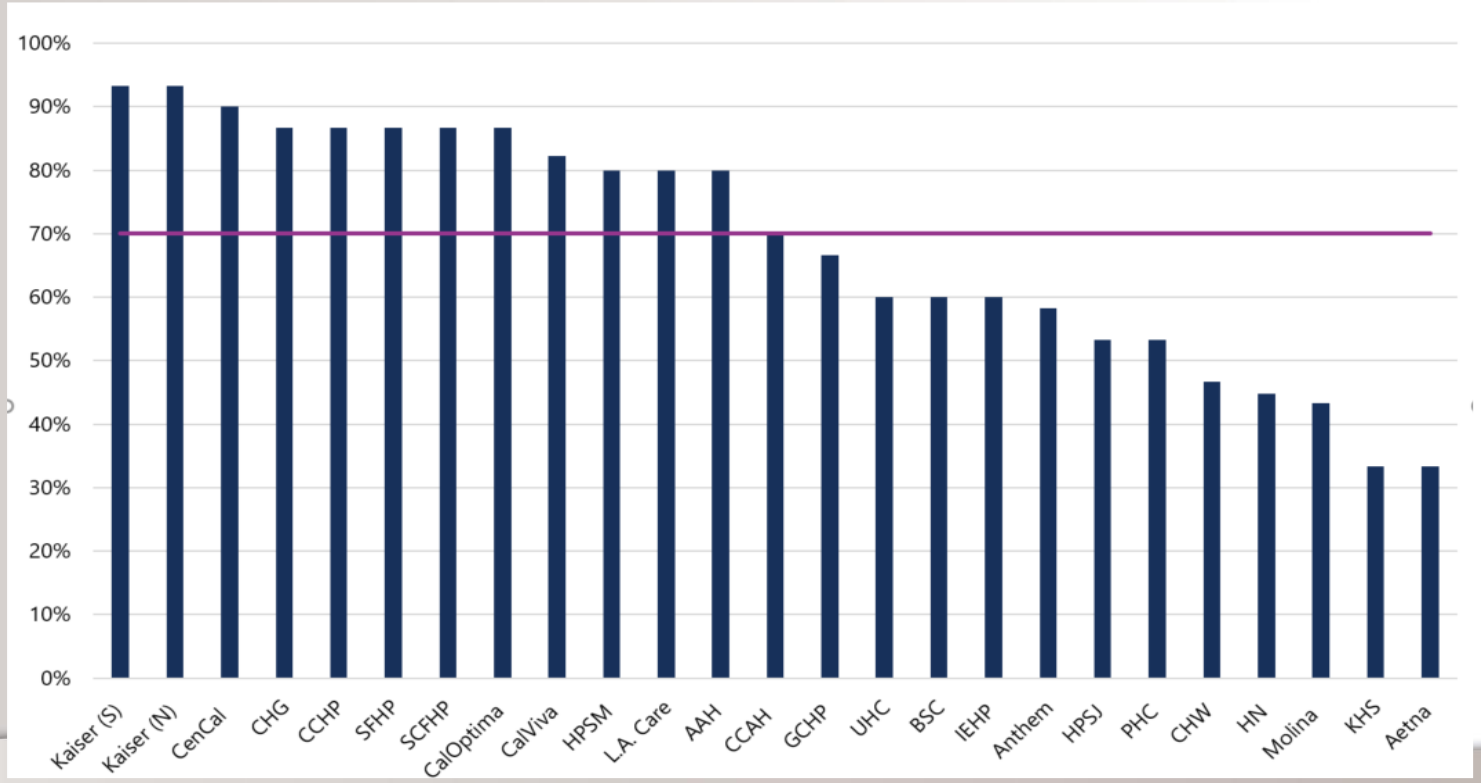
Department of Health Care Services: 2021 Health Plan Quality Ranking



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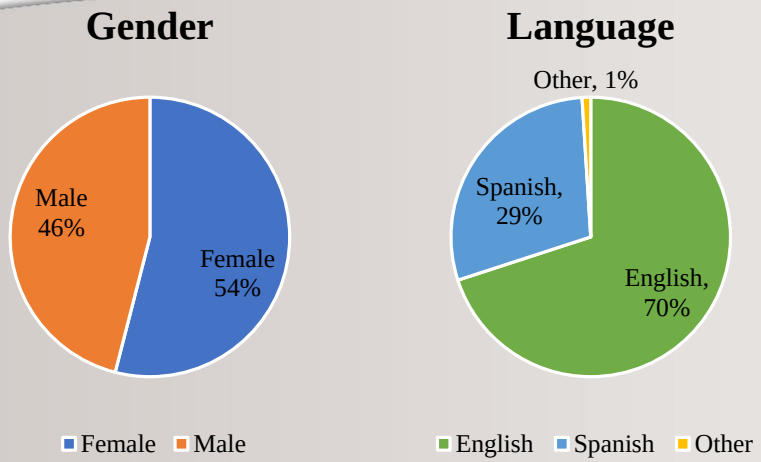
KHS Membership: *Demographics overview*



Ethnicity

Hispanic	63%
Caucasian	17%
No Valid Data	9%
Black/African American	6%
Asian Indian	1%
Filipino	1%
Unknown	1%
Asian/Pacific	1%
Other	1%

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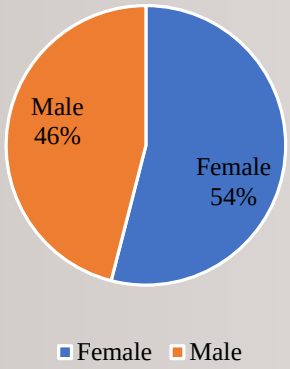
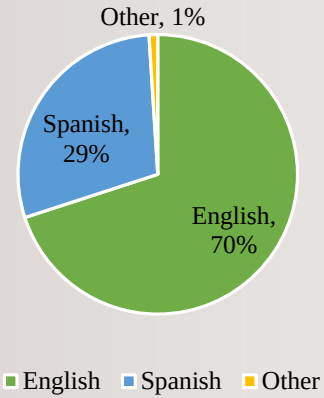
KHS Membership: *Demographics overview*

Gender



Language



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Other	1%

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KHS Population: *HPSA & MUA/P Status*

- The Plan's service area has historically faced challenges with provider shortages.
- Large portions of the county have been federally designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P).
- These issues are more prevalent and severe in Kern County than other counties within California.

Primary Care HPSA Score by Medical Service Study Area, Top Ten, California

HPSA Scores are developed for use by the National Health Service Corps to determine priorities for the assignment of clinicians. The higher the score, the greater the priority

HPSA Score	HPSA Name	County Name
19	**MSSA 57.2/Taft**	**Kern County, CA**
18	**MSSA 58.2 - Lost Hills/Wasco**	**Kern County, CA**
18	MSSA 29/Herndon/Kerman	Fresno County, CA
18	MSSA 78.2k/South Central Northwest	Los Angeles County, CA
17	**MSSA 57.1/Fort Tejon**	**Kern County, CA**
17	MSSA 143/Big River	San Bernardino County, CA
17	MSSA 194/Etna	Siskiyou County, CA
17	MSSA 78.1/Avalon	Los Angeles County, CA
17	**MSSA 63/Lake Isabella**	**Kern County, CA**
17	MSSA 67 Avenal	Kings County, CA

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KHS Population: *Education Level*

Kern County Education Level, State Ranking				
Education Level		**2019**	**2020**	**2021**
High School Graduate or Higher	**Percentage**	74.10%	75.30%	75.90%
	County Ranking	51st of 58	50th of 58	51st of 58
Bachelor's Degree or Higher	**Percentage**	16.40%	17.10%	17.6%
	County Ranking	46th of 58	48th of 58	47th of 58

KERN HEALTH SYSTEMS

KHS Population: *Poverty Rate*

Poverty Rate by County, Top Ten, California					
2018		**2019**		**2020**	
County	**% in Poverty**	**County**	**% in Poverty**	**County**	**% in Poverty**
Tulare County	22.2	Imperial County	22	Del Norte County	18.5
Trinity County	21.6	Fresno County	20.5	**Kern County**	**18.3**
Imperial County	21.4	Modoc County	20.5	Imperial County	18.1
Fresno County	21.3	Humboldt County	19.1	Trinity County	18
Merced County	21.2	**Kern County**	**19**	Modoc County	17.9
Kern County	**20.5**	Tulare County	18.9	Butte County	17.3
Del Norte County	20.4	Lake County	18.3	Fresno County	17.1
Humboldt County	20.3	Del Norte County	17.9	Tulare County	17.1
Madera County	20.2	Madera County	17.6	Merced County	16.3
Yolo County	20.1	Siskiyou County	17.4	Yuba County	16.3

KERN HEALTH SYSTEMS

2023 MCAS Measures

Measures are held to 50th percentile Minimum Performance Level (MPL)

Behavior Health Domain

DRR-E: Depression Remission or Response for Adolescents and Adults
DSF-E: Depression Screening and follow-up for adolescents and Adults
FUM: Follow up After ED Visit for Mental Illness- 30 days
FUA: Follow up After ED Visit for Substance Abuse – 30 Days

Children's Health Domain

WCV: Child and Adolescent Well-Care Visits
CIS-10: Childhood Immunization Status – Combination 10
DEV: Developmental Screening in the First Three Years of Live
IMA – 2: Immunization for Adolescents – Combination 2
LSC: Lead Screening for Children
TFL – CH: Topical Fluoride for Children
W30 – 6+: Well Child Visits in the first 30 Months of Life – 0 to 15 Months – Six or More Well- Child Visits
W30-2+: Well- Child Visits in the First 30 Months of Life – 15 to 30 Months- Tow or More Well- Child Visits

KERN HEALTH SYSTEMS

2023 MCAS Measures

Measures are held to 50th percentile Minimum Performance Level (MPL)

Chronic Disease Management

AMR: Asthma Medication Ratio
CBP: Controlling High Blood Pressure
HBD: Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%)

Reproductive Health Domain

CHL: Chlamydia Screening in Women
PPC-Pst: Prenatal and Postpartum Care: Postpartum Care
PPC- Pre: Prenatal and Postpartum Care: Timeliness of Prenatal Care

Cancer Prevention Domain

BCS-E: Breast Cancer Screening
CCS: Cervical Cancer Screening

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2023 MCAS Measures

Report Only Measures to DHCS

AMB-ED ii	Ambulatory Care – Emergency Department (ED) Visits
AAP	Adults' Access to Preventive/Ambulatory Health Services
AMM-Acute	Antidepressant Medication Management: Acute Phase Treatment
AMM-Cont	Antidepressant Medication Management: Continuation Phase Treatment
COL-E	Colorectal Cancer Screening*
CCW-MMEC	Contraceptive Care – All Women: Most or Moderately Effective Contraception
CCP-MMEC60	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days
SSD	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications
FUM	Follow-Up After ED Visit for Mental Illness – 7 days*
FUA	Follow-Up After ED Visit for Substance Use – 7 days*
ADD-C&M	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
ADD-Init	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)
NTSV CB	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate
POD	Pharmacotherapy for Opioid Use Disorder*
PCR ii	Plan All-Cause Readmissions
PDS-E	Postpartum Depression Screening and Follow Up
PND-E	Prenatal Depression Screening and Follow Up
PRS-E	Prenatal Immunization Status
HFS	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*
SNF HAI	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*
PPR	Potentially Preventable 30-day Post-Discharge Readmission*

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2023 MCAS Measures

2023 MCAS measures total 20, compared to 15 in 2022

Complexity and Challenges of measures:

- Well child visits require a total of 6 visits during a 15 month period to meet compliance

Immunizations require the completion of the entire series before meeting compliance

- Age and timeframe limitations for certain measures
- Administrative data lag
- Scale of certain measures Ex: Well Child Visits has a denominator of over 142,000

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Quality Action Plan

KHS MCAS Team

- Create MCAS Strike Team to include representation of Medical Director, Quality Improvement, Provider Network, Member Engagement, and Data/Business Intelligence
- Providers meetings objectives will include:
  - Discuss "Top 5/Next 5" measures
  - Discuss missed opportunities for closing gaps in care
  - Discuss Provider group needs
  - Survey provider group to evaluate the effectiveness of the meeting

Member Engagement

- Expand Mobile Preventive Health Services Program
- Expand Point of services incentive/gift cards/movie tickets
- Ongoing, year-round, direct member outreach program for MCAS gaps in care
- Redesign/increase incentives MCAS member rewards program
- Establish member focus groups
- Clinical assessments in community settings such as DMV, homeless shelters, social security office, etc.

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Quality Action Plan

Provider Accountability

- Establish Provider Innovation Initiatives (PII) Program
- Augment P4P Program with alternative approaches (gap closure, SDoH coding)
- Implement member in-home monitoring program (e.g., hypertension, diabetes, etc.)
- Increase use/incentives to Specialist and Urgent Care providers for gap closures
- Support outreach via reimbursement or staffing
- Telehealth expansion
- Provider input on best practices

Data

- Educate/encourage Provider Groups to code/use electronic clinical data systems/exchange
- Enhance data/report QA process across all depts to ensure accuracy
- Increase Electronic Clinical Data Systems measure performance via access to electronic health records, lab data, and appointment data
- Increase measure stratification by race & ethnicity
- Expand and increase frequency of outcome reporting for all programs implemented to evaluate outcomes

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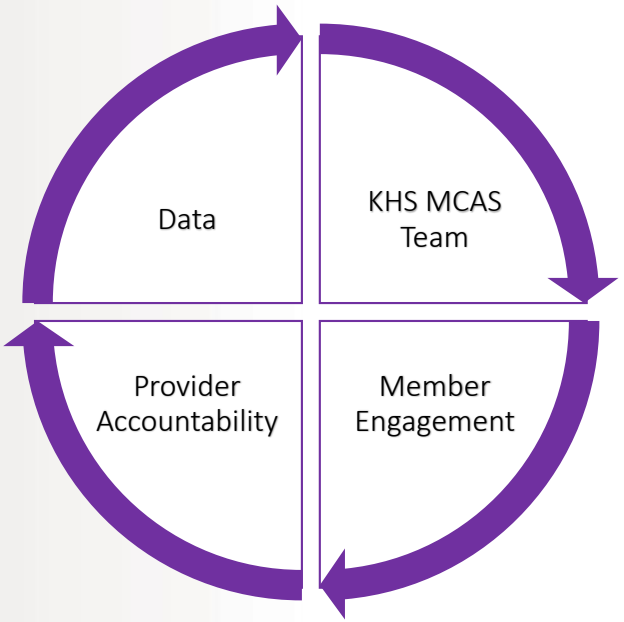
KHS Quality Strategies

KHS is committed to improving quality care for its members:

- KHS will closely monitor and provide technical assistance to providers
- KHS is creating a robust member engagement program
- KHS will expand transportation benefit
- KHS will partner with all providers, specialists, and hospitals to improve overall access, close gaps in care, and provide regular quality report cards
- KHS realigned P4P program
- KHS will work on process to assign based on quality score
- Grants will be contingent on quality initiatives and provider quality scores

Provider Support Needed:

- Create timely access to care
- Monitor gaps in care based on EMR data
- Outreach to those patients who have high no-show rates
- Expand outreach via CHWs
- Promote preventive care at every visit
- Keep in close communication with KHS to help address challenges to meeting MCAS



KERN HEALTH SYSTEMS

For additional Information:

Jake Hall, Deputy Director of Provider Contracting
Dr. Martha Tasinga, CMO
Timeshia Mackey, QI MCAS Supervisor

(661) 664-5000

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: February 16, 2023

Re: Review of Cyber Insurance Policy

Background

At the December 15, 2022 Board of Directors ("Board") Meeting, the Board requested a review of the KHS Cyber Insurance Policy. In particular, the Board wanted a better understanding of:

1) Covered items under the KHS cyber insurance policy
2) Adequacy of the dollar amount of the cyber insurance coverage

KHS utilizes Alliant Insurance Services ("Alliant") as its insurance agent to access the insurance carrier (including cyber insurance) market and perform the day-to-day servicing of the account.

Discussion

Cyber Coverage insures against the damages that can occur related to computer system breaches and other breaches of sensitive information. Alliant extensively marketed the KHS Cyber placement in May of 2022 (See Attachment 1) and at the time the incumbent was the most competitive option. Management recommended at the June 16, 2022 Board Meeting renewing coverage for Cyber Liability with Coalition as follows:

- Term: July 1, 2022 through June 30, 2023
- Per Claim Limit/Aggregate: $5,000,000
- Separate Limit/Aggregate for Breach Response: $5,000,000
- Self-Insured Retention: $250,000/8 hour waiting period
- Annual Premium: $231,311. Prior year's premium was $149,585.

The following coverages have a $5,000,000 Limit/Aggregate unless noted below with a sub-limit (sub-limit is the limit available for a specific coverage and is a part of the overall limit of the policy):

Third Party Liability Coverages:

- Network and Information Security Liability (a)
- Regulatory Defense and Penalties (b)
- Multimedia Content Liability (c)
- Payment Card Industry ("PCI") Fines and Assessments (d)

First Party Liability Coverages:

- Crisis Management and Public Relations (e)
- Cyber Extortion (f)
- Business Interruption and Extra Expenses (g)
- Extra Expense (h)
- Digital Asset Restoration (i)
- Non- IT Vendor Contingent Business Interruption and Extra Expense Security Failure $5,000,000/System Failure $2,500,000 sub-limit
- Funds Transfer Fraud - $250,000 sub-limit (j)
- Computer Replacement - $2,500,000 sub-limit (k)
- Criminal Reward - $25,000 sub-limit, $0 retention (l)
- Invoice Manipulation - $250,000 sub-limit (m)

The following coverage has separate $5,000,000 Limit/Aggregate and is not a part of the $5,000,000 limit above (limit is addition to the limits listed above).

Breach Response- Costs for an actual or suspected security failure or data breach including computer forensic fees/expenses; notification costs; legal fees; credit monitoring.

This is an added enhancement to the policy and is not widely available in today's market. It provides an additional tower of $5M in limits for Breach Response outside the other coverage limits. We were able to hold onto this enhancement at renewal due to Alliant's relationship with the market and KHS system and controls in place at the time.

Management believes that the $5 million coverage for Third Party and First Party Liability Coverage is adequate based on internal conversations with the KHS Chief Information Officer as to the Cyber Security standard controls in place. Additionally, management believes that there is limited exposure to business interruption and data restoration costs.

Management also believes that the $5,000,000 for Breach expenses is adequate based on assuming that KHS would need to notify approximately 350,000 individuals (mostly members) at a cost of $15 per notification.

Management will evaluate increasing the Cyber Insurance during the 2023 renewal.

Coverages are defined as follows:

(a) Network and Information Liability – Claims associated with security failure, data breach or privacy liability.

(b) Regulatory – Fines and penalties imposed in a regulatory proceeding.

(c) Multimedia Content Liability – Liability associated with gathering, communicating, reproducing, publishing, disseminating, displaying, releasing, transmitting, or disclosing media content including social media associated with defamation, libel, slander, violation of privacy, plagiarism, infringement of copyright and improper deep-linking or faming within electronic content.

(d) PCI Fines and Assessments – Fines and penalties for fraud recovery, operation expenses including card reissuance fees and notification of cardholders and case management fees under the terms of a merchant services agreement.

(e) Crisis Management and Public Relations – Costs for a public relations or crisis management consultant; media, printing or mailing materials about a public relations event and notifications where notifications are not required by law.

(f) Cyber Extortion – Money, Securities, Bitcoin or other virtual currencies paid due a threat is made for the purpose of demanding payment with the intent of access, acquire, sell, or disclose non-public information in your care, custody, or control, provided such information is stored in an electronic medium in a computer system and is retrievable in a perceivable form; alter, damage, or destroy any computer program, software, or other electronic data that is stored within a computer system; maliciously or fraudulently introduce malicious code or ransomware into a computer system; or initiate a denial of service attack on a computer system.

(g) Business Interruption – Loss of income due to partial or complete interruption of computer systems; $5,000,000 Limit/Aggregate.

(h) Extra Expense – Costs of employing contract staff or overtime costs, including internal IT department in order to continue KHS business operations; additional costs of employing specialist consultants, including IR forensic consultants, or order to diagnose and fix security failure or systems failure.

(i) Digital Asset Restoration – Costs to replace, restore or recreate digital assets to the level or condition that existed prior to a security failure.

(j) Funds Transfer Fraud – Fraudulent instruction transmitted by electronic means, including social engineering.

(k) Computer Replacement – Costs for computer replacement as a result of the loss of integrity in the firmware of any computer systems you own or lease due to security failure.

(l) Criminal Reward – Costs offered and paid for information that leads to the arrest and conviction of any individual(s) committing or trying to commit any illegal act related to coverage under the policy.

(m) Invoice Manipulation – The release or distribution of any fraudulent invoice or payment instruction by a third party as a result of a security failure.

Representatives from Alliant will be presenting a power-point presentation about the Cyber Insurance Market (Attachment 2) and will be available to answer questions relating to the KHS cyber insurance policy. Richard Pruitt, KHS Chief Information Officer, will also be present to answer questions.

Requested Action

Receive and File.

ATTACHMENT 1

Kern Health Systems
Cyber Liability Marketing Log
07/01/2022 - 07/01/2023

Market	Status
Coalition	Incumbent - Quoted - see proposal, $250K retention for premium of $233,676 and $500K retention for premium of $193,810.
Tokio Marine	Quoted - not as competitive as incumbent, $500K retention for premium of $207,052
Resilience	Quoted-not as competitive as incumbent, $1 Million retention for premium of $212,013 and $500K retention for premium of $240,406 but requires CPC engagement process with master service agreement.
XL	Declined – due to not writing new public entity business. Was on excess placement in 20/21 term.
AXIS	Declined – due to class of business, size and controls required. Was on excess placement in 20/21 term.
C&F	Declined – due to size of risk is too large.
Great American	Declined - due to size of risk is too large. Declined last year too.
AIG	Declined – due to exposure not a fit. Declined last year too.
Allianz	Declined – not writing Public Entity Cyber. Declined last year too.
Corvus	Declined - due to size of risk is too large. Declined last year too.
Westchester	Declined – no longer writing Public Entity Cyber risks
Cowbell	Declined – due to size of risk is too large. Declined last year too.
Beazley	Declined – no longer writing new business public entity. This carrier was on primary placement in 20/21 under SDRMA Package placement.
Hiscox	Declined – due to size of risk is too large
Sompo	Declined – no longer writing Public Entity Cyber risks
Markel	Declined – no longer writing Public Entity Cyber risks

6/2/2022

Attachment 2

Preparing For Today's Cyber Market

PRESENTED BY:

ALLIANT INSURANCE SERVICES

Alliant

Agenda

- Cyber Liability – State of the Market
- Minimum Security Standards
- Expectations for 2023 Renewal

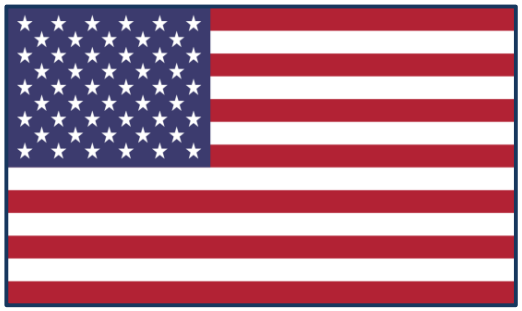
State of the Market

Cyber – State of the Market

Financial Impact of Cyber Crime

Estimated to have cost $6 Trillion globally in 2021

If viewed as a country, would be third largest economy in the world!



Cyber – State of the Market

Other Scary Cyber Statistics

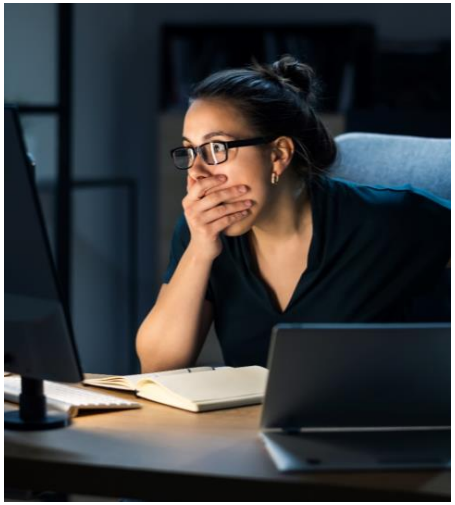
- Impact of cyber crime projected to be $10.5 Trillion by 2025
- A consumer or business suffered a ransomware attack every 11 seconds in 2021…expected to drop to every 2 seconds by 2031!
- World population on the internet is about 75%..expected to grow to 90% by 2030
- We will need to protect 200 Zetabytes of data by 2025!
- Global cybersecurity spend over the next 5 years expected to exceed $1.75 Trillion
- Cyber Insurance market expected to reach $15 Billion by 2025

**** SOURCE: 2022 Cybersecurity Almanac***

Cyber – State of the Market

The Ransomware Epidemic

Ransomware surged in recent years, and there is no foreseeable slowdown. All industry segments were impacted. Manufacturing and professional services were particularly hard hit, followed closely by healthcare, education and government entities.



Estimated global damage from ransomware.

2018	2019	2021
$8 Billion	**$11.5 Billion**	**$20 Billion**
2024	2028	2031
$42 Billion	**$157 Billion**	**$265 Billion**

Cyber – State of the Market

Recent Ransomware Losses

Colonial Pipeline was hit with a devastating cyberattack in 2021 that forced the company to shut down approximately 5,500 miles of pipeline in the United States, crippling gas delivery systems in Southeastern states. The FBI blamed the attack on DarkSide, a cybercriminal gang believed to be based in Eastern Europe, and Colonial reportedly paid a **$5 million ransom** to the group.

JBS SA, a leading food company and the largest meat producer globally, had to shut down production at multiple sites worldwide following a cyberattack. The incident impacted multiple JBS production facilities worldwide over the weekend, including those from the United States, Australia, and Canada. The FBI attributed the attack to REvil, a Russian-speaking gang that has made some of the largest ransomware demands on record in recent months.

Royal Dutch Shell became the next victim of the Clop ransomware gang. The gang exfiltrated sensitive data from a Accellion file transfer service used by the oil giant and later leaked the stolen data online to prompt them to pay a ransom. Some of the leaked data included employee visa and passport information.

US based insurance giant **CNA** were victim of a ransomware attack using a new variant called Phoenix CryptoLocker, possibly linked to the Evil Corp hacking group. Sources familiar with the attack have told BleepingComputer that over 15,000 devices on their network were encrypted and remote employees logged into the VPN were also affected. It's been reported that CNA paid the **$40 million demand** but the loss is likely to be north of $100 million after business interruption and data restoration costs are taken into account.

Cyber – State of the Market

Rate Trends	"Low End"	"High End"
Cyber	5%	200%

Capacity

Insurers have been extremely conservative with capacity, with most only offering $5M limits. Total capacity available in the marketplace is likely below $400 million and could continue to shrink. Energy sector being watched more closely, and avoided by some markets, given the conflict in the Ukraine.

Coverage

Coverage generally intact for most classes of business with mature information security programs and strong controls. However, leading Primary insurers are pushing for 50% coinsurance provisions and sublimits or other coverage restrictions for ransomware losses where companies are less secure. Dependent Business Interruption and Dependent System Failure coverage is slowly being lowered or removed entirely

Retentions

Continued pressure on primary retentions and waiting periods for business interruption losses

Pricing

Short-tail nature of Cyber risk results in rapid pricing feedback, with abrupt pricing correction due to uptick in severity of claims. Insurers have consistently secured primary increases of 80% - 250% on Q1 and Q2 2022 renewals, depending on controls and what increases they had in 2021. Still very dependent on strength of controls, with minimum standards being tightened. Excess insurers are following Primary increases and pushing for higher percentage increases on certain attachment points, with ILF's still well over 80%.

Cyber – State of the Market

Standalone Sample Market Capacity for PE's

AIG 2021 ($ Millions): 30 2021 ($ Millions): 5 – 10 2022 ($Millions): 5 - 10	beazley 2020 ($ Millions): 50 2021 ($ Millions): 5 – 10 2022 ($Millions): 5 - 10	AmTrust 2020 ($ Millions): 15 2021 ($ Millions): 5 – 10 2022 ($Millions): 5 - 10	AXA XL GROUP 2020 ($ Millions): 15 2021 ($ Millions): 5 – 10 2022 ($Millions): 5 - 10
Berkley 2020 ($ Millions): 5 2021 ($ Millions): 5 2022 ($Millions): 5 - 10	BRIT 2020 ($ Millions): 10 2021 ($ Millions): 0 – 5 2022 ($Millions): 0	CHUBB 2020 ($ Millions): 10 2021 ($ Millions): 1- 2 2022 ($Millions): 1 - 5	AXIS 2020 ($ Millions): 10 2021 ($ Millions): 0 – 5 2022 ($Millions): 0 - 5
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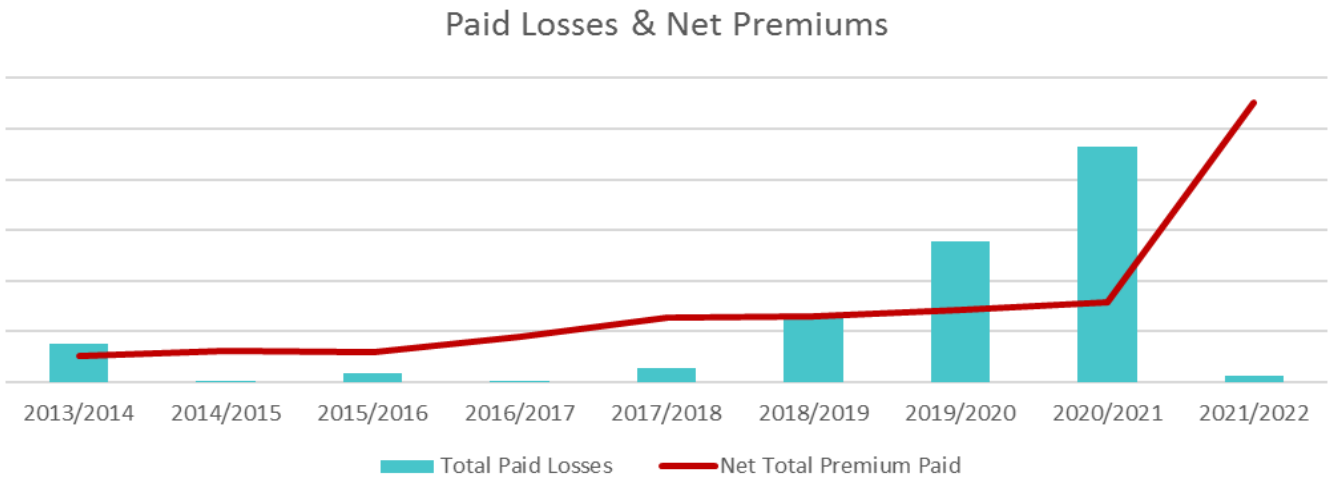
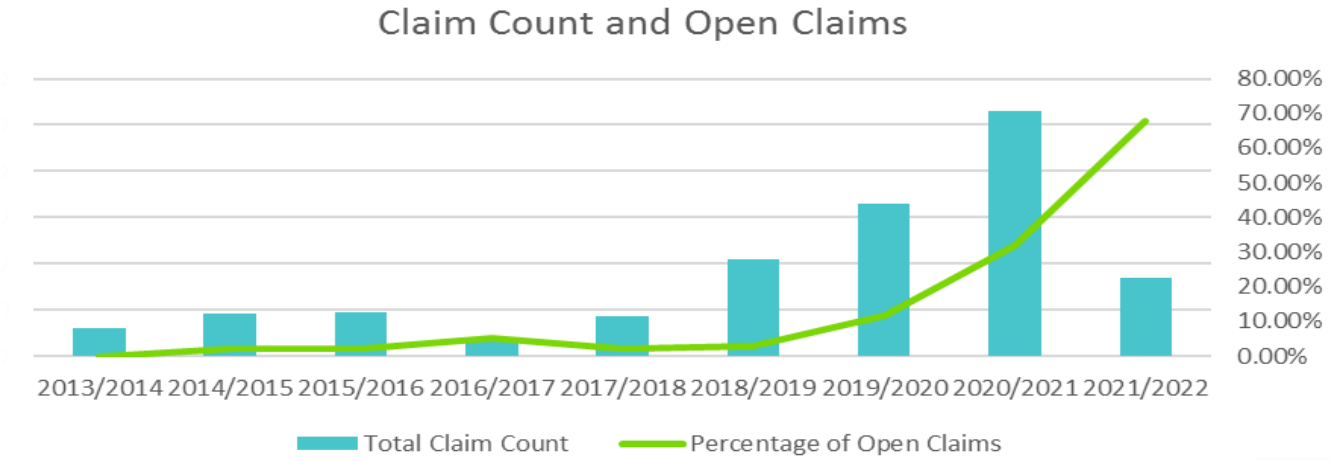
Public Entity Sector Cyber Loss Statistics





Source: Alliant Insurance Services, Inc.

Minimum Security Standards

Security Standards Guidelines

Minimum System Standards of Cyber Market Underwriters

There are several key areas which insurers focus on with regards to security controls, with the following nine as the most crucial. As a general rule, the larger the revenue/budget for an insured, the higher the expectations will be for their controls.

- **Multi-factor authentication – 100% implemented for:**
  - Remote access (Faulty, Staff, and Students – not uncommon with Universities, not yet required for K-12 students)
  - Laptops
  - Privileged access
- **Well managed end point detection**
- **Well managed RDP connections – VPN, MFA, etc.**
- **Back Ups**
  - 1 working copy, 1 offsite, disconnected not working, 1 onsite disconnected not working
  - Tested at least twice a year
  - Ability to bring up within 24-72 hours – less time for critical operations (4 hours)
  - Protected with antivirus or monitored on a continuous basis
  - Encryption

Security Standards Guidelines

- **Planning and Training**
  - Incident response plan
  - Business continuity plan
  - Social engineering training
  - Phishing training
  - Training of accounting/finance staff on fraudulent transactions
  - General cyber security training
- **Reasonable patching schedule/plan**
  - ✓ Critical & high severity patches installed within 30 or fewer days, optimally within 1-7 days for critical & high severity patches regarding active exploits
- **Plan or adequate measures in place to protect end of life software**
- **Email Security**
  - Screening for malicious attachments
  - Screening for malicious links
  - Quarantine Services
  - Tagging External Emails

Security Standards Guidelines

- **Privileged Access Management (PAM)**
  - Establish and enforce comprehensive privilege management policy
  - Identify and bring under management all privileged accounts and credentials
  - Enforce least privilege over end users, endpoints, accounts, services, systems, etc.
  - Enforce separation of privileges and separation of duties
  - Segment systems and networks
  - Enforce password security best practices
  - Monitor and audit all privileged activity
  - Enforce vulnerability based leas privilege access
  - Implement privileged threat/user analytics

2023 Cyber Renewal

2023 Renewal Expectations

Cyber Renewal Outlook

Leading insurers have indicated "We may have hit rate equilibrium"

2023 Forecast:

- 15% to 75% increases, at a minimum, for "good" risks and most starting much higher
- Lower overall capacity deployment
- Increased per-claim, self-insured retentions across the board
- Increased waiting period (time element deductible) before electronic business interruption (EBI) cover kicks in
- Potential coinsurance percentages added for ransomware
- Further reduction of ransomware limit

Requirement to evidence security posture:

- MFA
- Data Backups
- Endpoint Detection
- Employee Education & Training Programs

2023 Renewal Expectations

What we expect in 2023

- Too early to tell. Market still in flux
- Prepare for the worst. Controls are key!
- We expect that the largest changes will come from endorsements
- C&F and Chubb led the charge on endorsements in 21/22
- Other carriers to follow in the next renewal cycle

What can Kern Health Systems expect in 2023

- Marketing coverage this year – current carrier Coalition – Quota Share with five carriers
- Complete renewal applications early!
- Ransomware application Version 7 – 2022 two pages, 2023 seven pages – Most important and highly scrutinized
- Questions surrounding Budgets and Personnel within IT
- Be concise and detailed on answers, more is better!

Alliant

2023 Renewal Expectations

Cyber Insurance Wording Changes

End of Life Software, Patching (or Lack Of) and Government Required Shutdown: Reduced coverage for utilizing end of life software or for not patching within recommended timeframes. Exclusion of any government-mandated restriction of operations, closure, or shutdown, entity or person operating a computer system or any computer system that is not under a targeted cyber attack

Biometric Exclusion: Coverage may be excluded for any claim or circumstance arising out of the processing, storage, or compromise of biometric data. This includes but is not limited to fingerprints, iris scans, facial images, voice and/or other biometry used to for automatic recognition of individuals based on their biological or behavioural characteristic

Systemic Versus Targeted Coverage Differentiation: Markets in London have been making this distinction for a few years with regards to cyber coverage in property insurance placements. In the 2021, a large U.S. insurer made created the first widespread wording for standalone cyber

Software Vulnerability Exclusions: Insurers were excluding SolarWinds, Microsoft Exchange, Kaseya claims at the following renewal to reduce exposure

Co-Insurance: Generally on ransomware related coverages which have historically paid out large claim amounts, such as cyber extortion and business interruption as a result of a security breach. Also utilized to obtain the coverage in excess layers, or for entities with poorer controls / looking to reduce premium

2023 Renewal Expectations

Catastrophic Events Clauses

- Look to exclude events that have a detrimental effect on a nation's digital infrastructure (AWS, etc) or key services relied upon by a nation's core financial services utilities
- Such events have never happened
- Chubb already uses them
- London markets looking to introduce beyond 1st January 2023 (sub limits?)
- Reinsurers asking for such exclusions
- Insurers want to entice new capital into the market and such new capital is asking for clarity around these events.


THANK YOU!
PASSWORD
Alliant

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: February 16, 2023

Re: Report on Final Status of 2022 Corporate Goals and Department Goals

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Background

At the close of each calendar year Management summarizes the results of the annual departmental goals as well as the annual corporate goals. The attached presentation includes the year-end status report on KHS' 2022 Department and Corporate Goals and Objectives.

2022 Corporate Goals

The detailed descriptions outlining the final status of the 2022 Corporate Goals are included as a separate attachment. KHS was successful in executing the 2022 Corporate Goals except for one goal which was delayed by DHCS. As noted in the attachment, DHCS delayed the implementation of their permanent telehealth benefit into 2023. This item is being tracked as part of the 2023 Corporate Goals.

2022 Department Goals

As of the end of 2022 staff has completed 126 (96%) of the departmental goals and objectives. The remaining 5 (4%) in-progress goals have been rolled into 2023 and are scheduled to be completed. An overview of the in-progress and incomplete items are included in the accompanying presentation. As noted in the presentation, items in green were completed on time and the desired outcome was achieved. Items in yellow were partially or mostly completed and are still in progress with the desired outcome achievable in 2023. Finally, items in red were not completed or the desired outcome was not achieved. KHS did not have any goals in a red status for 2022.

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

Corporate Performance Goals for 2022

Background

The Corporate Performance Goals for 2022 are heavily influenced by the California Advancing and Innovating Medi-Cal or CalAIM, CalAIM is a series of initiatives proposed by the Department of Health Care Services (DHCS) to advance broad-based delivery system, program, and payment reform across the Medi-Cal program. Furthermore, CalAIM will address social determinants of health, streamline the statewide Medi-Cal delivery system, improve quality, and drive innovation.

Specifically, CalAIM has three primary goals:

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

Originally scheduled to begin in January 2021, the proposal was delayed due to the impact of COVID-19. CalAIM was re-announced in January 2021 with DHCS' release of updated policy materials and with the inclusion of CalAIM funding in the draft 2022 State budget.

Major CalAIM initiatives scheduled for implementation in 2022 include:

- Enhanced Care Management (ECM)
- Community Support Services (CSS)

At its conclusion, CalAIM will transform Medi-Cal Managed Care health plans to provide a broader range of benefits through an integrated delivery system comprised of traditional medical

services, behavior health services (including specialty mental health) substance use disorder services (detox and therapeutic) and dental care.

In general, Safety Net Providers (Kern Medical, Omni Family Health and Clinica Sierra Vista) will play an important role in accomplishing our goals and will be encouraged, where appropriate, to participate in its achievement or considered in its outcome. Where a goal is specific to one Safety Net Provider, the provider is identified as to whom the goal applies. For example, the 2022 CalAIM initiative goal identifies Kern Medical specifically and its role with Whole Person Care.

KHS keeps this in mind when establishing annual Corporate Goals always considering their impact on the Safety Net Providers. With Safety Net Providers representing an integral network component, no goal will be achieved without their consideration nor accomplished without their involvement.

Successful implementation of initial phases of ECM and CSS is the 1st Goal of our 2022 list of Corporate Goals. Among other things, this includes realigning KHS's Health Home Program and Kern Medical's Whole Person Care Program under ECM. In addition to ECM and CSS implementation, the 2022 Corporate Goals include the following seven goals:

1. A new **Three-Year Strategic Plan** will be adopted in early 2022 focused mostly around CalAIM initiatives scheduled for launch between January 1, 2023 and December 31, 2025. CalAIM will continue to preoccupy KHSs time and resources for the foreseeable future with its many initiatives scheduled for implementation as far out as 2026.

2. KHS will expand its **Major Organ Transplant** responsibilities with the addition of Heart, Lung, Liver and Pancreas**.** Historically, other than for kidneys, members needing organ transplants would disenroll with KHS and reenroll in the State's Medi-Cal Fee For Service Coverage Plan. To avoid fragmenting members care and shifting between two Medi-Cal enrollment programs, beginning 1/1/2022, members may remain in their current health plan where patients will be followed from pre-transplant to recovery.

3. The **Chief Executive Officer** will be retiring in 2022. Recruitment of his replacement will commence in 2021. It is anticipated it will take several months to locate and hire a suitable candidate including allowing for time to transition from current employment to the KHS leadership role.

4. **Pharmacy Benefits Management (PBM)** currently administered through health plans will be carved out and centrally administered through a statewide PBM. Originally scheduled to launch in 2021, it appears it will be delayed a year and likely to be implemented in early 2022.

5. **Medi-Cal Eligibility Expansion** will occur over 2022, adding six new Managed Care Medi-Cal eligibility population categories to Managed Care Plans like KHS.

6. An **Incentive Program** to promote health plan and provider participation in ECM and CSS will be created. The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024.

7. **Telehealth Services** has shown to be an effective method for maintaining the physician / patient relationship during the pandemic. DHCS modified its benefits to include telehealth as an alternative to office visits during the stay at home order. DHCS will make telehealth (audio services) a permanent benefit effective 2022.

Goal 1 – CalAIM 2022 Initiatives (Implementation and Monitoring) *(Completed)*

Effective 1/1/2022 health plans are expected to launch two major CalAIM initiatives:

- **Enhanced Care Management** is comprehensive approach to address the clinical and non-clinical needs of high-need, high-cost members through coordination of services and comprehensive care management. Kern Health Systems Health Home Program and Kern Medical's Whole Person Care Program will be incorporated under Enhanced Care Management. Over the years, more Medi-Cal members will qualify for Enhanced Care Management through expansion among existing qualified enrollees or adding of new member eligibility categories. Kern Medical is expected to continue delivering services under its Whole Person Care Program following its inclusion under Enhanced Care Management.

- **Community Support Services** are services provided as a substitute for, or used to avoid, other more costly covered services, such as a hospital or skilled nursing facility admission or a discharge delay. Such service may or may not be medically related but by their proper use should reduce medical cost.

Since development will occur in second half of 2021, in 2022, KHS will turn its focus to post operations to ensure:

- all program elements are in place and functioning accordingly
- program refinement occurs to improve chances for a successful outcome
- performance tracking and monitoring is in place to measure success and report outcomes for each initiative.

Deliverables:

- ***By 1st Quarter, 2022, establish methodology for monitoring program performance including identifying staff responsibilities for tracking and reporting on each program's performance against predetermine targets and DHCS performance measures.*** *ECM and CSS internal staff worked with the Business Intelligence department to outline monitoring and performance measures. The ECM invoice report is being validated, which identifies claims submitted by the ECM Providers. The BI team created the Census report that will identify the paid g-code that is used for compensation. CSS team worked with BI to create a weekly report to review referred members.*

  Ongoing operational assistance is being provided to existing ECM sites. Additional work is underway to launch additional ECM sites with Omni Health and Premier. CSS implementation and expansion is also ongoing with several Community Based Organizations in the pipeline.

- ***By 2nd Quarter, 2022, establish a data collection and reporting framework to track and monitor each initiative's performance to determine if it's meeting its intended purpose:***
  - ***Data will be developed for all critical components of each initiative.***
  - ***Analytics will track each critical component's performance***
  - ***Reports will be generated timely to measure outcomes***

  As of the 2nd Quarter, 2022, these reports have been vetted, the data points have been validated, and we are now receiving them monthly.

  Two new additional ECM sites have been established, including Omni Health on Stine and Premier on Stockdale. Many elements of the data exchange between the sites and KHS have been vetted and are currently in production. As to the clinical side, both sites have undergone clinical audits in Quarter 2 and have both passed by exceeding the threshold of 80%.

- ***By 2nd Quarter, 2022, design and format reports and schedules in accordance with DHCS reporting requirements and submission timelines.*** *The 1st Quarter ECM/CSS report were submitted to DHCS on May 15th. The 2nd quarter report was submitted to DHCS on Aug 15th. All required reports are in process; ECM and CSS teams will complete and submit to DHCS by the due date.*

Goal 2 – Kern Health Systems 2023 to 2025 Three Year Strategic Plan *(Completed)*

January 2022 will begin implementation of the initial phase of CalAIM. Over the next few years, several key priorities of the State, using Medi-Cal as its tool, will change how health care will impact California's most vulnerable population. Programs aimed at homelessness, behavioral health care access, children with complex medical conditions, justice involved populations and the growing aging population will be created to improve their health status and quality of life.

Critical to this change is its impact on network providers. An effort will be made to see to it Safety Net Providers maintain their key role in the delivery of patient care to their currently assigned members. Additionally, KHS will look to work collaboratively with Safety Net Providers on new care models or programs arising from CalAIM occurring between 2023 and 2025.

Under Medi-Cal, the State will create several initiatives to achieve this objective though enhanced services and benefits including:

- Development of a statewide population health management strategy and require health plans to submit local population health management plans.
- Implement a new statewide enhanced care management benefit.
- Implement Community Support services (e.g., housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and Community Support services capacity statewide.
- Pursue participation in the Serious Mental Illness (SMI) /Serious Emotional Disturbance (SED) demonstration opportunity.
- Require screening and enrollment for Medi-Cal prior to release from county jail.
- Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth

The new three-year strategic plan will be developed to guide management with planning, development and implementation of initiatives schedule for launch between 2023 to 2025. These initiatives include:

2023

- Enhanced Care Management (Phase 2 eligibility)
- CSS Services (Phase 2 services)
- Population Heath Management (patient centered health strategy)
- Long Term Care added to Medi-Cal Health Plans
- Advanced enrollment of soon-to-be-released (STBR) incarcerated in Medi-Cal
- Dual Eligible (Medicare and Medi-Cal eligible) Planning

2024/2025

- DSNP application submission with CMS to enroll Medicare eligible members with dual coverage. (25,000 Kern County eligible beneficiaries with Dual Eligibility)
- Begin NCQA preparation process (18 months before certification)

2026

- D-SNP Medicare health plan initial enrollment begins 01/01/2026
- Continue full integration implementation readiness and planning activities for the remaining outstanding CalAIM initiatives

Besides the number of new initiatives health plans are expected to launch, CalAIM will change how health plans are paid and incorporate new risk and incentive programs.

Prominent among these changes is the State's intent to shift from County based health plan reimbursement rates to regional based reimbursement rates. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM

Although CalAIM will dominate KHS's attention over the next three years and appear prominent in the three-year strategic plan, other significant goals the Board would like to see accomplished may be added to the list of CalAIM initiatives for inclusion in the three -year strategic plan.

The strategic planning process begins with engaging an outside consultant to outline the steps Board and Management will take leading to a one-day session moderated by the consultant.

For continuity's sake and CalAIM knowledge, Pacific Health Consulting Group (who assisted with developing the previous three strategic plans) will serve as our moderator.

The overarching themes of this one-day session should revolve around the changing healthcare environment (particularly CalAIM) and its impact to Kern Health Systems. From this evaluation, the Board will develop Goals and Strategies to position KHS for future success.

Deliverables:

- ***Q3 2022, KHS Board to receive overview of the process to be undertaken culminating with a new three-year Strategic Plan.*** *An update on the process overview and timeline of the Strategic Planning next steps was included under the CEO Report as part of the August Board materials. The team engaged Pacific Health Consulting Group (PHCG) in July to begin planning for the upcoming Strategic Planning Session. The Board was surveyed for availability to attend a Strategic Planning Session, and a final date of October 13th was set. Additional internal coordination occurred to develop an agenda, speakers, and meeting materials.*

- ***Q3 2022, Board members will receive background information and questionnaire in preparation for upcoming Board of Directors strategic planning retreat.*** *In September, PHCG developed and shared a survey to gather information prior to the Strategic Planning Session. Survey responses were gathered from the Board of Directors and key internal Leadership.*

- ***Q3 2022, Board to participate in a one-day strategic planning retreat to be held onsite at Kern Health Systems.*** *The Strategic Planning Session was held on October 13th following the regular Board of Directors meeting.*

- ***Q4 2022, from information and feedback obtained during the retreat, a draft version of the 2023 -2025 Three Year Strategic Plan will be sent to Board members for comment.*** *A draft Strategic Plan Summary document was developed and included as part of the December Board of Directors packet.*

- ***Q4 2022, Board to adopt the 2023 -2025 Three Year Strategic Plan.*** *As noted in the update given during the August Board of Directors meeting, approval of the final Strategic Plan is scheduled for the February Board meeting.*

Goal 3 - Major Organ Transplants *(Completed)*

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide. Beginning in 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled with a health plan.

Historically, KHS was only responsible for administering transplant benefits for patients who needed a Kidney transplant. Since 2018, on average, 20 KHS members would undergo Kidney transplants annually. Besides being financially responsible for Kidney transplant, KHS will become responsible for heart, liver, lung and pancreas transplants as well.

In preparation for this occurrence, KHS will need to establish a transplant care coordination team to follow these patients after qualifying for an organ transplant. Patients will be assigned to the organ transplant program where they will be followed through their pre-transplant care, transplant surgery and post discharge therapy and rehabilitation. Preliminary estimates are KHS could have upward of 100 patients at any given time participating in the transplant program.

Deliverables

- ***Identify qualified major organ transplant centers with whom KHS will contract for transplant services by 3rd Quarter, 2021.*** *Centers of Excellence (COE) have been identified, including currently in-network facilities. Letters of agreement will be used until final contracting in place.*

- ***Determine compensation arrangements and payment methodology with selected transplant centers 3rd Quarter, 2021.*** *Provider Network Management worked with finance to determine compensation arrangement and payment methodology. DHCS has outlined the required payment amounts for the new transplant services.*

- ***Negotiate an agreement for provision of transplant services with selected transplant centers by 4th Quarter, 2021.*** *Contracting Department has sent amendments to Keck and UCLA. Staff continues to negotiate contracts with Loma Linda, UC Irvine, UCSF, and*

California Pacific Medical Center. Currently UC Irvine and Loma Linda are willing to execute LOA's.

- ***Determine internal staffing requirements for the KHS Transplant Program based on the #, type and time involved with coordinating and overseeing services provided to qualified patients participating in the KHS Transplant Program by 3rd Quarter, 2021.*** *Major Organ Transplant team hired in January 2022 within the Population Health Management (PHM) department. The team will manage and coordinate care across the entire transplant process. Additionally, authorization review is performed by dedicated UM staff based on eligibility criteria.*

- ***Determine the impact to KHS, its policy, procedures, protocols, tracking and reporting by 4th Quarter, 2021.*** *Internal processes and policies developed as part of the new transplant team.*

- ***Launch Major Organ Transplant Program by 1st Quarter, 2022.*** *Program launched 1/1/2022. Ongoing items include meals/hotel accommodations for members. Ongoing coordination between Accounting, Corporate services, Member services, and PHM.*

- ***Post implementation, audit each activity to ensure installation and performance meets KHS and government agencies expectations (ongoing over 2022).*** *First DHCS reporting template was submitted in April. The utilization parameters and care management teams have been implemented to manage the new benefit. JIVA medical management system updates have been completed to track Major Organ Transplants phases: evaluation, waitlist, transplant, and post-transplant. Reconciliation reports are generated for financial oversight to incorporate both outpatient and inpatient costs across the life of the transplant process. Processes were implemented for managing pre- and post- transportation benefits, including housing and meals for appointments and for member pre-payment and reimbursement funding for expenses.*

Goal 4 - Selection of New Chief Executive Officer *(Completed)*

The transition of key employees, particularly the Chief Executive Officer (CEO) is one of the most formidable challenges an organization will face. In the CEO's case, the shift engenders a variety of adjustments including changes in style and sometimes substance. Each CEO makes his/her mark bringing about major directional, policy and priority revisions. As a rule, the longer and more successful the CEO, the more difficult the shift. This can be somewhat mitigated with a well thought out and effectively executed Succession Plan. Serving one of every three citizens, Kern Health Systems has experienced unprecedented growth over our current CEO's service tenure of

10 years to become Kern County's largest health plan. With success comes responsibility to assure there is a plan for leadership continuity. To achieve this Kern Health Systems will create a Search Committee charged with the responsibility to identify qualified candidates to replace the current retiring CEO. The following tasks and timeline were stipulated in the current CEO's employment agreement and adopted by the Board of Directors to aid in locating a suitable replacement in a timely manner.

1. 12 months before the CEO's retirement date, the Board shall receive notification of the CEO's retirement date from the CEO.

2. Upon receiving notice, the Board shall appoint 5 Board members to serve as a Search Committee who will be responsible for searching for and recommending the finalist(s) for the CEO position to the Board.

3. Within 45 days following its appointment, the Search Committee shall engage a professional executive search firm to assist with recruitment. The Director of Employee Relations shall serve as KHS staff to the Committee to assist with locating and providing background information to qualified search firms experienced with recruiting qualified candidates for the CEO position. An appropriate competitive process shall take place to select the search firm to find qualified candidates for the position.

4. Within 90 days following engagement, the search firm will present its slate of qualified, screened candidates to the Committee for interview consideration.

5. Within 30 days, all selected candidates must be interviewed by the Search Committee.

6. Within 30 days of the conclusion of interviews and evaluation of the candidates, the finalist shall be presented to the Board for recommendation for hire and the candidate will receive an employment offer.

7. If the finalist declines the offer of employment or is otherwise unavailable, the candidate ranked next in order by the search firm shall be recommended for hire.

8. Within 30 days, KHS will receive a signed employment agreement leaving up to 4.5 months for the newly hired CEO to give sufficient notice (if currently employed) to his/her current employer.

The CEO agrees, for purposes of continuity, to serve as consultant to KHS for a period no less than 90 days following retirement.

Deliverable

- ***Locate a suitable replace for the CEO, Kern Health Systems.*** *The CEO Search Committee was formed in June 2021. The committee engaged with a professional recruiting agency to conduct a search for candidates. This included the creation of the position profile, identification of qualified candidates, and a progressive interview process. The Search Committee was also involved in the interview process and ultimately made a recommendation to the full Board of Directors.*

Goal 5 – Medi-Cal Eligibility Expansion for 2022 *(Completed)*

In 2022, Medi-Cal will shift several new and currently covered population categories to health plans like KHS including:

- Undocumented Adults over 50 (pending approval of legislation)

- Enrollees from Medi-Cal Fee-For-Service eligible population:
  - Accelerated Enrollment (AE)
  - Pregnancy Related (Title XIX)
  - American Indian
  - Beneficiaries in Rural Zip Codes
  - Beneficiaries with Other Healthcare Coverage

It's not known how many eligible members are represented in the over 50 undocumented population in Kern County. Consequently, KHS is unsure how many new eligible members will enroll with Kern Family Health Care from this group. There are approximately 60,000 potential members among the five groups moving from Medi-Cal Fee-For-Service to a Medi-Cal Managed Care Health Plan (MCMCHP).

For Kern County, beneficiaries will choose between Kern Health Systems (Kern Family Health Care) and HealthNet. Typically, when newly eligible members are given a choice 80 -85% select Kern Family Health Care (KFHC). Each newly eligible enrollee will receive an enrollment packet 90 days in advance of their effective date of coverage (January 1st, 2022). Eligible members failing to select a health plan, will be automatically assigned by the State to either HealthNet or KFHC. Those coming to KFHC, are randomly assigned to Kern Medical, Omni Family Health and Clinica Sierra Vista (Safety Net Providers).

It is estimated approximately 20% will fail to select and will automatically be enrolled with one of the two available health plans. When this happens, members may change the States default selection anytime. For those who change, it's been KHS's experience we gain four members for each member lost to HealthNet.

Deliverables:

- ***Provide information and support to community-based organizations enrolling newly eligible members into full scope Medi-Cal by 1st Quarter, 2022.*** *The marketing team built relationships and enhanced partnerships with several community organizations in the Ridgecrest area. Many of these organizations will be further supported through the KHS Community Grant Program. Ridgecrest is a new service area for KHS due to a CalAIM initiative which enrolled members in rural zip codes into Managed Care.*

  The team also collaborated with and supported the efforts of several local enrollment entities and other community organizations in relation to the expansion of full-scope Medi-Cal to undocumented older adults over the age of 50. The transition to full-scope Medi-Cal coverage for this population took effect in May 2022.

- ***Initiate enrollment of newly eligible Medi-Cal members starting in 2nd Quarter, 2022.*** *As of July 29, 2022, over 3,000 undocumented adults over 50 have enrolled in Kern Family Health Care. KHS donated $6,000 to Friends of Mercy Foundation to support a Medi-Cal Expansion for Older Adults media campaign coordinated by the Outreach Enrollment Retention Utilization Committee (OERUC) of the Community Health Initiative of Kern County. KHS also sponsored the Cesar Chavez Foundation "Dia del Trabajador" Health Fair on Sunday, May 1st at 40 Acres in Delano. Since this was the first day undocumented adults over 50 could enroll in full scope Medi-Cal, this was a major focus of many of the organizations who participated in the health fair such as Clinica Sierra Vista, Delano Community Connection, Health Care Options, etc.*

***Dates may change based on final APL adoption and allowable timeframe for implementation**

Goal 6 – Prescription Drug Benefit Carved Out from Managed Care Plans *(Completed)*

The transition to a State operated pharmacy administrator was scheduled to take effect at the beginning of 2021. However, the State delayed implementation. It is believed the delay will be lifted shortly and a new transition date established. The new date will likely occur sometime 1st quarter, 2022. Despite the year delay, KHS fully expects the State to move forward with their original plan.

Therefore, beginning 2022, with few exceptions, the Medi-Cal prescription drug benefit will be administered by the State in partnership with Magellan Medicaid Administration. For managed care health plans like KHS, this will mean a diminished role in the administration and distribution of the pharmacy benefit. However, under certain circumstances and in specific situations, managed

care plans (MCP) will continue to administer the Medi-Cal pharmacy benefit. Transitioning to this new arrangement will again start sometime during the last quarter of this year and continue to a smaller extent in 2022. The transition to the new arrangement with realignments in place is expected to be finished by the end of 1st quarter, 2022.

Though the claims processing/payment and authorization for outpatient drugs will fall to the State, the KHS is expected to continue case management, Drug Utilization Review, Medication Therapy Management, and other related activities. Quality measures that involve administrative pharmacy data will also be activities the plans will be required to meet.

Assuming the State moves to transfer pharmacy administration responsibilities to Magellan 1st quarter, KHS will need to undertake the following changes in preparation for this change and the modified responsibilities remaining with KHS.

Deliverables:

- ***Continue to exchange data and reinstitute integration procedures to current system application (ongoing).*** *Minor modifications have been and continue to be made through the transition. This was needed due to some file templates and protocol specs not aligning or being changed by Magellan.*
- ***Incorporate Operational readiness for Member Services, Provider Network Management, Health Services, Claims Adjudication, and Business Intelligence beginning 1st Quarter, 2022.*** *Materials from DHCS/Magellan continue to be shared with our network providers. Post transition, KHS has been directing questions and concerns to*

DHCS as they arise. KHS has also been providing clarification to the network as appropriate to assist our members receiving the medically necessary services required.

- ***Transition Pharmacy Operations for outpatient pharmacy processing only beginning 1st Quarter, 2022.*** *This handoff was successfully accomplished.*
- ***Complete transition for TAR drugs or grandfathering medications by 2nd Quarter, 2022.*** *This was successfully performed by KHS. DHCS is no longer requiring MCP data regarding TARs or claims to be sent.*
- ***Continue to perform run out activities for outpatient pharmacy through 1st Quarter, 2022.*** *DHCS has delayed the reinstatement of some DUR edits and Prior Authorization requirements. They have also extended the timeline for the transition policy to be effective. KHS is sharing this information within the organization and with our provider network. Full transition is now scheduled for some time in 2023.*
- ***Complete Member and Provider transition for outpatient pharmacy from KHS to Magellan by beginning of 1st Quarter, 2022.*** *This transitioned as designed.*
- ***Transition department to providing ongoing support to members and providers for pharmacy prescription benefits remaining the responsibility of KHS (ongoing).*** *This is ongoing. Transition is taking longer to fully implement as some of the issues from the DHCS end of the transition are slowing the efforts.*

Goal 7 - CalAIM Incentive Payment Program (IPP) *(Completed)*

CalAIM's Enhanced Care Management (ECM) and Community Support Services (CSS) programs will launch in January 2022, requiring significant new investments in care management capabilities, CSS infrastructure, information technology (IT), data exchange, and workforce capacity for both health plans and providers. Incentives will be available over the next three years to help pay for these investments. DHCS has designed the proposed incentive payment approach with the goal of issuing initial payments to health plans beginning in January 2022 for the achievement of defined milestones such as:

- Build appropriate and sustainable ECM and CSS capacity
- Drive health plan investment in necessary delivery system infrastructure
- Incentivize health plans to progressively engage in development of CSS
- Bridge current silos across physical and behavioral health delivery
- Reduce health disparities and promote health equity

- Achieve improvements in quality performance

DHCS will use the following 8 guidelines for designing their incentive payment program:

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care and Health Home Programs
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

Incentive payments will be distributed over three payment cycles each year of the incentive program following determining the maximum potential annual incentive dollar amount for each health plan like KHS.

Beginning in 2021, KHS will create its incentive program focused on the following priority areas:

- Create / enhance delivery system infrastructure for health plan's, ECM and CSS provider health information technology and data exchange required for ECM and CSS
- Build ECM capacity with incentives to fund ECM workforce, training, technical assistance, workflow development, operational requirements, and oversight
- Build CSS capacity with incentives to fund CSS workforce, training, technical assistance, workflow development, operational requirements, and oversight

Each priority will have measurable outcomes to show progress toward achieving expectations. Awards will be based on achievement and payment will follow when evidence is provided showing outcomes were met.

Deliverables

- ***Following DHCS's priorities, complete a "Gap / Need Assessment" to determine what is necessary to meet structural and capacity requirements to fulfill ECM and CSS objectives under CalAIM by 4th Quarter, 2021.*** *Staff worked throughout the 4th quarter and into January on the Needs Assessment and Gap Filling Plan. There were several conversations with DHCS to gain additional insight and clarity on this exercise.*

- ***Submit to DHCS the "Gap-Filling Plan" outlining implementation approach to address gaps and needs by 4th Quarter, 2021.*** *DHCS revised the Needs Assessment Template and changed the due dates accordingly. KHS submitted the Needs Assessment and Gap Filling plan on 1/12/22 and have responded to DHCS' initial questions on 1/24/22.*

- ***Implement the "Gap-Filling Plan" outlining implementation approach to address gaps and needs by 1st Quarter, 2022.*** *KHS and HealthNet coordinated monthly Roundtable collaboration meetings with current ECM/CSS providers, hospital groups, and other Community Based Organizations (CBO) in Kern County to discuss the Gap Assessment analysis and Gap-Filling plan. In May 2022, KHS created a joint IPP Request for Application (RFA) with HealthNet, open to Network Providers and CBOs , with a due date of May 31, 2022. KHS reviewed and scored the IPP applications in June and sent out all award letters prior to June 30, 2022.*

- ***Create performance monitoring capability to measure the "Gap-Filling Plan success as defined as demonstrated performance against measure targets linked to achievement of "Gap-Filling Plan" milestones by 1st Quarter, 2022.*** *In July, the IPP agreements and budget were finalized with providers. We will monitor the success of the Gap-Filing Plan and the IPP by outlining increased capacity within KHS' ECM and CSS programs.*

- ***Create an earned incentive payment mechanism around DHCS reporting requirements to demonstrate when incentives are earned by 2nd Quarter, 2022.*** *All IPP applications identify the milestones and completion dates outlined by the provider; these are tied directly to the fund amounts for each individual milestone. This will help KHS track the outcomes and ensure that the provider earned the incentive for each completed milestone.*

Goal 8 - Instituting Telehealth as New (Permanent) Medi-Cal Benefit *(Moved to 2023 Goals)*

The Governor's Budget proposes to make permanent and expand certain telehealth flexibilities currently in place due to COVID-19. Telehealth has shown to be an effective method for maintaining the physician / patient relationship during the pandemic. DHCS modified its benefits to include telehealth as an alternative to office visits during the stay-at-home order. DHCS will make telehealth (audio services) a permanent benefit effective 2022.

Specifically, DHCS proposes:

- Establishing a distinct rate for audio-only telehealth services
- Authorizing audio-only telehealth reimbursement for FQHCs to allow telehealth services to be provided in the patient's home.
    - Currently payment is restricted to clinical onsite services only
    - FQHCs would have their own rate for telephonic care
- Providing for remote patient monitoring as an option for established patients (subject to a separate fee schedule and not including FQHCs)
- Establishing specific utilization management protocols for all telehealth services
- allowing use of telehealth to meet network adequacy standards in health plans (revise the alternate access standards (AAS) submission process accordingly)

With a large portion of Kern County designated as a medically underserved geographical area, KHS is challenged with meeting access standards based on the size of our enrolled population and provider availability. Allowing including Telehealth services to our provider count will favorably impact service access and improve our scores.
The State Budget passed in July 2021 instructed DHCS to extend the Public Health Emergency (PHE) telehealth flexibilities through 2022. It also required DHCS to form a workgroup to further discuss the ongoing permanent telehealth flexibilities that will be effective beginning 2023. The details of DHCS' proposal were included in the 2022-2023 State Budget and will be implemented when the PHE ends.

Despite DHCS' delay, KHS continues to support and encourage contracted network providers to perform services via telehealth as appropriate. Telehealth allows members choice for their preferred modality of obtaining health care services in addition to increasing access to care. In 2022, KHS contracted with an E-Consult provider, ConferMED, which increased member access to adult and pediatric specialty services.

Deliverables

- ***Determine the impact to the participating provider network by 4th Quarter, 2021.***

- ***Determine the impact to KHS, its policy, procedures, protocols, tracking and reporting by 4th Quarter, 2021***

- ***Inform participating providers telehealth will become a permanent benefit effective 2022 under Medi-Cal by 4th Quarter, 2021***

- ***Convey logistical information about the benefit and procedures providers will need to follow when using telehealth services and receiving payment for telehealth services by 1st Quarter, 2022***

- ***Inform members that telehealth will be added to their Medi-Cal benefits explaining what it is, why it is beneficial and how this service will be provided and used for the member's benefit by 1st Quarter, 2022***

- ***Post implementation, audit each activity to ensure installation and performance meets KHS and government agencies expectations (ongoing over 2022)***

****Dates may change based on final APL adoption and allowable timeframe for implementation.***

KERN HEALTH SYSTEMS

Report on Final Status of 2022 Corporate Goals and Department Goals

February 16, 2023

Jeremy McGuire, Senior Director of Government Relations & Strategic Development

2022 Corporate Goals

- At the close of each calendar year Management provides a final report on the annual Corporate Goals. The detailed descriptions outlining the final status of the 2022 Corporate Goals is included as a separate attachment.

- KHS was successful in executing the 2022 Corporate Goals except for one goal which was delayed by DHCS.

- As noted in the attachment, DHCS delayed the implementation of their permanent telehealth benefit into 2023. This item is being tracked as part of the 2023 Corporate Goals.

KERN HEALTH SYSTEMS

2022 Department Goals

- With 2022 coming to an end, management has prepared a summary status report for the departmental goals and objectives.
- Overall department goal completion rate was 96%. Potentially becomes 100% completion rate when "in-progress" goals are completed.

2022 Goals and Objectives Summary			
Department	**Green**	**Yellow**	**Red**
Member Services	10	0	0
AIS Compliance	7	0	0
Claims	7	0	0
Corporate Services	4	0	0
Finance	15	0	0
Government Relations	7	0	0
Population Health Management	4	1	0
Health Education	8	1	0
Enhanced Care Management	6	0	0
Quality Improvement	5	1	0
Utilization Management	9	0	0
Pharmacy	5	1	0
Human Resources	15	0	0
Information Technology	3	0	0
Marketing	10	0	0
Provider Network Management	6	1	0
Project Management	5	0	0
Total	126	5	0
Percentage	96%	4%	0%

Green = Completed on time and desired outcome achieved

Yellow = In progress and desired outcome achievable in 2023

Red = Not completed or desired outcome not achieved

Incomplete Dept. Goals

- For those goals which were not completed, Management is providing the following updates:
  - **Population Health Management** – There was a goal related to defining the structure of a new PHM Committee. The structure has been defined and the committee will be operationalized in 2023.
  - **Health Education** – The team intended to expand the Diabetes Prevention Program (DPP) to new providers in 2022. The program was not expanded in 2022 due to provider constraints in obtaining and maintaining CDC recognition. Efforts to pilot programs through a vendor and partner with key providers to offer DPP under KHS' license is underway as 2023 goal.
  - **Quality Improvement** – KHS' software used to calculate and submit MCAS quality measures was up for renewal. Rather than replace the product, it was decided to stay with the current vendor for another year. There will be an RFP in 2023 related to MCAS software and the need for Medicare STARS support.
  - **Pharmacy** – The pharmacy team planned on engaging consulting services related to forthcoming Medicare Part D requirements. KHS instead contracted for more general operational gaps and fiscal analyses in 2022. The Part D work will be rolled into the scope of the 2023 D-SNP corporate project.
  - **Provider Network Management** – There was an RFP related to a Community Supports referral system. Implementation of the product was not completed in 2022 and was delayed to Q1 2023.

Next Steps

- Corporate Goals
  - Current year (2023) Corporate Goals were reviewed and approved during the June 2022 Board of Directors meeting
  - Quarterly Progress Reports provided to the Board of Directors
  - Regular internal Executive review

- Goals and Objectives
  - 2023 Department Goals and Objectives have been developed for each area
  - The Department Goals are monitored internally throughout the year
  - Final status of 2023 Department Goals will be presented to the Board of Directors in Q1 2024

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Martha Tasinga, MD, CMO, PAC Chair

Date: February 16, 2023

Re: KHS REVISED POLICY AND PROCEDURE – 4.01-P Credentialing, including Attachments A, B & C

Background

Modification to Kern Health Systems (KHS) policies pertaining to 4.01-P Credentialing has gone through major revision by KHS PNM Management as well as through legal review with DSR Health Law to bring into current practice, compliance with all state, federal, DHCS APLs and NCQA credentialing standards. In addition, DSR Health Law performed a regulatory review making further updates and revisions to bring into compliance with DHCS Contract language, DHCS All Plan Letters related to credentialing, CALAim and California Business and Professions Code where applicable.

The enclosed document (red-lined) shows the modifications of this policy and specific changes pertaining to the following sections:

Policy Description Modifications –

Policy Section	Policy Changes
4.01 Credentialing Policy	• Per DSR removed "practitioner" and collectively refer to "providers" throughout the policy. • Non-physician practitioners – removed "medical" in order to be inclusive & broader when referencing all provider types who are non-physicians.
4.01 Credentialing Procedures	• Enhanced language that the KHS Credentialing program will be in compliance with all applicable state, federal and NCQA requirements. • Minor revisions adding DHCS APL 22-013 Screen/Enroll requirements. • Reference: DHCS Two Plan Boilerplate Contract. Exhibit E, Attachment 1 Definitions.
4.01 Credentialing Scope	• Added language inclusive of all providers covered by credentialing as per NCQA standards and current KHS practice • Added language as to those provider types who do not need to be credentialed per NCQA standards. • Reference: NCQA Cred Stnd CR.1-Element A #1 Define scope of providers

Policy Section	**Policy Changes**
4.01 Credentialing Non-Discriminatory Credentialing for Providers	• Added this section as required by NCQA Credentialing Standards CR.1-Element A #6 -Cred/Recred process is conducted in non-discriminatory manner. **this will need a subsequent revision outlining annual review and monitoring process required by NCQA Cred Requirements.* • Reference: 2022 NCQA Cred Stnd CR.1-Element A #6
4.01 Credentialing 1.1.1 Application	• Updated current practice, changed PR to PNM, removed application attachments and added the applications are made available electronically on Provider Portal. **Will need to add CAQH once contract is initiated* • Added applications will be no older than 180-days and PSV from accurate, current and complete sources available. • Removed QI/UM and added PAC • Added missing information to be returned w/in 10-days and applicant's burden to resolve any difficulties in documentation to satisfy the credentialing process. • Added if provider fails to provide information it will be administrative denial/withdrawal of application with no rights to an appeal as they did not satisfy the credentialing process. • Added KHS reserves rights to exercise discretion when applying criteria and PAC/BOD may waive credentialing requirements as deemed necessary
4.01 Credentialing 1.1.1 Application Content	• Added language consistent with APL 22-013 Screen/Enroll Credentialing/Recredentialing • Renumbered 1.1 & Changed to Required Attestation • Confirmed NCQA required "A current and signed attestation by the applicant…" not to exceed 180-calendar days • Removed all the detailed "requirements" that will be in the addendums
4.01 Credentialing 2.2 Discrepancies in Credentialing Information	• Section was added to address credentialing discrepancies and process for correcting discrepancies with the provider. • Reference: 2022 NCQA Cred Stnd CR.1-Element A #7
4.01 Credentialing 2.3 Area of Practice	• Section was added to address provider's area of practice, verification of specialties to be used in the directory and the use of ABMS/AOA approved specialties. • Reference: 2022 NCQA Cred Stnd CR.1-Element A #3
4.01 Credentialing 2.4 Provider Rights	• Section was added to address provider rights as required by State & NCQA guidelines • Reference: 2022 NCQA Cred Stnd CR.1-Element B
4.01 Credentialing 2.5 Confidentiality	• Section was revised to address confidentiality of credentialing files and information used during the credentialing process and proceedings. • Reference: 2022 NCQA Cred Stnd CR.1-Element A #10 • **Will require separate policy address Credentialing Security Controls*
4.01 Credentialing 2.6 Credentialing File Review	• Section was enhanced to outline the credentialing file review in current process. • All primary source requirements will be addressed in separate internal credentialing policy. • Reference: 2022 NCQA Cred Stnd CR.1-Element A #3-5
4.01 Credentialing 2.7 Comprehensive Reviews	• Section was enhanced to outline current process for comprehensive reviews. • Removed reference to QI/UM review. • Reference: 2022 NCQA Cred Stnd CR.1-Element A #3-5 • Added sub-section B for lack of professional conduct, competence referred to peer review/provider hearing

Policy Section	**Policy Changes**
4.01 Credentialing 2.8 Provisional Approval	• Minor edits • Removed QI/UM review process • Reference: 2022 NCQA Cred Stnd CR.3
4.01 Credentialing 2.9 Locum Tenens	• Section was enhanced to outline current process for issuing locum tenens • Minor edits / Recommend moving this section to the Additional Information – "seems misplaced in the application section"
4.01 Credentialing 2.10 Credentialing Decisions	• Per DSR all credentialing decision in a health plan environment are considered final by the Peer Review body. Section was rephrased adding PAC decisions and process for transmitting denied applications to Board in following Provider Hearing P&P • Reference: 2022 NCQA Cred Stnd CR.1-Element A #3-5 • Added 2.13 Notification of Decisions regarding Initial Applicants
4.01 Credentialing 3.0 Provider Responsibilities	• Enhanced language to include all criteria for termination included in APL 21-003
4.01 Credentialing 4.0 Recredentialing & Compliance with Laws	• Removed "Periodic Review" and updated language to bring compliant with regulatory language. • Periodic Review removed and will be changed to Ongoing Monitoring – Separate Policy to be developed. • Reference: 2022 NCQA Cred Stnd CR.3 & 4
4.01 Credentialing 6.0 Release	• Added P&P 4.35 Reference
4.01 Credentialing 7.0 Additional Information	• DSR recommend removing 7.1 Radiology Claims since no longer a current practice nor relevant to Cred P&P
4.01 Credentialing 7.2 Specialist practicing primary care	• Minor Edits • Per DSR 2nd last sentence is conflict of interest for specialist to self refer. • Remove last sentence: HEDIS changed and not part of credentialing requirements
4.01 Credentialing 7.3 Scope of Mid-Levels	• Removed irrelevant language that is no longer current practice or required by state law, such as 30-mile radius to supervise. • Removed duplicative language that is referenced in P&P 4.04 for mid-levels • Reference: California Business & Professions Code 3502.1 • **Will need revisions based on Nurse Practitioner new laws*
4.01 Credentialing 7.4 Facility and Ancillary Providers	• F – Medical Transportation Providers – removed statement no longer relevant / current practice – Moved NMT/NEMT requirements to Additional Information • Reference: APL 19-004 and P&P 4.43-P • All Network Providers are required to be credentialed and be actively enrolled/approved in the DHCS Medi-Cal Fee-For-Service Program if there is a state pathway
4.01 Credentialing 7.5 Emergency Room Physicians	• Remove – not current practice and is address under Procedures "Providers who do not need to be Credentialed
4.01 Credentialing 7.5 Medical Transportation Providers	• Section added NMT & NEMT Transportation Vendors including credentialing and FFS enrollment requirements. • References: APL 19-004 and draft APL regarding NMT/NEMT providers

Policy Section	**Policy Changes**
4.01 Credentialing 7.6 ECM/CS Providers	• Section added ECM/CSS Providers including credentialing and FFS enrollment requirements. • References: CalAim EC/CS FAQs December 2021, APL 21-012 – Pg 7; APL 21-016 – Pg 3 • Added Enhanced Care Management & Community Support Service provider Language **Will need to add Doula, CHW, Dyadic Services Providers in future*
4.01 Credentialing 7.7 HIV/AIDS Providers	• Removed original 7.7 SBIRT requirements that are outdated and not a current credentialing function • HIV/AIDS replaces 7.7 - Section enhanced to meet compliance with AB2168 & Calif HS Code 1374.16
Attachments	• Attachment A-C combined and revised under new "Attachment A" which has been enhanced to incorporate all credentialed provider types, requirements, criteria and verification source. • Attachment D-Facilities, E-Pharmacies, F-Ancillary changed and revised to new "Attachment C – Organizational (HDO), Facilities, Pharmacies and Ancillary Providers" • Attachment G – Residents: Retire Attachment G and criteria added to Attachment A. • Attachment H – Behavioral Health Providers: Retire Attachment H and changed to Attachment B – Behavioral Health Providers • Retire all outdated applications attached to P&P 4.01 version 05-2015 as KHS utilizes the most current California participating application which is available on the KHS On-Line Portal. **KHS will also start using CAQH Application ProView soon.*

Requested Action

Approve policy revisions to the 4.01-P Credentialing Policy and Procedure and new Attachments A (Provider Specific Criteria-Practitioners), B (Provider Specific Criteria – Behavioral Health Providers) and & C (Provider Specific Criteria - Organizations/Facilities).

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Credentialing Program				POLICY #: 4.01-P	
DEPARTMENT: Director of Provider ~~Relations~~Network Management					
Effective Date: 01/1997	Review/Revised Date: ~~05/13/2015~~	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
~~Douglas A. Hayward~~ Emily Duran
Chief Executive Officer

_____ _____Date
_____
_Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
~~Senior~~~~Administrative Director of Health Services~~

_____ Date _____
~~Director of Pharmacy~~

_____ Date _____
~~Director of Provider Relations~~Senior Director of Provider Network

POLICY:

Kern Health Systems (“KHS”) ~~Plan~~ members are entitled to quality health care. It is the policy of KHS that every reasonable effort is made to verify health care ~~practitioners and~~ providers ~~(of service)~~ with whom KHS contracts meet the basic standards of training, certification, and performance. ~~It is ultimately the responsibility of the Board of Directors to achieve this goal. The credentialing process will adhere to applicable state regulations and statutes.~~ Credentialing and recredentialing requirements are applicable to all licensed practitioners, non-physician ~~medical~~ practitioners[LM1][YHCC2], ancillary and facility providers contracted ~~by~~with KHS (collectively referred to herein as “p~~P~~rovider(s)”). A contracted ~~practitioner and~~ provider ~~(of service)~~ must be credentialed with KHS in order to treat

KHS members.

PROCEDURES:

Credentialing is defined as the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership. [WSM3]

~~Credentialing~~ It is the process by which health care providers are evaluated and approved for provider ~~s~~status as contractors and subcontractors in the KHS network. The ~~C~~credentialing ~~P~~program has been developed in accordance with state and federal requirements, accreditation guidelines and comply with the Department of Managed Health Care ("D~~H~~MHC") and the Department of Health Care Services ("DHCS") requirements, including DHCS All Plan Letter ("APL") ~~19~~22-~~004~~013 and ~~any~~ subsequent updates to this APL, if any. KHS meets all DMHC and DHCS requirements, and has established credentialing criteria, including the verification sources used, based on state, federal and current accreditation guidelines from the National Committee for Quality Assurance ("NCQA") credentialing standards.

SCOPE OF ~~PRACTITIONERS~~PROVIDERS COVERED BY CREDENTIALING

All contracted practitioners and ~~organizational~~facility [LM4] providers (Hospitals, SNF, Surgery Centers, Home Health Agencies, Hospices, Dialysis Centers, Urgent Care Centers), including ancillary providers participating in the KHS ~~Health Plan~~network and who are published in the provider health plan directory must be credentialed. This includes, but is not limited to, MDs, DOs, DPMs, DCs and doctoral level Psychologists (PhD, PsyD). Non-physician practitioners, including behavioral health providers (MFTs, LCSWs, and Behavioral Analyst) and substance use disorder providers, Optometrists, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants who are certified or registered by the state to practice independently (with or without supervision), will also be credentialed[LM5][YHCC6]. KHS will credential and recredential:

- All providers who have a contracted, independent relationship with KHS;
- All providers who see KHS members outside the inpatient hospital setting;
- All providers who see KHS members in ~~an~~ outpatient ambulatory free-standing facilities;
- All physician executives who serve in an administrative capacity for KHS;
- All providers who are hospital based but render services or care to KHS members as a result of their independent relationship with KHS. Examples include: an anesthesiologist who is contracted to provide pain management to KHS members in an outpatient setting;
- All ~~practitioners~~providers who practice as a hospitalist or SNFist;
- All ~~practitioners~~providers who provide telemedicine consults interacting with members;
- All non-physician ~~medical~~ practitioners who may or may not have an independent relationship with KHS; ~~-~~
- All behavioral health care ~~practitioners~~providers such as doctoral or master's-level psychologists, clinical social workers, psychiatric nurses, or other behavioral health care specialists who are licensed, certified or registered by the state to practice independently;
- All ancillary, pharmacies and organization[LM7][YHCC8] providers ~~(Facilities)~~ who have a contract with KHS.

~~PRACTITIONERS~~PROVIDERS WHO DO NOT NEED TO BE CREDENTIALED[LM9][YHCC10][YHCC11]

~~Practitioners~~Providers who practice exclusively within the inpatient setting (hospital--based)~~, and~~ who

provide care for KHS members only as a result of the members being directed to the hospital or another inpatient setting and do not meet the definition of a "~~n~~Network ~~p~~Provider" as defined by DHCS APL 19-001 and any subsequent updates. ~~——~~Examples include: Pathologists, Radiologists, Anesthesiologists, Neonatologists, Emergency Department Physicians, and Resident Physicians in a teaching facility. Enhanced Care Management ("ECM") and Community Supports, or In Lieu of Services ("CS" or "ILOS") Providers without a state level enrollment pathway may also be subject to a different vetting process. KHS reserves the right to require any credentialing deemed necessary for any hospital based provider type, including but not limited to:~~.~~

- Hospitalist practicing exclusively in an in~~-~~patient setting
- Radiologist practice~~e~~ing in an out~~-~~patient setting
- Anesthesiologist in an ~~A~~ambulatory ~~C~~care ~~S~~setting or practicing in an office setting specific to pain management.

NON-DISCRIMINATORY CREDENTIALING FOR PROVIDERS

Credentialing and recredentialing will be conducted in a manner that is non-discriminatory. Credentialing and recredentialing decisions are made solely based on the results of the verification process. No decisions will be based on an applicant's race, ethnicity, national ~~identity~~origin, religious creed, gender, age, sexual orientation, disability, or area of practice (e.g. Medicaid) in which the ~~practitioner~~provider specializes.

All credentialing applicants are logged and their status (Approved/Denied) are recorded on a monthly report to the KHS Physician Advisory Committee ("PAC"). Annually, the voting members of PAC sign an affirmation confirming that credentialing decisions are solely based in a manner that is non-discriminatory and confidential.

1.0 APPLICATION

Application for provider status is made by submitting a completed application together with the applicable and required supporting documents ~~payment of all applicable fees~~ to the Provider ~~Relations~~ Network Management Department. Application forms are available through the Provider ~~Relations~~ Network Management Department and are available electronically on the KHS Provider Portal. ~~(See Attachments G through L),~~

All documents for any applicant or reapplicant must be no more than 180 days old at the time they are considered for participation or reapplication. Primary source verification will be obtained from the most accurate, current and complete source available.

No application shall be acted upon unless it is complete, signed and dated, which includes completion of the application form, attestation questionnaire, release of information and submission of all supporting documents, including any additional information requested by the ~~Quality Improvement/Utilization Management (QI/UM) Physician Advisory Committee (~~PAC~~)~~. If the provider is notified that the application (or supporting documents) is incomplete or illegible, the provider must provide the missing information for the credentialing process to continue within 10-calendar days. The provider is responsible for providing the information to satisfy the process or request by the PAC. It is the ~~applicant's~~ provider's burden to provide all information requested and to resolve any difficulties in verifying or obtaining the

documentation required to satisfy the credentialing requirements. If the provider fails to provide this information, the credentialing application will be deemed incomplete and will result in an administrative denial or withdrawal of application from the KHS ~~N~~network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Applications are evaluated according to the credentialing criteria and verification sources set forth in Attachments A & B ~~through G~~. An application that does not satisfy these criteria, as determined by the PAC or Board of Directors, may be denied. The PAC ~~Board~~ may deny provider status if the information submitted is insufficient to resolve reasonable doubts as to the provider's qualifications. KHS reserves the right to exercise discretion when applying any criteria and to exclude providers who do not meet the criteria. KHS Board of Directors, after considering PAC recommendation, may waive any requirement for network participation established by these policies and procedures for good cause if it is determined that such waiver is necessary to meet the needs of KHS and the community it serves. The refusal to waive any requirement shall not entitle the provider to a hearing or any other rights of review.

~~1.1.1~~ ~~Application~~[LM12] ~~Content~~ Required Attestation

The application includes an attestation ~~to the following~~[i] which includes, but is not limited to the following statements by the applicant:

A. ~~Reasons for a~~A~~A~~ny limitation or ~~in ability~~ inabilities that affect the provider's ability to perform any of the position's essential functions, ~~of the position~~ with or without accommodation, and reasons for the same[LM13];

B. History of loss of license ~~or~~ and/or felony conviction(s), including plea of *nolo contendere*;

C. History of loss or limitation of privileges and/or disciplinary activity;

D. Lack of present illegal drug use;

E. A current and signed ~~and dated~~ attestation by the applicant of the ~~Correctness correctness~~ accuracy and completeness of the application.[LM14][YHCC15]

2.0 APPLICATION REVIEW~~,~~/~~-~~COMMITTEE AND BOARD REVIEW

2.1 Application Review

The ~~Physician Advisory Committee (~~PAC~~)~~ shall serve as the Credentials Committee~~.~~ and ~~The PAC~~ shall be responsible for the review of all applications. ~~submitted by physicians (M.D.s and D.O.s), podiatrists, midlevel practitioners, facilities, included but limited to pharmacies, and ancillary services.~~[LM16][YHCC17][YHCC18]

KHS monitors the initial credentialing process ~~and obtains~~ and verifies the following information[ii] along with other documents required by DMHC, DHCS, NCQA and KHS:

A. ~~A current valid license, registration or certificate~~ The appropriate license and/or board certification or registration to practice in California.

B. Evidence of graduation or completion of any required education

C. Proof of completion of any relevant medical residency and/or specialty training.

D. Work history

E. Hospital and clinic privileges in good standing

F. History of suspension or curtailment of hospital and clinic privileges

G. Current Drug Enforcement Administration identification number.
H. National Provider Identifier number
I. Current malpractice or professional insurance in an adequate amount, as required for the particular provider type
J. History of liability claims against the provider
K. Provider information, if any, entered in the National Practitioner Data Bank, when applicable
L. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network

~~A.~~M.

~~B. A current valid Drug Enforcement Agency (DEA) registration number as applicable with a California address. Radiologist and Pathologists who do not prescribe scheduled medications are exempt from the requirement to have a current valid DEA number. Other practitioners who do not prescribe scheduled medications may be exempted on a case by case basis[iii] if , as authorized by KHS,are~~

~~C. A current valid NPI number.~~

~~Graduation from a medical/professional school, and/or completion of an accredited residency and/or an accredited fellowship (initial application only) school, completion of a residency, Board certified or Board eligible as applicable; education as required.~~

~~D. Board certification is not required by NCQA; however, KHS will verify current certification status of the providers who state they are board certified.~~

~~E. Clinical privileges in good standing at a KHS contracted hospital designated by the practitioner as the primary admitting Facility facility (this requirement may be waived for practices which do not have or do not need access to hospitals), includes review of past history of curtailment or suspension of medical staff privileges. Practices deemed by KHS not to have or need access to a hospital and are limited to outpatient services include: Dermatology, Psychiatry, and Optometry. All others may be exempted on a case by case basis.~~

~~F. Work History (initial application only) [LM19][YHCC20]A minimum of five (5) years work history will be included in the initial credentialing file on the application or curriculum vitae or resume.~~

~~G. Proof of current and adequate Professional professional liability claims history insurance with minimum coverage as determined by KHS.~~

~~Current, adequate general liability insurance. (Health Delivery Organizations (facilities, pharmacies, and ancillary organizations at initial and recredentialing cycles only)[LM21][YHCC22]~~

~~H. Professional liability claims history: Requested information from: National Practitioner Data Bank [LM23][YHCC24] and the Medical Board of California (MBC).~~

~~I.~~N. ~~Any sanctions, exclusions or debarments~~ imposed by Medi-Cal, Medicaid and Medicare.ee for Service (F)denied participation in the KHS networksubproviders

~~J. Current use of any illegal drugs.~~

~~K. Current, adequate malpractice insurance[iv]~~

~~L. Current, adequate general liability insurance~~
~~M. Sanctions or limitations on licensure from State agencies or licensing boards~~*
L. Meets the requirements for Medi-Cal ~~Fee-for-Service~~FFS enrollment and is approved with ~~the Department of Health Care Services (~~DHCS~~)~~ as defined by ~~the~~ the relevant DHCS All Plan Letter and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy.

2.2 Discrepancies in Credentialing Information

In the event there is information obtained by the credentialing staff that substantially differs from that supplied by the ~~practitioners~~provider, the credentialing staff will contact the ~~practitioners~~provider to have them either correct or provide an explanation of the differences. ~~Practitioners~~Providers have the right to correct erroneous information submitted during the application process; corrections must be submitted in writing to the credentialing staff within 10-calendar days of the notification.

2.3 Area of Practice / Listing in ~~Practitioner~~Provider Directories and Other Member Materials

~~Practitioners~~Providers will only be credentialed in the area of practice in which they have adequate education and training verified through primary source verification, if applicable, from an ACGME accredited residency and/or fellowship as set forth by the American Board of Medical Specialties ("ABMS") or American Osteopathic Association ("AOA") for requested sub-specialties (~~outlined in the~~ see credentialing requirements in Attachments A).[LM25][YHCC26] KHS uses specialties and sub-specialties recognized by the ~~American Board of Medical Specialties (~~ABMS~~)~~ and AOA. It is expected that ~~practitioners~~providers confine their practice to their credentialed specialty when providing services to ~~Kern Family Health Care~~KHS members. KHS will only list those specialties verified through primary source and recognized according to ABMS/AOA, if applicable or non-physician professional certificate description in the Provider Directory Listing.

2.4 P~~ractitioner~~rovider Rights

~~Practitioners~~Providers have the right, upon request, to review the information submitted in support of their credentialing application; additionally, ~~practitioners~~providers have the right ~~—~~to:

- review information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. This includes information obtained from outside sources such as malpractice carriers or state licensing ~~boards, but~~boards but does not extend to review of information from references, or recommendations protected by law from disclosure. ~~Practitioners~~Providers may submit their request for review to their Provider Relations Representative via email, letter or fax.
- correct erroneous information;
- be informed of the status of his/her application during the credentialing process, upon request.
- to be notified, in writing, of the initial credentialing decisions within 60-days

from the date the decision was made.

2.5 Confidentiality

~~Each provider will have a confidential credential [LM27][VHCC28][VHCC29]file which contains credentialing information as well as quality performance information. Quality performance information will be contained in the Quality Improvement Department file s. Provider performance review summaries will be contained in the provider's recredentialing file. Credential files are stored in a secure and locked environment. All confidential electronically-stored credentialing information will be stored in a secure repository only accessiblesord to authorized Provider Relations and Credentialing Staff.~~

The KHS credentialing program has transitioned from a paper-based file to an electronic credentialing (paperless) file system as of March 2020. All existing paper credentialing files have been scanned and archived into an electronic filing central repository. Existing paper-files will be maintained at an off-site, secured file room. Access to the off-site, secured file room is restricted and accessible to PNM credentialing staff under the oversight of the Chief Network Administrative Officer.

The electronic credentialing files will be maintained in a central repository that can only be accessed by PNM/Credentialing Staff who have been issued access using their unique electronic identifier and user-specific password for access to prevent unauthorized access or release of information.

All information collected during the credentialing, recredentialing and through the proceedings of PAC shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and Health and Safety Code 1370 and will be maintained as confidential records.

2.6 Credentialing File Review

The Provider ~~Relations~~ Network Management Department and the Chief Medical Officer, (CMO) or his/her designee ~~(CMO)~~ assist the PAC in investigating and evaluating applications. The Provider ~~Relations~~ Network Department representatives and the ~~Chief Medical Officer~~CMO shall be deemed agents of the PAC in any such investigation or evaluation.

All ~~practitioners~~providers participating in the KHS network must be approved by the ~~KHS Physician Advisory Committee (~~PAC~~)~~. The ~~Chief Medical Officer~~CMO has the authority to determine whether or not credentialing or recredentialing files are "clean" and meet~~ing~~ established criteria. A file must meet the following criteria to be considered a "clean file":

A. No malpractice cases that resulted in settlement or judgment paid on behalf of the ~~practitioner~~provider within the previous 5-years for initial applicants or since the last credentialing/recredentialing review date;
B. No 805/805.1 reports, State Licensing accusations, limitations or sanctions on licensure;
C. No adverse events from other regulatory, state or federal agencies, i.e. OIG, NPDB, Medicare Opt Out, Medi-Ceal Suspended or Ineligible list, System for

Award Management, etc.

D. Current and signed attestation confirming correctness and completeness of application

E. For those offices requiring an office site visit, overall score of ~~80~~90% or higher;

F. For recredentialing, no more than seven (7) member complaints, no internal quality of care case reviews, no utilization management or compliance issues or trends in the prior 3-years.

G. The ~~Chief Medical Officer~~CMO will have the discretion to refer any member complaint or quality of care concern for a comprehensive review by the PAC regardless of the severity score.

Those files determined by the ~~Chief Medical Officer~~CMO not meeting the above criteria or at his/her sole discretion, will require comprehensive review by the PAC.

~~Investigation may include, but is not limited to:~~

~~A. Primary source verification, as specified in the National Committee for Quality Assurance credentialing standards and applicable state and federal guidelines. The following information is verified from primary sources[vi]:~~

~~1, License to practice~~

~~2. Education and training, including evidence of graduation from the appropriate professional school and completion of a residency or specialty training~~

~~3. Board certification, if claimed at time of application~~

~~B. Collection of information about the applicant from designated references, interested persons, individuals, and entities with whom the practitioner has trained or worked.~~

~~C. Conducting a site visit, if applicable~~

~~D. Recredentialing shall also include a review of incidents identified by the Quality Improvement, Utilization Management, and Member Services Departments, and Audits and Investigations Department.~~

2.~~2~~7 ~~Recommendations~~ Comprehensive Reviews

Credentialing files determined to not meet "clean file" criteria (as listed above in 2.6) will require comprehensive review by PAC.

The ~~Chief Medical Officer~~CMO or his/her designee reviews the applications ~~and the results of the investigations~~ and prepares ~~their~~his/her approval or recommendations to the ~~responsible committee~~PAC[LM30][YHCC31], as follows:

A. ~~A.~~ The recommendation is reviewed by the PAC which prepares its ~~own~~ approval or recommendation, such as ~~modified~~modification or ~~denied~~denial, which is submitted to the ~~QI/UM Committee~~ Board of Directors.

B. If the PAC recommends the denial of the application based on[YHCC32]:

a. A perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; and/or

b. A perceived issue with conduct or professional competence which affects or could affect adversely the health or welfare of a patient or patients

Then the application shall be referred to Peer Review and/or the Board for

consideration and recommendation. The Peer Review and/or Board has the authority to request additional information, interview the applicant, or implement the Fair Hearing Policy before it is submitted to the Board for final action. If the Peer Review determines that neither of the above factors exist or should be cited as grounds for denial, the matter shall be forwarded, with associated recommendations, to the Board.

C. ~~If the PAC is disinclinednot inclined to make a favorable recommendation based on: (a) A a perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or (b) r~~Aa lack of professional conduct or competence, ~~the matter shall be referred to Peer Review and/or the Board of Directors for consideration and recommendation. The Peer Review and/or Board of Directors has the authority to request additional information, interview the applicant, or implement the Fair Hearing Plan [LM33]~~[VHCC34]~~before it is submitted to the Board of Directors for final action. If the Peer Review determines that neither of the above factors exists or should be cited as grounds for denial, the matter shall be forwarded, with any associated recommendations, to the Board of Directors.~~

~~B. The QI/UM Committee may review the recommendation of the PAC and prepare its own recommendation which shall be submitted to the Board of Directors. The QI/UM Committee may delegate the entire process of credentialing to the PAC, in which case the recommendation will go directly from the PAC to the Board of Directors without review by the QI/UM Committee.~~

2.~~3~~8 Provisional ~~Privileges~~Approval

In the circumstance where a provider file is ready for presentation to the PAC, however there is no PAC meeting scheduled prior to the next Board of Directors meeting, the ~~Chief Medical Officer, or designee~~CMO may recommend the applicant(s) to the Board of Directors for ~~P~~provisional ~~Privileges~~Aapproval. In order to be considered for ~~P~~provisional ~~Privileges~~Aapproval, the applicant must meet the criteria in the applicable exhibit (Attachments A ~~G~~& B)~~,~~ and have no malpractice action (pending or closed) within the previous five years (three years if the applicant is being recredentialed). In the case of recredentialing, in addition, there may not be any incidents noted by the Quality Improvement, Utilization Management, Member Services Departments or Audits and Investigations in the interval since the applicant was last credentialed. Furthermore, no provider may remain in provisional status for more than 60 days.

If ~~Provisional~~ provisional ~~Privileges~~ Aapprovals are granted by the Board of Directors, the applicant shall be presented to the PAC at its next meeting for approval. ~~If approval is recommended by the PAC, the recommendation is forwarded to the QI/UM~~

~~Committee and then to the Board of Directors as with any other application.~~

2.~~4~~ ~~89~~ Locum Tenens[LM35]

KHS ~~Practitioners~~ providers may utilize ~~locum~~ Locum ~~tenens~~ Tenens if ~~the~~ an existing ~~contracted~~contracted ~~practitioner~~ provider is unavailable to see ~~n~~ ~~KFHC~~ KHS ~~Members~~members. KHS ~~Practitioners~~providers, joining an existing contracted group may also utilize a newly hired ~~practitioner~~ provider as a ~~locum~~ Locum ~~tenens~~ Tenens while the new ~~practitioner~~ provider is in the process of being ~~-~~ credentialed when there is a written request documenting the urgent or emergent need. In either situation, **the following conditions must be met prior to a ~~locum~~ Locum Tenens rendering services** to ~~KFHC~~ KHS Members.

A. Locum Tenens must be of the same ~~provider~~ ~~practitioner~~provider type ~~or~~ and specialty as the ~~provider~~ ~~practitioner~~provider on leave, e.g., a physician must substitute for a physician ~~and~~ in same designated specialty; a non-physician for a non-physician.
B. KHS must be notified of the request for ~~locum~~ Locum ~~tenens~~ Tenens in writing from the existing contracted group or ~~practitioner~~provider.
C. KHS must be provided with a copy of a current, ~~/~~valid and unrestricted California ~~Medical~~ medical ~~License~~license
D. KHS must be provided with a copy of a current~~/~~, valid and unrestricted DEA issued with a California address, if applicable
E. KHS must have ~~proof~~ copy of the ~~locum~~ practitioner's ~~has~~ professional liability insurance in the amounts of $1,000,000.00 per occurrences and $3,000,000.00 in aggregate
F. In order to be considered for Locum Tenens, the applicant must meet the established clean file criteria ~~in the applicable exhibit (Attachments A-G)~~, and have no malpractice actions (pending or closed).

If there are malpractice actions pending and/or closed against a Locum Tenens provider, ~~the Health Plan~~KHS may at its sole discretion allow for the provider to serve as a ~~locum~~ Locum Tenens depending on the nature of the malpractice actions. In ~~this~~ any of the described situations, the ~~contracted~~ Locum Tenens provider must receive written approval from KHS prior to ~~the Locum Tenens provider~~ rendering services to ~~our~~ KHS members, if payment ~~consideration~~ is to be made.

If the ~~locum~~ Locum ~~tenens~~ Tenens status is approved by KHS, the ~~locum~~ Locum ~~tenens~~ Tenens ~~provider~~ ~~practitioner~~provider will be compensated for services at the same rate as the KHS contracted ~~vendor~~provider. However, KHS is not responsible for the

compensation arrangement between the ~~practitioner~~ provider on leave and the ~~locum~~ Locum ~~tenens~~ Tenens provider. The use of the same ~~locum~~ Locum Tenens provider will be limited to 90 consecutive days. KHS reserves the right to approve a ~~locum~~ Locum Tenens status extension due to extenuating circumstances.

~~If ALL of the above conditions are not met, KHS will deny payment for any services provided by or ordered by the intended locum Locum practitioner Tenens provider and the contracted practitioner provider will be responsible for all charges associated with same.~~

[LM36][YHCC37]KHS will deny payment for any services provided by or ordered by the Locum Tenens Provider if not all the conditions above are met. The contracted provider will be responsible for all charges associated with same[YHCC38].

2.~~5~~910 ~~Credentialing~~ PAC Decision Regarding Credentialing

Decisions made by PAC are considered to be final. The Board of Directors will be notified of all determinations in accordance with this policy.

If provider is approved for network participation, an official letter of appointment is sent to the ~~applicant~~provider and two copies of the ~~IPA~~ Provider ~~Contract~~ [LM39] Agreements with a request for signature and return to KHS. Once fully executed, a copy of the contract is returned to the new provider.

If provider is denied for network participation, a letter of denial is sent to the ~~applicant~~provider by certified mail, return receipt required. ~~An applicant~~applicantA provider who has been denied ~~appointment~~ network participation is not eligible to reapply for a period of one year. Exceptions may be made based on the need for providers in the ~~applicant~~provider's area of practice or when incomplete information was obtained with the original application. A second or subsequent application, pursuant to an applicable exception, is processed as if it is the original ~~an initial~~ application, and the process will start over.[LM40][YHCC41]

~~If recommendation is to approve the application, the recommendation along with all supporting information is transmitted to the Board of Directors for final action.~~

If the recommendation by the PAC is to deny the application, the recommendation alone, without any supporting information, is forwarded to the Board of Directors. The Board shall not take any action on the recommendation or review other information regarding the application except in accordance with *KHS Policy and Procedure #4.35-P – Provider Hearings*.[LM42][YHCC43]

~~In acting on an application, the Board shall consider the recommendation of the PAC, QI/UM Committee, or Chief Medical OfficerCMO, and the information upon which it is based.~~[LM44][YHCC45]

~~The Board shall approve, deny, or defer each application. If the Board defers action on an application, it is returned to the Associate Medical Director with instructions for further review.~~

2.~~6~~10~~1~~1 Effective Date

An applicant's provider status shall take effect on the first day of the month following the ~~Board of Directors~~ PAC Meeting in which the provider is approved to provide health care services to KHS members.

2.1~~1~~2 Notification of Decisions [LM46][YHCC47] ~~for~~**Regarding Initial Applicants**

KHS will notify, in writing, initial credentialing applicants of the decision within 60-days from the date the decision was made. Initial applicants should refrain from rendering treatment, care or services until they are in receipt of the official KHS letter with effective date.

3.0 PROVIDER RESPONSIBILITY TO REPORT CHANGES

Once approved, each provider shall remain in compliance with the credentialing criteria and report to the ~~Chief Medical Officer~~CMO all of the following[LM48][YHCC49]:

~~A.~~ The commencement or resolution of any civil action against the provider for professional negligence

~~B.~~ Any change in the provider's license or DEA status

~~C.~~ The initiation of and reason for any investigation or the filing of any complaint against the provider by any government agency

D. Any adverse determination by any facility or entity with a credentialing or peer review process concerning provider's quality of care.

~~E.~~ A change in any hospital or practice privilege granted to the practitioner by any facility or entity with a credentialing or peer review process

~~F.~~ Any change in the provider's errors and omissions or professional negligence insurance coverage including changes affecting coverage of specific clinical procedures or privileges of the practitioner

~~G.~~ Conviction of the provider or entry of a plea of ~~-~~*nolo contendere* to any felony;

H. Conviction of a provider or entry of a plea of *nolo contendere* to any misdeameanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services

I. Conviction of the provider of any ~~or~~ crime or an entry of a plea of *nolo contendere* to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to practice medicine or deliver health care services

~~H~~J. The filing of any charges against the provider alleging unlawful sale, use, or possession of any controlled substance.

K. Suspension from the federal Medicare or Medicaid programs for any reason;

L. Lost or surrendered a license, certificate, or approval to provide health care; [WSM50]

M. Any other adverse occurrence that relates to the provider's license or practice, including but not limited to revocation or suspension of a license by a federal, California, or another state's licensing, certification, or approval authority;

N. If the provider is a clinic, group, corporation or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization of any crimes set forth above.

4.0 ~~PERIODIC REVIEW (~~RECREDENTIALING~~)~~ AND COMPLIANCE WITH LAWS

Each provider is recredentialed every ~~three years~~36-months. However, recredentialing ~~but~~ may be ~~repeated more frequently~~made sooner when required by a change in relevant provider information or if the PAC makes such recommendation.[vii] The process includes a review of all applicable areas for credentialing~~., excluding previously researched past history, and previously verified education/training and work history~~[LM51][YHCC52].

~~The following information is also verified as part of the recredentialing process:~~

~~A. A valid medical license within the Medical Board of California website at https://www.breeze.ca.gov/;~~

~~B. Office of the Inspector General (OIG) website will be reviewed for any exclusions at http://exclusions.oig.hhs.gov/;~~

~~C. DHCS Medi-Cal Provider Suspended and Ineligible List will be reviewed on a monthly basis at http://files.medi-cal.ca.gov/pubsdoco/bulletins_menu.asp;~~

~~D. CMS Medicare Opt-Out list will be reviewed on a monthly basis at http://med.noridianmedicare.com/web/jeb;~~

~~E. Performance reviews which includes Quality Improvement, Utilization Management, Member Services, and AIS Compliance;~~

~~F. Member satisfaction surveys from Member Services Department;~~

~~G. Site review from Quality Improvement Department.~~

Provider shall provide all requested documentation to KHS for recredentialing and KHS reserves the right to consider information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews.[WSM53]

A provider may be reviewed any time at the request of the QI/UM Committee, the PAC, the Chief Executive Officer, the ~~Chief Medical Officer~~CMO, or the Board of Directors. During recredentialing, KHS will consider information from other sources pertinent to the credentialing process, including but not limited to, quality improvement activities, member grievances, and medical record reviews.

KHS[LM54][YHCC55] complies with all reporting requirements, including those required by the California Business & Professions Code and the Federal Health Care Quality Improvement Act.

All credentialing and peer review records and proceedings shall be confidential as contemplated by section 1157 of the California Evidence Code, section 1370 of the California Health & Safety Code, and section 14087.38 of the California Welfare & Institutions Code.

In the event of any conflict between these credentialing policies and the Federal Health Care Quality Improvement Act, the latter shall be deemed to prevail.

These credentialing policies shall be reviewed at least annually by the PAC ~~and the QI/UM Committee,~~ which may recommend revisions or amendments to the Board of Directors.

5.0 ~~PROCEDURAL~~ HEARING RIGHTS

~~Procedural~~ Hearing rights, if any, are as set forth in *KHS Policy and Procedure #4.35-P – Provider Hearings*.

6.0 RELEASE

By applying for or accepting provider status, an applicant releases KHS and its members, employees, officers, and agents from any liability associated with processing and investigating the ~~application, and~~application and submits to KHS' corrective action and disciplinary process and to the relevant KHS Policies and Procedures, including but not limited to, *KHS Policy and Procedure #4.35-P – Provider Hearings*. ~~Hearing Policy and Procedures.~~ This release is in addition to any immunities available under California or federal law.

7.0 ADDITIONAL INFORMATION[LM56][YHCC57]

~~7.1 Radiology Claims~~[viii]

~~KHS only reimburses practitioners providers for the professional component of CPT[YHCC58][LM59][YHCC60][YHCC61] codes when the reading is performed by a KHS contracted radiologist or by a KHS contracted specialist who has received training to do so. A written report must be generated in order to receive reimbursement. The Chief Medical OfficerCMO in consultation with the Physician Advisory CommitteePAC will determine adequacy of training.~~

~~7.2.1~~ 7.1 Specialists Practicing Primary Care

~~Practitioners~~ Providers with sub-specialties recognized by the ABMS or one of its member boards may function in the role of a Primary Care Practitioner (PCP) if they meet the requirements to be a PCP (See Attachment A). However, KHS credentialed specialists functioning as a KHS credentialed PCP may not self-refer for specialty care. If the ~~practitioner~~ provider sees a member assigned to him/her for primary care, he/she may not bill as a specialist even if that member's condition is within the ~~practitioners~~ provider's sub-specialty. The ~~practitioner~~ provider may accept authorized sub-specialty referrals from ~~practitioners~~ providers outside of his/her group for those services provided as a sub-specialist. ~~The exception to this would be those specialists that are serving as the SPD member's PCP. KHS would allow for them to self-refer for specialty services they have been credentialed by KHS to provide.[LM62][YHCC63] In addition, sub-specialist/OBGYN's serving as PCPs must meet KHS' previous year median HEDIS results to continue serving as a PCP for the following contract year.[YH64][LM65][YHCC66][YHCC67]~~

~~7.3~~7.2 Scope of Mid-~~level~~ Level Practitioners

KHS ~~Plan~~ members either select or are randomly assigned to a contracted ~~primary care provider practitioner (~~PCP~~)~~. The PCP may choose to arrange with a mid-level ~~provider~~ practitioner to provide primary care to assigned members but must provide active supervision of the care delivered. ~~Mid-levels functioning as a primary care provider may perform minor procedures, such as simple I & D and suturing of minor wounds, if the Mid-level's (SP) or (DSA) lists the procedure and the Mid-level has demonstrated training/skill to perform the procedures. A Supervising Physician does~~

~~not need to be present during the aforementioned simple procedure; however, if the Mid-level is performing a complete procedure that requires informed consent, the Supervising Physician must be immediately available to deal with any emergency complication that may occur. Immediately available is defined as being in the same building/office at the time the procedure is being performed and not to imply available by electronic means.~~

A current specialty ~~provider~~ practitioner may employ a mid-level ~~provider~~ practiti~~t~~oner and may permit this

~~provider~~ practitioner to participate in the care delivered to members in accordance with the Standardized Procedure Guidelines, Delegation of Services Agreement, and KHS Policy and Procedure *4.04-P Non-Physician Medical Practitioners*. Mid-level practitioners will be credentialed in the specific specialty in which they will be working. The credentialing will be dependent on the~~ir~~ training and experience in the field in which the mid-level is requesting to be credentialed.[ix] ~~Mid-levels practicing in a specialty setting may perform an initial evaluation of the patient as long as there are no significant clinical decisions or recommendations (i.e. surgery, admission, etc.) that are made as a result of the initial evaluation, and the supervising physician's attestation in the clinical note indicates physician and mid-level have discussed and are in agreement with the treatment plan. The specialty physician must regularly monitor the patient's progress if follow-up care is provided by a mid-level practitioner, and see the patient at least every third visit. All communication between the specialty physician and the referring physician must be written or directly communicated by the specialty physician.~~

~~Supervising physicians must be within a thirty (30) mile radius of the mid-level they supervise. KHS may consider a waiver of the 30 mile radius requirement. Any and all waivers must be approved by the Physician Advisory Committee (PAC) and Board of Directors (BOD) prior to the mid-level being eligible to see KFHC Members.~~

~~Mid-level training is variable. Not only are there differences between Nurse Practitioners and Physician Assistants, but there are significant differences between the programs themselves. In addition, some mid-levels go on to receive formal "specialty" training in areas like OB, peds, surgery, ortho, oncology, etc..~~ [LM68][YHCC69]KHS will require either 6 months formal training in a program or one year of full time experience in the field which credentialing is requested.

Nurse Practitioners with a furnishing license may furnish drugs. Physician Assistants may ~~only transmit prescriptions or issue a drug order~~ administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to the guidelines in California Business and Professions Code, Section 3502.1 subdivisions (c) and (d).

~~Midlevel Practitioners may only function in a hospital setting and commensurate with their hospital privileges and limitations of their license so long as the hospital bylaws/policies allow for it, and KHS has had the opportunity to approve the~~

~~bylaws/policies. Physician oversight in the inpatient setting must however be by direct supervision with direct face to face patient contact within 24 hours of admission and at least once every 24 hours thereafter. This supervising requirement does not apply to Certified Nurse Midwives.~~

~~7.4~~7.3 Facility and Ancillary Providers

KHS will contract with new ~~Facilities~~facilities, ~~P~~pharmacies and ~~Ancillary~~ ancillary (~~Non~~non-practitioner) providers ~~of service~~ if these providers meet and remain in compliance with KHS requirements including but not limited to:

A. Provider must be physically located in and providing services in Kern County for one year prior to application;
B. must be in good standing with ~~Kern Health Systems~~KHS;
C. must be able to submit claims electronically;
D. must be able to participate in the KHS electronic funds transfer (EFT) program;
E. laboratory providers must be able to submit lab results/data to KHS electronically;
~~F. new Medical Transportation Providers must be members of the Kern County Ambulance Association~~[YHCC70][LM71][YHCC72]~~;~~
F. Durable medical equipment (DME) p~~P~~roviders must be able to service KFHC Members seven (7) days a week.
~~G.~~ Meets the requirements for Medi-Cal ~~Fee-for-Service~~FFS enrollment and is approved with ~~the Department of Health Care Services (~~DHCS~~)~~ as defined by the DHCS ~~All Plan Letter~~APL 19-004 and/or within the established process outlined in *KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy*.

~~7.5 Emergency Room Physicians~~[YHCC73]

~~G. KHS will not require Emergency Room Physicians providing services to KHS Members in an Emergency Room Setting and under contract to be credentialed through KHS. KHS will accept the credentialing performed by the hospital where the emergency room physician is practicing. This is limited to those Emergency Room Physicians providing services in the Emergency Room. This is in no way intended to eliminate the need for an emergency room trained physician to complete the credentialing process when they will be providing non-emergent services outside of the Emergency Room to KHS Members.~~

7.5 Medical Transportation Providers (Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT[YHCC74])

KHS will require all NMT/NEMT providers to be credentialed and contracted by KHS in accordance with ancillary credentialing requirements, as applicable, and subject to utilization controls, grievances/appeals process, and permissible time and distance standards. KHS may subcontract with transportation brokers for the provision of the NMT/NEMT services who may have their own network of NMT/NEMT providers; however, KHS cannot delegate their obligation related to grievances and appeals, enrollment of NMT/NEMT providers as Medi-Cal providers, or utilization management functions including the review of Physician Certification Statement (PCS) forms to a transportation broker.

All current and prospective NMT/NEMT providers must be screened, enrolled and approved through DHCS Medi-Cal Fee-For-Service in accordance with APL 22-013 Screening and Enrollment and KHS Policy and Procedure, 4.43-P Medi-Cal Enrollment Policy and 5.15-P Member Transportation Assistance to be considered for KHS Network.

7.6 Enhanced Care Management (ECM) and Community Supports (CS) Providers[YHCC75]

If there is no state-level Medi-Cal FFS enrollment pathway, ECM and Community Support Providers (CS) are not subject to APL 22-013 related to Medi-Cal screening and enrollment, credentialing, and background checks. To include an ECM/CS Provider, when there is no state-level Medi-Cal enrollment pathway, KHS is required to vet the qualifications of the Provider or Provider organization to ensure they meet the standards and capabilities required to be an ECM or CS Provider and comply with all applicable state and federal laws, regulations, ECM/CS requirements, contract requirements, and other DHCS guidance, including relevant APLs and Policy Letters.

7.6~~5~~7 HIV/AIDS ~~Practitioner~~Provider

On an annual basis, ~~practitioners~~ providers recognized as HIV/AIDS ~~S~~specialist ~~Providers~~ providers must complete the HIV/AIDS Specialist Certification ~~(See Attachment M)~~ certifying their completion of the requirements set forth in AB 2168-Standing Referral for HIV/AIDS Patients, California Health & Safety Code 1374.16 and Title 28 Section 1300.67.60 to be recognized as an HIV/AIDS ~~S~~specialist ~~Provider~~provider.

All ~~I~~infectious ~~D~~disease specialists and/or other qualified physicians will be surveyed annually to determine the following:

1. Whether ~~or not~~ they wish to be designated an HIV/AIDS specialist
2. Whether ~~or not~~ they meet the defined criteria as per California H&S Code 1374.16

A list of those specialists who meet the defined criteria and who wish to be designated as HIV/AIDS specialist will be sent to the ~~department~~UM Department responsible for referrals (e.g. UM Director) via e-mail annually. If the survey reveals that none of the physicians within the KHS network qualify as HIV/AIDS specialist , this information will ~~also~~ be communicated to the UM Director.

~~**7.7 Screening, Brief Intervention, and Referral to Treatment (SBIRT) Provider Requirements**~~

~~A. All licensed providers, as well as non-licensed providers who meet the requirements below, may offer SBIRT services in the primary care setting.~~

~~B. Non-licensed health care providers must provide SBIRT under the supervision of a~~

licensed health care provider. Licensed health care providers eligible to supervise staff are currently limited to a:

a. Licensed Physician;
b. Physician Assistant;
c. Nurse Practitioner; and
d. Psychologist.

C. At least one supervising licensed provider per clinic or practice must take four hours of SBIRT training within 12 months after initiating SBIRT services.

a. Beyond the first 12 months of providing SBIRT services, at least one supervising licensed provider per clinic or practice must have completed training.
b. At all times, rendering licensed providers are highly encouraged, but not required, to take training in order to provide the services.
c. A minimum of four hours of SBIRT training is highly encouraged for both supervising and rendering licensed providers within the first 12 months after initiating SBIRT services; however rendering licensed providers are not required to take training in order to provide the services.
d. For solo physician practices, the physician is highly encouraged, but not required, to take the training within 12 months after initiating SBIRT services.

D. Trained non-licensed providers, including but not limited to health educators, Certified Addiction Counselors, health coaches, medical assistants, and non-licensed behavioral assistants, must meet the following requirements. Requirements listed under b and c must be completed before providing SBIRT services.

a. Be under the supervision of a licensed provider listed in B above.
b. Complete a minimum of 60 documented hours of professional experience such as coursework, internship, practicum, education or professional work within their respective field. This experience should include a minimum of 4 hours of training directly related to SBIRT services (such as motivational interviewing).
c. Complete a minimum of 30 documented hours of face-to-face client contact within his or her respective field, in addition to the 60 hours of clinical professional experience described above. These contact hours may include internships, on-the-job training, or professional experience and SBIRT services training.

E. The supervising licensed provider and the non-licensed providers of SBIRT services must provide a copy of SBIRT certification to KHS within 12 months after initiating the provision of SBIRT services. The training is a one-time requirement.

ATTACHMENTS:

Attachment A: Provider Specific Credentialing Criteria – Physicians
Attachment B: Provider Specific Credentialing Criteria – Podiatrist
Attachment C: Provider Specific Credentialing Criteria – Mid-Level Providers
Attachment ~~D~~B: Provider Specific Credentialing Criteria – Facilities, Pharmacies & Ancillary Services
Attachment E: Provider Specific Credentialing Criteria – Pharmacies
Attachment F: Provider Specific Credentialing Criteria – Ancillary Services
Attachment G: Check List and California Participating Physician Application
Attachment H: Provider Specific Credentialing Criteria – Behavioral Health Providers
Attachment I: Behavioral Health Application
Attachment J: Pharmacy Application
Attachment K: Ancillary Application

~~Attachment L: Hospital/Facility Application~~
~~Attachment M: HIV/AIDS Specialist Certification~~
~~Attachment N: Walk-In Clinic Providers~~
~~Attachment O: Non-Licensed Qualified Autism Services (QAS) Provider Supervisor Agreement~~

REFERENCE:

Revisin 2019-09: **Revision 2015-06:** QAS Provider requirements per DHCS 14-026; and Behavioral Health Provider requirements. Revision **2014-12:** Item B. in Section 7.4 "cannot be physician owned, either directly or indirectly;" was deleted as requested by Compliance Director 10/01/2014. SBIRT training removed from *Policy 2.22-I Facility Site Review* and added to credentialing per COO. **Revision 2013-07**: New Attachment "N" Walk in Clinic Providers. Approved at the Physician Advisory Committee (PAC) Meeting on March 6, 2013. [i]**Revision 2012-10:** Language added to allow Mid-levels participate in a specialty settings and perform initial evaluations. The specialty physician must see the patient at lease every third visit. **Revision 2012-08**: Deleted requirement for non-physicians to pay $100 Credentialing process fee. **Revision 2012-01:** Revisions to attachments only. **Revision 2011-06:** Policy approved by management 11/15/10. However additional changes we provided by Director of Claims and Provider Relations regarding SPD members, Specialists and Emergency Room Physicians. Policy KHS Board approved 4/14/11. Revision to Attachments A and D regarding credentialing criteria. Board approved on 10/14/2010. Additional language added (01/2011) per Director of Claims and Provider Relations see Section 7.3 and 7.4 language from policies 4.4-P and 4.25-P respectively. **Revision 2010-05:** Physicians Advisory Committee added clarification of credentialing requirements in Attachment A #6. **Revision 2009-09: Revised by Provider Relation Director. Revision 2007-03:** Revised per DHS/DMHC Medical Review Audit (YE 10/31/06). **Revision 2005-11:** Revised per DHS Work Plan (07/10/05). **Revision 2005-04**: **Revision 2003-06**: Revised per DHS comment letter 03/04/03. **Revision 2002-08:** Routine review/revision. Revised per DHS Comment (10/30/01). Hospital Based Physicians section added per request of Medical Director. Radiology claims section added per request of Medical Director. *Policy #4.03 – Pharmacy Credentialing* deleted and necessary information added to this policy. Pharmacy portion revised per DHS Comment (09/19/01). Revised per MMCD Policy Letter 02-03.

~~[i] MMCD Policy Letter 02-03 § IV~~
[ii] DHS Contract Section 6.5.4.2
~~[iii] Per John Kaylen (DHS) it is acceptable with MMCD to have a physician without a DEA number as long as it is stipulated in the contract that the physician will not be prescribing medication that require a DEA. Exhibit A of our contract provides this exception.~~
~~[iv] MMCD Policy Letter 02-03 § I~~
~~[v] MMCD Policy Letter 02-03 § I~~
~~[vi] MMCD Policy Letter 02-03 § I~~
[vii] MMCD Policy Letter 02-03 § II
~~[viii] Statement approved as policy at 4/11/02 Board meeting. Effective 06/01/02. Statement revised per information received from Stacy Reeves 06/20/02. Revised statement approved by the PAC.~~
~~[ix] Mid-level training is variable. Not only are there differences between Nurse Practitioners and Physician Assistants, but there are significant differences between the programs themselves. In addition, some mid-levels go on to receive formal "specialty" training in areas like OB, peds, surgery, ortho, oncology, etc.. KHS will require either 6 months formal training in a program or one year of full-time experience in the field which credentialing is requested~~.

Attachment A
4.01-P

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Application Form Form/Document which includes elements required by this Policy, completed by an applicant who is requesting network participation with KHS. ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner types approved by the KHS Physician Advisory Committee	**Requirement:** Application must be signed, dated, complete, accurate and current. The application includes an attestation which includes, but is not limited to the following statements by the applicant: A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with our without accommodation and reasons for the same; B. History of loss of license and/or past or present felony conviction(s); C. History of loss or limitation of privileges and/or disciplinary activity voluntary or in-voluntary; D. Lack of present illegal drug use; E. Current and signed attestation by the applicant of the accuracy and completeness of the application. **Criteria**: 1) All attestations questions answered "no" and written explanation for affirmative "yes" answers; 2) All credentials verified must be consistent with attested application; and 3) Providers can clarify discrepancies in writing or verbally. **Source**: Application – Faxed, digital, electronic, scanned or photocopied signatures will be accepted. Stamped signatures or font print will not be accepted on the credentialing application. **Exceptions**: 1) Incomplete applications will be returned to the applicant with a request for the missing items and will be considered incomplete and withdrawn if no response. 2) Applications exceeding 180-days will require provider to update the information, sign and date with statement attesting the application is current, complete and accurate.	✔ Initial Credentialing ✔ Recredentialing
California State License State Sanctions, restrictions on licensure or limitations on scope of practice ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner	**Requirement:** Current and valid California Licensure with no previous or current state sanctions, restrictions on license, or limitations to scope of practice including 805 Reports. **Primary Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method. **Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ NPDB Continuous Query

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ Other practitioner types with State License		
Certifying Agency Verification Time Limit: 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ BCBA, BCBA-D ☒ RD ☒ Other practitioner types with professional certificate	**Requirement:** Current and valid professional certificate with no previous or current sanctions, restrictions on certification, or limitations to scope of practice. **Primary Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method. **Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license/certification or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration
Drug Enforcement Agency (DEA) ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with DEA Certificate and/or furnishing licensure	**Requirement:** A current valid Drug Enforcement Agency (DEA) registration number as applicable. - DEA must be issued to practitioner's California address - Practitioners with pending DEA or those who choose not to have a DEA: must submit written letter from an alternate credentialed practitioner who is in possession of DEA and willing to write prescriptions on his/her behalf. - DEA cannot be linked to another facility or institution only or reflect "exempt" or "Limited to" status. **Primary Source**: DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile. **Criteria**: 1) DEA Certificate must be current at all times and reflect an address in the state of California; 2) If provider does not have a DEA as a result of disciplinary action, including but not limited to, being revoked, or relinquished (voluntary or involuntary) the practitioner may not be eligible to participate in the KHS Network, PAC will review on case by case basis if alternate arrangements met the satisfaction of this requirement. **Exceptions**: Radiology, Pathology, CRNAs *Other practitioners who do not prescribe scheduled medications may be exempt on a case by case basis.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
NPI Number ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ All practitioner types / Type 1 Individual NPI ☒ All provider types / Type 2 Organizational NPI	**Requirement:** A current valid NPI number. **Primary Source**: NPPES Registry **Exceptions**: Atypical Providers who may not require NPI Number, example Qualified Autism Service Professionals or Paraprofessionals, and Community Healthcare Workers.	✔ Initial Credentialing ✔ Recredentialing
Education and Training ***Verification Time Limit:*** Prior to the credentialing decision. *Note: verification must be conducted after the completion date of the highest level of education, if not board certified.* ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** Graduation from a medical/professional school, or completion of an accredited residency and/or an accredited fellowship. Successful completion of accredited residency training, approved by the Accreditation Council for Graduate Medical Education (ACCGME), in the applicable field of practice is necessary in order to be credentialed as a specialist. For Chiropractors, Optometry, and other non-physician practitioners, including behavioral health practitioner, the highest level of education will be verified. **Primary Source**: Medical or Professional School directly, AMA Masterfile, AOA Official Osteopathic Masterfile, ABMS Board Certification, National Student Clearinghouse for non physician providers or appropriate board/registry if board performs primary source verification education & is confirmed annually. **Criteria**: 1) Primary source verification without red flags; 2) Post-Graduate training is fully completed. **Exceptions**: None	✔ Initial Credentialing
Board Certification ***Verification Time Limit:*** 180 calendar days at time of the decision.	Board certification as applicable; verification of education is not required if provider meets board certification as highest level of education requirements. Board certification is not required but is verified when indicated on the credentialing application or	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ Upon New Certification

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Practitioner Type: ☒ MD/DO ☒ DPM ☒ PA, NP, CNM ☒ Other practitioner and non-practitioner types with board certifying agency.	when newly reported. **Primary Source**: American Board of Medical Specialties (Certifacts), AMA Masterfile, AOA Official Osteopathic Masterfile, or American Board of Podiatric Surgery Foot & Ankle. For non-physician providers appropriate board/registry if indicated on the application or newly reported. **Criteria**: 1) Board Certification (if applicable) is current, with our without Maintenance of Certification (MOC); 2) If Board Certification has expired it may be used for verification of education/training (per NCQA MD/DO/DPM Only)	
Specialty / Scope of Practice ***Practitioner Type:*** ☒ MD/DO	**Requirements:** Completion of accredited residency training or ACGME accredited fellowship in the applicable field of practice is necessary in order to be credentialed as a specialist. Specialists that want to serve as SPD member's primary care physician must have completed a residency in Internal medicine, or a residency in Pediatrics. ~~Completion of an internal medicine residency, general surgery residency, or family practice residency with a hospital based practice is necessary in order to be credentialed as a hospitalist.~~ **Criteria:** Only those specialties and sub-specialties recognized by the ABMS will be listed in the Kern Health Systems Provider Directory. Additionally, the Medical Board of California & CA Business & Professions Code Section 651 recognizes ABMS and 4-additional Boards that meet the equivalent certification requirements as with ABMS. The 4-Boards include: American Board of Facial and Reconstructive Surgery, American Board of Pain Medicine, American Board of Sleep Medicine, and American Board of Spine Surgery.	✔ Initial Credentialing ✔ Upon newly reported
Primary Care Providers ***Practitioner Type:*** ☒ MD/DO	**Requirements/Criteria:** Completion of a Family Practice, Pediatric, Internal Medicine or an Obstetrics and Gynecology residency is necessary in order to be credentialed as a PCP. **Exceptions:** Providers who do not meet the above criteria, must have practiced exclusively in the Primary Care setting for at least five (5) consecutive years ~~or for at least two (2) consecutive years within the last five (5) years~~ to be considered a General Practitioner eligible to be a PCP and have	

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Practitioners / Mid-Levels-Advanced Practice Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	members assigned. PCPs who were credentialed prior to 04/01/02 and who meet the above criteria will be allowed to continue as PCPs. a. ~~General Practitioner must work for six months as a supervised, non-assignable locum tenens. At the end of the six months the applicant will be reviewed for quality of care issues.~~ b. General Practitioner must agree as part of their credentialing to provide evidence of participation in at least twelve hours a year in prior authorized primary care CME activity, upon request.	
Advanced Practice Professionals (formerly Mid-Levels): PA, NP, CNM, CRNA • ***Education and Training*** • ***Provider Information Letter*** **Verification Time Limit:** *Prior to the credentialing decision.* ***Practitioner Type:*** ☒ PA, NP, CNM, CRNA	**Requirement:** Successful completion from a relevant professional school. ***Specialty Training:*** Mid-level training is variable. Not only are there differences between Nurse Practitioners and Physician Assistants, but there are significant differences between the programs themselves. In addition, some mid-levels go on to receive formal "specialty" training in areas like OB, peds, surgery, ortho, oncology, etc.. KHS will require either 6 months formal training in a program or one year of full-time experience in the field which credentialing is requested. ***Supervising Physician Agreement:*** Designated Physician Supervisor(s) ~~and alternate physician supervisor(s)~~ with signed supervision agreement per group affiliation ~~(including supervision guidelines) with a KHS credentialed physician (renewed annually)~~ **Primary Source**: Professional School directly, AMA Masterfile, National Student Clearinghouse for non-physician providers or appropriate board/registry if board performs primary source verification education & is confirmed annually. **Criteria**: 1) Primary source verification without red flags. **Exceptions**: None	✔ Initial Credentialing ✔ Initial Credentialing ✔ Upon newly reported
Residents (Moonlighting) ***Scope of Practice*** ***Practitioner Type:*** ☒ MD/DO	**Requirements:** A. Application Form B. Current and valid Post-Graduate California Licensure *Must apply in advanced for full California Physician & Surgeon's licensure prior to completion of residency otherwise the resident will be terminated upon expiration date of Post-Training License. C. Current and valid DEA	

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Practitioners / Mid-Levels-Advanced Practice Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	D. Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering all of the procedures or services the provider expects to perform for KFHC E. Signed letter of permission to moonlight by Residency Program Director F. Under Existing Contracted Provider Group **Primary Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method; DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile.	
Specialty / Scope of Practice ***Practitioner Type:*** ☒ MD/DO	**Requirements:** Completion of accredited residency training or ACGME accredited fellowship in the applicable field of practice is necessary in order to be credentialed as a specialist. Specialists that want to serve as SPD member's primary care physician must have completed a residency in Internal medicine, or a residency in Pediatrics. ~~Completion of an internal medicine residency, general surgery residency, or family practice residency with a hospital based practice is necessary in order to be credentialed as a hospitalist.~~ Only those specialties and sub-specialties recognized by the ABMS will be listed in the Kern Health Systems Provider Directory.	✔ Initial Credentialing ✔ Upon newly reported
Hospital Clinical Privileges (CMS/DHCS/DMHC) ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ MD/DO ☒ DPM ☒ CRNA	**Requirement:** Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; All Plan Letter (APL) 22-013 and DMHC Tag 6/09/14) Formal inpatient coverage arrangements in a written and dated letter delineating the inpatient coverage is sufficient. ~~Membership in good standing on the Medical Staff of a hospital, or have a written admitting agreement with a KHS credentialed provider with clinical privileges appropriate to the provider's same field of medicine, or coverage by a hospitalist group for primary care (unless the provider practices a field of medicine for which hospital privileges are not required to render the customary scope of services for that field, or is able to provide documentation of other~~	✔ Initial Credentialing ✔ Recredentialing ✔ Upon newly reported

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	~~arrangements for hospital admission that ensure continuity of care and they are acceptable to the Kern Health Systems Board of Directors)~~. *Contracted Ambulatory Surgery Centers may also satisfy this requirement if provider does not utilize the hospital. **Primary Source**: verbal, written or internet/electronic verification directly with the institution, hospital letter or directory which must include include current status (e.g. unrestricted or restricted), type of admitting privileges (e.g. Active, Courtesy, temporary), and practitioner specialty. **Exceptions**: *Specialties deemed by KHS not to have hospital privileges and are documented to be limited to outpatient services include: Dermatology, Podiatry, Ophthalmology, Chiropractor, Psychiatry, Optometry, Physical Medicine &Rehabilitation, Radiology, Pain Medicine, Behavioral Health Providers, and/or practice limited to outpatient services only, Mid-Level Providers, any others	
Work History ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** A minimum of five (5) years work history will be included in the initial credentialing file on the application or curriculum vitae. Relevant work history includes work history as a health professional in month/year beginning and month/year end dates. **Primary Source**: Documented on application or curriculum vitae/resume in month/year format. **Criteria**: 1) If practitioner has practiced less than 5-years, work history begins at the time of initial licensure date. 2) If the practitioner has had continuous employment for five years or more with no gap, providing the year is sufficient. 3) If gap in employment exceeds six (6)-months, but less than 1-year, the provider clarifies the gap verbally or in writing/email. 4) If the gap in employment exceeds one (1)-year the provider must clarify in writing and the organization documents review. **Exceptions**: Academic, Unpaid voluntary work, or unrelated to practice of medicine or health care.	✔ Initial Credentialing
Malpractice History (NPDB) **Verification Time Limit:** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs	**Requirements:** **Initial** - Verification of the past five (5) years of malpractice or professional liability claims history that resulted in settlement or judgment paid on behalf of the practitioner. **Recredentialing** - Verification of the past three (3) years or since last credentialing cycle. **Primary Source**: National Practitioner Data Bank (NPDB)	✔ Initial Credentialing ✔ Recredentialing ✔ **Ongoing** - Continuous Enrollment

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Practitioners / Mid-Levels-Advanced Practice Practitioners

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APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Exceptions**: None	
Sanction Information: ***Medicare, Medi-Cal, OIG/LEIE Database, DHCS Restricted Provider List and EPLS/SAM*** ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no providers who have been sanctioned, restricted, terminated or debarred from any state or federal agency/registry. **Primary Source**: NPDB, OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database. **Exceptions**: None.	✔ Initial Credentialing ✔ Recredentialing ✔ Continuous Query
DHCS Medi-Cal Fee-For-Service Proof of enrollment or applicable alternate enrollment process, when applicable ***Practitioner Type:*** ☒ Practitioner & Provider Types as Per DHCS State Level Resource Listing who have a State Pathway for Enrollment	**Requirement:** Proof of Medi-Cal Fee-for-Service screening, enrollment and approval with the Department of Health Care Services (DHCS) as defined by the DHCS All Plan Letter 22-013 and/or within the established process outlined in KHS Policy & Procedure 4.43-P "Medi-Cal Enrollment Policy" for those practitioner and provider types where there is a state pathway for enrollment. **Primary Source**: CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion. **Exceptions:** When there is no state pathway or KHS, at their discretion, choses to screen and enroll at the plan level or other Managed Care health plan approval.	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliatons
Professional Liability Coverage **Verification Time Limit:**	**Requirement:** Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering ~~all of the procedures~~ designated specialty or services the provider expects to perform for KFHC members.	✔ Initial Credentialing ✔ Recredentialing

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels-Advanced Practice Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Prior to the credentialing decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Primary Source**: Copy of Certificate Face Sheet, Federal Tort Letter, or if the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. **Exceptions**: None	✔ Changes in Group Affiliatons
Facility Site Review ***Verification Time Limit:*** *Prior to the credentialing decision* ☒ PCPs ☒ OB/GYN who are SPD member's PCP, ~~and Urgent Care Centers~~	**Requirement:** Satisfactory site audit (is required for all primary care providers and OB/GYNs ~~high volume specialists~~ serving as an SPD member's PCP ~~and other providers at the discretion of KHS.~~) It is necessary to have a minimum passing score of 80% and a completed CAP. **Primary Source**: KHS QI Dept / FSR Database **Exceptions**: As required or determined by QI Policy and Procedure	✔ Initial Credentialing ✔ Recredentialing
Contract: Provider Service Agreement, Facility Agreement and Pharmacy Agreement ☒ All Contract Providers	**Requirement:** Signed contract between KHS and the provider to provide health care services to KFHC Members. Support Documents Includes: • Contract pre-review criteria • W9 • 274 Group and Site Forms • Roster of Providers, if applicable	✔ Initial Credentialing

Attachment B
4.01-P

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Application Form Form/Document which includes elements required by this Policy, completed by an applicant who is requesting network participation with KHS. ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** *KHS individually credentials and recredentials the following categories of clinicians in private solo or group behavioral health practice settings:* • Behavior Analyst – All Levels • Licensed Marriage and Family Therapist • Licensed Clinical Social Worker • Nurse – RN, LPN, NA • Nurse Practitioner/PA/Advance/Masters RN • Psychiatrist/Physician/MD/DO • Psychologist – PhD-Level • Substance Abuse Professional – All Levels	**Requirement:** Application must be signed, dated, complete, accurate and current. The application includes an attestation which includes, but is not limited to the following statements by the applicant: A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with our without accommodation and reasons for the same; B. History of loss of license and/or past or present felony conviction(s); C. History of loss or limitation of privileges and/or disciplinary activity voluntary or in-voluntary; D. Lack of present illegal drug use; E. Current and signed attestation by the applicant of the accuracy and completeness of the application. **Criteria**: 1) All attestations questions answered "no" and written explanation for affirmative "yes" answers; 2) All credentials verified must be consistent with attested application; and 3) Providers can clarify discrepancies in writing or verbally. **Source**: Application – Faxed, digital, electronic, scanned or photocopied signatures will be accepted. Stamped signatures or font print will not be accepted on the credentialing application. **Exceptions**: 1) Incomplete applications will be returned to the applicant with a request for the missing items and will be considered incomplete and withdrawn if no response. 2) Applications exceeding 180-days will require provider to update the information, sign and date with statement attesting the application is current, complete and accurate.	✔ Initial Credentialing ✔ Recredentialing
California State License State Sanctions, restrictions on licensure or limitations on scope of practice ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:***	**Requirement:** Current and valid California Licensure with no previous or current state sanctions, restrictions on license, or limitations to scope of practice including 805 Reports. **Primary Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ NPDB Continuous Query

Attachment B
4.01-P

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ ALL BH Practitioner Types	**Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	
Certifying Agency Verification Time Limit: 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ BCBA, BCBA-D ☒ BCaBA, RDT ☒ Other practitioner types with professional certificate	**Requirement:** Current and valid professional certificate with no previous or current sanctions, restrictions on certification, or limitations to scope of practice. **Primary Source**: applicable state licensing or certifying agency via verbal, written or internet/electronic method. **Criteria**: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license/certification or limitations to scope of practice. PAC will review on case by case basis. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration
Drug Enforcement Agency (DEA) ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** A current valid Drug Enforcement Agency (DEA) registration number as applicable. - DEA must be issued to practitioner's California address - Practitioners with pending DEA or those who choose not to have a DEA: must submit written letter from an alternate credentialed practitioner who is in possession of DEA and willing to write prescriptions on his/her behalf. - DEA cannot be linked to another facility or institution only or reflect "exempt" or "Limited to" status. **Primary Source**: DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile. **Criteria**: 1) DEA Certificate must be current at all times and reflect an address in the state of California; 2) If provider does not have a DEA as a result of disciplinary action, including but not limited to, being revoked, or relinquished (voluntary or involuntary) the practitioner may not be eligible to participate in the KHS Network, PAC will review on case by case basis if alternate arrangements met the satisfaction of this requirement. **Exceptions**: Radiology, Pathology, CRNAs	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration

Attachment B
4.01-P

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	*Other practitioners who do not prescribe scheduled medications may be exempt on a case by case basis.	
NPI Number ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** A current valid NPI number. **Primary Source**: NPPES Registry **Exceptions**: Atypical Providers who may not require NPI Number, example Qualified Autism Service Professionals or Paraprofessionals, and Community Healthcare Workers.	✔ Initial Credentialing ✔ Recredentialing
Education and Training ***Verification Time Limit:*** Prior to the credentialing decision. *Note: verification must be conducted after the completion date of the highest level of education, if not board certified.* ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** Graduation from a medical/professional school, or completion of an accredited residency and/or an accredited fellowship. Successful completion of accredited residency training, approved by the Accreditation Council for Graduate Medical Education (ACCGME), in the applicable field of practice is necessary in order to be credentialed as a specialist. For Chiropractors, Optometry, and other non-physician practitioners, including behavioral health practitioner, the highest level of education will be verified. **Primary Source**: Medical or Professional School directly, AMA Masterfile, AOA Official Osteopathic Masterfile, ABMS Board Certification, National Student Clearinghouse for non physician providers or appropriate board/registry if board performs primary source verification education & is confirmed annually. **Criteria**: 1) Primary source verification without red flags; 2) Post-Graduate training is fully completed. **Exceptions**: None	✔ Initial Credentialing
Board Certification ***Verification Time Limit:***	Board certification as applicable; verification of education is not required if provider meets board certification as highest level of education requirements.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration

Attachment B
4.01-P

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	Board certification is not required but is verified when indicated on the credentialing application or when newly reported. **Primary Source**: American Board of Medical Specialties (Certifacts), AMA Masterfile, AOA Official Osteopathic Masterfile, or American Board of Podiatric Surgery Foot & Ankle. For non-physician providers appropriate board/registry if indicated on the application or newly reported. **Criteria**: 1) Board Certification (if applicable) is current, with our without Maintenance of Certification (MOC); 2) If Board Certification has expired it may be used for verification of education/training (per NCQA MD/DO/DPM Only)	✔ Upon New Certification
Specialty / Scope of Practice ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirements:** Completion of accredited residency training or ACGME accredited fellowship in the applicable field of practice is necessary in order to be credentialed as a specialist. Specialists that want to serve as SPD member's primary care physician must have completed a residency in Internal medicine, or a residency in Pediatrics. ~~Completion of an internal medicine residency, general surgery residency, or family practice residency with a hospital based practice is necessary in order to be credentialed as a hospitalist.~~ **Criteria:** Only those specialties and sub-specialties recognized by the ABMS will be listed in the Kern Health Systems Provider Directory. Additionally, the Medical Board of California & CA Business & Professions Code Section 651 recognizes ABMS and 4-additional Boards that meet the equivalent certification requirements as with ABMS. The 4-Boards include: American Board of Facial and Reconstructive Surgery, American Board of Pain Medicine, American Board of Sleep Medicine, and American Board of Spine Surgery.	✔ Initial Credentialing ✔ Upon newly reported
Scope of Practice / Pervasive Developmental Disorder or Autism Provider Credentialing ***Practitioner Type:***	Requirements: 1. QAS Provider must meet the following requirements: 2. Be certified by a national entity accredited by the National Commission for Certifying Agencies (e.g. Behavior Analyst Certification Board (BACB)); supervise the work of qualified autism service (QAS) Professionals and Paraprofessionals who implement behavior analytic interventions; and, have minimum of master's degree, including:	✔ Initial Credentialing ✔ Upon newly reported

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Services must be provided under a treatment plan developed and approved by a contracted and credentialed qualified autism service as defined by Health & Safety Code Section 1374.73. Treatment may be administered by one of the following: • Qualified Autism Service (QAS) Provider • QAS Professional • QAS Paraprofessional	3. 225 classroom hours of graduate level instruction; 4. 1500 hours of supervised independent fieldwork; and, 5. 1000 hours of practicum or 750 hours of intensive practicum in behavior analysis. OR 6. Be licensed as a physician, psychologist, marriage and family therapist, educational psychologist, clinical social worker, and professional clinical counselor provided the duties are within the experience and competence of the licensee. 7. Graduated from a medical school or professional school; completion of a residency; and, education as required. Completion of accredited residency training in the applicable field of practice is necessary in order to be credentialed as a specialist. (Proof of highest level of education (e.g. diploma, transcript, etc.) must be submitted with application.) 8. Adequate experience, education, and training (as documented by curriculum vitae covering all work history over at least the past five years). 9. Current valid Drug Enforcement Agency (DEA) and/or Controlled Substance Distribution (CSD) certification, if applicable. Other practitioners who do not prescribe scheduled medications may be exempted on a case by case basis. 10. Required to submit National Provider Identifier (NPI) with each KHS behavioral health application packet. 11. Board certified or Board eligible, as applicable. 12. Documentation of any state sanctions, restrictions on licensure or limitations on scope of practice (only for the most recent 5 years). 13. Documentation of any sanctions imposed by Medi-Cal, Medicaid, and Medicare. 14. Eligibility in good standing to provide services to Medicare and Medi-Cal patients. 15. All applicants must provide reasons for the inability to perform the essential functions of the position with or without accommodation and attest to the lack of present illegal drug use and attest to the loss or limitation of privileges or disciplinary actions taken. 16. Document history of loss license, history of felony convictions, and history of past and present issues regarding loss or limitation of clinical privileges as all facilities or organizations with which a practitioner has had privileges. 17. Professional (Malpractice) Liability Certificate of Insurance in the amounts of: $1,000,000.00 per occurrence $3,000,000.00 annual aggregate 18. Documentation of any professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner. 19. Signed and dated QAS Supervisor Agreement which designates QAS Provider Supervisor(s) and alternate QAS Provider supervisor(s) with signed supervision agreement	

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	(including supervision guidelines) with a KHS credentialed QAS Provider (renewed annually). (Applicable to ALL Non-Licensed QAS Professionals and Paraprofessionals.) **20. QAS Staff Roster including:** Please note: The QAS Professional may assist a QAS Provider with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each QAS Professional practice under the supervision of a QAS Provider who has submitted a QAS Supervisory Agreement attesting to the qualifications of the QAS Professional and Paraprofessionals as follows: 1. QAS Professional (Non-Licensed): a) Be certified by a national entity accredited by the National Commission for Certifying Agencies (e.g. Behavior Analyst Certification Board (BACB)); and, educational and training requirements include possession of a minimum of a bachelor's degree, including: i. 135 classroom hours of instruction; ii. 1000 hours of supervised independent fieldwork; and, iii. 670 hours of practicum or 500 hours of intensive practicum in behavior analysis. OR b) Possesses a Bachelor of Arts or Science Degree and has either: i. 12 semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services; or, ii. 2 years of experience in designing and/or implementing behavior modification intervention services. OR c) Is registered as either: i. Psychological assistant of psychologist by the Medical Board of California or Psychology Examining Board; or, ii. An associate Licensed Clinical Social Worker. 2. QAS Paraprofessional: Have any combination equivalent to completion of the twelfth grade education, supplemented by courses in the following: a) childcare; b) psychology;	

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PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	c) education and training of autistic students; and, d) some experience working with autistic students in a structured environment.	
Work History ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** A minimum of five (5) years work history will be included in the initial credentialing file on the application or curriculum vitae. Relevant work history includes work history as a health professional in month/year beginning and month/year end dates. **Primary Source**: Documented on application or curriculum vitae/resume in month/year format. **Criteria**: 1) If practitioner has practiced less than 5-years, work history begins at the time of initial licensure date. 2) If the practitioner has had continuous employment for five years or more with no gap, providing the year is sufficient. 3) If gap in employment exceeds six (6)-months, but less than 1-year, the provider clarifies the gap verbally or in writing/email. 4) If the gap in employment exceeds one (1)-year the provider must clarify in writing and the organization documents review. **Exceptions**: Academic, Unpaid voluntary work, or unrelated to practice of medicine or health care.	✔ Initial Credentialing
Malpractice History (NPDB) **Verification Time Limit:** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirements:** **Initial** - Verification of the past five (5) years of malpractice or professional liability claims history that resulted in settlement or judgment paid on behalf of the practitioner. **Recredentialing** - Verification of the past three (3) years or since last credentialing cycle. **Primary Source**: National Practitioner Data Bank (NPDB) **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ **Ongoing** - Continuous Enrollment
Sanction Information: Medicare, Medi-Cal, OIG/LEIE Database, DHCS Restricted Provider List and EPLS/SAM ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no providers who have been sanctioned, restricted, terminated or debarred from any state or federal agency/registry. **Primary Source**: NPDB, OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database. **Exceptions**: None.	✔ Initial Credentialing ✔ Recredentialing ✔ Continuous Query

Attachment B
4.01-P

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Behavioral Health Practitioners

LIPs – Licensed Independent Practitioners
APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
DHCS Medi-Cal Fee-For-Service Proof of enrollment or applicable alternate enrollment process, when applicable ***Practitioner Type:*** ☒ ALL BH Practitioner Types, if applicable	**Requirement:** Proof of Medi-Cal Fee-for-Service screening, enrollment and approval with the Department of Health Care Services (DHCS) as defined by the DHCS All Plan Letter 22-013 and/or within the established process outlined in KHS Policy & Procedure 4.43-P "Medi-Cal Enrollment Policy" for those practitioner and provider types where there is a state pathway for enrollment. **Primary Source**: CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion. **Exceptions:** When there is no state pathway or KHS, at their discretion, choses to screen and enroll at the plan level or other Managed Care health plan approval.	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliatons
Professional Liability Coverage **Verification Time Limit:** *Prior to the credentialing decision.* ***Practitioner Type:*** ☒ ALL BH Practitioner Types	**Requirement:** Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering ~~all of the procedures~~ designated specialty or services the provider expects to perform for KFHC members. **Primary Source**: Copy of Certificate Face Sheet, Federal Tort Letter, or if the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliatons
Contract: Provider Service Agreement, Facility Agreement and Pharmacy Agreement ☒ All Contract Providers	**Requirement:** Signed contract between KHS and the provider to provide health care services to KFHC Members.	✔ Initial Credentialing

Attachment C

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
Application **Organization/HDO** ***Provider Type:*** ☒ Organizations/HDO	Current Organizational Application is completed, signed, and dated. • Signed and dated attestation questions. • Signed and dated information release and acknowledgements. Organizational Providers/HDO include: Hospital; Home Health; Skilled Nursing Facilities (SNF); Free-Standing Ambulatory Surgery Centers. Additional HDO Providers: Hospices; clinical laboratories; comprehensive outpatient rehab facilities (CORF); Outpatient Physical Therapy Clinics; Outpatient Speech Therapy; Dialysis/ESRD Clinic; Imaging Services/Portable X-Ray; DMEPOS; Home Infusion; Ambulance; Transportation Providers; Hearing Aid Dispenser; and Urgent Care Centers. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Application **Pharmacies** ***Provider Type:*** ☒ Pharmacy ☒ Pharmacy additional locations	Current Organizational Application is completed, signed, and dated. • Signed and dated attestation questions. • Signed and dated information release and acknowledgements. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Additional Site Locations
California State License State Sanctions, restrictions on licensure or limitations on scope of practice Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ***Provider Type:*** ☒ CBAS-Adult Day Care ☒ Dialysis Clinic	KHS: Eligibility in good standing to provide services to Medicare and Medi-Cal patients Current and valid California State Licensure with no previous or current state sanctions, restrictions on license, or limitations to scope of practice, if applicable. Pharmacies: 1. Valid pharmacy permit 2. Valid pharmacist-in-charge license Primary Source: California Department of Public Health (CDPH), applicable state licensing or certifying agency via verbal, written or internet/electronic method. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing

Attachment C

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
☒ Home Health ☒ Hospice ☒ Hospitals ☒ Lab License ☒ X-Ray Division ☒ SNFs		
NPI Number Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ ALL - Type 2	A current valid NPI number. Primary Source: NPPES Registry **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Drug Enforcement Agency (DEA) Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ Organizations/HDO, if applicable ☒ Pharmacy ☒ Hospitals ☒ Ambulatory Surgery Centers	A current valid Drug Enforcement Agency (DEA) registration number as applicable. If facility does not have a DEA as a result of disciplinary action, including but not limited to, being revoked, or relinquished (voluntary or involuntary) the practitioner is not eligible to participate in the KHS Network. - DEA must be issued to provider's California address location Primary Source: DEA Office of Diversion Control Agency **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration
Accreditation Verification Time Limit: Prior to the decision. ***Provider Type:*** ☒ Hospitals	**Hospitals**: Documentation of accreditation letter from AOA/HFAP, DNV, TJC, CIHQ **KHS Policy Requirement**: Surgery Centers must be accredited by one of the following agencies: AAAHC, AAAASF, TJC, AOA, HFAP • ~~Institute for Medical Quality~~Remove • AOA – American Osteopathic Association • HFAP- Healthcare Facilities Accreditation Program	✔ Initial Credentialing ✔ Recredentialing

Attachment C

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
☒ Ambulatory Surgery Centers ☒ Home Health ☒ Hospice ☒ Imaging Clinics/Centers ☒ Laboratories	**Laboratories** must be accredited by the following agencies: CLIA, COLA, CAP, other CMS approved sources **Home Health**: ACHC, CHAP, TJC **Hospice**: CHAP, TJC **Imaging Services/Portable X-Ray**: Documentation of FDA Certificate Primary Source: applicable accreditation agency via verbal, written or internet/electronic method. **Exceptions**: *HH, Hospice, Imaging & Labs – If not accredited a site review or CMS / State Report is required.	
CMS or California Dept of Public Health Site Visit Verification Time Limit: Current within 36-months prior to the credentialing decision. ***Provider Type:*** ☒ Dialysis/ESRD Clinic ☒ DMEPOS ☒ Home Health ☒ Home Infusion ☒ Hospice ☒ Imaging Service and or Portable X-Ray ☒ Laboratory ☒ SNF	**Requirement:** When organizational facility is not accredited, an on-site quality assessment must be conducted or a CMS or State of California Dept of Public Health Site Review may be used in lieu of an on-site visit and may not be greater than 3-years old at the time of verification/approval. Primary Source: California Department of Public Health (CDPH.CA.GOV) **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
City Business License Verification Time Limit:	**City Business license as applicable.** **Ambulance**: CHP Business License & Kern County Ambulance Service Operations Permit	✔ Initial Credentialing ✔ Recredentialing

Attachment C

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
180 calendar days at time of the decision. ***Provider Type:*** ☒ Ambulance ☒ Dialysis Clinic ☒ DMEPOS ☒ Hearing Aid Dispenser ☒ Imaging Service and or Portable X-Ray ☒ Laboratory ☒ SNF	**DME**: Retail License (additional) Primary Source: Copy of city business license or applicable agency who issues city business licenses via verbal, written or internet/electronic method. **Exceptions**: None	
Clinical Lab License & CLIA Accreditation Certificate ***Provider Type:*** ☒ Ambulatory Surg Ctr ☒ Dialysis Clinic ☒ Laboratory ☒ Urgent Care	Copy of CLIA Accreditation Certificate. Primary Source: Copy and verified via CMS CLIA Website **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Malpractice History (NPDB) Verification Time Limit: 180 calendar days at time of the decision. ***Provider Type:*** ☒ ALL	**Initial** - Verification of the past five (5) years of malpractice or professional liability claims history that resulted in settlement or judgment paid on behalf of the practitioner. **Recredentialing** - Verification of the past three (3) years or since last credentialing cycle. Primary Source: National Practitioner Data Bank (NPDB) **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing
Sanction Information: Medicare, Medi-Cal, OIG/LEIE Database, and SAM Verification Time Limit: 180 calendar days at time of the decision.	Eligibility in good standing to provide services to Medicare and Medi-Cal beneficiaries. KHS will query the required state and federal databases to ensure there are no organizational providers or pharmacies who have been sanctioned, restricted, terminated or debarred. Primary Source: OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List and the SAM-System for Award Management	✔ Initial Credentialing ✔ Recredentialing ✔ Ongoing Monitoring

Attachment C

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
Provider Type: ☒ ALL	**Exceptions**: None	
Department of Health Care Services (DHCS) Medi-Cal Fee-For-Service Proof of enrollment or applicable alternate enrollment process, when applicable ***Provider Type:*** ☒ ALL	Proof of Medi-Cal Fee-for-Service enrollment and approval by the DHCS All Plan Letter and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy for those practitioner and provider types where there is a state pathway for enrollment. Risk Level 3 Providers: DMEPOS and Home Health agencies must be enrolled and approved through DHCS Medi-Cal FFS Program. Alternate pathways are not acceptable. Primary Source: CHHS Portal; Copy of welcome/approval letter from DHCS; ORP Portal for rendering providers; attestation of enrollment at KHS discretion. **Exceptions**: When there is no state pathway or plan opts, at their discretion to screen and enroll at the plan level or other MCP approval.	✔ Initial Credentialing ✔ Recredentialing ✔ Additional location requests
Professional Liability Coverage ***Provider Type:*** ☒ ALL	Professional liability insurance: a. **Acute care hospitals**: at least $3,000, 000.00 per occurrence and $5,000,000.00 annual aggregate, covering all of the procedures or services the provider expects to perform for Kern Health Systems b. **Other facilities:** at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering all of the procedures or services the provider expects to perform for KHS Primary Source: Copy of Certificate Exceptions: None	✔ Initial Credentialing ✔ Recredentialing
General Liability Coverage ***Provider Type:*** ☒ ALL	Current general liability insurance, at least $1,000,000.000 Primary Source: Copy of Certificate Exceptions: None	✔ Initial Credentialing ✔ Recredentialing
Contract: Provider Service Agreement, Facility Agreement and Pharmacy Agreement ***Provider Type:***	Signed contract between KHS and the provider to provide health care services to KFHC Members. **KHS requirement**: Must by physically located in and providing services in Kern County for one year prior to application; tertiary are excluded from this requirement	✔ Initial Credentialing

Attachment C

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Organizational (HDO) / Pharmacy / Facilities / Ancillary Providers

Criteria	Requirement/Verification Source	Credentialing Instance
☒ ALL	KHS reserves the right to review and approve facilities policy & procedures, quality management program, upon request **Exceptions**: None	

KERN HEALTH SYSTEMS

To: **KHS Board of Directors**

From: **Martha Tasinga, MD, CMO, PAC Chair**

Date: **February 16, 2023**

Re: **KHS REVISED POLICY AND PROCEDURE – 4.47-P Clinical Laboratory Improvements Amendments (CLIA) Certification Requirements**

Background

Modification to Kern Health Systems (KHS) policies pertaining to Clinical Laboratory Improvement Amendments (CLIA) Certification Requirements were approved by the Physician Advisory Committee on 2/1/2023.

The enclosed document (red-lined) shows the modifications of this policy and specific changes pertaining to the following sections:

Policy Description Modification –

- Section 3.0 - DOCUMENTATION AND VERIFICATION OF CLIA CERTIFICATION
  - Added language describing how CLIA Certificates are verified at initial credentialing and recredentialing, include website source verification.
- Section 3.0 - DOCUMENTATION AND VERIFICATION OF CLIA CERTIFICATION
  - 3.2 On-going Verification
  - Added language describing how CLIA Certificates are verified at expiration date, include website source verification.

These changes were made to bring policy up-to-date with the National Committee for Quality Assurance (NCQA) Credentialing Standards requiring the approved "source" used for primary verification.

Requested Action

Approve policy revisions to the 4.47-P Clinical Laboratory Improvements Amendments (CLIA) Certification Requirements.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Clinical Laboratory Improvements Amendments (CLIA) Certification Requirements				POLICY #: 4.47-P	
DEPARTMENT: Provider Network Management					
Effective Date: 02/2002	Review/Revised Date: ~~05/20/2020~~01/04/2023	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
~~Douglas A. Hayward~~Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Chief Health Services Officer

POLICY[1]:

All Kern Health Systems (KHS) laboratory contracts require compliance with 42 United States Code 263a, 42 CFR, Part 493, and Chapter 3 (commencing with Section 1200) of Division 2 of the California Business and Professions Code. KHS contracted laboratories from which members receive services are (CLIA) certified.

PROCEDURES:

1.0 PROVIDERS REQUIRED TO BE CLIA CERTIFIED

All contracted providers must have appropriate, current, unrevoked and/or unsuspended CLIA certification for each site location where testing is performed for KHS members, unless the laboratory qualifies for one of the exceptions under the CLIA Regulations. The CLIA regulations established quality standards for laboratory testing to be performed on specimens

from humans, such as blood, body fluid, and tissue, for the purpose of a diagnosis, prevention, or treatment of disease, or assessment of health. All Clinical Laboratories must be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 [2].

2.0 TYPES OF CLIA CERTIFICATION AND ALLOWED PROCEDURES

The following types of CLIA certification are available:

A. **Certificate of Waiver** –Issued to a laboratory that performs waived tests.

B. **Certificate for Provider-Performed Microscopy (PPM) Procedures** – allows a physician, midlevel practitioner, or dentist to perform PPM procedures during the course of a patient's visit and waived tests.

C. **Certificate of Registration** - allows a laboratory to conduct non-waived moderate and/or high complexity laboratory testing until the entity is determined by survey to be in compliance with the CLIA regulations. Only laboratories applying for a certificate of compliance or a certificate of accreditation will receive a certificate of registration.

D. **Certificate of Compliance** - issued to a laboratory after an inspection once the State Agency or CMS Surveyors find the laboratory to be in compliance with all applicable CLIA requirements. Allows a laboratory to conduct non-waived moderate and/or high complexity testing.

E. **Certificate of Accreditation** - issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by Centers of Medicare and Medicaid services (CMS). Allows a laboratory to conduct non-waived moderate and/or high complexity testing.

E.1 – The following seven CMS-approved accreditations organizations are recognized by CMS:

- AABB Accreditation Program
- American Association for Laboratory Accreditation
- Accreditation Association for Hospitals and Health Systems/Healthcare facilities Accreditation Program (AAHHS/HFAP)
- American Society for Histocompatibility and Immunogenetics (ASHI)
- COLA, Inc
- College of American Pathologists (CAP)
- The Joint Commission

2.1 Procedures Subject to CLIA

The law requires that all laboratories performing testing must have a CLIA certificate for each location where testing is performed unless the laboratory qualifies for one of the approved exceptions:

- Laboratories that are not at a fixed location; that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address.
- Not-for-profit or Federal, State or local government laboratories that engage in limited public health testing (not more than a combination of 15 moderately complex or waived tests per certificate) may file a single application.

- Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application for the laboratory sites within the same physical location or street address.

Specimen collection is not subject to CLIA Regulations. All other tests require the appropriate certificate according to CLIA classification. CMS maintains the following lists:

A. Tests Granted Waived Status Under CLIA
B. Provider-performed Microscopy Procedures

Current versions of the list can be found on the internet at www.cms.gov/CLIA.

3.0 DOCUMENTATION AND VERIFICATION OF CLIA CERTIFICATION

Documentation of CLIA compliance for all on-site and reference laboratories is maintained at KHS in the Provider Network Management credentialing system. Copies of valid CLIA certificates are maintained in the electronic provider files.

3.1 Initial Verification & Recredentialing

Providers must include a copy of their current CLIA certificate in their credentialing and recredentialing application packages. CLIA certificates are verified using the CMS website for listings of CLIA Laboratories and other facilities that are certified by the US Government Department of Health and Human Services under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) 42 USC §263a to perform laboratory testing as of the data source date listed at https://qcor.cms.gov/advanced_find_provider.jsp?which=4&backReport=active_CLIA.jsp.

3.2 On-going Verification

Facility inspection will include confirmation that CLIA requirements are met, if applicable during facility site review. Facilities subject to CLIA certification will not be approved without confirmation that these requirements have been satisfied. Copies of valid CLIA certificates with the certificate type must be kept on file in the provider's office and provided upon request to the Provider Network Management Credentialing staff upon ~~renewal~~request. CLIA certificates are verified prior to expiration using the CMS data source website at; https://qcor.cms.gov/advanced_find_provider.jsp?which=4&backReport=active_CLIA.jsp.

REFERENCE:

Revision 2023-01: Section 3 – Added CMS' CLIA Data Source Website used to verify certificates.

[1] **Revision 2020-05:** Recommended by QI to be moved to PNM; PNM Revisions based on credentialing requirements; Policy updated to reflect current CMS/CLIA Regulations CMS.Gov. **Revision 2017-04:** Three year review requested by Compliance. **Revision 2014-10:** Policy reformatted. Policy provided to QI Supervisor for review and/or revision.

[2] DHS Contract Section 3.25

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: February 16, 2023

Re: 2023-2025 KHS Strategic Plan

Background

Every three years, Kern Health Systems (KHS) updates its Corporate Strategic Plan in alignment with its established mission, vision, and values. The strategic plan serves as a roadmap to ensure KHS remains focused and transparent about its direction, has clear directives regarding how the organization will achieve desired goals, and includes strategies for addressing impending industry challenges, identifying new opportunities, and strengthening competitive differentiation, member services, and community impact. In essence, the Corporate Strategic Plan summarizes how KHS will effectively achieve its goals and remain financially viable.

In October of 2022, a strategy meeting was held with the Board of Directors and Executive Team to begin shaping the 2023-2025 KHS Corporate Strategic Plan. This brainstorming session was followed by internal efforts to further define the strategies and key activities to directly support the newly defined Corporate Strategic Plan goals. A high-level summary document was shared with the Board of Directors in December 2022.

Enclosed is a final proposal of the 2023-2025 KHS Corporate Strategic Plan. Jeremy McGuire, Senior Director of Government Relations, and Strategic Development will present a high-level overview of the new 3-year Strategic Plan.

Requested Action

Board of Director's approval of the 2023-2025 Corporate Strategic Plan.

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Kern Health Systems 2023-2025 Strategic Plan

Board of Directors Meeting

February 16, 2023

Background

- In October of 2022, a Board and Executive strategy meeting was held to begin shaping the 2023-2025 KHS strategic plan.
- This was followed by an internal work effort to further define the strategies and key activities to directly support the newly defined Strategic Plan goals.
- A high-level summary document was shared with the Board in December.
- Now requesting Board approval of the KHS strategic plan

Strategic Plan Example

- Each goal has multiple strategies, and each strategy has several key activities
- Below is an example of the key activities outlined for this specific strategy

Goal: Quality and Equity - Deliver exceptional quality outcomes and health equity for KHS members

Strategies Description and Key Activities	Start Date	Due Date
Increase overall quality with a drive toward achieving Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps.		
Define and document annual MCAS analysis and program framework/process	1/1/2023	3/1/2023
Analyze, develop, and implement strategies to Improve administration and timely completion of preventative health services	1/1/2023	6/1/2023
Fortify reporting and monitoring systems for transparency and oversight	1/1/2023	9/1/2023
Expand member engagement processes to improve accountability for Gaps in Care closure across all domains (staff/provider/community)	1/1/2023	6/1/2023
Implement education program (staff/provider/community) outlining quality performance program (QAPI)	3/1/2023	9/1/2023
Strengthen incentives for providers/members for completion of preventative health services	1/1/2023	3/1/2023
Augment outreach through targeted and risk-based segmentation and stratification	1/1/2023	6/1/2023
Expand data integration with providers EMR to support quality measures	1/1/2023	12/31/2023
Establish partnerships through KHS marketing and community events to expand exposure	3/1/2023	6/1/2023
Annual review of outcomes to determine feasibility of long term continuation	6/1/2023	9/1/2023
Review upcoming MCAS measure changes and determine necessary strategies to impact	12/1/2023	2/1/2024
Conduct 2024 process for MCAS analysis, program design, and intervention execution	1/1/2024	12/31/2024
Conduct 2025 process for MCAS analysis, program design, and intervention execution	1/1/2025	12/31/2025
Conduct focus group conversations regarding health equity and identify barriers	3/1/2023	12/31/2023
Develop concrete action plans to address barriers to health equity	6/1/2023	12/31/2023
Measure outcomes resulting from the action plan	1/1/2024	6/1/2024

Goal: Quality and Equity - Deliver exceptional quality outcomes and health equity for KHS members

Strategy: Increase overall quality with a drive toward achieving Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps.

Example Key Activities:

- Expand member engagement processes to improve closure of Gaps in Care
- Implement updated quality education programs
- Conduct focus groups to identify barriers in health equity

Strategy: Meet National Committee for Quality Assurance (NCQA) standards and work toward accreditation.

Example Key Activities:

- Conduct comprehensive internal gap analysis
- Remediate policies, procedures, and staffing to align with NCQA standards
- Conduct mock audit and other readiness activities in advance of accreditation

Goal: Quality and Equity - Deliver exceptional quality outcomes and health equity for KHS members

Strategy: Further maturity of the organization's Health Equity programs under the direction of the Chief Health Equity Officer.

Example Key Activities:

- Develop formalized internal Health Equity Strategy with input from DHCS' Comprehensive Quality Strategy
- Assess priority areas and opportunities for Health Equity trainings
- Conduct 2023 Health Equity trainings as identified
- Develop the 2024 and 2025 Health Equity Strategies

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Goal: Workforce - Develop initiatives for the recruitment and retention of both internal and external workforce needed to fulfill KHS' mission

Strategy: Identify Provider Network needs and gaps to inform target areas and approaches.

Example Key Activities:

- Continually assess network capacity and accessibility
- Incorporate assessment findings into Provider Network Management's workplan

Strategy: Strengthen and expand the KHS provider network through innovative and effective recruitment and retention programs.

Example Key Activities:

- Develop recruitment and contract strategy
- Conduct recruitment efforts based off findings in the needs assessment
- Explore partnerships to expand available residency slots
- Create scholarship programs for RNs and LCSWs to support non-physician workforce

Goal: Workforce - Develop initiatives for the recruitment and retention of both internal and external workforce needed to fulfill KHS' mission

Strategy: Identify business needs and gaps in current workforce to inform target areas and approaches.

Example Key Activities:

- Talent and Development team meet with Department Leadership to assess needs and gaps
- Collaborate with HR leaders in other Local Plans to share growth strategies and compare organizational structures

Strategy: Meet the growing operational demands of the organization by creating recruitment and retention programs for internal staffing and leadership needs.

Example Key Activities:

- Update the KHS Recruitment and Retention Plan to include a 3-year outlook
- Develop and expand internship programs
- Conduct onsite career events

Goal: CalAIM - Continue to develop, implement, and grow the programs and policies included under DHCS' CalAIM initiative

Strategy: Continued growth and maturity of existing CalAIM programs – Population Health Management, Enhanced Care Management, Community Supports, and Long-Term Care.

Example Key Activities:

- Expansion of Enhanced Care Management and Community Supports to additional provider sites
- Expansion and maturity of the Long-Term Care program

Strategy: Strengthen Existing and Establish New Community Partnerships to Support CalAIM.

Example Key Activities:

- Enhance and support network of Enhanced Care Management and Community Supports providers through the CalAIM Incentive Program (IPP), and other grant programs
- Establish collaborations with new Community Based Organizations

Goal: CalAIM - Continue to develop, implement, and grow the programs and policies included under DHCS' CalAIM initiative

Strategy: Ongoing collaboration between KHS staff and the Department of Health Care Services (DHCS) on the development and implementation of future CalAIM initiatives.

Example Key Activities:

- Development and implementation of future Enhanced Care Management Populations of Focus
- Development and implementation of future Community Supports Benefits
- Transition and management of additional Long-Term Care populations

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Goal: Medicare Duals Special Needs Plan (D-SNP) - Develop and implement a competitive Medicare Duals Special Needs Plan (D-SNP) product in alignment with State and Federal requirements

Strategy: Development of the long-term D-SNP strategy and implementation roadmap.

Example Key Activities:

- Develop Medicare business strategy and timeline delivery plan
- Develop & Design 3-year Roadmap to document end-to-end product development
- Develop budget and plan for delivering MA capabilities

Strategy: Analysis of the appropriate market factors to maximize the competitiveness of the product.

Example Key Activities:

- Complete initial Market and competitor analysis
- Annual updates to the Market and competitor analysis

Goal: Medicare Duals Special Needs Plan (D-SNP) - Develop and implement a competitive Medicare Duals Special Needs Plan (D-SNP) product in alignment with State and Federal requirements

Strategy: Design and implementation of an efficient Medicare D-SNP offering with competitive advantages, leveraging KHS innovation and new business/new product development capabilities.

Example Key Activities:

- Conduct organization-wide effort to understand Medicare requirements
- Develop resource plan, staffing model & operating model
- Designs solutions and determine build vs. buy strategies
- Procure required vendors and delegates

Goal: Behavioral Health - Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions

Strategy: Development and maturity of an internal Behavioral Health Department.

Example Key Activities:

- Develop internal Behavioral Health framework including policies and procedures
- Identify and hire required staff to screen members and coordinate care with BH providers
- Update provider contracting to support screening and management of members seeking Behavioral Health services

Strategy: Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS).

Example Key Activities:

- Evaluate and assess the NSMHS network adequacy
- Conduct geographic accessibility analysis and mapping
- Incorporate identified shortages into the Provider Network workforce initiatives

Goal: Behavioral Health - Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions

Strategy: Communication and coordination with County Behavioral Health regarding DHCS requirements.

Example Key Activities:

- Participate in Quality Improvement & Clinical Oversight Quarterly Meetings
- Implement recurring member data sharing with Kern Behavioral Health and Recovery Services
- Implement process for coordination based on Monthly Referral Outcome Reports

Strategy: Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment services.

Example Key Activities:

- Identify and Contract with Network PCPs who are certified to provide Medication Assisted Treatment (MAT)
- Develop processes to identify and refer Members to MAT providers
- Expand sharing of Admission, Discharge, and Transfer (ADT) data with hospitals

Goal: Member Engagement- Increase member engagement in their health care

Strategy: Identify and implement innovative and effective offerings designed to engage members more in their health care.

Example Key Activities:

- Identify key causes (cultural, geographical, social barriers) of members who are not engaged in their own healthcare
- Develop strategies in collaboration with providers and community partners to meet the member where they are to improve their engagement
- Develop member engagement programs to improve access to care in ways that will improve health status

Strategy: Work with internal staff and external partners to develop strategies that ensure continuity of coverage for our members.

Example Key Activities:

- Operationalize agreement with the Kern County Department of Human Services (KCDHS) to include data sharing and staffing
- Create timely member outreach strategies to target members who must complete the renewal process, including those hard-to-reach members

Goal: Member Engagement- Increase member engagement in their health care

Strategy: Leverage convenient technology to enhance the effectiveness of engagement and suit members' needs.

Example Key Activities:

- Procure and implement an updated Member Rewards solution
- Expand use of technology for staff/providers to conduct member assessments to identify care needs
- Leverage existing and new data to inform stakeholders of relevant health information to close gaps in care

Goal: KHS Foundation - Explore the opportunity for KHS to create a non-profit foundation to further its mission in the community

Strategy: Conduct exploratory analysis of the necessary major components needed for the creation of a KHS non-profit foundation.

Example Key Activities:

- Conduct internal analysis of requirements, structure, and financing mechanisms
- Determine feasibility and develop implementation roadmap recommendation
- Review recommendation with the Board of Directors to determine next steps

Next Steps

- Staff will continue to provide quarterly Board updates which will provide insight on specific undertakings.
- Staff will continue to monitor current industry and regulatory trends. Key Activities will be evaluated and updated accordingly.
- This Strategic Plan will drive annual departmental goals and objectives, project planning, and the budgeting process.

Requested Action

Requesting Board of Directors approval of the 2023-2025 Corporate Strategic Plan.

Strategic Goal:		
Deliver exceptional quality outcomes and health equity for KHS members		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Increase overall quality with a drive toward achieving Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps.		
Define and document annual MCAS analysis and program framework/process	1/1/2023	3/1/2023
Analyze, develop, and implement strategies to Improve administration and timely completion of preventative health services	1/1/2023	6/1/2023
Fortify reporting and monitoring systems for transparency and oversight	1/1/2023	9/1/2023
Expand member engagement processes to improve accountability for Gaps in Care closure across all domains (staff/provider/community)	1/1/2023	6/1/2023
Implement education program (staff/provider/community) outlining quality performance program (QAPI)	3/1/2023	9/1/2023
Strengthen incentives for providers/members for completion of preventative health services	1/1/2023	3/1/2023
Augment outreach through targeted and risk-based segmentation and stratification	1/1/2023	6/1/2023
Expand data integration with providers EMR to support quality measures	1/1/2023	12/31/2023
Establish partnerships through KHS marketing and community events to expand exposure	3/1/2023	6/1/2023
Annual review of outcomes to determine feasibility of long term continuation	6/1/2023	9/1/2023
Review upcoming MCAS measure changes and determine necessary strategies to impact	12/1/2023	2/1/2024
Conduct 2024 process for MCAS analysis, program design, and intervention execution	1/1/2024	12/31/2024
Conduct 2025 process for MCAS analysis, program design, and intervention execution	1/1/2025	12/31/2025
Conduct focus group conversations regarding health equity and identify barriers	3/1/2023	12/31/2023
Develop concrete action plans to address barriers to health equity	6/1/2023	12/31/2023
Measure outcomes resulting from the action plan	1/1/2024	6/1/2024
Meet National Committee for Quality Assurance (NCQA) standards and work toward accreditation.		
Establish training program for internal staff on NCQA standards and processes	1/1/2023	6/1/2023
Delivery of comprehensive readiness review and action plan to Executive team to identify gaps	1/1/2023	12/31/2023
Explore NCQA accreditation process for Health Equity	3/1/2023	12/31/2023
Align Health Plan Accreditation with Health Equity Accreditation and Medicare Advantage	1/1/2023	6/1/2023
NCQA standards, policy, and staffing remediation to drive timeline development towards application	6/1/2023	12/1/2023
Document, design, build, test, and begin to implement systems and reporting requirements	1/1/2024	12/1/2024
Conduct readiness activities including Mock Audit	9/1/2024	3/1/2025
Submission of application for Health plan accreditation	3/1/2025	12/1/2025
Submission of application for Health Equity accreditation	6/1/2025	12/1/2025
Execute communication and marketing plan in preparation for final readiness	9/1/2025	12/1/2025
Further maturity of the organization's Health Equity programs under the direction of the Chief Health Equity Officer.		

Strategic Goal:		
Deliver exceptional quality outcomes and health equity for KHS members		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Identify and hire required staff to manage health equity programs and conduct thorough analysis	1/1/2023	5/31/2023
Develop formalized internal Health Equity Strategy with input from DHCS' Quality Strategy	1/1/2023	9/30/2023
Assess and identify organizational culture gaps related to Diversity, Equity, and Inclusion (DEI)	1/1/2023	12/31/2023
Launch DEI program to address internal gaps and solidify health equity awareness and understanding	1/1/2023	12/31/2023
Develop formal Health Equity framework and structure, including policies and procedures	1/1/2023	12/31/2023
Assess priority areas and opportunities for future Health Equity trainings	3/1/2023	12/31/2023
Conduct 2023 Health Equity trainings as identified	9/1/2023	12/31/2023
Prepare 2024 Health Equity Strategy	6/1/2023	9/30/2023
Implement program changes needed based on the 2024 Strategy	1/1/2024	6/30/2024
Prepare 2025 Health Equity Strategy	6/1/2024	9/30/2024
Implement program changes needed based on the 2025 Strategy	1/1/2025	6/30/2025

Strategic Goal:		
Develop initiatives for the recruitment and retention of both internal and external workforce needed to fulfill KHS' mission		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Identify Provider Network needs and gaps to inform target areas and approaches.		
Continually assess regulatory network capacity and accessibility requirements for goal setting	1/1/2023 (annually)	6/30/2023 (annually)
Incorporate findings into Provider Network Management workplan including network expansion activities	4/1/2023 (annually)	12/31/2023 (annually)
Analyze network changes to gauge success in growing network	10/1/2023 (annually)	3/31/2024 (annually)
Strengthen and expand the KHS provider network through innovative and effective recruitment and retention programs.		
Continue on-going recruitment efforts based off previously identified needs assessment (LTC, out of area specialist contracting, etc.)	1/1/2023 (annually)	12/31/2023 (annually)
Utilizing provider gap assessment, strategically develop recruitment/contracting strategy	4/1/2023 (annually)	12/31/2023 (annually)
Collaborate internally to develop and implement programs designed to address identified gaps	4/1/2023 (annually)	12/31/2023 (annually)
Explore partnerships to expand available residency programs	1/1/2023	12/31/2023
Continue expansion of providers utilizing telehealth in light of DHCS' approved service delivery options	4/1/2023	12/31/2023
Create scholarship programs for RNs and LCSWs to support non-physician workforce	1/1/2023 (annually)	12/31/2023 (annually)
Identify business needs and gaps in current workforce to inform target areas and approaches.		
Talent & Development team meet with each department's leadership to determine current and future workforce/staffing needs of their department to meet their strategic goals	1/15/2023 (annually)	3/15/2023 (annually)
Monitor current and ongoing unemployment status by sectors quarterly to stay abreast of the available talent pools both locally and statewide to meet our growth strategy	3/15/2023	Each quarter end
Collaborate with other Local Plan HR Leaders to share our growth strategies and compare and contrast organizational structures to identify any gaps in our organizational structure	2/1/2023	Monthly
Remain informed and up to date on industry standards of staffing ratios, i.e., employee to member and supervisor to staff. This will ensure appropriate staffing levels for each business unit	3/1/2023 (annually)	6/1/2023 (annually)
Work with Medicare leadership to develop a plan and strategy for the Medicare workforce recruitment	7/1/2024	12/31/2024
Meet the growing operational demands of the organization by creating recruitment and retention programs for internal staffing and leadership needs.		
Conduct Semi-Annual Onsite Career Events	1/1/2023	12/31/2023
Implement CSUB and BC internship programs	1/1/2023	6/1/2023
Implement Talent Intelligence Module in Dayforce inclusive of Dayforce Skills Engine, Ideal Talent Marketplace and Career Explorer in Charter	7/1/2023	9/30/2023
Update and revise the KHS Recruitment and Retention Plan to include a 3 -yr. outlook	2/1/2023 (annually)	3/30/2023 (annually)

Strategic Goal:		
Develop initiatives for the recruitment and retention of both internal and external workforce needed to fulfill KHS' mission		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Conduct an Employee Survey regarding post-secondary education to inform internal mobility strategy	2/1/2023	6/30/2023
Restart the KHS Summer Internship Program with expanded opportunities for college students and business school students	3/1/2023 (annually)	9/30/2023 (annually)
Update and revise the KHS sign-on bonus program to be more market competitive	2/1/2023	6/30/2023
Execute the Medicare workforce strategy to recruit, hire and onboard in preparation of program go-live	1/1/2025	12/31/2025

Strategic Goal:		
Continue to develop, implement, and grow the programs and policies included under DHCS' CalAIM initiative		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Continued growth and maturity of existing CalAIM programs – Population Health Management, Enhanced Care Management, Community Supports, and Long-Term Care.		
2023 expansion of Enhanced Care Management to 4-6 new provider sites	1/1/2023	12/31/2023
2023 expansion of existing Community Support Services to new 4-6 providers	1/1/2023	12/31/2023
Deliver, exchange and execute data quality management between KHS and providers	1/1/2023	12/31/2023
Improve administration and timely completion of preventative health screenings by providers serving populations and patients adversely affected by disparities in a multipronged approach	4/1/2023	12/31/2023
Expand and enhance equitable access to comprehensive, quality and culturally competent health care services in Long-Term Care settings	1/1/2023	12/31/2023
2024 expansion of Enhanced Care Management to new provider sites	1/1/2024	12/31/2024
2024 expansion of existing Community Support Services to new providers	1/1/2024	12/31/2024
2025 expansion of Enhanced Care Management to new provider sites	1/1/2025	12/31/2025
2025 expansion of existing Community Support Services to new providers	1/1/2025	12/31/2025
Strengthen Existing and Establish New Community Partnerships to Support CalAIM.		
Develop strategic partnerships in the community to promote, enhance, and expand the Enhanced Care Management and Community Supports programs (annually)	1/1/2023	12/31/2023
Enhance and support network of Enhanced Care Management and Community Supports providers through the CalAIM Incentive Program (IPP), and other grant programs	1/1/2023	12/31/2023
Establish collaborations with new Community Based Organizations such as parole/probation, homeless shelters, CBAS Centers, Aging and adult collaborations (annually)	4/1/2023	12/31/2023
Ongoing collaboration between KHS staff and the Department of Health Care Services (DHCS) on the development and implementation of future CalAIM initiatives.		
Execute the transition of Long Term Care services for members in Intermediate/Subacute Care Facilities	7/1/2023	4/30/2024
Implement Enhanced Care Management for the Child/Youth Population of Focus	4/1/2023	12/31/2023
Implement Enhanced Care Management for pregnancy Population of Focus	10/1/2023	6/30/2024
Implement Enhanced Care Management for Justice Involved Population of Focus	10/1/2023	6/30/2024
Implement 2 New Community Supports Benefits	10/1/2023	6/30/2024
Work with DHCS to integrate with the State's Population Health Management Service	4/1/2023	12/31/2023

Strategic Goal:		
Develop and implement a competitive Medicare Duals Special Needs Plan (D-SNP) product in alignment with State and Federal requirements		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Development of the long-term D-SNP strategy and implementation roadmap.		
Develop Medicare business strategy and timeline delivery plan	1/1/2023	7/31/2023
Develop Compliance strategy & readiness plan	3/1/2023	8/30/2023
Develop Health Services strategy and population health risk analysis	2/1/2023	12/31/2023
Develop & Design 3-year Roadmap to document end to end product development	1/1/2023	12/31/2023
Develop budget and plan for delivering MA capabilities	1/1/2023	9/1/2025
Medicare Strategy and Strategic Roadmap implementation	1/1/2024	10/1/2025
Analysis of the appropriate market factors to maximize the competitiveness of the product.		
Complete initial Market and competitor analysis	1/1/2023	5/1/2023
Update competitor and market analysis for 2024	1/1/2024	5/1/2024
Update competitor and market analysis for 2025	1/1/2025	5/1/2025
Design and implementation of an efficient Medicare D-SNP offering with competitive advantages, leveraging KHS innovation and new business/new product development capabilities.		
Use Capability framework across functional area's to assign and complete requirement gathering	1/1/2023	7/15/2023
Create Resource plan, staffing model & operating model	1/1/2023	12/31/2023
Update Resource plan, staffing model & operating model	1/1/2024	12/31/2024
Solution Definitions and designs	1/1/2023	9/1/2023
Develop provider network strategy	1/1/2023	12/31/2023
Conduct procurement for required vendors & delegates	4/1/2023	12/31/2023
Conduct core platform test, IT estimates	8/1/2023	12/31/2023
Complete business and technical solutions, including designs with budget estimates for people, process, and technology	10/1/2023	12/31/2023
Finalize strategies & Approach, budget and develop 2024 plan	9/1/2023	12/31/2023
Development and testing for Delivery of the intended solution or selected solutions and implementation	1/1/2024	12/31/2024
Stand up end-to-end Medicare product and operationalization of a MA D-SNP	1/1/2025	10/1/2025

Strategic Goal:		
Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Development and maturity of an internal Behavioral Health Department.		
Identify and hire required staff to screen members and coordinate care with BH providers	1/1/2023	6/30/2023
Develop internal Behavioral Health framework including policies and procedures	1/1/2023	5/31/2023
Update provider contracts to support screening and management of members seeking Behavioral Health	2/1/2023	6/30/2023
Prepare 2024 Program Strategy	6/1/2023	9/30/2023
Implement program changes needed based on the 2024 Strategy	1/1/2024	6/30/2024
Prepare 2025 Program Strategy	6/1/2024	9/30/2024
Implement program changes needed based on the 2025 Strategy	1/1/2025	6/30/2025
Participate in NCQA readiness and accreditation process	1/1/2024	12/31/2025
Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS).		
Ensure network adequacy standards are met based on appointment type, appointment availability and grievances (annually)	1/1/2023	12/31/2023
Conduct geographic accessibility analysis and mapping (annually)	4/1/2023	12/31/2023
Track timely access from point of referral to initial appointment to ensure standard of 10 business days are met (annually)	4/1/2023	9/30/2023
Work with Care Coordination Unit (CCU) to problem solve delays and provide alternative providers available within network to serve members (annually)	1/1/2023	12/31/2023
Continue quarterly surveys to providers to obtain Point of Contact (POC) access time (annually)	1/1/2023	12/31/2023
Incorporate identified shortages into the Provider Network workforce initiatives (annually)	1/1/2023	12/31/2023
Communication and coordination with County Behavioral Health regarding DHCS requirements.		
Participate in joint Quality & Clinical Oversight Quarterly Meetings with Kern Behavioral Health (annually)	1/1/2023	12/31/2023
Participate in monthly small work groups to maintain efficiency in processes (annually)	1/1/2023	12/31/2023
Implement process for coordination based on Monthly MCP-MHP Referral Outcome Reports	4/1/2023	9/30/2023
Implement recurring member data sharing with Kern Behavioral Health and Recovery Services	1/1/2023	12/31/2023
Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment services.		
Identify Network PCPs who are certified to provide Medication Assisted Treatment services	2/1/2023	6/31/2023

Strategic Goal:		
Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Modify contracting arrangements to support Medication Assisted Treatment service coverage	6/1/2023	9/30/2023
Implement sharing of Admission, Discharge, and Transfer (ADT) data with hospitals	1/1/2023	3/31/2023
Develop the process to identify and refer Members to Medication Assisted Treatment providers	7/1/2023	9/30/2023
Develop and implement oversight and monitoring processes	10/1/2023	12/31/2023
Identify and contract with additional Medication Assisted Treatment services providers (annually)	1/1/2024	6/30/2024
Assess member satisfaction with Medication Assisted Treatment services program/providers (annually)	4/1/2024	6/30/2024

Strategic Goal:		
Increase member engagement in their health care		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Identify and implement innovative and effective offerings designed to engage members more in their health care.		
Develop centralized policies and procedures for the execution of Member Engagement programs	1/1/2023	6/30/2023
Identify key causes (cultural, geographical, social barriers) of members who are not engaged in their own healthcare	1/1/2023	5/31/2023
Develop strategies in collaboration with providers and community partners to meet the member where they are to improve their engagement	2/1/2023	4/30/2023
Develop member engagement programs to improve access to care in ways that will improve health status	3/1/2023	12/31/2023
Develop performance standards, data tracking system and reporting structure for the member engagement programs	3/1/2023	12/31/2023
Evaluate Member Transportation Program and implement enhancements to improve access, effectiveness, and efficiency	1/1/2024	12/30/2024
Co-Locate Member Engagement Staff in Community Settings	3/1/2023	9/30/2023
Prepare 2024 Member Engagement Strategy	6/1/2023	9/30/2023
Implement Member Engagement Programs based on the 2024 Strategy	1/1/2024	6/30/2024
Prepare 2025 Member Engagement Strategy	6/1/2024	9/30/2024
Implement Member Engagement Programs based on the 2025 Strategy	1/1/2025	6/30/2025
Work with internal staff and external partners to develop strategies that ensure continuity of coverage for our members.		
Operationalize agreement with the Kern County Department of Human Services (KCDHS) to include data sharing and staffing	1/1/2023	3/31/2023
Develop procedures for a seamless coordination between KCDHS and KHS internal staff to ensure improved member experience	1/1/2023	3/31/2023
Develop processes to provide KHS staff, providers, community partners, and members access to accurate renewal date information and status	1/1/2023	3/31/2023
Create timely member outreach strategies to target members who must complete the renewal process, including those hard-to-reach members	1/1/2023	12/31/2023
Create post PHE Unwinding Medi-Cal renewal process to continue collaboration with KCDHS, providers, and community partners to ensure continuity of coverage for eligible members	1/1/2024	12/31/2024
Leverage convenient technology to enhance the effectiveness of engagement and suit members' needs.		
Conduct procurement for updated Member Rewards partner	3/1/2023	10/31/2023

Strategic Goal:		
Increase member engagement in their health care		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Implement new Member Rewards partner	11/1/2023	6/30/2024
Expand use of technology for staff/providers to conduct member assessments to identify care needs	2/1/2023	12/31/2023
Review member assessment needs, update technology, expand to additional providers	1/1/2024	12/31/2024
Leverage existing and new data to inform stakeholders of relevant health information to close gaps in care	2/1/2023	12/31/2023
Explore options to systematically track and consolidate all KHS staff member interactions to provide oversight and visibility across departments	1/1/2023	3/31/2023

Strategic Goal:		
Explore the opportunity for KHS to create a non-profit foundation to further its mission in the community		
Strategies Description and Key Activities	**Start Date**	**Due Date**
Conduct exploratory analysis of the necessary major components needed for the creation of a KHS non-profit foundation.		
Conduct internal analysis of requirements, structure, and financing mechanisms	2/1/2023	4/30/2023
Determine feasibility and develop implementation roadmap recommendation	5/1/2023	8/31/2023
Review recommendation with the Board of Directors to determine next steps	6/1/2023	12/31/2023

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: February 16, 2023

Re: 2023 Marketing Plan and Advertising Campaign

Background

The objective of our 2023 Marketing Plan is to remain the Health Plan of choice for the Medi-Cal population of Kern County.

Our Marketing Goals in 2023 are:

1. Member Retention (at 2022 membership level of 350,000 enrollees).
2. Member Growth (approximating 15,000 new enrollees expected in 2023). Increase KFHC presence in Ridgecrest.
3. Continued outreach to enrollment gateways (e.g. safety-net providers, community-based organizations and Kern County Department of Human Services) to support new enrollment and reenrollment efforts.
4. Retain current Medi-Cal member voluntary selection rate of over 80%.
5. Maintain 80% Medi-Cal managed care market share.
6. Begin marketing and branding for the Medicare population.

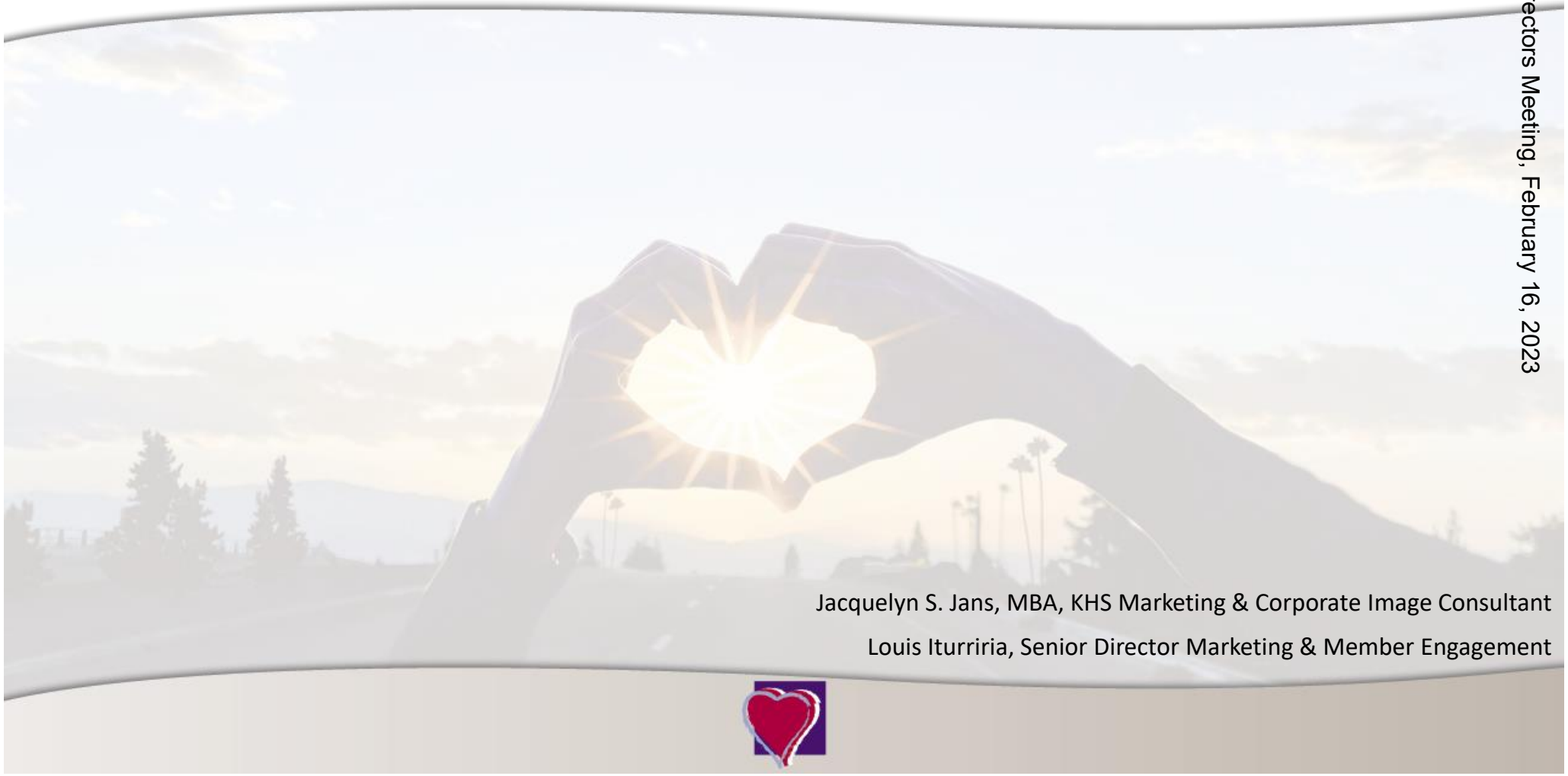
The enclosed PowerPoint presentation covers our new advertising media campaign and key areas KHS's Marketing Department will undertake or become involved with if we are to achieve our 2023 Marketing Goals.

Our "You + Us = a better day!" media campaign leverages our 25+ years foundation and commitment to our community. The vision for our "You + Us = a better day!" media campaign emphasizes our Kern County roots as an organization that provides health care benefits and programs specific to the needs and circumstances of Kern County's Medi-Cal population.

Requested Action

Receive and File.

2023 Marketing Plan and Advertising Campaign



Jacquelyn S. Jans, MBA, KHS Marketing & Corporate Image Consultant

Louis Iturriria, Senior Director Marketing & Member Engagement

Marketing Goal

KHS' marketing goal is to remain the Health Plan of choice for the low-income population of Kern County

Demonstrated through:

- Kern Family Health Care serving one of three Kern County residents
- Kern Family Health Care being the largest health plan in Kern County with enrollment of over 365,000 members

2023 Marketing Objectives

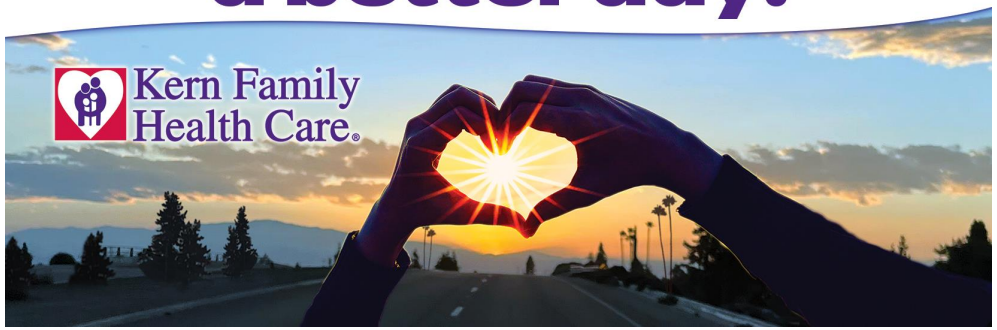
1. Member Retention (at 2022 membership level of 350,000 enrollees).
2. Member Growth (approximating 15,000 new enrollees expected in 2023). Increase KFHC presence in Ridgecrest.
3. Continued outreach to enrollment gateways (e.g. safety-net providers, community-based organizations and Kern County Department of Human Services) to support new enrollment and reenrollment efforts.
4. Retain current Medi-Cal member voluntary selection rate of over 80%.
5. Maintain 80% Medi-Cal managed care market share.

2023-2024 Advertising Campaign Strategy

- Keep the KFHC brand in the mind of our members and potential members
- Protect KFHC's positive reputation/brand among our constituents (providers, members and community)
- Reinforce our brand of being a local, responsive and caring health plan
- Emphasize our Kern County roots…as an organization that provides health care benefits and programs specific to the needs and circumstances of Kern County's Medi-Cal population
- Coming off of three intense years with COVID, we need to calm fear and reinstate "back to basics"
- Goal is to keep this Campaign simple, due to the complexity of previous Campaigns (when we educated who, where and what we are).

Billboard/Transit/Digital/Print Campaign

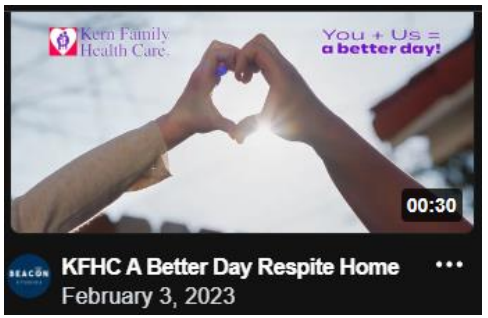
You + Us =
a better day!



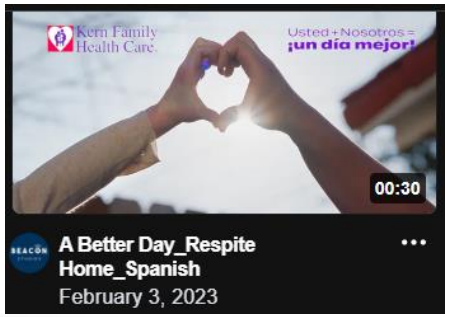
Usted + Nosotros =
¡un día mejor!

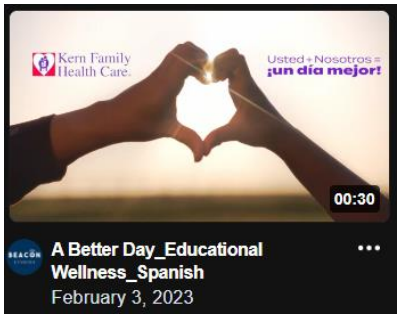
Television Campaign

English :30 second commercials (click on each graphic for links)



Spanish :30 second commercials (click on each graphic for links)





4 Key Areas of Involvement for Achieving our 2023 Marketing Objectives

Area 1. Manage 2023 media campaign, including campaign development and launch, to convey message and KFHC language to target populations.

Area 2. Through our public relations activities, continue to demonstrate to our community why Kern Family Health Care is the health plan of choice for Med-Cal beneficiaries in Kern County.

Area 3. Continue to support non-profit community partners serving our same population through nominal community-based organization grants.

Area 4. Sponsor health related events and charitable fundraising activities which promote health, address disease or improve the quality of life of Kern County's low-income population.

You + Us = **a better day!**

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: February 16, 2023

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
December 31, 2022

Short Term Portfolio (under 1 year)

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

Description			Dollar Amount	% of Portfolio	Maximum Allowed Per Policy	Approximate Current Yield	Liquidity	Principal Fluctuation
Wells Fargo - Cash		(1)	$ 2,900,000	0.69%	100%		1 Day	None
Money Market Accounts	(A)	(1)	$ 24,100,000	5.74%	40%	4.10%	1 Day	None
Local Agency Investment Fund (LAIF)	(B)	(2)	$ 74,500,000	17.76%	50%	1.98%	2 Days	None
US T-Bills & Federal Agencies at Wells Fargo		(1)	$ 244,600,000	58.29%	100%	3.74%	1 Day	Subject to Interest Rate Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)	(1)	$ 4,100,000	0.98%		1.80%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 350,200,000	83.46%		3.34%		

Long Term Port Folio (1 - 5 years)

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

UBS Managed Portfolio	(D)		$ 59,500,000	14.18%		4.88%	3 Days	Subject to Interest Rate and Credit Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)		$ 9,900,000	2.36%		4.53%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 69,400,000	16.54%		4.83%		
Total Portfolio			$ 419,600,000	100.00%		3.58%		

Yield Curve	Treasuries	Yield Curve AA Corporate Bonds	A Corporate Bonds	CD's
1 year	4.76%	4.80%	4.85%	4.70%
2 year	4.47%	4.64%	4.80%	4.50%
3 year	4.24%	4.59%	4.75%	4.20%
5 year	3.95%	4.53%	4.76%	4.00%

(A) Money market fund comprised of US Treasury and Repurchase Agreement Obligations.
(B) LAIF is part of a $200 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 2023 capital projects.

UBS

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

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

UBS Client Review

as of December 31, 2022

Prepared for

Kern Health Systems

Accounts included in this review

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

What's inside

UBS

Portfolio review

as of December 31, 2022

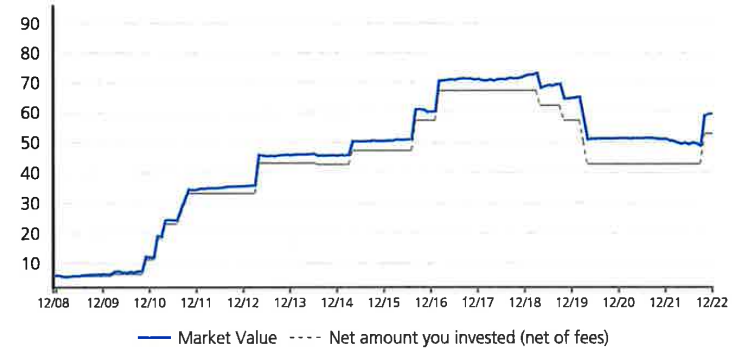
EX XX120 • BOND PORTFOLIO • Portfolio Management Program
Prepared for **Kern Health Systems**
Risk profile: Conservative
Return Objective: Current Income

Asset allocation review

		Value on 12/31/2022 ($)	% of Portfolio
A	**Cash**	**77,477.04**	**0.13**
	Cash	77,477.04	0.13
	US	77,477.04	0.13
B	**Fixed Income**	**59,413,099.80**	**99.87**
	US	59,413,099.80	99.87
	Government	6,668,558.42	11.21
	Corporate IG Credit	52,744,541.38	88.66
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	**$59,490,576.84**	**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 12/31/2021 to 03/31/2022	For the period of 03/31/2022 to 06/30/2022	For the period of 06/30/2022 to 09/30/2022	For the period of 09/30/2022 to 12/31/2022
Opening value	**51,044,313.37**	**49,921,494.38**	**49,436,575.37**	**48,891,651.24**
Net deposits/withdrawals	-16,286.52	-15,979.52	-16,089.16	9,983,979.61
Div./interest income	153,776.90	292,223.52	183,397.34	259,091.84
Change in accr. interest	75,535.73	-57,125.76	65,091.19	67,996.15
Change in value	-1,335,845.10	-704,037.25	-777,323.50	287,858.00
Closing value	**49,921,494.38**	**49,436,575.37**	**48,891,651.24**	**59,490,576.84**
Net Time-weighted ROR	-2.20	-0.97	-1.10	1.06

Net deposits and withdrawals include program and account fees.

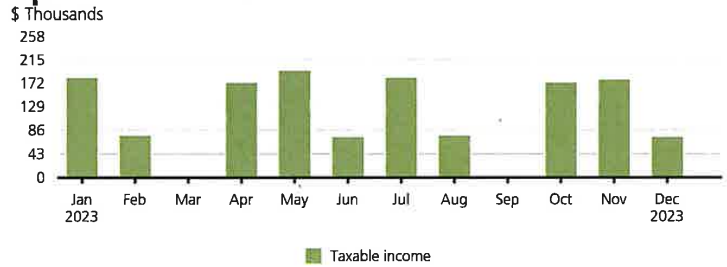
Summary of gains and losses

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

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

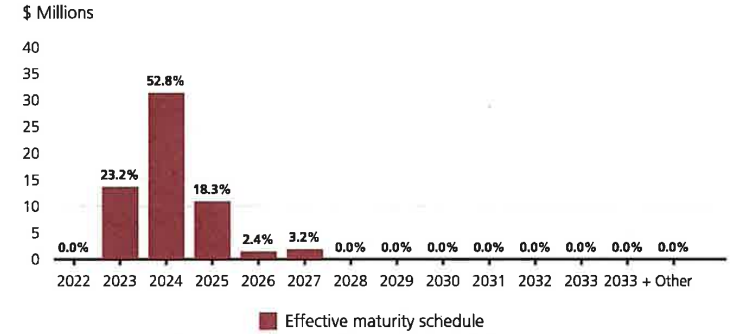
Portfolio review - as of December 31, 2022 (continued)

Expected cash flow



Total taxable income: $1,405,287.50
Total expected cash flow: $1,405,287.50
Cash flows displayed account for known events such as maturities and mandatory puts.

Bond maturity schedule



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

Equity sector analysis

Compared to S&P 500 index

	Value on 12/31/2022 ($)	Actual (%)	Model (%)	Gap (%)
Communication Services	0.00	0.00	7.79	-7.79
Consumer Discretionary	0.00	0.00	10.55	-10.55
Consumer Staples	0.00	0.00	7.43	-7.43
Energy	0.00	0.00	5.02	-5.02
Financials	0.00	0.00	11.29	-11.29
Health Care	0.00	0.00	14.93	-14.93
Industrials	0.00	0.00	8.49	-8.49
Information Technology	0.00	0.00	25.63	-25.63
Materials	0.00	0.00	2.73	-2.73
Real Estate	0.00	0.00	2.54	-2.54
Utilities	0.00	0.00	2.83	-2.83
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.

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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 December 31, 2022 (continued)

Summary of performance by account

		Performance start date	Value on 12/31/2022 ($)	% of portfolio		Performance returns (annualized > 1 year) For the period of 12/31/2021 to 03/31/2022	For the period of 03/31/2022 to 06/30/2022	For the period of 06/30/2022 to 09/30/2022	For the period of 09/30/2022 to 12/31/2022
EX XX120	BOND PORTFOLIO•PMP•The Cohen Group Fixed Income - PIV Risk profile: Conservative Return objective: Current Income	Dec 08, 2008	59,490,576.84	100.00%	Net time-weighted	-2.20%	-0.97%	-1.10%	1.06%
Total Portfolio		**Dec 08, 2008**	**$59,490,576.84**	**100%**	**Net time-weighted**	**-2.20%**	**-0.97%**	**-1.10%**	**1.06%**

Benchmarks - Annualized time-weighted returns	For the period of 12/31/2021 to 03/31/2022	For the period of 03/31/2022 to 06/30/2022	For the period of 06/30/2022 to 09/30/2022	For the period of 09/30/2022 to 12/31/2022
Blended Index	-2.48%	-0.81%	-1.36%	1.12%
Blended Index 2	-1.21%	-0.47%	-0.58%	1.00%
US Treasury Bill - 3 Mos	0.03%	0.12%	0.47%	0.89%
BBG US Agg (1-3 Y)	-2.50%	-0.64%	-1.50%	0.90%
S&P 500	-4.60%	-16.10%	-4.88%	7.56%

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

UBS

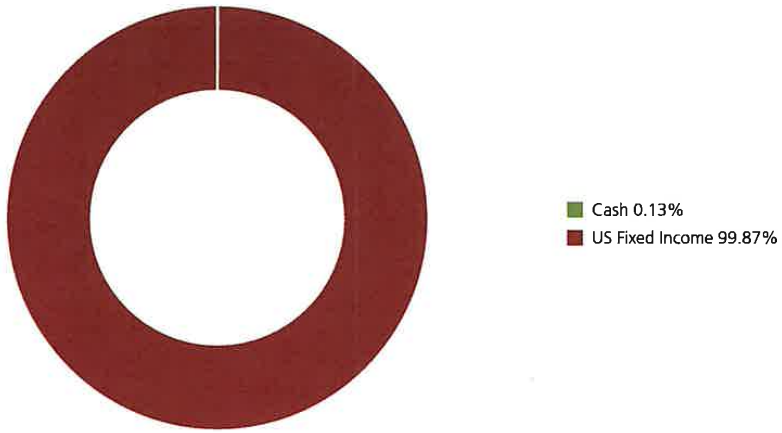
Asset allocation review

as of December 31, 2022

Summary of asset allocation

	Market value ($)	% of Portfolio
Cash	**77,477.04**	**0.13**
Cash	77,477.04	0.13
Fixed Income	**59,413,099.80**	**99.87**
US	59,413,099.80	99.87
Equity	**0.00**	**0.00**
Commodities	**0.00**	**0.00**
Non-Traditional	**0.00**	**0.00**
Other	**0.00**	**0.00**
Total Portfolio	**$59,490,576.84**	**100%**

Balanced mutual funds are allocated in the 'Other' category



UBS

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

Asset allocation by account

as of December 31, 2022

		Equities ($/%)			Fixed Income ($/%)						
	Cash ($/%)	U.S.	Global	International	U.S.	Global	International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	**Total**
	77,477.04	**0.00**	**0.00**	**0.00**	**59,413,099.80**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$59,490,576.84**
Total Portfolio	**0.13**	**0.00**	**0.00**	**0.00**	**99.87**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**
	77,477.04	0.00	0.00	0.00	59,413,099.80	0.00	0.00	0.00	0.00	0.00	**$59,490,576.84**
	0.13	0.00	0.00	0.00	99.87	0.00	0.00	0.00	0.00	0.00	**100.00%**

EX XX120 . BOND PORTFOLIO . BSA PMP

Risk profile: Conservative
Return objective: Current Income

		Equities ($/%)			Fixed Income ($/%)						
	Cash ($/%)	U.S.	Global	International	U.S.	Global	International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	**Total**
	77,477.04	**0.00**	**0.00**	**0.00**	**59,413,099.80**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$59,490,576.84**
Total Portfolio	**0.13**	**0.00**	**0.00**	**0.00**	**99.87**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**

Balanced mutual funds are allocated in the 'Other' category

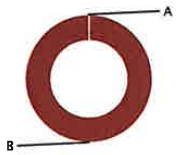
Portfolio holdings

as of December 31, 2022

Summary of Portfolio Holdings

	Cost basis ($)	Value on 12/31/2022 ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of Portfolio
A Cash	**77,477.04**	**77,477.04**	**0.00**	**0.00%**	**0.00**	**0.00%**	**0.13%**
Cash	77,477.04	77,477.04	0.00	0.00%	0.00	0.00%	0.13%
B Fixed Income	**61,370,840.01**	**59,413,099.80**	**-1,957,740.21**	**-3.19%**	**1,422,162.50**	**2.39%**	**99.87%**
US	61,370,840.01	59,413,099.80	-1,957,740.21	-3.19%	1,422,162.50	2.39%	99.87%
C Equity	**0.00**	**0.00**	**0.00**	**0.00%**	**0.00**	**0.00%**	**0.00%**
D Commodities	**0.00**	**0.00**	**0.00**	**0.00%**	**0.00**	**0.00%**	**0.00%**
E Non-Traditional	**0.00**	**0.00**	**0.00**	**0.00%**	**0.00**	**0.00%**	**0.00%**
F Other	**0.00**	**0.00**	**0.00**	**0.00%**	**0.00**	**0.00%**	**0.00%**
Total Portfolio	**$61,448,317.05**	**$59,490,576.84**	**$-1,957,740.21**	**-3.19%**	**$1,422,162.50**	**2.39%**	**100%**

Balanced mutual funds are allocated in the 'Other' category



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Portfolio holdings - as of December 31, 2022 (continued)

Details of portfolio holdings

	Cost basis ($)	Market value ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of asset class	% of Portfolio
Total Portfolio	**$61,448,317.05**	**$59,490,576.84**	**$-1,957,740.21**	**-3.19%**	**$1,422,162.50**	**2.39%**	**100%**	**100%**

Cash	Quantity	Purchase price ($) / Avg Price	Price on 12/31/2022 ($)	Cost basis ($)	Market value ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of Cash	% of Portfolio
Cash											
UBS INSURED SWEEP PROGRAM	77,477.04	1.00	1.00	77,477.04	77,477.04	0.00	0.00%	0.00	0.00%	100.00%	0.13%
Total Cash				**$77,477.04**	**$77,477.04**	**$0.00**	**0.00%**	**$0.00**	**0.00%**	**100.00%**	**0.13%**
Total Cash				**$77,477.04**	**$77,477.04**	**$0.00**	**0.00%**	**$0.00**	**0.00%**	**100.00%**	**0.13%**

Fixed Income	Quantity	Purchase price ($) / Avg Price	Price on 12/31/2022 ($)	Cost basis ($)	Market value ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of Fixed Income	% of Portfolio
US											
AMAZON COM INC NTS B/E 00.450% 051224 DTD051221 CALL@MW+2.5BP	2,000,000.00	99.88	94.23	1,997,660.00	1,885,725.00	-111,935.00	-5.60%	9,000.00	0.48%	3.17%	3.17%
AMAZON.COM INC NTS B/E 03.300% 041327 DTD041322 FC101322 CALL@MW+10BP	1,000,000.00	94.29	95.04	942,880.00	957,590.00	14,710.00	1.56%	33,000.00	3.47%	1.61%	1.61%
APPLE INC NTS B/E 00.750% 051123 DTD051120 FC111120 CALL@MW+10BP	3,000,000.00	100.16	98.56	3,004,689.99	2,959,864.99	-44,824.99	-1.49%	22,500.00	0.76%	4.98%	4.97%
APPLE INC NTS B/E 2.850% 051124 DTD051117 FC111117 CALL@MW+12.5BP	400,000.00	103.25	97.39	412,993.17	391,159.33	-21,833.84	-5.29%	11,400.00	2.93%	0.66%	0.66%
BANK OF NY MELLON CORP 00.350% 120723 DTD120720 FC060721 NTS B/E	2,000,000.00	100.02	95.95	2,000,419.52	1,919,526.67	-80,892.85	-4.04%	7,000.00	0.36%	3.23%	3.23%
BB&T CORP MED TERM NTS 02.850% 102624 DTD102617 FC042618 B/E	2,000,000.00	99.69	96.47	1,993,761.22	1,939,651.67	-54,109.55	-2.71%	57,000.00	2.95%	3.26%	3.26%
BB&T CORP NTS B/E 02.500% 080124 DTD072919 FC020120	1,000,000.00	103.07	96.12	1,030,654.04	971,616.67	-59,037.37	-5.73%	25,000.00	2.60%	1.64%	1.63%

Portfolio holdings - as of December 31, 2022 (continued)

Fixed Income	Quantity	Purchase price ($) / Avg Price	Price on 12/31/2022 ($)	Cost basis ($)	Market value ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of Fixed Income	% of Portfolio
US											
BK OF NY MELLON CORP B/E 03.000% 022425 DTD022415 FC082415	1,300,000.00	102.89	96.45	1,337,613.03	1,267,569.33	-70,043.70	-5.24%	39,000.00	3.11%	2.13%	2.13%
BK OF NY MELLON CORP NTS 00.850% 102524 DTD102521 FC042522 B/E	1,500,000.00	100.09	92.98	1,501,280.85	1,396,992.50	-104,288.35	-6.95%	12,750.00	0.91%	2.35%	2.35%
BURLINGTN NORTH SANTA FE 03.000% 040125 DTD030915 FC100115 CALL@MW+15BP	1,000,000.00	95.72	96.22	957,230.00	969,690.00	12,460.00	1.30%	30,000.00	3.12%	1.63%	1.63%
COMCAST CORP NTS B/E 03.700% 041524 DTD100518 FC041519 CALL@MW+15BP	1,500,000.00	101.49	98.51	1,522,300.91	1,489,396.67	-32,904.24	-2.16%	55,500.00	3.76%	2.51%	2.50%
COMCAST CORP NTS B/E 3.950% 101525 DTD100518 FC041519 CALL@MW+15BP	1,000,000.00	96.82	98.02	968,230.00	988,518.89	20,288.89	2.10%	39,500.00	4.03%	1.66%	1.66%
FANNIE MAE NTS 00.310 % DUE 111623 DTD 111620 FC 05162021	2,000,000.00	99.99	96.09	1,999,800.00	1,922,495.00	-77,305.00	-3.87%	6,200.00	0.32%	3.24%	3.23%
FFCB BOND 00.290 % DUE 110223 DTD 110220 FC 05022021	2,000,000.00	99.94	96.27	1,998,818.00	1,926,370.56	-72,447.44	-3.62%	5,800.00	0.30%	3.24%	3.24%
FFCB BOND 05.200 % DUE 110325 DTD 110322 FC 05032023	1,300,000.00	99.95	99.87	1,299,350.00	1,309,149.11	9,799.11	0.75%	67,600.00	5.21%	2.20%	2.20%
FHLMC MED TERM NTS 05.250 % DUE 110824 DTD 110822 FC 05082023	1,500,000.00	100.00	99.93	1,500,000.00	1,510,543.75	10,543.75	0.70%	78,750.00	5.25%	2.54%	2.54%
GENERAL DYNAMICS CORP 02.375% 111524 DTD091417 FC051518 CALL@MW+10BP	1,750,000.00	103.04	95.50	1,803,127.49	1,676,473.26	-126,654.23	-7.02%	41,562.50	2.49%	2.82%	2.82%
JOHN DEERE CAPITAL CORP 00.625% 091024 DTD091021 FC031022 NTS B/E	1,400,000.00	100.08	93.36	1,401,054.38	1,309,723.92	-91,330.46	-6.52%	8,750.00	0.67%	2.20%	2.20%
JOHN DEERE CPTL CORP 00.700% 070523 DTD060420 FC010521 MED TERM NTS	1,000,000.00	100.18	97.95	1,001,771.13	982,902.22	-18,868.91	-1.88%	7,000.00	0.71%	1.65%	1.65%
JPMORGAN CHASE & CO B/E 03.125% 012325 DTD012315 FC072315	2,400,000.00	104.29	96.57	2,503,054.45	2,350,524.67	-152,529.78	-6.09%	75,000.00	3.24%	3.96%	3.95%
JPMORGAN CHASE & CO NTS 03.625% 051324 DTD051314 FC111314 B/E	1,800,000.00	104.07	98.31	1,873,228.34	1,778,280.00	-94,948.34	-5.07%	65,250.00	3.69%	2.99%	2.99%
LOCKHEED MARTIN CORP B/E 03.550% 011526 DTD112315 FC071516 CALL@MW+20BP	1,500,000.00	96.38	97.24	1,445,685.00	1,483,094.17	37,409.17	2.59%	53,250.00	3.65%	2.50%	2.49%

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

Portfolio holdings - as of December 31, 2022 (continued)

Fixed Income	Quantity	Purchase price ($) / Avg Price	Price on 12/31/2022 ($)	Cost basis ($)	Market value ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of Fixed Income	% of Portfolio
US											
MICROSOFT CORP NTS B/E 02.875% 020624 DTD020617 FC080617 CALL@MW+12.5BP	750,000.00	101.17	98.14	758,757.58	744,734.90	-14,022.68	-1.85%	21,562.50	2.93%	1.25%	1.25%
MORGAN STANLEY B/E 03.625% 012027 DTD012017 FC072017	1,000,000.00	91.31	94.42	913,100.00	960,391.81	47,291.81	5.18%	36,250.00	3.84%	1.62%	1.61%
MORGAN STANLEY B/E 04.000% 072325 DTD072315 FC012316 CALL@MW+25BP	1,800,000.00	99.90	97.78	1,798,200.00	1,791,604.00	-6,596.00	-0.37%	72,000.00	4.09%	3.02%	3.01%
ORACLE CORP NTS B/E 02.950% 111524 DTD110917 FC051518 CALL@MW+15BP	1,000,000.00	103.74	96.36	1,037,407.63	967,379.44	-70,028.19	-6.75%	29,500.00	3.06%	1.63%	1.63%
PACCAR FINANCIAL CORP 00.350% 081123 DTD081120 FC021121 MED TERM NTS	2,000,000.00	100.00	97.18	2,000,000.00	1,946,402.22	-53,597.78	-2.68%	7,000.00	0.36%	3.28%	3.27%
PAYPAL HOLDINGS INC NTS 02.400% 100124 DTD092619 FC040120 CALL@MW+15BP	2,250,000.00	100.96	95.88	2,271,537.78	2,170,845.00	-100,692.78	-4.43%	54,000.00	2.50%	3.65%	3.65%
PEPSICO INC NTS B/E 00.400% 100723 DTD100720 FC040721	600,000.00	100.13	96.60	600,783.02	580,166.00	-20,617.02	-3.43%	2,400.00	0.41%	0.98%	0.98%
PEPSICO INC NTS B/E 00.750% 050123 DTD050120 FC110120 CALL@MW+10BP	1,500,000.00	100.15	98.71	1,502,197.82	1,482,450.00	-19,747.82	-1.31%	11,250.00	0.76%	2.50%	2.49%
PNC BK B/E 03.250% 060125 DTD060115 FC120115	300,000.00	98.46	96.54	295,368.00	290,441.50	-4,926.50	-1.67%	9,750.00	3.37%	0.49%	0.49%
PNC FINL SERV GRP INC WT 02.200% 110124 DTD110119 FC050120 EXP NTS B/E	2,000,000.00	103.05	95.59	2,060,920.13	1,919,193.33	-141,726.80	-6.88%	44,000.00	2.30%	3.23%	3.23%
SIMON PPTY GROUP LP B/E 03.375% 100124 DTD091014 FC040115 CALL@MW+15BP	1,900,000.00	104.19	97.05	1,979,572.47	1,859,943.25	-119,629.22	-6.04%	64,125.00	3.48%	3.13%	3.13%
STATE STREET CORP B/E 03.300% 121624 DTD121514 FC061615	1,200,000.00	100.25	97.63	1,203,010.23	1,173,162.00	-29,848.23	-2.48%	39,600.00	3.38%	1.97%	1.97%
TRUIST BANK NTS B/E 02.150% 120624 DTD120619 FC060620	2,000,000.00	100.14	95.03	2,002,879.96	1,903,526.11	-99,353.85	-4.96%	43,000.00	2.26%	3.20%	3.20%
UNION PAC CORP NTS B/E 03.750% 071525 DTD060818 FC011519 CALL@MW+15BP	2,000,000.00	97.04	97.25	1,940,760.00	1,979,523.33	38,763.33	2.00%	75,000.00	3.86%	3.33%	3.33%
UNITEDHEALTH GROUP INC 02.375% 081524 DTD072519 CALL@MW+10BP NTS	2,250,000.00	100.51	96.20	2,261,548.10	2,184,732.50	-76,815.60	-3.40%	53,437.50	2.47%	3.68%	3.67%

Portfolio holdings - as of December 31, 2022 (continued)

Fixed Income	Quantity	Purchase price ($) / Avg Price	Price on 12/31/2022 ($)	Cost basis ($)	Market value ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of Fixed Income	% of Portfolio
US											
US BANCORP MED TERM NTS 03.375% 020524 DTD020419 FACTOR 1.000000000000	300,000.00	103.13	98.24	309,378.30	298,835.25	-10,543.05	-3.41%	10,125.00	3.44%	0.50%	0.50%
US BANCORP NTS B/E 02.400% 073024 DTD072919 FC013020	2,000,000.00	98.38	96.18	1,967,640.00	1,943,500.00	-24,140.00	-1.23%	48,000.00	2.50%	3.27%	3.27%
WAL MART STORES INC NTS 02.650% 121524 DTD102017 FC061518 CALL@MW+10BP	1,900,000.00	103.80	96.17	1,972,177.47	1,829,410.78	-142,766.69	-7.24%	50,350.00	2.76%	3.08%	3.08%
Total US				**$61,370,840.01**	**$59,413,099.80**	**$-1,957,740.21**	**-3.19%**	**$1,422,162.50**	**2.39%**	**100.00%**	**99.87%**
Total Fixed Income				**$61,370,840.01**	**$59,413,099.80**	**$-1,957,740.21**	**-3.19%**	**$1,422,162.50**	**2.39%**	**100.00%**	**99.87%**

	Cost basis ($)	Market value ($)	Unrealized gain/loss ($)	Unrealized gain/loss (%)	Est. annual income ($)	Current yield (%)	% of asset class	% of Portfolio
Total Portfolio	**$61,448,317.05**	**$59,490,576.84**	**$-1,957,740.21**	**-3.19%**	**$1,422,162.50**	**2.39%**	**100%**	**100%**

Total accrued interest (included in market values): $368,573.30

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Bond summary

as of December 31, 2022

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

Bond overview

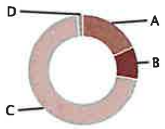
Total quantity	61,100,000
Total market value	$59,044,526.50
Total accrued interest	$368,573.30
Total market value plus accrued interest	$59,413,099.80
Total estimated annual bond interest	$1,422,162.50
Average coupon	2.34%
Average current yield	2.41%
Average yield to maturity	4.88%
Average yield to worst	4.88%
Average modified duration	1.60
Average effective maturity	1.69

Investment type allocation

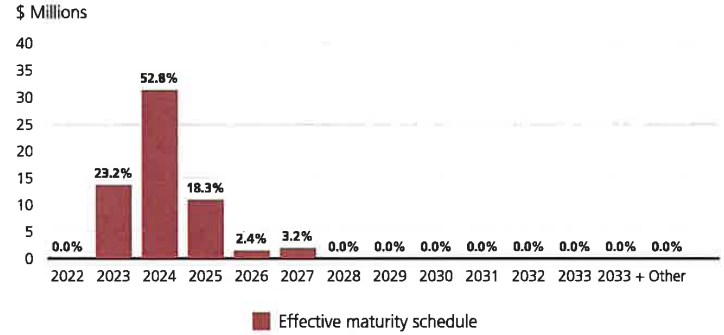
Investment type	Taxable ($)	Tax-exempt / deferred ($)	Total ($)	% of bond port.
U.S. corporates	52,744,541.38	0.00	52,744,541.38	88.78
U.S. federal agencies	6,668,558.42	0.00	6,668,558.42	11.22
Total	**$59,413,099.80**	**$0.00**	**$59,413,099.80**	**100%**

Credit quality of bond holdings

Effective credit rating		Issues	Value on 12/31/2022 ($)	% of port.
A	Aaa/AAA/AAA	7	10,764,317.65	18.17
B	Aa/AA/AA	4	5,642,415.78	9.53
C	A/A/A	28	42,038,986.93	70.68
D	Baa/BBB/BBB	1	967,379.44	1.63
E	Non-investment grade	0	0.00	0.00
F	Certificate of deposit	0	0.00	0.00
G	Not rated	0	0.00	0.00
Total		**40**	**$59,413,099.80**	**100%**



Bond maturity schedule



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

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

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Additional information about your portfolio

as of December 31, 2022

Benchmark composition

Account EX XX120

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

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

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Disclosures applicable to accounts at UBS Financial Services Inc.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Margin: The quantity value may indicate that all or part of this position is held on margin or held in the short account. When an account holds a debit balance, this debit balance is incorporated into the account's total market value and deducted from the total value. When calculating the percent of portfolio on each security, the percentage will be impacted by the total market value of the account. Therefore, if the account's market value is reduced by a debit value of a holding the percent of portfolio will be greater and if the account's market value is increased by a holding then the percent of portfolio will be less.

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

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

multiple equity sectors, this report will proportionately allocate the underlying holdings of the fund to those sectors measured as a percentage of the total fund's asset value as of the date shown.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UBS

Kern Health Systems

Account Number: EBXXX20

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

Filtered by: Entry Date 10/01/2022-12/31/2022, Call/Redemption

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
			No Activity				

Filtered by: Entry Date 10/01/2022-12/31/2022, Bought

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
11/22/22	11/25/22	BOUGHT	MICROSOFT CORP NTS B/E 02.875% 020624 DTD020617 Trade#:22149 Blot:97	773EL1	250,000.000	$98.229	-247,748.72
10/26/22	11/03/22	BOUGHT	FFCB BOND 05.200 % DUE 110325 Trade#:27770 Blot:08	FQ8Q35	1,300,000.000	$99.950	-1,299,350.00
10/24/22	10/26/22	BOUGHT	UNION PAC CORP NTS B/E 03.750% 071525 DTD060818 Trade#:05678 Blot:97	8818C0	2,000,000.000	$97.038	-1,961,801.67
10/24/22	10/26/22	BOUGHT	BB&T CORP MED TERM NTS 02.850% 102624 DTD102617 Trade#:05485 Blot:97	674HH5	1,000,000.000	$95.622	-956,220.00
10/20/22	10/24/22	BOUGHT	MORGAN STANLEY B/E 03.625% 012027 DTD012017 Trade#:37336 Blot:97	670UJ3	1,000,000.000	$91.310	-922,565.28
10/17/22	11/08/22	BOUGHT	FHLMC MED TERM NTS 05.250 % DUE 110824 Trade#:07153 Blot:08	FQ8CN5	1,500,000.000	$100.000	-1,500,000.00
10/14/22	10/18/22	BOUGHT	LOCKHEED MARTIN CORP B/E 03.550% 011526 DTD112315 Trade#:49536 Blot:9	753FN3	1,500,000.000	$96.379	-1,459,441.25
10/13/22	10/17/22	BOUGHT	COMCAST CORP NTS B/E 3.950% 101525 DTD100518 Trade#:33932 Blot:97	682TX3	1,000,000.000	$96.823	-968,449.44
10/13/22	10/17/22	BOUGHT	BURLINGTN NORTH SANTA FE 03.000% 040125 DTD030915 Trade#:39358 Blot:9	658DP2	1,000,000.000	$95.723	-958,563.33
10/11/22	10/13/22	BOUGHT	AMAZON.COM INC NTS B/E 03.300% 041327 DTD041322 Trade#:24999 Blot:97	702U21	1,000,000.000	$94.288	-942,880.00

WELLS FARGO SECURITIES

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

JONATHAN CHUANG
1-213-253-6202

Bank Account Statement
Wells Fargo Bank, N.A.

Statement Period
12/01/2022 - 12/31/2022

KERN HEALTH SYSTEMS
2900 BUCK OWENS BOULEVARD

Account Number
[redacted]

Account Value Summary *USD*

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

	Amount Last Statement Period	Amount This Statement Period	% Portfolio
Cash	$ 0.00	**$ 0.00**	0%
Money Market Mutual Funds	101,781,589.73	**23,839,290.35**	8%
Bonds	152,007,138.40	**258,569,826.26**	92%
Stocks	0.00	**0.00**	0%
Total Account Value	**$ 253,788,728.13**	**$ 282,409,116.61**	**100%**

Value Change Since Last Statement Period	**$ 28,620,388.48**
Percent Increase Since Last Statement Period	**11%**
Value Last Year-End	**$ 158,053,433.16**
Percent Increase Since Last Year-End	**79%**

Income Summary *USD*

	This Period	Year-To-Date
Interest	$ 141,625.00	$ 776,636.24
Dividends/Capital Gains	0.00	0.00
Money Market Mutual Funds Dividends	329,581.17	1,108,101.29
Other	0.00	0.00
Income Total	**$ 471,206.17**	**$ 1,884,737.53**

Interest Charged *USD*

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

Money Market Mutual Funds Summary *USD*

Description	Amount
Opening Balance	**$ 101,781,589.73**
Deposits and Other Additions	168,541,625.00
Distributions and Other Subtractions	(246,813,505.55)
Dividends Reinvested	329,581.17
Change in Value	0.00
Closing Balance	**$ 23,839,290.35**

Important Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial Statements: WFS financial statements are available upon request.

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

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

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

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

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

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

Statement Ending: December 31, 2022

KERN HEALTH SYSTEMS
Account Number: [redacted]

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

Security ID	Description	Maturity Date	Coupon	Current Par / Original Par	Market Price*	Market Value	Original Par Pledged**	Callable
Bonds *USD*								
912796ZH5	UNITED STATES TREASURY BILL	01/03/23	0.000%	20,000,000.000	100.0000	20,000,000.00		
313384AE9	FED HOME LN DISCOUNT NT	01/05/23	0.000%	20,000,000.000	99.9762	19,995,248.20		N
912796X95	UNITED STATES TREASURY BILL	01/05/23	0.000%	40,000,000.000	99.9786	39,991,446.80		
912796ZJ1	UNITED STATES TREASURY BILL	01/10/23	0.000%	20,000,000.000	99.9331	19,986,623.40		
912796XR5	UNITED STATES TREASURY BILL	01/12/23	0.000%	30,000,000.000	99.9124	29,973,709.80		
912796ZK8	UNITED STATES TREASURY BILL	01/17/23	0.000%	20,000,000.000	99.8512	19,970,246.80		
313312AU4	FED FARM CRD DISCOUNT NT	01/19/23	0.000%	20,000,000.000	99.8101	19,962,016.40		N
90331HNL3	US BANK NA CINCINNATI	01/23/23	2.850%	3,000,000.000	99.9066	2,997,198.00		Y
313312BA7	FED FARM CRD DISCOUNT NT	01/25/23	0.000%	20,000,000.000	99.7390	19,947,791.20		N
313312CD0	FED FARM CRD DISCOUNT NT	02/21/23	0.000%	20,000,000.000	99.4001	19,880,016.60		N
3130AS4V8	FEDERAL HOME LOAN BANK	03/09/23	2.000%	10,000,000.000	99.5967	9,959,665.70		Y
3130AT2E6	FEDERAL HOME LOAN BANK	06/15/23	3.330%	5,000,000.000	99.7933	4,989,664.15		Y
912796ZQ5	UNITED STATES TREASURY BILL	06/22/23	0.000%	5,000,000.000	97.8920	4,894,602.35		
06406FAD5	BANK OF NY MELLON CORP	08/16/23	2.200%	1,090,000.000	98.4503	1,073,108.46		Y
3130AU4F8	FEDERAL HOME LOAN BANK	09/27/23	4.875%	5,000,000.000	100.2209	5,011,047.05		Y
3130ATJB4	FEDERAL HOME LOAN BANK	10/26/23	4.500%	5,000,000.000	99.9336	4,996,680.80		Y
3130ATVJ3	FEDERAL HOME LOAN BANK	12/06/23	5.000%	5,000,000.000	100.0514	5,002,567.95		N
3134GY6Z0	FREDDIE MAC	03/22/24	5.050%	5,000,000.000	100.0592	5,002,960.25		Y
3134GXS88	FREDDIE MAC	02/28/25	4.000%	5,000,000.000	98.7046	4,935,232.35		Y
				259,090,000.000		258,569,826.26	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*									
12/05/22	12/05/22	Security Receipt	313384AE9	FED HOME LN DISCOUNT NT	20,000,000.00	99.6641667	(19,932,833.33)	0.00	(19,932,833.33)
12/08/22	12/08/22	Security Receipt	313312AU4	FED FARM CRD DISCOUNT NT	20,000,000.00	99.5450000	(19,909,000.00)	0.00	(19,909,000.00)
12/13/22	12/14/22	Security Receipt	912796ZH5	UNITED STATES TREASURY BILL	20,000,000.00	99.8072222	(19,961,444.44)	0.00	(19,961,444.44)

Statement Ending: December 31, 2022

KERN HEALTH SYSTEMS
Account Number: [redacted]

Daily Account Activity (Continued)

Your investment transactions during this statement period.

Transaction Activity *USD*

Transaction / Trade Date	Settlement / Effective Date	Activity	Security ID	Description	Par / Quantity	Price	Principal Amount	Income Amount	Debit / Credit Amount
12/13/22	12/14/22	Security Receipt	912796ZJ1	UNITED STATES TREASURY BILL	20,000,000.00	99.7270000	(19,945,400.00)	0.00	(19,945,400.00)
12/13/22	12/14/22	Security Receipt	912796ZK8	UNITED STATES TREASURY BILL	20,000,000.00	99.6515000	(19,930,300.00)	0.00	(19,930,300.00)
12/20/22	12/20/22	Security Receipt	313312BA7	FED FARM CRD DISCOUNT NT	20,000,000.00	99.5950000	(19,919,000.00)	0.00	(19,919,000.00)
12/20/22	12/20/22	Security Receipt	313312CD0	FED FARM CRD DISCOUNT NT	20,000,000.00	99.2650000	(19,853,000.00)	0.00	(19,853,000.00)
12/05/22	12/22/22	Security Receipt	3134GY6Z0	FREDDIE MAC	5,000,000.00	100.0000000	(5,000,000.00)	0.00	(5,000,000.00)
12/19/22	12/22/22	Security Receipt	912796ZQ5	UNITED STATES TREASURY BILL	5,000,000.00	97.7250000	(4,886,250.00)	0.00	(4,886,250.00)
12/05/22	12/27/22	Security Receipt	3130AU4F8	FEDERAL HOME LOAN BANK	5,000,000.00	100.0000000	(5,000,000.00)	0.00	(5,000,000.00)
12/28/22	12/29/22	Security Receipt	912796X95	UNITED STATES TREASURY BILL	40,000,000.00	99.9406945	(39,976,277.78)	0.00	(39,976,277.78)

Income / Payment Activity *USD*

12/09/22	12/09/22	Interest	3130AS4V8	FEDERAL HOME LOAN BANK				100,000.00	100,000.00
12/13/22	12/13/22	Matured	912796YY9	UNITED STATES TREASURY BILL			30,000,000.00		30,000,000.00
12/13/22	12/13/22	Matured	912796YY9	UNITED STATES TREASURY BILL	(30,000,000.00)				
12/15/22	12/15/22	Interest	3130AT2E6	FEDERAL HOME LOAN BANK				41,625.00	41,625.00
12/16/22	12/16/22	Matured	23102VMG2	CUMMINS INC 4(2) DISCOUNTED			2,000,000.00		2,000,000.00
12/16/22	12/16/22	Matured	23102VMG2	CUMMINS INC 4(2) DISCOUNTED	(2,000,000.00)				
12/20/22	12/20/22	Matured	912796YZ6	UNITED STATES TREASURY BILL			20,000,000.00		20,000,000.00
12/20/22	12/20/22	Matured	912796YZ6	UNITED STATES TREASURY BILL	(20,000,000.00)				
12/21/22	12/21/22	Matured	313313T99	FED FARM CRD DISCOUNT NT			10,000,000.00		10,000,000.00
12/21/22	12/21/22	Matured	313313T99	FED FARM CRD DISCOUNT NT	(10,000,000.00)				
12/27/22	12/27/22	Matured	912796ZA0	UNITED STATES TREASURY BILL			20,000,000.00		20,000,000.00
12/27/22	12/27/22	Matured	912796ZA0	UNITED STATES TREASURY BILL	(20,000,000.00)				
12/28/22	12/28/22	Matured	69448XMU3	PACIFIC LIFE SHORT TERM 4(2)			3,000,000.00		3,000,000.00
12/28/22	12/28/22	Matured	69448XMU3	PACIFIC LIFE SHORT TERM 4(2)	(3,000,000.00)				
12/29/22	12/29/22	Matured	69372BMV9	PACCAR FINANCIAL CORP			3,400,000.00		3,400,000.00
12/29/22	12/29/22	Matured	69372BMV9	PACCAR FINANCIAL CORP	(3,400,000.00)				

Cash Activity *USD*

Transaction / Trade Date	Settlement / Eff. Date	Activity	Description	Debit Amount / Disbursements	Credit Amount / Receipts
12/06/22	12/06/22	ACH/DDA Transaction	DESIGNATED DDA	11,500,000.00	
12/13/22	12/13/22	ACH/DDA Transaction	DESIGNATED DDA	15,500,000.00	
12/14/22	12/14/22	ACH/DDA Transaction	DESIGNATED DDA	4,000,000.00	
12/14/22	12/14/22	ACH/DDA Transaction	DESIGNATED DDA		50,000,000.00
12/14/22	12/14/22	ACH/DDA Transaction	DESIGNATED DDA		50,000,000.00
12/19/22	12/19/22	ACH/DDA Transaction	DESIGNATED DDA	1,000,000.00	
12/20/22	12/20/22	ACH/DDA Transaction	DESIGNATED DDA	14,500,000.00	
12/21/22	12/21/22	ACH/DDA Transaction	DESIGNATED DDA	5,000,000.00	

Statement Ending: December 31, 2022

KERN HEALTH SYSTEMS
Account Number: [redacted]

Daily Account Activity (Continued)

Your investment transactions during this statement period.

Cash Activity *USD*

Transaction / Trade Date	Settlement / Eff. Date	Activity	Description	Debit Amount / Disbursements	Credit Amount / Receipts
12/27/22	12/27/22	ACH/DDA Transaction	DESIGNATED DDA	20,000,000.00	
12/28/22	12/28/22	ACH/DDA Transaction	DESIGNATED DDA	1,000,000.00	

Money Market Fund Activity

Morgan Stan TreasSvc 8314
*As of December 31, 2022
USD

Dividend paid this period	7 day* simple yield	30 day* simple yield
98,307.90	4.040%	3.800%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**31,670,825.70**		**31,670,825.70000**
12/01/22	Reinvest	98,307.90000			98,307.90	31,769,133.60000
12/06/22	Redemption	(11,500,000.00000)		(11,500,000.00)		20,269,133.60000
12/08/22	Redemption	(19,909,000.00000)		(19,909,000.00)		360,133.60000
12/14/22	Purchase	50,000,000.00000		50,000,000.00		50,360,133.60000
12/19/22	Redemption	(1,000,000.00000)		(1,000,000.00)		49,360,133.60000
12/20/22	Redemption	(14,500,000.00000)		(14,500,000.00)		34,860,133.60000
12/21/22	Redemption	(5,000,000.00000)		(5,000,000.00)		29,860,133.60000
12/27/22	Redemption	(20,000,000.00000)		(20,000,000.00)		9,860,133.60000
12/28/22	Redemption	(1,000,000.00000)		(1,000,000.00)		8,860,133.60000
	Ending Balance		**1.0000**	**8,860,133.60**		**8,860,133.60000**

Goldman FS Tr Ob Ins 468
*As of December 31, 2022
USD

Dividend paid this period	7 day* simple yield	30 day* simple yield
231,273.27	4.140%	3.910%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**70,110,764.03**		**70,110,764.03000**
12/01/22	Reinvest	231,273.27000			231,273.27	70,342,037.30000
12/05/22	Redemption	(19,932,833.33000)		(19,932,833.33)		50,409,203.97000
12/09/22	Purchase	100,000.00000		100,000.00		50,509,203.97000
12/13/22	Purchase	30,000,000.00000		30,000,000.00		80,509,203.97000
12/13/22	Redemption	(15,500,000.00000)		(15,500,000.00)		65,009,203.97000
12/14/22	Redemption	(59,837,144.44000)		(59,837,144.44)		5,172,059.53000

Statement Ending: December 31, 2022

KERN HEALTH SYSTEMS
Account Number: [redacted]

Money Market Fund Activity (Continued)

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
12/14/22	Purchase	50,000,000.00000		50,000,000.00		55,172,059.53000
12/14/22	Redemption	(4,000,000.00000)		(4,000,000.00)		51,172,059.53000
12/15/22	Purchase	41,625.00000		41,625.00		51,213,684.53000
12/16/22	Purchase	2,000,000.00000		2,000,000.00		53,213,684.53000
12/20/22	Redemption	(19,772,000.00000)		(19,772,000.00)		33,441,684.53000
12/21/22	Purchase	10,000,000.00000		10,000,000.00		43,441,684.53000
12/22/22	Redemption	(9,886,250.00000)		(9,886,250.00)		33,555,434.53000
12/27/22	Redemption	(5,000,000.00000)		(5,000,000.00)		28,555,434.53000
12/27/22	Purchase	20,000,000.00000		20,000,000.00		48,555,434.53000
12/28/22	Purchase	3,000,000.00000		3,000,000.00		51,555,434.53000
12/29/22	Redemption	(39,976,277.78000)		(39,976,277.78)		11,579,156.75000
12/29/22	Purchase	3,400,000.00000		3,400,000.00		14,979,156.75000
	Ending Balance		**1.0000**	**14,979,156.75**		**14,979,156.75000**

PMIA/LAIF Performance Report as of 01/18/23

PMIA Average Monthly Effective Yields[1]

December	**2.173**
November	2.007
October	1.772

Quarterly Performance Quarter Ended 12/31/22

LAIF Apportionment Rate[2]:	2.07
LAIF Earnings Ratio[2]:	0.00005680946709337
LAIF Fair Value Factor[1]:	0.981389258
PMIA Daily[1]:	2.29
PMIA Quarter to Date[1]:	1.98
PMIA Average Life[1]:	287

Pooled Money Investment Account Monthly Portfolio Composition [1] 12/31/22 $199.6 billion

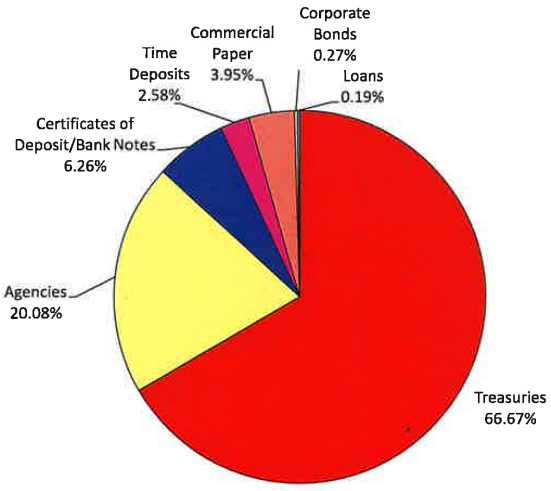

Chart does not include $3,466,000.00 in mortgages, which equates to 0.002%. Percentages may not total 100% due to rounding.

Daily rates are now available here. View PMIA Daily Rates

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

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

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: February 16, 2023

Re: 2022 Annual Review of Kern Health Systems Investment Policy

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Background

The KHS Investment Portfolio follows the Board approved Investment Policy (Attachment 1). As part of their annual review, Senior Management **is not recommending any revisions to the Investment Policy at this time.** The Investment Policy stipulates the following order of investment objectives:

KHS utilizes three different investment organizations to invest the cash that is not needed for the immediate needs of the agency (Attachment 2). All investments follow the Board approved investment policy that stipulates the following order of investment objectives:

- Preservation of principal
- Liquidity
- Yield

UBS is a national brokerage firm with a Bakersfield office that administers the KHS Board approved investment policy in a segregated account. Investments are in high quality bonds and FDIC insured certificates of deposit with an average effective maturity of slightly less than 1 3/4 years. For the 2022-year UBS investments earned the highest returns.

The **Local Agency Investment Fund (LAIF)** is a public agency that allows smaller public agencies to pool their money and get the economies of scale that larger agencies with large portfolios receive. The California State Treasurer operates LAIF. Because it serves many agencies with short term liquidity needs, investments have an average maturity of approximately 10 months.

Wells Fargo is KHS' local bank. This is beneficial since surplus cash can be easily moved to and from the checking accounts. KHS invests directly with the Wells Fargo Securities Fixed Income division in high quality bonds, commercial paper and Money Market Funds.

Requested Action

Receive and File.

Attachment 1

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Investment Policy				POLICY #: 80.11-I	
DEPARTMENT: Finance					
Effective Date:	Review/Revised Date:	DMHC		PAC	
2010-10	7/21/2020	DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

Doug Hayward Date 7/21/2020
Douglas A. Hayward
Chief Executive Officer

Robert Landis Date 7/20/2020
Chief Financial Officer

Alan Avery Date 7/20/2020
Chief Operating Officer

Veronica Barker Date 7/13/2020
Controller

POLICY:

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

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

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

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

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

I. OBJECTIVES

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

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

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

II. PRUDENCE

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

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

III. ETHICS AND CONFLICTS OF INTEREST

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

IV. DELEGATION OF AUTHORITY

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

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

A. Financial Benchmarks

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

B. Safekeeping

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

C. Periodic Review of the Investment Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

V. DEFINITIONS

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

VI. PERMITTED INVESTMENTS

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

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

Permitted investments shall include:

A. U.S. Treasuries

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

U.S. Government securities include:

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

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

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

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

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

Maximum term: Five Years

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

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

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

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

Maximum Term: Five years

C. State of California and Local Agency Obligations

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

Maximum Term: Five years

D. State and Local Agency Obligations Outside of California

Registered state warrants, treasury notes or bonds of any U.S. State and bonds, notes, warrants or other evidences of indebtedness of any local agency of the State, including bonds payable solely

out of revenues from a revenue producing property owned, controlled, or operated by the state Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's and A-1 by Standard & Poor's or equivalent or better for short-term obligations, or A by Moody's or A by Standard & Poor's or better for long-term debt. Public agency bonds issued for private purposes (industrial development - bonds) are specifically excluded as allowable investments. Any single investment in a particular State is limited to 5% of portfolio at time of Purchase.

Maximum Term: Five years

Maximum of 20% of the portfolio

E. Bankers Acceptances

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

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

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

Maximum Term: 180 days

F. Commercial Paper

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

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

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

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

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

Maximum Term: 270 days

G. Negotiable Certificates of Deposit

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

Maximum Term: Five years

H. Repurchase Agreements

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

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

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

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

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

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

Maximum Term: One year

Reverse repurchase agreements are not allowed.

I. Corporate Debt Securities

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

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

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

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

Maximum Term: Five years

J. Money Market Funds

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

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

2. Such investment may not represent more than five percent (5%) of the money market fund's assets.

K. Mortgage or Asset-backed Securities

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

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

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

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

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

Maximum Term: Five years

L. Variable and Floating Rate Securities

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

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

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

Maximum Term: Five Years

M. Local Agency Investment Fund (LAIF)

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

Maximum Term: Five Years

VII. POLICIES

A. Securities Lending

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

B. Leverage

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

C. Other Investments

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

D. Underlying Nature of Investments

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

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

E. Investment Managers

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

F. Derivatives

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

G. Rating Category

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

H. Rating Downgrades

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

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

I. Maximum Stated Term

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

J. Diversification Guidelines

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

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

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

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
J. Money Market Funds	40%
K. Mortgage and Asset-backed Securities	20%
L. Variable and Floating Rate Securities	30%
M. Local Agency Investment Fund (KAIF)	50%

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

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

ii. Any one repurchase agreement counterparty name

If maturity/term is ≤ 7 days 50%

If maturity/term is > 7 days 25%

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

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

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

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

REFERENCE:

Revision 2020-06: Policy updated to reflect Board of Directors approved changes on 6/11/2020. **Revision 2015-04:** Item "M" Local Agency Investment Fund (LAIF) added to Section VII Permitted Investments as approved by KHS Board of Directors at April 2015 meeting. **Revision 2014-08:** Policy revised by Controller to allow for non-California municipal investments as approved by KHS Board of Directors. **Revision 2010-11:** Policy revised to conform to government code requirements. The Board of Directors approved current policy on October 14, 2010.

KERN HEALTH SYSTEMS **Attachment 2**

2022 INVESTMENT ANALYSIS

	UBS	LAIF	Wells Fargo Securities
December 31, 2022 Balance	59,486,759	74,496,510	282,409,117
Average Monthly Balance	52,163,873	74,223,084	222,667,313
Total Dividend/Revenue (YTD)	1,036,171	838,883	1,884,738
Percentage	1.99%	1.13%	0.85%

To: KHS Board of Directors

From: Robert Landis, CFO

Date: February 16, 2023

Re: Request to Change 2023 Reinsurance Carrier

Background

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

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

Discussion

At the December 15, 2022 Board Meeting, Management recommended changing the KHS reinsurance carrier from IOA RE to HM Life based on receiving a lower quote from HM Life. Based on a review of recently paid claims, the HM Life underwriters determined that a significant increase to their 2023 proposed reinsurance rates was required. Our insurance broker, Arthur J. Gallagher re-approached our 2022 carrier IOA RE for an updated 2023 quote.

Fiscal Impact

For the renewal, HM Life Insurance Company (AM Best Rating A Excellent Financial Rating Size Category XV) originally proposed a blended rate of $.22 pmpm with the current deductible of $350,000 per member and a $.16 pmpm aggregate deductible for an overall expected reinsurance cost of $1,580,401. (This is comprised of $914,969 for premiums and $665,432 for the aggregate deductible).

The new revised rate with HM Life is at a blended rate of $.36 pmpm with the current deductible of $350,000 per member and a $.27 pmpm aggregate deductible for an overall expected reinsurance cost of $2,620,139. (This is comprised of $1,497,222 for premiums and $1,122,917 for the aggregate deductible).

The lowest quote is now with the current carrier IOA Re (AM Best Rating A+ Superior Financials Rating; Financial Size Category X) at a blended rate of $.27 pmpm with the current deductible of $350,000 per member and a $.23 pmpm aggregate deductible for an overall expected reinsurance cost of $2,079,476. (This is comprised of $1,122,917 for premiums and $956,559 for the aggregate deductible). All 2023 rates include new transplant services for which we accepted risk in 2022.

The 2023 Budget includes estimated reinsurance premium payments of $914,969. The revised reinsurance quote will have a negative impact of $207,948 ($1,122,917-$914,969) to the 2023 Budget.

Recommendation

Renew the 2023 reinsurance with the incumbent reinsurance carrier IOA RE as they provided the lowest 2023 renewal quote.

Requested Action

Approve.

KERN HEALTH SYSTEMS

To: **KHS Board of Directors**

From: **Robert Landis, CFO**

Date: **February 16, 2023**

Re: **2022 Annual Report for Travel**

Background

Kern Health Systems Employee Travel and Expense Reimbursement Policy requires an annual report (attached) to be submitted to the KHS Board of Directors.

Discussion

KHS encourages employees to attend conferences and seminars to:

1. Obtain updated information on key issues that they are concerned about.
2. Interact with other health plans that may be experiencing similar issues and problems and to solve those issues together.
3. Have issues addressed on a specific topic by recognized experts who are up to date with the latest developments in the field.
4. Evaluate the latest technologies that can potentially help make KHS more efficient.
5. Learn about facts and statistics that will help employees better understand the changing dynamics in the healthcare industry.

Examples of KHS travel includes attending meetings with State regulators such as DHCS & DMHC, attending trade association conferences hosted by the Local Health Plans of California (LHPC), California Association of Health Plans (CAHP), Association for Community Affiliated Plans (ACAP) and participating on vendor advisory boards and professional education and training seminars.

During 2022 $7,582 was spent on regulatory or trade association travel, $399 was spent on vendor meetings and $41,179 was spent on conference attendance travel. The total travel expenses incurred for 2022 was $49,160 which was approximately $34,400 more than the prior year. **This increase is primarily due to the resumption of employees attending conferences due to less Covid-19 travel restrictions in place during 2022.**

Requested Action

Receive and file, for informational purposes only.

KERN·HEALTH SYSTEMS

	EMPLOYEE TITLE	CONFERENCE TITLE	REGULATORY OR TRADE ASSOCIATON (R), PROFESSIONAL DEVELOPMENT (P), CONFERENCES (C), OTHER (O)	In County (In), Out of County (Out), or Out of State (OS)	LOCATION	START DATE	END DATE	TRAVEL & LODGING	MEALS	TOTAL AMOUNT SPENT
1	Senior Director of Government Relations & Strategic Development	Association for Community Affiliated Plans 2022 Spring Meeting	C	Out	San Diego	3/27/2022	3/30/2022	668.73	92.50	761.23
2	Chief Executive Officer (Former)	Association for Community Affiliated Plans 2022 Spring Meeting	C	Out	San Diego	3/27/2022	3/30/2022	1,716.89	240.50	1,957.39
3	Chief Executive Officer (Former)	Local Health Plans of California Board Meeting and Strategic Retreat	C	Out	Sacramento	4/17/222	4/18/2022	1,076.48	103.40	1,179.88
4	Chief Executive Officer (Former)	Local Health Plans of California Board Meeting and Strategic Retreat	C	Out	Santa Barbara	5/15/2022	5/17/2022	1,135.18	92.50	1,227.68
5	Chief Executive Officer	Local Health Plans of California Board Meeting and Strategic Retreat	C	Out	Santa Barbara	5/15/2022	5/17/2022	820.87	92.50	913.37
6	Senior Director of Government Relations & Strategic Development	Local Health Plans of California Board Meeting and Strategic Retreat	C	Out	Santa Barbara	5/15/2022	5/17/2022	821.46	92.50	913.96
7	Chief Operating Officer	Zelis Forum 2022	C	Out	Carlsbad	5/22/2022	5/25/2022	1,162.41	240.50	1,402.91
8	Chief Executive Officer	CAHP Annual Conference	C	Out	Palm Desert	10/17/2022	10/19/2022	1,318.89	189.75	1,508.64
9	Senior Director of Government Relations & Strategic Development	CAHP Annual Conference	C	Out	Palm Desert	10/17/2022	10/19/2022	1,229.38	86.15	1,315.53
10	Chief Operating Officer	CAHP Annual Conference	C	Out	Palm Desert	10/17/2022	10/19/2022	1,229.28	189.75	1,419.03
11	Chief Information Officer	CAHP Annual Conference	C	Out	Palm Desert	10/17/2022	10/19/2022	1,936.53	51.70	1,988.23
12	Chief Information Officer	LHPC CIO Meeting	R	Out	San Francisco	8/25/2022	8/26/2022	892.71	118.50	1,011.21
13	Chief Information Officer	LHPC CIO Meeting	R	Out	Alameda	12/1/2022	12/2/2022	1,158.85	111.00	1,269.85
							Executive Total	**15,167.66**	**1,701.25**	**16,868.91**

KERN·HEALTH SYSTEMS

	EMPLOYEE TITLE	CONFERENCE TITLE	REGULATORY OR TRADE ASSOCIATON (R), PROFESSIONAL DEVELOPMENT (P), CONFERENCES (C), OTHER (O)	In County (In), Out of County (Out), or Out of State (OS)	LOCATION	START DATE	END DATE	TRAVEL & LODGING	MEALS	TOTAL AMOUNT SPENT
14	Senior Director of Technical Operations	Client Meeting	O	Out	Agoura Hills	4/27/2022	4/27/2022	340.10	59.25	399.35
15	Senior Director of Technical Operations	Zelis Forum 2022	C	Out	Carlsbad	5/23/2022	5/26/2022	1,504.66	185.00	1,689.66
16	Enterprise Configuration Manager	ZeOmega Client Conference	C	OS	Frisco	5/23/2022	5/26/222	1,474.67	128.00	1,602.67
17	Director of Development	Evolution California Conference	C	Out	San Francisco	9/28/2022	10/1/2022	1,671.13	217.25	1,888.38
18	Director of Development	LHPC CIO Meeting	R	Out	Alameda	12/1/2022	12/2/2022	1,122.73	173.00	1,295.73
							MIS Total	**6,113.29**	**762.50**	**6,875.79**
19	Director of Business Intelligence	RISE Quality Leadership Summit	C	OS	Las Vegas	6/27/2022	6/26/2022	593.48	207.00	800.48
20	Director of Business Intelligence	LHPC CIO Meeting	R	Out	San Francisco	8/25/2022	8/26/2022	956.32	138.25	1,094.57
							Business Intelligence Total	**1,549.80**	**345.25**	**1,895.05**
21	Director of Claims	Zelis Forum	C	Out	Carlsbad	5/23/2022	5/26/2022	1,615.87	58.50	1,674.37
22	Claims Operation Senior Specialist	Zelis Forum	C	Out	Carlsbad	5/23/2022	5/26/2022	1,282.29	58.50	1,340.79
							Claims Total	**2,898.16**	**117.00**	**3,015.16**
23	PM Program Manager I	PMI Global Summit 2022	C	OS	Las Vegas	12/1/2022	12/3/2022	1,104.76	241.50	1,346.26
24	PM Program Manager II	PMI Global Summit 2022	C	OS	Las Vegas	12/1/2022	12/3/2022	1,073.88	189.75	1,263.63
							Project Management Total	**2,178.64**	**431.25**	**2,609.89**
25	Director of Quality Improvement	Rise Quality Leadership Summit	C	OS	Las Vegas	6/27/2022	6/29/2022	965.58	172.50	1,138.08
26	QI Senior Operational Analyst	Rise Quality Leadership Summit	C	OS	Las Vegas	6/27/2022	6/29/2022	752.70	172.50	925.20
							Health Services - QM/QI Total	**1,718.28**	**345.00**	**2,063.28**

KERN • HEALTH SYSTEMS

	EMPLOYEE TITLE	CONFERENCE TITLE	REGULATORY OR TRADE ASSOCIATON (R), PROFESSIONAL DEVELOPMENT (P), CONFERENCES (C), OTHER (O)	In County (In), Out of County (Out), or Out of State (OS)	LOCATION	START DATE	END DATE	TRAVEL & LODGING	MEALS	TOTAL AMOUNT SPENT
27	Cultural & Linguistic Specialist II	CHIA 22nd Annual Educational Conference	C	Out	San Jose	5/12/2022	5/142022	656 47	148 00	804 47
28	Health Education Specialist - Bilingual	CalFresh Healthy Living Forum	C	Out	Garden Grove	10/17/2022	10/19/2022	353 86	166 50	520 36
29	Health Education Specialist	CalFresh Healthy Living Forum	C	Out	Garden Grove	10/17/2022	10/19/2022	353 86	166 50	520 36
					Health Services - Health Ed Total			**1,364.19**	**481.00**	**1,845.19**
30	Director of Pharmacy	APHA 2022	C	OS	San Antonio	3/17/2022	3/22/2022	2,572 96	368 00	2,940 96
					Health Services - Pharmacy Total			**2,572.96**	**368.00**	**2,940.96**
31	Administrative Director	LHPC Cal AIM Learning Collaborative	R	Out	Sacramento	9/20/2022	9/23/2022	1,273 56	138 00	1,411 56
					Enhanced Care Management Total			**1,273.56**	**138.00**	**1,411.56**
32	Director of Community & Social Services	LHPC Cal AIM Learning Collaborative	R	Out	Sacramento	9/20/2022	9/23/2022	1,360 86	138 00	1,498 86
					Community Support Services Total			**1,360.86**	**138.00**	**1,498.86**
33	Deputy Director of Provider Network	CAHP Seminar: Unprecedented Investment in Home & Community Based Services	C	Out	Los Angeles	3/23/2022	3/23/2022	113 31	-	113 31
34	Provider Relations Manager, Special Projects	4th Annual LA Street Medicine Symposium	C	Out	Los Angeles	8/10/2022	8/13/2022	537 48	185 00	722 48
35	Deputy Director of Provider Network	CAHP Annual Conference	C	Out	Palm Desert	10/16/2022	10/19/2022	940 53	34 50	975 03
36	Grants Manager	The Rise Women in Healthcare Leadership Summit	C	Out	San Diego	12/13/222	12/15/2022	1,024 11	148 00	1,172 11
					Provider Network Management Total			**2,615.43**	**367.50**	**2,982.93**
37	Facilities Superintendent	IFMA Facility Fusion 2022	C	OS	Austin	4/26/2028	4/28/2022	1,429 60	224 00	1,653 60

KERN · HEALTH SYSTEMS

	EMPLOYEE TITLE	CONFERENCE TITLE	REGULATORY OR TRADE ASSOCIATON (R), PROFESSIONAL DEVELOPMENT (P), CONFERENCES (C), OTHER (O)	In County (In), Out of County (Out), or Out of State (OS)	LOCATION	START DATE	END DATE	TRAVEL & LODGING	MEALS	TOTAL AMOUNT SPENT
							Corporate Services Total	**1,429.60**	**224.00**	**1,653.60**
38	Payroll and HCM Manager	Ceridian Insights 2022 Conference	C	OS	Las Vegas	11/7/2022	11/11/222	1,230.45	207.00	1,437.45
39	Chief Human Resources Offices	Ceridian Insights 2022 Conference	C	OS	Las Vegas	11/7/2022	11/11/222	-	166.50	166.50
40	HR and HCM Manager	Ceridian Insights 2022 Conference	C	OS	Las Vegas	11/7/2022	11/11/222	497.50	310.50	808.00
41	Chief Human Resources Offices	The Global Research Conference for HR	C	Out	Los Angeles	5/23/2022	5/25/2022	920.18	166.50	1,086.68
							Human Resources Total	**2,648.13**	**850.50**	**3,498.63**

	Travel & Lodging	Meals		
Sub-Totals	**42,890.56**	**6,269.25**	**Grand Total**	**49,159.81**

	Regulatory or Trade Associations	Professional Development	Conferences	Other-Vendor	Total
Sub-Totals by Travel Type	**7,581.78**	**-**	**41,178.68**	**399.35**	**49,159.81**

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: February 16, 2023

Re: 2022 Annual Report for Disposed Assets

Background

Kern Health Systems Asset and Surplus Property or Equipment Disposition Policy (Attachment 2) requires an annual report (Attachment 1) to be submitted to the KHS Finance Committee.

Discussion

KHS Department Managers are to identify property or equipment that is no longer being used in operations, indicate an item as non-repairable, obsolete, or surplus and are to submit a request for disposal of the item. It is the responsibility of the Corporate Services Department to dispose of equipment in a manner that maximizes returns while ensuring open and effective competition.

The principal methods for disposing of equipment no longer in use (in priority order) are:

1. Determine if the equipment can be used by another department at KHS.
2. Sale by competitive bid or direct negotiation.
3. Trade-in towards the purchase of a new, like item.
4. Donate surplus equipment within Kern County according to the following priority:
    a) Offer equipment to contracted providers to promote electronic business to business interactions
    b) Offer to non-profit organizations and government agencies
5. Sell or donate to KHS employees.
6. Items with a value of less than $50 which cannot be sold or donated will be recycled using an E-Waste vendor.

During 2022, a loss of $1,813 was recorded on the disposition of obsolete equipment.

Requested Actions

Receive and file, for informational purposes only.

KERN • HEALTH SYSTEMS

Attachment 1

2022 Asset Dispositions

Date in Service	Category	Description	Book Value at Date of Disposal	Disposition Date	Reason for Disposal	Disposition Notes
11/5/2003	Furniture	4 Sofas & 11 Chairs	-	4/30/2022	Obsolete	Donated to Kern Bridges Youth Homes
10/24/2003	Furniture	Furn - Office	-	5/31/2022	Obsolete	Donated to Premier Valley Medical Group
10/24/2003	Furniture	Furniture- Desk	-	5/31/2022	Obsolete	Donated to Premier Valley Medical Group
8/6/2015	Furniture	Furniture - Desk - 3 in 1 -Long desk -Mecry	-	5/31/2022	Obsolete	Donated to Premier Valley Medical Group
2/6/2008	Equipment	Powered Quick Lift	-	6/30/2022	Obsolete	Disposed-Recycled
4/20/2017	Furniture	Desk MS PR analysts	-	6/30/2022	Obsolete	Donated to Parkside Congregate Living
10/24/2003	Furniture	Desk w/ 6/6/12 Pedestal Drawer 24x72	-	6/30/2022	Obsolete	Donated to Parkside Congregate Living
8/19/2010	Equipment	Dell Latitude E6410	-	6/30/2022	Obsolete	Disposed-Recycled
7/2/2014	Equipment	Fujitsu FI-7160 Col Duplex 60PPM USB	-	6/30/2022	Obsolete	Disposed-Recycled
4/20/2017	Equipment	HEX Surface Pro 4 sleeve w/rear	-	6/30/2022	Obsolete	Disposed-Recycled
9/29/2017	Equipment	12 - Dell Latitude E5470	104.10	6/30/2022	Obsolete	Disposed-Recycled
10/15/2013	Equipment	13- E6330 Laptop w/Doc Station	-	6/30/2022	Obsolete	Disposed-Recycled
4/13/2015	Equipment	10 - Dell Latutude E5450	-	6/30/2022	Obsolete	Disposed-Recycled
8/7/2015	Equipment	12 - Dell Venue 11 Pro	-	6/30/2022	Obsolete	Disposed-Recycled
9/14/2015	Equipment	4 - Dell Latitude e5400	-	6/30/2022	Obsolete	Disposed-Recycled
2/20/2014	Equipment	14 - Latitude 14 5000 w/dual monitor	-	6/30/2022	Obsolete	Disposed-Recycled
5/4/2012	Equipment	3 - Latitude E6320	-	6/30/2022	Obsolete	Disposed-Recycled
1/18/2013	Equipment	6 - XPS 12 Mobile Device	-	6/30/2022	Obsolete	Disposed-Recycled
6/4/2014	Equipment	4 - Optiplex 3020	-	6/30/2022	Obsolete	Disposed-Recycled
2/16/2012	Equipment	15 - 790 Optiplex Desktop	-	6/30/2022	Obsolete	Disposed-Recycled
4/22/2017	Equipment	2 - Checkpoint CPAP-4-1C	-	6/30/2022	Obsolete	Disposed-Recycled
12/7/2011	Equipment	Copier-IR 5050n w/Finisher AD1	-	6/30/2022	Obsolete	Disposed-Recycled
12/7/2011	Equipment	Copier-IR advanced C5035	-	6/30/2022	Obsolete	Disposed-Recycled
10/24/2003	Furniture	Desk W/2 Pedestal	-	8/31/2022	Obsolete	Disposed-Recycled
4/1/2020	Equipment	Surface Pro 7	-	10/30/2022	Obsolete	Disposed-Sold
4/15/2008	Equipment	2 - 1841 Router Cisco	-	11/30/2022	Obsolete	Disposed-Recycled
7/1/2011	Equipment	Blade Server Enclosure	-	11/30/2022	Obsolete	Disposed-Recycled
12/31/2013	Equipment	Canon ImageRunner Adv.	-	11/30/2022	Obsolete	Disposed-Recycled
4/22/2017	Equipment	Checkpoint CPAP- SG3200 NGTX	-	11/30/2022	Obsolete	Disposed-Recycled
7/1/2011	Equipment	Checkpoint UTM Device and Subscription	-	11/30/2022	Obsolete	Disposed-Recycled
7/11/2012	Equipment	Checkpoint-4200 Series Appliance with 7 Blades	-	11/30/2022	Obsolete	Disposed-Recycled
7/1/2011	Equipment	2 - Cisco Catalyst	-	11/30/2022	Obsolete	Disposed-Recycled
2/8/2013	Equipment	Cisco Ironport	-	11/30/2022	Obsolete	Disposed-Recycled
12/4/2008	Equipment	Cisco 3845	-	11/30/2022	Obsolete	Disposed-Recycled
11/11/2016	Equipment	16 - Dell Latitude E5470 CXCTO	38.22	11/30/2022	Obsolete	Disposed-Recycled
8/8/2013	Equipment	Dell Latitude E6540	-	11/30/2022	Obsolete	Disposed-Recycled
4/22/2010	Equipment	E6400 Latitude Intel Core	-	11/30/2022	Obsolete	Disposed-Recycled
5/6/2016	Equipment	5 - EX3300 , 48 Port connection	-	11/30/2022	Obsolete	Disposed-Recycled
5/6/2016	Equipment	EX3300 48-Port Juniper Care	-	11/30/2022	Obsolete	Disposed-Recycled
7/11/2013	Equipment	IR Advance 6255	-	11/30/2022	Obsolete	Disposed-Recycled
4/9/2015	Equipment	Latitude 14 5000 Series	-	11/30/2022	Obsolete	Disposed-Recycled
1/30/2015	Equipment	Latitude E7440	-	11/30/2022	Obsolete	Disposed-Recycled
1/30/2015	Equipment	15 - Optiplex 3020	-	11/30/2022	Obsolete	Disposed-Recycled
4/5/2012	Equipment	4 - Optiplex 790 desktop	-	11/30/2022	Obsolete	Disposed-Recycled
12/1/2013	Equipment	5 - PCW-EX2200-48P-4G	-	11/30/2022	Obsolete	Disposed-Recycled
10/12/2016	Equipment	3 - PowerEdge M360 Blade Server	-	11/30/2022	Obsolete	Disposed-Recycled
12/31/2013	Equipment	2 - PowerEdge M520 Server Node for VRTX Chasis	-	11/30/2022	Obsolete	Disposed-Recycled
12/31/2013	Equipment	PowerEdge VRTX Rack	-	11/30/2022	Obsolete	Disposed-Recycled
6/4/2008	Equipment	Port Console & Adaptor	-	11/30/2022	Obsolete	Disposed-Recycled
6/6/2018	Equipment	Rack Shelf for Dual 1400/700 Appliances 14-D8DB5-	27.81	11/30/2022	Obsolete	Disposed-Recycled
11/9/2015	Equipment	Optiplex Small Form Factor	-	11/30/2022	Obsolete	Disposed-Recycled
9/14/2015	Equipment	3 - Dell Latitude E5450	-	11/30/2022	Obsolete	Disposed-Recycled
6/6/2018	Equipment	CPAP SG1470 NGTP POE	298.59	11/30/2022	Obsolete	Disposed-Recycled
2/28/2018	Equipment	3 - Dell Latitude 5480XCTO	449.25	11/30/2022	Obsolete	Disposed-Recycled
5/10/2019	Equipment	2 - Dell Latitude 5490 XCTO 210-ANMX	895.18	11/30/2022	Obsolete	Disposed-Recycled
3/31/2012	Equipment	Voice Galerway & Postacard	-	11/30/2022	Obsolete	Disposed-Recycled
12/7/2004	Automobile	Ford Escape	-	12/30/2022	Obsolete	Disposed-Sold
TOTAL LOSS RECOGNIZED ON DISPOSITION OF OFFICE FURNITURE & EQUIPMENT			$ 1,813.15			

Attachment 2

KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES

SUBJECT: Asset and Surplus Property or Equipment Disposition	INDEX NUMBER 80.21-I	Page 1 of 4
RESPONSIBLE DEPARTMENT HEAD: Controller		

Review Date	01/01/12						
Effective Date	01/06/12						
Revision No.	2012-01						

Approved _____ Date 1/6/12
Acting Chief Executive Officer

Approved _____ Date 1-5-12
Chief Financial Officer

Approved _____ Date 1-5-12
Controller

Approved _____ Date 1-5-12
Purchasing Manager

POLICY[1]: Asset and Surplus Property or Equipment Disposition

PURPOSE: To appropriately dispose of Kern Health Systems (KHS) owned tagged assets and surplus equipment that no longer has operational value.

DEFINITIONS:

Asset	Any tangible property owned by KHS, either with or without value, excluding real property
Disposal/Disposition	The sale, replacement, transfer, scrap, discard, recycling or other means of disposing of assets
E Waste	Electronic items to be recycled such as computers, monitors, phones
Fixed Asset	Classification of an item determined at the time of purchase to meet the capitalization requirements established by policy 80.11 Budget Guidelines
Item	Any piece of property or equipment

KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES

SUBJECT: Asset and Surplus Property or Equipment Disposition	INDEX NUMBER 80.21-I	Page 2 of 4

Obsolete	Significant decline in the competitiveness, usefulness, or value of an item or property whether due to alternatives that perform better, are cheaper, or both; or due to changes in user preference or requirements. For the purposes of this policy, obsolete will mean little to no monetary value.
Salvage Value	The estimated residual value of a depreciable asset (fixed asset) at the end of its economic or useful life.
Surplus Equipment	Excess, obsolete, salvageable or non-salvageable assets which are sold, replaced through the budget process, transferred, scrapped, discarded or otherwise removed from service by any other means of disposal.
Useful Life	The number of years an asset is determined to last at the time of purchase, to which a matching depreciation period is assigned.

ASSET DISPOSITION AUTHORITY:

1.0 Any Department Manager may identify KHS' property or equipment that is no longer being used in operations, whether that item is non-repairable, obsolete, or surplus, and may submit a request for disposal of that item. It is the responsibility of the Corporate Services department to dispose of surplus equipment in a manner that maximizes returns while ensuring open and effective competition. Surplus equipment and property may be disposed of via: interdepartmental transfer, sale by competitive bid or direct negotiation, trade-in on new property, donation, e-waste recycling, or scrap. Proceeds from the sale or recycling of equipment shall go into the KHS General Fund.

NOTIFICATION AND VERIFICATION:

1.0 Notification to Accounting of intent to dispose of property

a) When a Department Manager has determined an item is non-repairable, obsolete or surplus, they will notify the Accounting department to obtain the necessary specification details located on either the item's existing equipment card (in the case of a fixed asset), or purchasing documentation for non-capitalized items.

b) Upon receipt of the information from the Accounting department, the Department Manager will complete the Intent to Dispose of Property (IDP) form and will submit the form to Corporate Services.

2.0 Verification of Non-Repairable, Obsolete or Surplus

Corporate Services will make a reasonable effort to classify the item into one of the following categories: Non-Repairable, Obsolete or Surplus.

a) Non-Repairable Equipment: equipment that is broken beyond repair

b) Obsolete Equipment: equipment that has no useful value to KHS, has little to no monetary value, but may have value to another organization

c) Surplus Equipment: equipment in working order that is no longer being used by a

KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES

SUBJECT: Asset and Surplus Property or Equipment Disposition	INDEX NUMBER 80.21-I	Page 3 of 4

3.0 Notification to Accounting of sale, donation or recycling of property
When a fixed asset is sold, donated, or recycled, Corporate Services will notify Accounting by completing a Disposal of Fixed Asset (DFA) form. Corporate Services will attach the completed and executed IDP form to the DFA form. Accounting will review the DFA form and will record the disposition of the fixed asset on the equipment card.

4.0 The Controller will maintain the log of assets sold, transferred, traded, donated or scrapped.

5.0 On an annual basis, the CFO will present a listing of disposed assets for review by the Finance Committee.

6.0 In the event a potential disposal item has a book or market value in excess of $5,000.00, then Board approval is required before disposition is authorized.

DISPOSITION METHODS:

The principal methods for disposal of surplus equipment are:

1.0 Interdepartmental transfer: Prior to disposal, Corporate Services will make a reasonable effort to ensure the equipment cannot be used by another department. If the item can be used by another department, Corporate Services will deliver that item to the requesting department. In the case of a fixed asset, Corporate Services will indicate the new location on the IDP form and will forward the form to Accounting so that a change in location can be recorded on the equipment card. A copy of the IDP form will also be sent to the requesting Department Manager.

2.0 Sale by competitive bid or direct negotiation: If obsolete or surplus equipment is in working condition and has previously been determined to have a resale value greater than $100, Corporate Services will attempt to bundle like (or networked) items and sell the equipment via an online auction competitive bidding process or directly negotiated sale. It will be made clear to all prospective buyers that assets are sold as-is and at the buyer's risk. No warranty or after sale service will be offered. Delivery of the equipment will be at the buyer's expense.

3.0 Trade-in: If the surplus equipment has trade-in value toward the purchase of a new, like item, the item will be hauled away by the new equipment vendor. The trade-in value will be reflected on the invoice for the new equipment.

4.0 Donate or Sell:
KHS will donate surplus equipment within Kern County according to the following priority list:
- KHS will offer computer equipment to contracted providers to promote electronic business to business interactions.
- KHS will offer equipment to non-profit organizations and governmental agencies.
- KHS will sell equipment to KHS employees.

5.0 Prior to the sale or donation of any computer equipment, KHS will ensure that the computers are scrubbed clean of all corporate information (all electronic files deleted and licensed software removed), and the operating system will be reloaded. Inventory and identification tags will be removed. KHS will donate computer equipment as is, with no guarantee toward the current or future working condition of the equipment. KHS will not provide technical assistance with set-up or operation of the equipment.

6.0 E-Waste: Electronic items that have monetary value less than $50, which cannot be sold or donated, will be recycled using an approved e-waste vendor selected by Corporate Services.

KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES

SUBJECT: Asset and Surplus Property or Equipment Disposition	INDEX NUMBER 80.21-I	Page 4 of 4

Corporate Services will complete a DFA form and will submit to Accounting.

7.0 Scrap: If the surplus equipment is broken and is not e-waste, Corporate Services will make a reasonable effort to determine the cost of repairs, the extended life of the repairs, and compare the repaired value against the cost of a replacement item. If the cost to repair the item is greater than replacement or if the item cannot be repaired due to the non-availability of parts, the item will be marked as scrap. Scrap equipment will be physically disposed of following current city and county dump site requirements.

Attachments:

- ❖ Attachment A – Intent to Dispose of KHS Property
- ❖ Attachment B – Disposal of Fixed Asset(s)

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[1] **Revision 2012-01**: Developed by KHS' Chief Financial Officer to appropriately dispose of KHS owned assets and surplus equipment that no longer have an operational value.

Attachment A

KERN HEALTH SYSTEMS

9700 Stockdale Hwy
Bakersfield, CA 93311
661-664-5000

Intent to Dispose of Property, Plant & Equipment

Department:	
Contact Person:	Phone:

QTY	Serial number	Description	KHS Tag #

Status of Item

Non-Repairable

Obsolete

Surplus

Comments:

Verification of Item Status: _____

New Location of Surplus Equipment: _____

Cc: Accounting, Corporate Service, Department Manager

Attachment B

KERN HEALTH SYSTEMS

9700 Stockdale Hwy
Bakersfield, CA 93311
661-664-5000

Disposal of Fixed Asset

Department:	
Contact Person:	**Phone:**

QTY	Serial number	Description	KHS Tag #

Disposition Notes: (method and details of disposal: donate, trade-in, sell, E-waste, scrap)

CHAIN OF CUSTODY

MIS (computer equip only): _____ **Date:** _____ **Time:** _____

Relinquished: _____ **Date:** _____ **Time:** _____

Received: _____ **Date:** _____ **Time:** _____

cc: Accounting, Relinquishing Department and Corporate Services (Original stays with accounting)

To: KHS Board of Directors

From: Robert Landis, CFO

Date: February 16, 2023

Re: Review of 2022 Budgeted Capital Projects Extended Into 2023

Background

At the December 15, 2022 Board of Directors ("Board") Meeting, the Board requested a review of the KHS 2022 Budgeted Capital Projects that were being extended into 2023. Management has identified the following 2022 Budgeted Capital Projects that will continue during 2023:

1) Community Based Organization (CBO) Referral System
2) Solar Panels

Discussion

Community Based Organization (CBO) Referral System

2022 Budget $1,105,080; 12/31/2022 Amount Outstanding $333,456

KHS established this project to acquire an integrated referral software system to support the Community Based Organizations (CBOs) for the new Medi-Cal Community Based Supports benefits (formerly known as In Lieu of Services, ILOS). This software will provide connectivity between the Health Plan and the CBO for a seamless process to coordinate the new non-clinical services/benefits.

Expected Completion Date: 2nd Quarter 2023

Solar Panels

2022 Budget $2,400,00; 12/31/2022 Amount Outstanding $1,040,000

Purchase of an additional carport solar system that will expand our electricity production capacity to approximately 100% of what we consume. (Amount Outstanding reflects expected Tax Credit of $560,000)

Expected Completion Date: 4th Quarter 2023

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: February 16, 2023

Re: November 2022 Financial Results

The November results reflect a $11,631,938 Net Increase in Net Position which is a $11,823,282 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $9.9 million favorable variance primarily due to:

   A) $6.5 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $1.5 million favorable variance in Premium-Hospital Directed Payments primarily due to higher-than-expected budgeted membership offset against amounts included in 2B below.

   C) $1.3 million favorable variance in Rate/Income Adjustments primarily due to earning additional Covid-19 Vaccination Incentive Funds from the High Performance Pool for meeting an additional qualifying measurement for children between 5-11 being within 10% of the County Rate.

2) Total Medical Costs reflect a $1.5 million favorable variance primarily due to:

   A) $2.5 million favorable variance in Inpatient primarily due to lower-than-expected utilization over the last several months by Family and Expansion members.

   B) $1.5 million unfavorable variance in Hospital Directed Payments primarily due to higher-than-expected budgeted membership offset against amounts included in 1B above.

The November Medical Loss Ratio is 80.8% which is favorable to the 92.9% budgeted amount. The November Administrative Expense Ratio is 6.4% which is favorable to the 6.8% budgeted amount.

The results for the 11 months ended November 30, 2022 reflects a Net Increase in Net Position of $46,650,958. This is a $50,036,818 favorable variance to the budget and includes approximately $14.5 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 87.9% which is favorable to the 92.9% budgeted amount. The year-to-date Administrative Expense Ratio is 6.4% which is favorable to the 7.0% budgeted amount.

Kern Health Systems
Financial Packet
November 2022

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF NOVEMBER 30, 2022

ASSETS	NOVEMBER 2022	OCTOBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 179,619,246	$ 155,712,819	$ 23,906,427
Short-Term Investments	210,720,910	216,266,372	(5,545,462)
Premiums Receivable - Net	109,732,438	106,316,288	3,416,150
Premiums Receivable - Hospital Direct Payments	396,795,571	377,478,453	19,317,118
Interest Receivable	168,011	84,010	84,001
Provider Advance Payment	2,361,487	2,599,965	(238,478)
Other Receivables	2,071,184	1,973,160	98,024
Prepaid Expenses & Other Current Assets	2,723,407	3,011,430	(288,023)
Total Current Assets	$ 904,192,254	$ 863,442,497	$ 40,749,757
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,259,875	1,307,117	(47,242)
Computer Hardware and Software - Net	20,493,849	18,555,056	1,938,793
Building and Building Improvements - Net	33,791,308	33,867,417	(76,109)
Capital Projects in Progress	4,168,950	6,353,893	(2,184,943)
Total Capital Assets	$ 63,804,688	$ 64,174,189	$ (369,501)
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,604,652	1,604,652	-
Total Long Term Assets	$ 1,904,652	$ 1,904,652	$ -
DEFERRED OUTFLOWS OF RESOURCES	$ 4,731,067	$ 4,731,067	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 974,632,661	$ 934,252,405	$ 40,380,256
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 4,033,090	$ 5,183,589	(1,150,499)
Accrued Other Operating Expenses	2,223,938	2,332,830	(108,892)
Accrued Taxes and Licenses	21,611,880	10,728,420	10,883,460
Claims Payable (Reported)	19,495,865	25,138,610	(5,642,745)
IBNR - Inpatient Claims	56,225,683	55,619,619	606,064
IBNR - Physician Claims	19,440,798	19,630,283	(189,485)
IBNR - Accrued Other Medical	26,682,535	24,071,362	2,611,173
Risk Pool and Withholds Payable	5,714,494	5,220,812	493,682
Statutory Allowance for Claims Processing Expense	2,509,938	2,509,938	-
Other Liabilities	119,115,609	117,487,167	1,628,442
Accrued Hospital Directed Payments	396,613,229	377,296,111	19,317,118
Total Current Liabilities	$ 673,667,059	$ 645,218,741	$ 28,448,318
NONCURRENT LIABILITIES:			
Net Pension Liability	1,500,000	1,200,000	300,000
TOTAL NONCURRENT LIABILITIES	$ 1,500,000	$ 1,200,000	$ 300,000
DEFERRED INFLOWS OF RESOURCES	$ 5,338,319	$ 5,338,319	$ -
NET POSITION:			
Net Position - Beg. of Year	247,476,325	247,476,325	-
Increase (Decrease) in Net Position - Current Year	46,650,958	35,019,020	11,631,938
Total Net Position	$ 294,127,283	$ 282,495,345	$ 11,631,938
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 974,632,661	$ 934,252,405	$ 40,380,256

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED NOVEMBER 30, 2022

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
208,436	209,700	(1,264)	Family Members	2,247,076	2,235,200	11,876
95,468	85,030	10,438	Expansion Members	980,921	905,330	75,591
17,063	16,530	533	SPD Members	184,376	176,330	8,046
10,012	7,740	2,272	Other Members	103,980	85,140	18,840
14,433	13,000	1,433	Kaiser Members	150,407	143,000	7,407
345,412	332,000	13,412	Total Members - MCAL	3,666,760	3,545,000	121,760
			REVENUES			
39,648,035	36,853,398	2,794,637	Title XIX - Medicaid - Family and Other	411,947,301	395,128,449	16,818,852
32,934,833	29,613,473	3,321,360	Title XIX - Medicaid - Expansion Members	337,202,475	315,343,901	21,858,574
15,878,315	15,489,195	389,120	Title XIX - Medicaid - SPD Members	168,270,099	165,227,449	3,042,650
10,883,460	10,982,734	(99,274)	Premium - MCO Tax	113,781,623	113,616,188	165,435
19,322,384	17,817,966	1,504,418	Premium - Hospital Directed Payments	201,736,942	190,390,843	11,346,099
888,027	85,637	802,390	Investment Earnings And Other Income	873,726	913,851	(40,125)
-	57,420	(57,420)	Reinsurance Recoveries	-	612,360	(612,360)
(5,267)	-	(5,267)	Rate Adjustments - Hospital Directed Payments	22,549,622	-	22,549,622
1,298,007	-	1,298,007	Rate/Income Adjustments	(304,086)	-	(304,086)
120,847,794	110,899,823	9,947,971	TOTAL REVENUES	1,256,057,702	1,181,233,042	74,824,660
			EXPENSES			
			Medical Costs:			
18,483,343	17,860,248	(623,095)	Physician Services	204,344,404	190,423,868	(13,920,536)
5,432,710	5,974,188	541,478	Other Professional Services	56,353,862	64,434,083	8,080,221
5,682,299	5,811,901	129,602	Emergency Room	52,536,673	61,971,376	9,434,703
18,414,421	20,880,163	2,465,742	Inpatient	229,630,704	222,591,306	(7,039,398)
58,838	57,420	(1,418)	Reinsurance Expense	536,175	612,360	76,185
8,727,267	8,876,430	149,163	Outpatient Hospital	98,400,821	94,627,967	(3,772,854)
16,382,849	16,352,220	(30,629)	Other Medical	177,956,606	174,779,573	(3,177,033)
493,681	478,500	(15,181)	Pay for Performance Quality Incentive	5,267,489	5,103,000	(164,489)
19,322,384	17,817,966	(1,504,418)	Hospital Directed Payments	201,736,942	190,390,843	(11,346,099)
(5,266)	-	5,266	Hospital Directed Payment Adjustment	22,882,779	-	(22,882,779)
4,018	-	(4,018)	Non-Claims Expense Adjustment	(872,920)	-	872,920
(436,641)	-	436,641	IBNR, Incentive, Paid Claims Adjustment	(17,018,623)	-	17,018,623
92,559,903	94,109,038	1,549,135	Total Medical Costs	1,031,754,912	1,004,934,377	(26,820,535)
28,287,891	16,790,785	11,497,106	GROSS MARGIN	224,302,790	176,298,665	48,004,125
			Administrative:			
3,241,130	3,369,438	128,308	Compensation	34,686,341	37,138,823	2,452,482
1,034,408	1,108,544	74,136	Purchased Services	10,648,876	12,193,986	1,545,110
258,430	212,108	(46,322)	Supplies	1,142,900	2,333,183	1,190,283
622,602	526,572	(96,030)	Depreciation	6,437,253	5,792,291	(644,962)
320,234	366,066	45,832	Other Administrative Expenses	3,531,773	4,026,722	494,949
299,689	-	(299,689)	Administrative Expense Adjustment	2,704,279	-	(2,704,279)
5,776,493	5,582,728	(193,765)	Total Administrative Expenses	59,151,422	61,485,005	2,333,583
98,336,396	99,691,765	1,355,369	TOTAL EXPENSES	1,090,906,334	1,066,419,382	(24,486,952)
22,511,398	11,208,057	11,303,341	OPERATING INCOME (LOSS) BEFORE TAX	165,151,368	114,813,660	50,337,708
10,883,460	10,982,733	99,273	MCO TAX	113,775,355	113,616,188	(159,167)
11,627,938	225,324	11,402,614	OPERATING INCOME (LOSS) NET OF TAX	51,376,013	1,197,472	50,178,541
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
4,000	(333,334)	337,334	Provider Grants/CalAIM Initiative Grant	(4,091,430)	(3,666,666)	(424,764)
-	(83,334)	83,334	Health Home	(633,625)	(916,666)	283,041
4,000	(416,668)	420,668	TOTAL NONOPERATING REVENUE (EXPENSE)	(4,725,055)	(4,583,332)	(141,723)
11,631,938	(191,344)	11,823,282	NET INCREASE (DECREASE) IN NET POSITION	46,650,958	(3,385,860)	50,036,818
80.8%	92.9%	12.1%	MEDICAL LOSS RATIO	87.9%	92.9%	4.9%
6.4%	6.8%	0.4%	ADMINISTRATIVE EXPENSE RATIO	6.4%	7.0%	0.6%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED NOVEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
208,436	209,700	(1,264)	Family Members	2,247,076	2,235,200	11,876
95,468	85,030	10,438	Expansion Members	980,921	905,330	75,591
17,063	16,530	533	SPD Members	184,376	176,330	8,046
10,012	7,740	2,272	Other Members	103,980	85,140	18,840
14,433	13,000	1,433	Kaiser Members	150,407	143,000	7,407
345,412	332,000	13,412	Total Members - MCAL	3,666,760	3,545,000	121,760
			REVENUES			
181.50	169.49	12.01	Title XIX - Medicaid - Family and Other	175.22	170.29	4.93
344.98	348.27	(3.29)	Title XIX - Medicaid - Expansion Members	343.76	348.32	(4.56)
930.57	937.04	(6.47)	Title XIX - Medicaid - SPD Members	912.65	937.04	(24.39)
32.88	34.43	(1.55)	Premium - MCO Tax	32.36	33.40	(1.04)
58.38	55.86	2.52	Premium - Hospital Directed Payments	57.37	55.96	1.41
2.68	0.27	2.41	Investment Earnings And Other Income	0.25	0.27	(0.02)
0.00	0.18	(0.18)	Reinsurance Recoveries	0.00	0.18	(0.18)
(0.02)	0.00	(0.02)	Rate Adjustments - Hospital Directed Payments	6.41	0.00	6.41
3.92	0.00	3.92	Rate/Income Adjustments	(0.09)	0.00	(0.09)
365.12	347.65	17.47	TOTAL REVENUES	357.20	347.22	9.99
			EXPENSES			
			Medical Costs:			
55.84	55.99	0.14	Physician Services	58.11	55.97	(2.14)
16.41	18.73	2.31	Other Professional Services	16.03	18.94	2.91
17.17	18.22	1.05	Emergency Room	14.94	18.22	3.28
55.64	65.46	9.82	Inpatient	65.30	65.43	0.13
0.18	0.18	0.00	Reinsurance Expense	0.15	0.18	0.03
26.37	27.83	1.46	Outpatient Hospital	27.98	27.82	(0.17)
49.50	51.26	1.76	Other Medical	50.61	51.38	0.77
1.49	1.50	0.01	Pay for Performance Quality Incentive	1.50	1.50	0.00
58.38	55.86	(2.52)	Hospital Directed Payments	57.37	55.96	(1.41)
(0.02)	0.00	0.02	Hospital Directed Payment Adjustment	6.51	0.00	(6.51)
0.01	0.00	(0.01)	Non-Claims Expense Adjustment	(0.25)	0.00	0.25
(1.32)	0.00	1.32	IBNR, Incentive, Paid Claims Adjustment	(4.84)	0.00	4.84
279.65	295.01	15.36	Total Medical Costs	293.42	295.40	1.98
85.47	52.64	32.83	GROSS MARGIN	63.79	51.82	11.97
			Administrative:			
9.79	10.56	0.77	Compensation	9.86	10.92	1.05
3.13	3.48	0.35	Purchased Services	3.03	3.58	0.56
0.78	0.66	(0.12)	Supplies	0.33	0.69	0.36
1.88	1.65	(0.23)	Depreciation	1.83	1.70	(0.13)
0.97	1.15	0.18	Other Administrative Expenses	1.00	1.18	0.18
0.91	0.00	(0.91)	Administrative Expense Adjustment	0.77	0.00	(0.77)
17.45	17.50	0.05	Total Administrative Expenses	16.82	18.07	1.25
297.11	312.51	15.41	TOTAL EXPENSES	310.24	313.47	3.23
68.01	35.13	32.88	OPERATING INCOME (LOSS) BEFORE TAX	46.97	33.75	13.22
32.88	34.43	1.55	MCO TAX	32.36	33.40	1.04
35.13	0.71	34.43	OPERATING INCOME (LOSS) NET OF TAX	14.61	0.35	14.26
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
0.01	(1.04)	1.06	Reserve Fund Projects/Community Grants	(1.16)	(1.08)	(0.09)
0.00	(0.26)	0.26	Health Home	(0.18)	(0.27)	0.09
0.01	(1.31)	1.32	TOTAL NONOPERATING REVENUE (EXPENSE)	(1.34)	(1.35)	0.00
35.14	(0.60)	35.74	NET INCREASE (DECREASE) IN NET POSITION	13.27	(1.00)	14.26
80.8%	92.9%	12.1%	MEDICAL LOSS RATIO	87.9%	92.9%	4.9%
6.4%	6.8%	0.4%	ADMINISTRATIVE EXPENSE RATIO	6.4%	7.0%	0.6%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH NOVEMBER 30, 2022	NOVEMBER 2021	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022
ENROLLMENT							
Members - MCAL	296,989	298,205	309,342	310,281	312,490	314,691	315,663
REVENUES							
Title XIX - Medicaid - Family and Other	37,111,335	36,899,197	37,009,614	37,126,546	36,539,594	36,762,722	35,766,911
Title XIX - Medicaid - Expansion Members	31,001,586	30,241,720	29,968,453	29,945,915	29,350,530	29,812,384	29,600,713
Title XIX - Medicaid - SPD Members	16,254,790	16,506,513	14,953,594	14,858,906	14,791,754	14,924,745	14,887,158
Premium - MCO Tax	10,229,533	10,273,393	9,899,314	9,894,054	9,893,826	9,894,054	9,872,493
Premium - Hospital Directed Payments	16,753,272	16,836,470	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276
Investment Earnings And Other Income	157,659	(694,967)	329,573	86,457	(1,241,065)	(326,288)	357,517
Rate Adjustments - Hospital Directed Payments	8,691	(3,586)	230,177	24,013	26,907,309	3,898	(23,892)
Rate/Income Adjustments	66,815	5,625	957,475	977,794	493,268	59,935	(4,649,731)
TOTAL REVENUES	111,583,681	110,064,365	110,955,070	110,568,181	134,684,350	109,037,367	103,739,445
EXPENSES							
Medical Costs:							
Physician Services	17,258,969	17,972,930	17,538,030	19,319,317	19,919,152	18,291,501	17,895,843
Other Professional Services	4,829,415	4,344,076	5,041,033	4,902,710	5,254,779	5,361,545	4,835,075
Emergency Room	4,818,883	4,391,622	5,209,937	5,098,972	5,150,400	5,098,584	4,139,529
Inpatient	21,256,426	17,137,562	20,610,105	20,031,970	20,232,342	20,364,608	21,395,635
Reinsurance Expense	86,151	86,147	53,660	53,896	57,686	56,409	56,248
Outpatient Hospital	7,793,785	6,083,159	8,214,215	8,223,126	8,686,122	8,458,833	8,281,163
Other Medical	12,549,269	11,502,354	17,263,621	17,534,988	15,788,879	16,341,907	16,301,024
Pharmacy	10,196,195	10,620,178	-	-	-	-	-
Pay for Performance Quality Incentive	-	1,420,000	464,013	465,422	465,421	472,037	473,494
Hospital Directed Payments	16,753,272	16,836,470	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276
Hospital Directed Payment Adjustment	8,691	(3,586)	230,177	24,013	26,678,156	3,898	(3,419)
Non-Claims Expense Adjustment	24,857	(44,256)	43,538	4,118	572,469	62,025	(1,371,999)
IBNR, Incentive, Paid Claims Adjustment	(1,378,922)	(1,022,824)	627	(1,010,781)	(3,987,493)	(2,812,496)	(3,724,314)
Total Medical Costs	94,196,991	89,323,832	92,275,826	92,302,247	116,767,047	89,604,768	86,206,555
GROSS MARGIN	17,386,690	20,740,533	18,679,244	18,265,934	17,917,303	19,432,599	17,532,890
Administrative:							
Compensation	2,775,542	2,592,690	3,116,842	2,847,002	3,108,703	3,075,151	3,259,102
Purchased Services	1,095,098	1,355,474	846,917	877,498	1,098,614	783,960	927,532
Supplies	188,536	164,659	191,908	(8,268)	103,207	41,533	145,499
Depreciation	716,552	746,072	571,126	571,126	571,126	570,835	575,899
Other Administrative Expenses	276,718	605,706	389,918	259,997	346,089	252,930	300,845
Administrative Expense Adjustment	77,569	(194,326)	(1,904)	(44,283)	31,776	164,256	(2,834)
Total Administrative Expenses	5,130,015	5,270,275	5,114,807	4,503,072	5,259,515	4,888,665	5,206,043
TOTAL EXPENSES	99,327,006	94,594,107	97,390,633	96,805,319	122,026,562	94,493,433	91,412,598
OPERATING INCOME (LOSS) BEFORE TAX	12,256,675	15,470,258	13,564,437	13,762,862	12,657,788	14,543,934	12,326,847
MCO TAX	9,894,054	9,895,157	9,894,054	9,894,054	9,893,826	9,894,054	9,888,018
OPERATING INCOME (LOSS) NET OF TAX	2,362,621	5,575,101	3,670,383	3,868,808	2,763,962	4,649,880	2,438,829
TOTAL NONOPERATING REVENUE (EXPENSE)	(1,516,642)	(175,210)	(400,389)	(986,700)	(1,001,012)	(1,110,153)	744,870
NET INCREASE (DECREASE) IN NET POSITION	845,979	5,399,891	3,269,994	2,882,108	1,762,950	3,539,727	3,183,699
MEDICAL LOSS RATIO	91.5%	87.4%	89.4%	89.9%	90.2%	88.3%	89.9%
ADMINISTRATIVE EXPENSE RATIO	6.1%	6.4%	6.1%	5.4%	6.6%	6.0%	6.9%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH NOVEMBER 30, 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	319,333	323,572	324,961	325,920	329,121	330,979	4,111,547
REVENUES							
Title XIX - Medicaid - Family and Other	37,731,384	37,514,641	37,941,354	37,957,277	37,949,223	39,648,035	485,957,833
Title XIX - Medicaid - Expansion Members	30,533,210	30,993,375	31,238,545	31,275,148	31,549,369	32,934,833	398,445,781
Title XIX - Medicaid - SPD Members	15,402,431	15,833,803	15,065,828	15,760,220	15,913,345	15,878,315	201,031,402
Premium - MCO Tax	9,910,584	10,883,460	10,883,459	10,883,460	10,883,459	10,883,460	134,284,549
Premium - Hospital Directed Payments	18,280,365	18,674,627	18,595,974	18,857,014	18,961,885	19,322,384	235,326,684
Investment Earnings And Other Income	(633,952)	1,002,315	(121,473)	353,347	179,268	888,027	336,418
Rate Adjustments - Hospital Directed Payments	5,129	9,235	(4,343)	(4,606,563)	9,926	(5,267)	22,554,727
Rate/Income Adjustments	(364,397)	350,036	245,168	203,911	124,448	1,298,007	(231,646)
TOTAL REVENUES	110,864,754	115,261,492	113,844,512	110,683,814	115,570,923	120,847,794	1,477,705,748
EXPENSES							
Medical Costs:							
Physician Services	18,921,901	18,984,281	18,198,409	18,622,853	18,169,774	18,483,343	239,576,303
Other Professional Services	5,112,961	5,137,341	5,208,793	5,024,917	5,041,998	5,432,710	65,527,353
Emergency Room	3,167,228	4,764,039	4,661,044	4,773,821	4,790,820	5,682,299	61,747,178
Inpatient	19,551,774	22,935,749	20,834,103	22,797,560	22,462,437	18,414,421	268,024,692
Reinsurance Expense	57,216	(33,668)	(25,136)	142,533	58,493	58,838	708,473
Outpatient Hospital	9,196,013	10,013,268	9,928,749	9,352,210	9,319,855	8,727,267	112,277,765
Other Medical	15,522,071	15,416,935	15,241,576	15,744,662	16,418,094	16,382,849	202,008,229
Pharmacy	-	-	-	-	-	-	20,816,373
Pay for Performance Quality Incentive	478,060	485,358	485,358	490,964	493,681	493,681	6,687,489
Hospital Directed Payments	18,280,365	18,674,627	18,595,974	18,857,014	18,961,885	19,322,384	235,326,684
Hospital Directed Payment Adjustment	5,129	9,235	(4,343)	(4,064,727)	9,926	(5,266)	22,887,884
Non-Claims Expense Adjustment	29,799	17,040	5,019	9,821	(248,768)	4,018	(892,319)
IBNR, Incentive, Paid Claims Adjustment	(4,072,490)	(238,100)	487,881	(789,121)	(435,695)	(436,641)	(19,420,369)
Total Medical Costs	86,250,027	96,166,105	93,617,427	90,962,507	95,042,500	92,559,903	1,215,275,735
GROSS MARGIN	24,614,727	19,095,387	20,227,085	19,721,307	20,528,423	28,287,891	262,430,013
Administrative:							
Compensation	2,980,813	3,307,910	3,148,970	3,213,222	3,387,496	3,241,130	40,054,573
Purchased Services	850,526	1,078,360	1,144,312	997,356	1,009,393	1,034,408	13,099,448
Supplies	66,970	74,368	117,566	85,530	66,157	258,430	1,496,095
Depreciation	626,073	576,074	583,814	583,673	584,905	622,602	7,899,877
Other Administrative Expenses	329,335	414,331	315,625	298,240	304,229	320,234	4,414,197
Administrative Expense Adjustment	811,890	425,467	300,000	420,793	299,429	299,689	2,587,522
Total Administrative Expenses	5,665,607	5,876,510	5,610,287	5,598,814	5,651,609	5,776,493	69,551,712
TOTAL EXPENSES	91,915,634	102,042,615	99,227,714	96,561,321	100,694,109	98,336,396	1,284,827,447
OPERATING INCOME (LOSS) BEFORE TAX	18,949,120	13,218,877	14,616,798	14,122,493	14,876,814	22,511,398	192,878,301
MCO TAX	9,894,051	10,883,459	10,883,460	10,883,459	10,883,460	10,883,460	133,564,566
OPERATING INCOME (LOSS) NET OF TAX	9,055,069	2,335,418	3,733,338	3,239,034	3,993,354	11,627,938	59,313,735
TOTAL NONOPERATING REVENUE (EXPENSE)	(1,996,822)	(3,380)	57,925	(27,966)	(5,428)	4,000	(6,416,907)
NET INCREASE (DECREASE) IN NET POSITION	7,058,247	2,332,038	3,791,263	3,211,068	3,987,926	11,631,938	52,896,828
MEDICAL LOSS RATIO	82.2%	90.4%	88.9%	89.0%	88.7%	80.8%	88.2%
ADMINISTRATIVE EXPENSE RATIO	6.9%	6.9%	6.6%	6.5%	6.6%	6.4%	6.4%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH NOVEMBER 30, 2022	NOVEMBER 2021	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022
ENROLLMENT							
Members - MCAL	296,989	298,205	309,342	310,281	312,490	314,691	315,663
REVENUES							
Title XIX - Medicaid - Family and Other	183.31	181.56	177.17	177.17	173.28	173.44	168.25
Title XIX - Medicaid - Expansion Members	393.96	382.19	357.24	355.03	344.90	345.21	341.10
Title XIX - Medicaid - SPD Members	1,026.19	1,042.14	903.21	907.36	895.60	912.10	913.04
Premium - MCO Tax	34.44	34.45	32.00	31.89	31.66	31.44	31.28
Premium - Hospital Directed Payments	56.41	56.46	56.92	56.90	57.44	56.90	56.80
Investment Earnings And Other Income	0.53	(2.33)	1.07	0.28	(3.97)	(1.04)	1.13
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	0.03	(0.01)	0.74	0.08	86.11	0.01	(0.08)
Rate/Income Adjustments	0.22	0.02	3.10	3.15	1.58	0.19	(14.73)
TOTAL REVENUES	375.72	369.09	358.68	356.35	431.00	346.49	328.64
EXPENSES							
Medical Costs:							
Physician Services	58.11	60.27	56.69	62.26	63.74	58.13	56.69
Other Professional Services	16.26	14.57	16.30	15.80	16.82	17.04	15.32
Emergency Room	16.23	14.73	16.84	16.43	16.48	16.20	13.11
Inpatient	71.57	57.47	66.63	64.56	64.75	64.71	67.78
Reinsurance Expense	0.29	0.29	0.17	0.17	0.18	0.18	0.18
Outpatient Hospital	26.24	20.40	26.55	26.50	27.80	26.88	26.23
Other Medical	42.25	38.57	55.81	56.51	50.53	51.93	51.64
Pharmacy	34.33	35.61	0.00	0.00	0.00	0.00	0.00
Pay for Performance Quality Incentive	0.00	4.76	1.50	1.50	1.49	1.50	1.50
Hospital Directed Payments	56.41	56.46	56.92	56.90	57.44	56.90	56.80
Hospital Directed Payment Adjustment	0.03	(0.01)	0.74	0.08	85.37	0.01	(0.01)
Non-Claims Expense Adjustment	0.08	(0.15)	0.14	0.01	1.83	0.20	(4.35)
IBNR, Incentive, Paid Claims Adjustment	(4.64)	(3.43)	0.00	(3.26)	(12.76)	(8.94)	(11.80)
Total Medical Costs	317.17	299.54	298.30	297.48	373.67	284.74	273.10
GROSS MARGIN	58.54	69.55	60.38	58.87	57.34	61.75	55.54
Administrative:							
Compensation	9.35	8.69	10.08	9.18	9.95	9.77	10.32
Purchased Services	3.69	4.55	2.74	2.83	3.52	2.49	2.94
Supplies	0.63	0.55	0.62	(0.03)	0.33	0.13	0.46
Depreciation	2.41	2.50	1.85	1.84	1.83	1.81	1.82
Other Administrative Expenses	0.93	2.03	1.26	0.84	1.11	0.80	0.95
Administrative Expense Adjustment	0.26	(0.65)	(0.01)	(0.14)	0.10	0.52	(0.01)
Total Administrative Expenses	17.27	17.67	16.53	14.51	16.83	15.53	16.49
TOTAL EXPENSES	334.45	317.21	314.83	311.99	390.50	300.27	289.59
OPERATING INCOME (LOSS) BEFORE TAX	41.27	51.88	43.85	44.36	40.51	46.22	39.05
MCO TAX	33.31	33.18	31.98	31.89	31.66	31.44	31.32
OPERATING INCOME (LOSS) NET OF TAX	7.96	18.70	11.87	12.47	8.84	14.78	7.73
TOTAL NONOPERATING REVENUE (EXPENSE)	(5.11)	(0.59)	(1.29)	(3.18)	(3.20)	(3.53)	2.36
NET INCREASE (DECREASE) IN NET POSITION	2.85	18.11	10.57	9.29	5.64	11.25	10.09
MEDICAL LOSS RATIO	91.5%	87.4%	89.4%	89.9%	90.2%	88.3%	89.9%
ADMINISTRATIVE EXPENSE RATIO	6.1%	6.4%	6.1%	5.4%	6.6%	6.0%	6.9%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH NOVEMBER 30, 2022	JUNE 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	319,333	323,572	324,961	325,920	329,121	330,979	4,111,547
REVENUES							
Title XIX - Medicaid - Family and Other	176.65	173.99	175.92	175.56	174.37	180.89	176.23
Title XIX - Medicaid - Expansion Members	343.27	340.07	338.95	338.39	334.55	344.93	349.90
Title XIX - Medicaid - SPD Members	917.14	941.54	880.12	911.57	926.33	919.20	929.85
Premium - MCO Tax	31.04	33.64	33.49	33.39	33.07	32.88	32.66
Premium - Hospital Directed Payments	57.25	57.71	57.23	57.86	57.61	58.38	57.24
Investment Earnings And Other Income	(1.99)	3.10	(0.37)	1.08	0.54	2.68	0.08
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	0.02	0.03	(0.01)	(14.13)	0.03	(0.02)	5.49
Rate/Income Adjustments	(1.14)	1.08	0.75	0.63	0.38	3.92	(0.06)
TOTAL REVENUES	347.18	356.22	350.33	339.60	351.15	365.12	359.40
EXPENSES							
Medical Costs:							
Physician Services	59.25	58.67	56.00	57.14	55.21	55.84	58.27
Other Professional Services	16.01	15.88	16.03	15.42	15.32	16.41	15.94
Emergency Room	9.92	14.72	14.34	14.65	14.56	17.17	15.02
Inpatient	61.23	70.88	64.11	69.95	68.25	55.64	65.19
Reinsurance Expense	0.18	(0.10)	(0.08)	0.44	0.18	0.18	0.17
Outpatient Hospital	28.80	30.95	30.55	28.69	28.32	26.37	27.31
Other Medical	48.61	47.65	46.90	48.31	49.88	49.50	49.13
Pharmacy	0.00	0.00	0.00	0.00	0.00	0.00	5.06
Pay for Performance Quality Incentive	1.50	1.50	1.49	1.51	1.50	1.49	1.63
Hospital Directed Payments	57.25	57.71	57.23	57.86	57.61	58.38	57.24
Hospital Directed Payment Adjustment	0.02	0.03	(0.01)	(12.47)	0.03	(0.02)	5.57
Non-Claims Expense Adjustment	0.09	0.05	0.02	0.03	(0.76)	0.01	(0.22)
IBNR, Incentive, Paid Claims Adjustment	(12.75)	(0.74)	1.50	(2.42)	(1.32)	(1.32)	(4.72)
Total Medical Costs	270.09	297.20	288.09	279.09	288.78	279.65	295.58
GROSS MARGIN	77.08	59.01	62.24	60.51	62.37	85.47	63.83
Administrative:							
Compensation	9.33	10.22	9.69	9.86	10.29	9.79	9.74
Purchased Services	2.66	3.33	3.52	3.06	3.07	3.13	3.19
Supplies	0.21	0.23	0.36	0.26	0.20	0.78	0.36
Depreciation	1.96	1.78	1.80	1.79	1.78	1.88	1.92
Other Administrative Expenses	1.03	1.28	0.97	0.92	0.92	0.97	1.07
Administrative Expense Adjustment	2.54	1.31	0.92	1.29	0.91	0.91	0.63
Total Administrative Expenses	17.74	18.16	17.26	17.18	17.17	17.45	16.92
TOTAL EXPENSES	287.84	315.36	305.35	296.27	305.95	297.11	312.49
OPERATING INCOME (LOSS) BEFORE TAX	59.34	40.85	44.98	43.33	45.20	68.01	46.91
MCO TAX	30.98	33.64	33.49	33.39	33.07	32.88	32.49
OPERATING INCOME (LOSS) NET OF TAX	28.36	7.22	11.49	9.94	12.13	35.13	14.43
TOTAL NONOPERATING REVENUE (EXPENSE)	(6.25)	(0.01)	0.18	(0.09)	(0.02)	0.01	(1.56)
NET INCREASE (DECREASE) IN NET POSITION	22.10	7.21	11.67	9.85	12.12	35.14	12.87
MEDICAL LOSS RATIO	82.2%	90.4%	88.9%	89.0%	88.7%	80.8%	88.2%
ADMINISTRATIVE EXPENSE RATIO	6.9%	6.9%	6.6%	6.5%	6.6%	6.4%	6.4%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
28,700,729	27,593,304	1,107,425	Premium - Medi-Cal	303,420,239	295,323,339	8,096,900
3,187,586	2,764,572	423,014	Premium - Maternity Kick	32,006,336	30,410,295	1,596,041
559,463	479,368	80,095	Premium - Enhanced Care Management	5,823,869	5,165,303	658,566
148,100	134,568	13,532	Premium - Major Organ Transplant	1,547,044	1,444,608	102,436
785,076	508,286	276,790	Premium - Cal AIM	8,749,345	5,424,008	3,325,337
732,099	784,923	(52,824)	Premium - BHT Kick	8,495,053	8,376,046	119,007
3,633,757	4,159,580	(525,823)	Premium - Provider Enhancement	42,091,674	44,400,206	(2,308,532)
218,246	210,101	8,145	Premium - Ground Emergency Medical Transportation	2,310,158	2,245,826	64,332
145,996	106,841	39,155	Premium - Behavorial Health Integration Program	2,851,811	1,140,119	1,711,692
590,888	-	590,888	Premium - Vaccine Incentive	1,405,896	-	1,405,896
178,858	-	178,858	Premium - Student Behavioral Health Incentive	543,680	-	543,680
646,227	-	646,227	Premium - Housing and Homelessness Incentive	1,298,910	-	1,298,910
121,010	111,854	9,156	Other	1,403,286	1,198,698	204,588
39,648,035	36,853,398	2,794,637	Total Title XIX - Medicaid - Family & Other	411,947,301	395,128,449	16,818,852
			Title XIX - Medicaid - Expansion Members			
28,622,534	25,781,359	2,841,175	Premium - Medi-Cal	293,317,416	274,464,593	18,852,823
450,227	234,964	215,263	Premium - Maternity Kick	4,597,058	2,584,604	2,012,454
1,025,844	864,351	161,493	Premium - Enhanced Care Management	10,501,173	9,199,273	1,301,900
244,258	215,878	28,380	Premium - Major Organ Transplant	2,504,765	2,297,583	207,182
342,943	473,600	(130,657)	Premium - Cal AIM	3,646,876	5,042,509	(1,395,633)
-	-	-	Premium - BHT Kick	12,659	-	12,659
1,555,696	1,698,490	(142,794)	Premium - Provider Enhancement	17,577,146	18,084,135	(506,989)
240,311	215,041	25,270	Premium - Ground Emergency Medical Transportation	2,465,866	2,289,579	176,287
63,262	99,550	(36,288)	Premium - Behavorial Health Integration Program	1,163,755	1,059,929	103,826
7,351	-	7,351	Premium - Vaccine Incentive	266,803	-	266,803
77,915	-	77,915	Premium - Student Behavioral Health Incentive	226,848	-	226,848
270,529	-	270,529	Premium - Housing and Homelessness Incentive	534,057	-	534,057
33,963	30,240	3,723	Other	388,053	321,696	66,357
32,934,833	29,613,473	3,321,360	Total Title XIX - Medicaid - Expansion Members	337,202,475	315,343,901	21,858,574
			Title XIX - Medicaid - SPD Members			
13,781,940	13,137,218	644,723	Premium - Medi-Cal	146,160,261	140,138,266	6,021,996
504,582	472,593	31,989	Premium - Enhanced Care Management	5,352,302	5,041,278	311,024
157,010	150,258	6,752	Premium - Major Organ Transplant	1,665,130	1,602,843	62,287
61,333	241,356	(180,023)	Premium - Cal AIM	686,641	2,574,611	(1,887,970)
694,510	798,256	(103,746)	Premium - BHT Kick	7,226,214	8,515,207	(1,288,993)
447,218	491,004	(43,786)	Premium - Provider Enhancement	5,121,624	5,237,678	(116,054)
154,076	147,778	6,298	Premium - Ground Emergency Medical Transportation	1,634,003	1,576,388	57,615
11,524	50,733	(39,209)	Premium - Behavorial Health Integration Program	223,714	541,179	(317,465)
1,512	-	1,512	Premium - Vaccine Incentive	56,559	-	56,559
14,096	-	14,096	Premium - Student Behavioral Health Incentive	42,078	-	42,078
50,514	-	50,514	Premium - Housing and Homelessness Incentive	101,573	-	101,573
15,878,315	15,489,195	389,120	Total Title XIX - Medicaid - SPD Members	168,270,099	165,227,449	3,042,650

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
3,684,488	4,105,418	420,930	Primary Care Physician Services	41,197,251	43,781,956	2,584,705
12,648,430	12,061,595	(586,835)	Referral Specialty Services	140,573,500	128,586,083	(11,987,417)
2,141,425	1,684,236	(457,189)	Urgent Care & After Hours Advise	22,473,453	17,955,629	(4,517,824)
9,000	9,000	-	Hospital Admitting Team	100,200	100,200	-
18,483,343	17,860,248	(623,095)	TOTAL PHYSICIAN SERVICES	204,344,404	190,423,868	(13,920,536)
			OTHER PROFESSIONAL SERVICES			
326,879	335,229	8,350	Vision Service Capitation	3,481,454	3,575,070	93,616
1,936,887	2,154,063	217,176	Medical Departments - UM Allocation *	20,715,532	23,694,687	2,979,155
1,371,019	1,583,178	212,159	Behavior Health Treatment	14,816,522	16,891,254	2,074,732
221,811	158,952	(62,859)	Mental Health Services	1,714,316	1,695,049	(19,267)
1,576,114	1,742,766	166,652	Other Professional Services	15,626,038	18,578,023	2,951,985
5,432,710	5,974,188	541,478	TOTAL OTHER PROFESSIONAL SERVICES	56,353,862	64,434,083	8,080,221
5,682,299	5,811,901	129,602	EMERGENCY ROOM	52,536,673	61,971,376	9,434,703
18,414,421	20,880,163	2,465,742	INPATIENT HOSPITAL	229,630,704	222,591,306	(7,039,398)
58,838	57,420	(1,418)	REINSURANCE EXPENSE PREMIUM	536,175	612,360	76,185
8,727,267	8,876,430	149,163	OUTPATIENT HOSPITAL SERVICES	98,400,821	94,627,967	(3,772,854)
			OTHER MEDICAL			
1,514,523	1,670,892	156,369	Ambulance and NEMT	15,061,423	17,818,116	2,756,693
1,034,966	720,263	(314,703)	Home Health Services & CBAS	9,683,083	7,681,076	(2,002,007)
884,261	1,106,708	222,447	Utilization and Quality Review Expenses	8,765,185	12,173,788	3,408,603
1,390,150	1,505,377	115,227	Long Term/SNF/Hospice	17,979,306	16,051,079	(1,928,227)
5,354,477	6,061,593	707,116	Provider Enhancement Expense - Prop. 56	61,545,984	64,639,884	3,093,900
455,360	544,274	88,914	Provider Enhancement Expense - GEMT	5,074,274	5,806,210	731,936
11,536	-	(11,536)	Vaccine Incentive Program Expense	3,180,904	-	(3,180,904)
220,783	257,124	36,341	Behaviorial Health Integration Program	4,239,281	2,741,228	(1,498,053)
1,511,694	1,816,311	304,617	Enhanced Care Management	20,119,777	19,405,849	(713,928)
521,901	501,428	(20,473)	Major Organ Transplant	5,431,092	5,344,150	(86,942)
2,527,452	1,223,243	(1,304,209)	Cal AIM Incentive Programs	16,489,538	13,041,130	(3,448,408)
955,746	945,007	(10,739)	DME/Rebates	10,386,759	10,077,063	(309,696)
16,382,849	16,352,220	(30,629)	TOTAL OTHER MEDICAL	177,956,606	174,779,573	(3,177,033)
493,681	478,500	(15,181)	PAY FOR PERFORMANCE QUALITY INCENTIVE	5,267,489	5,103,000	(164,489)
19,322,384	17,817,966	(1,504,418)	HOSPITAL DIRECTED PAYMENTS	201,736,942	190,390,843	(11,346,099)
(5,266)	-	5,266	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	22,882,779	-	(22,882,779)
4,018	-	(4,018)	NON-CLAIMS EXPENSE ADJUSTMENT	(872,920)	-	872,920
(436,641)	-	436,641	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(17,018,623)	-	17,018,623
92,559,903	94,109,038	1,549,135	Total Medical Costs	1,031,754,912	1,004,934,377	(26,820,535)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED NOVEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
11.13	12.87	1.74	Primary Care Physician Services	11.72	12.87	1.15
38.22	37.81	(0.40)	Referral Specialty Services	39.98	37.80	(2.18)
6.47	5.28	(1.19)	Urgent Care & After Hours Advise	6.39	5.28	(1.11)
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
55.84	55.99	0.14	TOTAL PHYSICIAN SERVICES	58.11	55.97	(2.14)
			OTHER PROFESSIONAL SERVICES			
0.99	1.05	0.06	Vision Service Capitation	0.99	1.05	0.06
5.85	6.75	0.90	Medical Departments - UM Allocation *	5.89	6.96	1.07
4.14	4.96	0.82	Behavior Health Treatment	4.21	4.97	0.75
0.67	0.50	(0.17)	Mental Health Services	0.49	0.50	0.01
4.76	5.46	0.70	Other Professional Services	4.44	5.46	1.02
16.41	18.73	2.31	TOTAL OTHER PROFESSIONAL SERVICES	16.03	18.94	2.91
17.17	18.22	1.05	EMERGENCY ROOM	14.94	18.22	3.28
55.64	65.46	9.82	INPATIENT HOSPITAL	65.30	65.43	0.13
0.18	0.18	0.00	REINSURANCE EXPENSE PREMIUM	0.15	0.18	0.03
26.37	27.83	1.46	OUTPATIENT HOSPITAL SERVICES	27.98	27.82	(0.17)
			OTHER MEDICAL			
4.58	5.24	0.66	Ambulance and NEMT	4.28	5.24	0.95
3.13	2.26	(0.87)	Home Health Services & CBAS	2.75	2.26	(0.50)
2.67	3.47	0.80	Utilization and Quality Review Expenses	2.49	3.58	1.09
4.20	4.72	0.52	Long Term/SNF/Hospice	5.11	4.72	(0.39)
16.18	19.00	2.82	Provider Enhancement Expense - Prop. 56	17.50	19.00	1.50
1.38	1.71	0.33	Provider Enhancement Expense - GEMT	1.44	1.71	0.26
0.03	0.00	(0.03)	Vaccine Incentive Program Expense	0.90	0.00	(0.90)
0.67	0.81	0.14	Behaviorial Health Integration Program	1.21	0.81	(0.40)
4.57	5.69	1.13	Enhanced Care Management	5.72	5.70	(0.02)
1.58	1.57	(0.00)	Major Organ Transplant	1.54	1.57	0.03
7.64	3.83	(3.80)	Cal AIM Incentive Programs	4.69	3.83	(0.86)
2.89	2.96	0.07	DME	2.95	2.96	0.01
49.50	51.26	1.76	TOTAL OTHER MEDICAL	50.61	51.38	0.77
1.49	1.50	0.01	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	0.00
58.38	55.86	(2.52)	HOSPITAL DIRECTED PAYMENTS	57.37	55.96	(1.41)
(0.02)	0.00	0.02	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	6.51	0.00	(6.51)
0.01	0.00	(0.01)	NON-CLAIMS EXPENSE ADJUSTMENT	(0.25)	0.00	0.25
(1.32)	0.00	1.32	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(4.84)	0.00	4.84
279.65	295.01	15.36	Total Medical Costs	293.42	295.40	1.98

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH NOVEMBER 30, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	3,472,901	3,950,940	3,869,340	4,216,012	3,710,885	3,643,312
Referral Specialty Services	11,390,029	12,825,148	13,133,782	12,603,720	12,666,671	14,157,633
Urgent Care & After Hours Advise	2,665,800	2,534,829	2,906,730	1,462,769	1,508,987	1,111,956
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300	9,000
TOTAL PHYSICIAN SERVICES	17,538,030	19,319,317	19,919,152	18,291,501	17,895,843	18,921,901
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	298,113	299,421	320,479	313,381	312,490	317,864
Medical Departments - UM Allocation *	1,874,290	1,814,144	1,930,871	1,799,307	1,920,750	1,835,227
Behavior Health Treatment	1,143,733	984,520	1,425,684	1,406,426	1,172,372	1,493,794
Mental Health Services	385,915	151,598	138,742	134,047	69,233	98,672
Other Professional Services	1,338,982	1,653,027	1,439,003	1,708,384	1,360,230	1,367,404
TOTAL OTHER PROFESSIONAL SERVICES	5,041,033	4,902,710	5,254,779	5,361,545	4,835,075	5,112,961
EMERGENCY ROOM	5,209,937	5,098,972	5,150,400	5,098,584	4,139,529	3,167,228
INPATIENT HOSPITAL	20,610,105	20,031,970	20,232,342	20,364,608	21,395,635	19,551,774
REINSURANCE EXPENSE PREMIUM	53,660	53,896	57,686	56,409	56,248	57,216
OUTPATIENT HOSPITAL SERVICES	8,214,215	8,223,126	8,686,122	8,458,833	8,281,163	9,196,013
OTHER MEDICAL						
Ambulance and NEMT	1,321,069	1,293,500	1,339,544	1,466,846	1,405,832	825,707
Home Health Services & CBAS	733,519	813,833	841,676	781,545	1,039,980	1,056,675
Utilization and Quality Review Expenses	767,373	755,405	504,541	724,744	1,037,565	642,907
Long Term/SNF/Hospice	1,585,601	1,669,982	1,938,253	1,975,528	1,770,701	1,113,446
Provider Enhancement Expense - Prop. 56	5,806,204	5,819,707	5,888,710	5,878,051	5,871,736	6,032,156
Provider Enhancement Expense - GEMT	463,070	463,069	300,851	354,994	480,313	494,051
Vaccine Incentive Program Expense	1,143,595	1,628,354	173,216	136,387	739	85,682
Behaviorial Health Integration Program	824,339	824,339	824,339	225,048	216,518	220,783
Enhanced Care Management	2,023,406	1,561,486	1,821,649	1,818,393	1,820,636	1,866,858
Major Organ Transplant	472,866	473,613	496,178	480,362	480,654	492,226
Cal AIM Incentive Programs	1,241,196	1,257,731	1,089,466	1,285,346	1,268,891	1,807,413
DME	881,383	973,969	570,456	1,214,663	907,459	884,167
TOTAL OTHER MEDICAL	17,263,621	17,534,988	15,788,879	16,341,907	16,301,024	15,522,071
PAY FOR PERFORMANCE QUALITY INCENTIVE	464,013	465,422	465,421	472,037	473,494	478,060
HOSPITAL DIRECTED PAYMENTS	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276	18,280,365
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	230,177	24,013	26,678,156	3,898	(3,419)	5,129
NON-CLAIMS EXPENSE ADJUSTMENT	43,538	4,118	572,469	62,025	(1,371,999)	29,799
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	627	(1,010,781)	(3,987,493)	(2,812,496)	(3,724,314)	(4,072,490)
Total Medical Costs	92,275,826	92,302,247	116,767,047	89,604,769	86,206,555	86,250,027

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH NOVEMBER 30, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	3,951,533	3,298,914	3,859,118	3,539,808	3,684,488	41,197,251
Referral Specialty Services	12,653,874	12,435,011	13,253,634	12,805,568	12,648,430	140,573,500
Urgent Care & After Hours Advise	2,369,574	2,455,184	1,501,101	1,815,098	2,141,425	22,473,453
Hospital Admitting Team	9,300	9,300	9,000	9,300	9,000	100,200
TOTAL PHYSICIAN SERVICES	18,984,281	18,198,409	18,622,853	18,169,774	18,483,343	204,344,404
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	315,663	323,003	327,811	326,350	326,879	3,481,454
Medical Departments - UM Allocation *	1,913,288	1,861,229	1,890,140	1,939,399	1,936,887	20,715,532
Behavior Health Treatment	1,392,248	1,798,262	1,282,862	1,345,602	1,371,019	14,816,522
Mental Health Services	112,742	68,357	180,406	152,793	221,811	1,714,316
Other Professional Services	1,403,400	1,157,942	1,343,698	1,277,854	1,576,114	15,626,038
TOTAL OTHER PROFESSIONAL SERVICES	5,137,341	5,208,793	5,024,917	5,041,998	5,432,710	56,353,862
EMERGENCY ROOM	4,764,039	4,661,044	4,773,821	4,790,820	5,682,299	52,536,673
INPATIENT HOSPITAL	22,935,749	20,834,103	22,797,560	22,462,437	18,414,421	229,630,704
REINSURANCE EXPENSE PREMIUM	(33,668)	(25,136)	142,533	58,493	58,838	536,175
OUTPATIENT HOSPITAL SERVICES	10,013,268	9,928,749	9,352,210	9,319,855	8,727,267	98,400,821
OTHER MEDICAL						
Ambulance and NEMT	1,358,335	1,416,945	1,597,466	1,521,656	1,514,523	15,061,423
Home Health Services & CBAS	1,083,945	780,644	739,073	777,227	1,034,966	9,683,083
Utilization and Quality Review Expenses	696,258	672,539	1,076,096	1,003,496	884,261	8,765,185
Long Term/SNF/Hospice	1,750,512	1,694,897	1,573,989	1,516,247	1,390,150	17,979,306
Provider Enhancement Expense - Prop. 56	5,197,617	5,212,169	5,228,484	5,256,673	5,354,477	61,545,984
Provider Enhancement Expense - GEMT	503,001	546,014	520,821	492,730	455,360	5,074,274
Vaccine Incentive Program Expense	2,148	1,922	825	(3,500)	11,536	3,180,904
Behaviorial Health Integration Program	220,782	220,783	220,783	220,784	220,783	4,239,281
Enhanced Care Management	1,907,842	1,905,031	1,936,841	1,945,941	1,511,694	20,119,777
Major Organ Transplant	504,463	485,910	510,244	512,675	521,901	5,431,092
Cal AIM Incentive Programs	1,195,617	1,328,191	1,352,580	2,135,655	2,527,452	16,489,538
DME	996,415	976,531	987,460	1,038,510	955,746	10,386,759
TOTAL OTHER MEDICAL	15,416,935	15,241,576	15,744,662	16,418,094	16,382,849	177,956,606
PAY FOR PERFORMANCE QUALITY INCENTIVE	485,358	485,358	490,964	493,681	493,681	5,267,489
HOSPITAL DIRECTED PAYMENTS	18,674,627	18,595,974	18,857,014	18,961,885	19,322,384	201,736,942
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	9,235	(4,343)	(4,064,727)	9,926	(5,266)	22,882,779
NON-CLAIMS EXPENSE ADJUSTMENT	17,040	5,019	9,821	(248,768)	4,018	(872,920)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(238,100)	487,881	(789,121)	(435,695)	(436,641)	(17,018,623)
Total Medical Costs	96,166,105	93,617,427	90,962,508	95,042,500	92,559,903	1,031,754,912

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH NOVEMBER 30, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	11.23	12.73	12.38	13.40	11.76	11.41
Referral Specialty Services	36.82	41.33	42.03	40.05	40.13	44.34
Urgent Care & After Hours Advise	8.62	8.17	9.30	4.65	4.78	3.48
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	56.69	62.26	63.74	58.13	56.69	59.25
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	0.96	0.96	1.03	1.00	0.99	1.00
Medical Departments - UM Allocation *	6.06	5.85	6.18	5.72	6.08	5.75
Behavior Health Treatment	3.70	3.17	4.56	4.47	3.71	4.68
Mental Health Services	1.25	0.49	0.44	0.43	0.22	0.31
Other Professional Services	4.33	5.33	4.60	5.43	4.31	4.28
TOTAL OTHER PROFESSIONAL SERVICES	16.30	15.80	16.82	17.04	15.32	16.01
EMERGENCY ROOM	16.84	16.43	16.48	16.20	13.11	9.92
INPATIENT HOSPITAL	66.63	64.56	64.75	64.71	67.78	61.23
REINSURANCE EXPENSE PREMIUM	0.17	0.17	0.18	0.18	0.18	0.18
OUTPATIENT HOSPITAL SERVICES	26.55	26.50	27.80	26.88	26.23	28.80
OTHER MEDICAL						
Ambulance and NEMT	4.27	4.17	4.29	4.66	4.45	2.59
Home Health Services & CBAS	2.37	2.62	2.69	2.48	3.29	3.31
Utilization and Quality Review Expenses	2.48	2.43	1.61	2.30	3.29	2.01
Long Term/SNF/Hospice	5.13	5.38	6.20	6.28	5.61	3.49
Provider Enhancement Expense - Prop. 56	18.77	18.76	18.84	18.68	18.60	18.89
Provider Enhancement Expense - GEMT	1.50	1.49	0.96	1.13	1.52	1.55
Vaccine Incentive Program Expense	3.70	5.25	0.55	0.43	0.00	0.27
Behaviorial Health Integration Program	2.66	2.66	2.64	0.72	0.69	0.69
Enhanced Care Management	6.54	5.03	5.83	5.78	5.77	5.85
Major Organ Transplant	1.53	1.53	1.59	1.53	1.52	1.54
Cal AIM Incentive Programs	4.01	4.05	3.49	4.08	4.02	5.66
DME	2.85	3.14	1.83	3.86	2.87	2.77
TOTAL OTHER MEDICAL	55.81	56.51	50.53	51.93	51.64	48.61
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	1.49	1.50	1.50	1.50
HOSPITAL DIRECTED PAYMENTS	56.92	56.90	57.44	56.90	56.80	57.25
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.74	0.08	85.37	0.01	(0.01)	0.02
NON-CLAIMS EXPENSE ADJUSTMENT	0.14	0.01	1.83	0.20	(4.35)	0.09
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(3.26)	(12.76)	(8.94)	(11.80)	(12.75)
Total Medical Costs	298.30	297.48	373.67	284.74	273.10	270.09

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH NOVEMBER 30, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	12.21	10.15	11.84	10.76	11.13	11.72
Referral Specialty Services	39.11	38.27	40.67	38.91	38.22	39.98
Urgent Care & After Hours Advise	7.32	7.56	4.61	5.51	6.47	6.39
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	58.67	56.00	57.14	55.21	55.84	58.11
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	0.98	0.99	1.01	0.99	0.99	0.99
Medical Departments - UM Allocation *	5.91	5.73	5.80	5.89	5.85	5.89
Behavior Health Treatment	4.30	5.53	3.94	4.09	4.14	4.21
Mental Health Services	0.35	0.21	0.55	0.46	0.67	0.49
Other Professional Services	4.34	3.56	4.12	3.88	4.76	4.44
TOTAL OTHER PROFESSIONAL SERVICES	15.88	16.03	15.42	15.32	16.41	16.03
EMERGENCY ROOM	14.72	14.34	14.65	14.56	17.17	14.94
INPATIENT HOSPITAL	70.88	64.11	69.95	68.25	55.64	65.30
REINSURANCE EXPENSE PREMIUM	(0.10)	(0.08)	0.44	0.18	0.18	0.15
OUTPATIENT HOSPITAL SERVICES	30.95	30.55	28.69	28.32	26.37	27.98
OTHER MEDICAL						
Ambulance and NEMT	4.20	4.36	4.90	4.62	4.58	4.28
Home Health Services & CBAS	3.35	2.40	2.27	2.36	3.13	2.75
Utilization and Quality Review Expenses	2.15	2.07	3.30	3.05	2.67	2.49
Long Term/SNF/Hospice	5.41	5.22	4.83	4.61	4.20	5.11
Provider Enhancement Expense - Prop. 56	16.06	16.04	16.04	15.97	16.18	17.50
Provider Enhancement Expense - GEMT	1.55	1.68	1.60	1.50	1.38	1.44
Vaccine Incentive Program Expense	0.01	0.01	0.00	(0.01)	0.03	0.90
Behaviorial Health Integration Program	0.68	0.68	0.68	0.67	0.67	1.21
Enhanced Care Management	5.90	5.86	5.94	5.91	4.57	5.72
Major Organ Transplant	1.56	1.50	1.57	1.56	1.58	1.54
Cal AIM Incentive Programs	3.70	4.09	4.15	6.49	7.64	4.69
DME	3.08	3.01	3.03	3.16	2.89	2.95
TOTAL OTHER MEDICAL	47.65	46.90	48.31	49.88	49.50	50.61
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.49	1.51	1.50	1.49	1.50
HOSPITAL DIRECTED PAYMENTS	57.71	57.23	57.86	57.61	58.38	57.37
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.03	(0.01)	(12.47)	0.03	(0.02)	6.51
NON-CLAIMS EXPENSE ADJUSTMENT	0.05	0.02	0.03	(0.76)	0.01	(0.25)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(0.74)	1.50	(2.42)	(1.32)	(1.32)	(4.84)
Total Medical Costs	297.20	288.09	279.09	288.78	279.65	293.42

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED NOVEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
510,892	459,798	(51,094)	110 - Executive	4,945,911	5,132,776	186,865
197,832	234,469	36,637	210 - Accounting	2,295,751	2,579,159	283,408
460,864	359,967	(100,897)	220 - Management Information Systems	4,016,430	3,959,636	(56,794)
28,206	54,298	26,092	221 - Business Intelligence	382,646	597,278	214,632
315,687	383,664	67,977	222 - Enterprise Development	3,170,912	4,220,304	1,049,392
576,799	533,193	(43,606)	225 - Infrastructure	5,403,787	5,865,123	461,336
567,845	615,321	47,476	230 - Claims	6,276,472	6,768,531	492,059
163,970	187,947	23,977	240 - Project Management	1,775,876	2,067,417	291,541
168,427	180,989	12,562	310 - Health Services - Utilization Management	1,701,990	1,990,879	288,889
121	14,039	13,918	311 - Health Services - Quality Improvement	1,400	154,429	153,029
88	513	425	312 - Health Services - Education	1,260	5,643	4,383
35,770	50,828	15,058	313- Pharmacy	393,642	559,108	165,466
924	2,308	1,384	314 - Enhanced Care Management	109,549	25,388	(84,161)
59,675	74,558	14,883	316 -Population Health Management	654,829	820,138	165,309
34	333	299	317 - Community Based Services	483	3,663	3,180
-	-	-	318 - Housing & Homeless Incentive Program	6	-	(6)
297,803	359,942	62,139	320 - Provider Network Management	3,407,528	3,959,362	551,834
750,638	871,663	121,025	330 - Member Services	7,669,220	9,588,293	1,919,073
814,807	721,857	(92,950)	340 - Corporate Services	8,604,089	7,940,427	(663,662)
98,518	97,177	(1,341)	360 - Audit & Investigative Services	928,047	1,068,947	140,900
127,122	92,450	(34,672)	410 - Advertising Media	637,122	1,016,950	379,828
31,931	76,696	44,765	420 - Sales/Marketing/Public Relations	753,794	843,656	89,862
268,851	303,042	34,191	510 - Human Resourses	3,316,399	3,333,462	17,063
299,689	(92,324)	(392,013)	Administrative Expense Adjustment	2,704,279	(1,015,564)	(3,719,843)
5,776,493	5,582,728	(193,765)	Total Administrative Expenses	59,151,422	61,485,005	2,333,583

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED NOVEMBER 30, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
110 - Executive	424,308	403,286	429,743	446,418	470,648	353,073
210 - Accounting	233,241	178,928	252,864	163,976	225,728	222,884
220 - Management Information Systems (MIS)	335,777	238,917	337,588	352,426	352,473	336,194
221 - Business Intelligence	13,042	65,687	31,834	45,508	45,708	16,186
222 - Enterprise Development	307,654	250,898	286,566	265,813	303,353	291,350
225 - Infrastructure	473,799	427,685	536,529	343,776	562,405	524,493
230 - Claims	582,040	548,583	591,767	559,648	590,588	529,776
240 - Project Management	171,917	152,433	174,210	123,662	152,467	105,055
310 - Health Services - Utilization Management	139,536	126,622	128,165	132,502	154,797	166,719
311 - Health Services - Quality Improvement	277	15,545	(90)	186	(15,257)	178
312 - Health Services - Education	-	180	2,174	310	89	222
313- Pharmacy	39,824	36,716	38,879	36,385	35,680	34,727
314 - Enhanced Care Management	3,281	241	19	12,005	22,519	12,559
316 -Population Health Management	65,121	62,696	63,150	64,161	66,172	55,430
317 - Community Based Services	-	24	22	17	5	36
318 - Housing & Homeless Incentive Program	-	-	-	-	9,346	(9,346)
320 - Provider Network Management	327,923	326,761	325,559	269,804	308,858	305,807
330 - Member Services	754,477	623,424	700,611	644,994	694,732	635,012
340 - Corporate Services	786,930	685,514	778,083	735,005	751,597	842,924
360 - Audit & Investigative Services	69,757	69,895	71,016	82,269	83,957	69,158
410 - Advertising Media	11,825	27,353	55,984	38,254	34,202	52,260
420 - Sales/Marketing/Public Relations	66,531	51,460	70,326	65,913	62,815	72,927
510 - Human Resourses	309,451	254,507	352,740	341,377	295,995	236,093
Total Department Expenses	5,116,711	4,547,355	5,227,739	4,724,409	5,208,877	4,853,717
ADMINISTRATIVE EXPENSE ADJUSTMENT	(1,904)	(44,283)	31,776	164,256	(2,834)	811,890
Total Administrative Expenses	5,114,807	4,503,072	5,259,515	4,888,665	5,206,043	5,665,607

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED NOVEMBER 30, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	YEAR TO DATE 2022
110 - Executive	504,491	507,150	480,177	415,725	510,892	4,945,911
210 - Accounting	202,574	217,615	205,332	194,777	197,832	2,295,751
220 - Management Information Systems (MIS)	449,253	372,062	379,477	401,399	460,864	4,016,430
221 - Business Intelligence	42,730	15,934	35,696	42,115	28,206	382,646
222 - Enterprise Development	256,153	306,526	262,856	324,056	315,687	3,170,912
225 - Infrastructure	450,547	601,972	415,178	490,604	576,799	5,403,787
230 - Claims	654,284	578,899	474,159	598,883	567,845	6,276,472
240 - Project Management	152,605	157,820	252,716	169,021	163,970	1,775,876
310 - Health Services - Utilization Management	167,284	163,063	169,157	185,718	168,427	1,701,990
311 - Health Services - Quality Improvement	1,002	823	317	(1,702)	121	1,400
312 - Health Services - Education	895	37	(2,865)	130	88	1,260
313- Pharmacy	33,787	23,774	43,043	35,057	35,770	393,642
314 - Enhanced Care Management	16,919	22,248	18,382	452	924	109,549
316 -Population Health Management	54,747	51,020	55,570	57,087	59,675	654,829
317 - Community Based Services	7	157	25	156	34	483
318 - Housing & Homeless Incentive Program	42	(42)	-	6	-	6
320 - Provider Network Management	307,080	299,800	313,213	324,920	297,803	3,407,528
330 - Member Services	682,669	677,858	715,313	789,492	750,638	7,669,220
340 - Corporate Services	814,888	815,575	836,837	741,929	814,807	8,604,089
360 - Audit & Investigative Services	91,281	88,356	86,380	117,460	98,518	928,047
410 - Advertising Media	169,122	54,424	23,027	43,549	127,122	637,122
420 - Sales/Marketing/Public Relations	58,511	60,358	75,839	137,183	31,931	753,794
510 - Human Resourses	340,172	294,858	338,192	284,163	268,851	3,316,399
Total Department Expenses	5,451,043	5,310,287	5,178,021	5,352,180	5,476,804	56,447,143
ADMINISTRATIVE EXPENSE ADJUSTMENT	425,467	300,000	420,793	299,429	299,689	2,704,279
Total Administrative Expenses	5,876,510	5,610,287	5,598,814	5,651,609	5,776,493	59,151,422

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF NOVEMBER 30, 2022

ASSETS	NOVEMBER 2022	OCTOBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,145,891	$ 1,145,891	-
Interest Receivable	2,400	1,200	1,200
TOTAL CURRENT ASSETS	$ 1,148,291	$ 1,147,091	$ 1,200
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,136,102	1,136,102	-
Increase (Decrease) in Net Position - Current Year	12,189	10,989	1,200
Total Net Position	$ 1,148,291	$ 1,147,091	$ 1,200
TOTAL LIABILITIES AND NET POSITION	$ 1,148,291	$ 1,147,091	$ 1,200

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED NOVEMBER 30, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
1,200	-	1,200	Interest	9,287	-	9,287
-	-	-	Other Investment Income	2,902	-	2,902
1,200	-	1,200	TOTAL REVENUES	12,189	-	12,189
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
1,200	-	1,200	GROSS MARGIN	12,189	-	12,189
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
1,200	-	1,200	OPERATING INCOME (LOSS)	12,189	-	12,189
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
1,200	-	1,200	NET INCREASE (DECREASE) IN NET POSITION	12,189	-	12,189
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
0%	0%	0%	ADMINISTRATIVE EXPENSE RATIO	0%	0%	0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2022 MEMBER MONTHS	JAN'22	FEB'22	MAR'22	APR'22	MAY'22	JUN'22	JULY'22	AUG'22	SEPT'22	OCT'22
ADULT AND FAMILY											
ADULT	***691,093***	60,708	60,882	61,379	61,726	61,739	62,276	63,581	64,006	64,336	65,252
CHILD	***1,555,983***	139,223	139,605	140,344	141,029	141,356	141,902	142,505	142,059	142,208	142,524
SUB-TOTAL ADULT & FAMILY	***2,247,076***	***199,931***	***200,487***	***201,723***	***202,755***	***203,095***	***204,178***	***206,086***	***206,065***	***206,544***	***207,776***
OTHER MEMBERS											
PARTIAL DUALS - FAMILY	***9,050***	824	801	811	796	815	837	842	814	844	828
PARTIAL DUALS - CHILD	***0***	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	***68***	4	13	6	5	5	5	6	6	6	6
FULL DUALS (SPD)											
SPD FULL DUALS	***94,862***	8,138	8,257	8,336	8,411	8,662	8,572	8,684	8,794	8,813	9,027
SUBTOTAL OTHER MEMBERS	***103,980***	***8,966***	***9,071***	***9,153***	***9,212***	***9,482***	***9,414***	***9,532***	***9,614***	***9,663***	***9,861***
TOTAL FAMILY & OTHER	***2,351,056***	***208,897***	***209,558***	***210,876***	***211,967***	***212,577***	***213,592***	***215,618***	***215,679***	***216,207***	***217,637***
SPD											
SPD (AGED AND DISABLED)	***184,376***	16,556	16,376	16,516	16,363	16,305	16,794	16,817	17,118	17,289	17,179
MEDI-CAL EXPANSION											
ACA Expansion Adult-Citizen	**965,493**	82,803	83,199	83,828	85,037	85,412	87,526	89,680	90,672	90,902	92,658
ACA Expansion Duals	**15,428**	1,086	1,148	1,270	1,324	1,369	1,421	1,457	1,492	1,522	1,647
SUB-TOTAL MED-CAL EXPANSION	***980,921***	***83,889***	***84,347***	***85,098***	***86,361***	***86,781***	***88,947***	***91,137***	***92,164***	***92,424***	***94,305***
TOTAL KAISER	***150,407***	***12,787***	***13,032***	***13,253***	***13,407***	***13,552***	***13,722***	***13,842***	***13,972***	***14,126***	***14,281***
TOTAL MEDI-CAL MEMBERS	***3,666,760***	***322,129***	***323,313***	***325,743***	***328,098***	***329,215***	***333,055***	***337,414***	***338,933***	***340,046***	***343,402***

KERN·HEALTH SYSTEMS

November AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T1071	CLINICA SIERRA VISTA ****	880,584.52	2,760,963.65	AUG. & SEPT. 2022 PROVIDER CARE QUALITY GRANT PROGRAM & SPONSORSHIP	COMMUNITY GRANTS
T1045	KAISER FOUNDATION HEALTH - HMO	557,622.06	5,656,164.23	NOV. 2022 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE	484,489.78	3,799,310.60	SEPT. & OCT. 2022 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T4695	EDIFECS, INC ****	208,884.20	227,371.33	ANNUAL LICENSE TSM RENEWAL 2022	MIS INFRASTRUCTURE
T1408	DELL MARKETING L.P.	99,856.78	1,358,744.06	HARDWARE - (47) DELL LATITUDE	MIS INFRASTRUCTURE
T4982	NGC US, LLC	88,090.64	2,841,007.92	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T5337	CAZADOR CONSULTING GROUP INC ****	81,068.42	391,040.45	SEPT. & OCT. 2022 TEMPORARY HELP - (2) IT: (11) MS (1): CS	VARIOUS
T1180	LANGUAGE LINE	79,917.48	723,525.90	OCT. 2022 INTERPRETATION SERVICES	MEMBER SERVICES
T5466	ZIPARI, INC ****	78,762.88	343,008.00	OCT. & NOV. 2022 JIVA MEMBER PORTAL	MIS INFRASTRUCTURE
T3449	CDW GOVERNMENT ****	74,517.58	261,948.10	(9) DELL DOCKS, ADOBE LICENSES, FORTINET CO-TERM RENEWAL & KINGSTON 16 GB	MIS INFRASTRUCTURE
T1001	KERN MEDICAL CENTER ****	73,500.00	93,375.00	(21) POP UP COVID 19 CLINICS	PROVIDER NETWORK MANAGEMENT
T4059	KERN VALLEY HEALTHCARE DISTRICT ****	68,719.83	113,434.63	SEPT. & OCT. 2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	66,300.00	482,242.50	AUG., SEPT. & OCT. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5022	SVAM INTERNATIONAL INC	63,192.50	427,702.50	SEPT. & OCT. 2022 PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE

KERN·HEALTH SYSTEMS

November AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T2458	HEALTHCARE FINANCIAL, INC	62,598.53	299,288.44	SEPT. 2022 PROFESSIONAL SERVICES	ADMINISTRATION
T4733	UNITED STAFFING ASSOCIATES	61,415.38	628,340.92	SEPT. & OCT. 2022 TEMPORARY HELP - (12) MS; (1) HE	VARIOUS
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC. ****	57,155.50	90,318.00	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T5546	BITWISE TECHNOLOGY CONSULTING, LLC	53,935.71	113,667.63	OCT. 2022 OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T2686	ALLIANT INSURANCE SERVICES INC.	51,820.13	1,122,033.92	2022 -2023 INSURANCE PREMIUMS - EARTHQUAKE RENEWAL	ADMINISTRATION
T4699	ZEOMEGA	48,000.00	403,202.65	SEPT. & OCT. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	47,265.63	1,321,951.97	OCT. 2022 PROFESSIONAL SERVICES & EDI CLAIM PROCESSING	VARIOUS
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	42,337.75	443,657.50	NOV. 2022 EMPLOYEE HEALTH BENEFITS	VARIOUS
T5421	PREMIER ACCESS INSURANCE COMPANY	41,615.74	424,338.35	NOV. 2022 EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T4737	TEKSYSTEMS, INC	40,950.00	438,587.35	OCT. & NOV. 2022 PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T2584	UNITED STATES POSTAL SVC. - HASLER ****	40,000.00	320,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	40,000.00	367,303.70	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI

KERN·HEALTH SYSTEMS

November AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5562	JDM SOLUTIONS INC. ****	39,900.00	39,900.00	SEPT. & OCT. 2022 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T3130	OPTUMINSIGHT, INC ****	39,737.00	581,767.00	EASY GROUP LICENSE RENEWAL	MIS INFRASTRUCTURE
T5435	TEGRIA SERVICES GROUP - US, INC ****	38,750.00	170,750.00	SEPT. & OCT. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5509	NGUYEN CAO LUU-TRONG	38,212.50	145,500.00	OCT. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2509	USPS ****	37,374.92	66,842.25	FUND MAILING PERMIT #88	CORPORATE SERVICES
T5479	TRANSFORMING LOCAL COMMUNITIES, INC	36,629.03	227,592.46	SEPT. 2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4792	KP LLC ****	33,156.02	83,712.56	PROVIDER DIRECTORY/PROVIDER DIRECTORY UPDATES/PRENATAL & POSTPARTUM MAILING	PROVIDER NETWORK MANAGEMENT
T2167	PG&E	32,347.39	360,395.50	OCT. 2022 USAGE / UTILITIES	CORPORATE SERVICES
T5321	TYK TECHNOLOGIES LTD ****	32,250.00	32,250.00	TYK LICENSE RENEWAL 2022/2023	MIS INFRASTRUCTURE
T1861	CERIDIAN HCM, INC.	27,776.05	246,489.11	OCT. & NOV. 2022 MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4452	WELLS FARGO	26,822.94	261,490.04	NOV. - ACH MISC CREDIT CARD PURCHASES	VARIOUS
T4353	TWE SOLUTIONS, INC. ****	25,602.52	219,139.32	ANNUAL SUPPORT RENEWAL	MIS INFRASTRUCTURE
T4657	DAPONDE SIMPSON ROWE PC	24,836.75	276,781.06	SEPT. 2022 LEGAL FEES	VARIOUS

KERN·HEALTH SYSTEMS

November AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4484	JACOBSON SOLUTIONS	24,430.50	92,640.11	OCT. & NOV. 2022 TEMPORARY HELP (3) UM	VARIOUS
T3011	OFFICE ALLY, INC ****	23,825.93	231,036.74	OCT. 2022 EDI CLAIM PROCESSING	CLAIMS
T1005	COLONIAL LIFE & ACCIDENT ****	22,850.40	141,846.21	NOV. 2022 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC.	21,600.00	591,682.10	OCT. 2022 CONSULTING SERVICES	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	20,918.16	295,820.96	OCT. 2022 EDI CLAIM PROCESSING	CLAIMS
T1183	MILLIMAN USA	20,770.75	136,171.75	SEPT. 2022 PROFESSIONAL SERVICES	FINANCE
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT ****	20,000.00	40,000.00	1ST INSTALLMENT SCHOOL WELLNESS GRANT	HEALTH EDUCATION
WT/ACH	USPS	20,000.00	110,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES
		4,100,391.90			
	TOTAL VENDORS OVER $20,000	4,100,391.90			
	TOTAL VENDORS UNDER $20,000	505,041.80			
	TOTAL VENDOR EXPENSES- NOVEMBER	$ **4,605,433.70**			

Note:
****New vendors over $20,000 for the month of November

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	5,656,164.23	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE INC.	3,799,310.60	PROFESSIONAL SERVICES / CONSULTING SERVICES	VARIOUS
T4391	OMNI FAMILY HEALTH	3,009,560.61	HEALTH HOMES GRANT	COMMUNITY GRANTS
T4982	NGC US, LLC	2,841,007.92	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T1071	CLINICA SIERRA VISTA	2,760,963.65	2022 HEALTH HOMES GRANT & PROVIDER CARE QUALITY GRANT PROGRAM	COMMUNITY GRANTS
T1408	DELL MARKETING L.P.	1,358,744.06	HARDWARE & COMPUTER EQUIPMENT & LICENSE FEES	MIS INFRASTRUCTURE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	1,321,951.97	PROFESSIONAL SERVICES & ANNUAL LICENSING	VARIOUS
T2704	MCG HEALTH LLC	1,214,288.28	HEALTH CARE MANAGEMENT & SOFTWARE LICENSE 8/5/2022 -08/04/2023	UTILIZATION MANAGEMENT
T2686	ALLIANT INSURANCE SERVICES INC.	1,122,033.92	2022 -2023 INSURANCE PREMIUMS	ADMINISTRATION
T5111	ENTISYS 360	850,833.77	ACROPOLIS ANNUAL LICENSE 2022	MIS INFRASTRUCTURE
T1180	LANGUAGE LINE SERVICES INC.	723,525.90	INTERPRETATION SERVICES	MEMBER SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4483	INFUSION AND CLINICAL SERVICES, INC	660,808.66	HEALTH HOMES GRANT	COMMUNITY GRANT
T4733	UNITED STAFFING ASSOCIATES	628,340.92	TEMPORARY HELP	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC.	591,682.10	CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T3130	OPTUMINSIGHT, INC	581,767.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T1845	DEPARTMENT OF MANAGED HEALTH CARE	482,779.20	2022-2023 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	482,242.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	443,657.50	VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T4737	TEKSYSTEMS, INC.	438,587.35	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T5022	SVAM INTERNATIONAL INC	427,702.50	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T5421	PREMIER ACCESS INSURANCE COMPANY	424,338.35	EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T4699	ZEOMEGA, INC.	403,202.65	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T5337	CAZADOR CONSULTING GROUP INC	391,040.45	TEMPORARY HELP	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4165	SHI INTERNATIONAL CO.	370,563.89	NETWORK SWITCHES WITH SUPPORT	MIS INFRASTRUCTURE
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	367,303.70	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI
T2167	PG&E	360,395.50	USAGE / UTILITIES	CORPORATE SERVICES
T5466	ZIPARI, INC	343,008.00	2022 JIVA MEMBER PORTAL	MIS INFRASTRUCTURE
T2584	UNITED STATES POSTAL SVC. - HASLER	320,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T2458	HEALTHCARE FINANCIAL, INC	299,288.44	PROFESSIONAL SERVICES	ADMINISTRATION
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	295,820.96	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4193	STRIA LLC	285,379.86	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T4657	DAPONDE SIMPSON ROWE PC	276,781.06	LEGAL FEES	VARIOUS
T3449	CDW GOVERNMENT	261,948.10	HEADSETS, CABLES & ADOBE LICENSES	MIS INFRASTRUCTURE
T4452	WELLS FARGO	261,490.04	ACH- MISC CREDIT CARD PURCHASES	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1861	CERIDIAN HCM, INC.	246,489.11	MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T5005	CRAYON SOFTWARE EXPERTS LLC	233,512.45	ANNUAL SOFTWARE LICENSE AND ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T3011	OFFICE ALLY, INC	231,036.74	EDI CLAIM PROCESSING	CLAIMS
T5155	A-C ELECTRIC COMPANY	229,186.50	CARPOOL SOLAR PROJECT DEPOSIT	CAPITAL
T2726	DST PHARMACY SOLUTIONS, INC.	227,677.01	PHARMACY CLAIMS	PHARMACY
T5447	PROSPHIRE, LLC	227,620.00	CONSULTING - CLINICAL ADMINISTRATOR STAFF AUGMENTATION	UTILIZATION MANAGEMENT
T5479	TRANSFORMING LOCAL COMMUNITIES, INC	227,592.46	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4695	EDIFECS, INC. ****	227,371.33	ANNUAL LICENSE TSM RENEWAL 2022	MIS INFRASTRUCTURE
T5319	CITIUSTECH INC.	219,162.00	FAST+ ANNUAL MAINTENANCE & SUPPORT	MIS INFRASTRUCTURE
T4353	TWE SOLUTIONS, INC	219,139.32	INTERNAL AUDIT SOFTWARE	MIS INFRASTRUCTURE
T4460	PAYSPAN, INC	213,825.67	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T5145	CCS ENGINEERING FRESNO INC.	201,296.41	JANITORIAL & ADDITIONAL DAY PORTER	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5435	TEGRIA SERVICES GROUP - US, INC.	170,750.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2469	DST HEALTH SOLUTIONS, LLC.	156,427.30	ANNUAL ACG LICENSE & SUPPORT	BUSINESS INTELLEGENCE
T5333	CENTRAL CALIFORNIA ASTHMA COLLABORATIVE	154,812.20	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5322	MANINDER KHALSA	154,030.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4707	SHAFTER PEDIATRICS	150,000.00	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5509	NGUYEN CAO LUU-TRONG	145,500.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T1005	COLONIAL LIFE & ACCIDENT	141,846.21	LIFE INSURANCE PREMIUM	VARIOUS
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	138,936.44	2022 ANNUAL DUE ASSESSMENT	VARIOUS
T1183	MILLIMAN USA	136,171.75	CY2020/2021 TNE & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T4582	HEALTHX, INC.	124,728.00	MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5275	CREATIVE FINANCIAL STAFFING, LLC.	123,966.32	RECRUITMENT FEES	HUMAN RESOURCES
T1128	HALL LETTER SHOP	120,372.91	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS	VARIOUS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5292	ALL'S WELL HEALTH CARE SERVICES	113,965.22	TEMPORARY HELP	VARIOUS
T5546	BITWISE TECHNOLOGY CONSULTING, LLC	113,667.63	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T4059	KERN VALLEY HEALTHCARE DISTRICT	113,434.63	2022 PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T2918	STINSONS	109,370.98	2022 OFFICE SUPPLIES	VARIOUS
T5360	SYNERGY PHARMACY SOLUTIONS INC.	108,900.00	2021 KOMOTO ASTHMA PROGRAM	POPULATION HEALTH MANAGEMENT
T5300	CENTRAL VALLEY OCCUPATION MEDICAL GROUP, INC	105,960.00	COVID-19 TESTING	HUMAN RESOURCES
T2961	SOLUTION BENCH, LLC	104,061.95	2022/2023 ANNUAL M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE
T4038	POLYCLINIC MEDICAL CENTER, INC	102,089.73	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
WT/ACH	USPS	110,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES
T3001	MERCER	99,500.00	PROFESSIONAL SERVICES	HUMAN RESOURCES
T4688	VANGUARD MEDICAL CORPORATION	95,000.00	2021-2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T1001	KERN MEDICAL CENTER ****	93,375.00	(21) POP UP COVID 19 CLINICS	PROVIDER NETWORK MANAGEMENT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2933	SIERRA PRINTERS, INC	93,164.65	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T4484	JACOBSON SOLUTIONS	92,640.11	TEMPORARY HELP	UTILIZATION MANAGEMENT-UM
T5486	ALLIED GENERAL CONTRACTORS, INC	92,425.76	BUILDING IMPROVEMENTS	CORPORATE SERVICES
T4503	VISION SERVICE PLAN	90,487.76	EMPLOYEE HEALTH BENEFITS	VARIOUS
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC.	90,318.00	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T1022	UNUM LIFE INSURANCE CO.	88,925.06	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T4686	CENTRIC HEALTH	86,939.92	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5121	TPX COMMUNICATIONS	86,417.74	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	85,646.25	CONSULTING SERVICES	ADMINISTRATION
T4792	KP LLC	83,712.56	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PHARMACY/PROVIDER RELATIONS
T5529	FINDHELP	83,000.00	COMMUNITY SUPPORT REFERRAL SYSTEM IMPLEMENTATION	CAPITAL PROJECT
T1272	COFFEY COMMUNICATIONS INC.	82,955.73	MEMBER NEWSLETTER/WEBSITE IMPLEMENTATION	HEALTH EDUCATION/MEDIA & ADVERTISING

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4963	LINKEDIN CORPORATION	81,729.00	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T4501	ALLIED UNIVERSAL SECURITY SERVICES	76,314.18	ONSITE SECURITY	CORPORATE SERVICES
T2413	TREK IMAGING INC	75,884.44	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T4217	CONTEXT 4 HEALTHCARE, INC	75,142.83	AMA ROYALTY FEE & CPT RENEWAL	MIS INFRASTRUCTURE
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	73,600.00	2022 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T5329	RELAY NETWORK, LLC	73,333.37	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	70,414.30	EDI CLAIM PROCESSING	CLAIMS
T4052	RAHUL SHARMA	70,000.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4585	DELANO UNION SCHOOL DISTRICT	70,000.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T5185	HOUSING AUTHORITY COUNTY OF KERN	67,600.00	2021 HOUSING AUTHORITY GRANT	POPULATION HEALTH MANAGEMENT
T2509	USPS	66,842.25	FUND MAILING PERMIT #88	CORPORATE SERVICES
T5109	RAND EMPLOYMENT SOLUTIONS	61,061.46	TEMPORARY HELP	VARIOUS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5377	TELEHEALTHDOCS MEDICAL GROUP	59,047.43	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5376	KCHCC	58,200.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T3986	JACQUELYN S. JANS	57,742.25	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T5313	HEALTH LITERACY INNOVATIONS, LLC	57,630.00	LITERACY ADVISOR ANNUAL SOFTWARE LICENSE	MIS INFRASTRUCTURE
T2969	AMERICAN BUSINESS MACHINES INC	57,327.17	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T5132	TIME WARNER CABLE LLC	55,025.27	INTERNET SERVICES	MIS INFRASTRUCTURE
T1195	KOMOTO PHARMACY, INC	54,500.00	COVID-19 POP UP CLINIC	PROVIDER NETWORK MANAGEMENT
T5387	NAVIA BENEFITS SOLUTIONS, INC.	52,724.21	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS
T5420	PAYPRO ADMINISTRATORS	52,016.12	FSA EMPLOYEE BENEFIT	VARIOUS
T5396	NYMI INC	51,520.00	WEARABLES/ SOFTWARE/MAINTENANCE FOR TRACING DEVICES	CORPORATE SERVICES
T4182	THE LAMAR COMPANIES	50,807.00	OUTDOOR ADVERTISEMENT - BILLBOARDS	ADVERTISING
T4934	APPLE INC.	50,202.17	EQUPMENT - CELL PHONES	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5426	UNIVERSAL HEALTHCARE SERVICES, INC	50,000.00	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5367	ADVENTIST HEALTH DELANO	49,697.20	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	49,500.00	2021 AUDIT FEES	FINANCE
T5487	MR2 SOLUTIONS, INC	49,400.00	2022/2023 VIRTUAL CHIEF INFORMATION SECURITY OFFICER	MIS INFRASTRUCTURE
T2441	LAURA J. BREZINSKI	48,400.00	MARKETING MATERIALS	MARKETING
T5215	RICHARD GARCIA	46,837.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4563	SPH ANALYTICS	46,784.40	2021/2022 PROVIDER SATISFACTION SURVEYS	MEMBER SERVICES
T5018	FIRESTONE GRILL - BAKERSFIELD	46,599.64	EMPLOYEE SERVICE AWARDS 2022	MARKETING
T2446	AT&T MOBILITY	46,350.67	CELLULAR PHONE/INTERNET USAGE	MIS INFRASTRUCTURE
T4607	AGILITY RECOVERY SOLUTIONS INC.	45,633.35	PROFESSIONAL SERVICES	ADMINISTRATION
T4785	COMMGAP	44,465.00	INTERPRETATION SERVICES	HEALTH EDUCATION
T5340	GARTNER INC	42,391.67	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	MIS ADMINISTRATION

KERN·HEALTH SYSTEMS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2941	KERN PRINT SERVICES INC.	42,234.09	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T5408	MARY HARRIS	42,000.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5455	HC2 STRATEGIES, INC	41,345.00	CALAIM ROUNDTABLE SUPPORT	COMMUNITY SUPPORT SERVICES
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT	40,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T5389	ADAKC	38,953.97	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5562	JDM SOLUTIONS INC. ****	39,900.00	2022 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T5107	CITRIX SYSTEMS, INC.	38,250.00	ANNUAL SERVICE RENEWAL	MIS INFRASTRUCTURE
T5286	BROOKLYNNS BOX INC.	37,750.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5467	MOSS ADAMS LLP	36,997.00	2022 CLAIMS AUDIT TOOL ANNUAL SUPPORT	CLAIMS
T3515	DOUG HAYWARD	36,565.85	CONSULTING SERVICES	ADMINISTRATION
T5398	GOLDEN EMPIRE GLEANERS	36,372.59	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4605	KERNVILLE UNION SCHOOL DISTRICT	36,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	35,953.34	COMMUNITY SPONSORSHIP	ADMINISTRATION
T4502	MORGAN CONSULTING RESOURCES, INC.	35,840.00	RECRUITMENT FEES - DIRECTOR OF POPULATION HEALTH MANAGEMENT	HUMAN RESOURCES
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO. INC.	33,892.86	2022 BUILDING MAINTENANCE	CORPORATE SERVICE
T5520	BG HEALTHCARE CONSULTING, INC	33,825.00	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T3092	LINKS FOR LIFE, INC.	33,100.00	COMMUNITY RESOURCES GRANT PROGRAM	COMMUNITY GRANT
T5401	KERN MEDICAL SUPPLY, LLC	32,303.30	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5321	TYK TECHNOLOGIES LTD ****	32,250.00	TYK LICENSE RENEWAL 22/23	MIS INFRASTRUCTURE
T4514	A.J. KLEIN, INC. T.DENATALE, B. GOLDNER	32,129.32	LEGAL FEES	ADMINISTRATION
T5574	CARMAX AUTO SUPERSTORES, INC	31,952.35	2022 EQUINOX COMPANY VEHICLE	CORPORATE SERVICES
T5490	WORKSITE LABS, INC	31,620.00	EMPLOYEE ON-SITE COVID TESTING	HUMAN RESOURCES
T5325	WADE A MCNAIR	30,000.00	LEADERSHIP ACADEMY TRAINING	HUMAN RESOURCES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1097	NCQA	29,247.00	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	HEALTH SERVICES - QI
T4944	CENTRAL VALLEY FARMWORKER FOUNDATION	28,600.50	COVID EDUCATION OUTREACH SPECIALIST	PROVIDER NETWORK MANAGEMENT
T4496	VOX NETWORK SOLUTIONS, INC	28,310.97	TELSTRAT LICENSES & ANNUAL HOSTING	MIS INFRASTRUCTURE
T4331	COTIVITI, INC ****	28,075.47	CALIFORNIA MEDI-CAL MEDICAID MEASURES-HEALTH RISK ASSESSMENT	QUALITY IMPROVEMENT
T4417	KAISER FOUNDATION HEALTH PLAN - OR	28,045.13	2021-2022 EMPLOYEE HEALTH BENEFITS PREMIUM	VARIOUS
T5503	SECURE-CENTRIC INC ****	27,699.60	POLARIS LICENSE, SUPPORT & CLOUD VAULT BACKUP SUPPORT	CAPITAL PROJECT
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	27,530.00	ADVERTISEMENT - MEDIA	MARKETING
T5494	LDP ASSOCIATES, INC	27,300.00	2022/2023 DISASTER RECOVERY & PC COOLING MAINT.	VARIOUS
T1694	KERN COUNTY FAIR ****	27,104.00	2022 KHS COMPANY EVENT	MARKETING
T5201	JAC SERVICES, INC	26,593.50	AC MAINTENANCE & SERVICE	CORPORATE SERVICES
T4424	GUROCK SOFTWARE GmbH	26,565.00	TESTRAIL RENEWAL	MIS INFRASTRUCTURE
T4993	LEGALSHIELD	26,554.10	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION
T5488	SALUSKY LAW GROUP	25,417.00	LEGAL FEES	ADMINISTRATION

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4466	SMOOTH MOVE USA	25,346.45	OFF SITE STORAGE	CORPORATE SERVICES
T4663	DEVELOPMENT DIMENSIONS INTERNATIONAL, INC	25,000.00	2021-2023 LEADERSHIP LICENSE	HUMAN RESOURCES
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	24,739.50	EMPLOYEE PREMIUM	ADMINISTRATION
T4228	THE SSI GROUP, LLC	24,194.20	EDI CLAIM PROCESSING	CLAIMS
T4731	LOGMEIN USA, INC.	23,137.81	INTERNET SERVICES	MIS INFRASTRUCTURE
T5568	MICHELLE OXFORD ****	23,100.00	CONSULTING SERVICES	EXECUTIVE
T1347	ADVANCED DATA STORAGE	22,872.28	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T4920	OTIS ELEVATOR COMPANY ****	22,509.30	ELEVATOR INSPECTION AND MAINTENANCE	CORPORATE SERVICES
T5480	PRESS GANEY ASSOCIATES LLC	22,500.00	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T5366	CONCUR TECHNOLOGIES, INC	22,131.30	2021 - 2022 SAP PROFESSIONAL SERVICES	FINANCE
T4611	LAMONT SCHOOL DISTRICT	22,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4216	NEXSTAR BROADCASTING INC	20,650.00	ADVERTISEMENT - MEDIA	MARKETING
T5161	INTEGRATED HEALTHCARE ASSOCIATION	20,142.92	CONSULTING SERVICES	PROVIDER NETWORK MANAGEMENT
		44,373,246.53		
	TOTAL VENDORS OVER $20,000	44,373,246.53		
	TOTAL VENDORS UNDER $20,000	1,676,922.52		
	TOTAL VENDOR EXPENSES-YTD	**46,050,169.05**		

Note:
****New vendors over $20,000 for the month of November

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
January							
FluidEdge	$50,000.00	Yes	PNM	Emily Duran	Interim Program Manager for ECM and PNM dept. (Katie Sykes)	1/3/2022	3/31/2022
CEI	$93,555.00	Yes	PM	LaVonne Banks	Project Manager/Scrum Master professional resources (Mark Stepko)	1/3/2022	4/30/2022
HD Dynamics	$53,760.00	Yes	PNM	Emily Duran	Support and consulting hours for CRM for HHP	1/3/2022	12/31/2022
Symplr	$35,700.00	Yes	IT	Richard Pruitt	Annual support for Cactus SaaS & DEA licenses	1/6/2022	1/5/2023
Mercer	$95,000.00	Yes	HR	Anita Martin	Compensation study for 75 KHS jobs	1/20/2022	12/31/2022
KP	$35,000.00	Yes	HE	Isabel Silva	Prenatal, postpartum, and COVID guides insert mailing	1/2/2022	12/31/2022
Lamar	$37,336.00	Yes	MRK	Louie Iturriria	5 Billboard Advertisement	1/24/2022	1/23/2023
Jacquelyn Jans	$63,000.00	Yes	MRK	Louie Iturriria	Marketing and corporate image consultant	1/2/2022	12/31/2022
Poppyrock	$99,600.00	Yes	MRK	Louie Iturriria	Graphic design for KHS/KFHC members and provider	1/2/2022	12/31/2023
February							
Gartner	$42,391.67	Yes	IT	Richard Pruitt	Individual Access Advisor license	2/1/2022	1/31/2023
MKB Landscaping	$30,800.00	Yes	CS	Alonso Hurtado	Weekly landscaping services	2/10/2022	2/9/2023
Dell	$56,799.22	Yes	IT	Richard Pruitt	Dell laptops (18), Docking Stations (18), and monitors (36)	2/9/2022	2/8/2026
Coffey Communications	$70,000.00	Yes	HE	Isabel Silva	Provider Directory Print agreement	2/15/2022	2/14/2023
ZeOmega	$57,818.70	Yes	IT	Richard Pruitt	Member portal implementation	2/9/2022	12/31/2022
March							
Wade McNair	$30,000.00	Yes	HR	Anita Martin	Leadership Academy Training for new and experienced leaders	3/1/2022	6/17/2022
Ceridian	$34,170.00	Yes	HR	Anita Martin	Additional 201 bulk of hours for project driven work and configurations	3/10/2022	3/9/2023
HC2	$54,756.00	Yes	PNM	Emily Duran	Needs assessment for CalAIM initiatives	3/10/2022	3/9/2023
April							
TWE Solutions	$91,450.00	Yes	IT	Richard Pruitt	1,355 Cortex XDR Pro licenses and 100 Annual Forensics licenses	4/29/2022	4/29/2023
Citrix	$38,250.00	Yes	IT	Richard Pruitt	403 Citrix ADC Premium Edition and Desktop licenses	4/2/2022	4/1/2023
SSI Group, LLC	$56,000.00	Yes	Claims	Robin Dow-Morales	EDI claims and electronic transactions	4/4/2022	4/3/2024
FluidEdge	$67,200.00	Yes	PNM	Emily Duran	Interim Program Manager, Katie Sykes	4/2/2022	6/30/2022
Dell	$53,328.33	Yes	IT	Richard Pruitt	25 Dell 5420 Laptops and 25 Docking stations	4/21/2022	4/20/2026
Cognizant	$54,000.00	Yes	IT	Richard Pruitt	Claims Integrity Implementation for Zelis	4/21/2022	3/20/2025
Coffey Communications	$89,360.00	Yes	MRK	Louie Iturriria	KHS Digital platform agreement	4/1/2022	3/31/2023
May							
Dell	$98,096.46	Yes	IT	Richard Pruitt	Dell 5520 Latitude, Qnty 49	5/18/2022	5/17/2026
Cognizant	$99,999.00	Yes	IT	Richard Pruitt	Nutanix Xi Leap Cloud annual renewal	5/27/2022	5/26/2023
MR2	$44,400.00	Yes	IT	Richard Pruitt	vCISO (Virtual Chief Information Security) Services	5/26/2022	5/25/2023
June							

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
Milliman	$99,900.00	Yes	ACCT	Veronica Barker	D-SNP (Base, Level and Gap Analysis)	6/1/2022	5/31/2023
HMA	$99,000.00	Yes	ACCT	Veronica Barker	Actuarial Services (RDT, SDR's & Rate Analysis)	6/1/2022	5/31/2023
LDPq	$40,365.00	Yes	CS	Alonso Hurtado	Support and maintenance for 3 APC InRow cooling units (1st floor)	6/4/2022	6/3/2025
Presidio	$50,550.00	Yes	IT	Richard Pruitt	Exchange Online Migration	6/14/2022	6/13/2023
Presidio	$57,174.00	Yes	IT	Richard Pruitt	SSRS Dashboard Discovery & Power BI implementation	6/14/2022	6/13/2023
TWE Solutions	$99,946.40	Yes	IT	Richard Pruitt	24x7 Managed Security services	6/14/2022	6/13/2023
Context4 Healthcare	$75,142.83	Yes	IT	Richard Pruitt	ICD-10 and CPT codes through AMA co-termed w/HCPCS codes	6/27/2022	6/27/2023
LDP	$41,535.00	Yes	CS	Alonso Hurtado	Support & maint. for 3 APC cooling units	6/4/2022	6/3/2025
JLL/Technologies	$38,752.00	Yes	CS	Alonso Hurtado	Cubicle resource scheduling app	6/28/2022	6/27/2023
July							
Spectrum	$61,164.00	Yes	IT	Richard Pruitt	1Gbps of Internet access	7/17/2022	7/16/2025
AT&T	$63,576.00	Yes	IT	Richard Pruitt	1Gbps of Internet access for KHS building	7/13/2022	7/12/2025
Rest and Reassure, LLC	$72,000.00	Yes	IT	Richard Pruitt	Consulting services for Cal-Aim & PHM dept requirements	7/15/2022	12/31/2022
Solution Bench	$76,461.95	Yes	IT	Richard Pruitt	M-files subscription base licenses & 2 add-on modules	7/23/2022	7/22/2022
CDW-G	$41,811.41	Yes	IT	Richard Pruitt	Juniper switches support & maint.	7/1/2022	6/30/2023
FluidEdge	$67,200.00	Yes	PNM	Amisha Pannu	PNM consultant, Katie Sykes	7/1/2022	9/30/2022
BG Healthcare Consulting	$30,000.00	Yes	PHM	Deborah Murr	Consulting services to audit KHS policies	7/13/2022	12/31/2022
August							
Octopai	$64,800.00	Yes	IT	Richard Pruitt	Data Lineage System	8/10/2022	8/9/2023
Cotiviti	$80,750.00	Yes	PHM	Deborah Murr	HRA outreach of SPD members	8/1/2022	7/31/2023
Dell	$98,099.72	Yes	IT	Richard Pruitt	(49) 5520 laptops	8/30/2022	8/29/2026
September							
CCS	$193,740.00	Yes	CS	Alonso Hurtado	Janitorial Services for KHS building	9/6/2022	9/5/2023
Spectrum	$84,480.00	Yes	IT	Richard Pruitt	Cloud Connect to Azure	9/24/2022	9/23/2024
The Periscope Group	$98,880.00	Yes	UM	Deb Murr	In-home assessment visits to members	9/5/2022	9/4/2023
JMD Solutions	$144,000.00	Yes	IT	Richard Pruitt	Kern Medical Data Extration and Transformation	9/26/2022	1/31/2023
TriZetto	$95,000.00	Yes	CL	Robin Dow-Morales	Electronic claims processing	9/6/2022	9/5/2025
October							
HMA	$99,150.00	Yes	COMP	Jane MacAdam	One (1) Senior Consultant to assist withing KHS Complinace Dept	10/5/2022	5/30/2023
Catalyst Solutions	$90,720.00	Yes	IT	Richard Pruitt	D-SNP Advisor/ Program Manager	10/11/2022	12/31/2022
FluidEdge	$96,200.00	Yes	COMP	Jane MacAdam	Consulting services	10/4/2022	12/31/2022
Dell	$99,856.63	Yes	IT	Richard Pruitt	Additional (47) Dell Latitude 5530 Laptops	10/27/2022	10/26/2026
Optum	$61,177.00	Yes	IT	Richard Pruitt	Payment system	10/1/2022	4/30/2024

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
Secure-Centric	$191,889.68	Yes	IT	Richard Pruitt	Rubrik brick	10/20/2022	10/19/2023
Coffey Communications	$111,674.00	Yes	HE	Isabel Silva	Printing services Addendum	10/26/2022	2/14/2023
November							
FluidEdge	$62,400.00	Yes	PM	LaVonne Banks	NCQA Program Manager	11/1/2022	12/31/2022

2022 TECHNOLOGY CONSULTING RESOURCES																		
ITEM	PROJECT	CAP/EXP	BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	YTD	TOTAL	REMAINING BALANCE
#	Project Name																	
1	*Community Based Organization Referral System*	*CAP*	$370,080	$15,440	$30,360	$20,160	$20,160	$0	$0	$0	$0	$0	$7,920				$94,040	$276,040
2	*Medical Management/Fraud, Waste, and Abuse Programs*	*CAP*	$500,000	$21,120	$35,798	$25,066	$17,472	$0	$0	$0	$0	$0					$99,456	$400,544
3	*Claims Workflow Conversion (QNXT)*	*CAP*	$472,800		$8,826	$51,501	$57,335	$40,726	$37,318	$45,317	$38,701	$18,094	$7,120	$0			$304,938	$167,862
4	*Data Linage System*	*CAP*	$184,800	$17,472	$0	$19,320	$0	$0	$37,789	$0	$0	$0	$0	$15,840			$90,421	$94,379
5	*Analytic Software (Power BI) Migration*	*CAP*	$124,800						$36,691	$17,472	$0	$0					$54,163	$70,637
6	*Communication Software Replacement*	*CAP*	$121,800					$17,600	$0	$23,920	$0	$0	$0	$0			$41,520	$80,280
8	*Staff Augmentation*	*EXP*	$7,393,315	$410,586	$359,294	$356,945	$344,059	$373,337	$342,030	$312,222	$392,822	$442,916	$518,851	$515,914			$4,368,976	$3,024,339
	Totals:	**Totals**	**$9,167,595**	**$464,618**	**$434,278**	**$472,992**	**$439,026**	**$431,663**	**$453,828**	**$398,931**	**$431,523**	**$461,010**	**$533,891**	**$531,754**	**$0**		**$5,053,514**	**$4,114,081**

Updated 1/19/23

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
February 16, 2023

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 02/01/2023				
Raymund R. David dba: Child Neurology Center of Bakersfield Inc	Pediatric Neurology	5701 Young Street Ste. C203 Bakersfield CA 93311	Expedited Review via Clean File approved by Dr. Tasinga & Emily Duran	**Retro-Eff 01/01/2023**
Bakersfielddidence Opco LLC dba: Kern River Transitional Care	SNF	5151 Knudsen Drive Bakersfield CA 93308		**Retro-Eff 02/01/2023**
Graceful Palms Hospice and Palliative Care Corp	Hospice/Palliative Care	38700 5th St W., Bldg A, Ste G Palmdale CA 93551		**Retro-Eff 02/01/2023**
Prestige Anesthesia A Nursing Corporation	Anesthesiology	12615 Sawtooth Avenue Bakersfield CA 93312		3/1/2023
Renaissance Imaging Medical Associates, Inc.	Radiology	1081 North China Lake Blvd. Ridgecrest CA 93555	Hosp Based Radiology Group	3/1/2023
Tandem Diabetes Care Inc	DME	11075 Roselle Street San Diego CA 92121		3/1/2023

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
February 16, 2023

Legal Name DBA	Specialty	Address	Comments	Term Effective Date
Delano Surgical Group, A Prof Med Corp	General Surgery	1205 Garces Hwy Ste. 303 Delano CA	Retirement	12/31/2022
Heartwatch Solutions, Inc	Assisted Device/DME	9400 Empire State Drive Bakersfield CA	Change of Ownership	12/31/2022
Manbir Singh/McFarland Singh Medical Clinic	Internal Medicine	733 3rd Street McFarland CA	Change of Ownership	12/31/2022
Ming & H Drugs	Pharmacy/DME	1717 Ming Avenue Bakersfield CA	Change of Ownership	11/30/2022
Tesa Kurin	Licensed Midwife	1505 West Ave J Ste. 203 Lancaster CA	Voluntary Termed Contract	12/3/2022

KERN HEALTH SYSTEMS

TO: **KHS Board of Directors**

FROM: **Alan Avery, COO**

DATE: **February 16, 2023**

RE: **4th Quarter 2022 Operations Report**

Kern Health Systems Operational Departments finished the year strong, meeting and, in many cases, exceeding all regulatory and health plan performance goals during the 4th Quarter of 2022. Operational efficiency and productivity continue to look great as we adapt to the changing work model, aided by the flexibility of conducting meetings with vendors, regulators, and staff through a mixture of on-site and remote/hybrid participants. We are truly "back to normal".

Claims

Incoming provider claims receipts for the 4th Quarter of 2022 continued to exceed 2021 volumes, ending the year with 3.8 million claims, an additional 400,000 claims when compared to the prior year. This increase can be attributed to significant new member growth, lack of member redeterminations, and members once again seeking healthcare services post COVID-19 pandemic. Even though claim receipts continue to increase, we are not concerned with this increased volume, as 99% of those claims continue to be submitted electronically, with only 1% of claims received on paper. These paper claims are forwarded to a local partner (Stria) who scans and converts them into an electronic file format, allowing them to load electronically into the KHS claims workflow. Once loaded into the claims workflow, the QNXT core system processes them automatically. We identified a slight increase amongst auto adjudication rates, up to 86%, meaning an increase in claims received and processed without any manual intervention.

Earlier in the year, the Claims Department implemented the Claims Provider Call Center, where providers could contact Claims staff directly with questions and concerns. Previously, providers would call the Member Services Department, leave a message, and Claims staff would return the call. Provider calls are now routed directly to Claims Department staff. The staff managing these calls are seasoned Claims Processors III who can resolve most calls immediately or with minimal delay. During the 4th Quarter of 2022, the Claims Provider Call Center received 8,841 calls, compared to 7,705 calls received in the previous quarter. This metric will be reviewed as a Claims Department indicator in 2023.

Member Services

Member and Provider call volume into the Member Services Department had a slight decrease during the 4th Quarter of 2022, attributed to the Thanksgiving, Christmas, and New Year's holidays. The top five reasons members called Member Services remain in line with prior quarters: (1) New Member questions, (2) Changing PCP, (3) Making demographic changes, (4) ID Card replacement and (5) Checking referral status. Outbound phone activity remained strong with over 325,000 outbound calls

in 2022, a growth of 40,000 outbound calls. This increase can be attributed to new member growth and gaps-in-care wellness calls, including asthma, cancer screenings, initial health assessments, pre-natal, and well-baby calls. With the reopening of the building last July, members are once again welcome to meet with us in-person and have their questions answered with a face-to-face meeting with a member services representative. Member visits in the 4th Quarter of 2022 doubled in volume when compared to the prior quarter, reaching 540 visits. We continue to successfully manage phone activity by encouraging members to obtain their own personal account on the KHS Member Portal, powered by the Zipari/HealthX platform. Currently 57,145 members have online accounts, allowing them to perform all of the top five reasons they would normally call Member Services.

Provider Network Management

On a quarterly basis, the Provider Network Management Department monitors network growth, capacity, and accessibility.

In the 4th Quarter of 2022, the Plan's network of Primary Care Providers (PCP) experienced a slight decrease of 6 providers, while the network of core Specialty providers increased by 10. Our complete contracted provider network was 2503 providers as of the 4th Quarter of 2022.

The Provider Network Management Department monitors network capacity/adequacy via a Full-Time Equivalency (FTE) provider to member ratio, based on regulatory requirements. For PCPs, the regulatory standard is one FTE PCP for every 2,000 members; as of the 4th Quarter of 2022, the Plan maintains a network of one FTE PCP for every 1,755 members, meeting the requirement. The Plan is also required to maintain a network of one FTE physician for every 1,200 members; as of the 4th Quarter of 2022, the Plan maintains a network of one FTE Physician for every 393 members, meeting the requirement. Even as our membership continues to grow, the Plan's network continues to meet all regulatory capacity/adequacy requirements. The Plan's Provider Network Management Department maintains ongoing recruitment and contracting efforts to promote network growth and ensure access to care for Plan members.

On a quarterly basis, the Provider Network Management Department conducts an appointment availability survey. Per Plan policy and regulatory requirements, PCPs are required to offer a non-urgent appointment within 10 days of request; the results of the survey found an average wait of 2.8 days for this appointment type, meeting the requirement. Specialist providers are required to offer a non-urgent appointment within 15 days of request; the results of the survey found an average wait of 6.9 days for this appointment type, meeting the requirement.

Human Resources

During the 4th Quarter of 2022, the Human Resources Department continued to support the increased recruiting efforts of the Health Plan. In addition, they conducted open enrollment meetings, a benefits fair, annual performance reviews/merit increases, the employee satisfaction survey, and numerous training and development seminars.

During the quarter, staffing increased slightly to 486 employees, with employee turnover for the year averaging a remarkably low 8.53%. Most of the turnover occurred due to voluntary separations, with 19 of the 27 employees who voluntarily left KHS taking positions elsewhere. Of the remaining employees, 3 resigned without giving a reason, 2 quit for health reasons, 2 quit to stay at home to care for dependents, and 1 quit to go to school.

Grievance Report

Total grievances (formal and exempt) decreased during the 4th Quarter of 2022 by over 300 grievances, following a historic pattern of lower grievances being received in the 4th quarter of the year. Formal grievances increased by 172 and exempt grievances decreased by 512. Even though there was a sizeable decrease in exempt cases, it may have been caused by a significant increase in Potential Inappropriate Care and Quality of Services grievances.

The Department of Healthcare Services (DHCS) requires health plans to forward copies of all member discrimination grievances within 10 days to the DHS Office of Civil Rights when members allege discrimination based on any characteristic protected by federal or state nondiscrimination laws. Characteristics protected by federal or state nondiscrimination laws include sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental ability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, or health status. The Plan received 46 grievances classified as discrimination during the 4th Quarter of 2022, compared to 73 received during the previous quarter. All discrimination grievances were reported timely to DHS Office of Civil Rights.

Part two of the Grievance Report required by the regulators is the disposition of the formal grievances. All formal grievances are now sent to the Quality Department for clinical review to identify Potential Inappropriate Care issues. Following their review of the 1353 grievances received, 743 of the decisions were upheld, 26 required further review, 544 were overturned and ruled in favor of the member, and 40 are still under review. The Quality Department has not identified any trends amongst the grievances reviewed. The primary reason for overturning the original decision of the grievance occurs when we receive additional supporting documentation from the member or the provider.

Lastly, to fully understand the dynamics and relativity of the grievance volume, the Plan calculates the number of grievances received in relation to the number of medical visits and Plan enrollment. During the 4th Quarter of 2022, there were over 950,000 medical visits provided to over 340,000 members, many of whom are new to managed care. KHS received 1.01 grievances per 1,000 members, below the average of the other Local Health Plans, which average between 1.00 – 3.99 per month.

Transportation Update

Transportation activity during the 4th Quarter of 2022 continued to grow with overall ridership increasing by over 4,400 rides. The ride share programs (GET OnDemand and Uber) continue to reflect increased activity with an increase of 5.5% over the 3rd Quarter of 2022. All other transportation options had minor increases/decreases. Overall, the use of transportation services continues to inch closer to pre-COVID-19 activity. Management is recommending discontinuing presenting this metric as part of the quarterly operations board report, as the new benefit has stabilized following the COVID-19 pandemic and will continue to be closely monitored by the Member Services and Finance management team.

4th Quarter 2022 Operational Report

Alan Avery
Chief Operating Officer
02/16/2023

4th Quarter 2022 Claims Department Indicators

Activity	Goal	4th Quarter	Status	3rd Quarter	2nd Quarter	1st Quarter 2022	4th Quarter 2021
Claims Received		**958,308**		982,337	954,234	913,452	853,656
Electronic	95%	**99%**		99%	98%	98%	98%
Paper	5%	**1%**		1%	2%	2%	2%
Claims Processed Within 30 days	90%	**99%**		99%	99%	99%	99%
Claims Processed within 45 days	95%	**99%**		99%	99%	99%	99%
Claims Processed within 90 days	99%	**100%**		100%	100%	99%	99%
Claims Inventory-Under 30 days	96%	**99%**		99%	99%	99%	99%
31-45 days	<3%	**<1%**		<1%	1%	<1%	<1%
Over 45 days	<1%	**<1%**		<1%	<1%	<1%	1%
Auto Adjudication	85%	**86%**		85%	87%	88%	87%
Audited Claims with Errors	<3%	**<2%**		2%	2%	1%	2%
Claims Disputes	<5%	**<1%**		1%	1%	1%	1%

KERN HEALTH SYSTEMS

4th Quarter 2022 Member Service Indicators

Activity	Goal	4th Quarter 2022	Status	3rd Quarter 2022	2nd Quarter 2022	1st Quarter 2022	4th Quarter
Incoming Calls		**56,216**		66,020	66,410	70,459	63,724
Abandonment Rate	<5%	**1%**		1.00%	1.00%	3.39%	1.14%
Avg. Answer Speed	<2:00	**:16**		:09	:05	:23	:13
Average Talk Time	<8:00	**8:14**		7:34	7:22	7:10	8:00
Top Reasons for Member Calls	Trend	1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals		1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demo 4. Referrals 5. ID Card	1. New Member 2. PCP Change 3. Referrals 4. Demo 5. ID Card
Outbound Calls	Trend	**72350**		85,326	77,818	89,784	79,894
# of Walk Ins	Trend	**540**		204	0	0	0
Member Portal Accounts-Q/Total	4%	**2778** **57145** **(16.41%)**		4058 54,361 (15.93%)	3163 50,303 (15.09%)	3640 47,937 (14.70%)	2605 44,301 (14.23%)

KERN HEALTH SYSTEMS

4th Quarter Provider Network Indicators

Activity	Goal	4th Quarter	Status	3rd Quarter	2nd Quarter	1st Quarter 2022	4th Quarter 2021
Provider Counts							
# of PCP		428		434	441	441	425
% Growth		(1.38%)		(1.81%)	0%	3.76%	2.84%
# of Specialist		505		495	448	442	444
% Growth		2.02%		10.49%	1.34%	[.45%]	5.21%
FTE PCP Ratio	1:2000	1:1755		1:1759	1:1938	1:1893	1:1819
FTE Physician Ratio	1:1200	1:393		1:507	1:704	1:685	1:671
PCP	< 10 days	2.8 days		4.3days	6.5days	4.1 days	2.5 days
Specialty	< 15 days	6.9 days		12.2 days	9.5 days	11.4 days	6.3 days

KERN HEALTH SYSTEMS

4th Quarter Human Resources Indicators

Activity	Budget	4th Quarter	Status	3rd Quarter	2nd Quarter	1st Quarter 2022	4th Quarter 2021
Staffing Count	522	**486**		480	478	459	431
Employee Turnover	12%	**8.53%**		8.97%	8.8%	6.32%	10.83%
Turnover Reasons	Voluntary (27) Involuntary (6) Retired (7)	**68%** **15%** **17%**		61% 16% 23%	65% 10% 25%	85.7% 0% 14.3%	60.87% 23.91% 8.70%

KERN HEALTH SYSTEMS

4th Quarter 2022 Grievance Report

Category	4th Quarter 2022	Status	Issue	Q3	Q2	Q1 2022	Q4 2021
Access to Care	**108**		Appointment Availability	132	117	169	131
Coverage Dispute	**0**		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	**335**		Questioning denial of service	346	259	138	266
Other Issues	**38**		Miscellaneous	30	20	41	36
Potential Inappropriate Care	**670**		Questioning services provided. All cases forwarded to Quality Dept.	514	415	479	256
Quality of Service	**156**		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	86	120	125	55
Discrimination (New Category)	**46**		Alleging discrimination based on the protected characteristics	73	34	15	
Total Formal Grievances	**1353**			1181	965	967	744
Exempt	**1816**		Exempt Grievances-	2328	2087	1404	1431
Total Grievances (Formal & Exempt)	**3169**			3509	3052	2371	2175

KHS Grievances per 1,000 members – 1.01/month.
LHPC Average 1.0 – 3.99/month

KERN HEALTH SYSTEMS

Additional Insights-Formal Grievance Detail

Issue	2022 4th Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	59	27	0	25	7
Coverage Dispute	0	0	0	0	0
Specialist Access	49	25	0	18	6
Medical Necessity	335	146	0	181	8
Other Issues	38	22	0	11	5
Potential Inappropriate Care	670	381	26	263	0
Quality of Service	156	103	0	44	9
Discrimination	46	39	0	2	5
Total	**1353**	**743**	**26**	**544**	**40**

KERN HEALTH SYSTEMS

4th Quarter 2022 Transportation Update

Operational Statistics	4th Quarter 2022	Q3	Q2	Q1 2022	Q4 2021
ALC Calls	**93,326**	93,642	80,404	63,118	63,425
One Way Rides Scheduled	**105,565**	101,117	86,068	70,936	78,330
NMT	**66,875**	63,341	48,968	38,685	39,898
Bus Passes Distributed	**1063**	1096	878	749	1047
GET Van Share	**4465**	5099	3720	5258	5248
Ride Share Rides	**61,347**	57,146	44,370	32,678	32,315
No Shows	**5292**	5883	4958	3866	4320
NEMT	**38,690**	37,776	37,100	32,251	38,162
Van Rides Scheduled	**37,844**	37,077	36,625	31,815	37,632
Gurney Rides Scheduled	**846**	699	475	436	530
Member Reimbursement	**3067**	2365	2975	1361	1785
ALC Admin Expense	**$683,181.00**	$512,637.00	$548,696.30	$387,173.70	$423,776.90

This report is being retired 12/31/2022. Mature benefit will be monitored internally by Member Services and Finance management

KERN HEALTH SYSTEMS

Questions

For additional information, please contact:

Alan Avery
Chief Operating Officer
(661) 664-5005

KERN HEALTH SYSTEMS

To: KHS Board of Directors

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

Date: February 16, 2023

Re: Health Services Trend Report

Medical Cost and Utilization Trend Analyses: (Attachment A)

Physician Services: *(*PCPs, Specialist, Hospitalist and Ancillary Services):

The utilization of physician services by all Aide codes in 2022 was above projections. This was a welcomed finding which signaled that our members were going to their doctors to get the care they might not have had because of the COVID-19 Pandemic.

The seniors and persons with disabilities (SPD) population is made up of mainly members with multiple chronic conditions and we see this in the number of visits per 1000 members. The difference between expected and observed was higher than that seen in the other Aide groups. Despite the higher-than-expected utilization, the cost per professional visit remained closed to expected for all Aide codes.

The top 3 diagnosis driving utilization of professional services are chronic kidney/end stage kidney disease, hypertension, and diabetes. These same diagnoses are driving out patient utilization. This is a good sign that our patients with these diagnoses are going to the doctors to get the care they need. These 3 diagnoses are the focus of our population health programs: ensure the diseases are controlled and reduce complications, identify social and behavioral factors that influence the development and control of these conditions, and develop holistic interventions to manage the members in collaboration with their primary care provider as the "Quarter Back" of their care team.

Inpatient Services:

The overall Per Member Per Month (PMPM) for inpatient utilization for all Aid codes remained stable and close to projection from March 2022. The higher than normal SPD PMPM for the month of October and November are not significant because of the sudden drop in December. In our calculations we would consider a significant trend if it persist for at least 4 months. In October and November 2022, we had 2 patients with extended lengths of stay.

For all Aide codes combined, the top 4 reasons for inpatient stay is related to pregnancy and delivery. We have on the average 400 deliveries every month.

Most of the inpatient stays continue to be at BMH with Kern Medical a close second. KHS'sPopulation Health programs are focusing on care coordination and safe transitions of our members through the continuum of care. This focus will ensure that there is continuity of care at all levels of the system and reduction of readmissions to the acute hospital.

Emergency Room (ER):

The number of ER visits remained at or below projections for all of 2022. Most of our members use Kern Medical and Bakersfield Memorial Hospital for ER services. The most frequent diagnoses associated with an ED visit in the combine Aide codes in December 2022 were Upper respiratory infection and urinary tract infections.

Obstetrics Services:

The primary C/Section (18%) in December 2022 is below the State averages. Most of the deliveries are occurring at Bakersfield memorial hospital and Kern Medical Hospital

MCAS tracking Update:

The purpose of this report is to show, in "real time", how KHS is performing year-to-date in the MCAS measurement categories. For the most part, the data for this report is based on information from medical service claims. The report compares the current month performance against the plan performance the same moth in the previous year and against the Minimum Performance Level (MPL) set by the State

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 the previous year's MPL is used here to determine how well our MCAS program performs against this standard.

The report gives a snapshot summary of each measurement year- to- date. It is color coded in green, if we are meeting MPL, yellow when we are below MPL, but we are statistically close enough that with a bit more effort we will meet MPL by the anchor date; and red shows that we are very far from the MPL and we need to reevaluate our interventions and shift as soon as possible to be able to meet MPL. The report also shows our year-to-date performance compared to same

time in the previous year. This allows us to see if our interventions are resulting in any improvements year over year. Those that are now showing any improvement will be modified or terminated and new ones developed. The state has increased the number of measures that we are held to the MPL from 15 in 2022 to 20 in 2023. KHS Business intelligent team is working with our MCAS vendor to incorporate the new measure into this report by next Board meeting. Of the 15 MCAS measures displayed here, 1 measure (Breast Cancer Screening) is green and we have exceeded MPL. on target to meet expectation. The rest of the measures for 2022 we are so far from MPL. We are currently doing medical records abstractions and some of these would change but difficult to say which one. We expect to review about 8000 medical records to look for services that were provided but not coded in the claims. This process will close out 2022 measuring year by May 2023.

Kern Health Systems

KHS Medical Management Performance Dashboard (Critical Performance Measurements)

KERN HEALTH SYSTEMS

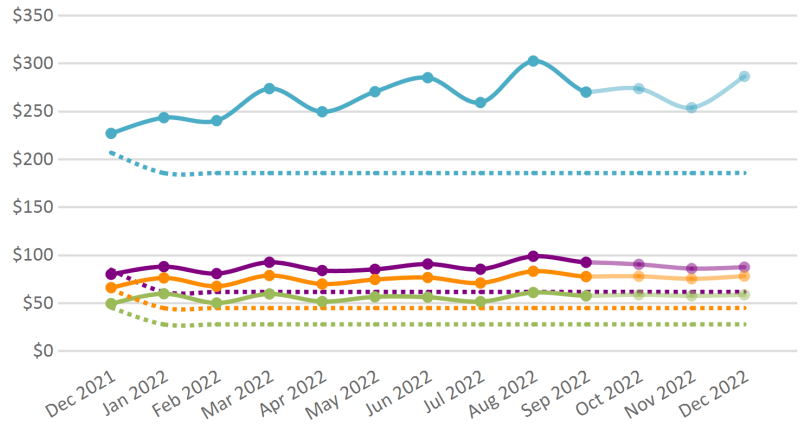
Governed Reporting System

Physician Services

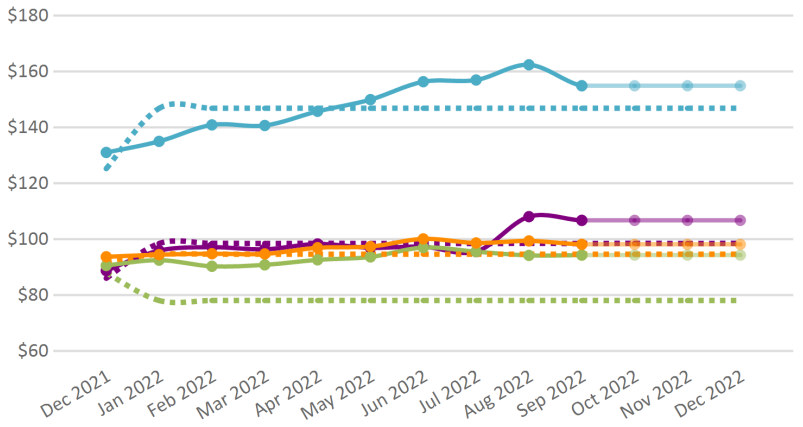
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

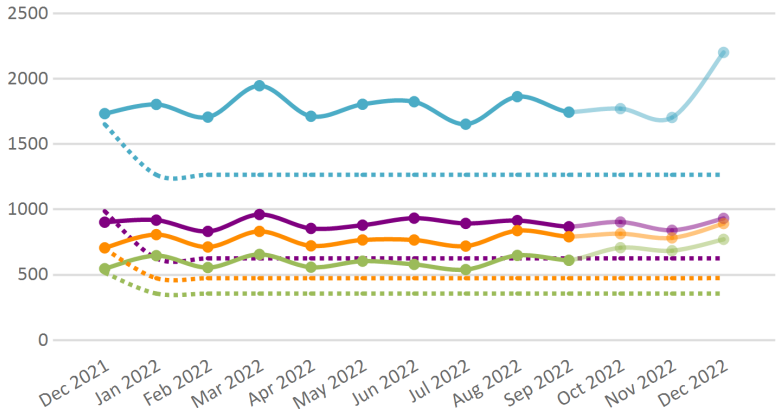
Professional Services Incurred by Aid Group PMPM



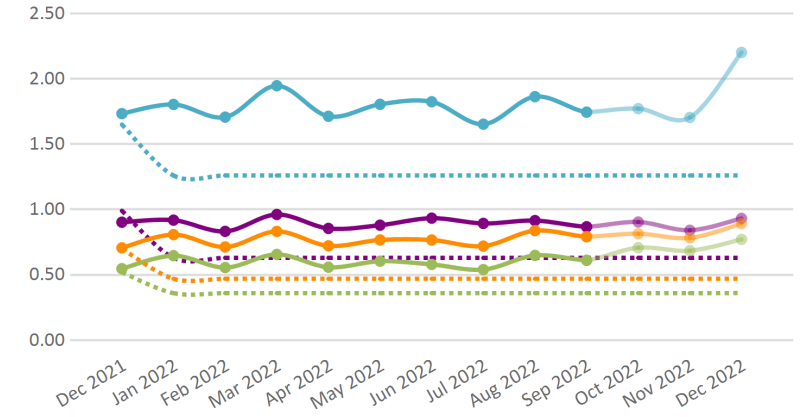
Cost per Professional Service Visit by Aid Group



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



Professional Service Visits per Member per Month by Aid Group



KERN HEALTH SYSTEMS

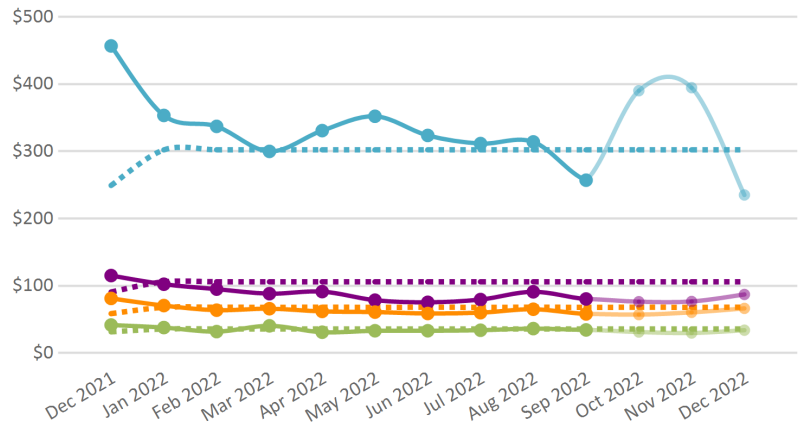
Governed Reporting System

Inpatient

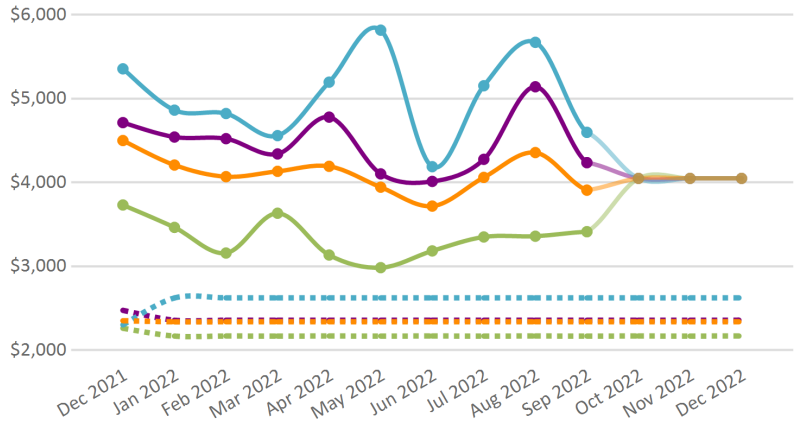
(Includes: Inpatient Hospital Claims)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

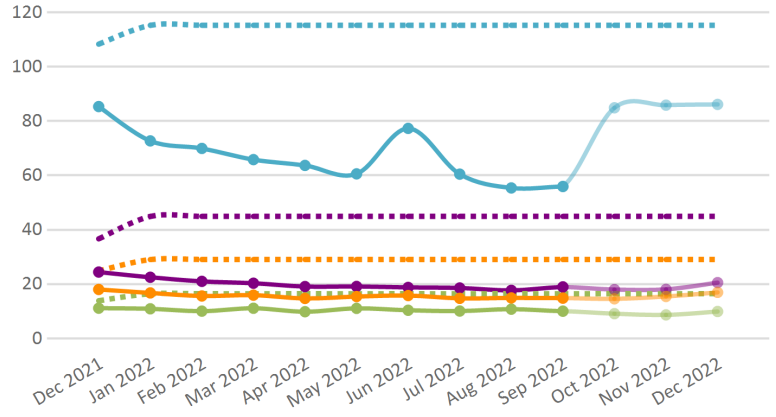
Inpatient Services Incurred by Aid Group PMPM



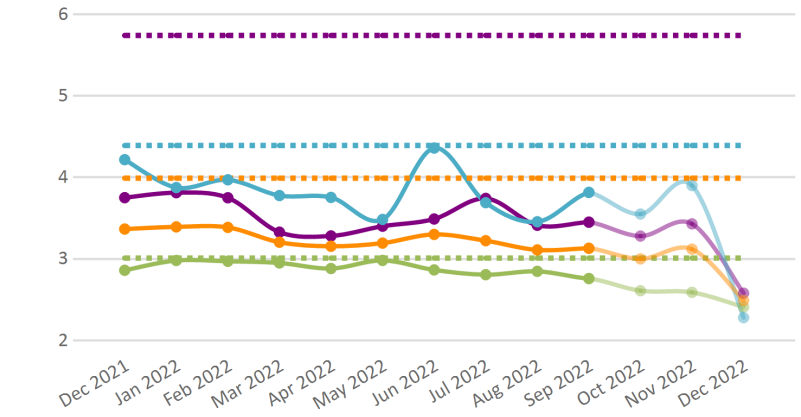
Cost Per Bed Day by Aid Group



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

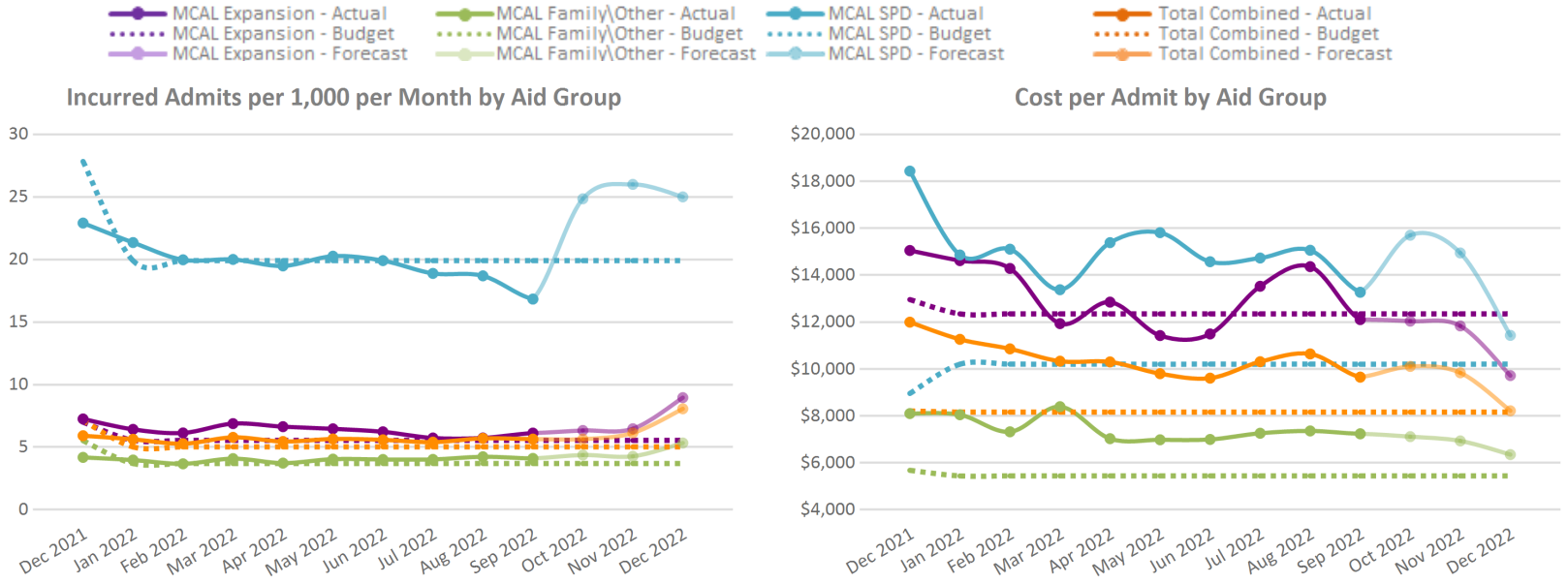


Average Length of Stay in Days by Aid Group



Inpatient

(Includes: Inpatient Hospital Claims)



KERN HEALTH SYSTEMS

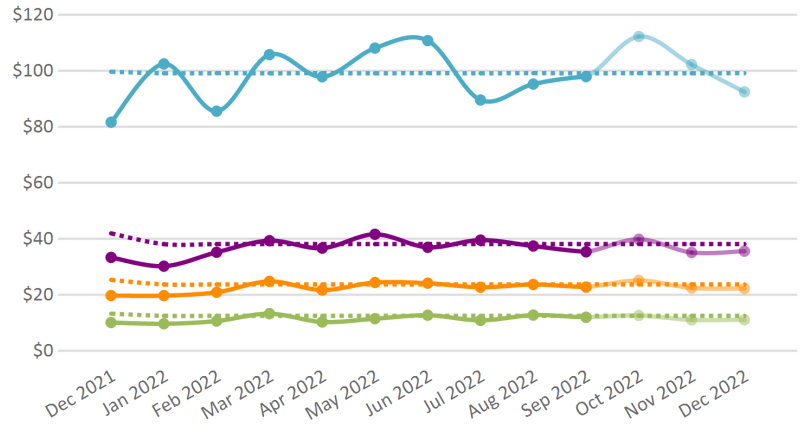
Governed Reporting System

Outpatient Hospital

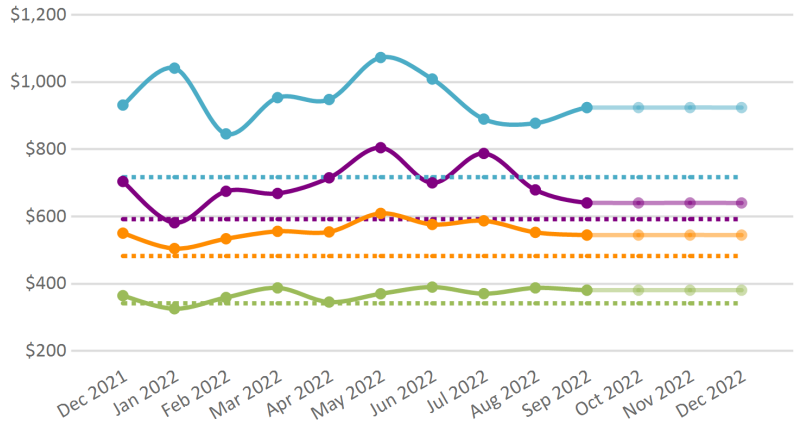
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

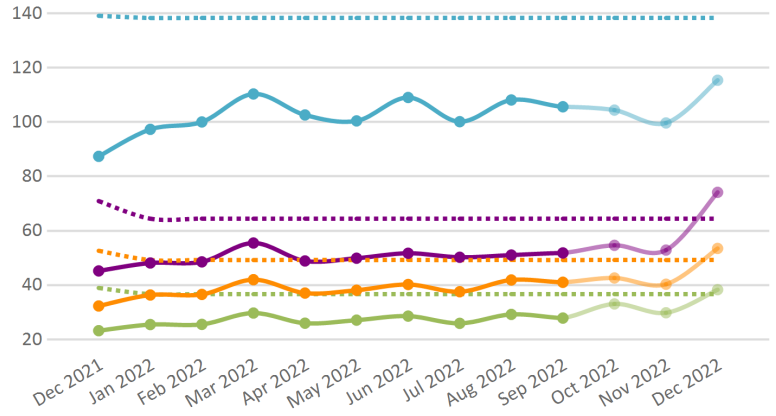
Outpatient Services Incurred by Aid Group PMPM



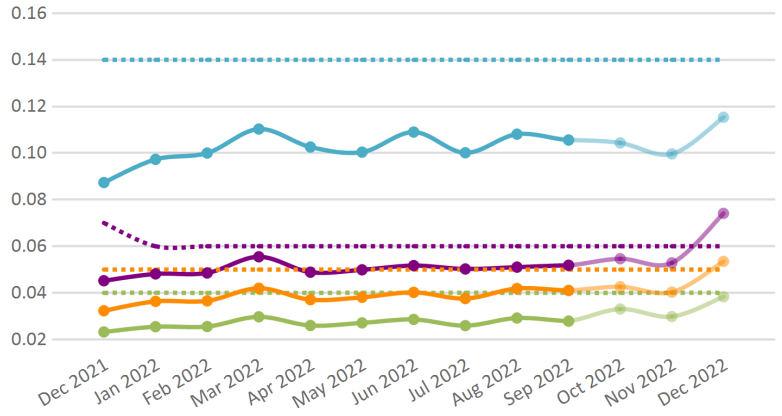
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



Outpatient Visits per Member per Month by Aid Group

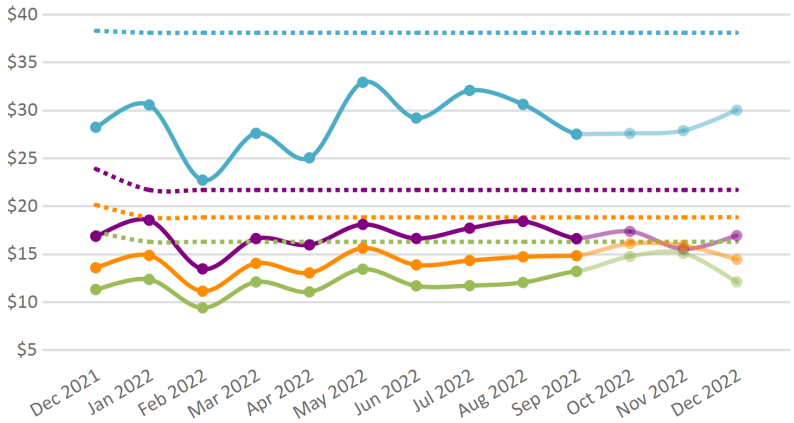


KERN HEALTH SYSTEMS

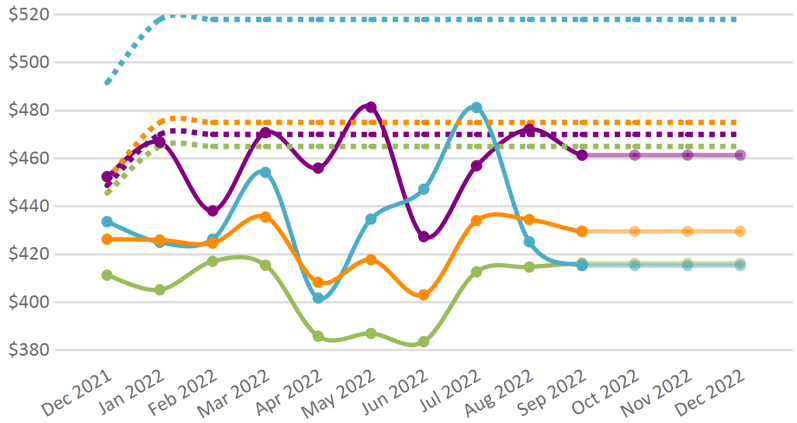
Governed Reporting System

Emergency Room

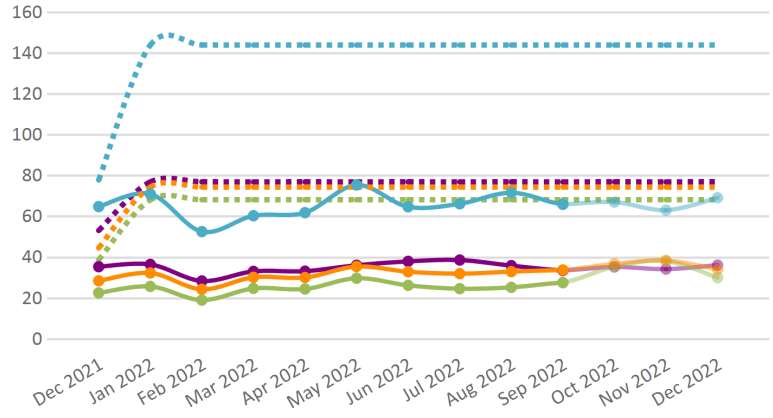
ER Services Incurred by Aid Group PMPM



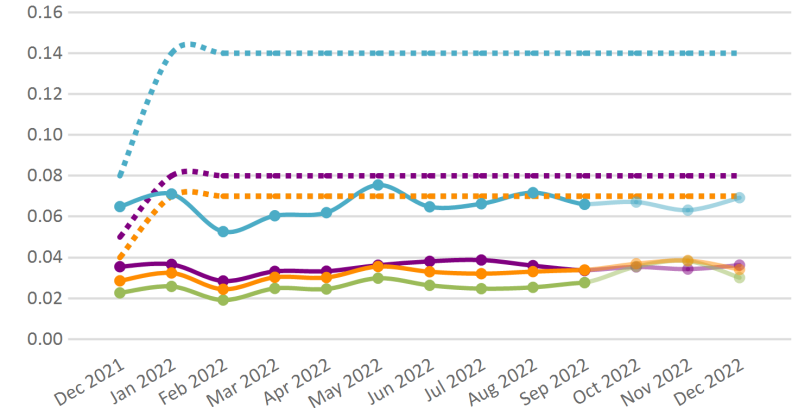
Cost Per ER Visit by Aid Group



ER Visits per 1,000 per Month by Aid Group



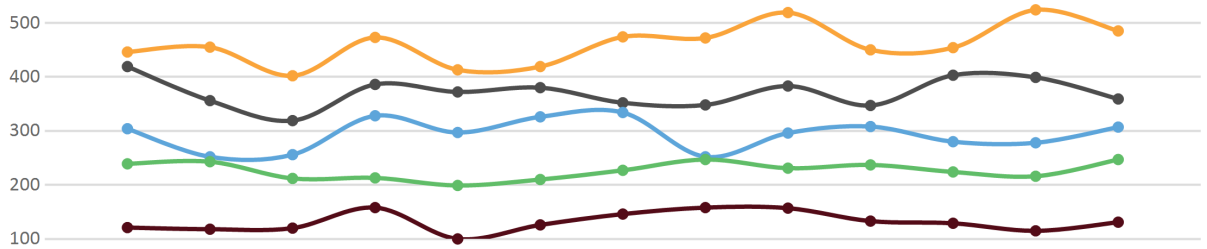
ER Visits per Member per Month by Aid Group



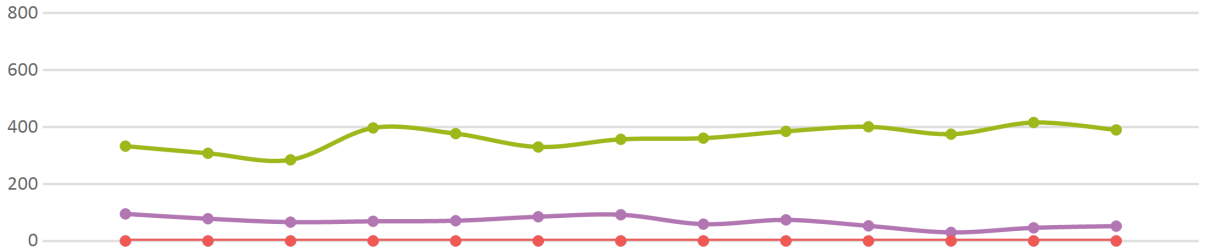
KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient Admits by Hospital



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
KERN MEDICAL	446	455	402	473	413	419	474	472	519	450	454	524	485
BAKERSFIELD MEMORIAL	419	356	319	386	372	380	352	348	383	347	403	399	359
ADVENTIST HEALTH	304	252	256	328	297	326	334	252	296	308	280	278	307
MERCY HOSPITAL	239	243	212	213	199	210	227	247	231	237	224	216	247
GOOD SAMARITAN HOSPITAL	121	118	120	158	100	126	146	158	157	133	129	115	131

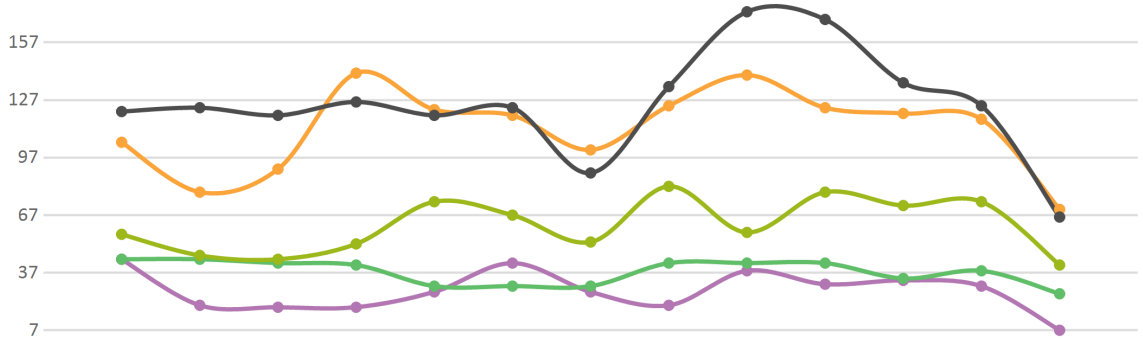


	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
DELANO REGIONAL HOSPITAL	95	78	66	69	71	85	92	59	74	53	30	46	52
OUT OF AREA	333	308	285	397	377	330	357	361	385	401	375	416	390
BAKERSFIELD HEART HOSP	39	33	38	37	22	37	42	34	44	31	34	34	37

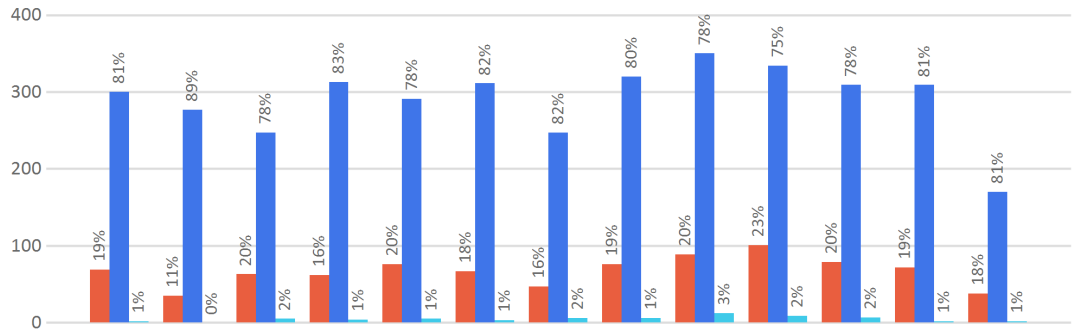
KERN HEALTH SYSTEMS

Governed Reporting System

Obstetrics Metrics



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
BAKERSFIELD MEMORIAL	121	123	119	126	119	123	89	134	173	169	136	124	66
KERN MEDICAL	105	79	91	141	122	119	101	124	140	123	120	117	70
OTHER	57	46	44	52	74	67	53	82	58	79	72	74	41
MERCY HOSPITAL	44	44	42	41	30	30	30	42	42	42	34	38	26
DELANO REGIONAL HOSPITAL	44	20	19	19	27	42	27	20	38	31	33	30	7



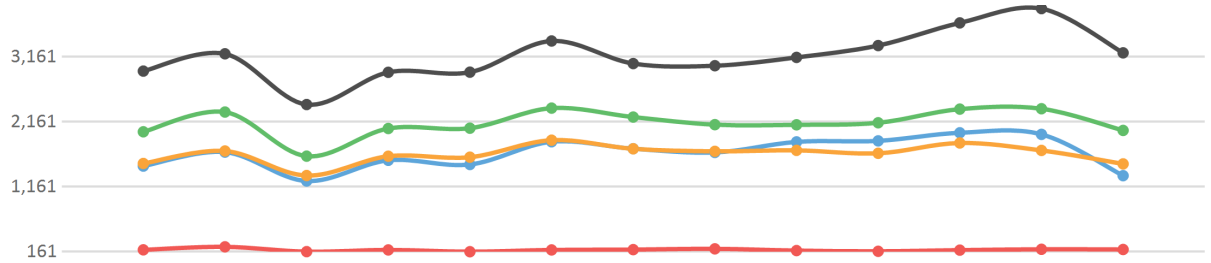
	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
VAGINAL DELIVERY	300	277	247	313	291	311	247	320	350	334	309	309	170
C-SECTION DELIVERY	69	35	63	62	76	67	47	76	89	101	79	72	38
PREVIOUS C-SECTION DELIVERY	2	0	5	4	5	3	6	6	12	9	7	2	2

KERN HEALTH SYSTEMS

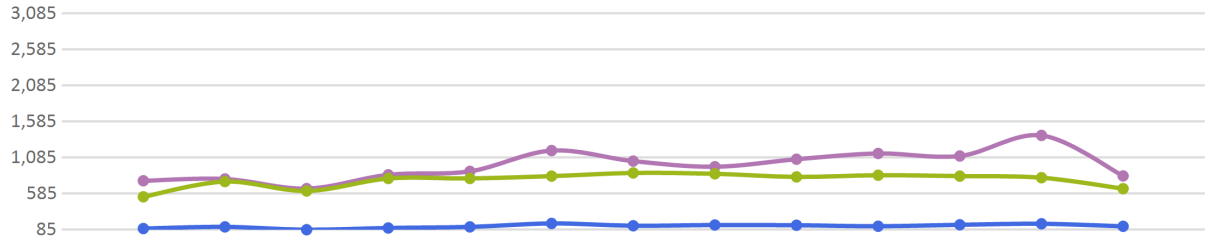
Governed Reporting System

Attachment D

Emergency Visits by Hospital



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
BAKERSFIELD MEMORIAL	2,937	3,203	2,423	2,919	2,921	3,400	3,053	3,020	3,148	3,330	3,678	3,898	3,218
MERCY HOSPITAL	2,004	2,308	1,630	2,055	2,060	2,368	2,231	2,114	2,112	2,143	2,353	2,359	2,025
KERN MEDICAL	1,517	1,709	1,332	1,629	1,614	1,875	1,743	1,704	1,719	1,674	1,832	1,718	1,511
ADVENTIST HEALTH	1,477	1,692	1,248	1,566	1,502	1,851	1,744	1,687	1,849	1,865	1,989	1,965	1,330
BAKERSFIELD HEART HOSP	190	236	162	188	161	188	193	205	178	167	185	198	195



	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
DELANO REGIONAL HOSPITAL	763	788	655	846	894	1,182	1,036	958	1,062	1,142	1,107	1,392	830
OUT OF AREA	541	752	622	795	795	828	872	860	817	840	828	806	654
KERN VALLEY HEALTHCARE	101	124	85	109	124	172	140	150	147	133	153	167	132

MCAS MY2023 Performance Trending Metrics through January 2023

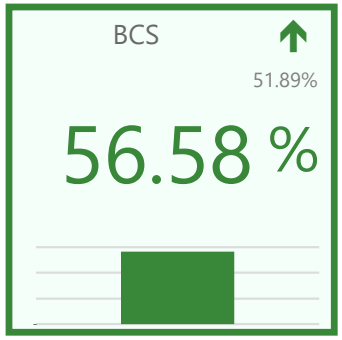
BCS	CBP	CCS	CHL Adults and Peds	CIS
56.58 %	7.11 %	46.29 %	51.83 %	19.66 %
MPL: 50.95% Over MPL by 5.63% Previous YTD: 51.89%	MPL: 59.85% Under MPL by 52.74% Previous YTD: 3.32%	MPL: 57.64% Under MPL by 11.35% Previous YTD: 43.66%	MPL: 55.32% Under MPL by 3.49% Previous YTD: 50.41%	MPL: 34.79% Under MPL by 15.13% Previous YTD: 19.30%
FUA 30 Day Follow-up	**FUM 30 Day Follow-up**	**HBD HBA1C >9%**	**IMA**	**LSC**
6.49 %	21.05 %	99.70 %	19.13 %	42.88 %
MPL: 21.24% Under MPL by 14.75% Previous YTD: 3.03%	MPL: 54.51% Under MPL by 33.46% Previous YTD: 9.76%	MPL: 39.90% Under MPL by 59.80% Inverted Measure Previous YTD: 99.84%	MPL: 35.04% Under MPL by 15.91% Previous YTD: 30.38%	MPL: 63.99% Under MPL by 21.11% Previous YTD: 50.08%
PPC Post	**PPC Pre**	**W30 0 - 15 Months**	**W30 15 - 30 Months**	**WCV**
45.43 %	21.50 %	2.04 %	41.44 %	1.82 %
MPL: 77.37% Under MPL by 31.94% Previous YTD: 70.28%	MPL: 85.40% Under MPL by 63.90% Previous YTD: 44.41%	MPL: 55.72% Under MPL by 53.68% Previous YTD: 20.76%	MPL: 65.83% Under MPL by 24.39% Previous YTD: 48.67%	MPL: 48.93% Under MPL by 47.11% Previous YTD: 1.40%

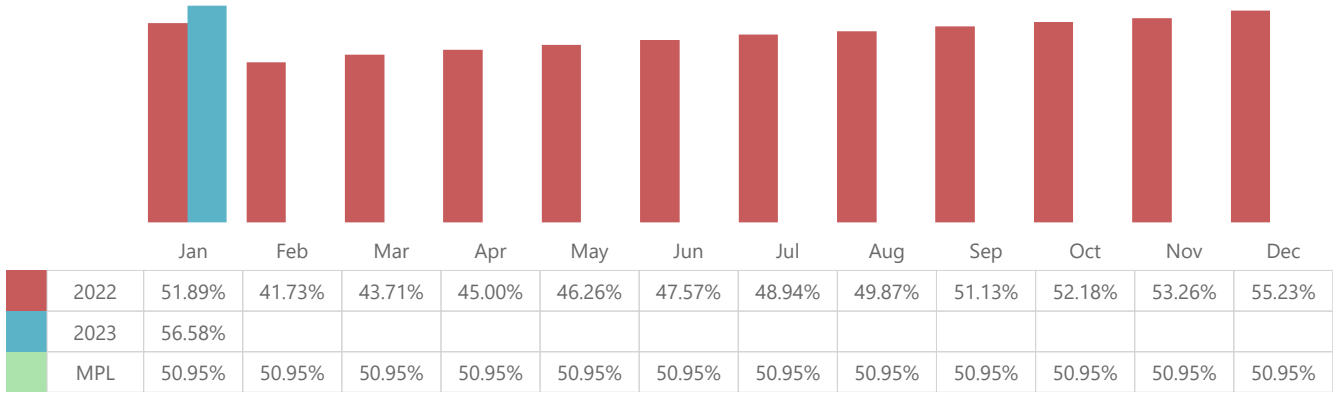
Measure rates are thru claims only - no supplemental data nor medical record reviews are included

MCAS MY2023 Performance Trending Metrics through January 2023

Breast Cancer Screening

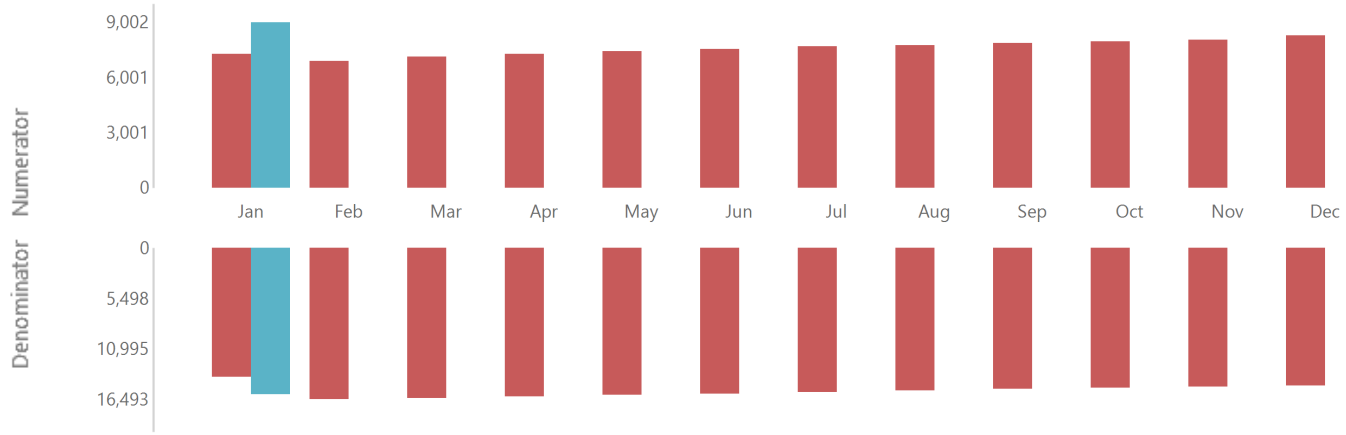
The percentage of women 50–74 years of age who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	51.89%	41.73%	43.71%	45.00%	46.26%	47.57%	48.94%	49.87%	51.13%	52.18%	53.26%	55.23%
	2023	56.58%											
	MPL	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%

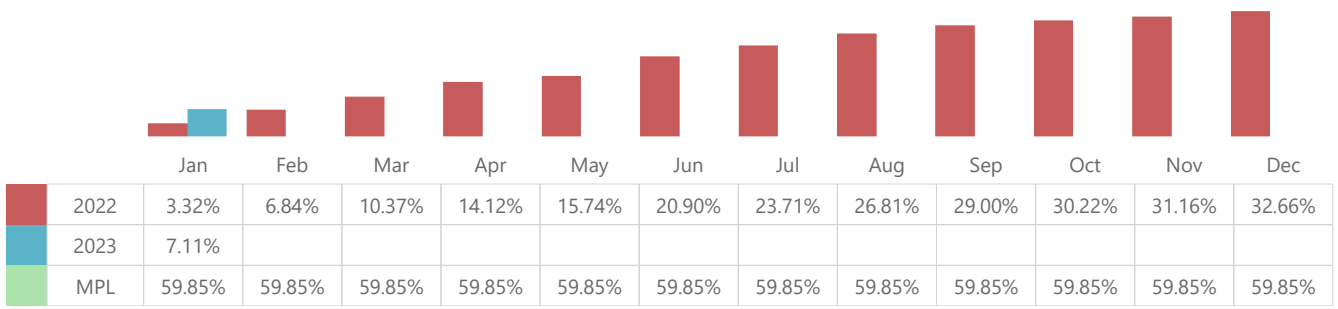
9,002
15,911



MCAS MY2023 Performance Trending Metrics through January 2023

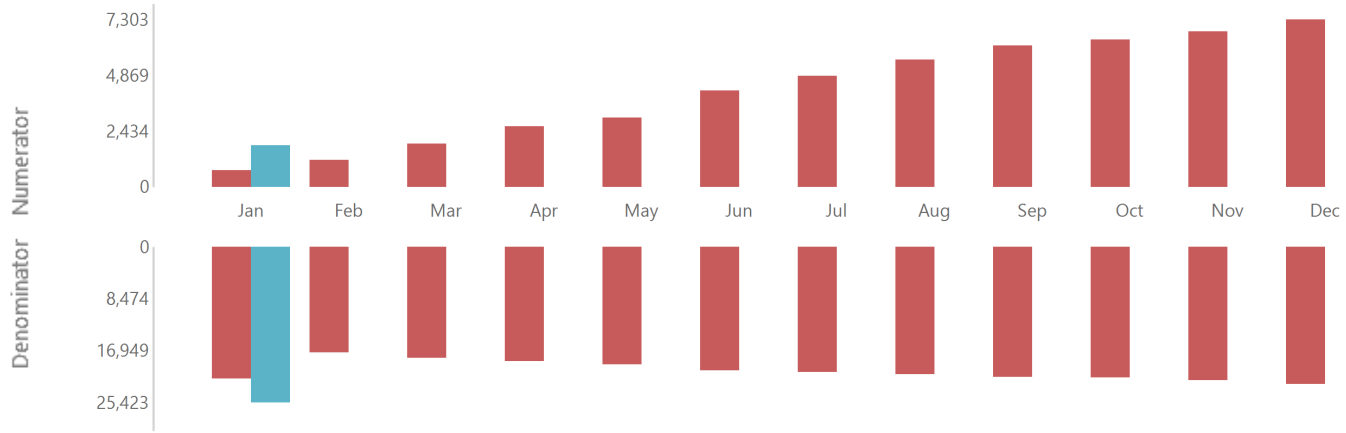
Controlling High Blood Pressure

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
	2022	3.32%	6.84%	10.37%	14.12%	15.74%	20.90%	23.71%	26.81%	29.00%	30.22%	31.16%	32.66%
	2023	7.11%											
	MPL	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%

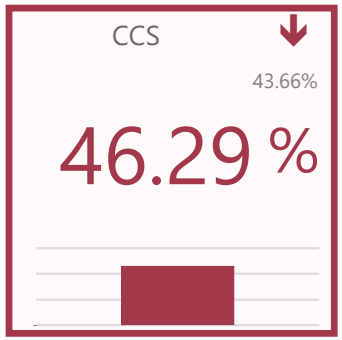
1,808
25,423

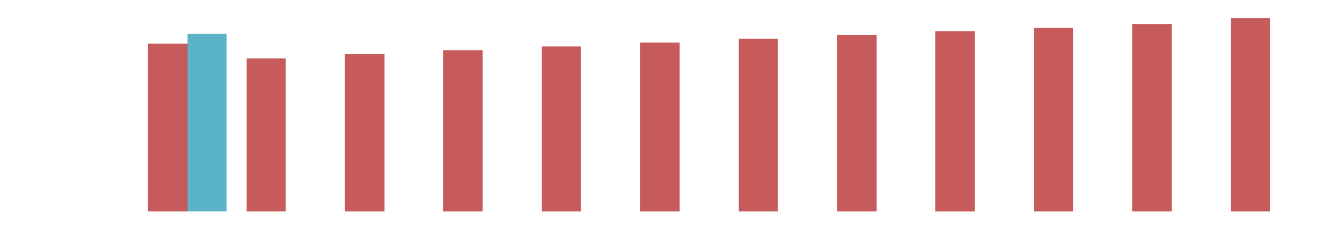


MCAS MY2023 Performance Trending Metrics through January 2023

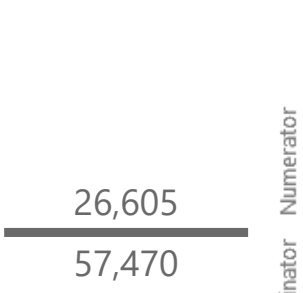
Cervical Cancer Screening

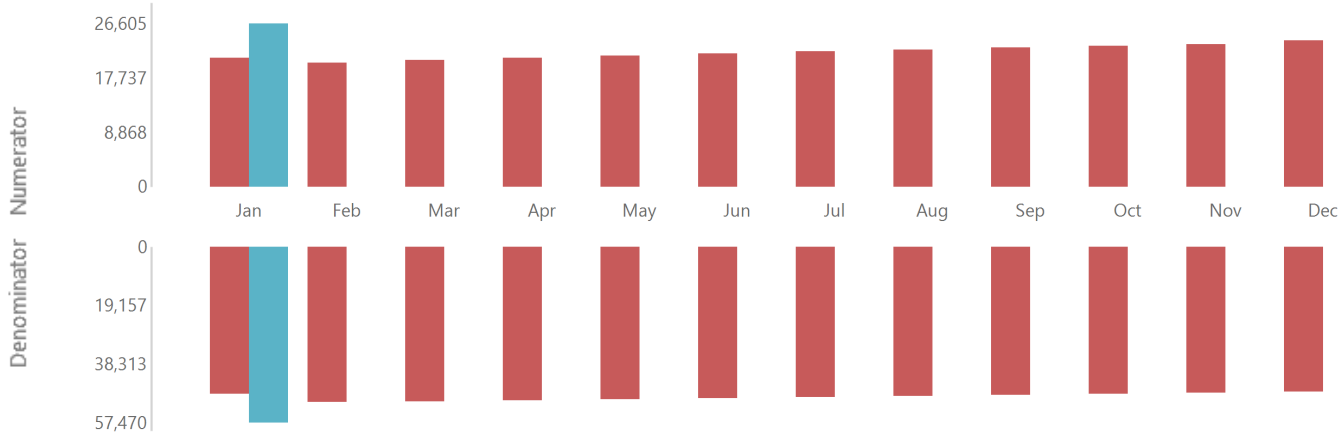
The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:• Women 21–64 years of age who had cervical cytology performed within the last 3 years.• Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed 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
	2022	43.66%	39.89%	41.06%	41.99%	43.02%	43.93%	45.00%	46.02%	47.04%	47.87%	48.87%	50.46%
	2023	46.29%											
	MPL	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%

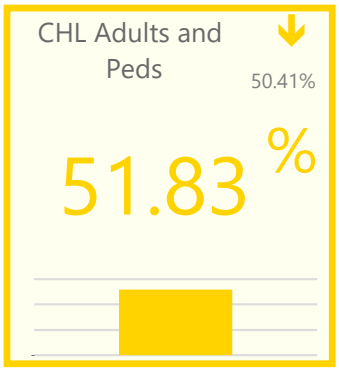


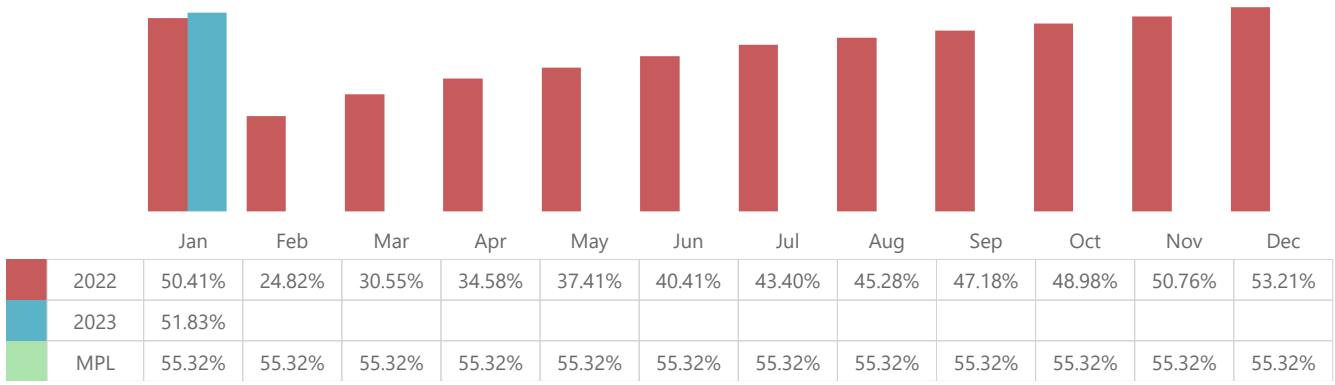


MCAS MY2023 Performance Trending Metrics through January 2023

Chlamydia Screening in Women

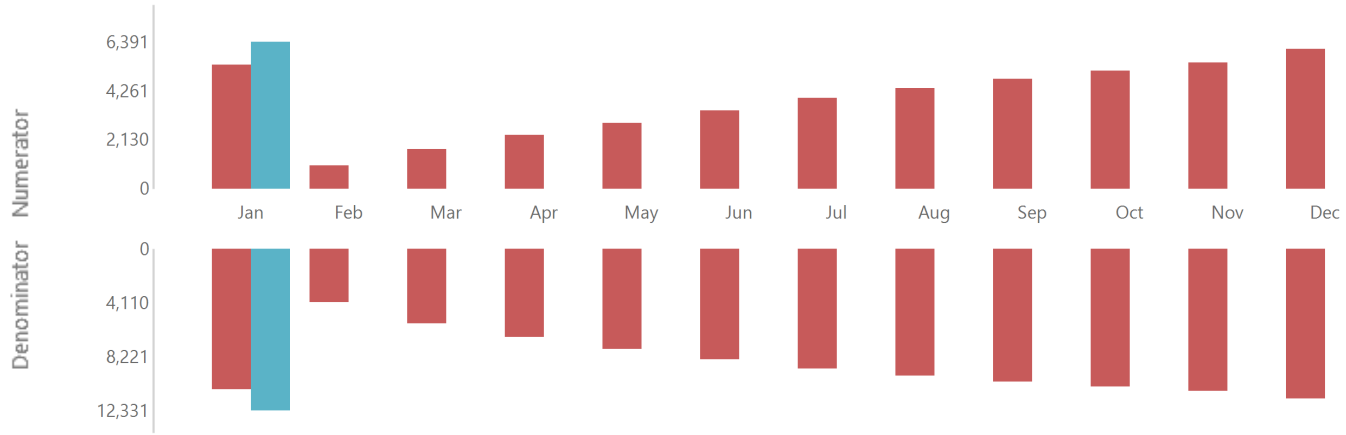
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	50.41%	24.82%	30.55%	34.58%	37.41%	40.41%	43.40%	45.28%	47.18%	48.98%	50.76%	53.21%
	2023	51.83%											
	MPL	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%

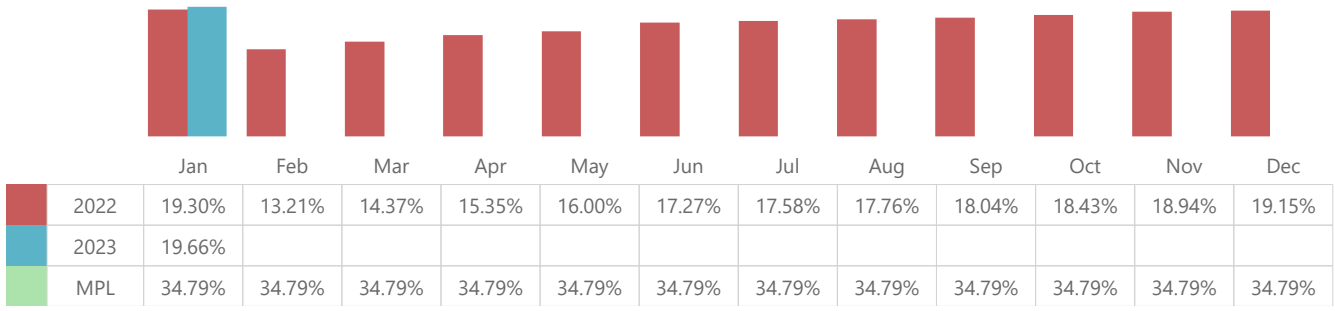
6,391
12,331



MCAS MY2023 Performance Trending Metrics through January 2023

Childhood Immunization Status

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

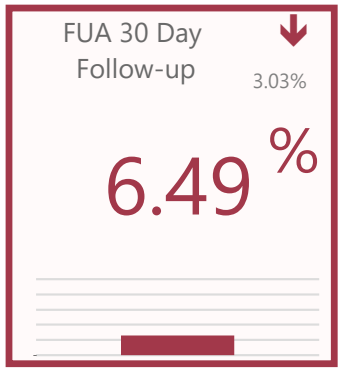


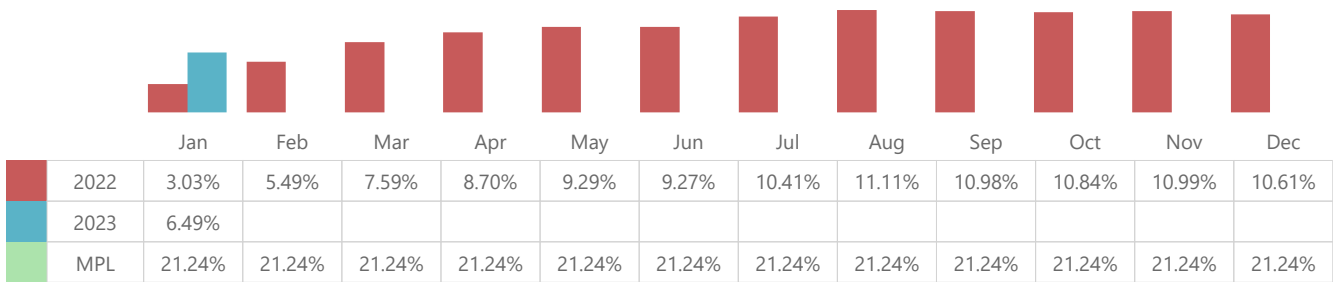
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	19.30%	13.21%	14.37%	15.35%	16.00%	17.27%	17.58%	17.76%	18.04%	18.43%	18.94%	19.15%
2023	19.66%											
MPL	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%	34.79%

MCAS MY2023 Performance Trending Metrics through January 2023

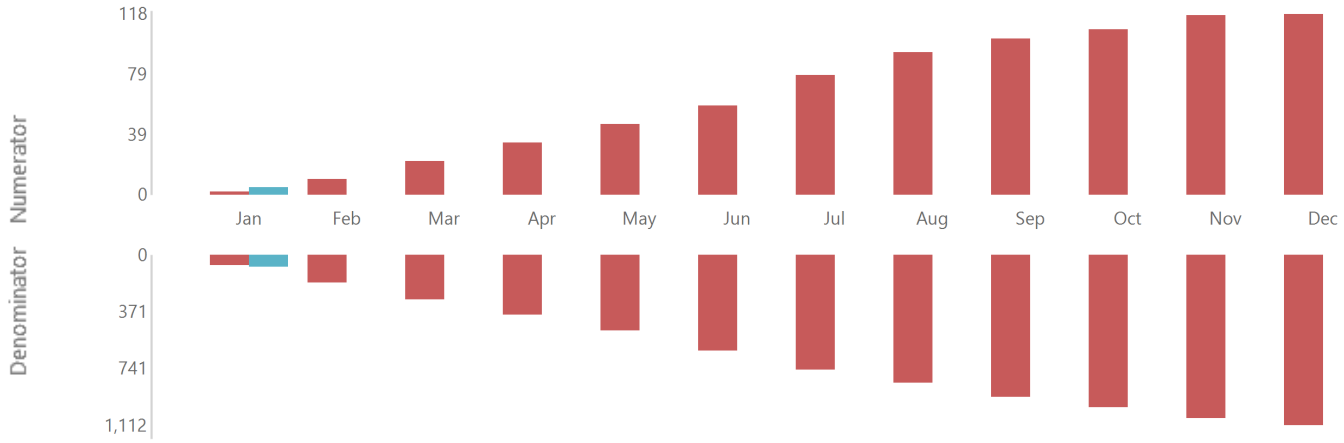
Follow-Up After Emergency Department Visit for Substance Use

The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).





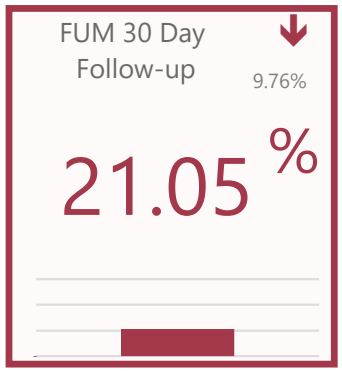
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	3.03%	5.49%	7.59%	8.70%	9.29%	9.27%	10.41%	11.11%	10.98%	10.84%	10.99%	10.61%
	2023	6.49%											
	MPL	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%

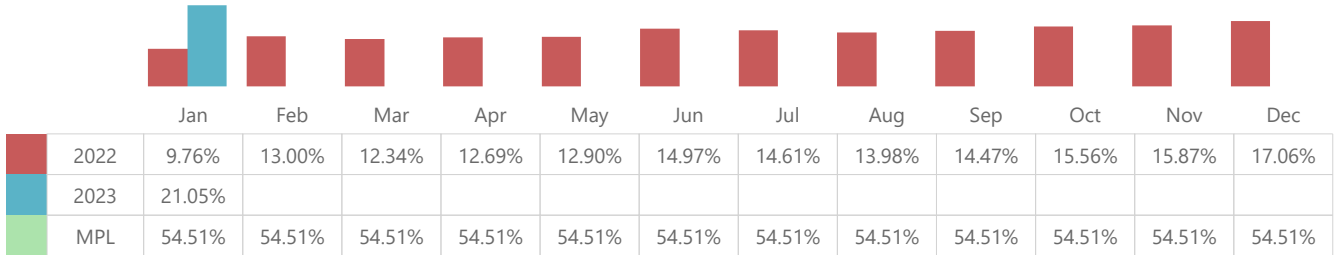


MCAS MY2023 Performance Trending Metrics through January 2023

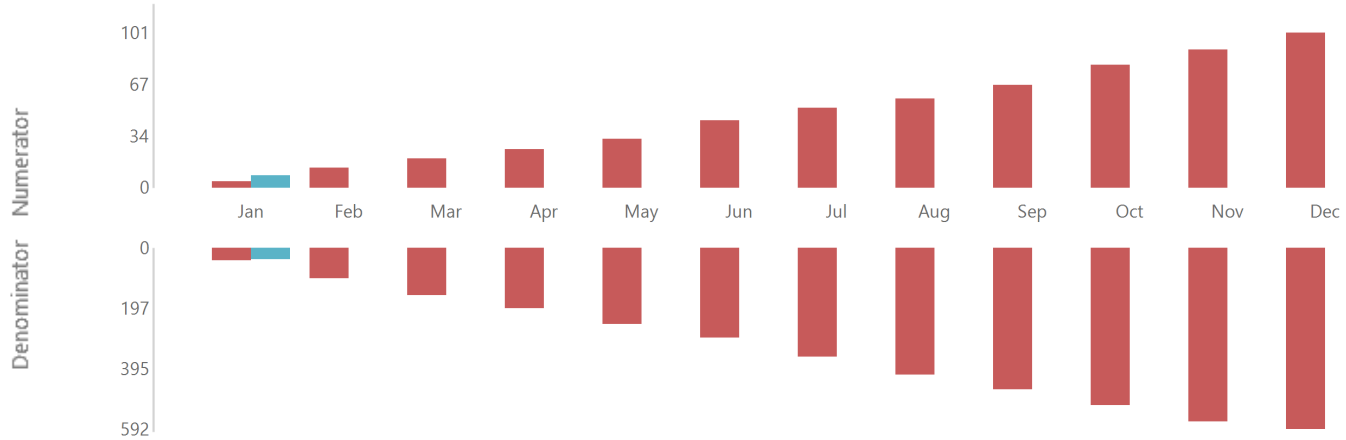
Follow-Up After Emergency Department Visit for Mental Illness

The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).





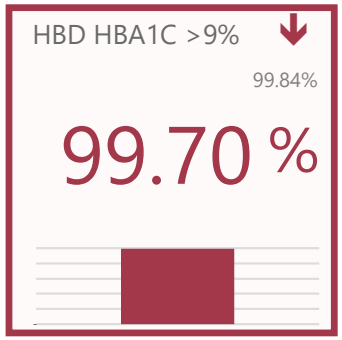
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	9.76%	13.00%	12.34%	12.69%	12.90%	14.97%	14.61%	13.98%	14.47%	15.56%	15.87%	17.06%
	2023	21.05%											
	MPL	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%

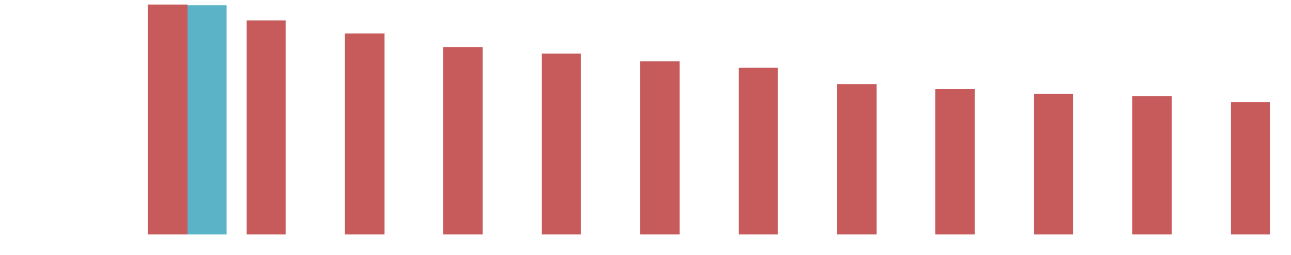


MCAS MY2023 Performance Trending Metrics through January 2023

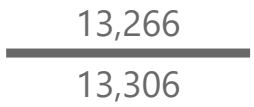
Hemoglobin A1c Testing & Control for Patients With Diabetes

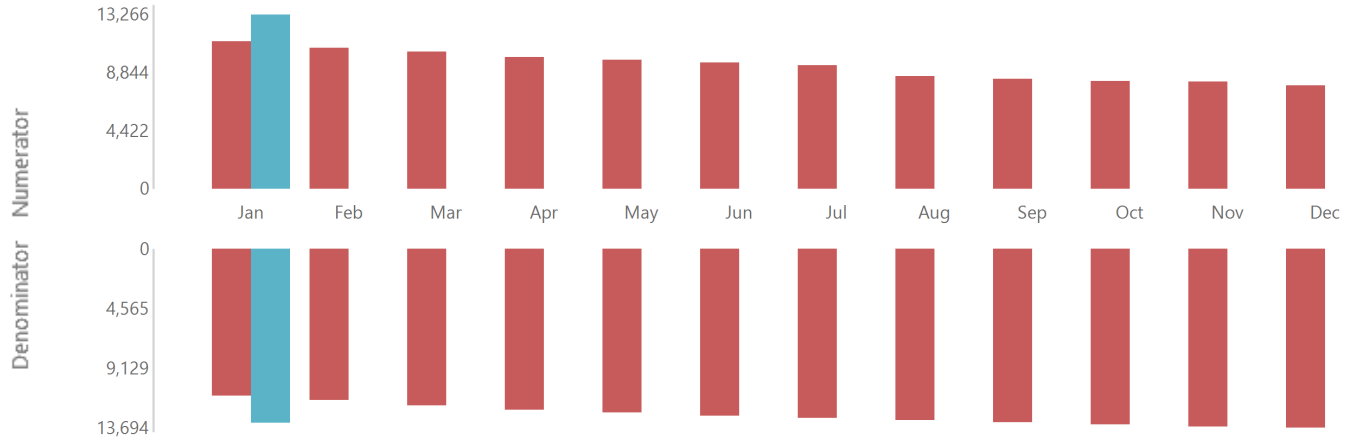
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Inverted Measure - a lower rate is desired for this measure.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	99.84%	92.93%	87.25%	81.38%	78.48%	75.26%	72.48%	65.22%	63.19%	60.91%	60.01%	57.54%
	2023	99.70%											
	MPL	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%

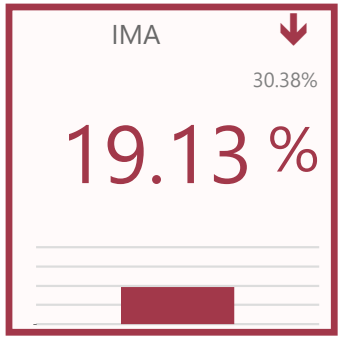


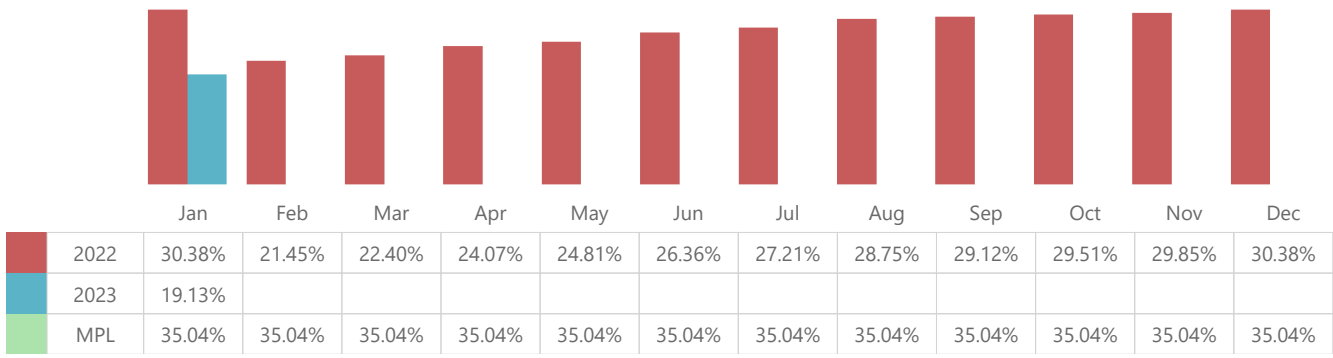


MCAS MY2023 Performance Trending Metrics through January 2023

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.

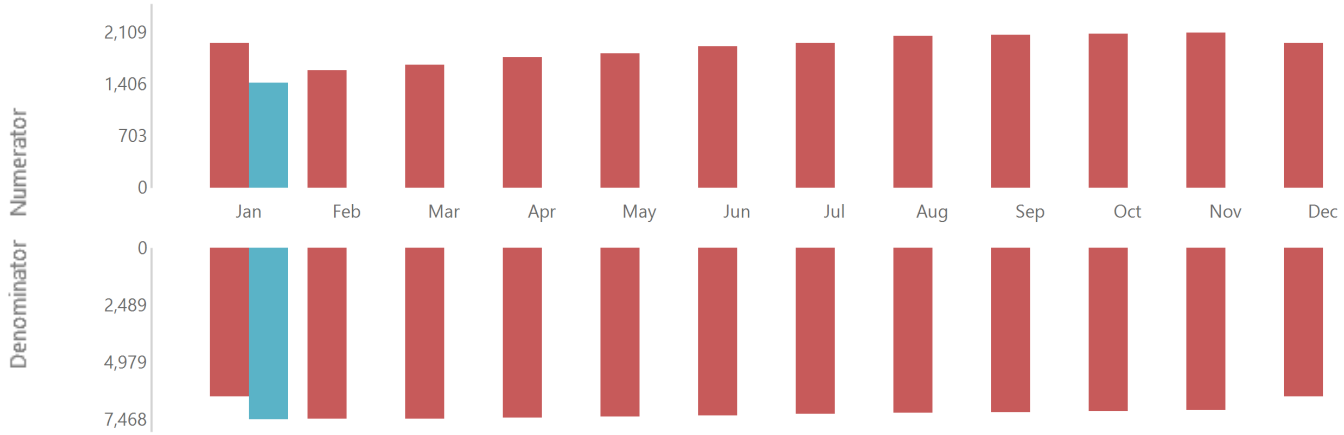




		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	30.38%	21.45%	22.40%	24.07%	24.81%	26.36%	27.21%	28.75%	29.12%	29.51%	29.85%	30.38%
	2023	19.13%											
	MPL	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%

1,429

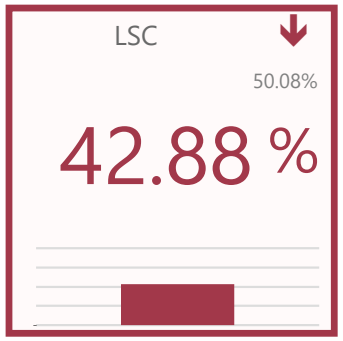
7,468



MCAS MY2023 Performance Trending Metrics through January 2023

Lead Screening in Children

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

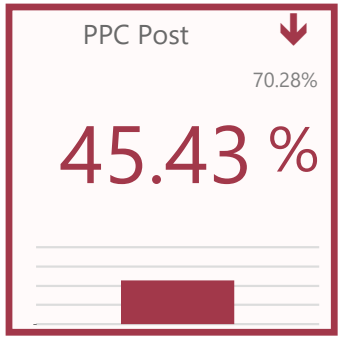


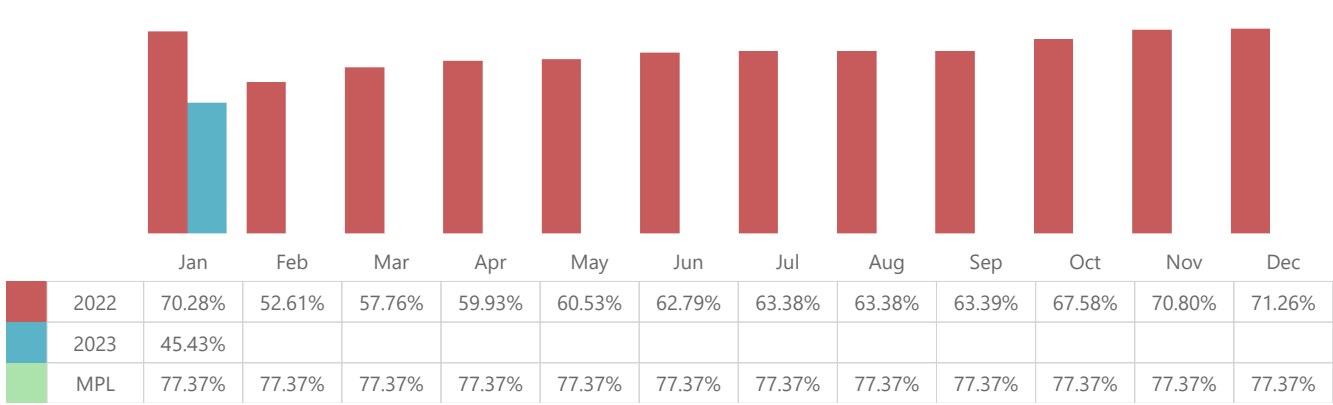
2,873
6,700

MCAS MY2023 Performance Trending Metrics through January 2023

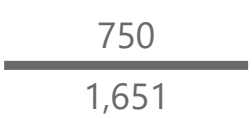
Postpartum Care

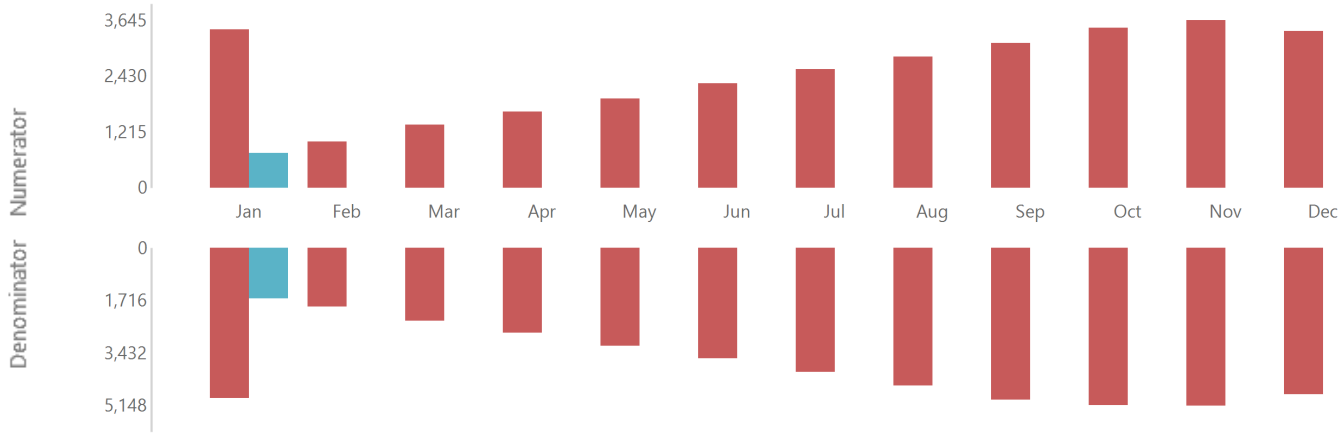
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	70.28%	52.61%	57.76%	59.93%	60.53%	62.79%	63.38%	63.38%	63.39%	67.58%	70.80%	71.26%
	2023	45.43%											
	MPL	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%

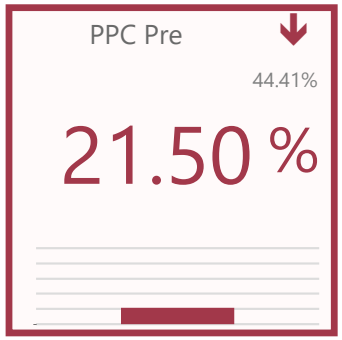


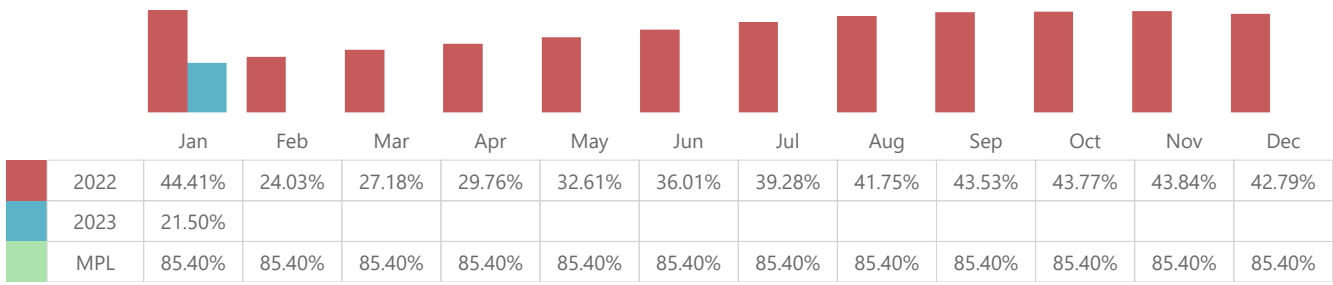


MCAS MY2023 Performance Trending Metrics through January 2023

Prenatal Care

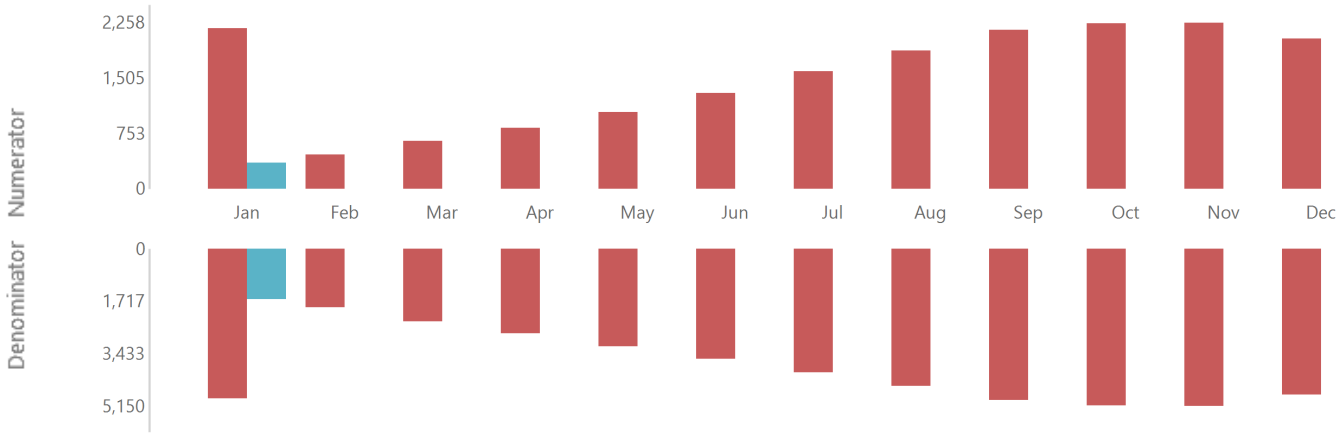
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date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





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	44.41%	24.03%	27.18%	29.76%	32.61%	36.01%	39.28%	41.75%	43.53%	43.77%	43.84%	42.79%
	2023	21.50%											
	MPL	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%

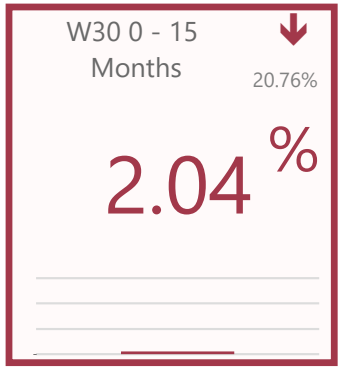
355
1,651

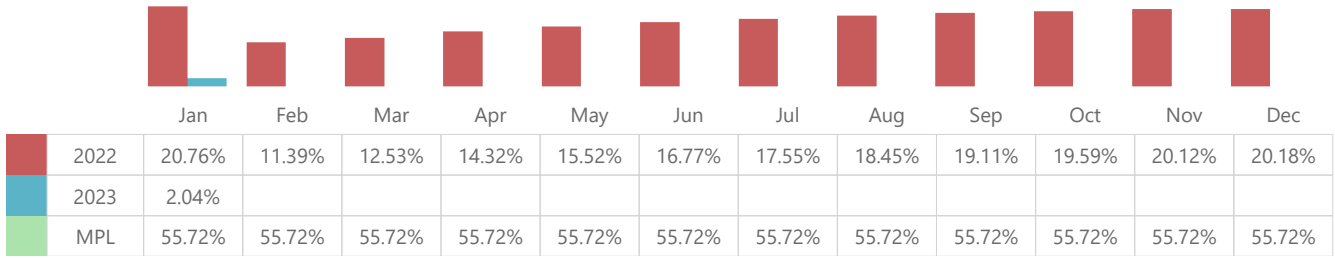


MCAS MY2023 Performance Trending Metrics through January 2023

Well-Child Visits in the First 30 Months of Life

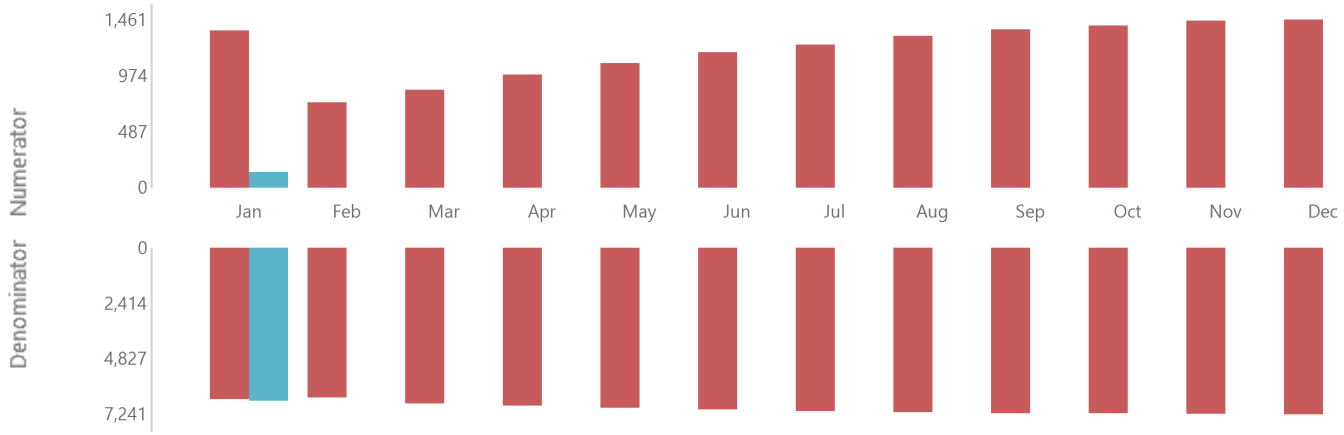
The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	20.76%	11.39%	12.53%	14.32%	15.52%	16.77%	17.55%	18.45%	19.11%	19.59%	20.12%	20.18%
	2023	2.04%											
	MPL	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%

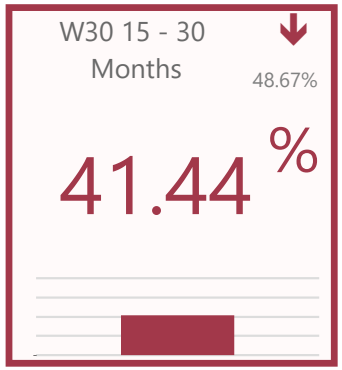
136
6,668

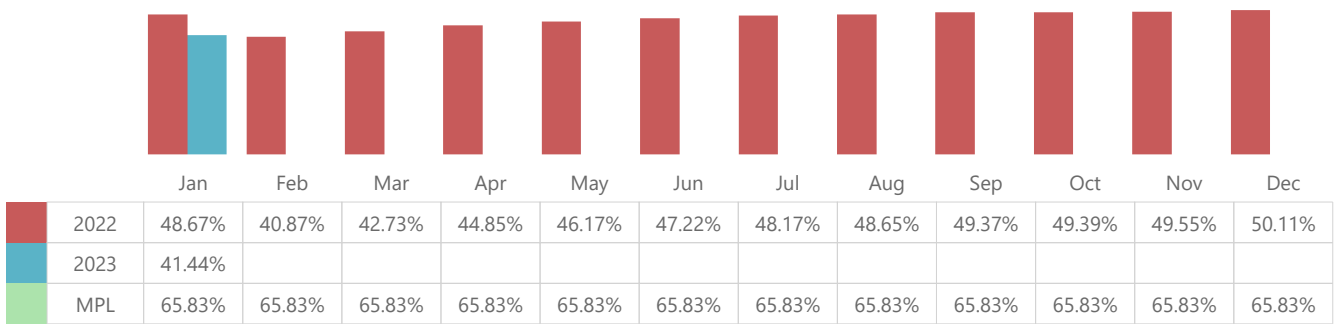


MCAS MY2023 Performance Trending Metrics through January 2023

Well-Child Visits in the First 30 Months of Life

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





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	48.67%	40.87%	42.73%	44.85%	46.17%	47.22%	48.17%	48.65%	49.37%	49.39%	49.55%	50.11%
	2023	41.44%											
	MPL	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%

2,886
6,965

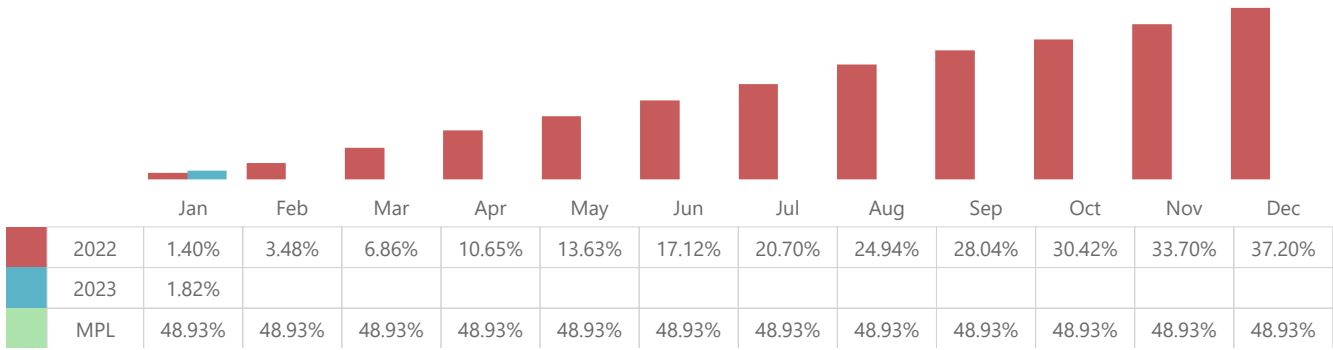
KERN HEALTH SYSTEMS

Governed Reporting System

MCAS MY2023 Performance Trending Metrics through January 2023

Child and Adolescent Well-Care Visits

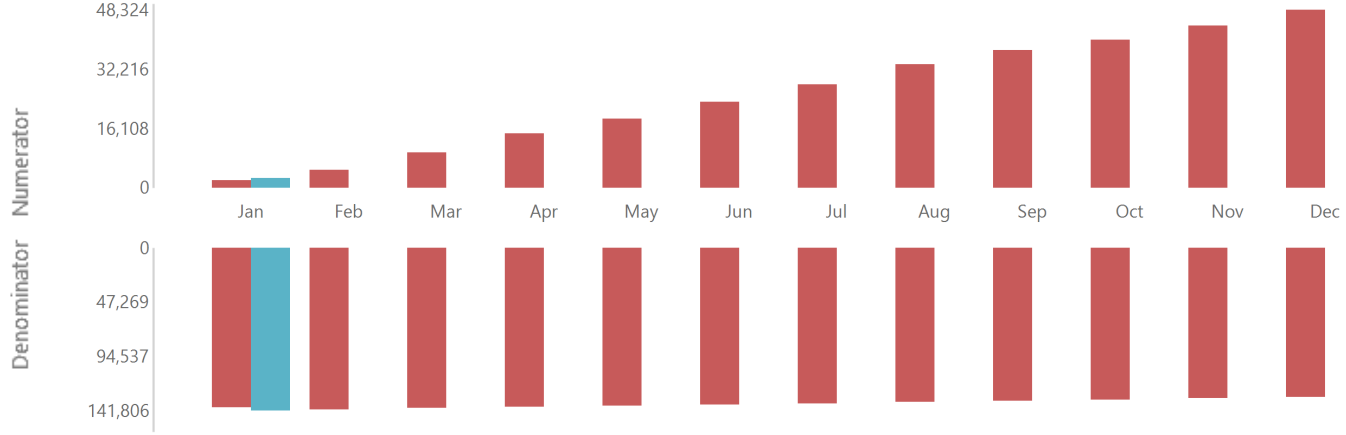
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	1.40%	3.48%	6.86%	10.65%	13.63%	17.12%	20.70%	24.94%	28.04%	30.42%	33.70%	37.20%
	2023	1.82%											
	MPL	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%

2,581

141,806



KERN HEALTH SYSTEMS

Chief Executive Officer's Report

Board of Directors Meeting

February 16, 2023

COMPLIANCE AND REGULATORY ACTIVITIES

The February 2023 Compliance and Regulatory Affairs Report highlights current KHS oversight activities with details included under ***Attachment A*** of this report. Of importance is the MY 2021 DHCS Monetary Sanctions for Medi-Cal Managed Care Plans failure to meet the MCAS minimum performance levels. The MCAS Action Plan presentation will elaborate on the strategies that will be taken to improve provider performance and member quality scores.

KHS STRATEGIC PLAN UPDATE

The KHS Strategic Plan has been developed and will be presented for approval during this board meeting. Further updates and progress reports will be incorporated into the board agendas.

PUBLIC HEALTH EMERGENCY (PHE) END DATE

On January 30th, the White House announced its intention to discontinue the national emergency declarations related to the COVID-19 outbreak as of May 11th. This will formally restructure the federal government's response to align with more normal operations. The main implication of the PHE ending was the resumption of Medicaid redeterminations, but that was set on its own timeline with the passage of the above-mentioned Consolidated Appropriations Act. DHCS has also already moved to make permanent the Telehealth flexibilities that were allowed because of the PHE. That said, there are still other flexibilities and temporary policies which will require unwinding once the PHE ends. DHCS has committed to reviewing the implications and providing additional details to Plans as the date approaches. Staff will remain engaged on this topic as more information is provided.

STATE PROGRAM DEVELOPMENT

CalAIM

Below is the latest information related to CalAIM initiatives which were newly effective on 1/1/23:

> ***Population Health Management (PHM):*** The PHM program went live effective 1/1/23. This will require that MCPs utilize data-driven strategy focused on improving the health of all members by delivering high-quality comprehensive care. The key to PHM is to engage members with their health care and address social determinants of health and gaps in care while reducing costs. DHCS shared a final All-Plan Letter (APL) and Policy Guide in mid-December to reflect updated transitional care requirements. As part of the DHCS' operational readiness requirements, the PHM team developed a comprehensive program description. The team hired Community Health Workers and Licensed Vocational Nurses to help bridge relationships from within the community to address member needs across continuum of care. Currently, the PHM team is working seamlessly with members, providers and community partners to link members to necessary interventions including Care Management, Basic PHM, Enhanced Care Management (ECM), and Wellness/Prevention Programs.

Long Term Care (LTC): Effective 1/1/23, DHCS requires most members to enroll in an MCP and receive their LTC benefits at skilled nursing facilities, including both freestanding and hospital-based SNFs, from their MCP. KHS received over 1,200 members who transitioned from Fee-For-Service to Managed Care with LTC services. KHS met DHCS requirements for network adequacy and other operational readiness requirements. Internal efforts have been underway to coordinate with existing SNFs to ensure a smooth transition into Managed Care. The LTC team has also been established which comprised of a nurse, social worker and two outreach specialists. Members are assigned to a nurse and social worker to ensure timely transition to and from SNF to prevent delays or interruption of any medically necessary services or care. The outreach specialists conduct facility visits to ensure member needs are addressed.

Mandatory Managed Care Enrollment (MMCE) Phase 2: DHCS required additional populations be mandatorily enrolled into Managed Care Plans effective 1/1/23. As of 2/1, KHS has received over 14,000 new members as part of this transition. Over 2/3^{rds} of these members are dually enrolled in both Medicare and Medi-Cal. The Plan is analyzing State-provided utilization and authorization data for the transitioned members.

Screening and Transition Tools*:* As of 1/1/23, DHCS finalized the standardized, statewide Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services. These tools are to be used by KHS and County Behavioral Health to assist members in need of Behavioral Health Services. The goal of these tools is to direct members to the correct system of care based on their needs. Along with the final tools, DHCS provided final guidance via APL. KHS staff are working to meet the compliance requirements outlined in the APL.

Concurrently, staff continue to participate in policy development discussions for future CalAIM transitions later in 2023 and beyond. This includes discussions with DHCS on future ECM Populations of Focus, additional LTC populations, NCQA accreditation requirements, and Medicare D-SNP preparations.

Doula Services

Doula Services became effective on 1/1/23. Doula providers are required to submit information through the DHCS provider enrollment process. Internal staff are in the process of identifying local providers who have enrolled with DHCS. The final APL was shared by the State in late December. This includes key implementation requirements and expectations. KHS Staff have reviewed the APL guidance and are working toward compliance.

Dyadic Services

Dyadic Services became a new benefit in Medi-Cal effective 1/1/23. Dyadic care refers to serving both parent(s) or caregiver(s) and child together as a dyad and is a form of treatment that targets family well-being as a mechanism to support healthy child development and mental health. This type of care is generally provided within pediatric primary care settings. KHS received the final APL from DHCS

which outlines specific program requirements. Internal system configuration and provider education are underway.

Justice-Involved In-Reach Waiver

In late January DHCS received federal approval to provide targeted Medi-Cal services to incarcerated individuals 90-days prior to release. The intent of the demonstration is to build a bridge to community-based care for justice-involved Medi-Cal members, offering them services to stabilize their condition(s) and establishing a reentry plan for their community-based care prior to release. DHCS intends to begin these services in 2024, with a 24-month phase-in statewide. As more information is released, KHS staff will stay apprised of the intended role of the Health Plan and the specific timing in Kern County.

DHCS Statewide Medi-Cal Procurement

In late August, DHCS announced the results of their Statewide re-procurement of the Commercial Health Plans who serve Medi-Cal. This included the announcement that Health Net would be replaced by Anthem Blue Cross as the commercial option in Kern County. There were many other Counties across the State which were subject to Commercial Plan changes in 2024. Subsequently, those Plans who lost the bids had filed appeals and lawsuits to challenge the outcome. After negotiations with those Plans, DHCS announced in late December that the results of the procurement would be nullified. Instead DHCS was able to reach a compromise with the impacted Plans and their future service areas. This ultimately did not impact Kern County and the commercial option will remain Anthem Blue Cross in 2024. Also notable, the local non-profit Plan in San Diego was re-awarded their contract after initially being left out. The results of this process also did not impact Kaiser, as they are still scheduled to become an option statewide in 2024**.**

Student Youth Behavioral Health Initiative (SBHIP)

Background: The State Budget for 2021-2022 included $13.2 million over three years in incentive funding to build infrastructure, partnerships, and capacity for school behavioral health services in Kern County. In collaboration, KHS and HealthNet convened several stakeholders in Kern County including local education and behavioral health agencies, to collectively identify specific school districts, student populations, and interventions to build infrastructure and support behavioral services on or near campuses. KHS and HealthNet engaged a consultant to complete a county wide needs assessment to collect both qualitative and quantitative data to identify the existing gaps and opportunities within the county education system. Nine school districts in total agreed to participate and include Arvin Union, Bakersfield City, Edison Elementary, Kern High, Lost Hills Union Elementary, Kernville Union, McFarland Union, Pond Union, and Kern County Superintendent of Schools Special Education and Alternative Education Program. Pond Union has since withdrawn the districts participation.

Update: All the district's needs assessments, each detailing the school districts' identified gaps, were completed and recommendations for aligning the corresponding targeted interventions under the SBHIP program have been selected. The interventions selected across the school districts include implementation of Behavioral Health and Wellness Programs, Substance Use Disorder Programs, Family and Parent Support Services, and building stronger partnerships between the schools, managed

care plans and county behavioral health to increase access to Medi-Cal services. The consultant, along with KHS and Health Net leadership, have initiated the design and content of the project plan with specific milestones for each district.

KHS submitted the project plans and identified milestones to Department of Health Care Services (DHCS) on December 29, 2022. Upon DHCS's approval in early 2023, infrastructure builds can begin based on the selected targeted interventions, thereby initiating the receipt of the allocated incentive dollars over the next two years until the program sunsets in December 2024. Each district's milestone progress and funding allocations will be tracked internally by KHS and reported to DHCS bi-quarterly to ensure transparency and feasibility of completion towards a successful launch of this critical behavioral health support program within Kern County's schools.

Incentive Payment Program (IPP)

Background: The CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of Enhanced Care Management (ECM) and Community Supports (CS) by incentivizing managed care plans (MCPs), in accordance with 42 CFR Section 438.6(b), to drive MCP delivery system investment in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports. In January, KHS submitted a gap assessment report to DHCS identifying the gaps in services for ECM and Community Supports in Kern County. Based on the gap assessment report, KHS has been approved for $14.2 million dollars in incentive funds to expansion our ECM and CS programs. We are also supporting some of the current ECM and CS programs with delivery system infrastructure upgrades. All projects have milestones that the provider must meet to earn the incentive funds. The IPP program time frame is January 1, 2022 to December 31, 2023.

Update: The Incentive Payment Program supported the implementation of 4 new ECM programs in 4th quarter of 2022. Adventist Health in Tehachapi, Clinica Sierra Vista 1st Street Bakersfield, Comprehensive Medical Group, Delano and Premier Medical Group Columbus Street, Bakersfield. Incentive Payment Program also supported the implementation of 4 new Community Support Services during 4th quarter in 2022 and 1st quarter 2023, Community Action Partnership of Kern (Housing Deposits, Housing Tenancy and Sustaining Services, and Housing Transition Navigation Services) in Bakersfield. Corbow Inc. (Recuperative Care (Medical Respite) in Bakersfield, SD Healthcare Consulting (Respite for Caregivers) in Kern County, and Good Samaritan Healing Center (Short Term Post-Hospitalization Housing) Weedpatch Highway, Bakersfield. In addition, in 2023 4 new ECM programs will be implemented with the support of IPP, Vanguard (Shafter/Wasco), Universal Healthcare East Bakersfield (Niles), Omni (Mall View), and Premier Medical Group (Weedpatch).

KHS has been approved for an additional $14.7 million dollars in incentive funds to continue to expand ECM and CS services to underserved geographical areas in Kern County.

Housing and Homelessness Incentive Program (HHIP)

Background: As a part of the State's overarching home and community-based services (HCBS) spending plan, the California Department of Health Care Services (DHCS) launched the Housing and Homelessness Incentive Program (HHIP) from January 1, 2022, to December 31, 2023. HHIP aims to prevent and reduce homelessness and housing instability & insecurity by addressing social determinants of health while improving health outcomes and accessibility to whole-person care for those who are a part of the Medi-Cal population and simultaneously experiencing or at risk of being homeless. HHIP is a voluntary incentive program that will allow Medi-Cal Managed Care Plans (MCPs) to earn incentive funds by collaborating with providers and community-based organizations to build capacity & infrastructure to streamline a continuity of housing and homelessness services. All projects have milestones approved by DHCS, and the provider must meet to earn the incentive funds.

Update: KHS has partnered with agencies to advance health equity and housing accessibility to one of our most vulnerable populations, those who are at risk or are experiencing homelessness. Kern Health Systems has awarded 13 network providers and community-based organizations in support of 19 housing and homelessness service delivery projects. These 19 projects range from Street Medicine, Mental & Behavioral Health Support Services, Prevention & Diversion, Non-Congregate Shelters & Expanding Emergency Shelters for Youth, Adults and Families, and includes Non-Congregate Permanent Housing for Youth, Adults and Families. These projects demonstrate a commitment to address inequities and disparities in homeless populations in Kern County. In addition, these projects aim to achieve equitable provision wrap-around services for those who are disproportionately impacted by homelessness, are at risk of homelessness, and/or are experiencing housing instability. This population of focus also includes those who are from marginalized communities such as at-risk youth; aging and older adults; veterans and their families who do not qualify for veteran's health care services; people with disabilities; and individuals who identify as LGBTQ+ community members. We have received 2 of 4 full payments from DHCS for our 2022 submissions (the Local Health Plan & Investment Plan) indicating our success in meeting DHCS metrics and scoring to receive full payment. The next two reports that are tied to fund drawdowns from DHCS are HHIP performance reports: Report 1 due in March 2023 and Report 2 due in January 2024.

LEGISLATIVE SUMMARY UPDATE

State Legislation*:* The State Legislature reconvened in early January and began the process of Bill introductions. The deadline for bill introductions is February 17th. As the deadline approaches, it is anticipated that many new bills will be introduced. To-date, staff is tracking 13 bills of relevance. The bill tracking document is included as a separate attachment. Staff are highly engaged with our Associations in reviewing and discussing relevant bills.

State Budget*:* On January 10th, the Governor released the proposed 2023-2024 State Budget. Generally, the State is forecasting a budget shortfall of $22.5 billion. This led to proposed delays and reductions in funding for some areas within the State. Notably, the Governor is not proposing to cut recent Medi-Cal programs related to coverage for undocumented immigrants, CalAIM, and certain grant funds. In fact, the budget proposes significant new investments in the Medi-Cal program related to Behavioral Health,

PCP/OB rate increases, and a new Community Support to provide transitional rent assistance. The Governor is also proposing to reinstitute the MCO tax beginning in 2024.

The Governor's January Budget is the first step in a longer budget process that will culminate in late June with the passage of a final State Budget. This January proposal is the starting point for negotiations between the Governor's administration and the Legislature. Over the coming months we'll see budget bill language introduced which will go through the various legislative channels. We'll also see a revised budget in May which will include more up-to-date fiscal projections.

Federal Legislation*:* On December 29, President Biden signed into law the Consolidated Appropriations Act of 2023 (also referred to as the omnibus spending bill), which has broad implications for the Medi-Cal program and in particular the resumption of Medi-Cal redeterminations. Previously, the resumption of Medi-Cal redeterminations was tied to the termination of the COVID-19 public health emergency (PHE). With the passage of this bill, the continuous coverage requirements that paused all Medi-Cal redeterminations since March 2020 would be decoupled from the PHE termination date as of April 1, 2023, setting the stage for the resumption of Medi-Cal redeterminations.

The federal Centers for Medicare & Medicaid Services (CMS) provided updated guidance to states in January 2023 on the implications for the Medicaid program. DHCS has updated the Medi-Cal COVID-19 PHE Operational Unwinding Plan and is working on additional guidance to stakeholders.

KHS FEBRUARY 2023 ENROLLMENT:

Medi-Cal Enrollment

As of February 1, 2023, Medi-Cal enrollment is 235,268, which represents an increase of 5.8% from January enrollment.

Seniors and Persons with Disabilities (SPDs)

As of February 1, 2023, SPD enrollment is 17,983, which represents an increase of 4.9% from January enrollment.

Expanded Eligible Enrollment

As of February 1, 2023, Expansion enrollment is 97,012, which represents an increase of 1.2% from January enrollment.

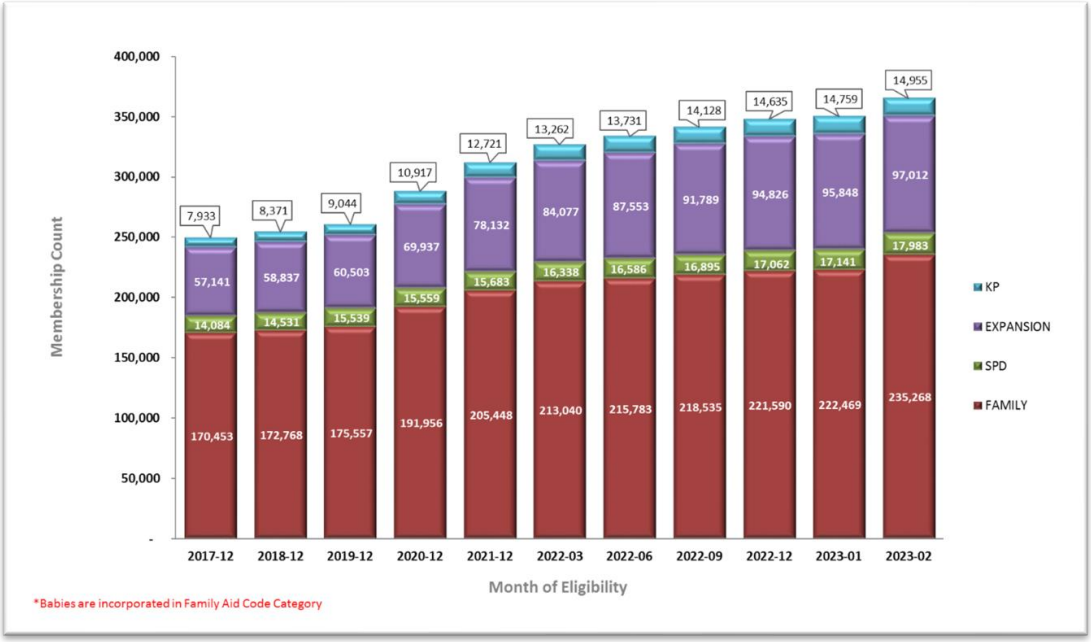
Kaiser Permanente (KP)

As of February 1, 2023, Kaiser enrollment is 14,955, which represents an increase of 1.3% from January enrollment.

Total KHS Medi-Cal Managed Care Enrollment

As of February 1, 2023, total Medi-Cal enrollment is 365,218, which represents an increase of 4.3% from January enrollment.

Membership as of Month of Eligibility	FAMILY	SPD	EXPANSION	KP	BABIES	Member Total
2017-12	170,006	14,084	57,141	7,933	447	249,611
2018-12	172,290	14,531	58,837	8,371	478	254,507
2019-12	175,128	15,539	60,503	9,044	429	260,643
2020-12	191,549	15,559	69,937	10,917	407	288,369
2021-12	204,999	15,683	78,132	12,721	449	311,984
2022-03	212,615	16,338	84,077	13,262	425	326,717
2022-06	215,318	16,586	87,553	13,731	465	333,653
2022-09	218,005	16,895	91,789	14,128	530	341,347
2022-12	221,102	17,062	94,826	14,635	488	348,113
2023-01	221,965	17,141	95,848	14,759	504	350,217
2023-02	234,819	17,983	97,012	14,955	449	365,218



Enrollment Update

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

According to analysis by KHS Business Intelligence, to date we have received 13,992 MMCE members. This comprises 84% of the expected membership volume that was estimated in the Oct 2022 DHCS dataset. We are also finding that we have an additional 4,246 members with the MMCE Phase II or SNF-LTC designation through the Weekly Plan File which were not included in the estimated DHCS Oct 2022 dataset. If the remainder of the original 16,608 members targeted by DHCS in Oct 2022 were to enroll with KHS, this would push us to over 20,000 new members.

Kern DHS Medi-Cal Renewal Partnership

Background: As the public health emergency (PHE) remains in place, the Department of Health Care Services continues to freeze Medi-Cal redeterminations. Thus, the Kern County Department of Human Services' suspension of their "automated discontinuance process" for Medi-Cal Redeterminations continues. The automated discontinuance process was in place locally prior to the PHE when Medi-Cal beneficiaries did not complete the Annual Eligibility Redetermination process. However, Kern DHS continues working new Medi-Cal applications, reenrollments, successful renewals, additions, etc. (anything with a positive outcome). In preparation for the unwinding of Medi-Cal continuous enrollment, the State, County, KHS and other stakeholders are working together to ensure continuity of coverage once the complete Medi-Cal redetermination process resumes. Since more than half of Medi-Cal enrollees complete their annual renewal through the manual mailing process, it is important Kern DHS has updated contact information of Medi-Cal enrollees. As such, Kern DHS is educating local residents about the importance of sharing updated contact information such as mailing addresses, phone numbers, email addresses, etc. KHS is supporting their efforts by educating our health plan members about this through printed materials, website, social media, text messages, and robocalls. KHS is also sharing demographic updates via a data exchange with Kern DHS.

Update: The Consolidated Appropriations Act of 2023 passed by Congress decoupled redeterminations from the PHE declaration. The unwinding of Medi-Cal continuous enrollment provision will begin April 1 for Medi-Cal eligible individuals who are due to renew their Medi-Cal eligibility in June 2023. Kern DHS will place two full time Human Services Technicians (HST) staff on-site at KHS beginning on February 27, 2023. KHS will fund these positions to assist Kern DHS process updates from KHS and complete the renewal process for Kern Family Health Care members. The number of HSTs can increase if needed based on workload (agreement covers up to 5 per year). Kern DHS will notify KHS which members must complete the manual mailing renewal process and provide timelines and due dates. KHS will communicate the importance of this process to members and share the information with staff, contracted providers, and local enrollment entities. KHS will continue to work with the local Medi-Cal enrollment entities to support the correct completion of the renewal applications which Kern DHS will review and use to determine eligibility. KHS Leadership is meeting with Kern DHS Leadership regularly.

COMMUNITY EVENTS

KHS will share sponsorship in the following events in February and March:

- KHS donated $5,000 to Kern Partnership for Children & Families (the nonprofit organization for the Kern County Department of Human Services) to support the production of :30 second Safe Surrender PSAs in English and Spanish to air in local movie theatres, web, and social media.
    - English PSA: https://drive.google.com/file/d/1XclmEmVE4CdU6LqvWQUqp4BBPg8OV6KQ/view?usp=share_link
    - Spanish PSA: https://drive.google.com/file/d/1IYVvrt5XMOO_f5_B5qVvhMzRoRkylKsv/view?usp=share_link
- KHS donated $2,500 to Garden Pathways to sponsor the "2023 Heart of the Country".
- KHS donated $5,000 to the Kern County Hispanic Chamber of Commerce to sponsor their "2023 Installation and Awards Gala".
- KHS donated $5,000 to NAACP to sponsor the "NAACP Awards Extravaganza". Traco Matthews, KHS Chief Health Equity Officer, was honored as "Man of the Year".
- KHS donated $2,500 to Links for Life to sponsor "Love Links".
- KHS donated $1,500 to the Valley Fever Americas Foundation to sponsor their "Foundation Night at the Bakersfield Condors".
- KHS donated $1,500 to the Boys and Girls Club of Kern County to sponsor "Open Door and Open Hearts".
- KHS donated $2,500 to United Way of Kern County to sponsor the "9th Annual A Chocolate Affair".
- KHS donated $1,200 to The Plank Foundation to sponsor their "Game Night/Game Show Connection".
- KHS donated $15,000 to Kern Medical Foundation to sponsor their "2023 Valley Fever Walk" benefitting the Kern Medical Valley Fever Institute.
- KHS donated $2,500 to the Kern County Black Chamber of Commerce to sponsor their "21st Annual Raising the Bar Gala".
- KHS donated $5,000 to Cal State University Bakersfield University Advancement to sponsor their "2023 Alumni Hall of Fame". Emily Duran, KHS Chief Executive Officer, is part of the 2023 Alumni Hall of Fame class.
- KHS donated $3,000 to the Lamont Chamber of Commerce to sponsor their "2023 Installation and Awards Night".
- KHS donated $1,000 to Becoming Phenomenally You to sponsor their "Bakersfield's 5th Phenomenal Woman Event".
- KHS donated $1,000 to Mercy House to sponsor their "Pickleball and Music Festival".
- KHS donated $2,500 to The Wildlands Conservancy - Wind Wolves Preserve to sponsor their "8th Annual Spring Nature Festival".
- KHS donated $1,000 to National Chavez Center to sponsor their "2023 Cesar Chavez Legacy Awards Gala".

- KHS donated $2,500 to the Bakersfield Memorial Hospital Foundation to sponsor the "Larry Carr Memorial Golf Tournament".
- KHS donated $2,750 to Flood Ministries to sponsor their "Spring Fling Gala".
- KHS donated $2,500 to Bakersfield College Foundation to sponsor their "15th Annual Sterling Silver Dinner".
- KHS donated $1,000 to Stewards Inc. to sponsor their "2023 Bakersfield Amazing Race".
- KHS donated $2,500 to the Kern County Cancer Foundation to sponsor "Teaming Up Against Cancer".
- KHS donated $3,000 to the Active Bakersfield Alliance/Mercury Events to sponsor the "2023 Bakersfield Marathon".
- KHS will sponsor the Spanish Radio Group's "Health & Consumer Fair".
- KHS donated $500 to the Bakersfield College Foundation benefiting the BC Music Department Chamber Singers as they raise funds for 50 students to travel to Berlin, Prague, and Berlin this summer.
- KHS donated $4,000 to the Komoto Family Foundation to print 1,000 coloring books on medication safety, pharmacy, and health education to help empower children to discuss their health with their caregivers and local pharmacists. Also, to promote careers in pharmacy and healthcare at career events in Delano.

Employee Video Newsletter

KHS' Video Employee Newsletter can be seen by clicking the following link:
https://vimeo.com/793173034

KHS Media Clips

We compiled local media coverage that KHS received in January and February. Please see **Attachment B** KHS Media Clips. Click on the title or "Read More" to view the complete article.

KERN HEALTH SYSTEMS

Compliance and Regulatory Affairs

Board of Directors Meeting

Jane MacAdam
Director of Compliance & Regulatory Affairs

February 16, 2023

Attachment A

All Plan Letters and Regulatory Guidance released since the December 2022 Kern Health Systems Board of Directors' meeting:

The Department of Health Care Services (DHCS) released four revised All Plan Letters (APL) and eleven new APLs during this time period.

- APL 22-024 Population Health Management Program Guide (Issued 11/28/2022)
  This APL provides guidance to Plans regarding the implementation of the Population Health Management (PHM) Program and the role of the PHM Program Guide.
- APL 22-025 Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (Issued 11/28/2022)
  This APL provides guidance to Plans related to the provision of the new annual Medi-Cal cognitive health assessment to eligible Members 65 years of age or older.
- APL 22-026 Interoperability and Patient Access Final Rule (Issued 11/29/2022)
  This APL notifies Plans of the Centers for Medicare and Medicaid Services Interoperability and Patient Access final rule requirements as required by federal law.

Continued…

STATE REGULATORY AFFAIRS (continued)

- APL 22-027 Cost Avoidance and Post-Payment Recovery for Other Health Coverage (Issued 12/06/2022)
  The APL provides clarification and guidance for cost avoidance and post-payment recovery requirements when a Member has other health care coverage.
- APL 17-020 American Indian Health Programs (Issued 12/15/2017 and Revised 12/23/2022)
  The APL provides a list of American Indian Health Program Providers in California to the Plan.
- APL 21-008 Attachment 2 Tribal Federally Qualified Health Center Providers (Issued 05/12/2021 and Revised 12/23/2022)
  The APL provides a list of Tribal Federally Qualified Health Center Providers.
- APL 22-018 Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Issued 09/28/2022 and Revised 12/27/2022)
  The APL provides the requirements for the Skilled Nursing Facility Long Term Care Benefit Standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of beneficiaries to managed care.

Continued…

STATE REGULATORY AFFAIRS (continued)

- APL 22-028 Adult and Youth Screening and Transition of Care Tools For Medi-Cal Mental Health Services (Issued 12/27/2021)
  The APL provides guidance on the implementation of Transition of Care Tools to guide referrals of adult and youth Members to the appropriate Medi-Cal mental health delivery system and ensure that Members requiring transition between delivery systems receive timely coordinated care.

- APL 22-029 Dyadic Care Services and Family Therapy Benefit (Issued 12/27/2022)
  The APL provides guidance on coverage requirements for the provision of the new Dyadic Care Services and family therapy benefit effective January 1, 2023.

- APL 22-030 Initial Health Appointment (Issued 12/27/2022)
  The APL provides guidance regarding the requirements of the Initial Health Appointment (IHA) beginning January 1, 2023.

- APL 22-031 Doula Services (Issued 12/27/2022)
  The APL provides guidance regarding the qualifications for providing doula services, implementation effective dates.

Continued…

STATE REGULATORY AFFAIRS (continued)

- APL 22-032 Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023 (Issued 12/27/2022)
  This APL provides guidance for the Continuity of Care for beneficiaries who are mandatorily transitioning from Medi-Cal Fee-For-Service to Medi-Cal Managed Care.

- APL 22-012 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX (Issued 7/11/2022 and Revised 12/30/2022)
  This APL provides guidance related to the oversight and administration of the Medi-Cal pharmacy benefit. The APL requires the Department of Health Care Services to transition Medi-Cal pharmacy services from the managed care delivery system to the Fee-For-Service delivery system known as Medi-Cal Rx, effective January 1, 2022.

- APL 23-001 Network Certification Requirements (Issued 1/6/2023)
  The APL provide guidance on the Annual Network Certification requirements. This APL also advises of the new requirements pertaining to good faith contracting requirements with certain cancer centers and referral requirements.

- APL 23-002 2023-2024 Medi-Cal Managed Care Health Plan MEDS/834 Cutoff and Processing Schedule (Issued 01/17/2023)
  The APL provides the 2023-2024 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.

Continued…

STATE REGULATORY AFFAIRS (continued)

The Department of Managed Health Care (DMHC) released six All Plan Letters (APL) during this time period that apply to KHS.

- APL 22-028 - Health Equity and Quality Measure Set and Reporting Process (Issued 12/21/2022)
  The purpose of the APL is to inform Plans of the Department of Managed Health Care's Health Equity and Quality Measure Set and stratification requirements that will take effect beginning Measurement Year 2023.

- APL 22-029 - RY 2024 MY 2023 Provider Appointment Availability Survey Manual and Report Form Amendments (Issued 12/21/2022)
  This APL directs Plans to use the Provider Appointment Availability Survey (PAAS) Manual, and PAAS Report Form instructions for the measurement year 2023 monitoring and reporting.

- APL 22-030 - Requirement for Plans to "Arrange for" Covered Services (Issued 12/22/2022)
  This APL provides guidance regarding the obligations of health plans to "arrange for" covered services to be delivered by a noncontracted provider when such services are not available from contracted providers within the Knox-Keene Act's timely and geographic access standards.

STATE REGULATORY AFFAIRS (continued)

- APL 22-031 - Newly Enacted Statues Impacting Health Plans (Issued 12/22/2022)
  In this APL, the Office of Plan Licensing identifies and discusses 19 bills enacted this session that may require Plans to update Evidences of Coverage, disclosure forms, provider contracts and/or other plan documents.

- APL 22-032 - Compliance with Senate Bill 1473 (Issued 12/27/2022)
  This APL requires Plans to cover therapeutics for the treatment of COVID-19 without cost sharing, utilization management, or in-network requirements.

- APL 23-002 - Senate Bill 979 – Health Emergencies Guidance (Issued 1/12/2023)
  The APL requires Plans to provide an enrollee who has been displaced or whose health may otherwise be affected by a state of emergency, as declared by the Governor, or a health emergency, as declared by the State Public Health Officer, access to medically necessary health care services. SB 979 also authorizes the Department of Managed Health Care to issue guidance to Plans regarding compliance with the bill's requirements during the first three years following the declaration of emergency, or until the emergency is terminated, whichever occurs first.

*DMHC also released two APLs that do apply to the Plan during this time period.

REGULATORY ENFORCEMENT ACTIONS

On 12/13/2022, DHCS imposed a monetary sanction to KHS for failure to meet required Medi-Cal Managed Care Accountability Set (MCAS) performance measures for measurement year 2021.

- KHS identified an error in the original calculation and also requested to “meet and confer” with the Department regarding the notice.
- The Department acknowledged the error identified by KHS and issued an updated sanction notice on 01/10/2023, reducing the sanction by $5,000, to a total sanction amount of $188,000.
- KHS failed to meet the minimum performance limit (MPL) for ten (10) measures.
- In addition to paying the sanction, KHS was required to submit a revised comprehensive quality strategy by 01/31/2023 that included new interventions designed to meet or exceed required 2023 milestones.
- KHS met with DHCS in person on 02/01/2023 to discuss the unique challenges experienced in Kern County, the strategy, and our commitment to quality improvement.

2024 Operational Contract Readiness

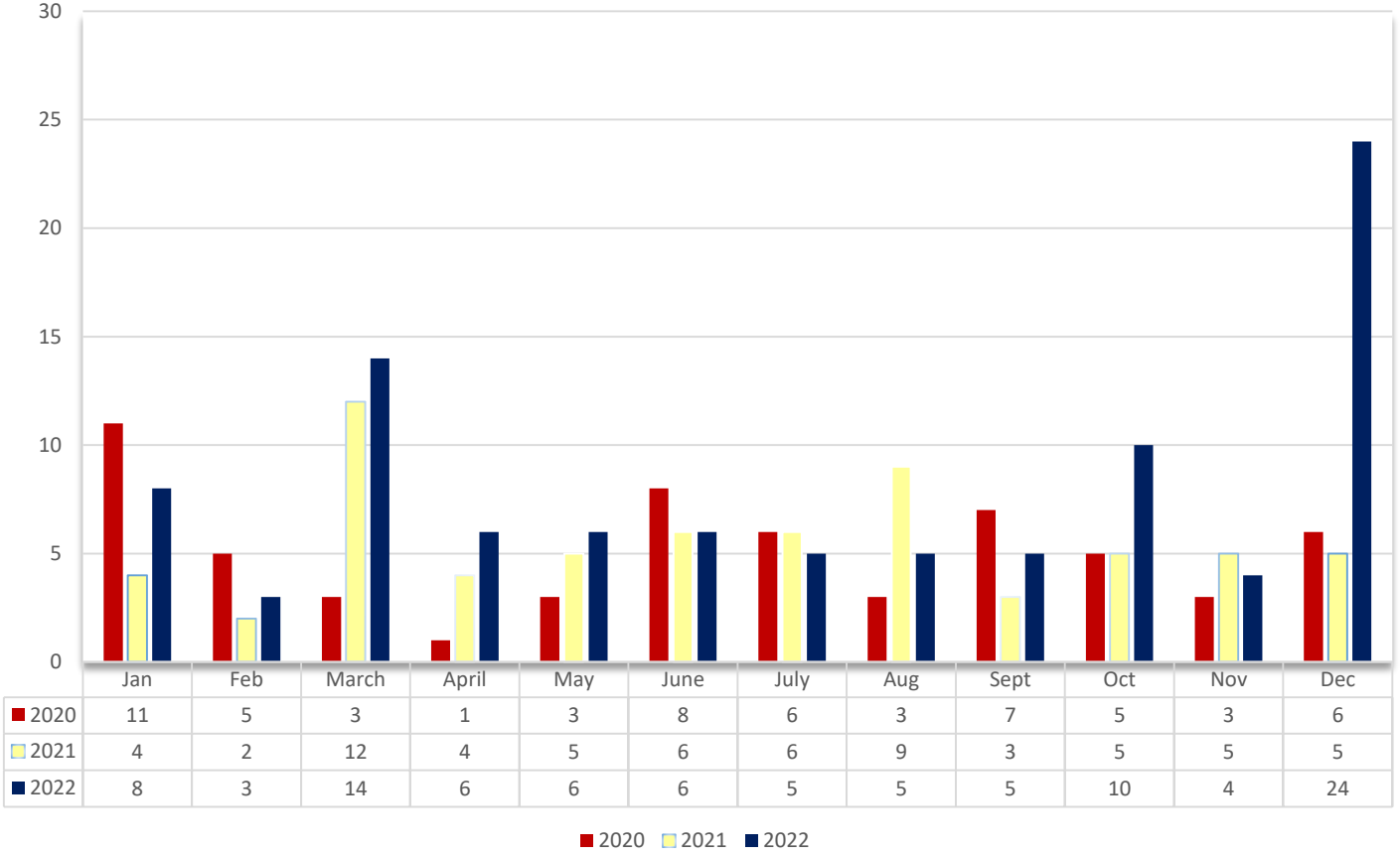
The DHCS has restructured and greatly enhanced many of the requirements in the Managed Care Plan contract that will be effective January 1, 2024. To prepare appropriately for the new requirements in the contract, Plans are required to submit documentation demonstrating readiness to comply with the various elements of the new contract. The current status of the KHS submissions is summarized below:

2024 Contract - Operational Readiness					
DHCS Deliverable Due Date	# of Deliverables Due	Current Status			
		Approved	In Review	Additional Information Requested	On Hold
8/12/2022	20	20	0	0	0
9/12/2022	27	27	0	0	0
10/3/2022	14	14	0	0	0
12/19/2022	38	26	4	6	2
1/9/2023	23	4	16	3	0
3/1/2023	2				
3/30/2023	4				
4/24/2023	36				
5/22/2023	39				
6/1/2023	1				
7/10/2023	2				
7/14/2023	4				
8/4/2023	15				
8/18/2023	2				
TBD	14				
Blanks	2				
Total	**243**	**91**	**20**	**9**	**2**

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

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



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2020	11	5	3	1	3	8	6	3	7	5	3	6
2021	4	2	12	4	5	6	6	9	3	5	5	5
2022	8	3	14	6	6	6	5	5	5	10	4	24

2022 Recap

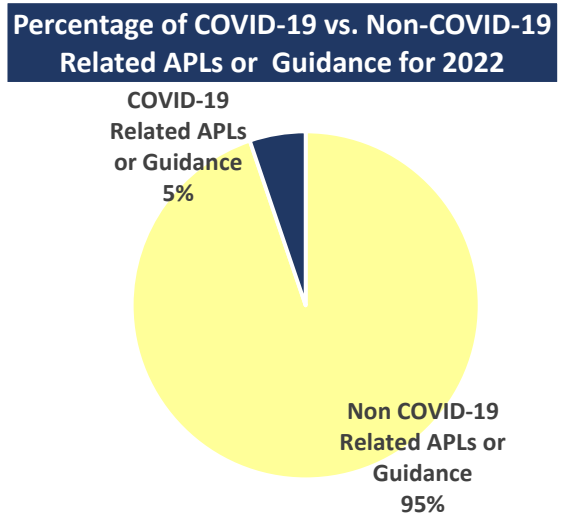
DHCS Released 32 All Plan Letters
DHCS Revised 10 Previously Released APLs
DHCS Released 11 Guidance Documents

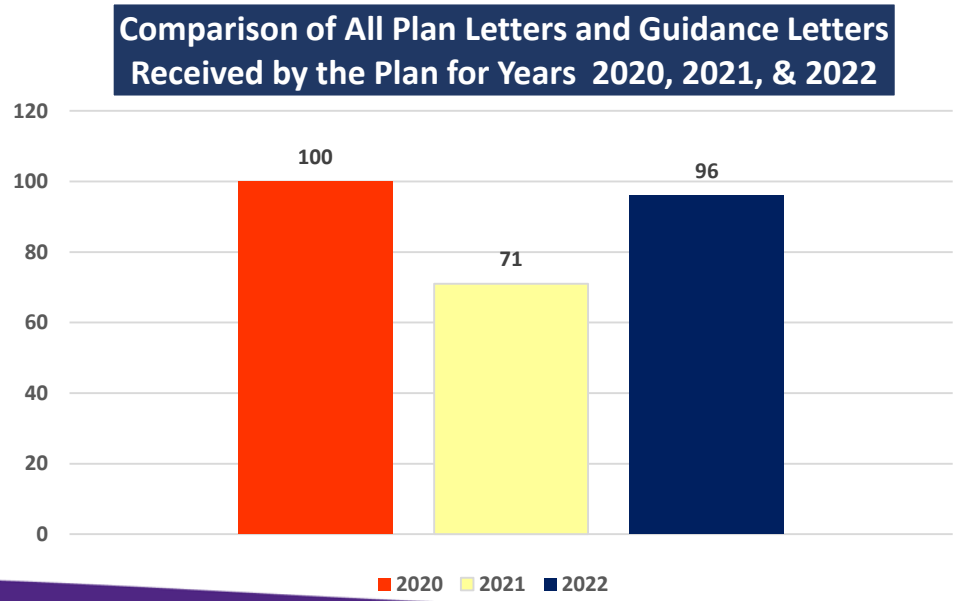
DMHC Released 32 All Plan Letters
*** One APL included 12 items of regulatory guidance.**

Continued...

COVID-19 Impact for 2022

Historical Comparison of Annual Regulatory Releases





KERN HEALTH SYSTEMS

Regulatory Reports & Filings
Submissions to Government Agencies
December 2022 and January 2023

Regulatory Agency	December 2022		January 2023	
	Ad Hoc	Standard	Ad Hoc	Standard
DHCS	11	27	1	42
DMHC	0	9	0	12

Regulatory Audits

Department of Managed Health Care (DMHC)

2020 DMHC Non-Routine Survey:

- The Plan is waiting for the DMHC to provide the Final Report and/or feedback regarding our response to the Preliminary Audit Report of the Non-Routine Survey:
  - Preliminary Report received 08/15/2022
  - KHS Response and Corrective Action Plan submitted 09/28/2022

DMHC Routine Medical Survey – January 2023:

- DMHC conducted interviews for the Routine Medical Survey in January of 2023
- The Survey Period is 09/1/2020 through 08/31/2022.
- For the audit, KHS submitted numerous documents:
  - over 1,000 documents for the pre-audit deliverables
  - over 700 detailed verification study requests (samples of grievances, call inquires, potential quality issues, etc.)
  - Additional follow-up requests received since the interviews
- Awaiting DMHC's completion of their reviews and issuance of their Preliminary Audit report

Regulatory Audits (continued)

Department of Health Care Services (DHCS)

2021 Medical Audit – September 2021

The DHCS conducted a Routine Medical Survey of Kern Health Systems from September 13, 2021, through September 24, 2021. The survey period was from August 1, 2019, through July 31, 2021.

- DHCS continues to review the KHS Corrective Action Plan submitted 03/11/2022 and additional supporting documentation has been provided.
- Compliance continues to monitor the elements of the Corrective Action Plan and respond to periodic follow up questions from DHCS.
- It is unclear how the open Corrective Action Plan from the prior audit period will impact the results of the 2022 Medical Audit conducted in November.

Regulatory Audits (continued)

Department of Health Care Services (DHCS)

2022 DHCS Routine Medical Survey – November 2022:

- DHCS is in the process of completing the routine medical survey for 2022
- The survey period is 11/01/2021 – 10/31/2022
- The interview portion of the Audit began the week of 11/28/2022 and continued through 12/09/2022
- For the audit, KHS submitted numerous documents:
  - Pre-Audit deliverables included over 1,000 documents submitted the week of 10/17/2022
  - Samples (verification studies) involved providing detailed screen prints, letters, case documentation, etc. for over 350 sample cases (Care Management, Potential Quality Issues, Grievances, Prior Authorizations, Claims, etc.)
  - KHS has also responded to over 250 follow up requests for additional information, including approximately and addition 800 documents in extremely short turn-around timeframes (often 24 hours)
- Awaiting DHCS' completion of their reviews and issuance of their Preliminary Audit report

Compliance Department
Fraud, Waste, & Abuse Activity
December 2022 and January 2023

KERN HEALTH SYSTEMS

The Compliance Department maintains communications with State and Federal agencies and cooperates with their related investigations and requests for information.

State Medi-Cal Program Integrity Unit, US Department of Justice, and the Kern County Deputy Attorney's Office Requests for Information for the months of December 2022 and January 2023

Providers:

The Plan received one (1) request for information from the State Medi-Cal Program Integrity Unit - related to potential provider fraud, waste, or abuse during this time period.

Members:

The Plan received zero (0) requests for information from the State Medi-Cal Program Integrity Unit related to Plan Members during this time period.

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

Continued…

Fraud, Waste & Abuse
Allegations Reported to the Plan
December 2022 and January 2023

The Plan investigates and reports information and evidence of alleged fraud, waste, & abuse cases to appropriate state and federal officials.

Information compiled during an investigation is forwarded to the appropriate state and federal agencies as required.

Members:

During the months of December 2022 and January 2023, the Compliance Department received fifteen (15) allegations of fraud, waste, or abuse involving Plan Members.

Providers:

During months of December 2022 and January 2023, the Compliance Department received twelve (12) allegations of Provider fraud.

The Plan continues to investigate the allegations and required reporting to DHCS has been submitted timely in all cases.

Compliance Department
HIPAA Breach Activity
December 2022 and January 2023

KERN HEALTH SYSTEMS

Summary of Potential Protected Health Information ("PHI") Disclosures for the months of December 2022 and January 2023 :

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").

During the months of December 2022 and January 2023, the Compliance Department received and reviewed thirty-six (36) allegations of privacy incidents. All thirty-six were closed as non-breaches.

KERN HEALTH SYSTEMS

Attachment B

MEDIA Clips

This news compilation is intended for KHS purposes only. KERN COUNTY

Fighting for those 'who can't help themselves'
By CSUB

A curious kid, Emily Duran discovered early that you learn a lot more by listening than talking. So when the adults in her life got together for conversation, she was all ears.

"They would talk about everything — work, family, what was going on with their friends. I heard gossip, I heard recipes, I heard about their dreams. 'This one is dating that one' and on and on," she said. "But any conversation about health care was always negative. 'So-and-so died of diabetes. So-and-so can't work because of cancer.' I thought, why can't we talk about the positive things out of health care? But there were not positive stories to tell."

Read More

KHS distributes $19M to help fill local gaps in homeless services
By The Bakersfield Californian

Kern's Medi-Cal plan administrator announced Wednesday it gave out more than $19 million in state money last fall to support new programs for addressing homelessness and related issues across the county.

Read More

Kern Health Systems secures more than $19 million in funding for homelessness, housing solutions
By KERO 23

Kern Health Systems has secured more than $19 million from the state's Health Care Services incentive funds to address housing and homelessness issues in Kern County.

Read More

Local Newscasts

KGET Channel 17 - NBC
Monday – Friday
5 am, 6 am, 12 pm, 5 pm - 6:30 pm, 11 pm
Sat. & Sun.
5 pm, 6 pm, 11 pm

KERO Channel 23 – ABC
Monday – Friday
4:30 am, 11 am, 5 pm, 6 pm, 7 pm, 11 pm
Sat. & Sun.
6 am, 8 am, 6 pm, 11 pm

KBAK Channel 29 – CBS
Monday – Friday
4:30 am, 12 pm, 5 pm, 6 pm, 7 pm, 11 pm
Sat. & Sun.
5 pm, 6 pm , 11 pm

KBFX Channel 58 – Fox
Monday – Friday
7 am, 12:30 pm, 10 pm
Sat. & Sun.
6 pm, 10 pm

KERN HEALTH SYSTEMS

MEDIA Clips

This news compilation is intended for KHS purposes only. KERN COUNTY

Kern Health Systems awarded $19 million to address homelessness in Kern County
By KBAK/KBFX

Funds were being awarded to organizations across Kern County who had a comprehensive plan to help the unhoused. Kern Health Systems, the independent public agency that governs Kern Family Health Care, received over $19 million dollars of state Department of Health Care Services incentive funds.

Read More

Bakersfield leaders share their love for celebrating Black History Month
By KGET

Traco Matthews is the Chief Health Equity Officer (CHEO) for Kern Health Systems (KHS). Working with the Executive team, he provides leadership in the design and implementation of KHS's business strategies, stakeholder relationships, and community programs to ensure health equity is prioritized and addressed.

Read More

Brundage Lane Navigation Center expands beds, adds medical services
By KERO 23

Emily Duran, Chief Executive Officer of Kern Health Systems, says in order to provide the most effective care, the best approach is a holistic approach.

Read More

Brundage Lane Navigation Center expands campus
By The Bakersfield Californian

The center will be operated by Kern Medical and Kern Health Systems, which will station nurses in the room and have separate office spaces in BLNC dedicated for case workers and examinations.

Read More

KERN HEALTH SYSTEMS

MEDIA Clips

This news compilation is intended for KHS purposes only. KERN COUNTY

Brundage Lane Navigation Center completes $6M expansion

By KGET

The Brundage Lane Navigation Center took a major step Thursday in addressing Bakersfield's growing homeless population.

Read More

KHS asegura millones para abordar la vivienda y la falta de vivienda en el condado de Kern

By El Popular

Kern Health Systems (KHS) ha obtenido más de $19 millones de los fondos de incentivos del Departamento de Servicios de Atención Médica del Estado de California (DHCS) para abordar la vivienda y la falta de vivienda en el condado de Kern.

Read More

KHS Secures Millions to Address Housing and Homelessness in Kern County

By Kern Sol News

Kern Health Systems (KHS) has secured more than $19 million from the California State Department of Health Care Services (DHCS) incentive funds to address housing and homelessness in Kern County.

Read More

28 A

SUMMARY OF PROCEEDINGS

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, February 24, 2022
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Blvd, Bakersfield, CA 93308 during regular business hours, 8:00 a.m.–5:00 p.m., Monday through Friday, 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 for review at the same location.

Members Present: Satya Arya, MD; Danielle C Colayco, PharmD; Allen Kennedy; Michael Komin, MD; Philipp Melendez, MD; John Miller, MD; Chan Park, MD; Martha Tasinga, MD, CMO

Members Absent: Jennifer Ansolabehere, PHN; Philipp Melendez, MD

Meeting was called to order at 7:06 A.M. by Dr. Martha Tasinga, M.D., Chief Medical Officer

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 COMMITTEE MEMBER 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 COMMITTEE MEMBERS CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee Members on any matter not on this agenda but under the jurisdiction of the Committee Members. 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 Members at a later meeting. Also, the Committee Members 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!

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 (Gov. Code Sec. 54954.2[a]) – **NO ONE HEARD.**

3) Announcements – **N/A**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Martha Tasinga gave committee overview of the current happenings in our Population Health Management Program:**

- **Major Organ Transplant- over 100 members getting evaluated for transplant, are on the transplant waitlist, or have received their transplant**
- **Transition of Care- revamped our TOC program to include an internal Case Management process to help prevent readmissions**
- **We're working on establishing other PHM programs like the Potentially Preventable Admissions (PPA) program, Diabetes program, Congestive Heart Failure (CHF)—etc.**

CA-6) QI/UM Committee Summary of Proceedings November 11th, 2021 – APPROVED
Arya-Kennedy: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 4th Quarter 2021–RECEIVED AND FILED
Arya-Kennedy: All Ayes
- October 2021
- November 2021
- December 2021

CA-8) Public Policy and Community Advisory Summary of Proceedings 4th Quarter 2021 – APPROVED
Arya-Kennedy: All Ayes

CA-9) Pharmacy & Therapeutics Committee Summary of Proceedings 4th Quarter 2021 - RECEIVED AND FILED
Arya-Kennedy: All Ayes

Pharmacy Reports – Arya-Kennedy: All Ayes
CA-10) Pharmacy TAR Log Statistics 4th Quarter 2021– RECEIVED AND FILED

- Executive Summary

Quality Improvement Department Summary Reports
Kennedy-Arya: All Ayes
11) Quality Improvement Department Summary Reports 4th Quarter 2021– APPROVED

- COVID-19 Updates
- Potential Inappropriate Care (PIC) Notifications
- Facility Site Reviews (FSRs)
    a. Initial Full Site Reviews
    b. Periodic Full Site Reviews
    c. Interim/ Focus Reviews
- Quality Improvement Projects
    a. Performance Improvement Projects (PIPs)
    b. MCAS Member Incentive and Engagement Project
    c. SWOT Project
- MCAS Accountability Set (MCAS) Updates
- Policy and Procedure and other program documents

Ms. Jane Daughenbaugh, Director of Quality Improvement, reviewed with the committee the executive summary for the 4th quarter QI Department reports. Some key points discussed were:

1. **COVID-19 Updates**
    - **There was a significant increase of new COVID cases in the last week of December 2021, compared to earlier in the quarter.**
2. **Potential Inappropriate Care (PIC) Notifications**
    - **There was a 32% increase in PIC notifications compared to previous quarter. This increase is due to assigning PICs to a nurse sooner in the receipt process which reflects more real time volumes.**
3. **Facility Site Reviews (FSR) and Medical Record Review (MRR) Description**
    - **Special DHCS Site Review Audit: DHCS conducted a random Full Scope Site Review Audit on December 7th-9th for nine KHS Providers. KHS's certified Master Trainer, QI Director and QI Manager attended the audits to provide support to our providers as well as the DHCS auditors.**

4. **Quality Improvement Projects**
    - **Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits.**
    - **Child/Adolescent Health Asthma Medication Ratio (AMR) focusing on increasing the level of compliance for members 5-21 years of age by approximately 15%.**
    - **Outreach activities by the Population Health Management (PHM) team included outreached to 39 eligible members.**
5. **MCAS Committee**
    - **2022 Provider Pay-for-Performance (P4P) Program being re-structured with payouts based on "pool reimbursement" to support compliance with MCAS measures and IHA's.**
    - **Member Engagement & Rewards Program (MERP) Campaigns: The Committee approved adding Blood Lead Screening, Breast Cancer Screening, and Cervical Cancer Screening to 2022 campaigns.**
6. **MCAS Updates**
    - **The MY2021 rates we have for the 4th quarter are admin rates only and do not include medical record reviews (MRR) and supplemental data. We anticipate medical record review abstraction to begin in February 2022.**

UM Department Reports – Arya-Kennedy: All Ayes

12) Combined UM Reporting 4th Quarter 2021– APPROVED
- Executive Summary
- Policies and Procedures

Hadassah Perez, Director of Utilization Management, reviewed with the committee the UM Department reports. Some key points discussed were:

- **Utilization Management reporting structure was changed late in the 4th Quarter.**
- **DHCS request for corrective action plan to remediate all findings. UM has been working collaboratively with KHS Health Services and Compliance departments to ensure our policies and practices are compliant with both state and federal regulatory agencies.**
- **Q4 ongoing efforts to support Cal-AIM new benefits implementations caused a great strain on the UM/HS analytical team. 2 staff members were repurposed and began training in Dec. 2021 to assist with the following programs: Major Organ Transplants; Enhanced Case Management; Community Support Services.**
- **Process Improvement Projects are going to transfer into Quarter 1 of 2022 to align with UM & KHS goals.**

Kaiser Organization Summary Reports

CA-13) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report-4th Quarter 2021– RECEIVED AND FILED
- KFHC Volumes Report 4th Quarter 2021– RECEIVED AND FILED
- Kaiser Reports will be available upon Request

Member Services Department Summary Reports – Park-Arya: All Ayes

14) Grievance Operational Board Update – APPROVED

- Executive Summary
- 4th Quarter 2021

15) Grievance Summary Reports – APPROVED

- Executive Summary
- 4th Quarter 2021

Amy Carrillo, Member Services Manager, went over the Grievance reports with the committee.

Provider Network Management Department Summary Reports
Arya-Kennedy: All Ayes

16) Re-credentialing Report 4th Quarter 2021– APPROVED
CA-17) Board Approved New Contracts Report – RECEIVED AND FILED
CA-18) Board Approved Providers Report – RECEIVED AND FILED
CA-19) Provider Relations Network Review Report 4th Quarter 2021– RECEIVED AND FILED

- Executive Summary

Melissa Lopez, Provider Relations Manager, presented to the committee all initial and re-credentialing files for providers and facilities were approved.

Policies and Procedures – Park-Kennedy: All Ayes

20) 3.22-P Referral and Authorization Process - APPROVED
21) 3.25-P Prior Authorization Services and Procedures – APPROVED

Health Education Department Summary Report – Arya-Kennedy: All Ayes

CA-22) Health Education Activity Report 4th Quarter 2021-APPROVED

Meeting adjourned by Dr. Martha Tasinga, M.D., Medical Director @ 8:12 A.M. to Thursday, May 26, 2022 at 7:00 A.M.

28 B

SUMMARY OF PROCEEDINGS

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, May 26, 2022
7:00 A.M.

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Members Present: Satya Arya, MD; Allen Kennedy; Michael Komin, MD; Philipp Melendez, MD; John Miller, MD; Chan Park, MD; Martha Tasinga, MD, CMO

Members Absent: Jennifer Ansolabehere, PHN; Danielle C Colayco, PharmD

Meeting was called to order at 7:00 A.M. by Dr. Martha Tasinga, M.D., Chief Medical Officer

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STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

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 (Gov. Code Sec. 54954.2[a]) – **NO ONE HEARD.**

3) Announcements – **N/A**

4) Closed Session – **Committee discussed and approved new member Yanis Almanza of Bakersfield Home Health-Hospice to be new member of QI-UM Committee.**
Melendez-Arya: All Ayes

5) CMO Report – **Dr. Martha Tasinga shared the following with the committee:**

- **In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS is requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.**
- **KHS has onboarded a consultant to assist with the selection of the NCQA consultant who will guide the organization through the multi-year project to obtain final NCQA accreditation.**

CA-6) QI/UM Committee Summary of Proceedings February 24, 2022 – APPROVED
Kennedy-Melendez: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 1st Quarter 2022–RECEIVED AND FILED
Arya-Park: All Ayes
- February 2022
- March 2022

CA-8) Public Policy and Community Advisory Summary of Proceedings 1st Quarter 2022 – APPROVED
Kennedy-Melendez: All Ayes

Pharmacy Reports – Melendez-Kennedy: All Ayes
CA-9) Pharmacy TAR Log Statistics 1st Quarter 2022– RECEIVED AND FILED

- Executive Summary

Quality Improvement Department Summary Reports
Park-Kennedy: All Ayes

10) Quality Improvement Department Summary Reports 1st Quarter 2022– APPROVED
    - COVID-19 Updates
    - Potential Quality Issues (PQI) Notifications
        - PQI Audit Summary
    - Facility Site Reviews (FSRs)
        a. Initial Full Site Reviews
        b. Periodic Full Site Reviews
        c. Interim/ Focus Reviews
    - Quality Improvement Projects
        a. Performance Improvement Projects (PIPs)
        b. MCAS Member Incentive and Engagement Project
        c. SWOT Project
    - MCAS Accountability Set (MCAS) Updates
    - Policy and Procedure and other program documents

Ms. Jane Daughenbaugh, Director of Quality Improvement, reviewed with the committee the executive summary for the 1st quarter of 2022 QI Department reports. Some key points discussed were:

1. **COVID-19 Updates**
    - **There was a significant decrease of new COVID cases and hospitalizations during Q1.**

2. **Potential Inappropriate Care (PIC) Notifications**
    - **There was a 58% increase in PQI referrals. The increase may be due to a change in process to refer all grievances with a validated PQI to the Quality Department for a full investigation.**

3. **Quality Improvement Projects**
    - **Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits.**
    - **Child/Adolescent Health Asthma Medication Ratio (AMR) focusing on increasing the level of compliance for members 5-21 years of age by 15%.**

4. **MCAS Committee**
    - **Review of Mobile Mammogram events with a recommendation to develop a Mobile Preventive Health program.**
    - **Review of member outreach conducted for the MERP campaign in March.**
    - **Review of MY2021 MCAS compliance rates to date. Final rates due no later than June 1st.**

5. **MCAS Updates**

- **The MCAS Audit and Rate Submission for MY2021 is underway and will wrap up by June 1st.**
- **Final rates submitted to DHCS and NCQA will be presented in the next QI-UM Committee meeting.**
- **There are more measures meeting the Minimum Performance Level and showing improvement compared to MY2020.**

UM Department Reports – Park-Komin: All Ayes

11) Combined UM Reporting 1st Quarter 2022 – APPROVED
- Executive Summary
- Policies and Procedures

Hadassah Perez, Director of Utilization Management, reviewed with the committee the UM Department reports. Some key points discussed were:

- **UM completed several policy revisions including 3.22 Referral and Authorization Process, and 3.25 Prior Authorization Services and Procedures.**
- **New projects include Medical Loss Ratio, Health Service Process Improvement, and Long-Term Care.**

Kaiser Organization Summary Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
- KFHC APL Grievance Report 1st Quarter 2022 – RECEIVED AND FILED
- KFHC Volumes Report 1st Quarter 2022 – RECEIVED AND FILED
- Kaiser Reports will be available upon Request

Member Services Department Summary Reports – Arya-Park: All Ayes

13) Grievance Operational Board Update – APPROVED
- Executive Summary
- 1st Quarter 2022

14) Grievance Summary Reports – APPROVED
- Executive Summary
- 1st Quarter 2022

Provider Network Management Department Summary Reports
Park-Komin: All Ayes

15) Re-credentialing Report 1st Quarter 2022 – APPROVED
CA-16) Board Approved New Contracts Report – RECEIVED AND FILED
CA-17) Board Approved Providers Report – RECEIVED AND FILED
CA-18) Provider Relations Network Review Report 1st Quarter 2022 – RECEIVED AND FILED

- Executive Summary

Melissa Lopez, Provider Relations Manager, presented to the committee all initial and re-credentialing files for providers and facilities were approved. Some key points discussed were:

- **9 new contracts were approved in Q1.**
- **Network Adequacy and Provider Counts -**
  KHS must maintain the following ratios:
  1 PCP for every 2,000 members
  1 Physician for every 1,200 members
  KHS review of network to member ratio is compliant with State regulations and Plan policy. KHS recruitment efforts are on-going. Provider counts remain consistent across the review period.
- **The Plan is currently working with VSP to have a more thorough analysis of the Plan's Service Area completed.**

Policies and Procedures – Park-Komin: All Ayes

19) 2.70- I Potential Quality of Care Issues - RECEIVED AND FILED
20) 2.72- I Provider Preventable Conditions - RECEIVED AND FILED
21) 3.22-P Referral and Authorization Process - RECEIVED AND FILED
22) 3.25-P Prior Authorization Services and Procedures - RECEIVED AND FILED

Health Education Department Summary Report – Arya-Kennedy: All Ayes
CA-23) Health Education Activity Report 1st Quarter 2022 - APPROVED

Meeting adjourned by Dr. Martha Tasinga, M.D., Medical Director @ 8:31 A.M.
to Thursday, July 28, 2022 at 7:00 A.M.

28 C

SUMMARY OF PROCEEDINGS

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, July 28, 2022
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Blvd, Bakersfield, CA 93308 during regular business hours, 8:00 a.m.–5:00 p.m., Monday through Friday, 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 for review at the same location.

Members Present: Yanis Almanza; Allen Kennedy; Danielle C Colayco, PharmD; Michael Komin, MD; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga, MD, CMO

Members Absent: Jennifer Ansolabehere, PHN; Satya Arya, MD; Debra Cox

Meeting was called to order at 7:07 A.M. by Dr. Martha Tasinga, M.D., Chief Medical Officer

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 COMMITTEE MEMBER 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 COMMITTEE MEMBERS CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee Members on any matter not on this agenda but under the jurisdiction of the Committee Members. 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 Members at a later meeting. Also, the Committee Members 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!

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 (Gov. Code Sec. 54954.2[a]) – **NO ONE HEARD.**

3) Announcements – **N/A**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Martha Tasinga shared the following with the committee:**

- **Katie Sykes, Consultant for Population Health Management is reviewing our current Model of Care (MOC) and updating it to include our PHM program changes in order to prepare for CalAIM.**

CA-6) QI/UM Committee Summary of Proceedings May 26, 2022 – APPROVED
Melendez-Kennedy: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 2nd Quarter 2022–RECEIVED AND FILED
Melendez-Kennedy: All Ayes
- April 2022
- May 2022
- June 2022

CA-8) Public Policy and Community Advisory Summary of Proceedings 2nd Quarter 2022 – APPROVED
Melendez-Kennedy: All Ayes

CA-9) Drug Utilization Review Committee Summary of Proceedings-1st Quarter 2022-RECEIVED AND FILED
Melendez-Kennedy: All Ayes

Pharmacy Reports
CA-10) Pharmacy TAR Log Statistics 2nd Quarter 2022 – RECEIVED AND FILED
Melendez-Kennedy: All Ayes

Quality Improvement Department Reports
Melendez-Colayco: All Ayes

11) Quality Improvement Program Report 2nd Quarter 2022 – APPROVED
- Executive Summary

12) QI Annual Program Reports APPROVED
- 2021 QI Program Evaluation
- 2022 QI Program Description
- 2022 QI Program Workplan

Ms. Jane Daughenbaugh, Director of Quality Improvement, reviewed with the committee the executive summary for the 2nd Quarter of 2022 QI Department reports. Some key points discussed were:

1. **COVID-19 Updates**
   - **Due to the pandemic and stay-at-home directives, a backlog of Facility Site and Medical Records Reviews had evolved. Our target date for full resolution was June 30, 2022, and that target was met.**
2. **Potential Inappropriate Care (PIC) Notifications**
   - **PQIs dipped slightly in the 2nd quarter but were essentially consistent with the 1st quarter. The increase since the first quarter is due to a change in process to refer all grievances with a validated PQI to the Quality Department for a full investigation.**
3. **Quality Improvement Projects**
   - **Health Care Disparity – Well Care Visits**
   - **Child/Adolescent Health Asthma Medication Ratio**
   - **SWOT Analysis and Action Plan Project**
   - **PDSA's – Breast Cancer Screening and Well Care Visits with Clinica Sierra Vista.**
4. **MCAS Committee**
   - **The MCAS Audit and Rate Submission for MY2021 was completed by June 1st with final rates submitted to DHCS and NCQA. MY2021 resulted in 5 out of 15 measures meeting the minimum performance level and 9 out of 15 measures improved compared to the previous year.**

UM Department Reports – Melendez-Kennedy: All Ayes

13) Combined UM Reporting 2nd Quarter 2022 – APPROVED
- Executive Summary
- VSP DER Effectiveness Report
- VSP Medical Data Summary
- Policies and Procedures

Deborah Murr, Chief Health Services Officer, reviewed with the committee the UM Department reports. Some key points discussed were:

- **UM continues to implement an initiative to support the authorization compliance which includes enhancements to our Medical Management platform JIVA, increasing automation, and simplification of our prior authorization requirements.**
- **New projects include Long-Term Care, Community Support Services for Social Determinants of Health, Dual Special Needs Plan, and NCQA Accreditation.**

Kaiser Organization Summary Reports

CA-14) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report 2nd Quarter 2022 – RECEIVED AND FILED
- KFHC Volumes Report 2nd Quarter 2022 – RECEIVED AND FILED
- Kaiser Reports will be available upon Request

Member Services Department Summary Reports – Melendez-Kennedy: All Ayes

15) Grievance Operational Board Update – APPROVED
- Executive Summary
- 2nd Quarter 2022

16) Grievance Summary Reports – APPROVED
- Executive Summary
- 2nd Quarter 2022

Provider Network Management Department Summary Reports
Park-Kennedy: All Ayes

17) Re-credentialing Report 2nd Quarter 2022 – APPROVED
CA-18) Board Approved New Contracts Report – RECEIVED AND FILED
CA-19) Board Approved Providers Report – RECEIVED AND FILED
CA-20) Provider Relations Network Review Report 2nd Quarter 2022 – RECEIVED AND FILED
- Executive Summary

Melissa Lopez, provider Relations Manager, presented to the committee all initial and re-credentialing files for providers and facilities. Some key points discussed were:

- **There were 4 new contracts approved in Q2.**
- **KHS randomly sampled 15 PCP, 15 Specialists, 15 psychiatrists, 5 Mental Health, 5 Ancillary, and 5 OB/GYN providers to ensure compliance with phone answering timeliness and appointment availability. All provider types surveyed were compliant with both components surveyed.**

- **No DHCS issues were identified in Q2 regarding the Quarterly Monitoring Report and Response Template.**

QI-UM Policies and Procedures – Melendez-Park: All Ayes
21) 2.70-I Provider Preventable Conditions – APPROVED
22) 2.72-I Potential Quality of Care Issues – APPROVED

- **Power Point Presentation given by Jane Daughenbaugh; she went over both policies in detail with the committee.**

Health Education Department Summary Report
CA-23) Health Education Activity Report 2nd Quarter 2022 – HELD UNTIL NEXT MEETING

- **Isabel went over the Executive Summary with the committee but will present 2nd Quarter Report at the next meeting.**

Meeting adjourned by Dr. Martha Tasinga, M.D., Medical Director @ 8:29 A.M. to Thursday, November 10, 2022 at 7:00 A.M.

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SUMMARY OF PROCEEDINGS

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, November 10, 2022
7:00 A.M.

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Members Present: Satya Arya, MD; Allen Kennedy; Danielle C Colayco, PharmD; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga, MD, CMO

Members Absent: Yanis Almanza; Jennifer Ansolabehere, PHN; Debra Cox; Michael Komin, MD

Meeting was called to order at 7:05 A.M. by Deborah Murr, MHA, BS-HCM, RN, Chief Health Services Officer

1) Quality Improvement – Utilization Management Committee Resolution to Allow Virtual Committee Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) – APPROVED
Arya-Melendez: All Ayes

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STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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4) Announcements – **Deborah Murr introduced 3 new KHS employees: Michelle Curioso, our new Director of Population Health Management; Misty Dominguez, our new Director of Utilization Management; and Timeshia Mackey, our new Supervisor of Quality Improvement-MCAS.**

5) CMO Report - **Dr. Martha Tasinga shared the following with the committee:**

- **As of Jan 1, 2023, Long Term Care is now a covered benefit for Managed Care members. Historically when a member qualified for LTC, they were switched back to straight Medi-Cal and were no longer our member. LTC is now housed in PHM and monitored and tracked. There is an entirely new process for managing these members to remain in compliance with the State's mandate.**

CA-6) QI-UM Committee held in Q3 Summary of Proceedings– APPROVED
Melendez-Colayco: All Ayes

CA-7) Physician Advisory Committee (PAC) held in Q3 Summary of Proceedings – APPROVED
Melendez-Colayco: All Ayes

CA-8) Public Policy – Community Advisory Committee (PP-CAC) held in Q3 Summary of Proceedings – APPROVED
Melendez-Colayco: All Ayes

CA-9) Drug Utilization Review (DUR) Committee held in Q3 Summary of Proceedings – APPROVED
Melendez-Colayco: All Ayes

Pharmacy Reports
CA-10) Pharmacy TAR Log Statistics for Q3 2022 – RECEIVED AND FILED
Melendez-Colayco: All Ayes

Quality Improvement Reports – Melendez-Kennedy: All Ayes
11) Quality Improvement Program Report for Q3 2022 – APPROVED
- QI Reporting for Q3
- Initial Health Assessment (IHA) Bi-Annual Audit Summary
- Potential Quality Issues (PQI) Audit Summary
- Policy 2.70-I Potential Quality of Care Issues (PQI)
- Policy 2.71-P Facility Site Review and Medical Records Review

Ms. Jane Daughenbaugh, Director of Quality Improvement, reviewed with the committee the executive summary for the 3rd Quarter of 2022 QI Department reports. Some key points discussed were:

1. **COVID-19 Updates**
   - **During the pandemic, site reviews were conducted virtually. Effective July 1st of this year, our Certified Site Review (CSR) nurses switched back to conducting the reviews on site and are restarting interim reviews. DHCS provided approval for Managed Care Plans (MCPs) to continue completing medical record reviews virtually on an ongoing basis.**

2. **Potential Quality of Care (PQI) Notifications**
   - **There was a notable increase in Level 1 and 2 PQI's compared to Q1 and Q2. We have begun conducting analysis of PQIs by provider for inpatient and outpatient PQIs. The report in the full Q3 report shows the table of results with provider names de-identified.**

3. **Facility Site Reviews (FSR) and Medical Record Review (MRR)**
   - **A new All Plan Letter (APL) is being finalized by DHCS for Site and Medical Record Reviews and is anticipated to be in effect this Fall.**

4. **Quality Improvement Projects**
   - **Health Care Disparity in WCV (Well Care Visits ages 3-21)**
   - **Child/Adolescent Health Asthma Medication Ratio (AMR)**

5. **MCAS Updates**
    - **As of September 2022, 6 out of 15 measures showed improvement compared to this month last year.**

Utilization Management Reports – Melendez-Park: All Ayes

12) Utilization Management Program Reporting for Q3 2022 – APPROVED
- UM Program Overview
- Delegated UM Functions

Misty Dominugez, Director of Utilization Managment, reviewed with the committee the UM Department reports. Some key points discussed were:

In Q3, membership has remained stable with approximately 340,000 enrolled lives resulting in the processing of 65,871 authorization requests. The increased volume of membership and subsequent referrals has impacted turnaround times. As such, in Q3 the Utilization Management Department has implemented initiatives focused on ensuring compliance.

Q3 Initiatives:
- **Enhancements to the medical management platform used to process authorizations.**
- **Increased access for providers to evidenced based criteria used to process authorization requests.**
- **Consistent review and revision of the Prior Authorization list based on utilization data trends.**

Kaiser Organization Summary Reports

CA-13) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
- KFHC APL Grievance Report for Q3 2022 – RECEIVED AND FILED
- KFHC Volumes Report for Q3 2022 – RECEIVED AND FILED
- Kaiser Reports will be available upon Request

Member Services Reports – Melendez-Kennedy: All Ayes

15) Grievance Operational Board Update for Q3 2022 – APPROVED
16) Grievance Summary Reports for Q3 2022 – APPROVED

Provider Network Management Reports – Melendez-Park: All Ayes

17) Credentialing Statistics for Q3 2022 – APPROVED
CA-18) Board Approved New & Existing Contracts Report – RECEIVED AND FILED
CA-19) Credentialing & Recredentialing Summary Report – RECEIVED AND FILED
CA-20) Network Review for Q3 2022 – RECEIVED AND FILED

Melissa McGuire, Deputy Director of Provider Network, went over the following points with the committee:

- **KHS conducts a survey to assess compliance with after-hours urgent and emergent guidance for members. During Q3, KHS conducted 139 calls resulting in compliance rates as follows: Emergent: 95%, Urgent: 92%. Any providers found to be non-compliant will receive a letter advising of standards.**
- **KHS randomly sampled 15 PCP, 15 Specialists, 5 Mental Health, 5 Ancillary, and 5 OB/GYN providers to ensure compliance with phone answering timeliness and appointment availability. All provider types surveyed were compliant with both components surveyed.**
- **The Plan identified two terminations – hematology and neurology in Q3 2022 and updated AAS were submitted.**

Health Education Reports – Melendez-Park: All Ayes
CA-21) Health Education Activity Report for Q3 2022 - APPROVED

Meeting adjourned by Deborah Murr, MHA, BS-HCM, RN, Chief Health Services Officer @ 8:23 A.M. to Thursday, March 16, 2023 at 7:00 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, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. 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.

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SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, December 9, 2022

8:00 A.M.

COMMITTEE RECONVENED

Members: Martinez, Garcia, McGlew, Watson
ROLL CALL: All present

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

COMMITTEE ACTION SHOWN IN CAPS

1) Finance Committee Resolution to Allow Virtual Committee Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) - APPROVED
McGlew-Watson: All Ayes

PUBLIC PRESENTATIONS

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NO ONE HEARD

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

3) On their own initiative, Committee members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Government Code Section 54954.2(a)(2))

DIRECTOR MCGLEW WISHED ALL A VERY HAPPY HOLIDAY SEASON

CA-4) Minutes for Kern Health Systems Finance Committee meeting on October 7, 2022- APPROVED
Watson-McGlew: All Ayes

5) Report on Kern Health Systems investment portfolio for the third quarter ending September 30, 2022 (Fiscal Impact: None) – IRA COHEN, UBS FINANCIAL SERVICES, INC., HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

6) Proposed reinsurance policy with HM Life Insurance to mitigate costs incurred by Kern Health Systems for members with high dollar inpatient admissions from January 1, 2023 through December 31, 2023 in an amount not to exceed $0.22 per member per month (Fiscal Impact: $914,969 estimated; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

7) Proposed Kern Health Systems 2023 Operating and Capital Budgets (Fiscal Impact: None) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew-Watson: All Ayes

8) Proposed Budget Request for 2023 Project Consulting Professional Services, from January 1, 2023 through December 31, 2023 (Fiscal Impact: $15,066,478; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

9) Proposed Agreement with Kern County Department of Human Services to facilitate Medi-Cal outreach and enrollment along with Medi-Cal renewal assistance for Kern County Medi-Cal enrollees; total cost not to exceed $425,000 per year with a maximum not to exceed $850,000 over the 2-year term of the agreement (Fiscal Impact: $425,000 annually; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

10) Proposed Agreement with OptumInsight, Inc., for the renewal of our Claims Edit Platform Solution, from December 22, 2022 through December 21, 2027 (Fiscal Impact: $3,845,563; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

11) Proposed Agreement with CDW, for the renewal of our Nutanix hardware and software solution with three years of support and maintenance, from January 1, 2023 through December 31, 2025 (Fiscal Impact: $1,328,560.25; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew: All Ayes

12) Report on Kern Health Systems financial statements for September 2022 and October 2022 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew: All Ayes

13) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for September 2022 and October 2022 and IT Technology Consulting Resources for the period ended September 30, 2022 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Garcia-McGlew: All Ayes

ADJOURN TO FRIDAY, FEBRUARY 10, 2023 AT 8:00 A.M.