KERN HEALTH SYSTEMS

REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, April 17, 2025
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, April 17, 2025

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, Elliott, Acharya, Alva, Bowers, Hoffmann, Johnson, Ma, McGlew, Meave, Singh, Tamsi, Turnipseed
ROLL CALL:

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

2) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
(Government Code § 54956.9 (e)(3).) Number of cases: one (1)
Significant exposure to litigation in the opinion of the Board of Directors on the advice of legal counsel, based on the receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection.

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))

DEPARTMENTAL MATTERS

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on February 20, 2025 (Fiscal Impact: None) –
APPROVE

CA-6) Minutes for Kern Health Systems Board of Directors special meeting on April 2, 2025 (Fiscal Impact: None) –
APPROVE

7) Report by Moss Adams on the audited financial statements of Kern Health Systems for the year ending December 31, 2024 (Fiscal Impact: None) –
APPROVE

CA-8) Report on Kern Health Systems 2024 Provider Satisfaction Survey (Fiscal Impact: None) –
RECEIVE AND FILE

CA-9) Report on Kern Health Systems 2024 Member Satisfaction Survey (Fiscal Impact: None) –
RECEIVE AND FILE

CA-10) Report on Kern Health Systems Quality Improvement Health Equity (QIHEC) Work Plan and the 2025 Work Plan (Fiscal Impact: None) –
APPROVE

CA-11) Proposed Increase in the Not-to-Exceed amount with Blackhawk by $287,400 from $195,000 to $482,400 for the Member Rewards Program, from July 1, 2025, through June 30, 2026, which includes a contract extension for one (1) year. (Fiscal Impact: $287,400 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-12) Proposed Increase in the Not-to-Exceed amount with Relay Network by $100,000 from $399,998 to $499,998 for the Text Messaging Solution, from June 1, 2025, through December 31, 2025, which includes a contract extension for seven (7) months.
(Fiscal Impact: $100,000 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-13) Proposed Agreement with e360 for Maintenance and Support for the Rubrik Disaster and Recovery Solution from April 29, 2025, through October 31,2026 (Fiscal Impact: $285,565 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-14) Proposed increase in the Not-to-Exceed amount with Cognizant by $161,865 from $6,445,522 to $6,607,387 for the Project Change Request, 24x7 Upgrade Emergency Support, TriZetto University, Technology Assessment, Data Purge, and Zelis integration licensing from April 21, 2025 through September 10, 2029 (Fiscal Impact: $161,865; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

15) Report on Kern Health Systems Financial Statements for December 2024 and January 2025 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-16) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for December 2024 and January 2025 and IT Technology Consulting Resources for the period ended December 31, 2024 (Fiscal Impact: None) –
RECEIVE AND FILE

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

CA-18) Kern Health Systems Chief Compliance and Fraud Prevention Officer report (Fiscal Impact: None) –
RECEIVE AND FILE

CA-19) Report on Kern Health Systems Enterprise Risk Management Project Update (Fiscal Impact: None) –
RECEIVE AND FILE

CA-20) Report on Kern Health Systems Proposed Draft Ticket Distribution Policy (Fiscal Impact: None) –
RECEIVE AND FILE

CA-21) Report on Kern Health Systems Artificial Intelligence Tool Readily (PandanAI) (Fiscal Impact: Not to Exceed $100,000; Budgeted) –
APPROVE

CA-22) Report on Kern Health Systems Managed Care Accountability Set (MCAS) (Fiscal Impact: None) –
RECEIVE AND FILE

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

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

CA-25) Miscellaneous Documents –
RECEIVE AND FILE

A) Minutes for Kern Health Systems Physician Advisory Committee meeting on February 5, 2025
B) Minutes for Kern Health Systems Delegation Oversight Committee meeting on February 10, 2025
C) Minutes for Kern Health Systems Health Equity Transformation Steering Committee meeting on February 11, 2025
D) Minutes for Kern Health Systems Finance Committee meeting on February 14, 2025
E) Minutes for Kern Health Systems Drug Utilization Review Committee meeting on February 24, 2025

F) Minutes for Kern Health Systems Fraud, Waste, and Abuse Committee meeting on February 25, 2025
G) Minutes for Kern Health Systems Utilization Management Committee meeting on February 26, 2025
H) Minutes for Kern Health Systems Compliance Committee meeting on February 28, 2025
I) Minutes for Kern Health Systems Physician Advisory Committee meeting on March 5, 2025
J) Minutes for Kern Health Systems Executive Quality Improvement Health Equity Committee Meeting on March 18, 2025
K) Minutes for Kern Health Systems Community Advisory Committee meeting on March 25, 2025
L) Minutes for Kern Health Systems Governance and Compliance Committee meeting on March 27, 2025

ADJOURN TO JUNE 19, 2025 AT 8:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, February 20, 2025

8:00 A.M.

BOARD RECONVENED

Directors: Watson, Thygerson, Patel, Elliott, Acharya, Alva, Bowers, Hoffmann, Ma, McGlew, Meave, Singh, Tamsi, Turnipseed
ROLL CALL: 9 – Present; 5 Absent – Patel, McGlew, Meave, Singh, Tamsi

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

ADJOURNED TO CLOSED SESSION

DIRECTOR PATEL ARRIVED AT 8:07 AM DURING CLOSED SESSION

DIRECTOR TAMSI ARRIVED AT 8:08 AM DURING CLOSED SESSION

CLOSED SESSION

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

2) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
(Government Code § 54956.9 (e)(3).) Number of cases: Five (5)
Significant exposure to litigation in the opinion of the Board of Directors on the advice of legal counsel, based on the receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection. SEE RESULTS BELOW

8:20 A.M.

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 1 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **INITIAL CREDENTIALING FOR FEBRUARY 2025** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON ALSAID ALKHREISAT, CEPONIS, JACOB, KAUR, MALAMET, VYAS; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON COJOCNEAN, REYES, ALALONG, IKETUBOSIN, PUNSALAN; DIRECTOR MEAVE ABSTAINED FROM VOTING COJOCNEAN, REYES, ALALONG, IKETUBOSIN, PUNSALAN; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON JENKINS, NUNEZ, REED CHANEY
Item No. 1 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **RECREDENTIALING FOR FEBRUARY 2025** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON BENAVIDES, MEADE; DIRECTOR ELLIOTT ABSTAINED FROM VOTING ON FARBER; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON FARBER, RABANAL, VILLATORO; DIRECTOR MEAVE ABSTAINED FROM VOTING ON JONES, RABANAL, VILLATORO; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON DECKER, KOTLER

Item No. 2 concerning a CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION (Government Code § 54956.9 (e)(3).) Number of cases: Five (5) Significant exposure to litigation in the opinion of the Board of Directors on the advice of legal counsel, based on the receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection. HEARD; NO REPORTABLE ACTION TAKEN

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 HOFFMANN REPORTED ON THE AD HOC LEGAL COUNSEL COMMITTEE MEETING; DIRECTOR HOFFMANN STATED THAT THE POSITION AND THE RFP WERE POSTED; THE BIDS WERE DUE FEBRUARY 18TH AND THAT THE COMMITTEE WILL MEET AGAIN AND WILL BRING THE RECOMMENDATION TO THE BOARD; DIRECTOR THYGERSON COMMENTED THAT THE LIST WAS KIND OF SHORT AND ASK THAT THE LIST BE SENT OUT TO MORE IN THE COMMUNITY; DEVIN BROWN REPLIED THAT MORE WERE OFFERED RFPS

DIRECTOR TURNIPSEED REPORTED ON HIS RECENT TRIP TO THE ACAP CONFERENCE IN WASHINGTON, D.C. AND STATED THAT IT WAS VERY INTERESTING AND THAT DAVID VALDAVIO IS TRYING TO PROTECT OUR MEDICAID

DIRECTOR BOWERS CONGRATULATED RUSSELL JOHNSON ON HIS APPOINTED TO THE KHS BOARD

DIRECTOR WATSON STATED THAT A NOMINATING COMMITTEE AND AN ORDINANCE CHARTER REVIEW COMMITTEE IS NEEDED AND IF YOU'RE INTERESTED IN SERVING ON EITHER COMMITTEE TO REACH OUT TO HER

DIRECTOR WATSON INTRODUCED NEW BOARD MEMBER RUSSELL JOHNSON; MR. JOHNSON RESPONDED AT THE PODIUM AND STATED THAT HE IS LOOKING FORWARD TO SERVING AND ALSO VOLUNTEERED TO SERVE ON ORDINANCE CHARTER REVIEW COMMITTEE

DEPARTMENTAL MATTERS

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on December 19, 2024 (Fiscal Impact: None) – APPROVED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-6) Minutes for Kern Health Systems Board of Directors special meeting on January 16, 2025 (Fiscal Impact: None) – APPROVED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

7) Kern County Board of Supervisors appointment of Russell Johnson, 2nd District Community Representative, for term expiring June 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED
Acharya-Bowers: 11 Ayes; 3 Absent – McGlew, Meave, Singh

DIRECTOR SINGH ARRIVED AT 8:44 AM DURING THE DISCUSSION OF ITEM 8

8) Presentation on Government Code Section 1090 Conflict of Interest by Olson Remcho (Fiscal Impact: None) – JAMES HARRISON, OLSON REMCHO, HEARD; RECEIVED AND FILED
Hoffmann-Bowers: 12 Ayes; 2 Absent – McGlew, Meave

9) Report on Kern Health Systems Healthcare Workforce Expansion Initiative (Fiscal Impact: None) – HEIDI HE, CALIFORNIA STATE UNIVERSITY, BAKERSFIELD, HEARD; MINTY DILLON, GOOD SAMARITAN HOSPITAL, HEARD; RECEIVED AND FILED
Hoffmann-Patel: 12 Ayes; 2 Absent – McGlew, Meave

10) Proposed Amendment No.3 to Employment Agreement with Emily Duran, for services as Chief Executive Officer (Fiscal Impact: None) - APPROVED; AUTHORIZED CHAIRMAN TO SIGN
Patel-Tamsi: 12 Ayes; 2 Absent – McGlew, Meave

CA-11) Report on Annual Kern Health Systems Health Equity Division (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-12) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2024 (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-13) Report on 2024 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

14) Special Requests for Funding by Local Community Partners and Providers (Fiscal Impact: $15,880,981; Not Budgeted; Discretionary)
DIRECTED KHS STAFF TO MANAGE GRANT REQUESTS IN ACCORDANCE WITH KHS GRANTS AND STRATEGIC INITIATIVES RFP PROCESS IN THE NORMAL COURSE OF BUSINESS
Patel-Tamsi: 12 Ayes; 2 Absent – McGlew, Meave

CA-15) Report on 2024 Annual Travel Report (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-16) Report on 2024 Annual Report of Disposed Assets (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-17) Proposed New Agreement with mPulse, for the Member and Provider Portal from March 1, 2025 through December 31, 2030 with a Not-to-Exceed amount of $5,966,116 over the term of the contract (Fiscal Impact: $5,966,116; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-18) Proposed Contract Extension and Retroactive Approval with Language Line, for Language Interpretation services, from February 28, 2025 through February 27, 2028 and increasing the Not-to-Exceed by $11,678,000 over the term of the contract (Fiscal Impact: $11,678,000; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-19) Proposed Contract Extension with LifeSigns, for American Sign Language Interpreting Services, from February 23, 2025 through February 22, 2027 and increasing the Not-to-Exceed amount by $120,000 from $160,000 to $280,000 (Fiscal Impact: $120,000; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-20) Proposed Contract Extension with Coffey Communications, for the Member Newsletters, from February 15, 2025 through February 14, 2026 and increasing the Not-to-Exceed amount by $200,000 from $170,000 to $370,000 (Fiscal Impact: $200,000; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-21) Proposed Contract Extension with Ceridian, for the Payroll and HRIS services, from March 18, 2025 through March 17, 2027 and increasing the Not-to-Exceed amount by $772,224 from $648,000 to $1,420,224 (Fiscal Impact: $772,224; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-22) Proposed Contract Extension with Change Healthcare, for Electronic Claims Processing, from February 20, 2025 through February 19, 2030 and increasing the Not-to-Exceed amount by $1,275,000 from $930,000 to $2,205,000 (Fiscal Impact: $1,275,000; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-23) Proposed Contract Extension with Health Management Associates, for Actuarial services, from March 1, 2025 through February 28, 2026 and increasing the Not-to-Exceed amount by $199,000 from $199,000 to $398,000 (Fiscal Impact: $199,000; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-24) Proposed Contract Extension with Milliman, for Actuarial services including D-SNP, from March 1, 2025 through December 31, 2026 and increasing the Not-to-Exceed amount by $750,000 from $762,000 to $1,512,000 (Fiscal Impact: $750,000; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

25) Report on Kern Health Systems financial statements for November 2024 (Fiscal Impact: None) – RECEIVED AND FILED
Singh-Patel: 12 Ayes; 2 Absent – McGlew, Meave

CA-26) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2024 and IT Technology Consulting Resources for the period ended November 30, 2024 (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-27) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-28) Kern Health Systems Chief Human Resources Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-29) Kern Health Systems Chief Compliance and Fraud Prevention Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

30) Report on Kern Health Systems 2025 Compliance Program Description (Fiscal Impact: None) – APPROVED
Acharya-Bowers: 12 Ayes; 2 Absent – McGlew, Meave

DIRECTOR SINGH LEFT THE DAIS AT 10:17 AM AND DID NOT VOTE ON ITEM 31

31) Report on Kern Health Systems 2025 Code of Conduct (Fiscal Impact: None) – APPROVED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

32) Report on Kern Health Systems 2025 Compliance Guide (Fiscal Impact: None) – APPROVED
Turnipseed-Alva: 11 Ayes; 3 Absent – McGlew, Meave, Singh

33) Report on Kern Health Systems 2025 Anti-Fraud Plan (Fiscal Impact: None) – APPROVED
Bowers-Thygerson: 11 Ayes; 3 Absent – McGlew, Meave, Singh

34) Report on Kern Health Systems 2024 Compliance Work Plan Q4 update (Fiscal Impact: None) – APPROVED
Alva-Tamsi: 11 Ayes; 3 Absent – McGlew, Meave, Singh

35) Report on Kern Health Systems 2025 Compliance Work Plan (Fiscal Impact: None) – APPROVED
Ma-Tamsi: 11 Ayes; 3 Absent – McGlew, Meave, Singh

CA-36) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

DIRECTOR TURNIPSEED LEFT THE DAIS AT 10:57 AM AND DID NOT VOTE ON ITEM 37

37) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Patel-Acharya: 10 Ayes; 4 Absent – McGlew, Meave, Singh, Turnipseed

DIRECTOR BOWERS LEFT THE DAIS AT 11:08 DURING THE DISCUSSION OF ITEM 38 AND DID NOT VOTE ON ITEM 38

38) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Elliot-Patel: 9 Ayes; 5 Absent – Bowers, McGlew, Meave, Singh, Turnipseed

CA-39) Miscellaneous Documents – RECEIVED AND FILED
Turnipseed-Patel: 11 Ayes; 3 Absent – McGlew, Meave, Singh

A) Minutes for Kern Health Systems Drug Utilization Review Committee meeting on November 25, 2024
B) Minutes for Kern Health Systems Physician Advisory Committee meeting on December 4, 2024
C) Minutes for Kern Health Systems Community Advisory Committee meeting on December 10, 2024
D) Minutes for Utilization Management Committee meeting on December 11, 2024
E) Minutes for Kern Health Systems Executive Quality Improvement Health Equity Committee Meeting on December 12, 2024
F) Minutes for Kern Health Systems Finance Committee meeting on December 13, 2024
G) Minutes for Kern Health Systems Governance and Compliance Committee meeting on February 7, 2025

ADJOURN TO APRIL 17, 2025 AT 8:00 A.M.

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

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Special Meeting
Wednesday, April 2, 2025

2:30 P.M.

BOARD RECONVENED

Directors: Watson, Thygerson, Patel, Elliott, Acharya, Alva, Bowers, Hoffmann, Johnson, Ma, McGlew, Meave, Singh, Tamsi, Turnipseed
ROLL CALL: 8 – Present; 7 Absent – Thygerson, Pate, Bowers, Ma, McGlew, Meave, Singh

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

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

BOARD ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

ADJOURNED TO CLOSED SESSION

DIRECTOR PATEL ARRIVED AT 2:44 PM DURING CLOSED SESSION

CLOSED SESSION

2) CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION (Government Code § 54956.9 (d) (1) and (g))
Name of case: *Anita Martin v. Kern Health Systems*, BCV-23-103336. SEE RESULTS BELOW

BOARD TO RECONVENE

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 2 concerning a CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION (Government Code § 54956.9 (d) (1) and (g))
Name of case: *Anita Martin v. Kern Health Systems*, BCV-23-103336. HEARD; NO REPORTABLE ACTION TAKEN

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

ADJOURN TO APRIL 17, 2025 AT 8:00 A.M.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: Report by Moss Adams Regarding the 2024 Audit

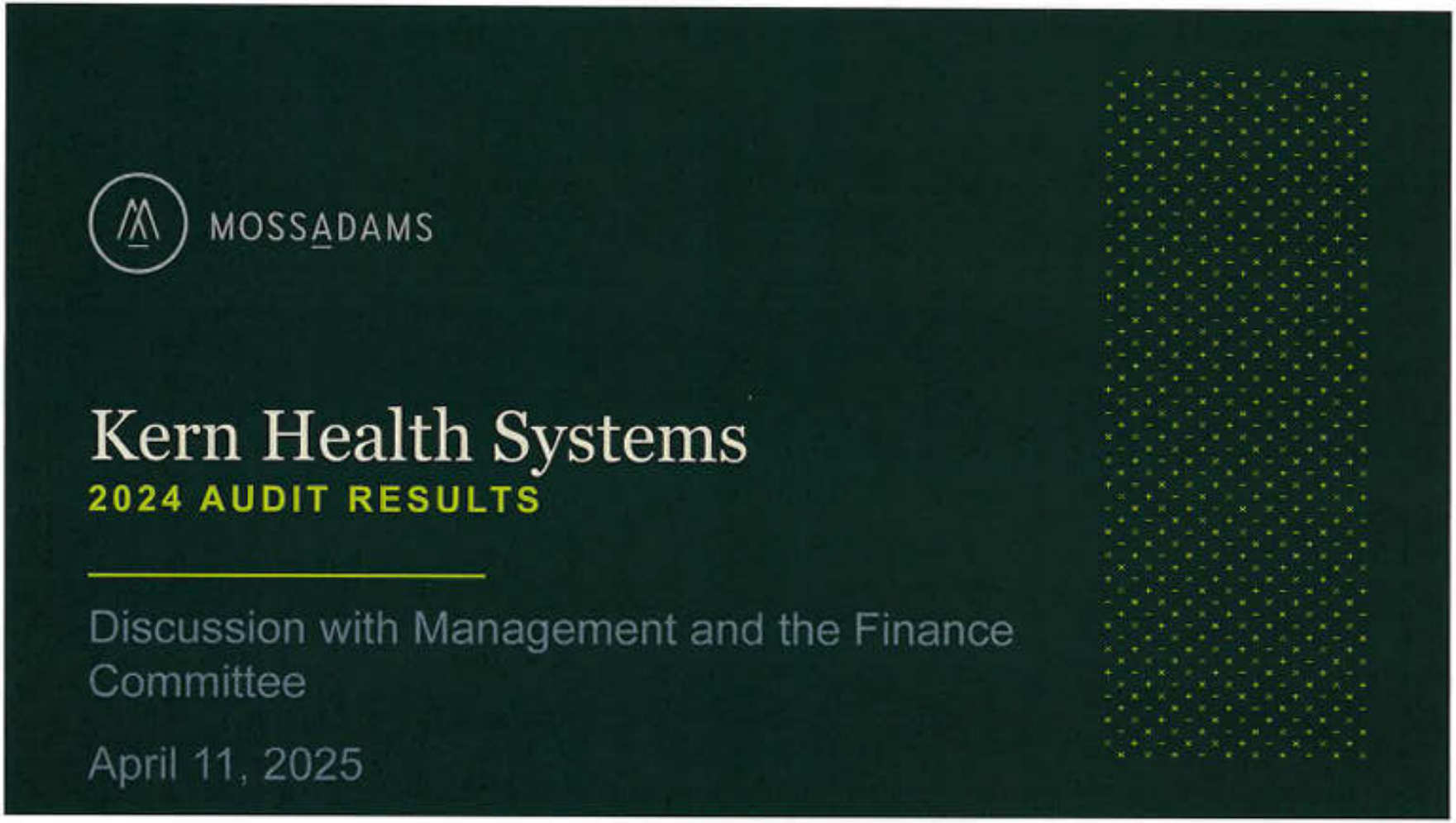
DATE: April 17, 2025

Background

Attached for your review are the December 31, 2024 audited financial statements for Kern Health Systems. The scope of the audit comprises the Statements of Net Position, the Statements of Revenues, Expenses and Changes in Net Position, Statements of Cash Flows, and the related notes to the financial statements. Representatives from the accounting firm Moss Adams will be providing a report on the 2024 audit.

Requested Action

Approve.


MOSSADAMS
Kern Health Systems
2024 AUDIT RESULTS
Discussion with Management and the Finance Committee
April 11, 2025

Agenda

1. Scope of Services
2. Summary of Audit Process
3. Significant Risks Identified
4. Matters Required to be Communicated with Those Charged with Governance
5. Your Service Team
6. About Moss Adams

Scope of Services

We have been engaged to perform the following services for Kern Health Systems:

Annual Audit

- Annual financial statement audit as of and for the year ending December 31, 2024.

Non-Attest Services

- Assist management with drafting the financial statements for the year ending December 31, 2024, except for management's discussion and analysis section.
- Provide Claims Audit Tool (CAT) software maintenance and support services.
- Assist management with the Enterprise Risk Assessment project.

Summary of Audit Process

- Our audit was generally performed in accordance with our initial plan. When the results of a planned audit procedure did not provide sufficient evidence or our original plan was based on an incorrect understanding of a transaction, process, or accounting policy of the entity, we made the necessary adjustments to our audit plan to incorporate the procedures necessary to support our opinion on the financial statements.
- We have completed our testing of all significant account balances and classes of transactions.
- We issued our independent auditor's report on April 4, 2025.

Significant Risks Identified

During the planning of the audit, we have identified the following significant risks:

Significant Risks	Procedures
Medical claims liability and claims expense	• Tested the internal controls for claims payments • Tested the data used by the actuary to estimate the claims liability and review the experience and qualifications of the actuary • Performed a retrospective review of the prior year's claims liability • No exceptions noted in procedures performed
Capitation revenue and receivables	• Developed independent expectations of revenue using membership data and rates and cash receipts • Obtained an understanding of Management's reserve methodology and validated key inputs through our audit procedures • Verified subsequent receipt of cash and performed other substantive procedures • No exceptions noted in procedures performed
Amounts due to the State of California or DHCS	• Tested the accrual calculations and agreed amounts accrued to subsequent payments if applicable • Obtained an understanding of the nature of the amounts payable to the State of California • Tested inputs into the estimates used to calculate the amounts due • No exceptions noted in procedures performed

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) as well as *Government Auditing Standards*, issued by the Comptroller General of the United States and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts.. As part of an audit conducted in accordance with those standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

Our audit of the financial statements included obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control or to identify deficiencies in the design or operation of internal control. Accordingly, we considered the entity's internal control solely for the purpose of determining our audit procedures and not to provide assurance concerning such internal control.

Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

MOSS ADAMS COMMENTS

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

- Significant management estimates impacted the financial statements including the following: fair value of investments, capital asset lives, medical loss ratio rebate liability, risk corridor liabilities and receivables, actuarially determined accruals for IBNR claims liabilities, other accrued medical expenses payable, employee pension plans, deferred inflows and outflows of resources, net pension liability.

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

- Significant disclosures include the following:
  - Note 1 – Nature of activities and summary of significant accounting policies
  - Note 2 – Cash, cash equivalents, and investments
  - Note 9 – Accrued medical expenses payable
  - Note 12 – Employee pension plans
  - Note 14 – Commitments and contingencies

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Unusual Transactions

MOSS ADAMS COMMENTS

No significant unusual transactions were identified during our audit of the entity's financial statements.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Significant Difficulties Encountered During the Audit

We are to inform those charged with governance of any significant difficulties encountered in performing the audit. Examples of difficulties may include significant delays by management, an unreasonably brief time to complete the audit, unreasonable management restrictions encountered by the auditor, or an unexpected extensive effort required to obtain sufficient appropriate audit evidence.

MOSS ADAMS COMMENTS

No significant difficulties were encountered during our audit of the entity's financial statements.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Disagreements With Management

Disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the entity's financial statements, or the auditor's report.

MOSS ADAMS COMMENTS

We are pleased to report that there were no disagreements with management.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED	MOSS ADAMS COMMENTS
Circumstances that affect the form and content of the auditor's report	There were no circumstances that affected the form and content of the auditor's report.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED	MOSS ADAMS COMMENTS
Other findings or issues arising from the audit that are, in the auditor's professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process	There were no other findings or issues arising from the audit to report.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Material, Corrected Misstatements

Material, corrected misstatements that were brought to the attention of management as a result of audit procedures.

MOSS ADAMS COMMENTS

No material corrected misstatements were identified.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Uncorrected Misstatements

The Finance Committee should be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the consolidated financial statements as a whole.

MOSS ADAMS COMMENTS

No uncorrected misstatements were noted during the audit.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED	MOSS ADAMS COMMENTS
Representations requested of management We will request certain representations from management that will be included in the management representation letter dated upon the date of the auditor's report.	A copy of the management representation letter is available upon request.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Management's consultation with other accountants

When we are aware that management has consulted with other accountants about significant auditing or accounting matters, we discuss with those charged with governance our views about the matters that were the subject of such consultation.

MOSS ADAMS COMMENTS

We are not aware of instances where management consulted with other accountants about significant auditing or accounting matters.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED	MOSS ADAMS COMMENTS
Significant issues arising from the audit that were discussed, or the subject of correspondence with management	No significant issues arose during the audit that have not been addressed elsewhere in this presentation.

Matters to Be Communicated to the Governing Body

MATTERS TO BE COMMUNICATED

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control or of internal control over compliance that came to the auditor's attention during the audit must be reported to the Finance Committee.

Moss Adams Comments

There were no material weaknesses noted and no significant deficiencies to communicate.

Your Service Team

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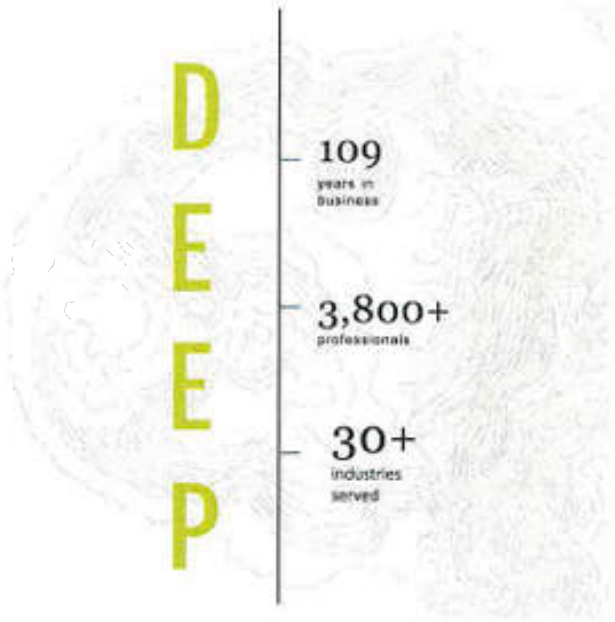
Other team members:

Desiree Osias
Audit Staff

Danila Antonin
Audit Staff

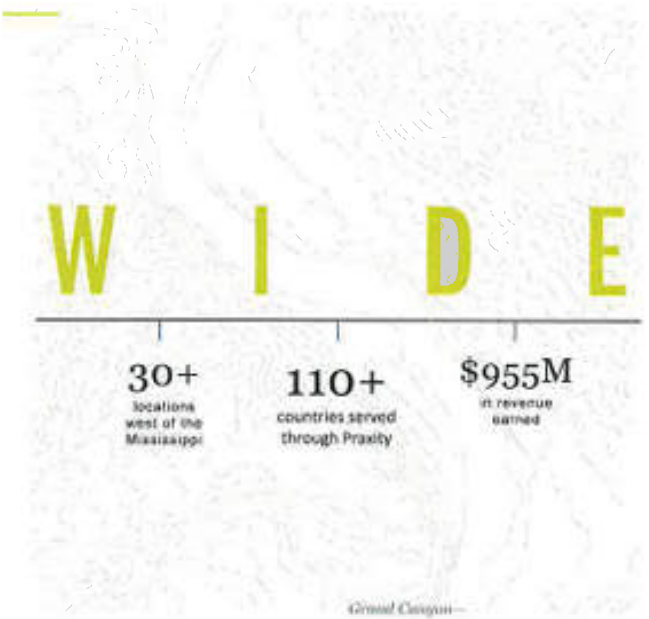
About Moss Adams

Our Expertise



Crater Lake—
A monument to perseverance, North America's deepest lake filled to 1,949 feet over 720 years.

Our Reach



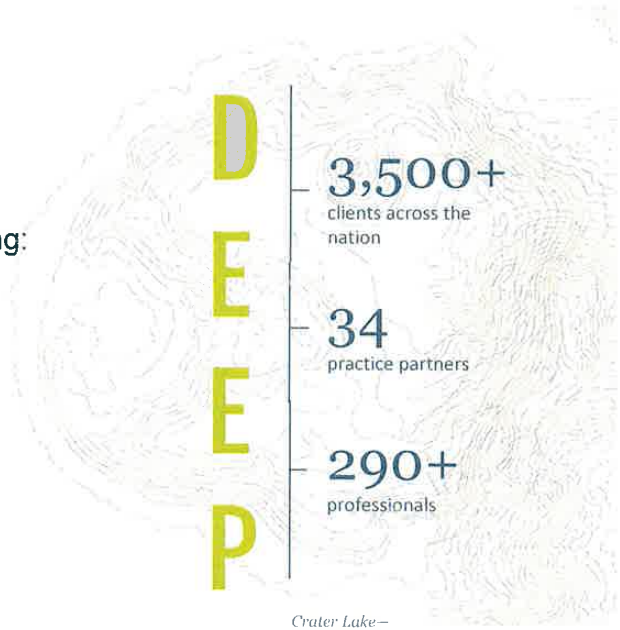
Grand Canyon—
At 277 miles long and up to 18 miles wide, this icon serves as a testament to determination and time.

Health Care Industry Experience

Our health care professionals dedicate their careers to serving the industry.

We cover the full spectrum of health care including:

- Hospitals and health systems
- Independent practice associations
- Medical groups
- Community health centers
- Behavioral health organizations
- Long-term care
- Surgery centers
- Knox Keene licensed health plans
- Health care ancillary services



Crater Lake—
A monument to perseverance, North America's deepest lake filled to 1,949 feet over 720 years.

Additional Services

Audit and tax are vital. But you have complex needs that go beyond these core functions. Our dedicated health care consulting team provides a range of services to address all your needs—both now and in the future.

Health Plans, Insurance, & Risk-Bearing Organizations

In today's health care landscape, managed care risk-bearing organizations (RBOs) come in many different forms.

We serve the needs of over 220 clients ranging in size and structure from large, billion-dollar member insurers to small, captive insurers. In addition to tax and assurance services, we also focus on operational and systems infrastructure, and our services and knowledge of the insurance managed care market have been used for numerous litigation matters involving payers and providers.

Who we serve:

- HMOs
- Insurance exchanges
- Exclusive provider organizations
- Risk pools
- Self-ensured pools
- Medicare Advantage plans
- Medicaid health plans
- ACOs
- CCOs
- Knox-Keene plans
- Dental plans
- TPAs

Performance Excellence

Our team of seasoned health care professionals have a deep understanding of health care operations and best practices that comes from experience in working with a wide range of health care organizations. We will work collaboratively with your management team to design and implement performance improvement initiatives.

Our services include:

- Financial turnaround
- Process assessment and redesign
- Labor productivity improvement
- Non-labor cost management expense reduction
- Department and process assessment and redesign
- Benchmarking
- Management span of control optimization

Lean Consulting

Our certified lean professionals assist in transforming organizations in implementing a lean management system through educating, training, and coaching executives, managers, clinicians, and frontline staff.

We are committed to helping organizations achieve the highest quality through zero defects, increased patient satisfaction, empowerment of staff, and improvement of financial performance through the application of the Toyota Management System. Improvement work ranges from the strategic planning process at the top of the organization to complex clinical processes within care delivery and the supporting administrative processes.

Main practice areas include:

- 3P+ innovation
- Lean management systems and hoshin
- Lean operations
- Quality and patient safety

Internal Audit Solutions

We offer a custom, risk-based approach to helping you achieve the desired level of assurance, achieve your organization's goals, and reduce your compliance costs. Moss Adams works with clients on a wide range spectrum of internal audit capabilities—from organizations with deep and wide internal audit departments to those with no staff at all.

We're trusted advisors to management and boards. External auditors can be confident in our work and its results.

Working with you, we can address such challenges as:

- Finance Committee expectations
- Internal control problems
- Staff augmentation
- Inefficient business processes, costly or wasteful practices
- High fixed internal audit costs
- Unfulfilled internal audit needs
- Insufficient coverage of IT and tax
- Compliance failures

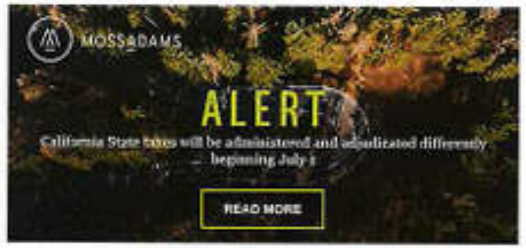
Insights and Resources

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key.
These resources offer what you need to know, when you need to know it, and are presented in the format that fits your life.

We'll keep you informed to help you stay abreast of critical industry issues.

Moss Adams closely monitors regulatory agencies, participates in industry and technical forums, and writes about a wide range of relevant accounting, tax, and business issues to keep you informed.

We also offer CPE webinars and events that are archived and available on demand, allowing you to watch them on your schedule.



2025 Executive Health Care Conference

30TH ANNIVERSARY | SAVE THE DATE!

NOVEMBER 12–14, 2025

Red Rock Casino Resort & Spa
Las Vegas, NV

REGRISTRATION OPENS APRIL 2025

Join C-suite professionals from across the health care ecosystem to discuss the state of the industry and prepare leaders for 2026.

HIGHLIGHTS

Nov 12: Women's Executive Healthcare Leadership Forum

Nov 13: State of the Union
Political Point-Counterpoints
Reception with Keynotes

Nov 14: Economic Forecast

Connect With Us

In today's fast-paced world, we know how precious your time is. We also know that knowledge is key. These resources offer what you need to know, when you need to know it, and are presented in the format that fits your life.

LinkedIn: www.linkedin.com/company/moss-adams-llp

Twitter: @Moss_Adams

Subscribe to our emails: www.mossadams.com/subscribe

RSS feeds: www.mossadams.com/RSS

YouTube: http://www.youtube.com/mossadamsllp

MOSSADAMS

Executive Session

Better Together: Moss Adams & Kern Health Systems

THANK YOU

Report of Independent Auditors
and Financial Statements
with Supplementary Information

Kern Health Systems

December 31, 2024 and 2023

MOSSADAMS

Table of Contents

Management's Discussion & Analysis

Kern Health Systems
Management's Discussion & Analysis

Our discussion and analysis of Kern Health Systems' (KHS, We, Us, Our) financial performance provides an overview of KHS' financial activities for the calendar years ended December 31, 2024 and 2023. Presentation of balances in the financial tables may differ from prior periods. Account balances have been reclassified to better present financial categories. Please read the discussion and analysis in conjunction with the KHS financial statements, which begin on page 13.

Overview

KHS is a County health authority established for the purpose of providing health care services to meet the health care needs of low-income families and individuals in Kern County, California. As a managed care health plan, KHS manages health care services for an enrolled population that qualifies for Medi-Cal, which is California's Medicaid health care program. Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. The Department of Health Care Services (DHCS) is the single state agency responsible for administering Medi-Cal. In 2024 and 2023, KHS received over 99% of its operating revenue from the State of California. KHS is committed to continually improving the quality of care and service to its members, and to help them access the right care at the right time in the appropriate setting.

Members can select the Medi-Cal health plan of their choice. In Kern County there are two additional Medi- Cal health plans to choose from besides KHS. The opportunity to select a health plan is at the time of initial enrollment and at a minimum, annually thereafter. If a member does not select a plan, the member will be auto-assigned to one of the Medi-Cal health plans located in Kern County.

In general, KHS members are required to use the KHS provider network to receive care. KHS contracts with various health care providers for the provision of medical care services to its members. The provider network consists of primary and specialty care physicians, hospitals, ancillary providers, and pharmacies. Primary Care Physicians (PCPs) along with Physician Assistants and Nurse Practitioners play an integral role in coordinating and managing the care of KHS members by delivering preventive services as well as referring members to other providers for medically necessary services. PCPs are typically trained in internal medicine, pediatrics, family practice and general practice. KHS compensates most of its providers on a fee for services basis. Under fee for service arrangements, KHS retains the financial responsibility for medical care provided and incurs costs based on the actual utilization of services. Additionally, KHS works with the provider network to operate efficiently by providing financial and utilization information, physician and patient educational programs, and disease and medical management programs. In 2024 and 2023, KHS used approximately 99% and 89%, respectively, of its reported premium revenue for medical care services. The increase in the percentage from 2023 to 2024 is primarily due to the reduction of rates received in 2024, subsequent 2023 retroactive rate reductions received in 2024, combined with higher utilization of medical services by KHS members during 2024.

Kern Health Systems
Management's Discussion & Analysis

KHS' long-term success depends on the quality of services provided to its members. KHS seeks to improve the quality of care delivered by its network providers by continual focus on:

- Provider access
- Preventive health and wellness
- Care and disease management
- Provider credentialing
- Provider education and incentives for closing care gaps
- Member education and outreach
- Information technology initiatives related to the above activities
- Social determinants of health
- Advocacy and community-based programs

KHS' mission is dedicated to improving the health status of its members through an integrated managed health care delivery system. KHS is focused on preventive health, wellness and a population health management model that coordinates medical, behavioral, and social programs to provide quality care, improve health outcomes, and reduce health disparities.

KHS' employee population reflects the diversity of the members and communities it serves with a focus on providing opportunities for our employees that are intellectually stimulating and emotionally fulfilling, and offering programs and benefits that are financially rewarding. KHS continues to introduce improvements focused on employee development, hiring strategies, diversity, equity, and inclusion.

2024 Financial Highlights:

- Our net position decreased in 2024 by $46.6 million or approximately (12.3%), while in 2023 our net position increased by $61.4. million or 19.3%.
- Our Medi-Cal enrollment growth showed an average monthly member increase of approximately 55,400 members or 15.8% in 2024 compared to 2023. This compared to an average monthly member increase of approximately 29,100 members or 9.1% in 2023 compared to 2022.
- We reported an operating loss of $67.8 million or ($13.93) PMPM in 2024, and operating income of $40.3 million or $9.59 PMPM in 2023. The decrease in operating income in 2024 is primarily due to reduction of rates received for the 2024 service period, subsequent 2023 retroactive rate reductions received in 2024 and higher utilization of medical services by our members.
- Managed Care Organization (MCO) Tax Revenues of $709.4 million or $145.78 PMPM are included in premiums earned in 2024 and $376.7 million or $89.66 PMPM in 2023. Beginning July 1, 2016, the MCO tax methodology changed from a percentage of premium revenue to a fixed PMPM rate. The rate was $147.99 PMPM for the period January 1, 2024 to December 31, 2024 and $113.33 PMPM for the period April 1, 2023 to December 31, 2023. Assembly Bill (AB) 119 authorized a MCO provider tax effective April 1, 2023, through December 31, 2026 which significantly increased the MCO tax for 2024. The increase in MCO tax revenue was used to support Medi-Cal programs including the new targeted rate increase (TRI) payments to providers to promote greater provider participation. The MCO tax revenue amounts are based on projected membership and MCO tax expense is assessed by quarter period. MCO Tax expense is reported as an operating expense and was $709.4 million or $145.77 PMPM in 2024 and $376.5 million or $89.60 PMPM in 2023.

- We reported a net increase in nonoperating income of $0.1 million between 2024 and 2023. We reported investment and other income of $31.1 million in 2024 or $6.40 PMPM and investment and other income of $21.1 million or $5.03 PMPM in 2023. We reported Community grant expense of $10.0 million or $2.05 PMPM in 2024. We reported no Community grant expense in 2023.
- We continued with provider quality incentive programs and reported expenses of approximately $7.3 million in 2024 to reward providers who demonstrate improved Managed Care Accountability Set (MCAS) outcomes.
- Effective January 1, 2024, KHS no longer has a capitated arrangement with any other health plans to provide health care services. In 2023, KHS had a capitated arrangement required by the DHCS with another health plan which allowed for that plan to provide health care services for assigned members. Assigned membership to this other health plan was 15,226 members at the end of 2023 which was not included in the enrollment amounts reported. The premium revenue earned for this population was $37.5 million for the year ended December 31, 2023 and was reported net of $36.8 million of associated capitated expense for the year ended December 31, 2023.

2024 Grants and Strategic Initiative Funding:

In August of 2023, the Kern Health Systems Board of Directors approved $20 million in grant and strategic initiative funding. These grants will support our health equity goals by expanding access to care in rural communities, improving the quality of care for our members, increasing provider capacity, enhancing creative workforce strategies and leveraging community partners to understand the challenges that our members face daily while providing solutions and addressing barriers.

Using this Annual Report

Our financial statements consist of three statements: the Statements of Net Position, the Statements of Revenues, Expenses and Changes in Net Position; and the Statements of Cash Flows. These financial statements and related notes provide information about the activities of KHS.

The Statements of Net Position and Statements of Revenues, Expenses and Changes in Net Position

One of the most important questions asked about our finances is, Is KHS as a whole better or worse off as a result of the year's activities? The Statements of Net Position and the Statements of Revenues, Expenses, and Changes in Net Position report information about our resources and activities in a way that helps answer this question. These statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when cash is received or paid. These two statements report our net position and changes in it. Our net position, the difference between the assets and liabilities, is one way to measure our financial health. Over time, increases or decreases in net position indicate whether our financial health is improving or deteriorating. Non-financial factors, however, such as changes in member base and measures of the quality of service to members should be considered in evaluating the overall health of KHS.

The Statements of Cash Flows

The final required statement is the Statement of Cash Flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operations, investing, and financing activities. It provides answers to such questions as Where did cash come from? What was cash used for? and What was the change in cash balance during the reporting period?

Condensed Financial Information

Statements of Net Position

KHS' net position is the difference between its assets and deferred outflows of resources, and liabilities and deferred inflows of resources, as reported in the Statement of Net Position. Our net position decreased in 2024 by $46.6 million and increased in 2023 by $61.4 million, respectively. Our Statements of Net Position as of December 31, 2024, 2023, and 2022, are as follows:

	2024 (Dollars in Millions)	2023 (Dollars in Millions)	2022 (Dollars in Millions)
Assets			
Cash and cash equivalents	$ 395.0	$ 115.8	$ 99.1
Investments	226.0	406.1	318.0
Premiums receivable	94.5	76.4	69.6
MCO tax receivable	220.3	375.8	32.7
Hospital directed payments receivable	555.7	462.0	436.8
Other current assets	10.7	8.8	6.3
Capital assets, net	59.3	59.1	64.4
Other assets	10.9	2.0	2.2
Total assets	$ 1,572.3	$ 1,506.0	$ 1,029.1
Deferred outflows of resources	$ 6.8	$ 8.4	$ 8.2
Liabilities			
Accrued medical expenses payable	$ 283.3	$ 253.8	$ 227.8
Hospital directed payments payable	557.2	462.0	436.6
MCO tax liability	369.4	391.7	32.7
Accrued expenses	15.6	13.9	10.9
Subscription liability	7.7	-	-
Net pension liability	12.3	12.7	10.2
Total liabilities	$ 1,245.5	$ 1,134.1	$ 718.2
Deferred inflows of resources	$ 0.1	$ 0.2	$ 0.2
Net position			
Net investment in capital assets	$ 60.4	$ 59.1	$ 64.4
Restricted	0.3	0.3	0.3
Unrestricted	272.8	320.7	254.0
Total net position	$ 333.6	$ 380.2	$ 318.8

KHS' net position for 2024, 2023, and 2022, exceeded all regulatory requirements for Tangible Net Equity (TNE).

December 31, 2024

- Total assets were $1,572.3 million and $1,506.0 million, as of December 31, 2024 and December 31, 2023, respectively. This was an increase of $66.3 million, or 4.4%. The increase is primarily attributed by increases in cash and cash equivalents, investments and hospital directed payments receivable and a decrease in the MCO tax receivable.

- Total liabilities were $1,245.5 million and $1,134.1 million as of December 31, 2024 and December 31, 2023, respectively. This is an increase of $1,134.1 million or 9.8%. The increase was primarily attributed by an increase in hospital directed payments and accrued medical expense payable.

- The Plan's total net position decreased by $46.6 million or (12.3%) during 2024. This decrease in net position was attributable to unfavorable capitation rates from the State and higher utilization of medical services by our members which resulted in a net position at December 31, 2024 of $333.6 million compared to a net position of $380.2 million as of December 31, 2023

- TNE at December 31, 2024, was 423.7% of the DHCS required minimum of $78.7 million.

December 31, 2023

- Total assets were $1,506.0 million and $1,029.1 million, as of December 31, 2023 and December 31, 2022 respectively. An increase of $477.0 million, or 46.3%. The increase is primarily attributed by increases in cash and cash equivalents, Investments, MCO Tax Receivable, and Hospital directed payments receivable.

- Total liabilities were $1,134.1 million and $718.2 million as of December 31, 2023 and December 31, 2022, or a 57.9% increase. The increase was primarily attributed to an increase in MCO tax liability.

- The Plan's total net position increased by $61.4 million or 19.3% during 2023. This increase in net position was attributable to favorability in capitation rates from the State and overall reduced utilization because of the COVID-19 pandemic, which resulted in a net position at December 31, 2023, of $380.2 million compared to a net position of $318.8 million at December 31, 2022.

- TNE at December 31, 2023, was 653.2% of the DHCS required minimum of $58.2 million.

Kern Health Systems
Management's Discussion & Analysis

Tangible Net Equity

KHS is required by DMHC to maintain certain levels of TNE. Regulatory TNE levels are determined by formula and are based on specified percentages of revenue and medical expenses. The Plan's TNE at December 31, 2024, was $333.6 million, which exceeded the required TNE amount of $78.7 million. The Plan's TNE at December 31, 2023, was $380.2 million, which exceeded the required TNE amount of $58.2 million.

	December 31, 2024 (Dollars in Millions)	December 31, 2023 (Dollars in Millions)	December 31, 2022 (Dollars in Millions)
Actual TNE, beginning balance	$ 380.2	$ 318.8	$ 247.5
Change in net position	(46.6)	61.4	71.3
Actual TNE, ending balance	$ 333.6	$ 380.2	$ 318.8
Required TNE	$ 78.7	$ 58.2	$ 50.8

Statements of Revenues, Expenses and Changes in Net Position

Operating results and changes in our net position show a decrease in net position of $46.6 million and an increase of $61.4 million for the years ended December 31, 2024 and 2023, respectively. The increases are made up of various components as outlined below:

	Enrollment Data 2024	2023	2022
Enrollment			
Total member months	4,856,241	4,387,884	4,017,909
Less nonrisk capitated member months	-	[188,108]	[155,042]
Net member months	4,856,241	4,201,776	3,862,867
Average monthly members	405,520	350,148	321,072

	Statements of Revenues, Expenses and Changes in Net Position (Dollars in Millions) 2024	2023	2022	Per Member Per Month in Dollars * 2024	2023	2022
Operating revenues						
Premiums earned	$ 1,544.7	$ 1,205.0	$ 1,002.3	$ 317.44	$ 286.79	$ 260.14
MCO premium tax earned	709.4	376.7	120.2	145.78	89.66	31.20
Hospital directed payments earned	288.8	233.3	264.3	59.34	55.52	68.60
Reinsurance recoveries	1.5	2.2	0.5	0.31	0.52	0.13
Total operating revenues	2,544.4	1,817.3	1,387.3	522.87	432.49	360.07
Operating expenses						
Medical and hospital	1,521.9	1,077.6	856.1	312.74	256.45	222.21
MCO premium tax	709.4	376.5	124.7	145.77	89.60	32.35
Hospital directed payments	291.6	231.9	264.6	59.93	55.19	68.69
Administrative	80.8	82.7	60.3	16.60	19.69	15.64
Depreciation	8.6	8.3	7.1	1.76	1.97	1.83
Total operating expenses	2,612.2	1,777.0	1,312.7	536.80	422.90	340.72
Operating (loss) income	(67.8)	40.3	74.6	(13.93)	9.59	19.35
Nonoperating revenues (expenses)						
Investment and other income	31.1	21.1	1.5	6.40	5.03	0.38
Community grants expense	(10.0)	-	(4.8)	(2.05)	-	(1.23)
Total nonoperating revenues (expense)	21.2	21.1	(3.3)	4.35	5.03	(0.85)
Changes in net position	(46.6)	61.4	71.3	(9.59)	14.62	18.50
Net position, beginning of year	380.2	318.8	247.5	78.13	75.86	64.23
Net position, end of year	$ 333.6	$ 380.2	$ 318.8	$ 68.54	$ 90.48	$ 82.73

* Per Member Per Month calculations are subject to immaterial rounding differences

Enrollment

Enrollment is divided into aid categories, which correspond to specific rates of capitation to be received by the Plan from the State. During 2024, the Plan served an average of 405,520 members per month, compared to an average of 350,148 members per month in 2023 and an average of 321,072 members per month in fiscal year 2022. The increase in enrollment for 2024 is attributed to the exit of an existing Medi-Cal health plan in Kern County, which resulted in increased enrollment. The increase in enrollment for 2023 is attributed to the moratorium on redeterminations because of the COVID-19 pandemic.

Enrollment Category	2024	2023	2022
Child	169,406	146,108	141,919
Adult	74,739	66,143	63,890
Adult Expansion	114,188	96,998	88,329
Seniors and Persons with Disabilities (SPD)	22,887	18,423	16,829
SPD - Dual	23,786	22,099	10,105
Long Term Care (LTC)	50	30	-
LTC - Dual	465	347	-
Total average monthly enrollment	405,520	350,148	321,072

Significant aid categories are defined as follows:

- Child: Qualifying members under age 21.
- Adult: Qualifying members between the ages of 21 and 64.
- Adult Expansion (AE): Refers to member who became eligible for the Medi-Cal Program effective January 1, 2014, as a result of the implementation of the Affordable Care Act (ACA) and the expanded eligibility criteria for Medicaid.
- Senior and Persons with Disabilities (SPD)*: Includes individuals who are 65 years of age and older who receive supplemental security income (SSI) checks or are medically needy if their income and resources are within the Medi-Cal limits, and individuals who met the criteria for disability set by the Social Security Administration and the State Program-Disability and Audit Program Division.
- Long-Term Care (LTC)*: Includes frail, elderly, nonelderly adults with disabilities and children with developmental disabilities, and other disabling conditions requiring long-term services.
- * "Dual" coverage refers to enrollees who are eligible for both Medi-Cal and Medicare Parts A, B, and D.

Operating (Loss) Income

The first component of the overall change in net position is our operating (loss) income. This is the difference between the premiums earned and the cost of medical services. We had an operating loss for the year ended December 31, 2024 of $67.8 million and positive operating income for year ended December 31, 2023 of $40.3 million.

The primary components of the operating loss for 2024 are:

- Premium revenue (capitation received by the Plan from the State) is determined by rates set by the State at the beginning of the plan year and generally are effective for the entire year. The State may, on occasion, provide updated rates during the fiscal year for the current year as well as retroactively make changes to rates for prior services years. Premiums earned increased $339.7 million, which is an increase of $30.65 PMPM in 2024 from 2023. The increase in premiums earned is attributed to an increase in membership and the assumption of new membership populations in 2024, increases in premium capitated rates, and the increase in MCO tax revenue from 2024. Despite the net increase received in revenue for the current year, the growth in medical expenses from 2024 to 2023 surpassed revenue earned.

- The medical and hospital services costs increased by $444.3 million and $56.29 PMPM between 2024 and 2023. This increase in expense is primarily attributed to the increased medical expense utilization resulting from DHCS program changes and changes in the population of members including the assumption of Long-term Care (LTC) and Full Dual members from FFS.

- Administrative expenses decreased by $1.9 million or a decrease of ($3.09) PMPM over 2024. Administrative expense as a percentage of total Operating Revenue (excluding MCO tax revenue and Hospital directed payments earned) was 5.2%% in 2024 compared to 6.9% in 2023.

Nonoperating Revenues and Expenses

Nonoperating revenues and expenses consist primarily of investment income, community grants and other expenses. In 2024, the net nonoperating income amount of $21.2 million was attributed to $31.3 million of investment income as the result of higher investment balances and better overall market performance offset by $10.0 million of community grant expenses.

KHS' Cash Flow

Changes in KHS' cash flows are consistent with changes in operating income and nonoperating revenues and expenses. Changes in KHS' cash flows are reflective of timing differences pertaining to the payment of accrued medical services and program liabilities and the volatility of premium rate payments impacted by changes in covered benefits, programs, rate assumptions, and regulatory changes.

General Economic and Political Environment Factors

Our continued growth may be affected by a variety of factors, including macro-economic conditions and enacted health care reforms that could affect our results of operations. Our operations depend primarily on the continuation of our contract with and funding by the State for the Two-Plan Model of the Medi-Cal Managed Care Program.

President Trump has issued a number of executive orders intended to reduce government spending, and we expect there will be continued proposals targeting reimbursement methodologies and the number of individuals eligible for government healthcare programs.

Contacting KHS' Financial Management

This financial report is designed to provide our members, providers, suppliers, regulatory agencies, taxpayers, and creditors with a general overview of KHS' finances and show KHS' accountability for the money it receives. If you have questions about this report or need additional financial information, please contact Robert Landis, CFO, Kern Health Systems, at 2900 Buck Owens Blvd, Bakersfield, California 93308.

MOSSADAMS

Report of Independent Auditors

The Board of Directors
Kern Health Systems

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Kern Health Systems, which comprise the statement of net position as of December 31, 2024, and the related statements of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of Kern Health Systems as of December 31, 2024, and the results of its operations and its cash flows for the year ended December 31, 2024, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS), the standards applicable to financial audits contained in *Government Auditing Standards (Government Auditing Standards)*, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Kern Health Systems and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Prior Period Financial Statements

The financial statements of Kern Health Systems as of and for the year ended December 31, 2023, were audited by other auditors whose report dated April 3, 2024, expressed an unmodified opinion on those statements.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Kern Health Systems's ability to continue as a going concern for twelve months beyond the financial statements date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Kern Health Systems's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Kern Health Systems's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the accompanying management's discussion and analysis (pages 1-9), schedule of changes in net pension liability and related ratios (page 49), and schedule of plan contributions for the defined benefit pension plan (page 50), be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Government Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, *Government Auditing Standards*, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated April 4, 2025, on our consideration of Kern Health Systems's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Kern Health Systems's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Kern Health Systems's internal control over financial reporting and compliance.

Moss Adams LLP

Irvine, California
April 4, 2025

Financial Statements

Kern Health Systems
Statements of Net Position
December 31, 2024 and 2023

	2024 (Dollars in Millions)	2023 (Dollars in Millions)
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
CURRENT ASSETS		
Cash and cash equivalents (Note 2)	$ 395.0	$ 115.8
Investments (Notes 2 and 3)	226.0	406.1
Premiums receivable	94.5	76.4
MCO tax receivable	220.3	375.8
Hospital directed payments receivable (Note 4)	555.7	462.0
Other receivables (Note 5)	2.6	2.3
Prepaid expenses	8.1	6.6
Total current assets	1,502.2	1,444.9
CAPITAL ASSETS (Note 6)		
Land	4.1	4.1
Buildings and improvements	37.9	37.0
Computer hardware and software	56.1	48.8
Furniture and equipment	5.6	4.8
Capital projects in process	1.0	2.3
	104.7	97.0
Less accumulated depreciation	45.4	37.8
Total capital assets, net	59.3	59.1
OTHER ASSETS		
Restricted investments (Notes 2, 3, and 11)	0.3	0.3
Intangible right to use subscription asset, net of accumulated amortization (Note 8)	8.9	-
Split dollar life insurance (Note 7)	1.7	1.7
Total other assets	10.9	2.0
Total assets	1,572.3	1,506.0
DEFERRED OUTFLOWS OF RESOURCES (Note 12)	6.8	8.4
Total assets and deferred outflows of resources	$ 1,579.2	$ 1,514.4

See accompanying notes.

Kern Health Systems
Statements of Net Position (Continued)
December 31, 2024 and 2023

	2024 (Dollars in Millions)	2023 (Dollars in Millions)
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Accrued medical expenses payable (Note 9)	$ 283.3	$ 253.8
MCO tax liability	369.4	391.7
Hospital directed payments payable (Note 4)	557.2	462.0
Accrued expenses (Note 10)	15.6	13.9
Subscription liability (Note 11)	2.2	-
Total current liabilities	1,227.8	1,121.4
NONCURRENT LIABILITIES		
Subscription liability, net of current portion (Note 8)	5.5	-
Net pension liability (Note 12)	12.3	12.7
Total noncurrent liabilities	17.7	12.7
Total liabilities	1,245.5	1,134.1
Commitments and contingencies (Note 14)		
DEFERRED INFLOWS OF RESOURCES (Note 12)	0.1	0.2
NET POSITION		
Net investment in capital assets	60.4	59.1
Restricted (Note 11)	0.3	0.3
Unrestricted	272.8	320.7
Total net position	333.6	380.2
Total liabilities, deferred inflows of resources, and net position	$ 1,579.2	$ 1,514.4

See accompanying notes.

Kern Health Systems
Statements of Revenues, Expenses, and Changes in Net Assets
Years Ended December 31, 2024 and 2023

	2024 (Dollars in Millions)	2023 (Dollars in Millions)
OPERATING REVENUES		
Premiums earned	$ 1,544.7	$ 1,205.0
MCO premium tax earned	709.4	376.7
Hospital directed payments earned (Note 4)	288.8	233.3
Reinsurance recoveries (Note 13)	1.5	2.2
Total operating revenues	2,544.4	1,817.3
OPERATING EXPENSES		
Medical and hospital	1,521.9	1,077.6
MCO premium tax (Note 1)	709.4	376.5
Hospital directed payments (Note 4)	291.6	231.9
Administrative	80.8	82.7
Depreciation	8.6	8.3
Total operating expenses	2,612.2	1,777.0
Operating (loss) income	(67.8)	40.3
NONOPERATING REVENUES (EXPENSES)		
Investment and other income	31.1	21.1
Community grants expense	(10.0)	-
Net nonoperating revenues	21.2	21.1
Change in net position	(46.6)	61.4
NET POSITION, beginning of year	380.2	318.8
NET POSITION, end of year	$ 333.6	$ 380.2

See accompanying notes.

Kern Health Systems
Statements of Cash Flows
Years Ended December 31, 2024 and 2023

	2024 (Dollars in Millions)	2023 (Dollars in Millions)
CASH FLOWS FROM OPERATING ACTIVITIES		
Premium received	$ 2,389.5	$ 1,248.4
Hospital directed payments received	195.1	208.1
Reinsurance recoveries	1.5	2.2
Medical and hospital payments	(1,492.4)	(1,051.6)
Hospital directed payments paid	(196.5)	(206.5)
Administrative expenses paid	(77.9)	(81.4)
MCO premium tax expense paid	(730.1)	(33.3)
Net cash provided by operating activities	89.3	86.0
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Payment of community grants	(10.0)	-
Net cash used in noncapital financing activities	(10.0)	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments of subscription liabilities	(2.3)	-
Acquisition of capital assets	(8.7)	(3.0)
Net cash used in capital and related financing activities	(11.0)	(3.0)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	(1,983.3)	(1,475.5)
Proceeds from maturities of investments	2,194.9	1,408.5
Payments (to) received on provider advances	(0.7)	0.7
Proceeds from (payments on) split dollar life insurance	-	(0.1)
Net cash used in investing activities	210.9	(66.4)
NET INCREASE IN CASH AND CASH EQUIVALENTS	279.2	16.6
CASH AND CASH EQUIVALENTS, beginning of year	115.8	99.1
CASH AND CASH EQUIVALENTS, end of year	$ 395.0	$ 115.8

See accompanying notes.

Kern Health Systems
Statements of Cash Flows (Continued)
Years Ended December 31, 2024 and 2023

	2024 (Dollars in Millions)	2023 (Dollars in Millions)
Reconciliation of operating activities to net cash provided by operating activities		
Operating (loss) income	$ (67.8)	$ 40.3
Adjustments to reconcile operating (loss) income to net cash provided by operating activities		
Depreciation	8.6	8.3
Provision for allowance for doubtful provider advances	-	(0.1)
Changes in		
Deferred outflows of resources	1.6	(0.3)
Net pension liability	(0.4)	2.4
Deferred inflows of resources	(0.1)	(0.1)
Changes in working capital components		
(Increase) decrease in assets		
Premiums receivable and other receivables	156.1	9.6
MCO tax receivable	(20.7)	(343.2)
Hospital directed payments receivable	(93.7)	(25.2)
Prepaid expenses	(1.5)	(3.3)
Increase (decrease) in liabilities		
Accrued medical expenses payable	29.5	26.0
MCO tax payable	(20.7)	343.2
Hospital directed payments payable	95.2	25.4
Accrued expenses	3.3	3.0
Net cash provided by operating activities	$ 89.3	$ 86.0

See accompanying notes.

Kern Health Systems
Notes to Financial Statements

Note 1 – Nature of Activities and Summary of Significant Accounting Policies

Nature of activities – Kern Health Systems (KHS) was originally formed on August 17, 1993, as a non-profit public benefit corporation. It was later dissolved and converted into a County health authority for the purpose of establishing and operating a comprehensive managed care system to provide health care services; to meet the health care needs of low-income families and individuals in the County of Kern; to demonstrate ways of promoting quality care and cost efficiency; to negotiate and enter into contracts authorized by Welfare and Institute Code Section 14087.3; to arrange for the provision of health care services provided pursuant to Chapter 7, of Part 3, of Division 9 (commencing with Section 14000) of the Welfare and Institutions Code; and to do all things reasonably related or incidental to those purposes. On December 6, 1994, the County of Kern Board of Supervisors enacted Chapter 2.94 of the Ordinance Code, creating KHS as the County health authority.

Membership – For the period during which the Public Health Emergency ("PHE") was in effect, Medicaid programs were required to keep individuals continually enrolled through the end of the PHE. With the passage and signing of the Consolidated Appropriation Act of 2023 (ACT), the continuous coverage requirement ended resulting in a redetermination period where member eligibility was reviewed. KHS membership for 2024 was expected to decrease due to enrolled members no longer qualifying for Medi-Cal. However, effective January 1, 2024, there were changes to the available Managed Care Plans (MCPs) in Kern County. An existing commercial MCP health plan was replaced in Kern County by another and a separate MCP also entered into the market. Members previously assigned to the exiting MCP were given notice 90-days prior to January 1, 2024 to make a health plan selection. Members who did not choose were defaulted to one of the three available MCPs. KHS gained the largest portion of members previously assigned to the exiting MCP which resulted in unexpected membership growth in 2024.

A summary of KHS' significant accounting policies follows:

Accounting policies – KHS uses the accrual basis of accounting. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB). In addition, KHS follows the provisions of the American Institute of Certified Public Accountants *Audit and Accounting Guide, Health Care Organizations.*

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates with respect to KHS' financial statements include the various components of accrued medical expenses payable, the deferred outflows and inflows of resources, and the net pension liability.

Cash and cash equivalents – Cash and cash equivalents include highly liquid instruments with an original maturity of three months or less when purchased.

Investment valuation and income recognition – Investments in marketable securities with readily determinable fair values and all investments in debt securities are reported at their fair values in the statements of net position. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 3 for further discussion of fair value measurements.

Capital assets – Capital assets are stated at cost. Depreciation is computed by the straight-line method over the estimated service lives of the related assets, which are as follows:

Buildings and improvements	10 – 40 years
Computer hardware and software	5 years
Furniture and equipment	5 years

KHS' capitalization policy is to capitalize all items with a unit cost greater than five thousand with the exception of computer software, which has a per unit capitalization of ten thousand and an expected useful life of greater than one year. Items that do not meet KHS' capitalization policy and that do not have a useful life of greater than one year are expensed in the period acquired.

Accrued compensated absences – KHS implemented GASB Statement No. 101, Compensated Absences (GASB 101), effective January 1, 2024.The objective of GASB 101 is to better meet the information needs of financial statement users by updating the recognition and measurement guidance for compensated absences. GASB 101 requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. It also requires that a liability for specific types of compensated absences not be recognized until the leave is used. KHS was in compliance with GASB 101 prior to its issuance, therefore, the implementation of GASB 101 had no effect on the beginning net position as of January 1, 2024 of KHS.

KHS employees earn personal time off (PTO) on a bi-weekly or semi-monthly basis at various rates based on continuous years of service. Employees are allowed to accumulate up to three times their annual benefit rate before accruals cease. Unused PTO is carried forward into subsequent years. Any unused accumulated balance will be paid to the employee upon separation of service. Compensated balances are accrued and recorded in accrued expenses on the accompanying statements of net position and amounted to $5.3 million and $4.1 million as of December 31, 2024 and 2023, respectively, a net increase of $1.2 million.

Net position – The basic financial statements utilize a net position presentation. Net position is categorized as net investment in capital assets, restricted and unrestricted.

- *Net investment in capital assets* consists of capital assets net of accumulated depreciation, reduced by the current balance of any outstanding borrowings used to finance the purchase or construction of those assets.
- *Restricted* net position is non-capital net position that must be used for a particular purpose, as specified by regulators, creditors, grantors, or contributors external to KHS.
- *Unrestricted* net position is the remaining net position that does not meet the definition of net investment in capital assets or restricted.

Operating revenues and expenses – KHS distinguishes operating revenues and expenses from nonoperating items. Operating revenues and expenses generally result from providing services and delivering services in connection with KHS' principal ongoing operations. The principal operating revenues of KHS are premium revenue received from the California Department of Health Care Services (DHCS). Operating expenses include the cost of medical and hospital services provided to members and administrative expenses. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

In 2013, KHS entered into a capitated agreement required by the DHCS with another Health Plan, which allows for that plan to provide health care services for their assigned members. As KHS had no obligation to provide care for this population, the Premiums earned amount included as part of operating revenue is reported net of the capitated expense associated with assigned members. Capitated expense was $40.6 million for 15,226 members assigned for the year ended December 31, 2023. This contract ended on December 31, 2023.

Premiums revenue – Premiums are due monthly from DHCS and are recognized as revenues during the period in which KHS is obligated to arrange payments for managed health care services provided to KHS members. Centers for Medicare and Medicaid Services (CMS) requires that the rates used in KHS' premiums are to be actuarially sound. Premium revenue is fixed in advance of the periods covered on a per member per month (PMPM) basis and are generally not subject to significant accounting estimates. Premium payments received from DHCS are based on an eligibility list produced by DHCS and are subject to eligibility redeterminations and enrollment backlogs related to the renewal of Medi-Cal coverage. Premium payments are required to be returned if DHCS later discovers that the eligibility list contains individuals who were not eligible. KHS' PMPM rates are typically adjusted annually. KHS receives additional premium revenue in the form of a "maternity kick payment", which is a one-time payment for the delivery of a child. For the years ended December 31, 2024 and 2023, maternity kick payments in the amount of $49.9 million or 3.2% and $39.8 million or 3.3%, respectively, of total premium revenues were recognized.

KHS receives supplemental revenue funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) for the purpose of paying additional amounts for qualifying physician services based on certain specified eligible current procedural terminology (CPT) procedure codes. For the years ended December 31, 2024 and 2023, Proposition 56 payments in the amount of $18.9 million or 1.2% and $76.0 million or 6.3%, respectively, of total premium revenues were recognized. Proposition 56 physician services supplemental payments ended December 31, 2023 as DHCS has developed Targeted Rate Increases (TRI) for providers in Medi-Cal effective for dates of service on or after January 1, 2024. The TRI for targeted services is to be no less than 87.5% of the Medicare rate. For the year ended December 31, 2024 KHS received $110.7 million in TRI payments or approximately 7.2% of total premium revenues. KHS also receives supplemental Ground Emergency Medical Transportation (GEMT) revenue provided for the purpose of paying additional amounts to qualifying GEMT providers based on certain specified eligible CPT procedure codes. For the years ended December 31, 2024 and 2023, GEMT payments in the amount of $7.3 million or 0.5% and $6.4 million or 0.5%, respectively, of total premium revenue were recognized.

Premiums are also subject to prior year retroactive rate adjustments based on actual and expected health care costs and are recognized when known in the current year. For the years ended December 31, 2024 and 2023, KHS recognized a net reduction of $5.4 million or (0.3%) and a net increase of $3.8 million or 0.2%, respectively, of premium revenue as a result of retroactive membership and rate adjustments.

KHS' premiums may be periodically amended to include or exclude certain health benefits such as pharmacy and behavioral health treatment and major organ transplants services or introduce new programs such as the services provided under the Enhanced Care Management Program (ECM). Premium rates can also be amended to include supplemental payments for providers, such as those paid under Proposition 56 or GEMT, or to cover a new population of members such as seniors and persons with disabilities (SPD) expansion members and long-term care services.

Health care service cost recognition – KHS contracts with various health care providers for the provision of certain medical care services to its members. The provider network consists of primary and specialty care physicians, hospitals, ancillary providers and pharmacies. KHS compensates most of these providers on a fee for services basis. Under fee for service arrangements, KHS retains the financial responsibility for medical care provided along with the costs incurred based on the actual utilization of services. The cost of health care services provided but unpaid is accrued in the period in which it is provided to a member based in part on estimates, including an accrual for medical services provided but not reported to KHS. KHS also includes certain medically related administrative costs such as preventative health and wellness, care management, health education, disease management, 24 hour on-call nurses and other quality improvement costs under medical care services. KHS funds a provider performance quality incentive pool on a PMPM basis. Provider participation is based on the similar Managed Care Accountability Set (MCAS) scores that DHCS uses to measure KHS in determining member assignment. KHS determines the level of provider participation based on MCAS scores, with any remaining funds in the pool allocated to the following year incentive pool, community grants, or other quality improvement projects.

Income taxes – KHS is exempt from Federal and State income taxes pursuant to Internal Revenue Code (IRC) Section 115 and similar provisions of the California Franchise Tax Code and is also exempt from Federal and State income tax filing requirements.

Managed Care Organization premium taxes – Beginning July 1, 2016, under Senate Bill X2-2, the Managed Care Organization (MCO) tax rate was payable to DHCS on a quarterly basis based on projected annual membership. MCO Tax Revenue is received from DHCS monthly based on actual membership on a per member per month fixed dollar amount. This change in MCO tax methodology puts KHS at risk if the assumed membership used in the calculated tax expense is different than the actual membership KHS experiences during the rate year. The premium revenues received include the premium tax assessment. These amounts are reported on a gross basis and are included in total operating revenues with the MCO tax expense presented separate from all other medical and administrative expense. Due to the pause in member redeterminations and continued increases in member enrollment, Medi-Cal plans received significantly more MCO tax revenue than was required to be paid in quarterly MCO tax expense. DHCS indicated excess funds received were subject to recoupment. For the years ended December 31, 2024 and 2023, KHS recognized MCO tax revenue of $709.4 million and $376.7 million, respectively. For the years ended December 31, 2024 and 2023, KHS recognized, MCO tax expense in the amount of $709.4 million and $376.5 million, respectively.

Risk management – KHS is exposed to various risks of loss from Health Insurance Portability and Accountability Act (HIPAA) violations; data breaches from cyber-attacks; torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; and natural disasters. Commercial insurance coverage is purchased for claims arising from such matters.

Pass-through funding from DHCS – During the years ended December 31, 2024 and 2023, KHS received $164.9 million and $92.4 million, respectively, of supplemental hospital quality assurance (HQAF) fee revenue from DHCS. KHS passes these funds through to the designated hospitals and providers. This amount is not reflected in the statements of revenues, expenses, and changes in net position for the years ended December 31, 2024 and 2023, as this pass-through amount does not meet the requirements for revenue recognition under Governmental Accounting Standards.

Premium deficiency reserve – KHS performs periodic analyses of its expected future healthcare costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. KHS's management determined that no premium deficiency reserves were necessary as of December 31, 2024 and 2023.

Advertising – KHS expenses advertising costs as they are incurred. Advertising expenses totaled $2.1 million and $1.7 million for the years ended December 31, 2024 and 2023, respectively.

Reclassifications – Certain items in the financial statements as of and for the year ended December 31, 2023 have been reclassified to conform to the presentation of the financial statements as of and for the year ended December 31, 2024, with no effect on change in net position.

Subsequent events – KHS has evaluated subsequent events through April 4, 2025, the date on which the financial statements were available to be issued. There were no subsequent events identified by management that would require disclosure in the financial statements.

Recently adopted authoritative pronouncements – In June 2022, the GASB issued Statement No. 100, *Accounting Changes and* Error Corrections – *An Amendment of GASB Statement No. 62* (GASB 100). The primary objective of this Statement is to enhance accounting and financial reporting requirements for accounting changes and error corrections to provide more understandable, reliable, relevant, consistent, and comparable information for making decisions or assessing accountability.

This Statement defines accounting changes as changes in accounting principles, changes in accounting estimates, and changes to or within the financial reporting entity and describes the transactions or other events that constitute those changes. As part of those descriptions, for (1) certain changes in accounting principles and (2) certain changes in accounting estimates that result from a change in measurement methodology, a new principle or methodology should be justified on the basis that it is preferable to the principle or methodology used before the change. That preferability should be based on the qualitative characteristics of financial reporting—understandability, reliability, relevance, timeliness, consistency, and comparability. This Statement also addresses corrections of errors in previously issued financial statements.

This Statement prescribes the accounting and financial reporting for (1) each type of accounting change and (2) error corrections. This Statement requires that (a) changes in accounting principles and error corrections be reported retroactively by restating prior periods, (b) changes to or within the financial reporting entity be reported by adjusting beginning balances of the current period, and (c) changes in accounting estimates be reported prospectively by recognizing the change in the current period. The requirements of this Statement for changes in accounting principles apply to the implementation of a new pronouncement in absence of specific transition provisions in the new pronouncement. This Statement also requires that the aggregate amount of adjustments to and restatements of beginning net position, fund balance, or fund net position, as applicable, be displayed by reporting unit in the financial statements.

This Statement requires disclosure in notes to financial statements of descriptive information about accounting changes and error corrections, such as their nature. In addition, information about the quantitative effects on beginning balances of each accounting change and error correction should be disclosed by reporting unit in a tabular format to reconcile beginning balances as previously reported to beginning balances as restated.

Furthermore, this Statement addresses how information that is affected by a change in accounting principle or error correction should be presented in required supplementary information (RSI) and supplementary information (SI). For periods that are earlier than those included in the basic financial statements, information presented in RSI or SI should be restated for error corrections, if practicable, but not for changes in accounting principles.

KHS adopted GASB 100 as of January 1, 2024, however, it did not have a significant impact on the financial statements.

KHS implemented GASB Statement No. 96, *Subscription-Based Information Technology Arrangements* (GASB 96), as of January 1, 2024. GASB 96 provides guidance on the accounting and financial reporting for SBITAs for government end users (governments). GASB 96 (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. See Note 8 for further discussion of SBITAs.

Authoritative pronouncements not yet adopted – In December 2023, the GASB issued Statement No. 102, *Certain Risk Disclosures* (GASB 102). State and local governments face a variety of risks that could negatively affect the level of service they provide or their ability to meet obligations as they come due. Although governments are required to disclose information about their exposure to some of those risks, essential information about other risks that are prevalent among state and local governments is not routinely disclosed because it is not explicitly required. The objective of this Statement is to provide users of government financial statements with essential information about risks related to a government's vulnerabilities due to certain concentrations or constraints.

This Statement defines a concentration as a lack of diversity related to an aspect of a significant inflow of resources or outflow of resources. A constraint is a limitation imposed on a government by an external party or by formal action of the government's highest level of decision-making authority. Concentrations and constraints may limit a government's ability to acquire resources or control spending.

This Statement requires a government to assess whether a concentration or constraint makes the primary government reporting unit or other reporting units that report a liability for revenue debt vulnerable to the risk of a substantial impact. Additionally, this Statement requires a government to assess whether an event or events associated with a concentration or constraint that could cause the substantial impact have occurred, have begun to occur, or are more likely than not to begin to occur within 12 months of the date the financial statements are issued.

If a government determines that those criteria for disclosure have been met for a concentration or constraint, it should disclose information in notes to financial statements in sufficient detail to enable users of financial statements to understand the nature of the circumstances disclosed and the government's vulnerability to the risk of a substantial impact. The disclosure should include descriptions of the following:

- The concentration or constraint;
- Each event associated with the concentration or constraint that could cause a substantial impact if the event had occurred or had begun to occur prior to the issuance of the financial statements;
- Actions taken by the government prior to the issuance of the financial statements to mitigate the risk.

The requirements of this Statement are effective for fiscal years beginning after June 15, 2024, and all reporting periods thereafter. Earlier application is encouraged. Management is evaluating the implementation of this statement on their financial statements.

In April 2024, GASB issued Statement No. 103, *Financial Reporting Model Improvements* (GASB 103). The objective of GASB 103 is to improve key components of the financial reporting model. The purposes of the improvements are to (a) enhance the effectiveness of the financial reporting model in providing information that is essential for decision making and assessing a government's accountability and (b) address certain application issues identified through preagenda research conducted by the GASB. GASB 103 is effective for KHS during the year ended December 31, 2026. Management is evaluating the implementation of this statement on their financial statements.

In September 2024, GASB issued Statement No. 104, *Disclosure of Certain Capital Assets* (GASB 104). The objective of GASB 104 is to provide users of government financial statements with essential information about certain types of capital assets. GASB 104 requires certain types of capital assets to be disclosed separately in the capital assets note disclosures required by Statement 34. Lease assets recognized in accordance with Statement No. 87, Leases, and intangible right to use assets recognized in accordance with Statement No. 94, Public-Private and Public-Public Partnerships and Availability Payment Arrangements, should be disclosed separately by major class of underlying asset in the capital assets note disclosures. Subscription assets recognized in accordance with Statement No. 96, Subscription- Based Information Technology Arrangements (SBITAs), also should be separately disclosed. In addition, this Statement requires intangible assets other than those three types to be disclosed separately by major class. GASB 104 also requires additional disclosures for capital assets held for sale. A capital asset is a capital asset held for sale if (a) the government has decided to pursue the sale of the capital asset and (b) it is probable that the sale will be finalized within one year of the financial statement date. Governments should consider relevant factors to evaluate the likelihood of the capital asset being sold within the established time frame. This Statement requires that capital assets held for sale be evaluated each reporting period. Governments should disclose (1) the ending balance of capital assets held for sale, with separate disclosure for historical cost and accumulated depreciation by major class of asset, and (2) the carrying amount of debt for which the capital assets held for sale are pledged as collateral for each major class of asset. GASB 104 is effective for KHS during the year ended December 31, 2026. Management is evaluating the implementation of this statement on their financial statements.

Note 2 – Cash, Cash Equivalents, and Investments

Cash, cash equivalents and investments as of December 31, 2024, are classified in the accompanying financial statements as follows:

Cash and cash equivalents	(Dollars in Millions)
Deposits	$ 11.4
Treasury bills, Local Agency Investment Fund (LAIF), and money market funds	383.6
Cash on hand	-
Total cash and cash equivalents	$ 395.0

	Cost	Fair Value
Investments		
Unrestricted		
Government agency bonds and notes	$ 159.5	$ 159.3
Corporate bonds and notes	66.4	66.7
Total unrestricted	225.9	226.0
Restricted		
Certificates of deposit	0.3	0.3
Total investments	$ 226.2	$ 226.3

Kern Health Systems
Notes to Financial Statements

Cash, cash equivalents and investments as of December 31, 2023, are classified in the accompanying financial statements as follows:

	(Dollars in Millions)
Cash and cash equivalents	
Deposits	$ 9.2
Treasury bills, Local Agency Investment Fund (LAIF), and money market funds	106.5
Cash on hand	-
Total cash and cash equivalents	$ 115.8

	Cost	Fair Value
Investments		
Unrestricted		
Government agency bonds and notes	$ 327.0	$ 327.2
Corporate bonds and notes	78.9	78.9
Total unrestricted	405.9	406.1
Restricted		
Certificates of deposit	0.3	0.3
Total investments	$ 406.2	$ 406.4

Investments are principally held in debt securities and are classified as current assets without regard to the securities' contractual dates because they may be readily liquidated. The securities are recorded at fair value with unrealized gains and losses, if any, recorded on a quarterly basis.

Certificates of deposit are carried at cost plus accrued interest. The bank balances are protected by a combination of Federal Deposit Insurance Corporation (FDIC) insurance and the bank's collateral pool, in accordance with California Government Code.

Investments authorized by KHS' investment policy – The investment portfolio is managed by KHS' Chief Financial Officer (CFO) to meet the short and long-term obligations of the business while maintaining liquidity and financial flexibility. Investments managed by the CFO are invested in accordance with KHS' investment policy and are reviewed by the KHS Board of Directors and the KHS Finance Committee quarterly. The investment policy stipulates the following order of investment objectives:

- Preservation of principal
- Liquidity
- Yield

Permitted investments are subject to a maximum maturity of five years. The investment portfolio is designed to attain a market-average rate of return through economic cycles given an acceptable level of risk. Additionally, under the supervision of the CFO, a portion of the investment portfolio is managed by an investment manager that adheres to the KHS investment policy.

The table below identifies the cash equivalent and investment types that are authorized by the KHS investment policy.

Authorized Investment Type	Maximum Maturity	Maximum Percentage of Portfolio	Maximum Investment of Portfolio of One Issuer	Allowed or Maximum Ratings
U.S. Treasury obligations	5 years	100%	None	Note rated
Federal agencies and U.S. government enterprises	5 years	100%	35%	Not rated
State of California and local agency obligations	5 years	100%	5%	A-1
State and local agency obligations outside of California	5 years	20%	5%	A-1
Banker's acceptances	180 days	40%	(1)	A-1
Commercial paper	270 days	25%	(2)	A-1
Negotiable certificates of deposit	5 years	30%	5% (7)	A-1
Government repurchase agreements	1 year	100%	(3)	A-1
Corporate debt securities	5 years	40%	(5)	A
Money market funds	5 years	40%	(4)	AAA
Mortgage or asset-backed securities	5 years	20%	(6)	AAA
Variable and floating rate securities	5 years	30%	5%	AAA
LAIF	5 years	50%	5%	Not rated

(1) May not exceed the 5.0% limit of any one commercial bank and may not exceed the 5.0% limit for any security on any bank.
(2) May not exceed more than 10.0% of the outstanding commercial paper of the issuing corporation.
(3) May not exceed 50.0% if maturity is less than or equal to 7 days; 25.0% if maturity is greater than 7 days.
(4) May not exceed more than 10.0% of the money market fund's assets.
(5) Medium-term notes or other corporate security of any one corporate issuer must not exceed more than 5.0% of the portfolio.
(6) Rated AAA by a nationally recognized rating service and issued by an issuer having an A or better rating for its long-term debt.
(7) Maturities greater than one year and less than five years may not exceed the FDIC Insurance maximum at the time of purchase.

Disclosures relating to interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. The longer the maturity of an investment, the greater the sensitivity of its fair value to changes in the market interest rates. Generally, investments will decrease in value if interest rates increase.

Disclosures relating to credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. KHS is required to disclose the rating for all investments. Cash invested in the LAIF is considered "exempt from disclosure" under GASB Codification Section 150.

GASB Codification Section 150 requires disclosure of any investments of any single issuer in excess of 5.0% of its total investments, excluding investments issued or explicitly guaranteed by the U.S. government and investments in mutual funds, external investment pools, and other pooled investments. There were no investments of any single issuer that exceeded 5.0% of its total investments as of December 31, 2024 or 2023.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, KHS will not be able to recover its deposits or not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, KHS will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code and KHS' investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits or investments, other than the following provision for deposits: The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110.0% of the total amount deposited by the public agencies.

Cash equivalents in State investment pool – KHS is a voluntary participant in the LAIF that is regulated by California Government Code Section 16429 under the oversight of the Treasurer of the State of California. The fair value of the KHS' investment in this pool is reported in the accompanying financial statements at amounts based upon the KHS' pro-rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to be the amortized cost of that portfolio). The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on an amortized cost basis.

Note 3 – Fair Value Measurements

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3).

The three levels of the fair value hierarchy under ASC 820 are described below:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that KHS has the ability to access.

Level 2 – Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.
- If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. Certificates of deposit: Valued based on amortized cost or original cost-plus accrued interest.

Corporate, Municipal and Government agency bonds and notes: Valued at the closing price reported on the active market on which the individual securities are traded.

All investments held by KHS as of December 31, 2024 and 2023, are considered to be Level 1 assets.

KHS invests in professionally managed portfolios that contains bonds of publicly traded companies and

U.S. Government obligations. Such investments are exposed to various risks such as interest rate, market and credit. Due to the level of risk associated with such investments and the level of uncertainty related to changes in the value of such investments, it is at least reasonably possible that changes in risks in the near term would materially affect investment balances and the amounts reported in the financial statements.

Note 4 – Hospital Directed Payments

Beginning with the July 1, 2017 rating period, the DHCS implemented two statewide directed payment programs for designated public hospitals (DPH), the Enhanced Payment Program (EPP) and the Quality Incentive Program (QIP), and one statewide directed payment program for private hospitals (PHDP). EPP provides supplemental reimbursement to network provider DPHs through uniform dollar increases for select inpatient and non-inpatient services, based on the actual utilization of qualifying services as reflected in encounter data reported to DHCS. QIP provides quality incentive payments to participating network provider DPHs that meet quality metrics designated in the program. PHDP provides supplemental reimbursement to participating network provider hospitals through uniform dollar increases for select inpatient and outpatient services based on actual utilization of qualifying services as reflected in encounter data reported to DHCS. The hospital directed payment programs were created to maintain access and improve the quality of care for Medi-Cal beneficiaries. These programs direct MCP, like KHS, to pay specified contracted network providers in accordance with terms approved by CMS and directed by DHCS.

The projected value of the program payment obligations to designated hospitals are accounted for as medical expenses and paid through additional capitation revenue. Due to the timing of the program acceptance by CMS and delays in funding to MCPs, final rates of the various hospital directed payment programs are not available until paid. KHS accrued hospital directed payments receivable of $555.7 million and hospital directed payments payable of $557.2 million as of December 31, 2024. For the year ended December 31, 2023, KHS accrued hospital directed payments receivable of $462.0 million and hospital directed payments payable of $462.0 million. The amount of premium revenue for hospital directed payment programs recognized for the years ended December 31, 2024 and 2023, was $288.8 million and $233.3 million, respectively, and is reported as part of operating revenues on the accompanying statements of revenues, expenses, and changes in net position. Hospital directed payment expense obligations recognized for the years ended December 31, 2024 and 2023, were $291.6 million and $231.9 million, respectively, and are reported as part of operating expenses on the accompanying statements of revenues, expenses, and changes in net position. As stated above, KHS has very little visibility as to the timing of these payments until actually paid by DHCS.

Note 5 – Other Receivables

Other receivables consist of the following as of December 31, 2024 and 2023:

	(Dollars in Millions) 2024	2023
Provider receivable	$ 2.4	$ 1.4
Interest	0.2	0.4
Other	-	0.5
	$ 2.6	$ 2.3

Kern Health Systems
Notes to Financial Statements

Note 6 – Capital Assets

Capital asset activity for the years ended December 31, 2024 and 2023, is as follows:

(Dollars in Millions)

	Balance January 1, 2024	Additions	Deletions	Transfers	Balance December 31, 2024
Capital assets not being depreciated					
Land	$ 4.1	$ -	$ -	$ -	$ 4.1
Capital projects in progress	2.3	6.8	-	(8.2)	1.0
Subtotal	6.4	6.8	-	(8.2)	5.1
Capital assets being depreciated					
Buildings and improvements	37.0	-	-	0.9	37.9
Computer hardware and software	48.8	1.6	(0.9)	6.6	56.1
Furniture and equipment	4.8	0.2	(0.1)	0.7	5.6
Subtotal	90.6	1.9	(1.0)	8.2	99.6
Accumulated depreciation					
Buildings and improvements	3.9	0.9	-	-	4.8
Computer hardware and software	30.2	6.9	(0.9)	-	36.2
Furniture and equipment	3.8	0.7	(0.1)	-	4.4
Subtotal	37.8	8.6	(1.0)	-	45.4
Net depreciable capital assets	52.8	(6.7)	-	8.2	54.2
Total capital assets	$ 59.1	$ 0.1	$ -	$ -	$ 59.3

(Dollars in Millions)

	Balance January 1, 2023	Additions	Deletions	Transfers	Balance December 31, 2023
Capital assets not being depreciated					
Land	$ 4.1	$ -	$ -	$ -	$ 4.1
Capital projects in progress	2.2	1.8	-	(1.7)	2.3
Subtotal	6.3	1.8	-	(1.7)	6.4
Capital assets being depreciated					
Buildings and improvements	36.7	-	-	0.3	37.0
Computer hardware and software	46.9	1.0	(0.3)	1.2	48.8
Furniture and equipment	4.4	0.1	(0.0)	0.3	4.8
Subtotal	88.0	1.2	(0.3)	1.7	90.6
Accumulated depreciation					
Buildings and improvements	3.0	0.9	-	-	3.9
Computer hardware and software	23.8	6.7	(0.3)	-	30.2
Furniture and equipment	3.2	0.6	(0.0)	-	3.8
Subtotal	29.9	8.3	(0.3)	-	37.8
Net depreciable capital assets	58.1	(7.1)	(0.0)	1.7	52.8
Total capital assets	$ 64.4	$ (5.3)	$ (0.0)	$ -	$ 59.1

Note 7 – Split-Dollar Life Insurance

In October 2017, KHS entered into a split-dollar life insurance agreement with a key employee and his beneficiary, whereby the employee is eligible to receive distributions, and KHS will receive $0.8 million upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $0.8 million and $0.9 million as of December 31, 2024 and 2023, respectively.

In June 2020, KHS entered into a second split-dollar life insurance agreement with the same employee and his beneficiary as the 2017 agreement, whereby the employee is eligible to receive distributions, and KHS will receive $0.8 million upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $0.8 million as of December 31, 2024 and 2023.

The employee retired from KHS in July 2022; however, the above agreements remain in place.

Note 8 – Subscription Based Information Technology Arrangements

GASB 96 statement regarding the recording of software subscription licenses was implemented as of January 1, 2024. The statement requires implementation to be applied retroactively by restating financial statements, if practicable, for all fiscal years presented. Restatement of prior fiscal years was not practicable due to incomplete available information and there was no cumulative effect of implementation on the beginning net position.

KHS is the end user for various short-term SBITAs. Short-term SBITAs that have a term of 12 months or less, are recognized as an outflow of resources when payment is made. For SBITAs with subscription terms extending beyond one year, KHS recognizes an intangible right to use subscription asset and a corresponding subscription liability on the accompanying statements of net position. The Plan has several subscription contracts that expire at various dates through 2029, some of which have renewal options. For those contracts where renewal options are reasonably certain to be exercised, the Plan recognizes renewal option periods in the determination of its intangible right to use subscription asset and subscription liability balances. The Plan uses rates ranging from 4.75% to 8.5% to determine the present value if its subscriptions liabilities.

KHS had the following intangible right to use subscription asset and subscription liability activities for the year ended December 31, 2024:

(Dollars in Millions)

	Balance January 1, 2024	Increase	Decrease	Balance December 31, 2024
Intangible right to use subscription asset	$ 8.0	$ 7.3	$ -	$ 15.3
Less accumulated amortization	-	(6.4)	-	(6.4)
Total Intangible right to use subscription asset, net	8.0	0.9	-	8.9
Subscription liability	$ 2.8	$ 7.3	$ (2.3)	$ 7.7

For the year ended December 31, 2024, KHS recognized $6.4 million in amortization expense, which is included in administrative expenses on the accompanying statements of revenues, expenses, and changes in net position.

The future principal and interest subscription payments as of December 31, 2024, were as follows:

	(Dollars in Millions)		
Years Ending June 30,	Principal	Interest	Total
2025	$ 2.2	$ 0.5	$ 2.7
2026	2.2	0.4	2.5
2027	1.3	0.3	1.6
2028	1.4	0.2	1.6
2029	0.6	0.2	0.8
	$ 7.7	$ 1.5	$ 9.2

Note 9 – Accrued Medical Expenses Payable

KHS accrues a liability of unpaid claims for medical services, including estimates of costs related to incurred but not yet reported (IBNR) claims using standard actuarial development methodologies based upon historical data. This data includes the period between the dates services are rendered, and the dates claims are received and paid, expected medical cost inflation, utilization trends, seasonality patterns, prior authorization of medical services, provider contract changes and/or changes in Medi-Cal fee schedules and changes in membership. A key component of KHS' IBNR estimation process is the completion factor, which is a measure of how complete the claims paid to date are relative to the estimate of the claims for services rendered in a given period. The completion factors are more reliable for claims incurred that are older than three months and are more volatile and less reliable for more recent periods, since a large portion of health care claims are not submitted to KHS until several months after services have been rendered. Accordingly, for the most recent months, the incurred claims are estimated from a trend analysis based on per member per month claims trends developed from the experience in preceding months.

The majority of the IBNR reserve balance held at year-end is associated with the most recent months' incurred services as these are the services for which the fewest claims have been paid. As mentioned in the preceding paragraph, the degree of uncertainty in the estimates of incurred claims is greater for the most recent months' incurred services.

Additionally, KHS contracts with an independent actuary to review the IBNR estimates. The independent actuary provides KHS with a review letter that includes the results of their analysis of the IBNR reserve. Actuarial Standards of Practice generally require that the medical claims liability be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. It is likely that claim amounts ultimately paid will be less than the estimate that satisfies the Actuarial Standards of Practice. This analysis is used as additional information, together with management's judgment, to determine the assumptions used in the calculation of the IBNR reserve.

KHS consistently applies the IBNR estimation from period to period. Any adjustments from the prior year are included in the current period as a change in accounting estimate. As more complete additional information becomes known, KHS will adjust assumptions accordingly to change the IBNR estimate. KHS recognized $4.7 million and $14.1 million of favorable prior year IBNR adjustments for the years ended December 31, 2024 and 2023, respectively, due to lower-than-expected utilization.

Proposition 56 and TRI – On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco revenue is allocation to the DHCS for use as the nonfederal share of health care expenditures in accordance with the annual state budget process. Proposition 56 appropriated funds resulted in directed payments made to Medi-Cal managed care health plans for the purposes of paying additional amounts for qualifying physician services based on certain specified CPT procedure codes. The directed payments are subject to a minimum medical expenditure percentage and a portion of capitation payments attributed to this directed payment arrangement will be subject to a two-sided risk corridor. As of December 31, 2024 and 2023, KHS had accrued $23.8 million and $55.8 million, respectively, in payments to providers for Proportion 56. If less than the targeted amount accrued is paid to providers, amounts will be returned to the State through the performance of DHCS' risk corridor calculation. Proposition 56 physician services supplemental payments ended December 31, 2023, as DHCS developed TRIs for providers in Medi-Cal effective for dates of service on or after January 1, 2024. The TRI for targeted services are to be no less than 87.5% of the Medicare rate. As of December 31, 2024, KHS has accrued $15.6 million in payments to providers for TRI.

Bridge risk corridor – Due to the unprecedented circumstances of the COVID-19 pandemic, DHCS and its contracted actuary determined that a two-sided, symmetrical risk corridor (bridge corridor) would appropriately provide protection for both the State and MCPs like KHS. The purpose of the risk corridor is to mitigate potentially significant upward or downward risk associated with COVID-19 that was not determinable at the time of rate development. The bridge corridor was retroactive to July 1, 2019 and is based on an estimate provided by guidance obtained from DHCS. As of December 31, 2024 and 2023, KHS had accrued $25.5 million owed to the state for the rate period July 1, 2019 through December 31, 2020.

Accrued medical expenses payable consist of the following as of December 31, 2024 and 2023:

	(Dollars in Millions) 2024	2023
Estimated incurred but not reported claims	$ 146.6	$ 123.6
Claims payable	28.4	18.2
Bridge risk corridor	25.5	25.5
Supplemental proposition 56 provider payments	23.8	55.8
Major organ transplant	18.5	11.2
Targeted rate increase (TRI) liability	15.6	-
Enhanced care management (ECM) risk corridor	11.5	9.2
Provider performance quality incentive	7.0	6.3
Allowance for claims processing expense	4.8	3.8
Unsatisfactory immigration status (UIS) risk corridor	1.2	-
California Advancing and Innovating Medi-Cal (CalAIM) incentive	0.4	0.4
Distinct part nursing facility liability	0.1	-
	$ 283.3	$ 253.8

Note 10 – Accrued Expenses

Accrued expenses consist of the following as of December 31, 2024 and 2023:

	(Dollars in Millions) 2024	2023
Salaries and employee benefits	$ 7.4	$ 5.6
Accounts payable	6.5	5.1
Other passthrough liability	0.9	1.3
CalPERS employee and employer contributions	0.5	0.8
Community grants payable	0.2	0.4
New building and construction	0.1	0.1
Other taxes and licenses	-	0.6
	$ 15.6	$ 13.9

Note 11 – Restricted Investments and Tangible Net Equity

As required by the State of California's Department of Managed Health Care (DMHC), Section 1300.76.1, KHS has acquired certificates of deposit with three financial institutions totaling $0.3. These certificates of deposit have been assigned to the Director of the Department of Managed Health Care as part of the process of obtaining and maintaining its Knox-Keene license and are legally restricted for this purpose. These certificates of deposit mature in amounts of $0.1 each on July 31, 2026, June 5, 2026 and June 8, 2026.

KHS is a fully licensed health-care service plan under the Knox-Keene Health Care Services Plan Act of 1975 (the Act). Under the Act, KHS is required to maintain a minimum level of tangible net equity. The required equity level was $78.7 million and $58.2 million as of December 31, 2024 and 2023, respectively. KHS' tangible net equity was $333.6 million and $380.2 million as of December 31, 2024 and 2023, respectively.

Note 12 – Employee Pension Plans

CalPERS

Plan description – All qualified permanent employees are eligible to participate in KHS' Miscellaneous Employee Pension Plan, a cost-sharing multiple-employer defined benefit pension plan administered by the California Public Employees' Retirement System (CalPERS). Benefit provisions under the Plan are established by State statute and Local Government resolution. CalPERS issues publicly available reports that include a full description of the pension plan regarding benefit provisions, assumptions and membership information that can be found on the CalPERS website at http://www.calpers.ca.gov.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments and death benefits to eligible employees. Benefits are based on years of credited service, equal to one year of full-time employment. Members with 5 years of total service are eligible to retire at age 50 or 52 (classic miscellaneous members or PEPRA miscellaneous members, respectively) with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: the Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost-of-living adjustments for each plan are applied as specified by the Public Employees' Retirement Law.

The Plans' provisions and benefits in effect as of December 31, 2024 and 2023, are summarized as follows:

	2024			2023	
		Classic	PEPRA	Classic	PEPRA
Hire date	Prior to January 1, 2013	On or After January 1, 2013	On or After January 1, 2013	On or After January 1, 2013	On or After January 1, 2013
Benefit formula	2% at 60	2% at 60	2% @ 62	2% at 60	2% @ 62
Benefit vesting schedule	5 years of service	5 years of service	5 years of service	5 years of service	5 years of service
Benefit payments	Monthly for life	Monthly for life	Monthly for life	Monthly for life	Monthly for life
Retirement age	50	50	52	50	52
Monthly benefits, as a percentage of eligible compensation	2%	2%	2%	2%	2%
Retirement employee contribution rates	7%	7.00%	7.75%	6.93%	7.75%
Required employer contribution rates	6.709% to 7.159%	10.10% to 10.15%	7.68% to 7.87%	8.63% to 10.100%	7.74% to 7.68%

Contributions – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. Funding contributions for both Plans are determined annually on the actuarial basis as of June 30 by CalPERS. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. KHS is required to contribute the difference between the actuarially determined rate and the contribution rate of employees.

For the years ended December 31, 2024 and 2023, the employer contributions recognized as part of pension expense were $5.3 million and $4.0 million, respectively.

Pension liabilities, pension expenses, and deferred outflows/inflows of resources related to pensions – As of December 31, 2024 and 2023, KHS reported a net pension liability for its proportionate share of the net pension liability of $12.3 million and $12.7 million, respectively.

KHS' fiduciary net pension as a percentage of KHS' total pension liability for the years ended December 31, 2024 and 2023, was 88.3% and 86.0%, respectively.

KHS' net pension liability is measured as the proportionate share of the net pension liability. The net pension liability is measured as of June 30, 2024, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2023, rolled forward to June 30, 2024, using standard update procedures. KHS' proportion of the net pension liability was based on a projection of KHS' long-term share of contributions to the plan relative to the projected contributions of all participating employers, actuarially determined. KHS' proportionate share of the net pension liability as of June 30, 2024 and 2023, was as follows:

Proportion, June 30, 2023	0.3995%
Proportion, June 30, 2024	0.4333%
Change - increase	0.0338%

KHS' net pension liability is measured as the proportionate share of the net pension liability. The net pension liability is measured as of June 30, 2023, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2022, rolled forward to June 30, 2023, using standard update procedures. KHS' proportion of the net pension liability was based on a projection of KHS' long-term share of contributions to the plan relative to the projected contributions of all participating employers, actuarially determined. KHS' proportionate share of the net pension liability as of June 30, 2023 and 2022, was as follows:

Proportion, June 30, 2022	0.3664%
Proportion, June 30, 2023	0.3995%
Change - increase	0.0331%

For the years ended December 31, 2024 and 2023, KHS recognized pension expense of $6.4 million and $6.7 million, respectively. As of December 31, 2024 and 2023, KHS reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

(Dollars in Millions)

	2024		2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Pension contributions subsequent to the measurement date	$ 3.3	$ -	$ 3.0	$ -
Changes in assumptions	0.5	-	1.2	-
Differences between expected and actual experiences	1.8	0.1	1.0	0.2
Net differences between projected and actual earnings on pension plan investments	1.2	-	3.2	-
Total	$ 6.8	$ 0.1	$ 8.4	$ 0.2

$3.3 million reported as deferred outflows of resources related to contributions subsequent to the measurement date will be recognized as an increase of the net pension liability in the year ending December 31, 2025. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended December 31,	(Dollars in Millions)
2025	$ 1.2
2026	2.7
2027	-
2028	(0.4)
	$ 3.5

Actuarial methods and assumptions – The total pension liabilities in the June 30, 2023 and 2022, actuarial valuations were determined using the following actuarial assumptions:

	2024	2023
Valuation date	June 30, 2023	June 30, 2022
Measurement date	June 30, 2024	June 30, 2023
Actuarial cost method	Entry-Age Normal Cost Method	
Actuarial assumptions		
Discount rate	6.90%	6.90%
Inflation	2.30%	2.30%
Payroll growth	2.80%	2.80%
Projected salary increase	Varies by Entry Age and Service	
Investment rate of return	7.00%(a)	7.00%(a)
Mortality	Derived using CalPERS' Membership Data for all Funds (b)	

(a) Net of pension plan investment and administrative expenses; includes inflation
(b) The mortality table used was developed based on CalPERS' specific data. The rates incorporate Generational Mortality to capture ongoing mortality improvements using 80.0% of Scale MP 2020 published by the Society of Actuaries.

Discount rate – The discount rate used to measure the total pension liability was 6.9% as of June 30, 2023 and 2022. To determine whether the municipal bond rate should be used in the calculation of a discount rate for the plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current discount rate of 6.9% as of June 30, 2023 and 2022, is adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 6.9% will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report that can be obtained from the CalPERS website at http://www.calpers.ca.gov.

Kern Health Systems
Notes to Financial Statements

According to Paragraph 30 of Statement 68, the long-term discount rate should be determined without reduction for pension plan administrative expense. The 6.9% as of June 30, 2023 and 2022, investment return assumption used in this accounting valuation is net of administrative expenses. Administrative expenses are assumed to be 15 basis points. An investment return excluding administrative expenses would have been 7.05% as of June 30, 2023 and 2022. Using this lower discount rate has resulted in a slightly higher Total Pension Liability and Net Pension Liability. CalPERS checked the materiality threshold for the difference in calculation and did not find it to be a material difference.

In determining the long-term expected rate of return, CalPERS took into account long-term market return expectations as well as the expected pension fund cash flows. Projected returns for all asset classes are estimated and combined with risk estimates, are used to project compound (geometric) returns over the long term. The discount rate used to discount liabilities was informed by the long-term projected portfolio return.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. The rates of return are net of administrative expenses.

Asset Class	Assumed Return Allocation	Real Return (1) (2)
Global Equity - Cap-weighted	30.0%	4.5%
Global Equity - Non-Cap-weighted	12.0%	3.8%
Private Equity	13.0%	7.3%
Treasury	5.0%	0.3%
Mortgage-backed Securities	5.0%	0.5%
Investment Grade Corporates	10.0%	1.6%
High Yield	5.0%	2.3%
Emerging Market Debt	5.0%	2.5%
Private Debt	5.0%	3.6%
Real Assets	15.0%	3.2%
Leverage	(5%)	(0.59%)

(1) An expected inflation of 2.3% was used for this period
(2) Figures are based on the 2021-22 Asset Liability Management study

Sensitivity of the proportionate share of the net pension liability to changes in the discount rate – The following presents KHS' proportionate share of the net pension liability, calculated using the discount rate, as well as what KHS' proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate:

	(Dollars in Millions) 2024	2023
1.0% decrease	5.9%	5.9%
Net pension liability	$ 20.5	$ 20.4
Current discount rate	6.9%	6.9%
Net pension liability	$ 12.3	$ 12.7
1.0% increase	7.9%	7.9%
Net pension liability	$ 5.5	$ 6.3

Pension plan fiduciary net position – Detailed information about the pension plan's fiduciary net position is available in the separately issued CalPERS financial reports.

Retirement Plan

Plan description and funding policy – KHS has a 401(a)-retirement plan, which was approved by the IRS on August 15, 1996. All full-time employees are eligible to participate in the Plan. KHS matches 100.0% of contributions made by KHS employees to their 457(b) plan up to a maximum of 6.0% of the employee's salary. KHS contributions do not vest until the employee has been employed for three years when at such time the employee becomes 100.0% vested. Participants are not allowed to make contributions to the Plan; only employer contributions are allowable. Expense determined in accordance with the plan formula was $2.8 million and $2.3 million for the years ended December 31, 2024 and 2023, respectively.

Note 13 – Reinsurance

KHS purchases reinsurance to reduce the risk associated with large losses on individual hospital claims. The premium costs are based on a deductible for each member in addition to a deductible layer for the plan referred to as an Aggregate Specific Retention amount.

For each of the years ended December 31, 2024 and 2023, coverage provides reimbursement of approximately 90 percent, of the cost of each member's acute care hospital admission(s) in excess of the deductibles, up to a maximum payable of $2.0 million per member per contract year.

For the years ended December 31, 2024 and 2023, the premium coverage is $0.28 and $0.27 PMPM, respectively, with no minimum annual premium requirement.

The deductible for each individual member was $0.35 for each of the years ended December 31, 2024 and 2023, and the Aggregate Specific Retention deductible was $0.20 PMPM and $0.23 PMPM, respectively, for the years ended December 31, 2024 and 2023.

Reinsurance premiums of $1.3 million and $1.1 million are included in medical and hospital expense on the accompanying statements of revenues, expenses, and changes in net position for the years ended December 31, 2024 and 2023, respectively. Reinsurance recoveries of $1.5 million and $2.2 million are included in operating revenues on the accompanying statements of revenues, expenses, and changes in net position for the years ended December 31, 2024 and 2023, respectively.

Note 14 – Commitments and Contingencies

Litigation – KHS is subject to litigation claims that arise in the normal course of business. A provision for a legal liability is made when it is both probable that a liability has been incurred and the amount of the loss can be reasonably estimated. These provisions, if any, are reviewed and adjusted to reflect the impacts of negotiations, estimated settlements, legal rulings, advice of legal counsel and other information and events pertaining to a matter. It is the opinion of management that there is no known existing litigation that would have a material adverse effect on the financial position, results of operations or cash flows of KHS.

Professional liability insurance – KHS maintains Managed Care Errors and Omissions Liability Insurance for an act, error, or omission in the performance of any health care or managed care services rendered by KHS. In addition, KHS maintains general liability insurance.

California Advancing and Innovating Medi-Cal (CalAIM) Program – Effective January 1, 2022, DHCS implemented CalAIM, a multi-year initiative aimed at improving the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of a broad delivery system, and program and payment reform across the Medi-Cal program. CalAIM's ECM and Community Support programs required significant investments in care management capabilities in which DHCS provided additional funding to Medi-Cal managed care plans. For the years ended December 31, 2024 and 2023, CalAIM initiative payments, including ECM funding and Housing and Homelessness Incentive Program (HHIP) funds, in the amount of $73.1 million or 4.7% and $48.1 million or 4.0%, respectively, of total premium revenues were recognized.

CalAIM is a multi-year initiative by DHCS to implement policy changes with the objectives of:

1. Reducing variation and complexity across the delivery system;
2. Identifying and managing member risk and need through population health management strategies; and
3. Improving quality outcomes and drive delivery system transformation through value-based initiatives and payment reform.

There are significant operational impacts to MCPs like KHS. Some examples include, transitioning the DHCS Health Homes Program and Whole Person Care Program to an Enhanced Care Management and Community Support Services programs along with additional Transplant services to MCPs, carve-in of Long Term Care to MCPs, requiring all MCPs to operate a Duals Special Needs Plan (D-SNP), a Student Behavioral Health Incentive Program to increase access to preventive, early intervention and behavioral health services for children, HHIP to address homelessness as a social determinant of health and keeping individuals housed, and requiring all MCPs to become NCQA accredited.

Regulatory matters – The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties. KHS is subject to periodic financial and information reporting and comprehensive quality assurance evaluations from state regulators. KHS regularly submits periodic financial, encounters, utilization and operational reports. Management believes that KHS is in compliance with fraud, waste and abuse laws, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretations as well as regulatory actions unknown or unasserted at this time.

DMHC conducted a routine medical audit in January 2023, as part of the regulatory oversight of medical services provisioned to KHS membership from September 1, 2020 through August 31, 2022. Upon completion of the audit, KHS was notified in March 2024 of audit findings related to emergency room and post stabilization denials for inpatient confinements. Corrective Action Plans (CAPs) were submitted to DMHC in March 2024 with a final report from DMHC received by KHS in October 2024. At that time, DMHC did not accept the Corrective Action Plans submitted and in turn, forwarded the audit findings to the Office of Enforcement (OOE). KHS continues to remediate the findings in preparation for OOE inquiry. To date, KHS has not been contacted by the OOE for additional information or audit. It is unknown if any adjustments from the audit findings would be material.

Changes in the regulatory environment and applicable laws and rules also may occur periodically in connection with political and administrative initiatives at the local, state, or national level. Much of the federal and state focus in 2022 and 2021 was related to the COVID-19 response. This included federal and state efforts to expand access to COVID testing and treatment services. The State budget also put forth retro-active and prospective rate reductions for Medi-Cal MCPs. Additionally, in 2022 and 2021 there were numerous temporary changes in regulatory requirements related to the COVID-19 PHE. Due to the State of California and Federal budget challenges, there could be a reduction on Medi-Cal spending such as reduced federal matching funds, which could limit future rate increases or reduce benefits to members, reversing the ACA expansion that enables coverage for all low-income childless adults, elimination of covering individuals with unsatisfactory immigration status, requiring Medi-Cal members to work, and limiting the amount of lifetime benefits for members.

The Governor's administration and the legislature also continue to consider a single-payer healthcare system for California.

Compliance – Our compliance efforts are aimed at prevention, detection, and resolution of variances.

The key components of the KHS's Compliance Plan are:

- Written policies and procedures
- Compliance leadership and oversight
- Effective training and education
- Effective lines of communication
- Enforcement Standards: consequences and incentives
- Risk Assessment, Auditing and Monitoring
- Responding to Detected Offenses and Developing Corrective Action Initiatives

The goal of our compliance program is to build a culture of integrity, ethics, and compliance, which is assessed periodically to measure engagement and effectiveness. Our program aims to mitigate risk for the organization protect privacy, maintain and promote high quality care delivery, and detect, prevent, and correct fraud, waste and abuse.

The Health Insurance Portability and Accountability Act – The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations adopted under HIPAA are intended to improve the portability and continuity of health insurance coverage and simplify the administration of health insurance claims and related transactions. All health plans are considered covered entities subject to HIPAA. HIPAA generally requires health plans, as well as their providers and vendors, to:

- protect patient privacy and safeguard individually identifiable health information; and
- establish the capability to receive and transmit electronically certain administrative health care transactions, such as claims payments, in a standardized format.

Specifically, the HIPAA Privacy Rule regulates use and disclosure of individually identifiable health information, known as "protected health information" (PHI). The HIPAA Security Rule requires covered entities to implement administrative, physical and technical safeguards to protect the security of electronic PHI. Certain provisions of the security and privacy regulations apply to business associates (entities that handle PHI on behalf of covered entities), and business associates are subject to direct liability for violation of these provisions. Furthermore, a covered entity may be subject to penalties as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity. HIPAA violations by covered entities may also result in civil and criminal penalties.

Information technology – KHS relies on effective and secure enterprise commercial information systems to support the operational processing and management of eligibility, benefits, payments, providers, clinical quality, benefit utilization, and clinical population oversight. These third-party systems, vendor relationships, and support models/contracts are critical in managing data that is essential for internal and external (regulators) oversight and require KHS to monitor data security measures to adhere to CMS and HIPAA regulations. This makes operations vulnerable to adverse effects if such third parties fail to perform adequately. KHS' Management Information Systems division is constantly engaged in the third-party contracts that govern these systems while reviewing technical architectures and roadmaps; third-party operational support function and models. Additionally, the department ensures business continuity and disaster recovery strategies are in place, leveraging both private and public cloud solutions to mitigate potential system disruptions. Due to rapid growth and the impact of COVID-19, KHS adapted to and now maintains a permanent hybrid telecommuting workforce. Operations, support teams, processes, and security have all been updated accordingly to sustain this new work model. KHS information systems necessitate continuous technical resource commitment for maintenance, protection, and enhancement. This includes keeping pace with evolving healthcare operations, information security standards, regulations, customer needs, acquisitions, and heightened security risks.

Cyber insurance – KHS maintains cyber insurance to reduce the financial risk associated from a cyber-attack and/or a data breach involving sensitive member or employee information. The policy also assists with notification costs and data restoration expenses.

Cybersecurity – The KHS cybersecurity program is an element of our enterprise-wide risk management practices. We use the NIST Cybersecurity Framework and ISO 27001 to guide the program utilizing policies, processes, and technologies to assess, identify, and manage the cybersecurity threats that we face. We use these policies, processes and technologies to identify internal and external threats, establish access control, data privacy and security measures, detect unauthorized activity, and respond to and recover from incidents. We leverage external experts and our internal threat and risk teams to assess potential threats, retain a third-party compliance firm to conduct penetration tests and health checks on our information systems, conduct cyber security and awareness training to help team members identify and manage common categories of cybersecurity threats, and utilize multiple defensive and investigative tools to identify active and potential threats. We leverage a 24/7 Security Operations Center (SOC) to ensure prompt response to potential security incidents that may occur outside business hours.

KHS' cybersecurity program also includes processes and controls to assess the cybersecurity risk associated with third-party vendors and partners. Following an initial assessment of the level of enterprise risk potentially posed by use of the third-party, the vendor is then subject to further risk-based assessments, the level of which depends upon the assigned risk value of the service being provided, which may include the completion of security questionnaires and the provision of independent security certifications.

Encounter data – KHS is required to submit complete and accurate encounter data to DHCS. The timely and precise reporting of encounter data is becoming increasingly important to determine compliance with performance standards and in setting KHS' premium rates. KHS submits encounters on a weekly basis allowing for continuous monitoring and to ensure that business operations can iteratively review submission rejections, denials, or errors for timely submission. Inaccurate encounter reporting could result in penalties and fines being assessed by DHCS.

Premium and eligibility reconciliations – Premium payments received by KHS from DHCS are based on eligibility lists generated between DHCS and by county agencies that are responsible for determining Medi-Cal eligibility. There were no significant recoupments during the years ended December 31, 2024 or 2023. Premium revenues could remain subject to reconciliation and recoupment for many years. The refund of a premium overpayment could be significant and would reduce the premium revenue in the year that the repayment obligation is identified.

Bridge risk corridor liability adjustment – Due to the unprecedented circumstances of the COVID-19 pandemic, DHCS and its contracted actuary determined that a two-sided, symmetrical risk corridor (bridge corridor) would appropriately provide protection for both the State and Medi-Cal MCPs like KHS. The purpose of the risk corridor is to mitigate potentially significant upward or downward risk associated with COVID-19 that was not determinable at the time of rate development. The bridge corridor was retroactive to July 1, 2019 and through December 31, 2020. The bridge corridor calculation is subject to the following adjustments:

- Revenue rate adjustments by DHCS
- The inclusion and/or exclusion of certain medical expenses
- Eligibility adjustments
- DHCS and CMS audit adjustments

Expansion risk corridor liability adjustment – The risk corridor liability is based on management's best estimate of a medical loss ratio estimate for KHS Expansion members that have medical expenses below 85.0% of premiums. KHS is required to refund to the State amounts below 85.0%. The calculation of the 85.0% medical loss ratio is subject to the following adjustments:

- Revenue rate adjustments by DHCS
- The inclusion and/or exclusion of certain medical expenses
- Eligibility adjustments
- DHCS and CMS audit adjustments

On April 1, 2019, KHS received notification from CMS that a California Medicaid Managed Care Medical Loss Ratio (MLR) Examination would be performed. The overall purpose of the MLR examinations performed by CMS is to ensure the financial information submitted by the Medicaid managed care plans like KHS and used by DHCS to perform MLR calculations for the newly eligible Expansion population was consistent with contractual obligations and matches each Medicaid MCP's internal data and accounting systems. CMS has engaged a contractor to review and assist with these examinations. The reporting periods under review are January 1, 2014 to June 30, 2015, and July 1, 2015 to June 30, 2016.

This examination has several objectives:

- Determine if the MLR was reasonably represented by Medicaid managed care plans, specifically whether the numerator was accurately reported to DHCS with appropriate documentation and consistent with generally accepted accounting principles;
- Assess if Medicaid managed care plans' provider incentive payments and payments to related party entities were consistent with California's contractual requirements and documented appropriately;
- Focus on Medicaid managed care plans who required multiple re-submissions of their MLR calculations to DHCS to determine the cause of those re-submissions and if the causes of the re-submissions have been corrected;
- Determine and understand what factors are responsible for large variations across Medicaid managed care plans in components of their MLR calculations to ensure that the Medicaid managed care plans have sufficient documentation related to the factors to support the MLR calculations.

As of December 31, 2024, KHS had not received any additional correspondence from CMS or the contractor designated to perform the examinations. It is unknown if there will be any adjustments resulting from the MLR examinations and whether such adjustments would be material. No liability had been recorded as of December 31, 2024 or 2023 related to this risk corridor liability.

Any adjustments to the bridge risk corridor liability or expansion risk corridor liability amounts could be significant and would increase or decrease reported medical expenses in the year the adjustment is required.

New MLR requirement beginning January 1, 2024 – Effective January 1, 2024, managed care plans like KHS must return funds to DHCS if their MLR falls below 85.0%. There was no liability recorded related to this requirement as of December 31, 2024.

Patient Protection and Affordable Care Act – In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transformed the U.S. health-care system and increased regulations within the U.S. health insurance industry. This legislation expanded the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that took effect from 2010 through 2020, with most measures effective in 2014. Under the Healthcare Reform Legislation, Medi-Cal coverage expanded as of January 2014 to nearly all low-income people under age 65 with income at or below 138.0% of the federal poverty line. The federal government paid 100.0% of the entire cost for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016, 95.0% in 2017, 94.0% in 2018, 93.0% in 2019, 90.0% from 2020 to 2024. For the years ended December 31, 2024 and 2023, KHS served an average of 114,934 and 98,676 Medi-Cal Expansion members per month, respectively, which generated revenues of approximately $535.4 million and $433.9 million, respectively.

Note 15 – Concentration of Revenue

KHS' operating revenue is primarily derived from DHCS. KHS' current contract term with DHCS is to provide health care services through December 31, 2025 and is subject to cancellation upon DHCS providing at least 60 days written notice and KHS providing at least 6 months written notice. For the years ended December 31, 2024 and 2023, over 99.0% of KHS' total operating revenues were received from DHCS. Future levels of funding and premium rates received by KHS could be impacted by state and federal budgetary constraints. The ability of KHS to continue as a going concern is dependent on its continued compliance with the DHCS requirements. The loss of this contract would have an adverse effect on KHS' future operations.

Required Supplementary Information

Kern Health Services
Schedules of Proportionate Share of the Net Pension (Asset) Liability
As of December 31, 2024

(Dollars in Millions)

	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
CalPERS - Miscellaneous Classic Plan- Last 10 Years*										
Proportion of the net pension liability	0.43333%	0.39949%	0.36636%	0.32206%	0.28810%	0.26415%	0.23579%	0.21146%	0.19046%	0.17122%
Proportionate share of the net pension (asset) liability	$ 12,251,788	$ 12,665,462	$ 10,218,206	$ (693,712)	$ 8,432,377	$ 7,038,233	$ 5,865,463	$ 6,082,752	$ 4,769,187	$ 3,104,717
Covered-employee payroll	$ 47,074,602	$ 21,502,725	$ 21,002,601	$ 20,710,645	$ 19,428,164	$ 19,020,118	$ 17,733,290	$ 17,150,840	$ 17,364,146	$ 9,949,051
Proportionate share of the net pension liability as a percentage of covered-employee payroll	0.00%	58.90%	48.65%	-3.35%	43.40%	37.00%	33.08%	35.47%	27.47%	31.21%
Plan's fiduciary net position (in thousands)	$ 19,241,278	$ 17,692,895	$ 16,770,671	$ 18,065,792	$ 14,702,361	$ 13,979,687	$ 13,122,440	$ 12,074,500	$ 10,923,476	$ 10,896,036
Plan fiduciary net position as a percentage of the total pension liability	79.91%	77.97%	78.19%	90.49%	77.71%	77.73%	77.69%	75.39%	75.87%	79.89%
KHS' fiduciary net position as a percentage of KHS' total pension liability	88.26%	86.03%	87.00%	101.08%	88.20%	85.18%	85.27%	82.04%	82.61%	83.03%
CalPERS - Miscellaneous PEPRA Plan- Last 10 Years*										
Proportion of the net pension liability										0.00362%
Proportionate share of the net pension (asset) liability										$ (30,922)
Covered-employee payroll										$ 6,909,343
Proportionate share of the net pension liability as a percentage of covered-employee payroll										-0.45%
Plan's fiduciary net position (in thousands)										$ 10,639,461
Plan fiduciary net position as a percentage of the total pension liability										79.89%
KHS' fiduciary net position as a percentage of KHS' total pension liability										83.03%

* For the fiscal year ended December 31, 2016, CALPERS combined the Classic and PEPRA Plans into one plan. Therefore, the information presented for the years ended 2023 through 2016 for the miscellaneous Classic Plan includes the PEPRA Plan.

** Fiscal year 2015 was the first year of implementation, therefore only one year is shown. For the fiscal year ended December 31, 2016 CALPERS combined the Classic and PEPRA Plans into one plan. Therefore, there is no information reported for the PEPRA Plan subsequent to the year ended December 31, 2015.

Kern Health Services
Schedules of Pension Contributions
Year Ended December 31, 2024

(Dollars in Millions)

*CalPERS - Miscellaneous Classic Plan- Last 10 Years**	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Contractually required contribution (actuarially determined)	$ 53,218,647	$ 4,036,369	$ 3,516,567	$ 2,951,981	$ 2,536,160	$ 2,074,974	$ 1,822,052	$ 1,625,952	$ 1,314,297	$ 841,252
Contributions in relation to the actuarially determined contributions	5,328,647	4,036,369	3,516,567	2,951,981	2,536,160	2,074,974	1,822,052	1,625,952	1,314,297	841,252
Contribution deficiency (excess)	$ 47,890,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 47,074,602	$ 21,502,725	$ 21,002,601	$ 20,710,645	$ 19,428,164	$ 19,020,118	$ 17,733,690	$ 17,150,940	$ 17,364,146	$ 9,949,051
Contributions as a percentage of covered-employee payroll	0.00%	18.77%	16.74%	14.25%	13.05%	10.91%	10.27%	9.48%	7.57%	8.46%
Notes to schedule										
Valuation date		June 30, 2022	June 30, 2021	June 30, 2020	June 30, 2019	June 30, 2018	June 30, 2017	June 30, 2016	June 30, 2015	June 30, 2014
Methods and assumptions used to determine contribution rates										
Actuarial cost method					Entry-Age Normal Cost Method					
Amortization method					Level percentage of assumed future payrolls					
Remaining amortization period	20 years	21 years	22 years	23 years	24 years	25 years	26 years	27 years	28 years	29 years
Asset valuation method					5-year smoothed market					
Inflation	2.30%	2.30%	2.30%	2.50%	2.50%	2.50%	2.50%	2.75%	2.75%	2.75%
Salary increases	2.80%	2.80%	2.55%	2.75%	2.75%	2.75%	2.75%	3.00%	3.00%	3.00%
Investment rate of return (a)	6.90%	6.90%	6.90%	7.00%	7.15%	7.15%	7.15%	7.15%	7.65%	7.50%
Retirement age					50 years and 5 years of service					
Mortality		(b)	(b)	(c)	(c)	(c)	(c)	(c)	(c)	(c)

(a) Net of pension plan investment and administrative expenses; includes inflation

(b) The mortality table used was developed based on CalPERS' specific data. The rates incorporate Generational Mortality to capture ongoing mortality improvements using 80.0% of Scale MP 2020 published by the Society of Actuaries.

(c) The mortality table used was developed based on CalPERS' specific data. The table includes 15 years of mortality improvements using Society of Actuaries Scale 90.0% of scale MP 2016.

* For the fiscal year ended December 31, 2016 CALPERS combined the Classic and PEPRA Plans into one plan. Therefore, the information presented for the years ended 2023 through 2016 for the miscellaneous Classic Plan includes the PEPRA Plan.

Kern Health Services
Schedules of Pension Contributions
Year Ended December 31, 2024

*CalPERS - Miscellaneous PEPRA Plan- Last 10 Years***	2015
Contractually required contribution (actuarially determined)	$ 367,525
Contributions in relation to the actuarially determined contributions	367,525
Contribution deficiency (excess)	$ -
Covered-employee payroll	$ 6,909,343
Contributions as a percentage of covered-employee payroll	5.32%
Notes to schedule	
Valuation date	June 30, 2014
Methods and assumptions used to determine contribution rates	
Actuarial cost method	Entry-Age Normal Cost Method
Amortization method	Level percentage of assumed future payrolls
Remaining amortization period	29 years
Asset valuation method	5-year smoothed market
Inflation	2.75%
Salary increases	3.00%
Investment rate of return (a)	7.50%
Retirement age	20 years of projected on-going mortality
Mortality	Improvement using Scale BB published by the Society of Actuaries

* For the fiscal year ended December 31, 2016 CalPERS combined the Classic and PEPRA Plans into one plan. Therefore, there is no information reported for the PEPRA Plan subsequent to the year ended December 31, 2015.

MOSSADAMS

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Board of Directors
Kern Health Systems

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Kern Health Systems, which comprise the statement of net position as of December 31, 2024, and the related statements of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated April 4, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Kern Health Systems's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Kern Health Systems's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit, we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether Kern Health Systems's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Moss Adams LLP

Irvine, California
April 4, 2025

COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS

Kern Health Systems

December 31, 2024

MOSSADAMS

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Communications of Internal Control Related Matters

To the Management and the Board of Directors of
Kern Health Systems

In planning and performing our audit of the financial statements of Kern Health Systems (the Company) as of and for the year ended December 31, 2024, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, we considered the Company's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit, we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the organization and is not intended to be and should not be used by anyone other than these specified parties.

Moss Adams LLP

Los Angeles, California
April 4, 2025

KERN HEALTH SYSTEMS

April 4, 2025

Moss Adams LLP
21700 Oxnard Street, Suite 300
Woodland Hills, CA 91367

We are providing this letter in connection with your audit of the financial statements of Kern Health Systems ("KHS"), which comprise the statement of net position and the related statements of revenues, expenses, and changes in net position, and cash flows as of December 31, 2024 and for the year then ended and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $1,320,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of April 4, 2025,

Financial Statements

1) We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated September 4, 2024, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.

2) We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

3) We acknowledge our responsibility for the design, implementation, and maintenance of internal controls to prevent and detect fraud.

4) Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

5) Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

6) All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.

7) The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

Information Provided

8) We have provided you with:

   a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation, and other matters;

   b. Minutes of the meetings of the Board of Directors, Finance Committee, or summaries of actions of recent meetings for which minutes have not yet been prepared;

   c. Additional information that you have requested from us for the purpose of the audit;

   d. Unrestricted access to persons within the Organization from whom you determined it necessary to obtain audit evidence.

9) All transactions have been properly recorded in the accounting records and are reflected in the financial statements.

10) We have retained copies of all information we provided to you during the engagement and have been provided copies of all necessary financial and non-financial schedules, memos, data, and other information related to all services performed by you, such that in our opinion our records are complete, including our records supporting our financial statements and all related accounting policies and positions. Furthermore, you do not act as the sole host of any financial or non-financial information system for us, nor do you provide any electronic security or back-up services for our data or records.

11) We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

12) We have no knowledge of any fraud or suspected fraud that affects the entity and involves—

   a. Management,

   b. Employees who have significant roles in internal control, or

   c. Others when the fraud could have a material effect on the financial statements.

13) We have no knowledge of any allegations of fraud or suspected fraud affecting the entity's financial statements communicated by employees, former employees, analysts, regulators, or others.

14) We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements. We also acknowledge our responsibility for the Organization's compliance with laws and regulations.

15) We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements.

16) We have disclosed to you the identity of all the Organization's related parties and all the related party relationships and transactions of which we are aware.

17) There have been no communications (oral or written) from regulatory agencies, governmental representatives, employees, or others concerning the investigations or allegations of noncompliance with laws and regulations in any jurisdiction, deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

18) Deposits and investment securities are properly classified in category of custodial credit risk.

19) Net position components (invested in capital assets; restricted; and unrestricted) are properly classified and, if applicable, approved.

20) We are not aware of any violation of the Health Insurance Portability and Accountability Act.

21) The methods and significant assumptions used to determine fair values of investments are appropriate. The methods and significant assumptions used result in a measure of fair value appropriate for financial statement measurement and disclosure purposes.

22) We have reviewed investments for impairment whenever events or changes in circumstances have indicated that the carrying amount of its assets might not be recoverable and have appropriately recorded the adjustment. Based on this review, we have identified no marketable securities with impairments as of December 31, 2024.

23) We agree with the findings of specialists in evaluating the Company's liability for claims liabilities and net pension liability and have adequately considered the qualifications of the specialists in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give or cause any instructions to be given to specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists. We believe that the actuarial assumptions and methods used to measure claims liabilities and costs for financial accounting purposes are appropriate in the circumstances.

24) As of December 31, 2024, we have determined that a premium deficiency reserve is not required.

25) Due to the timing of the hospital directed payment program acceptance by CMS and delays in funding to MCPs, final rates of the various hospital directed payment programs are not available until paid. KHS accrued hospital directed payments receivable of $555.7 million and hospital directed payments payable of $557.2 million as of December 31, 2024. The amount of premium revenue for hospital directed payment programs recognized for the year ended December 31, 2024 was $288.8 million, and is reported as part of operating revenues on the accompanying statements of revenues, expenses, and changes in net position. Hospital directed payment expense obligations recognized for the year ended December 31, 2024, were $291.6 million, and is reported as part of operating expenses on the accompanying statements of revenues, expenses, and changes in net position. As stated above, KHS has very little visibility as to the timing of these payments until actually paid by DHCS.

26) In October 2017, KHS entered into a split-dollar life insurance agreement with a key employee and his beneficiary, whereby the employee is eligible to receive distributions, and KHS will receive $0.8 million upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $0.8 million as of December 31, 2024. In June 2020, KHS entered into a second split-dollar life insurance agreement with the same employee and his beneficiary as the 2017 agreement, whereby the employee is eligible to receive distributions, and KHS will receive $0.8 million upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $0.8 million as of December 31, 2024. The employee retired from KHS in July 2022; however, the above agreements remain in place.

27) On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco revenue is allocation to the DHCS for use as the nonfederal share of health care expenditures in accordance with the annual state budget process. Proposition 56 appropriated funds resulted in directed payments made to Medi-Cal managed care health plans for the purposes of paying additional amounts for qualifying physician services based on certain specified CPT procedure codes. The directed payments are subject to a minimum medical expenditure percentage and a portion of capitation payments attributed to this directed payment arrangement will be subject to a two-sided risk corridor. As of December 31, 2024, KHS had accrued $23.8 million, in payments to providers for Proportion 56. If less than the targeted amount accrued is paid to providers, amounts will be returned to the State through the performance of DHCS' risk corridor calculation. Proposition 56 physician services supplemental payments ended December 31, 2023, as DHCS developed TRIs for providers in Medi-Cal effective for dates of service on or after January 1, 2024. The TRI for targeted services are to be no less than 87.5% of the Medicare rate. As of December 31, 2024, KHS has accrued $15.6 million in payments to providers for TRI.

28) Due to the unprecedented circumstances of the COVID-19 pandemic, DHCS and its contracted actuary determined that a two-sided, symmetrical risk corridor (bridge corridor) would appropriately provide protection for both the State and MCPs like KHS. The purpose of the risk corridor is to mitigate potentially significant upward or downward risk associated with COVID-19 that was not determinable at the time of rate development. The bridge corridor was retroactive to July 1, 2019 and is based on an estimate provided by guidance obtained from DHCS. As of December 31, 2024, KHS had accrued $25.5 million owed to the state for the rate period July 1, 2019 through December 31, 2020.

29) The Organization has evaluated all other medical claim (non-IBNR) liability reserves and considered all available information and believes there is a reasonable basis for the estimates recorded in the consolidated financial statements as of December 31, 2024.

30) KHS is a fully licensed health-care service plan under the Knox-Keene Health Care Services Plan Act of 1975 (the Act). Under the Act, KHS is required to maintain a minimum level of tangible net equity. The required equity level was $78.7 million as of December 31, 2024. KHS' tangible net equity was $333.6 million as of December 31, 2024. The Organization is in compliance with the tangible net equity and working capital requirements pursuant to the Knox-Keene Health Care Service Plan Act as of June 30, 2024.

31) We confirm that the eligibility of Medi-Cal beneficiaries is determined by the DHCS. The DHCS provides the Plan the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month.

32) We confirm that we have appropriately considered new accounting pronouncements issued by GASB and have properly reflected the results of adoption GASB No. 96, *Subscription-Based Information Technology Arrangements*, effective January 1, 2024.

33) We acknowledge our responsibility for presenting the following required supplementary information: management's discussion and analysis, schedule of proportionate changes in net pension liability and schedule of pension contributions required by the GASB, in accordance with U.S. GAAP and we believe the required supplementary information is measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the required supplementary information have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

34) In regards to the assistance provided with respect to drafting of the financial statements performed by you, we have:

    a. Made all management decisions and performed all management functions,

b. Designated an individual with suitable skill, knowledge, or experience to oversee the services,

c. Evaluated the adequacy and results of service performed, and

d. Accepted responsibility for the results of the services.

35) To the best of our knowledge and belief, no events have occurred subsequent to the statement of net position date and through the date of this letter that would require adjustment to or disclosure in the aforementioned consolidated financial statements.

36) We are not aware of any cybersecurity events that took place during the year ended December 31, 2024, or subsequent to the year ended December 31, 2024 that would have a material impact on the financial statements.

37) GASB 96 statement regarding the recording of software subscription licenses was implemented as of January 1, 2024. The statement requires implementation to be applied retroactively by restating financial statements, if practicable, for all fiscal years presented. Restatement of prior fiscal years was not practicable due to incomplete available information and there was no cumulative effect of implementation on the beginning net position.

38) The actuary used by management in estimating the incurred but not reported (IBNR) had a sufficient level of competence and experience, including an understanding of the appropriate methods for calculating such reserve estimates. We recognize that we are responsible for the actuarial amounts and balances and, in our opinion, all such amounts are fairly presented.

39) The liability for unpaid claims, including amounts for incurred but not reported claims, has been determined using estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other appropriate factors that would modify past experience. The estimated liabilities are an accurate estimate of our incurred but unreported claims liabilities as of December 31, 2024. The data used in projecting the ultimate unpaid claims is complete and accurate, and is reconciled to the underlying accounting records. The adjustment from the prior year is included in the current period as a change in accounting estimate.

Emily Duran, Chief Executive Officer

Robert Landis, Chief Financial Officer

Veronica Barker, Controller

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Alan Avery, Chief Operating Officer

SUBJECT: Provider Satisfaction Survey

DATE: April 17, 2025

BACKGROUND

Kern Health Systems (KHS) performs an annual Provider Satisfaction Survey to evaluate the level of engagement and satisfaction within our network of providers. KHS engaged a third-party vendor, Press Ganey, formerly SPH Analytics, to conduct the survey and provide baseline survey data and national industry benchmark comparison to other Medi-Cal plans.

The provider types surveyed are Primary Care Providers, Specialists, Behavioral Health, Hospitals, Urgent Care Facilities, and Ancillary Providers. The survey was conducted over three waves during Q2 2024 and measured the Plan's Calendar Year (CY) 2023 performance.

The survey is broken down into eight (8) attributes: Overall Satisfaction, Comparison to Other Plans, Compensation/Finance, Utilization Management & Quality Improvement, Network/ Coordination of Care, Call Center, Provider Relations, and Providers' likelihood to recommend to other providers.

One key rating to highlight is Kern Health Systems' overall satisfaction rating of 90.0%. The Medicaid Line of Business overall satisfaction rate for like plans surveyed was 68.4% satisfaction. KHS also scored much higher when compared to local competitors.

Included is a presentation that summarizes the CY 2023 Provider Satisfaction Survey results and outlines efforts to continue to the Plan’s favorable rating within our Provider Network.

REQUESTED ACTION

Receive and file.

KERN HEALTH SYSTEMS

2024 Provider Satisfaction Survey,
Calendar Year 2023
Survey Results

Report Prepared For
KHS Board of Directors
April 17, 2025

BACKGROUND/METHODOLOGY

On an annual basis, Kern Health System's Provider Network Management Department conducts a Provider Satisfaction Survey to gauge the level of satisfaction and engagement amongst our network of contracted providers. The 2024 Provider Satisfaction Survey asked providers to answer survey questions based on their experiences with KHS during Calendar Year 2023. We engaged an independent survey company, Press Ganey (PG) Analytics, formerly SPH Analytics, to conduct the survey on behalf of the Plan. PG Analytics is able to benchmark KHS performance against other organizations within the industry, by comparing our results against their National Medicaid and Aggregate Books of Business. The PG 2023 Medicaid Book of Business is made up of 108 plans with a total of 17,709 respondents. The PG 2023 Aggregate Book of Business is made up of 208 plans with a total of 27,121 respondents. This is seventh annual Provider Satisfaction Survey that PG Analytics has completed for the Plan.

The 2024 Provider Satisfaction Survey was conducted across three waves, in April, May, and June of 2024. Two waves of mailing outreach were conducted, followed by a third outreach via telephone. The survey is sent to and categorized by provider type, including PCP, Specialist, Behavioral Health, and Other (Facilities, Ancillary providers). All statistical testing is performed at the 95% confidence level.

For 2024, 175 total surveys were received, down from 182 surveys received the prior year. KHS utilizes incentives for provider offices to try and promote survey participation.

RESULTS

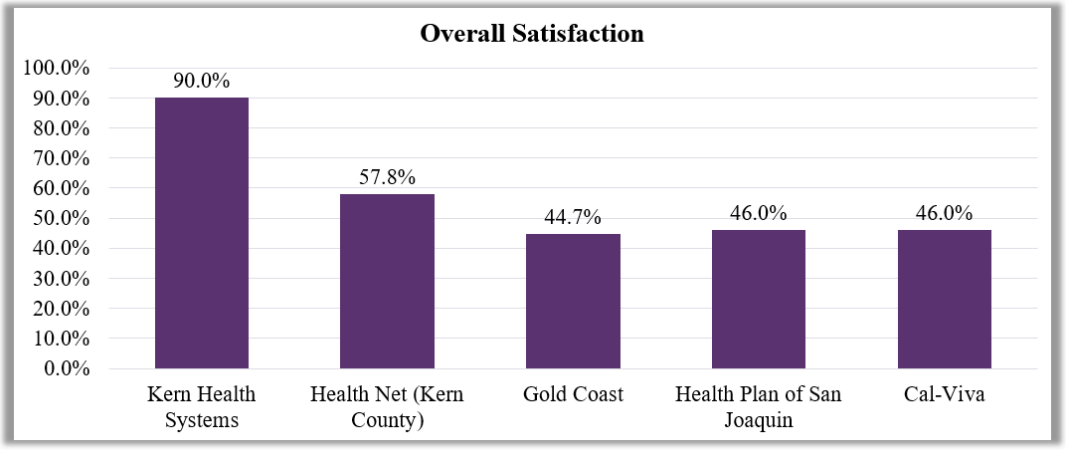
In the tables below, summary rate represents the most favorable response percentages. KHS scores remained in line with prior year’s scores (+/- 5%) in all composites/attributes except for Provider Relations which saw an 8% summary rate decrease. KHS scored within the 75th percentile or higher in all scoring composites/attributes when compared against PG's 2023 Medicaid Book of Business.

KHS' Year over Year Summary Rates				
Composites/ Attributes	**KHS CY 2020 Summary Rate**	**KHS CY 2021 Summary Rate**	**KHS CY 2022 Summary Rate**	**KHS CY 2023 Summary Rate**
Overall Satisfaction	84.70%	85.20%	90.50%	**90.00%**
Compared to Other Plans	55.70%	62.10%	70.80%	**68.40%**
Compensation	52.00%	53.50%	58.30%	**59.10%**
UM & Quality	50.70%	51.50%	64.20%	**61.40%**
Network/COC	47.70%	55.70%	50.60%	**53.10%**
Health Plan Call Center	61.10%	50.60%	64.50%	**61.40%**
Provider Relations	61.70%	70.80%	73.30%	**65.30%**
Recommend to Other MDs	94.80%	95.30%	98.30%	**98.80%**

Composite Scores: KHS vs SPH 2023 Medicaid Book of Business				
Composites/Attributes	**KHS 2023 Summary Rate**	**2023 National Medicaid Summary Scores**		**Percentile Ranking (At or Above 75th)**
Overall Satisfaction	90.00%	73.20%	**Favorable**	**97th**
Other Local Plans	68.40%	41.80%	**Favorable**	**98th**
Compensation	59.10%	38.60%	**Favorable**	**98th**
UM & Quality	61.40%	39.00%	**Favorable**	**97th**
Network/COC	53.10%	34.90%	**Favorable**	**98th**
Health Plan Call Center	61.40%	41.90%	**Favorable**	**97th**
Provider Relations	65.30%	38.10%	**Favorable**	**98th**
Would Recommend	98.80%	89.30%	**Favorable**	**98th**

Respondents were asked to rate their overall satisfaction in comparison to other plans they worked with in 2023. KHS scored well above all other listed plans.

Health Plan Comparison



STRENGTHS/OPPORTUNITIES

PG Analytics identified key measures that drove the overall satisfaction scores within KHS' results.

Strengths

- Quality of BH Providers in this health plan's provider network
- Number of BH providers in the health plan's provider network
- Timeliness of feedback/reports from BH providers in this health plan's provider network
- Timeliness of feedback/reports from specialists providers in this health plan's provider network
- Quality of specialists in this health plan's provider network
- Number of specialists in this health plan's provider network

Opportunities

- Provider Education Processes
    - Online training available through New Learning Management System accessed through the Provider Portal
- Specialty-Specific Provider Forums
    - Identify Specialties with additional support and education needs and provide targeted support via provider forums
- Rural Health Provider Engagement
    - Conduct in-office provider outreach to Plan's Rural Health provider offices, who are typically unable to attend in-town (Bakersfield) events

LANGUAGE ASSISTANCE PROGRAM ASSESSMENT

As required by the Department of Managed Health Care, KHS has additional questions included as part of Provider Satisfaction Survey to conduct a Language Assistance Program (LAP) Assessment. The questions included as part of this assessment aim to evaluate provider perspectives and concerns with the health plan's language assistance program, including coordination of appointments with an interpreter, availability of an appropriate range of interpreters, and training and competency of available interpreters. KHS in in the process of finalizing this report for submission to the DMHC in May 2024.

NEXT STEPS

The Provider Network Management Department met with KHS Department leadership individually and reviewed the survey results. As discussed above, the Plan identified a decrease in the Provider Relations summary rate; however, this composite/attribute remains the highest-scoring among internal departments. The Plan expects that both recently implemented and upcoming changes will enhance provider satisfaction in this area. Ongoing activities include improving our provider education processes, specialty-specific provider forums, and increased Rural Health provider engagement.

In 2025, the Plan will focus on maintaining the high provider satisfaction scores it consistently achieves while navigating upcoming organizational changes. To support this, the Plan is preparing for the successful rollout of two major initiatives that will significantly impact providers: the implementation of a D-SNP line of business and the launch of KHS' new Provider Portal.

KHS will continue to utilize PG Analytics and the 2025 Provider Satisfaction Survey, CY 2024 will kick off April 2025.

2024 Provider Satisfaction Survey Results

Calendar Year 2023

Board of Directors

April 17, 2025

KERN HEALTH SYSTEMS

Background & Timeline

- KHS conducts an annual provider satisfaction survey
- The 2024 survey measured the CY 2023 KHS performance with network providers
- Press Ganey (PG) Analytics, formerly SPH Analytics, conducted the survey on behalf of KHS
- KHS Performance is benchmarked to HMO industry performance for similar measures
- Survey was conducted over three (3) waves during Q2 2024

Survey Panel

Surveys were sent to the following provider types:

- **Primary Care Providers**
- **Specialists**
- **Behavioral Health**
- **Hospitals & Urgent care Facilities**
- **Ancillary Provider Types**

- 175 Total Surveys received in CY2023
  - *CY 2022: 182* surveys received
  - Provider offices incentivized for survey completion
- Confidence Level
  - Survey sample at 95% confidence level.

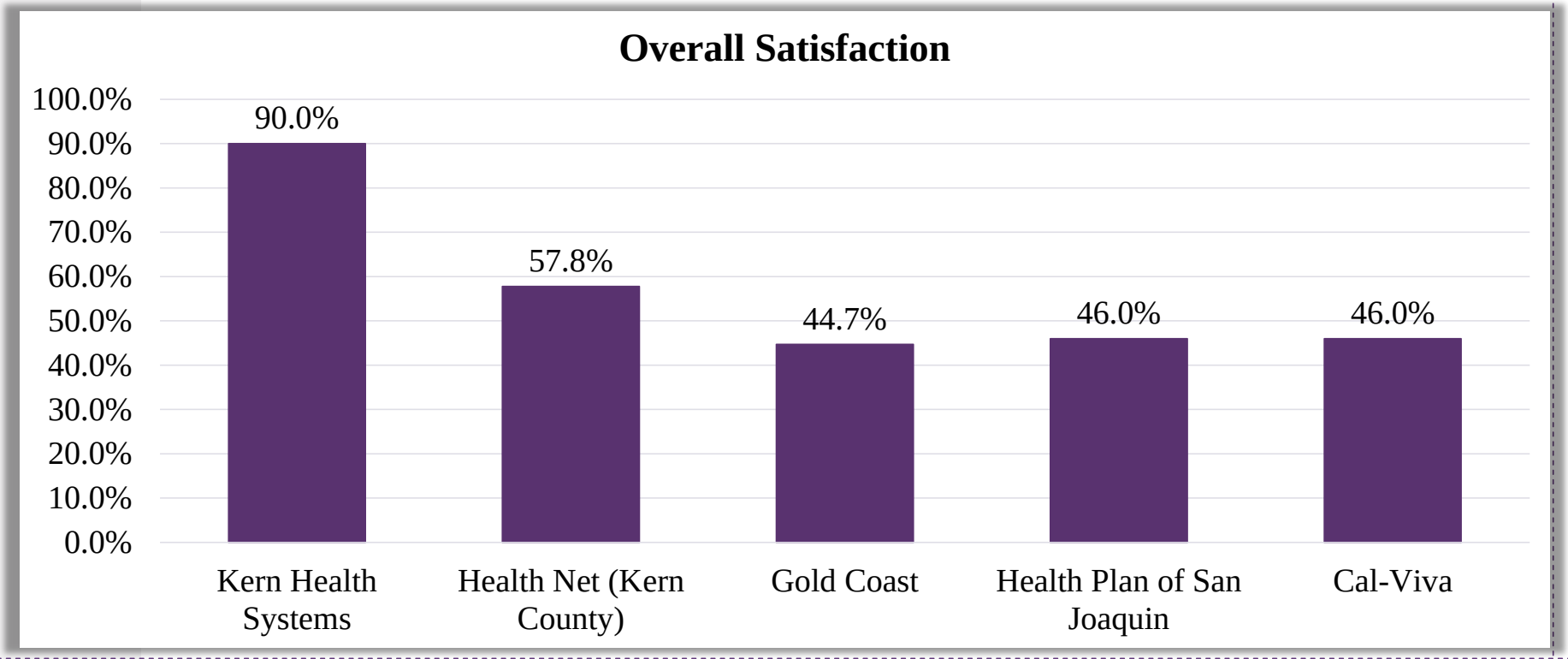
Report Highlights

Composites/ Attributes	KHS CY 2020 Summary Rate	KHS CY 2021 Summary Rate	KHS CY 2022 Summary Rate	KHS CY 2023 Summary Rate
Overall Satisfaction	84.7%	85.2%	90.5%	90.0%
Compared to Other Plans	55.7%	62.1%	70.8%	68.4%
Compensation	52.0%	53.5%	58.3%	59.1%
UM & Quality	50.7%	51.5%	64.2%	61.4%
Network/COC	47.7%	55.7%	50.6%	53.1%
Health Plan Call Center	61.1%	50.6%	64.5%	61.4%
Provider Relations	61.7%	70.8%	73.3%	**65.3%**
Recommend to Other MDs	94.8%	95.3%	98.3%	98.8%

Report Highlights

Composites/ Attributes	KHS Summary Rate	2023 National Medicaid Summary Scores		Percentile Ranking (At or Above 75th)
Overall Satisfaction	90.0%	73.2%	**Favorable**	**97th**
Other Local Plans	68.4%	41.8%	**Favorable**	**98th**
Compensation	59.1%	38.6%	**Favorable**	**98th**
UM & Quality	61.4%	39.0%	**Favorable**	**97th**
Network/COC	53.1%	34.9%	**Favorable**	**98th**
Health Plan Call Center	61.4%	41.9%	**Favorable**	**97th**
Provider Relations	65.3%	38.1%	**Favorable**	**98th**
Would Recommend	98.8%	89.3%	**Favorable**	**98th**

Health Plan Comparison



Strengths/Opportunities

Key measures the drove overall scores within KHS results

Strengths

- Quality of BH Providers in this health plan's provider network
- Number of BH providers in the health plan's provider network
- Timeliness of feedback/reports from BH providers in this health plan's provider network
- Timeliness of feedback/reports from specialists' providers in this health plan's provider network
- Quality of specialists in this health plan's provider network
- Number of specialists in this health plan's provider network

Opportunities

- Provider Education Processes
  - Online training available through New Learning Management System accessed through the Provider Portal
- Specialty-Specific Provider Forums
  - Identify Specialties with additional support and education needs and provide targeted support via provider forums
- Rural Health Provider Engagement
  - Conduct in-office provider outreach to Plan's Rural Health provider offices, who are typically unable to attend in-town (Bakersfield) events

Next Steps

- Reviewed survey results/provider feedback with KHS Department leadership
- Continue to maintain high provider satisfaction scores through organizational changes:
  - D-SNP implementation
  - New Provider Portal
- Continue to work with third party vendor, PG Analytics to gauge provider satisfaction. CY 2024 survey will kick-off Q2 2025

Questions

For additional information, please contact:

Alan Avery
Chief Operating Officer
(661) 664-5000

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Alan Avery, Chief Operating Officer

SUBJECT: 2024 Member Satisfaction Survey Summary

DATE: April 17, 2025

Background

Kern Health Systems (KHS) in partnership with participating providers, is committed to meeting the expectations of our members as they interact with the health plan and when receiving health care services through our provider network. Annually, KHS conducts a Member Satisfaction Survey to measure and evaluate how well we are meeting members' expectations.

For the past eight years, KHS has engaged SPH Analytics, now known as Press Ganey, to conduct our Member Satisfaction Survey. Press Ganey is a National Committee for Quality Assurance (NCQA) certified HEDIS® Survey Vendor.

2024 was the Fifth year KHS selected Press Ganey to conduct the KHS MY 2023 CAHPS® Medicaid Adult Simulation Survey for the 2024 Member Satisfaction Survey. NCQA requires health plans to submit CAHPS survey results in compliance with HEDIS® accreditation requirements. The objective of the study is to capture accurate and complete information about member-reported experiences with health care to measure how well health plans are meeting their members' expectations.

Press Ganey utilizes the scores from several benchmarks to provide comparative and trending data results from member responses to the forty questions provided in the survey tool. Their report provides two sets of benchmarks to consider – (1) National NCQA Accredited Adult Medicaid Health Plans and (2) Regional Health and Human Services Region 9 health care plans which includes California, Hawaii, Arizona, and Navada. As KHS is not yet NCQA accredited, we consider the Region 9 benchmark which is heavily weighted by California Health Plans.

The 2024 Member Satisfaction Survey results show that KHS, under the rating of health plan measure, has a 71.6% overall satisfaction rate which is higher than the 60.4% Region 9 benchmark. We continue our efforts to encourage members to be engaged in their health care and to use the results of tools such as the Member Satisfaction Survey to listen to their needs and improve our member engagement strategies.

Requested Action

Receive and File.

Kern Family Health Care

2024 Member Satisfaction Survey

Introduction and Objectives

Kern Health Systems conducted its MY 2023 CAHPS® Medicaid Adult Simulation Survey in compliance with HEDIS® accreditation requirements for the 2024 measurement year.

01 Capture accurate and complete information about consumer-reported experiences with health care.

02 Measure how well plans are meeting their members' expectations and goals.

03 Determine which areas of service have the greatest effect on members' overall satisfaction.

04 Identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

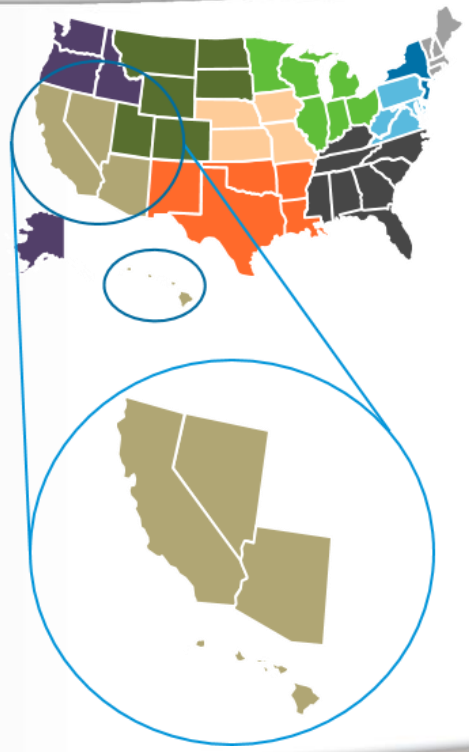
Kern Family Health Care

Methodology

- A sampling of 5,000 KFHC eligible member households was selected and 4997 were eligible.
  - Qualified respondents:
    - 18 years and older (as of December 31st of the measurement year)
    - Continuously enrolled in the plan for at least five of the last six months of the measurement year
  - There were a total of 524 completed responses.
    - 314 completed responses by mail.
    - 210 completed responses on the internet.
    - 10.5% response rate.
- Results were measured in comparison with other plan survey data for the Region.
  - Region 9: San Francisco includes American Samoa, California, Hawaii, Arizona, Guam, and Nevada

Region 9: San Francisco

- American Samoa (not shown)
- California
- Hawaii
- Arizona
- Guam (not shown)
- Nevada



Kern Family Health Care

Regional Performance

KHS scored significantly higher than the regional rate as compared to the 2024 Press Ganey Book of Business for Region 9 rates.

Patient Experience	KHS Summary Rate (%)	2024 SPH BoB Region (%)	Performance Indicator
Rating of Health Plan	71.6	60.4	↑
Rating of Health Care	62.6	53.4	↑
Rating of Personal Doctor	74.0	66.8	↑
Getting Needed Care	84.3	77.1	↑
Getting Care Quickly	84.1	74.9	↑
Customer Service	93.8	88.4	↑
Coordination of Care	85.5	81.4	
How Well Doctors Communicate	92.6	91.9	

Significance Testing
Current year score is significantly higher/lower (↑/↑) than the 2024 PG BoB Region score.

Kern Family Health Care

Key Drivers of Rating of Health Plan

TOP 10 KEY DRIVERS

YOUR PLAN

These items have a relatively large impact on the Rating of Health Plan. **Leverage** these questions since they are important to your members and the Rating of Health Plan score for this plan. They are listed in descending order of importance for your plan.

INDUSTRY

PG Book of Business regression analysis has identified **Key Drivers** of Rating of Health Plan. The numbers represent the ranked importance across the entire Book of Business.

ALIGNMENT *Are your key drivers typical of the industry?*	KEY DRIVER RANK		ATTRIBUTE		SUMMARY RATE SCORE		PG BoB %TILE*		CLASSIFICATION		
	YOUR PLAN	INDUSTRY			YOUR PLAN	INDUSTRY			2023		2024
			Q28	Rating of Health Plan	71.6%	63.1%	95th	(-1)			
✓	1	3	Q22	Rating of Specialist +	66.5%	68.5%	34th	(-19)	Power	→	Opp.
✓	2	1	Q8	Rating of Health Care	62.6%	57.3%	87th	(+4)	Power		Power
✓	3	2	Q18	Rating of Personal Doctor	74.0%	70.3%	81st	(+13)	Power		Power
	4	15	Q27	Ease of Filling Out Forms +	95.6%	94.8%	59th	(+2)	Retain	→	Power
✓	5	8	Q24	Provided information or help	90.8%	84.7%	94th	(+12)	Power		Power
✓	6	10	Q13	Dr. listened carefully	93.3%	93.3%	48th	(+1)	Opp.		Opp.
✓	7	9	Q20	Getting specialist appointment	82.5%	79.1%	73rd	(-7)	Retain	→	Power
✓	8	7	Q25	Treated with courtesy and respect	96.8%	94.8%	77th	(+39)	Opp.	→	Power
✓	9	5	Q9	Getting care, tests, or treatment	86.1%	85.1%	58th	(+3)	Power	→	Retain
	10	12	Q15	Dr. spent enough time	86.2%	91.4%	5th	(-17)	Wait		Wait

CLASSIFICATION LEGEND

Power	Opportunity	Retain	Wait
• Large impact on the rating of the Health Plan • Health Plan performance is above average • **Promote and leverage strengths**	• Large impact on the rating of the Health Plan • Health Plan performance is below average • **Focus resources on improvement**	• Small impact on the rating of the Health Plan • Health Plan performance is above average • **Maintain performance**	• Less impact on the rating of the Health Plan • Health Plan performance is below average • **Less priority - can wait to be dealt with**

2024 Performance Improvement Review

In 2023 the results of the study provided four recommended strategies to address deficient ratings in key areas for needed improvement. Listed are the strategies and subsequent efforts adopted by KHS. Summary rate scores saw an improvement based on 2024 results. More work is needed to bring scores up to meet or exceed regional rates and are the focus of these strategies.

2024 Recommended Strategy	2024 Result
Expand member engagement activities to assist members with coordination of care.	• Member Outreach Specialists performed outreach for members resulting in improved compliance with MCAS measures and assist with coordination of care where needed. • A Member Understanding of Benefits survey is now included in every new member packet. • Member Engagement conducts a qualitative and quantitative analysis of member understanding of benefits and the top reasons members call Member Services. Improvements to materials and other communication modalities are made based on the results.
Discover opportunities for improved member and provider communication through technology using multiple modalities.	• Member Outreach Specialists increased outreach in 2024 through manual outreach calls and improved text messages. • Member Services now has an email option so that members (and non-members) may communicate questions and comments via that channel.
Improve ongoing and timely reminders and messaging to promote rewards programs and encourage member engagement in their own health care.	• An effort to make efficient the process for sending out text messages was introduced as a project and approved for the 2025 project portfolio. • Member Engagement and Community Engagement staff attended mobile clinic events to hand out gift cards for qualifying health services.
Explore efforts to improve customer relations management to benefit the member experience.	• Member Engagement Project which includes the development of a Customer Relations Management platform was launched. The platform will provide member facing staff a 360 degree view of a member's profile thereby improving coordination of care when engaging with members.

Kern Family Health Care

2025 Performance Improvement Strategy

KHS will implement the following improvement strategies in 2025 based on the 2024 MSS responses.

- Evaluate current member and provider education pertaining to coordination of care to improve collaborative health practices between provider disciplines and member understanding of the needed inter-provider communication relationship.
- Create educational content on social media, website, and member portals to support members' confidence in asking needed questions and understanding their health status.
- Coordinate efforts with Provider Network Management to improve provider education on the importance of patient communication.
- Analyze grievances and call tracking to identify key causes of the low scores for *Rating of Specialist* and strategize ways to improve member satisfaction.

Kern Family Health Care

For more information:

Alan Avery

Chief Operating Officer

(661) 664-5000

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

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

SUBJECT: Report on KHS Quality Improvement Health Equity Work Plan and 2025 Work Plan

DATE: April 17, 2025

Background

Kern Health Systems remains dedicated to improving health outcomes, ensuring regulatory compliance, and advancing health equity for Medi-Cal members in Kern County. As part of its ongoing commitment to quality improvement, KHS has developed three key documents for review and approval: **the 2024 Quality Program Evaluation, 2025 Quality Improvement Health Equity Program Description, and 2025 Quality Improvement Work Plan.** These documents provide a comprehensive assessment of program performance, outline strategic priorities for the coming year, and establish measurable goals to enhance clinical care, service quality, and member experience. Approval of these documents will guide KHS's quality initiatives and reinforce its mission to deliver equitable, high-quality healthcare.

Discussion

2024 Quality Program Evaluation, 2025 Quality Improvement Health Equity Program Description, and 2025 Quality Improvement Work Plan

- The 2024 Quality Program Evaluation assesses the effectiveness of the QI Program in enhancing member health outcomes, ensuring regulatory compliance, and promoting health equity. It reviews governance, departmental changes, performance metrics, clinical care quality, safety, service quality, and member experience. Key achievements include meeting 26 of 28 program goals, improving several Managed Care Accountability Set (MCAS) measures, and enhancing provider engagement and member outreach. However, challenges remain in meeting minimum performance levels for select quality measures and timely grievance resolutions.

- The 2025 Quality Improvement Health Equity Program (QIHEP) Description outlines the organization's commitment to improving health outcomes, reducing disparities, and ensuring equitable care for Medi-Cal members in Kern County. It provides an in-depth framework for quality improvement, including governance, program scope, goals, and responsibilities of key committees and departments. The document highlights efforts to address social determinants of health (SDOH), expand provider networks, and enhance culturally competent care. Key initiatives include data-driven quality improvement projects, member engagement strategies, and oversight of performance metrics such as Managed Care Accountability Set (MCAS) measures. The program integrates clinical and non-clinical approaches to promote whole-person care, with a strong emphasis on health equity, member satisfaction, and continuous performance evaluation.

- The 2025 QI Work Plan lists the Key Performance measures with measurable goals for the year. The domains of the plan include program structure, quality and safety of clinical care, quality of service, and member and provider satisfaction.

Fiscal Impact

None

Requested Action

Approve:

1. 2024 Quality Program Evaluation
2. 2025 Quality Improvement Health Equity Program Description
3. 2025 Quality Improvement Work Plan

2024 Quality Program Evaluation

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/18/25

Table of Contents

I. Introduction

Kern Health Systems (KHS), doing business as Kern Family Health Care (KFHC), was established in 1993 by the Kern County Board of Supervisors as the local initiative, Medi-Cal managed care health plan. KFHC is the largest health plan in Kern County, serving most of the Medi-Cal beneficiaries through a contract with the State of California Department of Healthcare Services (DHCS).

KHS is a special county health authority created by special county ordinance and is governed by a board that consists of sixteen members. The board consists of the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by each of the five County Supervisors, two traditional Medi-Cal primary care physicians, one representative from a rural acute care general hospital within the county and one pharmacist. All members must be at least twenty-one years of age and work or reside within Kern County. The Board is responsible for establishing and operating a comprehensive managed care system providing health care services, ensuring delivery of publicly assisted medical care in Kern County, promoting quality and cost efficiency, and arranging for the provision of health care services pursuant to Chapter 7, Part 3 of Division 9, section 14000 of the Welfare and Institutions Code.

The mission of KHS is to improve our members' health status through an integrated managed health care delivery system. KHS strives to “meet people where they are” and nurture individual wellness one member at a time to cumulatively improve the overall health and wellness of our community. The objective of KHS is to provide equitable, high-quality, cohesive care to our members that not only addresses physical health but mental, emotional, and social health as well.

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

KHS’ total membership in 2024 is approximately 403,000 members with 49% assigned to the County Hospital system and two large Federally Qualified Health Centers (FQHC).

Over 66% of the population is concentrated in Bakersfield, while the remaining population reside in the rural areas. Highest racial group is the Hispanic population, which account for 63% of the membership.

English is the primary language spoken by 70% of the population, 29% speak Spanish and 1% is a mix of other languages.

Kern County’s health risk factors include higher rates of adult smoking, adult obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections and teen births compared to state-wide statistics. Kern County ranked better than California in state average for food environment index, due to percentage of l ow income and low access to grocery store, and excessive drinking.

II. Quality Program Governance

KHS has multiple provider specialties and members from the KHS community and population represented in the following committees:

Board of Directors (BOD)

The KHS Board of Directors (BOD) seeks to improve access to quality healthcare, maintain and preserve a healthcare safety net for Kern County, and ensure the fiscal integrity of KHS. The BOD has accountability, authority and responsibility for the overall QI program. The BOD has delegated the coordination of the QI Program to the Executive Quality Improvement Health Equity Committee (EQIHEC). The members of the BOD are appointed by the County Board of Supervisors with backgrounds in business, finance, managed care, hospital administration, information technology, medicine, healthcare policy and law. The BOD meets at least four times per year.

Chief Executive Officer

The KHS Chief Executive Officer (CEO) is responsible for the implementation of the QI Program. The CEO provides organizational leadership and direction, participate in prioritization and organizational oversight of quality improvement activities, and ensure availability of resources necessary to implement the approved QI Program. The Executive Team provides oversight, accountability and support for NCQA, HEDIS and related quality improvement initiatives. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the organizational goals.

Chief Medical Officer

The Chief Medical Officer (CMO) is responsible for the day-to-day oversight of the Medical Management, Quality Improvement, Utilization Management, Case Management, Behavioral Health, Community Based Programs and Peer Review Activities. The CMO serves as the Co-Chair of the EQIHEC and is involved in all QI and Health Services activities. The CMO provides oversight for the QI Program on a day-to-day basis and participates in the EQIHEC meetings.

The Health Services team is comprised of:

• Medical Directors – Assist CMO with utilization management review, review of appeals decisions and review of Potential Quality of Care Issues (PQI). The Medical Directors also provides physician support for varying activities within the Quality department, including Performance Improvement, Member Safety, and Peer Review. The time allocated and scope of responsibilities for quality activities was set appropriately to meet the needs of the QI department.

• Senior Director for Health Services – Reports to the CMO and works collaboratively with the CMO and Director of Quality Improvement on the QI Program. Responsible for the day-today implementation of Quality Improvement, Utilization Management, Pharmacy, Case Management, Community Based Programs and Behavioral Health programs. This role provides oversight, guidance, and evaluation of ongoing UM activities and programs.

• Director of Quality Improvement – Reports to the QI Medical Director and works collaboratively to define strategy, develop programs and services and evaluate effectiveness of the QI Program. Along

with the QI Management Team, including Medical Directors, provides oversight of PQIs, compliance with DHCS and NCQA standards, and other performance measures data collection and performance reporting.

The number of associated Health Services staff and level of involvement of the CMO was appropriate for meeting the objectives of the QI Program for 2024.

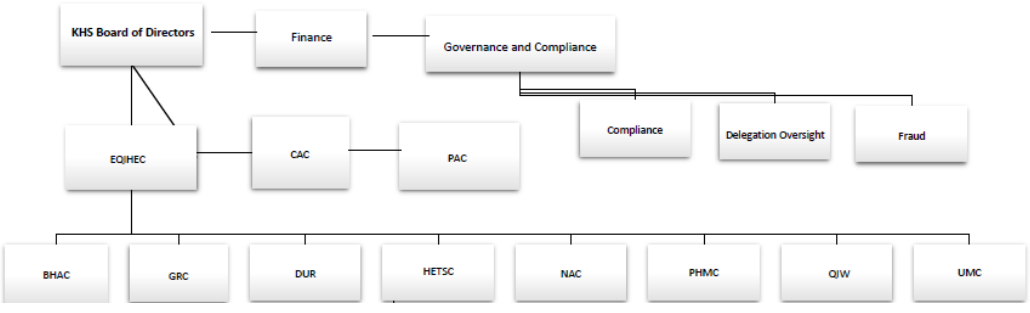
Chief Health Equity Officer

The Chief Health Equity Officer oversees development, implementation, review and revision of health equity policies and procedures; maintains the QIHEP description and work plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between Kern Health Systems and any regulatory agencies on health equity issues and programs. The CHEO sits on the EQIHEC and provides health equity perspective for all non-clinical areas; the CHEO seat may not be delegated. The CHEO oversees the development, evaluation, and/or revision of the QIHEP description. The CHEO also oversees how health equity is embedded into the KHS culture for all non-clinical aspects (i.e., marketing, member engagement, member services, community supports, etc.).

Executive Quality Improvement Health Equity Committee (EQIHEC)

The Executive Quality Improvement Health Equity Committee (EQIHEC) reports to the Board of Directors (BOD) and retains oversight of the QI Program with direction from the Chief Medical Officer (CMO). The EQIHEC provides overall direction for continuous improvement and evaluation of activities, including improving member outcomes. Additionally, EQIHEC is responsible for monitoring and ensuring that all QI activities are implemented to improve care and services for KHS members through a health equity lens. Thirteen (13) positions are filled; four (4) EQIHEC meetings were held in the reporting period with attendance from the CMO, CHEO, primary care practitioners, specialists, pharmacist, home health/hospice, DME providers, county Public Health Department, and members for the Community Advisory Committee (CAC). Quorum was met at every meeting. Overall, the EQIHEC structure was sufficient and EQIHEC provided oversight and support to the QI Program. The parameters for membership and meeting frequency were met for 2024, and activities included discussion, review and approval of reports and policies and procedures for QI and accreditation activities.

EQIHEC Sub-committees



There are KHS sub-committees in place to support the EQIHEC and QIHEP objectives and goals. The activities of the subcommittees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. This information is reported at a minimum quarterly to the EQIHEC in the format of formal reports.

Behavioral Health Advisory Committee (BHAC)

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee to the EQIHEC and is charged with facilitating collaborative coordination of medical and behavioral health and substance use disorder services between KHS and Kern County Medi-Cal Behavioral Organization (MBHO) and Certified SUD providers caring for KHS members with the goal to maintain continuity and reduce barriers to appropriate initial and continuity of care.

KHS responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County MBHO manages severe mental health impairment referred to as Specialty Mental Health Services.

For substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program. KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

The BHAC is chaired by a KHS credentialed and participating behavioral health provider. Committee attendees include community providers and stakeholders and internal KHS staff in Population Health Management, Utilization Management, Health Equity, Pharmacy, and Quality Improvement Departments. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Drug Utilization Review Committee (DUR)

The Drug Utilization Review (DUR) committee is a subcommittee that reports to the EQIHEC. The DUR is comprised of KHS' CMO and Director of Pharmacy along with network pharmacists and providers in the community serving KHS members. The DUR is responsible for reviewing matters related to the use of medications provided to KHS members. The basic objectives are to provide appropriate medication management for members improving their health and safety (administered in the outpatient settings by physicians under KHS' Division of responsibility, assist with case management, and monitor for possible FWA). RX Medi-Cal retains responsibility for formulary drugs carved out to them by the DHCS. KHS may address alternatives, based on safety and efficacy, and to minimize therapeutic redundancies; for those drugs dispensed under the MCRx program.

Four (4) DUR meetings were held during the reporting period with attendance from CMO, independent/retail pharmacy, pediatrician, RX representative (board member), pharmacy specialty practice, pharmacy/geriatric specialist, general practice/geriatrics and KHS Pharmacy Director/Alternate Chairperson. Quorum was met at every meeting. The parameters for membership

and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Grievance Review Committee (GRC)

Under the direction and oversight of the Chief Medical Officer (CMO) and physician designee, individual and aggregate data on member grievances are reviewed by the Grievance Review Committee (GRC). The GRC is a subcommittee of the EQIHEC. The committee is charged with evaluating and analyzing Grievance data to identify systemic patterns of improper services, denials and other trends impacting health care delivery to members by implementing necessary changes and process improvements for any adverse trends identified.

All complaints, grievances, investigations, follow-up, tracking, and trending reports are prepared by the KHS Member Services Department and submitted to the GRC. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024.

Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC) is a subcommittee of the EQIHEC. The HETSC is established to ensure that KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The HETSC is responsible for implementing organizational-wide initiatives that promote social and racial justice and health equity through various internal and external activities or training. The HETSC participates in the EQIHEC by assigning HETSC designees to regularly participate and provide input in the EQIHEC meeting. The HETSC is responsible for submitting and presenting regularly scheduled summaries of HETSC formal reports to the EQIHEC reflective of planned activities, goals, interventions, and ongoing goal progress. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Network Advisory Committee (NAC)

The Network Advisory Committee (NAC) is charged with implementing industry best practices related to KHS contracted providers and delegates to ensure network practitioners participation in the QI program through planning, design, and review of programs, quality improvement activities, interventions, and evidence based clinical practice guidelines designed to improve performance. Access and availability include meeting geographical distance, timeliness, network adequacy, and cultural and linguistic standards to meet the needs of the KHS membership. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Physician Advisory Committee (PAC)

Serves as the KHS Peer Review and Credentialing Committee on health care issues, peer review, provider discipline, the evaluation of basic practitioner qualifications, competency and professional conduct in the credentialing/recredentialing decisions. This committee meets at least ten times per year and is responsible for reviewing practitioner/provider grievances and/or appeals,

practitioner/provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer.

The PAC has a total of ten (10) voting committee positions. There were nine (9) active voting members in 2024. Ten (10) PAC meetings were held during the reporting period with attendance from CMO, pediatrician, cardiologist, ophthalmologist, OB-GYN, pain medicine provider, family practitioner and internal medicine provider. Quorum for voting members was met at each meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of credentialing policies and procedures, evaluating the credentials of all current and prospective practitioners and providers in a non-discriminatory manner; delegated credentialing oversight; conducting performance monitoring from quality improvement activities and member complaints in the recredentialing decision making process; and recommending corrective or disciplinary action concerning network participation in the KHS Provider Network, when applicable.

Population Health Management Committee (PHMC)

The Population Health Management Committee (PHMC) is a subcommittee of the EQIHEC. The PHMC oversees the Population Health Management (PHM) Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHMC is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions. The PHMC is a collaborative committee that engages community providers and partners along with internal business units from multiple KHS departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) meets every quarter and reports to the BOD. CAC has fourteen (14) committee positions. All fourteen (14) positions are filled; Four (4) CAC meetings were held in the reporting period with attendance from Kern County Dept of Public Health, Kern County Dept of Human Services, community representatives, participating healthcare provider, members of KHS BOD, and KFHC members. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

Quality Improvement Workgroup (QIW)

The focus of the QIW is on clinical quality, patient safety, and patient and provider experience in four functional areas of HEDIS, Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, and Network Clinical Oversight. The QIW is a subcommittee of the EQIHEC and is responsible for ensuring meeting or exceeding minimum performance levels (MPLs). The QIW oversees the DHCS-required Studies: Performance Improvement Projects (PIPs) selected by KHS. The QIW will ensure KHS members receive quality health care by identifying and addressing

outcomes that deviate from standards. Quorum was met at three (3) of four quarterly meetings. The parameters for membership and meeting frequency were met for 2024.

Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on UM activities. The UMC supports the EQIHEC in the appropriate provision of medical services and provides recommendations for UM activities. The UMC consists of actively participating KHS medical providers that include PCPs and Specialists including a Behavioral Health practitioner. The responsibilities of the UMC are to develop, recommend, and refine the UM program and policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information with the involvement of appropriate, actively practicing practitioners. Only physicians have voting rights on clinical matters. Quorum was met at every meeting. The parameters for membership and meeting frequency were met for 2024 and activities included review and approval of policies and procedures.

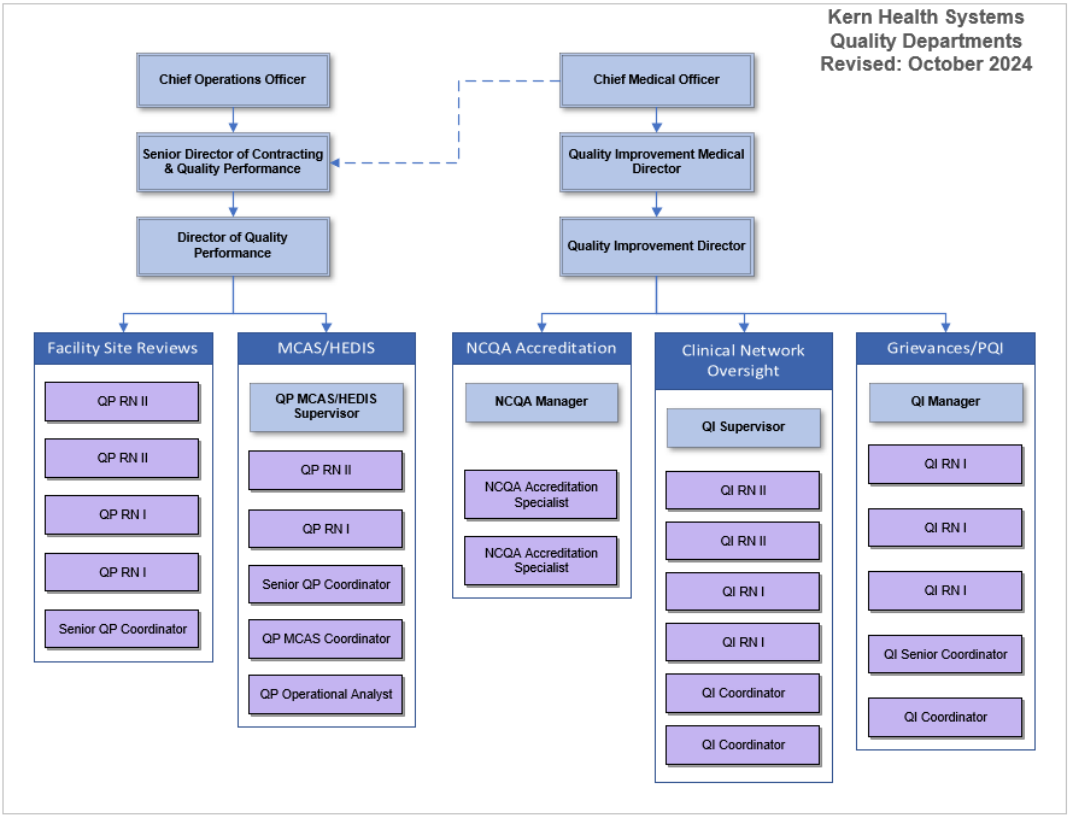
III. Quality Improvement Departmental Changes

The structure of the QI Department, including committee structure, position changes, staff and team roles and responsibilities are periodically assessed. Consideration is given to new state and regulatory directives and requirements, member safety and network needs, general business needs and capabilities, staff growth and development, and fiscal responsibility.

The following changes were made in 2024:

- Member Safety
    - Clinical Network Oversight was added as a function of the Quality Improvement Department. The goal of the Clinical Network Oversight (CNO) program is to support and improve the health and well-being of KHS members. This is achieved by ensuring consistency of KHS providers in the use of evidence-based standards of practice. Achieving this goal incorporates the following activities:
        - Defining and adopting evidence-based, clinical guidelines for key conditions.
        - Educating relevant providers of the adopted evidence-based, clinical standards of care.
        - Conducting an auditing process to measure actual provider performance against the adopted standards of practice.
        - Identifying opportunities for improvement using tools to evaluate network use of adopted standards of care.
        - Acting on identified opportunities for improvement.
        - Evaluating outcomes of changes made to ensure intended goals are achieved.
        - Sharing best practices identified with the provider network.

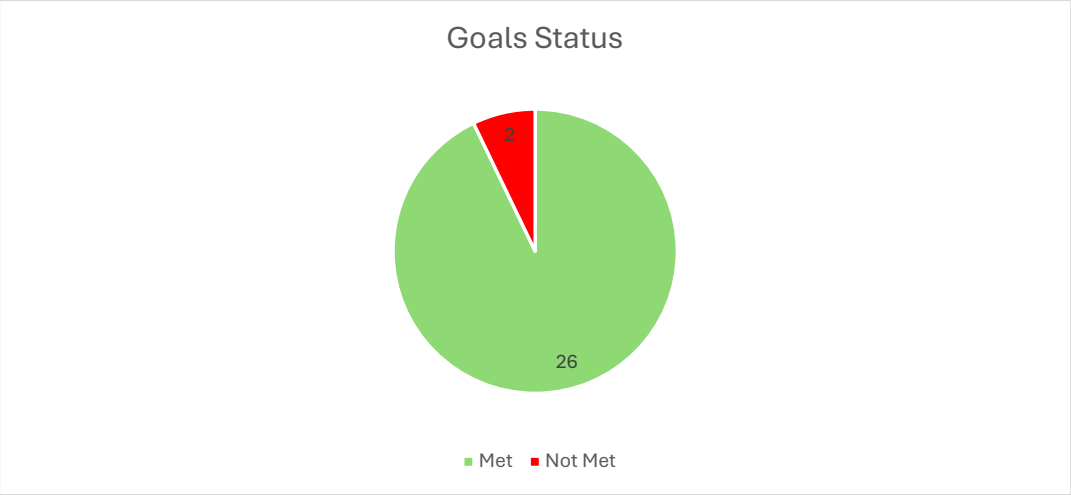
- Quality Performance
    - With the growing responsibilities and scope of the Quality program at KHS, the Quality Improvement Department split into two separate departments with distinct roles and shared responsibility of the QI Program.
        - The Quality Improvement Department is responsible for Quality-of-Care grievances, Appeals, Clinical claims and disputes, and Clinical Network Oversight.
        - The new Quality Performance Department is responsible for the Managed Care Accountability Set (MCAS) measures, Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Review Surveys.
- Personnel
    - The following positions were added to meet the demands of the business:
        - Senior Director of Contracting and Quality Performance
        - Director of Quality Performance
        - Quality Performance MCAS/HEDIS Supervisor
        - Quality Improvement Supervisor



IV. 2024 QI Work Plan Summary

The QI Work Plan is designed to track progress on key Quality activities and initiatives throughout the year. Approved by the EQIHEC and the Governing Board, it included progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care and quality of service. This update includes progress on activities from January 1, 2024 through December 31, 2024.

Goals were assessed on level of completion based on results presented from the responsible stakeholders. For 2024, KHS was able to achieve twenty-six (26) goals as "Met" and two (2) goals as "Not Met". Resources were adequate to support the QI Program overall. KHS has increased the number of resources in the Quality Departments and Member Services Department to meet the goals and work towards achieving the unmet goals in the near future (See Section *IV. Quality Improvement Departmental Changes*).



V. Quality Program Structure

	Metric	Goal	Result
1	QI Program Description	Annual Approval by the EQIHEC and the BOD	Met
2	Annual QI Work Plan	Annual Approval by the EQIHEC and the BOD	Met
3	Annual QI Evaluation	Annual Approval by the EQIHEC and the BOD	Met
4	Policies & Procedures	Annual Approval by the QI Subcommittee	Met
5	Executive Quality Improvement Health Equity Committee (EQIHEC)	Conduct Quarterly Meetings as required by the QI Program	Met

Kern Health Systems (KHS) maintains a comprehensive Quality Improvement (QI) Program designed to enhance member health outcomes, ensure regulatory compliance, and drive continuous improvement in healthcare services. The program is guided by structured policies, strategic

planning, and oversight from key governance bodies, ensuring that all initiatives align with organizational and regulatory standards.

The QI Program Description serves as the foundational document outlining the scope, objectives, and key components of the Quality Improvement Program. It defines the framework for monitoring performance, identifying opportunities for improvement, and implementing interventions that enhance member care. This document was reviewed and approved by the Executive Quality Improvement Health Equity Committee (EQIHEC) and the Board of Directors (BOD) to ensure alignment with strategic priorities and regulatory requirements.

The Annual QI Work Plan is a structured roadmap that details the initiatives and activities planned for the year to achieve quality improvement goals. It includes specific performance measures, responsible parties, and timelines for execution. The plan was reviewed and approved by the EQIHEC and BOD, ensuring that quality initiatives remain on track and are responsive to emerging healthcare trends and member needs.

The Annual QI Evaluation assesses the effectiveness of the QI Program by analyzing data, reviewing completed initiatives, and measuring progress against established goals. It identifies areas of success and opportunities for enhancement, providing a data-driven approach to refining the program. This evaluation undergoes annual approval by the EQIHEC and BOD, ensuring accountability and continuous program evolution.

To maintain compliance and standardization across quality initiatives, KHS implements and regularly updates QI Policies & Procedures. These policies provide clear guidelines for quality-related processes, ensuring that all actions align with best practices and regulatory requirements. The QI Department conducted an annual review and approval of these policies, reinforcing a structured approach to quality governance.

The Executive Quality Improvement Health Equity Committee (EQIHEC) plays a vital role in overseeing quality and health equity efforts across KHS. The committee convenes quarterly, as mandated by the QI Program, to review progress, address challenges, and guide strategic decision-making. In 2024, all required meetings were conducted, ensuring continuous oversight and engagement in quality and health equity initiatives.

Through these governance processes, KHS demonstrates its commitment to excellence in healthcare delivery, continuous quality improvement, and equitable health outcomes for all members.

VI. Quality of Clinical Care

	Metric	Goal	Result
6	MCAS Measures meet MPL	Timely submission of all 18 measures and meet MPL for all 18 measures	Not Met
7	Clinical PIP	Establish interventions in 2024	Met
8	Non-Clinical PIP	Establish interventions in 2024	Met
9	Monitor PQI Volume month over month	Decrease Median Volume of last 12 months	Met
10	PQI Volume by Provider and by severity	Severity Level 2/3 Volume is less than 30	Met

11	PQI Volume by Ethnicity and by Severity	Severity Level 2/3 Volume is less than 30	Met
12	PQI Timeliness of resolution	Within 120 Days	Met
13	Continuity and Coordination of Medical Care	Establish Baseline	Met
14	Continuity and Coordination Between Medical Care and Behavioral Healthcare	Establish Baseline	Met

A. Quality Measures & Performance Improvement

MCAS measures are selected by DHCS and typically include a combination of HEDIS and Medicaid's Adult and Child Health Care Quality Measures. The previous calendar year is the standard measurement year for MCAS data. Therefore, the MCAS Report Year (RY) 2024 results reflect Measurement Year (MY) 2023 data. MCAS RY 2025 results are not available until June 1, 2025, following the timeline for submission of these rates to NCQA and DHCS. The Minimum Performance Level (MPL) is set by DHCS, and the percentile benchmarks are provided by NCQA in their annual Quality Compass Report. All Managed Care Plans (MCPs) are required to exceed the 50th percentile for each measure benchmark.

Results:

	Measurement Year	MY2022			MY2023		
	Total Measures Held to MPL	15			18		
	Met MPL	5			8		
	Did not meet MPL	10			10		
	Measure	Rate	MPL	Rate Vs MPL	Rate	MPL	Rate Vs MPL
	Hybrid Measures Held to MPL						
AWC	Adolescent Well-Care Visits						
ABA	Adult Body Mass Index Assessment						
CCS	Cervical Cancer Screening	52.8	57.64	-4.84	57.18	57.11	0.07
CIS-3	Childhood Immunization Status – Combo 3						
CIS-10	Childhood Immunization Status Combo 10	27.98	34.79	-6.81	24.82	30.9	-6.08
CDC-E	Comprehensive Diabetic care- Eye Exam (Retinal) Performed						
CDC-HT	HbA1c Testing						
CDC-H9 *	HbA1c Poor Control (>9.0%)						
CDC-H8	HbA1c Control (<8.0%)						
CDC-N	Medical Attn. for Nephropathy						
CDC-BP	Blood Pressure Control <140/90						
CBP	Controlling High Blood Pressure	60.58	59.85	0.73	65.21	61.31	3.9
HBD*	Hemoglobin A1c Testing & Control for Patients With Diabetes	39.17	39.9	-0.73	32.85	37.96	-5.11
IMA-2	Immunizations for Adolescents (Combo 2)	29.68	35.04	-5.36	34.06	34.31	-0.25
LSC	Lead Screening in Children	47.45	63.99	-16.54	58.64	62.79	-4.15
PPC-Pre	Timeliness of Prenatal Care	87.35	85.4	1.95	87.1	84.23	2.87
PPC-Pst	Postpartum Care	83.94	77.37	6.57	86.37	78.1	8.27
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents						
WCC-N	Counseling for Nutrition						
WCC-PA	Counseling for Phys Activity						
W-34	Well-Child Visits						

Administrative Measures Held to MPL							
AMR	Asthma Medication Ratio				72.1	65.61	6.49
BCS	Breast Cancer Screening	56.68	50.95	5.73	59.3	52.6	6.7
CHL	Chlamydia Screening in Women Ages 16 – 24	53.67	55.32	-1.65	56.87	56.04	0.83
DEV	Developmental Screening in the First Three Years of Life				25.94	34.7	-8.76
FUA - 30 Day Follow-up*	Follow-Up After Emergency Department Visit for Substance Use	15.74	21.24	-5.5	18.85	36.34	-17.49
FUM - 30 Day Follow-up*	Follow-Up After Emergency Department Visit for Mental Illness	18.8	54.51	-35.71	19.12	54.87	-35.75
TFL-CH	Topical Fluoride for Children				16.44	19.3	-2.86
W30 (0-15M)	Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	37.12	55.72	-18.6	39.21	58.38	-19.17
W30(15-30M)	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.	55.12	65.83	-10.71	63.74	66.76	-3.02
WCV	Child and Adolescent Well-Care Visits	37.12	48.93	-11.81	46.55	48.07	-1.52

MCAS measures were stratified by race/ethnicity in MY 2023:

- Measures held to MPL:
  - Breast Cancer Screening (BCS-E)
  - Prenatal and Postpartum Care:
    - Timeliness of Prenatal Care (PPC-Pre)
    - Postpartum Care (PPC-Pst)
  - Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) - (HBD)
  - Asthma Medication Ratio (AMR)
  - Controlling High Blood Pressure (CBP)
  - Well-Child Visits in the First 30 Months of Life
    - 0-15 months (W30 15M)
    - 15-30 months (W30 30M)
  - Immunizations for Adolescents: Combo 2 (IMA2)
  - Follow-Up After ED Visit for Mental Illness – 30 Days (FUM)
  - Follow-Up After ED Visit for Substance Abuse - 30 Days (FUA)
  - Child and Adolescent Well-Care Visits (WCV)

- Measures not held to MPL
  - Colorectal Cancer Screening – (COL-E)
  - Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
  - Follow-Up After ED Visit for Mental Illness – 7 Days (FUM)
  - Follow-Up After ED Visit for Substance Abuse - 7 Days (FUA)
  - Pharmacotherapy for Opioid Use Disorder (POD)
  - Plan All-Cause Readmissions (PCR)

QUANTITATIVE ANALYSIS: Based on results for MY2023/RY2024:

KHS met the MPL in 8 out of 18 MCAS measures:

- Cervical Cancer Screening (CCS)
- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) - (HBD)
- Timely Prenatal Care (PPC-Pre)
- Timely Postpartum Care (PPC-Post)
- Breast Cancer Screening (BCS - E)
- Chlamydia Screening in Women (CHL)
- Asthma Medication Ratio (AMR)

13 out of 18 measures showed improvement from MY2023/RY2024 compared to MY 2022:

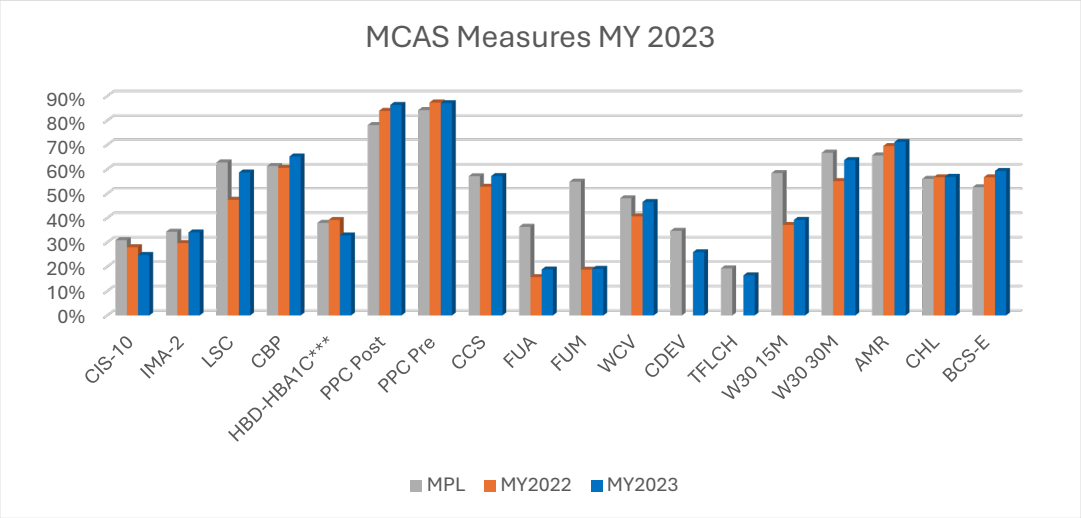
- Immunizations for Adolescents: Combo 2 (IMA2)
- Lead Screening in Children (LSC)
- Cervical Cancer Screening (CCS)
- Controlling High Blood Pressure (CBP)
- Postpartum Care (PPC-Post)
- Follow-up After ED Visit for Substance Use (FUA)
- Follow-up After ED Visit for Mental Illness (FUM)
- Breast cancer Screening (BCS-E)
- Well Child Visits (0-15 mos)
- Well Child Visits (15-30 mos)
- Child and Adolescent Well Care Visits (WCV)
- Chlamydia Screening for Women (CHL)
- Asthma Medication Ratio (AMR)

3 out of 18 measures had lower levels of compliance compared to MY2022/RY2023

- Childhood Immunization Status: Combo 10 (CIS-10)
- Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (>9%) - (HBD)
- Timeliness of Prenatal Care (PPC-Pre)

No measures were removed, and the following measures were added for monitoring starting in MY 2023:

- Asthma Medication Ratio
- Developmental Screening in the First Three Years of Life
- Topical Fluoride for Children



As illustrated above, measures that surpassed the minimum performance levels (MPL) include Controlling Blood Pressure, Prenatal and Postpartum Care, Breast Cancer Screening, Asthma Medication Ratio, Hemoglobin A1c Control for Patients with Diabetes, Cervical Cancer Screening, and Chlamydia Screening for Women.

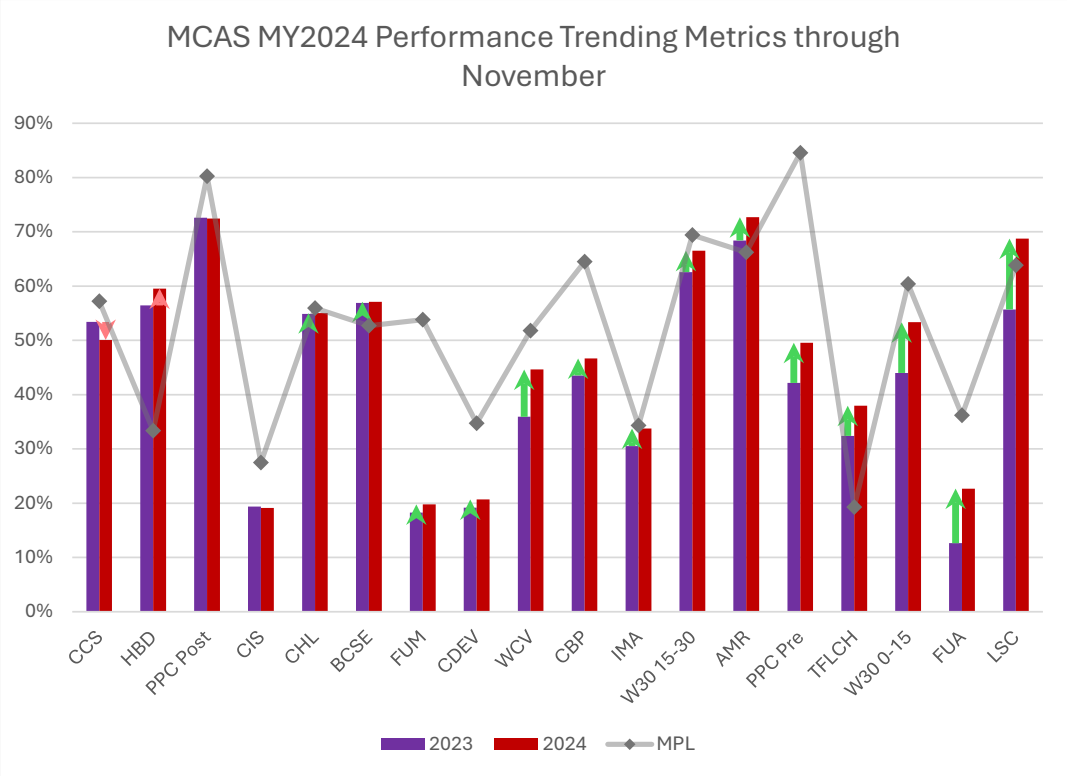
MCAS measures under the Children and Behavioral Health Domain not meeting state-wide minimum performance level (MPL), include:

- WCV
- CIS-10
- IMA 2
- LSC
- W30
- W15
- TFL
- CDEV
- FUM
- FUA

Year over Year MCAS Performance

Measurement Year	MY2017	MY2018	MY2019	MY2020	MY2021	MY2022	MY2023
KHS Membership	242,265	246,564	251,280	277,616	299,864	334,078	346,049
MPL Percentile	25th	25th	50th	50th	50th	50th	50th
Total Held to MPL	21	20	18	19	15	15	18
Met MPL	19	18	3	2	5	5	8
Did Not Meet MPL	1	2	15	17	10	10	10

MY2024 MCAS Trending Performance:



14 measures are trending higher than the previous year at the same point in time:

- Asthma Medication Ratio
- Breast Cancer Screening
- Controlling Blood Pressure
- Developmental Screening in the First 3 Years of Life
- Chlamydia Screening in Women
- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After Emergency Department Visit for Mental Illness
- Immunization for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care – Pre
- Topical Fluoride for Children
- Well-Child Visits in the First 30 Months of Life – 0-15months
- Well-Child Visits in the First 30 Months of Life – 15-30months
- Child and Adolescent Well-Care Visits

4 measures are trending lower than the previous year at the same point in time:

- Cervical Cancer Screening

- Childhood Immunization Status
- Hemoglobin A1c Testing & Control for Patients with Diabetes
- Prenatal and Postpartum Care – Post

QUALITATIVE ANALYSIS:

The primary factors impacting compliance with MCAS measures:

- Opportunity to improve software vendor processes and communication
- Acquisition of high-volume lab provider led to short term decreased incoming data, which impacted MCAS compliance rate for specific measures
- Residual effects of Covid 19
    - Vaccine hesitancy
    - Reduced volume of members going to their PCP for preventive health services continued to reflect in lower-than-normal compliance rates for the MCAS measures.
- Members in rural areas have difficulty accessing care because of difficulty in transportation services. KHS has a dedicated team focused on member outreach and transportation assistance.
- Members do not understand the importance of preventive care.
- Lack of primary care physicians to provide services in the rural areas.

In summary, these factors affected the results of MCAS measures:

1. **Training Resources**
    a) Insufficient QI knowledge for external staff (including leadership) to support quality initiatives.
    b) Lack of QI SMEs to serve as company-wide resources and to lead the initiatives.
    c) Ineffective member outreach to support member engagement and active participation in their care due to insufficient understanding of MCAS measures and development of effective engagement strategies.

2. **Collaboration/Communication**
    a) ELT working in silos and not coordinating with QI and other departments.
    b) Lack of staff and department accountability for not participating in QI activities.
    c) Lack of organization alignment with QI activities.
    d) Insufficient collaboration and coordination with community partners and provide network to support compliance with preventive health measures.

3. **Providers**
    a) Lack of accountability for providers to address gaps in care due to non-specific data exchange requirements.
    b) Provider contracts and payment structure do not follow a payment model for providers to proactively manage members from a quality-of-care perspective.
    c) Insufficient provider resources to fully establish quality goals within their practice management processes.

d) Lack of focused provider education to help with the interpretation of data and strategies to yield positive outcomes.

4. **Outcomes/Process**
   a) Departments work in silos due to lack of uniform communication process for issues and activities impacting MCAS.
   b) Lack of evaluation process for identifying the departments should be involved in the QI initiatives and projects.
   c) Lack of adequate staff and continuous staff turnover.
   d) Lack of timely and effective outcomes analysis to make strategic changes quickly in sync with the results due to untimely receipt of outcomes data.
   e) Lack of established process to identify lessons learned that strategically support changes for future MCAS initiatives to improve results.
   f) Lack of internal KHS staff accountability for follow-through due to lack of misaligned priorities of MCAS measures to the plan.

CORRECTIVE ACTION REQUIRED BY DHCS:
Failure to meet MPL resulted in corrective actions and financial penalties. DHCS established a new Performance Tier System effective for MY2024 MCAS compliance results with follow-up corrective actions and sanctions based on overall performance, domains of care, and improvements compared to previous performance years.

Strategies and Action Plan:

Goals: Improve the following QI Gaps and meet 50th percentile or minimum performance level.

1. Provider Engagement
2. Collaboration
3. Member Engagement
4. Collaboration and Partnerships

Strategies	Action Items
# 1 Provider Engagement Objective: Coordinate with providers to address appointment availability challenges with PCPs and BH within timeframe of 7 and/or 30 days of ED visit.	**1.a.** Identify 3 providers who are low performing for FUA and FUM MCAS measures and meet with them bi-monthly to develop interventions to support improvement. **1.b.** Leverage mobile units to increase appointment options.
# 2 Collaboration Objective: Increase timely ED visit notifications to providers and support outreach to members for timely follow-ups.	**2.a.** Update internal dashboard and provider portal for ease of access to members requiring follow-up visit. **2.b.** Focused outreach specialist to contact members with ED visits identified in dashboard and assist with scheduling appointment with PCP or BH.
# 3 Member Engagement Objective:	**3.a.** Work with Marketing and Member Engagement to develop a routine text message campaign for mobile unit notification for KHS members.

Leveraging internal (Marketing, Health Equity, Health Education) and external stakeholders to develop specific initiatives/engagement of efforts to the children's domain of care.	**3.b.** Leverage mobile units to close gaps in care in coordination with 5 mobile unit providers. **3.c.** Evaluate effectiveness of text messaging campaign
#4 Collaboration/Partnerships Objective: Improved communication and collaboration between MCP, providers, and parents/guardians. (Parent square, provider meetings, mobile units at schools).	**4.a.** Identify top 20 providers by membership volume and schedule routine joint operations meetings to support overall education and improvement of MCAS performance. **4.b.** Collaborate with school districts to promote school based mobile events via electronic parent communication systems.

Action Plan for 2025:

Ensuring access to high quality and equitable care is part of KHS' mission. The Quality Performance team will continue with initiatives that have led to positive outcomes and gaps in care closed for our members. This includes:

- Diabetic Management program led by a contracted Endocrinologist
- A dedicated Member Outreach team solely focused on telephonic outreach to close gaps in care
- Collaboration and partnerships with local providers to offer extended hours and weekend appointments for children and adolescents
- Mobile Unit partnerships across Kern County with school districts and various community-based organizations
- Improved data quality and increased data sources
- Monthly campaigns for preventive services in collaboration with Marketing and member facing departments

B. Performance Improvement Projects (PIPs)

Performance Improvement Projects (PIPs) are a key federal protocol used by DHCS for the External Quality Review (EQR) of MCPs. DHCS has identified two categories for the two PIPs MCPs are required to conduct: a) Children's Health and b) Behavioral Health. Each PIP occurs over approximately 3 years, from 2023-2026. MCPs must design PIPs to systematically improve these areas. The PIPs are designed to enhance quality and outcomes of health care for Medi-Cal members.

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

Both PIPs completed 2 of the 4 modules. Module 1 for both PIPs have been accepted by DHCS. Module 2 requires a re-submission to DHCS for both PIPs. Module 1 focused on outlining the framework for each project. Module 2 identified the Quality Improvement activities that have a potential impact to the SMART Aim (defining the population and PIP process). Module 3 will include continued incremental testing of interventions to support adjustments to the interventions and will

be submitted in September of 2025. Module 4 will be completed in September of 2026 and will provide a conclusive summary of outcomes and recommendations.

KHS initiated a cycle of PIPs for 2023-2026 in September of 2023 through the External Quality Review Organization (EQRO), HSAG, acting on behalf of DHCS. The two active PIPs during 2023 included:

1. **Clinical PIP: Improving W30 Measure Rates Among Black/African American Infants 0 -15 Months Old.**

This clinical Performance Improvement Project is three years in length, with a baseline measurement period of 2023 and remeasurements in 2024 and 2025. Yearly submissions are conducted the September of the following year, meaning the last submission will occur in September of 2026.

This PIP has the potential to improve member health, functional status, and/or satisfaction:

- Regular well care visits provide opportunities for preventive care, review and discussion of child's milestones/behaviors/development, and identification and prompt treatment of any delays or anomalies, resulting in a reduction of hospitalizations and emergency department use.
- Regular well care visits create stronger trust-based relationships between pediatrician, caregiver, and child, and engage families in care during a critical time of growth in early life.
- Regular well care visits provide a long-lasting foundation of preventive health care and education for caregivers/parents, passed along to the children as they grow, resulting in long-term benefits in the child's health and care costs.

The defining AIM statement for this PIP helps to maintain focus and set a framework for data collection, analysis, and interpretation: Do targeted interventions improve the percentage of Black/African American children who complete six (6) or more well care visits on or before fifteen (15) months of life?

Included in each measurement period are the total number of (self-reported within race/ethnicity stratification) Black/African American infants within KHS' health plan who turned 15 months during the measurement year. Continuous enrollment is required, and members who used hospice or died anytime during the measurement year are excluded.

Data Elements: Collecting and calculating the W30 (0-15 Months) compliance rate is an automated process. KHS creates a report (Real Time HEDIS Trending) that calculates real time HEDIS rate for HEDIS measures including the W30 (0-15 months) Compliance rate. This program uses NCQA Technical specifications to determine numerators and denominators based on administrative data for the W30 measure. This HEDIS Trending Data will be reviewed yearly from January to December to identify any health disparity in the W30 (0-15 months) measure. Final rate as of each December are run after the claims lag of three months and are reported to HSAG.

Final MCAS rates for the W30, 0-15 months measure were 20.47% in MY2022, and 33.33% in MY2023. Preliminary rates in November of 2024 show W30, 0-15 months at 53.33% overall. The Minimum Performance Level (MPL) for W30, 0-15 months in MY2024 is 60.38%.

Activities: Our Quality Performance Director, MCAS Program Supervisor, and QP RN have monitored and utilized data from collaborative activities that effect this PIP population, including working with our internal departments (Health Equity Team, Health Education Team, Member Services Team, Member Engagement Team, Business Intelligence Team) and with external provider partners.

Regular meetings were conducted within our Quality Team, with supporting KHS teams (above), and external provider partners to learn if/how identified barriers were being addressed. Where gaps in the care process were identified, brainstorming was conducted, with recommendations and modifications taken where feasible. Specific intervention details are included on the separate Intervention Worksheets. Ongoing and regular meetings with mobile clinic providers take place to tailor care, as well as monthly meetings within the Quality team to review interventions and adjust where necessary.

QI Tools used to identify and prioritize barriers include a Key Driver Diagram, Cause & Effect (Fishbone/Ishikawa) Diagram, and a Process Map.

Two interventions were initiated in 2024 and continue into 2025, addressing the following barriers:

1. Mobile Well Visit Clinics- Pediatric Population- Access to care concerns such as transportation difficulties (having to move/install car seats or bringing multiple children to an appointment via bus or rideshare), scheduling that does not accommodate working parent(s) schedules, and childcare needs for other dependents that may hinder the ability of the parent/guardian to bring the infant for well-baby visits. At the time of September 2024 submission, a limited volume of members were engaged in events for this PIP's specific age range. The feedback from providers active with these mobile events is that members are happy with and appreciate the opportunity/process. Due to the nature and infancy stage of these events, it will take time to grow our audience to its full potential.

2. Member Services Outreach to the W30 Population for Scheduling and Transportation Assistance- Identification and engagement of members with gaps in care through collaboration with providers for scheduling and supporting access to care through transportation arrangements as needed. Data from 01/01/24 – 08/27/24 shows a 27% correlation rate between outreach calls and completed well baby visits. Conclusions indicate that this personal outreach has the potential to build relationships with our members and their families over more automated options, such as robocalls, however, a multi-pronged approach may increase compliance even further.

2. Non-Clinical PIP: Improve the percentage of provider notifications for members with SMH/SUD diagnoses following or within 7 days of emergency department (ED) visit.

The Non-Clinical Performance Improvement Project runs the length of 3 years. The baseline measurement period is 2023. Remeasurements are performed in September of 2024 and 2025. The final submission will be in September of 2026 and will summarize outcomes and recommendations. The non-clinical PIP targets ED visits for members 6 years and older with a principal diagnosis of mental illness or intentional self-harm (SMH) and members 13 years and older with a principal diagnosis of substance use or and diagnosis of drug overdose (SUD). Submission 1 was completed in 2023 and accepted by HSAG. Final submission will

be in September of 2026, Submission 4 will be completed detailing outcomes and the sustainability of the interventions.

The question that KHS must answer is, "Do targeted interventions improve the percentage of provider notifications for members with SMH/SUD diagnoses following or within 7 days of ED visit?" This PIP focuses on developing targeted interventions that are sustainable and measurable. This topic has the possibility to enhance member health, functional status, and/or satisfaction due to the following reasons:

- The period immediately after the ED visit is important for engaging individuals in treatment and establishing continuity of care.
- Provider notification of ED visits has the potential to improve care coordination and ensuring timely follow-up care.
- Timely follow-up care after and ED visit for mental illness or substance use disorder may reduce repeat ED visits, prevent hospital admissions, improve physical and mental function, and increase compliance.

The Non-Clinical PIP is currently in the intervention development and implementation stage. We are leveraging the following resources during this phase:

- Daily Admission, Discharge, and Transfer (ADT) report from participating EDs.
- Participating Providers are provided the ADT report through secure email or SFTP files.
- The ADT report is uploaded to the Provider Portal, offering an additional option to Providers to obtain this information.
- Using the ADT report, the KHS Behavioral Health (BH) team has been performing Provider outreach.
- Provider meetings are performed regularly to share updates and education regarding the notification process.
- KHS Provider Network Management is notified and educated on updates to the notification process to also assist Providers with questions/issues.

These interventions have helped increase our Provider notifications to 84% in 2024.

C. Potential Quality of Care Issues (PQI)

PQI Identification and Review Process

When a potential quality issue (PQI) is identified from a member grievance, the Grievance Team refers the case to the Quality Improvement (QI) Registered Nurse (RN) for initial review. If the QI RN determines that a PQI may be present, the grievance is escalated to the Medical Director for further investigation and final determination. If the Medical Director confirms the presence of a PQI, the case is referred to the QI Department to initiate the formal PQI investigation.

The grievance referred as a PQI is entered into the KHS Medical Management System, triggering an RN to begin the investigation. After completing the investigation, the QI Medical Director conducts a final review, determines the existence of a quality-of-care issue, and assigns the PQI severity level as follows:

- **Level 0** – No quality of care concern
- **Level 1** – Potential for harm
- **Level 2** – Actual harm
- **Level 3** – Actual morbidity or mortality failure

PQI Volume Month over Month

Severity	2023 Total	2023 Median	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	2024 Total	2024 Median
0	855	58.5	42	44	45	19	34	33	19	25	21	10	30	32	354	31
1	582	45.5	50	31	27	30	39	38	44	40	23	39	23	42	426	38.5
2	10	1	0	0	0	2	0	0	0	0	0	0	0	2	4	0
3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1447	99	92	75	72	51	73	71	63	65	44	49	53	76	784	68

Quantitative Analysis:

In 2024, the total PQI volume was 784, achieving the target of reducing the median PQI volume from the previous 12 months. The 2024 median monthly PQI volume was 68, a reduction from 99 in 2023, indicating successful mitigation of quality concerns.

- Level 0 cases: 354
- Level 1 cases: 426
- Level 2 cases: 4 (below the target threshold of 30)
- Level 3 cases: 0

PQI volumes fluctuated month-to-month, with December 2024 having the highest number (76) and September 2024 the lowest (44). The data suggests that proactive quality interventions contributed to stabilization and reduction of PQIs across all severity levels.

Qualitative Analysis:

The timeliness of PQI resolution was maintained within the 120-day benchmark, meeting compliance standards. The severity-based target of keeping Level 2 and Level 3 cases below 30 was also achieved, highlighting the effectiveness of intervention efforts.

Analysis identified provider-patient communication gaps as a primary driver of PQIs, leading to targeted training initiatives and improved care coordination strategies. Collaboration between the Grievance Team, QI Department, and Medical Directors strengthened PQI identification and classification accuracy. Additionally, disparities in ethnicity-related PQI severity were closely monitored, with Level 2 and Level 3 cases remaining below established thresholds. Moving forward, provider engagement, member education, and culturally responsive care will remain key priorities to sustain quality improvements in 2025.

PQI Volume by Provider and by Severity

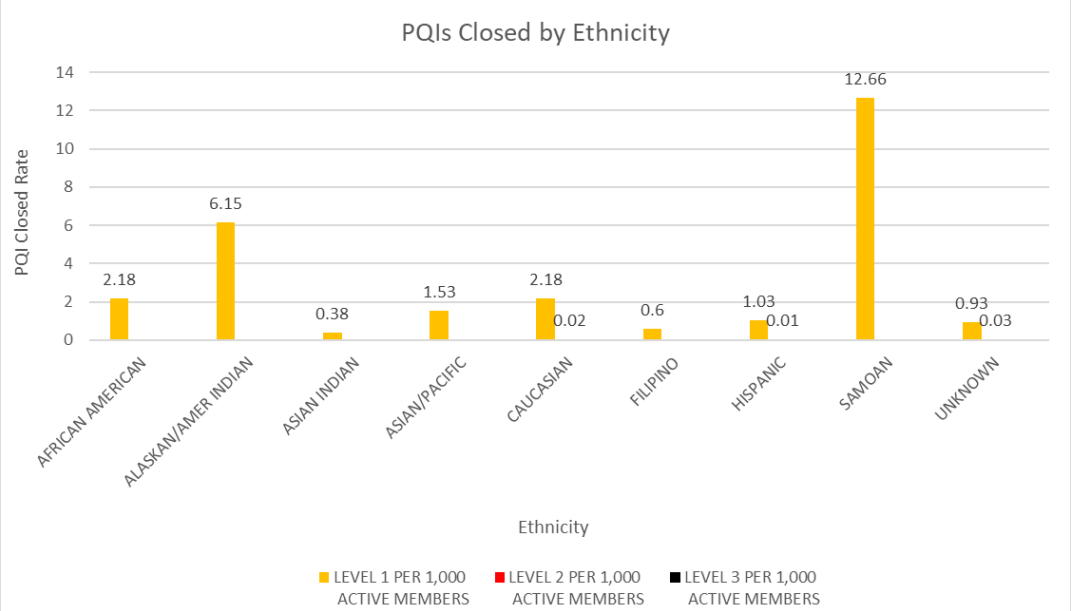
TOP 5 Outpatient Providers with PQIs January 2024 - December 2024					
Top 5 Providers with PQIs leading to Actual Harm or Morbidity (Level 2 and 3)	Level 1- Potential for Harm PQIs Per 1000 Visits	Level 2-- Potential for Harm PQIs Per 1000 Visits	Level 3-Actual Morbidity PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
PROVIDER A	0.0	1.86	0.00	539	1.86
PROVIDER B	0.0	0.46	0.00	2,174	0.46
Top 5 Provider for Total PQIs (Level 1, 2 and 3)	Level 1- Potential for Harm PQIs Per 1000 Visits	Level 2-- Potential for Harm PQIs Per 1000 Visits	Level 3-Actual Morbidity PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
PROVIDER C	0.97	0.00	0.00	10,334	0.97
PROVIDER D	0.56	0.00	0.00	14,221	0.56
PROVIDER E	0.53	0.00	0.00	15,175	0.53
PROVIDER F	0.20	0.00	0.00	9,946	0.20
PROVIDER G	0.51	0.00	0.00	7,826	0.51

Based on the trending analysis conducted, above are the top 5 outpatient providers for the rolling 12 months (January 2024 – December 2024). The top 5 providers with PQIs leading to actual harm or morbidity to the member is based on the PQIs per 1000 Outpatient visits. From the above data, there were no providers identified with severity Level 3. Provider A and B had one PQI each at severity Level 2. Majority of the PQIs were closed at severity Level 0 and Level 1. There were no Level 3's.

Top 5 Inpatient Providers with PQIs January 2024 - December 2024						
Top Providers with PQIs leading to Actual Harm or Morbidity (Level 2 and 3)	Level 1- Potential for Harm	Level 1-Potential for Harm PQIs Per 1000 Discharges	Level 2-PQIs Per 1000 Discharges	Level 3-PQI's Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
PROVIDER A	6	1.21	0.40	0	4,946	1.62
Top 5 Provider for Total PQIs (Level 1, 2 and 3)	Level 1- Potential for Harm	Level 1-Potential for Harm PQIs Per 1000 Discharges	Level 2-PQIs Per 1000 Discharges	Level 3-PQI's Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
PROVIDER B	1	0.2	0.00	0.00	4254	0.24
PROVIDER A	6	1.2	0.40	0.00	4946	1.62
PROVIDER C	4	0.6	0.00	0.00	6713	0.60
PROVIDER D	1	4.3	0.00	0.00	232	4.31
PROVIDER E	0	0.0	0.00	0.00	7249	0.00

One inpatient provider had two (2) PQIs with severity Level – 2. None had a PQI with severity Level – 3. No providers were flagged for systemic quality concerns. QI will continue monitoring PQI trends for any emerging patterns

PQI Volume by Ethnicity and by Severity



Although the Samoan population had the highest PQI rate per 1,000 active members, this was based on a single PQI case within the population. Samoans account for approximately 0.03% of KHS membership, and with only half of the total membership having at least one interaction over the rolling 12 months, the PQI rate appears disproportionately high compared to other populations. No concerns have been identified, and QI will continue monitoring for potential trends.

The largest active member populations by ethnicity are Hispanic and Caucasian, both of which had over 100 PQIs closed, with Hispanic members having the highest volume. The majority of Hispanic PQIs were classified as Level 1 (223 cases). No concerning trends have been identified, and QI will continue tracking these volumes.

The 2024 PQI analysis demonstrates significant improvements in quality issue mitigation, provider performance, and timeliness of resolution. Despite fluctuations in monthly PQI volumes, key targets were met, including:

- Reduction in median PQI volume from 99 (2023) to 68 (2024)
- Level 2 and Level 3 cases remained below the threshold of 30 by provider and by ethnicity
- Timeliness of PQI resolution within 120 days

While no urgent concerns were identified, QI will continue monitoring trends and strengthening provider engagement, member education, and culturally responsive care to drive continuous quality improvement into 2025.

D. Continuity and Coordination of Medical Care

Kern Health Systems (KHS) assessed continuity and coordination of medical care, focusing on member movement between practitioners and across care settings. Key findings revealed persistent gaps in diabetic eye exam rates, with only 33.66% of eligible members receiving exams, falling short of the 51.5% national benchmark. Barriers included lack of care coordination, insufficient provider communication, and member access challenges. Additionally, only 39% of discharged members had a follow-up visit within seven days, highlighting the need for improved hospital-to-PCP communication and patient education. Interventions proposed include provider education, enhanced referral processes, leveraging technology for interoperability, and increasing member outreach on available resources like transportation. KHS remains committed to implementing targeted strategies to improve care transitions and achieve measurable health equity outcomes. See Appendix B for the full report.

E. Continuity and Coordination Between Medical Care and Behavioral Healthcare

Kern Health Systems (KHS) focused on enhancing the continuity and coordination of care between medical and behavioral health services to improve member outcomes. Key areas of assessment included the exchange of information between providers, the appropriate diagnosis and treatment of behavioral health disorders, the management of psychotropic medications, and access to follow-up care for individuals with co-existing medical and behavioral health conditions. The evaluation identified ongoing challenges such as fragmented communication, lack of standardized referral processes, and limited provider collaboration, particularly between primary care providers (PCPs) and behavioral health (BH) specialists. Despite these challenges, notable improvements were achieved in areas such as antidepressant medication management (AMM) and follow-up care for children prescribed ADHD medication (ADD), with targeted interventions increasing medication adherence and provider engagement. Additionally, the Behavioral Health Advisory Committee (BHAC) played a critical role in identifying barriers and implementing strategies to enhance care coordination, including provider education, the development of a more integrated provider portal, and improved data-sharing mechanisms. Moving forward, the QI program will continue to prioritize strategies that enhance communication, streamline referral processes, and foster a collaborative approach between medical and behavioral health providers to ensure equitable, high-quality care for all members. See Appendix C for the full report.

VII. Safety of Clinical Care

	Metric	Goal	Result
15	Facility Site Review	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	Met
16	Physical Accessibility Review Surveys	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	Met
17	Medical Record Reviews	Achieve medical record review score of 85% for each practitioner	Met

18	Credentialing/Recredentialing	100% timely credentialing/recredentialing of practitioners	Met

A. Facility Site Review (FSR)

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

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

The purpose of conducting site reviews is to ensure that all contracted PCP sites used by managed care plans for delivery of services to plan members have sufficient capacity to:

1. provide appropriate primary health care services.
2. carry out processes that support continuity and coordination of care.
3. maintain patient safety standards and practices; and
4. operate in compliance with all applicable federal, state, and local laws and regulations.

Quantitative Analysis:
In 2024 YTD, 97% of the Initial and Periodic Facility Site Reviews performed passed, 3% of them scored less than 80%. There were 37 Facility Site Reviews completed YTD, 1 of these reviews failed in the first audit. The one failed site completed and closed their CAPs. We will continue to monitor this for any trends.

For YTD 2024, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

1. Site does not utilize California Immunization registry (CAIR).
2. Calibration of equipment not done.
3. Airway management- Ambu bags and masks are deflated.

Site Review Timeliness:

A spreadsheet of reviews due and reviews completed were obtained through our site review system. Following a Corrective Action Plan (CAP), education is given to the providers and Focus Reviews are conducted three months after CAP closure to ensure site review compliance. Below is a table summarizing the reviews completed in 2024.

Review Type	# Reviews Due	# Reviews Completed	# Reviews Not Completed
Initial Facility Site Review	15	15	0
Initial Medical Record Review	17	17	0

Periodic Facility Site Review	21	21	0
Periodic Medical Record Review	19	19	0
Interim Review	33	33	0
Focused Facility Site Review	0	0	0
Focused Medical Record Review	13	13	0
Annual Review Medical Record Review	2	2	0
Annual Facility Site Review	1	1	0

In 2024 YTD, 78% of the Initial and Periodic medical record reviews performed passed, 22% of them scored less than 80%. There were 50 medial record reviews completed YTD, 11 of these reviews failed in the first audit.

For YTD 2024, top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

1. Yearly HIV Screening not being performed for both pediatrics and adults.
2. Member Risk Assessments not being assessed for both pediatrics and adults.
3. Adult Immunization not being given according to ACIP guidelines.

Qualitative Analysis:

Due to the increase of failed reviews, there is initial outreach one month prior to reviews to offer onsite provider education to ensure site readiness, technical assistance and education is offered through the entire CAP process. We will continue to monitor for any trends.

Barriers:

A new All Plan Letter, 22-017 for Facility Site Reviews took effect July 1, 2022. The new Tools and Standards were released 7/1/2022 becoming fully effective 1/1/2023. Due to the new DHCS Tools and Standards, there has been an increase in failed Medical Record Reviews. Educational sessions are being provided to providers and continued support is consistently offered and provided by the site review nurses in collaboration with Provider Network Representatives.

B. Physical Accessibility Review Surveys (PARS)

The Physical Accessibility Review Survey (PARS) is not a scored review and focuses entirely on physical accessibility of the healthcare site for seniors and persons with disabilities (SPDs). The PARS assesses the physical accessibility of provider sites for PCPs and high-volume specialists, ancillary, and CBAS provider who serve KHS SPD members. PARS are available to any contracted provider that request to be evaluated, regardless of whether they are determined to be high volume. KHS conducts PARS for new PCP sites at the time of initial credentialing or contracting, and every three years thereafter as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program. In 2024, 16 PARS were completed.

C. Medical Records Review (MRR)

Quantitative Analysis:

1. Initial: 17 Initial Medical Record Reviews were due and 17 were completed.
2. Periodic:19 Periodic Medical Record Reviews (PMRR) were due and 19 were completed. 2 Annual MRR were completed.
3. Interim: 33 interim reviews were due, and 33 were completed.

Qualitative Analysis:

Several Provider offices that have not had a recent medical record review are having difficulty complying with the new tools and standards making it more difficult to pass the Medical Record Review. We will continue to monitor for trends.

Barriers

There is one common deficiency noted over the course of 2024: Risk assessments not being performed for both pediatric and adults. This has been impacted by the sunset of the Staying Healthy Assessment form (SHA) in 2023. Providers are now required to complete the Social Determinants of Health (SDOH), Adverse Childhood experiences (ACES), Pediatric ACES and Related Life Events Screener (PEARLS) in place of the SHA.

Focus in 2024

Starting in January of 2024 with the sunset of the Staying Healthy Assessment (SHA), we saw an increase in failed medical record reviews. In response, we developed a strategy of educating office staff before Site Reviews were scheduled. This is not mandatory, but many of our sites welcomed the opportunity for education, especially our new offices. These risk assessments are the cornerstone of this new tool. There are 6 or more risk assessments required at an IHA, and one on one education has been the best way to bond with the office staff and effect change in the office.

D. Credentialing & Recredentialing

Credentialing of new applicants are processed within 180 calendar days and recredentialing is processed every 36 months. In 2024, 100% of the providers were credentialed or recredentialed timely. There are access challenges within the provider network and KHS is working with its delegated groups and network providers to identify opportunities to improve access.

VIII. Quality of Service

	Metric	Goal	Result
19	Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	Met
20	Grievances & Appeals Timeliness of resolution	Within 30 calendar days	Not Met
21	Access to Care – PCP	80% of routine care within 10 days	Met
22	Access to Care – SCP	80% of specialty care within 15 days	Met

23	Telephone Access to Member Services	Speed of answer <30s and call abandonment rate <5%	Met

A. Grievance & Appeals

Metric	Goal	Result
Grievances & Appeals Timeliness of acknowledgement letters	Within 5 calendar days	93.1%
Grievances & Appeals Timeliness of resolution	Within 30 calendar days	76%

KHS continuously monitors and reports on member grievances related to access to care, coverage determinations, medical necessity, quality of care and services, cultural and linguistic sensitivity, and other concerns. In 2024, a total of 12,219 grievances were received. Of these, 4,476 were exempt (resolved within one day), while the remainder were processed as formal grievances.

Quantitative Analysis:

KHS achieved a 93.1% compliance rate for acknowledgment letters within the required 5-day timeframe, demonstrating strong performance in initial response timeliness. However, only 76% of grievances were resolved within the 30-day resolution period, indicating a 24% gap in compliance. This suggests potential challenges in case complexity, resource allocation, or operational workflows.

Qualitative Analysis:

A review of grievance trends reveals that Quality of Service, Access to Care, and Quality of Care remain the most frequently cited issues among members. Further analysis suggests that delays in provider access, care coordination issues, and administrative barriers contribute to member dissatisfaction. Additionally, cultural and linguistic sensitivity concerns continue to emerge, indicating opportunities to enhance language access services and culturally competent care delivery. Member feedback also highlights inconsistencies in communication regarding grievance resolutions, which may contribute to confusion or dissatisfaction with outcomes.

Opportunities for Improvement

- Enhance Resolution Timeliness – Address the 24% gap in resolution compliance by optimizing workflow efficiencies, increasing staffing resources, and implementing automated case management tools.
- Improve Member Communication – Strengthen member education on grievance processes to set expectations and ensure clear, transparent communication throughout the resolution process.
- Expand Provider and Staff Training – Focus on cultural competency training and grievance resolution best practices to improve service delivery and reduce the volume of avoidable grievances.
- Strengthen Data-Driven Interventions – Conduct root cause analyses on delayed resolutions to identify operational bottlenecks and implement targeted process improvements.

By leveraging these improvement strategies, KHS can enhance compliance, member satisfaction, and overall service quality, ensuring equitable and timely grievance resolution in 2025.

B. Access to Care

Access and Availability

The Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) maintain accessibility, availability, and adequacy standards the KHS Health System is required to meet. KHS' standards and monitoring activities are outlined in policy and procedure 4.30-P accessibility standards. KHS utilizes the Provider Network Management Network Review to monitor accessibility, availability, and adequacy standards.

The Provider Network Management Network Review provides the overview and results for the Plan's After-Hours Survey, Appointment Availability Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and DHCS Quarterly Monitoring Report Template Review.

A. After-Hours Survey

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, Kern Health Systems (KHS) uses an after-hours caller program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. KHS policy requires that:

1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by CareNet; the results are forwarded to KHS' Provider Network Analysts who make additional follow up calls based on compliant/noncompliant data received from the survey vendor. The goal is to achieve above 90%.

Results:

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan was found compliant with Emergency Access and Urgent Access remaining in line with prior quarters, with percentages in Q4 2024 above 90%.

Compliance with After-Hours Standard	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Emergency Access	99%	99%	100%	99%
Urgent Care Access	99%	99%	99%	99%

Quantitative and Qualitative Analysis:

Overall, the goal of 90% was met each quarter. For those offices that were identified as non-compliant, the Provider Relations Representatives conducted targeted education and sent letters notifying the provider groups of the survey results and Plan policy.

Upon review, KHS has found that the outreach and education conducted via both letter and the Provider Relations Representatives/Provider Relations Manager/Deputy Director of Provider Network has seen success.

Plan for 2025:
Continue tracking and trending the quarterly after-hour calls survey and conducting outreach and education for those offices identified as non-compliant.

B. Provider Accessibility Monitoring Survey

As required by the Department of Health Care Services (DHCS) and Title 28 CCR Section 1300.67.2.2, Kern Health Systems (KHS) uses a Provider Accessibility Monitoring Survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members. In line with KHS policies and procedures and Department regulation, the quarterly appointment availability survey monitors:

Type of Appointment	Time Standard
Urgent primary care appointment	Within 48 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Urgent appointment with a specialist	Within 96 hours of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a non-physician Mental health provider	Must offer the appointment within 10 business Days of request
Non-urgent appointment for ancillary services	Within 15 days of request
First prenatal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

The survey was conducted internally by KHS staff; the Plan's survey/compliance methodology is based on a survey/compliance methodology utilized by the Department of Health Care Services (DHCS) during their 2017 Medical Audit of the Plan.

The Provider Network Management Department randomly selects five primary care provider offices and five specialist offices in each of the five geographic regions determined by the Health Equity Department. Additionally random samples of 5 non-physician mental health offices, 5 ancillary offices, and 5 OBGYN offices were also contacted to monitor network compliance with regulatory accessibility metrics.

Results:
KHS utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. KHS reviewed the results of the Q4 2024 Provider Accessibility Monitoring Survey against the results of prior quarters. KHS recognized an increase in the wait time for Non-Urgent NPMH and OB/GYN appointments. KHS recognized decreases in wait time for Non-Urgent PCP, Specialist, Ancillary, Urgent PCP, and Urgent Specialist appointments. KHS does not consider

this increase as a trend currently, as the results are in line with prior quarters. KHS' average wait time remains well within regulatory standards for all appointment types.

Average Urgent Wait Time in Hours	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Primary Care (48 Hours)	34.4	11.9	21.8	20.0
Specialist (96 Hours)	46.2	75	32.5	31.3

Average Wait Time in Days	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Primary Care (10 Days)	2.7	3.2	2.5	1.3
Specialist (15 Days)	4.9	6.8	4.6	3.5
Non-Physician Mental Health (10 Days)	3.8	4.2	2.8	3.6
Ancillary (15 Days)	2.4	7.8	3.6	0.8
OB-GYN (10 Days)	8.2	4.6	1.2	3.0

Quantitative and Qualitative Analysis:
The timeframes for appointment waiting times for PCPs, specialists, Non-Physician Mental Health, OBGYN, and ancillary providers were all met for each quarter of study. For providers who remained noncompliant with Plan appointment availability standards, KHS' Provider Relations Representatives conducted targeted outreach and education to the identified providers regarding their contractual obligation to meet regulatory access standards.

Plan for 2025:
Continue the ongoing quarterly tracking and trending for Provider Accessibility

C. Geographic Accessibility and DHS Network Certification

Per Section 1300.51 (d)(H) of the California Code of Regulations, KHS shall ensure, "all enrollees have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a contracting or plan-operated primary care provider" as well as "within thirty (30) minutes or fifteen (15) miles of a contracting or plan operated hospital". Further, per Section 1300.67.2.1(b), if "a plan's standards of accessibility [...] are unreasonable restrictive [...] the plan may propose alternative access standards of accessibility for that portion of its service area.

Per Exhibit A, Attachment 6 of the KHS contract with the DHCS states that KHS "shall maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a member's residence unless [KHS] has a DHCS-approved alternative time and distance standard."

For all geographic areas in which KHS does not currently meet the regulatory accessibility standard, KHS monitors and maintains an alternative access standard that has been reviewed and approved by the DMHC and/or DHCS.

DHCS Annual Network Certification – 2023-2024

DHCS Network Adequacy Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes
Pharmacy	10 miles or 30 minutes
Non-Specialty Mental Health (Adult and Pediatric)	45 miles or 75 minutes

Results:
As part of its ongoing monitoring, the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis. As of the end of Q4 2024, the Plan did not identify any terminations that would affect the Plan's ability to provide access within required time or distance standards.

Plan for 2025:
In compliance with the Annual Network Certification requirement outlined in APL 23-001, KHS will submit geographic access analysis assessing compliance with DHCS Network Adequacy Standards.

D. Network Adequacy and Provider Counts

Per CCR § 1300.67.2, Kern Health Systems (KHS) shall maintain, "at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and [...] approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees."

In 2020, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "What portion of your managed care volume is represented by Kern Health Systems?" Outreach for the survey was placed to every contracted provider within the KHS network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected combined with the most recent available Medi-Cal membership market share data to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating physician-to-enrollee compliance ratios.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2024. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey.

Results:
Based on the results of 2024 survey, KHS calculated a network-wide FTE percentage of 70.81% for Primary Care Providers and 66.84% for Physicians.

PCP to Member Ratio:
As of the end of Q4 2024, KHS was contracted with 505 Primary Care Providers, a combination of 249 physicians and 256 mid-levels. Based on the FTE calculation process outlined above, with a 70.81% PCP FTE percentage, KHS maintains a total of 266.97 FTE PCPs. With a membership enrollment of 404,252 utilizing KHS contracted PCPs, KHS currently maintains a ratio of 1 FTE PCP to every 1,514.23 members; KHS is compliant with state regulations and Plan policy.

Physician to Member Ratio:
As of the end of Q4 2024, the plan was contracted with 2,365 Physicians. Based on the FTE calculation process outlined above, with a 66.84% Physician FTE percentage, KHS maintains a total of 1,580.72 FTE Physicians. With a total membership enrollment of 404,252 utilizing KHS contracted Physicians, KHS currently maintains a ratio of 1 FTE Physician to every 255.74 members; KHS is compliant with state regulations and Plan policy.

C. Telephone Access to Member Services

Activity	Goal	Q1-2024	Q2-2024	Q3-2024	Q4-2024
Incoming Calls		84,175	72,308	74,004	68,844
Abandonment Rate	<5%	10%	1%	1%	2%
Speed of Answer	<0:30	2:22	0:15	0:13	0:18

Ensuring timely access to Kern Health Systems (KHS) is essential in helping members receive the care they need and promptly resolve any issues. To measure and enhance accessibility, KHS closely monitors key performance metrics, including call speed of answer and call abandonment rate.

- **Call Speed of Answer:** A target of less than 30 seconds was established, and in 2024, this goal was exceeded with an average response time of 18 seconds by the 4th quarter.
- **Call Abandonment Rate:** The target was set at less than 5%, and KHS successfully achieved a 2% abandonment rate by the 4th quarter, demonstrating strong member engagement and responsiveness.

By maintaining these high service standards, KHS remains committed to providing seamless access to care, improving member satisfaction, and ensuring that all inquiries are addressed efficiently.

IX. Member Experience

	Metric	Goal	Result
24	Adult and Child CAHPS Survey	Establish baseline for Getting Care needed measure	Met
25	Member Rewards	Increase MCAS measure rates by 2% by EOY	Met

A. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

In 2024 Kern Health Systems again selected SPH Analytics, now under Press Ganey (PG), an NCQA-certified survey vendor, to conduct its Measurement Year (MY) 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1 Medicaid Adult Survey.

The objective of the CAHPS® study is to measure how well plans are meeting their members' expectations and goals, to determine which areas of service have the greatest effect on members' overall satisfaction, and to identify areas of opportunity for improvement to aid health plans in increasing the quality of provided care.

TOP THREE PERFORMING MEASURES

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
Rating of Health Plan *(% 9 or 10)*	511	72.0%	71.6%	-0.4	61.5% ▲	10.1	96th	63.1% ▲	8.5	95th
Customer Service + *(% Usually or Always)*	249	91.6%	93.8%	2.2	89.1% ▲	4.7	98th	89.8% ▲	4.0	95th
Rating of Health Care *(% 9 or 10)*	382	61.5%	62.6%	1.1	56.8% ▲	5.8	87th	57.3% ▲	5.3	87th

BOTTOM THREE PERFORMING MEASURES

MEASURE	2024 Valid n	PLAN SUMMARY RATE SCORE			2023 QC			2024 PG BoB		
		2023	2024	CHANGE	SCORE	GAP	PERCENTILE	SCORE	GAP	PERCENTILE
Coordination of Care + *(% Usually or Always)*	248	82.7%	85.5%	2.8	85.6%	-0.1	52nd	86.0%	-0.5	43rd
How Well Doctors Communicate + *(% Usually or Always)*	370	92.5%	92.6%	0.1	93.0%	-0.4	44th	93.2%	-0.6	39th
Rating of Specialist + *(% 9 or 10)*	272	67.5%	66.5%	-1.0	67.7%	-1.2	42nd	68.5%	-2.0	34th

Improvement Strategies

The following strategies are recommendations from PG to improve the performance measures that rated in the bottom three. KHS may adopt some of these strategies and will evaluate internal processes as well related to these measures to determine other strategies that KHS may adopt to improve the ratings of these measures.

Coordination of Care

a. Inform, support, remind and facilitate providers about coordination of care expectations, timely notification requirements, and standards of care for post-visit follow up to all PCPs. Explore options to encourage and support communications between specialists and PCPs.

b. Develop on-going and timely reminders/messaging to promote and improve communication and reporting between all provider types, ideally based directly on available data/information.
c. Assess the status and consistency of coordination of patient care, communication, and information shared within and across provider networks. Assure prompt feedback, standards.
d. Support and facilitate a patient-centered care management approach within and across provider networks. Facilitate a complementary plan-based patient centered care management approach.
e. Explore potential of aligning information flow/EHRs to better integrate, support or facilitate patient care, care coordination and vital medical and personal information among providers.
f. Encourage providers to prompt patients AND patients to prompt providers, i.e., mutual interactions that review and discuss care, tests and/or treatments involving other providers.
g. Encourage patients to bring a list of all medications, including dosage and frequency to all appointments. Encourage providers to prompt patients to do the same for their appointments.
h. How do PCP's, providers, facilities and/or the plan assure common patient "touch points" to facilitate/support scheduling of appointments, tests and/or procedures? Where is the over-arching guidance and support for the patient/member?

How Well Doctors Communicate

a. Cultivate a patient-centered care philosophy and programs across the provider network
b. Support, communicate and educate providers about the vital medical importance of effective doctor-patient communication (i.e., reduced hospitalizations & ER visits, improved adherence).
c. Provide readily available recommendations, tools and guidance to all providers to support and enhance communication skills and effective conversation skills with patients. Providers need to: Provide thorough explanations, provide written materials, illustrations and/or examples to help patient's understand, repeat the patient's concern and then address the topic, ask clarifying questions, make eye contact, avoid medical jargon and technical language, avoid multi-tasking, avoid rushing the patient, use constructive verbal responses and non-verbal cues, apply empathy and interest in response to concerns, by kind, avoid condescending language or actions, address questions and concerns-as much time as necessary, schedule adequate time for each visit, and follow-up after tests or procedures.
d. Collaborate and share with providers tools, resources, and best practices to support, or reinforce, a complete and effective information exchange with all patients (e.g., a summary of medical record or health assessment to facilitate an effective health or wellness discussion, patient testimonials - perhaps from focus groups - of effective and ineffective communication techniques, provide tips and/or testimonials in provider newsletters).

e. Develop tools and guidance for patients to optimize appointment time and specific topic-based conversation guides or question checklists with providers (e.g., Doc Talk).
f. Support patients with chronic illnesses/conditions and their providers with up-to-date tools, resources and conversation guides that address common clinical needs, continual review, modification and update of progress, next steps, and self-management topics.

Rating of Specialist

a. Analyze, investigate, and probe for weakness or QI opportunities among those measures or composites that are Key Drivers (or highly correlated) with rating of specialist or doctor. (e.g., HWDC, GCQ, GNC, Coordination of Care).
b. Review QI recommendations/actions for related CAHPS composite measures: How Well Doctors Communicate, Getting Care Quickly, Getting Needed Care, Coordination of Care.
c. Provide resources, articles, tools and training sessions via multiple channels to support and drive improvement in physician-patient communication and patient-centered interviewing. Examples include: Listen to patients' concerns, Follow-up with the patient. Provide thorough explanations. Ensure that all questions and concerns are answered. All staff focus on being helpful and courteous to patients.
d. Share, report and discuss relative CAHPS health care performance and feedback at the health system and/or within network level.
e. Promote use of a secure online patient portal which allows patients access to their medical record and health care information of relevant to patient needs.
f. Gather and analyze patient feedback on their recent office visit (i.e.., patient "comment cards," follow up call/text/email, CG CAHPS survey, etc.)
g. Assess adequacy of contracted specialist by specialty. If necessary, review quality of care information among specific specialties and/or identify practices of excellence.
h. Explore ability of providers to share with patient's a summary of their medical record or health assessments to facilitate conversation about relevant health and wellness issues.
i. Assess systems (e.g., EHRs) processes and/or procedures used to gather or facilitate distribution of patient information among providers.
j. Suggest providers/practices periodically analyze appointment scheduling timeframes versus types of office visits.

B. Member Rewards Program

The Member Engagement Reward Program (MERP) will continue its targeted outreach efforts in 2025 to encourage members to schedule necessary appointments and close gaps in care, with a focus on key Medi-Cal Accountability Set (MCAS) measures.

- Text Messaging Campaigns: Members will receive text reminders to schedule appointments, prioritizing measures such as Comprehensive Care for Children (CCS), Well-Child Visits in

the First 30 Months of Life (W30), and Child and Adolescent Well-Care Visits (WCV). A focused text messaging campaign for these measures will take place in June.

- Robocalls: Automated calls will be sent to members who do not receive text messages, ensuring outreach coverage across different communication preferences.
- Geomapping Insights: Data-driven geomapping strategies will be leveraged to identify optimal event locations and target outreach efforts toward specific populations in need of engagement.

Through these initiatives, MERP aims to improve health outcomes by increasing preventive care utilization, reducing gaps in care, and enhancing member engagement in their healthcare journey.

X. Provider Engagement

	Metric	Goal	Result
26	Provider Satisfaction Survey	Trend results by survey questions	Met
27	Provider Incentive Program	Improve A1C Level	Met
28	Provider Education	Meet Providers Quarterly	Met

A. Provider Satisfaction Survey

BACKGROUND/METHODOLOGY

On an annual basis, Kern Health System's Provider Network Management Department conducts a Provider Satisfaction Survey to gauge the level of satisfaction and engagement amongst our network of contracted providers. The 2023 Provider Satisfaction Survey asked providers to answer survey questions based on their experiences with KHS during Calendar Year 2022. We engaged an independent survey company, Press Ganey (PG) Analytics to conduct the survey on behalf of the Plan. PG Analytics is able to benchmark KHS performance against other organizations within the industry, by comparing our results against their National Medicaid and Aggregate Books of Business. The PG 2022 Medicaid Book of Business is made up of 104 plans with a total of 19,251 respondents. The PG 2022 Aggregate Book of Business is made up of 180 plans with a total of 27,767 respondents. This is sixth annual Provider Satisfaction Survey that PG Analytics has completed for the Plan.

The 2023 Provider Satisfaction Survey was conducted across three waves, in April, May, and June of 2023. Two waves of mailing outreach were conducted, followed by a third outreach via telephone. The survey is sent to and categorized by provider type, including PCP, Specialist, Behavioral Health, and Other (Facilities, Ancillary providers). All statistical testing is performed at the 95% confidence level.

RESULTS

The Provider Satisfaction Survey was presented and evaluated at the Quality Improvement Workgroup Committee Meeting and in the Executive Quality Improvement and Health Equity Committee.

KHS experienced increases amongst seven (7) of the eight (8) scoring composites (Overall Satisfaction, Compared to Other Plans, Compensation, UM & Quality Improvement, Network and

Continuity of Care, Health Plan Call Center, Provider Relations, and Recommend to Other Providers) when compared to the prior year's Provider Satisfaction Survey. KHS scored within the 90th percentile or higher in all scoring composites/attributes, with both Utilization Management & Quality Improvement and Provider Relations in the 100th percentile when compared against PG's 2022 Medicaid Book of Business.

As KHS scored within the 90th percentile or higher in all scoring composites/attributes, discussion focused on how to increase provider participation with the survey. The Plan determined that sending the survey out earlier in the year may increase provider participation.

B. Provider Incentive Program

The Endocrinologist Diabetic Program is designed to support members with uncontrolled diabetes by providing specialized care aimed at improving their A1C levels through appropriate interventions. This program operates under an incentive-based reimbursement structure, encouraging optimal diabetes management and patient outcomes.

To enhance accessibility and streamline care coordination, the QP leadership team is in the process of establishing an API that will facilitate direct appointment scheduling for this population with the endocrinologist's office. This technological integration aims to improve member engagement, reduce barriers to specialist care, and support more timely interventions for diabetes management.

Through these efforts, the program seeks to improve health outcomes, enhance provider collaboration, and optimize the management of diabetes within the member population.

C. Provider Education

The Quality Performance team has implemented a structured approach to provider engagement by initiating both monthly and quarterly meetings with assigned providers. These meetings, along with scheduled and ad hoc discussions with various provider groups, serve as a platform to address key topics such as reimbursement rates, operational challenges, barriers to care, and notable accomplishments. By maintaining routine interactions, the QP team fosters collaboration, identifies opportunities for improvement, and supports providers in delivering high-quality care to members.

Action Plan for 2025:

In 2025, the QP team will continue its structured monthly and quarterly meetings with providers, fostering ongoing collaboration and addressing key issues such as reimbursement rates, operational challenges, and barriers to care. These meetings will serve as a platform to support providers in delivering high-quality services and improving healthcare outcomes for members.

Additionally, the Quality Improvement (QI) Department remains committed to health education by continuing to provide tailored educational materials for both members and providers. These materials will focus on critical health topics, including chronic disease management, preventive care, and health equity, ensuring that individuals have the necessary knowledge to make informed healthcare decisions.

To further address pressing health concerns, the QI Department will also take a proactive approach to tackling obesity by organizing a dedicated conference on the topic. This event will bring together

healthcare professionals, community leaders, and subject matter experts to discuss the latest research, evidence-based interventions, and best practices for obesity prevention and management. The conference will also explore strategies to improve access to resources, address social determinants of health, and enhance collaboration among stakeholders to develop sustainable solutions for obesity-related challenges.

Through these initiatives, the Quality Departments aim to enhance health literacy, empower members to adopt healthier lifestyles, and support providers in delivering high-quality, equitable care.

XI. Conclusion

The 2024 Quality Improvement (QI) Program at Kern Health Systems (KHS) demonstrated measurable progress in enhancing healthcare quality, patient safety, and service accessibility. Key initiatives, including the MCAS performance improvement efforts, Performance Improvement Projects (PIPs), PQI mitigation strategies, and strengthened provider engagement, contributed to substantial advancements in member outcomes. However, opportunities remain to further refine interventions and optimize processes to ensure sustained, system-wide improvements in clinical care and health equity.

Effectiveness of the QI Program

In 2024, KHS achieved 26 of its 28 Quality Improvement goals, highlighting its strong commitment to quality enhancement. Areas of success included:

- Improved Access to Care: Compliance with state-mandated appointment wait times and telephone access to Member Services improved, with notable reductions in wait times for both primary and specialty care.
- Enhanced Member Engagement: Targeted outreach campaigns, mobile unit initiatives, and care coordination efforts led to higher engagement in preventive services.
- Network Performance Monitoring: Facility Site Reviews (FSRs) and Medical Record Reviews (MRRs) met compliance thresholds, ensuring provider adherence to quality and safety standards.
- Reduction in Potential Quality of Care Issues (PQIs): Median PQI volumes decreased from 99 (2023) to 68 (2024), with Level 2 and Level 3 cases remaining below established thresholds.

However, the failure to meet MCAS minimum performance levels (MPLs) for certain measures, such as Colorectal Cancer Screening, Depression Screening, and Follow-Up After Emergency Visits for Mental Illness and Substance Use, indicates an ongoing need for targeted interventions. Corrective actions required by DHCS, including provider engagement initiatives and expanded community partnerships, will be instrumental in addressing these deficiencies in 2025.

Influence on Network-Wide Safe Clinical Practices

KHS made significant strides in fostering network-wide safe clinical practices through:

- Provider Education and Accountability: Implementation of network-wide training sessions, corrective action plans, and compliance monitoring improved adherence to clinical guidelines. However, provider engagement gaps persist, particularly in addressing social determinants of health and culturally competent care.
- Care Coordination and Follow-Up Interventions: The Non-Clinical PIP targeting provider notifications for members with Severe Mental Health (SMH) and Substance Use Disorder (SUD) diagnoses following ED visits led to an 84% provider notification rate—a critical step in improving continuity of care.
- Safety and Quality Audits: FSR, PARS, and MRR results exceeded compliance targets, ensuring facilities maintained safe and accessible environments. However, challenges such as gaps in provider documentation, calibration issues, and risk assessment compliance indicate areas for process refinement.
- Population Health Management & Health Equity Integration: The integration of health equity principles within the QI framework led to expanded outreach programs, particularly targeting African American infant well-care visit rates (W30 PIP) and transportation barriers in rural communities.

Opportunities for 2025

While the 2024 QI Program laid a strong foundation for quality improvement and patient safety, areas for continued growth include:

- Strengthening Provider Engagement Strategies to improve compliance with MCAS measures and care coordination responsibilities.
- Enhancing Data Analytics & Timely Reporting to enable faster response times to emerging trends in quality and safety concerns.
- Expanding Access to Preventive Care & Behavioral Health Services through mobile health initiatives and innovative partnerships with local healthcare providers and community organizations.
- Addressing Health Equity Challenges by scaling up targeted interventions for high-risk populations and ensuring culturally competent care delivery.

In summary, the 2024 QI Program effectively advanced patient care, provider accountability, and member engagement, yet systemic challenges in provider collaboration, preventive care participation, and health equity require sustained focus in 2025. Through ongoing performance monitoring, strategic partnerships, and provider-driven initiatives, KHS remains committed to enhancing network-wide clinical quality, safety, and equity for its Medi-Cal population. Using the analysis and identified barriers in this evaluation, KHS will continue to plan for future interventions and develop the 2025 Work Plan and obtain approval from the Executive Quality Improvement Health Equity Committee (EQIHEC).

XII. Appendix

Appendix A: Population Needs Assessment October 2024

Appendix B: QI 3A – Continuity and Coordination of Medical Care

Appendix C: QI 4AB – Continuity and Coordination Between Medical Care and Behavioral Healthcare

2025 Quality Improvement Health Equity Program Description

Executive Quality Improvement Health Equity Committee (EQIHEC)
Approval Date: 03/18/25

Table of Contents

I. Introduction

Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), was established in 1993 by the Kern County Board of Supervisors as a local initiative Medi-Cal managed care health plan. KFHC is the largest health plan in Kern County, serving the majority of Kern County's Medi-Cal beneficiaries through a contract with the State of California Department of Health Care Services (DHCS).

KHS is a special county health authority governed by a 16-member Board of Directors. This diverse board includes representatives such as the Chief Executive Officer of the local safety net hospital, a safety net care provider, ten community representatives nominated by the County Supervisors, two Medi-Cal primary care physicians, one representative from a rural acute care general hospital, and one pharmacist. Board members must work or reside in Kern County and meet the minimum age requirement of 21. The Board oversees the establishment and operation of a comprehensive managed care system, ensuring access to high-quality medical care, promoting cost efficiency, and adhering to the principles of Chapter 7, Part 3 of Division 9, Section 14000 of the California Welfare, and Institutions Code.

As of 2024, KHS serves approximately 403,000 members, with 49% receiving care through the County Hospital system and two large Federally Qualified Health Centers (FQHCs). While 66% of the population resides in Bakersfield, the remainder is spread across rural areas of Kern County. The largest racial group is Hispanic, accounting for 63% of membership. Language diversity is a key factor, with 70% of members speaking English as their primary language, 29% speaking Spanish, and 1% speaking other languages.

Kern County faces significant health challenges compared to statewide statistics, including higher rates of adult smoking, obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births. However, the county ranks favorably in food environment indices due to fewer low-income residents with limited access to grocery stores and lower rates of excessive drinking.

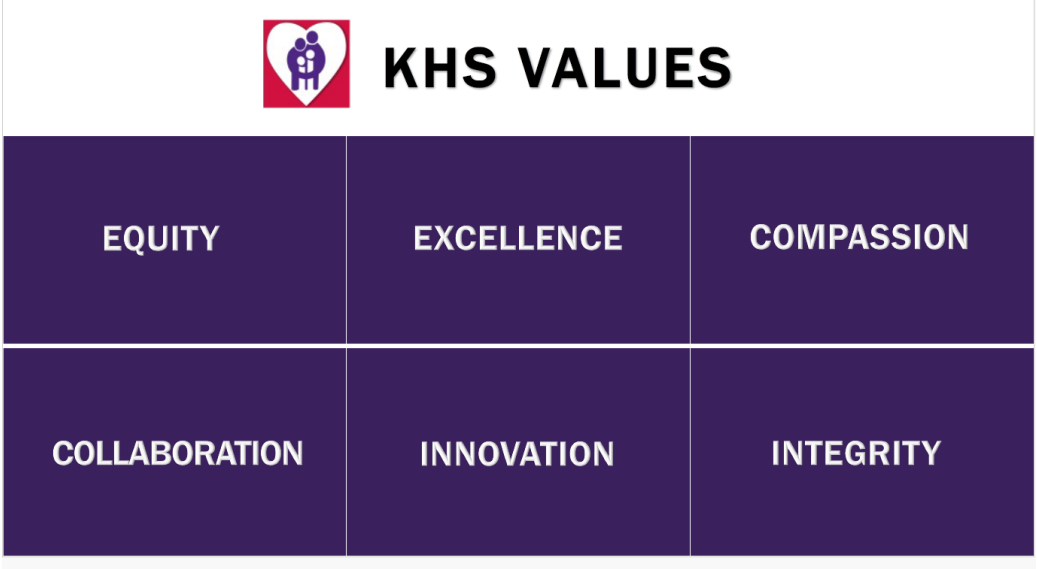
A. Mission & Values

Mission

KHS is committed to improving the health and well-being of our members and the community of Kern County through an integrated, equitable, and member-centered healthcare delivery system. The Quality Improvement Health Equity Program (QIHEP) is designed to objectively monitor, systematically evaluate, and effectively improve the quality, safety, and outcomes of care delivered to our members. By prioritizing health equity and addressing social determinants of health, KHS strives to meet members where they are, empowering them to achieve their optimal health outcomes.

The KHS Quality Improvement Department, in collaboration with the Quality Performance and Health Equity Departments, oversees the program's initiatives and activities, working closely with contracting providers to deliver high-quality care to the populations we serve.

Values



- **Equity**

We foster a culture of fairness and inclusion, ensuring all members and employees are supported, regardless of their zip code, race, ethnicity, preferred language, cultural preferences, or personal history. Equity is at the core of what we do because every person matters. We celebrate diversity and strive to create opportunities for everyone to thrive and contribute their unique gifts.

- **Excellence**

We uphold the highest standards in all that we do, aiming for outstanding results that resonate with the community we serve. Through continuous improvement and dedication, we achieve quality outcomes that lead to a stronger and healthier community. Excellence is reflected in our pride, commitment, and measurable impact.

- **Compassion**

We seek to understand and empathize with others' experiences, extending care and kindness to everyone we serve. Compassion drives our actions and shapes our solutions, ensuring we respond meaningfully to the needs of our members and colleagues.

- **Collaboration**

We harness the collective expertise of our team, providers, and community partners to solve problems and achieve shared goals. Collaboration brings diverse perspectives and strengths together, driving creativity and producing impactful, sustainable results.

- **Innovation**

We embrace new ideas, methods, and solutions to expand possibilities and improve outcomes. Through experimentation and forward-thinking, we adapt to the changing needs of our members and create innovative strategies that maximize efficiency and value.

- **Integrity**

We act with honesty and accountability, staying true to our commitments and values. Integrity builds trust and provides a strong foundation for performance and meaningful impact, ensuring we consistently do the right thing, even when it is not the easy thing.

KHS is committed to delivering on its values by:

- Ensuring all members obtain equal access to socioeconomic and environmental resources,
- Applying a health equity lens at all levels of and in all services provided by KHS,
- Embracing new knowledge and new ways of providing services,
- Practicing tolerance (accepting differences), embracing diversity (celebrating differences where possible), and pursuing inclusivity (finding commonalities and soliciting voice),
- Identifying and challenging historic assumptions and biases,
- Collaborating across programs, divisions, and community agencies/organizations to address community needs and barriers and obtain recommendations to improve services,
- Managing fiscal resources and the use of resources for greatest impact,
- Keeping consumers informed of Health Equity activities and outcome summaries by making them publicly available on the KHS website. Updates and ongoing information are posted at a minimum, on a quarterly basis,
- Leveraging our financial resources to help historically under-supported businesses and communities of color to build stronger capacity and economic health,
- Holding itself accountable through measurement and quality improvement/assurance,
- Building strong internal leaders in the health equity field that demonstrate a sustained, resolute commitment to DEI and collaboration with all stakeholders,
- Committing to eliminating health inequities in Kern County.

B. Background

Kern County is very diverse, with many residents identifying as Hispanic. As the racial and ethnic composition of Kern County continues to change, it is important to create culturally sensitive systems, policies, and environments while protecting the health of the public.

Spanish-language education, documents, and services will continue to be needed as the Hispanic population continues to grow. Additionally, while the total number of Non-Hispanic Asians in Kern County remains small, the proportion of residents identifying as Non-Hispanic Asian has increased 21 percent since 2009. In comparison, during the same time frame, the Hispanic population in Kern County grew by 11 percent.

In Kern County, children 17 and under are at higher risk of living below the poverty level than adults 18 and older. Overall, 31.3% of children live below the poverty level while 22.6% of all Kern County residents live below the poverty level. Studies have shown that children in poverty are more likely to have physical and mental health problems than their peers. This includes lower achievement in test scores, which could limit an individual's ability to make a living wage.

Moreover, Kern County continues to have a smaller proportion of residents with a high school diploma or equivalency than California's average. However, Kern County is expected to have the largest increase in high school graduates in the State by 2028.

Due to the diverse geography of Kern County, from arid high desert to the mountains to the valley, climate also varies. In the summer, heat exhaustion, heat stroke, and heat-related deaths are of concerns in Kern County (i.e., dehydration can exacerbate underlying conditions). Another example, high winds and dust storms in certain parts of the county can aggravate respiratory disorders and contribute to infectious diseases like Valley Fever (coccidioidomycosis).

Kern County's service area has been challenged with provider shortages. Large portions of the county are designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P). These issues are more severe and prevalent in Kern County than other counties within California. The following 4 rural areas are in this classification:

- Taft
- Lost Hills/Wasco
- Fort Tejon
- Lake Isabella

C. KHS Population

The population served by Kern Health Systems (KHS), operating as Kern Family Health Care (KFHC), reflects the diverse demographic, geographic, and socioeconomic characteristics of Kern County. As of 2024, KHS serves approximately 403,000 Medi-Cal members, encompassing a wide range of health and social needs.

Demographics

- Geographic Distribution:
    - Over 66% of KHS members reside in Bakersfield, the county's largest metropolitan area.
    - The remaining members are distributed across rural areas, highlighting a need for geographically equitable healthcare access.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	N	223,973	66.9%
Delano & North Kern	Y	30,610	9.1%
Arvin/Lamont	Y	21,978	6.6%
Shafter/Wasco	Y	21,596	6.4%
California City & Southeast Kern	Y	9,434	2.8%
Taft & Southwest Kern	Y	8,897	2.7%
Tehachapi	Y	5,632	1.7%
Ridgecrest & Northeast Kern	Y	4,883	1.5%
Lake Isabella & Kern River Valley	Y	4,023	1.2%
Lost Hills & Northwest Kern	Y	2,194	0.7%
Frazier Park & South Kern	Y	1,244	0.4%
Outside Service Area	N/A	465	0.1%

- Racial and Ethnic Composition:
    - The Hispanic population represents 63% of the membership, emphasizing the importance of culturally relevant care and services.
    - Other racial/ethnic groups include White, African American, Asian, Native American, and individuals identifying as multiracial, reflecting the community's diversity.

Ethnic or Racial Group	% KHS Enrollment
Hispanic	63%
Caucasian	17%
No valid data, unknown or other	11%
Black/African American	6%
Asian Indian	1%
Filipino	1%
Asian/Pacific	1%

- Language Diversity:
  - 70% of members identify English as their primary language.
  - 29% primarily speak Spanish, underscoring the need for language assistance services.
  - 1% speak other languages, requiring culturally and linguistically appropriate services to ensure equitable access to care.

Socioeconomic Characteristics

- Many KHS members face significant socioeconomic challenges, including:
  - Poverty: A large proportion of the population lives at or below the federal poverty level.
  - Unemployment: Economic instability affects access to housing, transportation, and other basic needs.
  - Educational Barriers: Limited education levels impact health literacy and the ability to navigate the healthcare system.

Health Risk Factors

- Kern County exhibits a higher prevalence of health risks compared to statewide averages:
  - Chronic Conditions: High rates of diabetes, hypertension, and obesity among the population.
  - Lifestyle Factors: Elevated smoking rates, physical inactivity, and alcohol use disorders.
  - Maternal and Child Health: Teen births and limited access to prenatal care contribute to poor outcomes in maternal and child health.

Key health behaviors affecting the Kern population are reflected in the following table obtained from County Health Rankings & Roadmaps. :

Health Factors			
Health Behaviors	Kern (KE) County	California	United States
Adult Smoking	15%	10%	16%
Adult Obesity	36%	26%	32%
Food Environment Index	7.4	8.9	7.8
Physical Inactivity	33%	22%	26%
Access to Exercise Opportunities	82%	93%	80%
Excessive Drinking	16%	19%	20%
Alcohol-Impaired Driving Deaths	32%	28%	27%
Sexually Transmitted Infections	763.8	599.1	551.0
Teen Births	32	16	19

Social Determinants of Health (SDOH)

- KHS actively identifies and addresses social determinants that impact the health of its members, including:
    - Housing Insecurity: A significant portion of the population experiences unstable or unsafe housing conditions.
    - Food Insecurity: Access to affordable and nutritious food remains a concern for many families.
    - Transportation Barriers: Limited public transportation options impede access to healthcare facilities, particularly in rural areas.
    - Access to Technology: Digital inequities hinder member engagement in telehealth services and health education initiatives.

Behavioral Health Needs

The mental health and substance use disorder needs of KHS members are significant, with many individuals requiring coordinated care for mild-to-moderate behavioral health conditions. KHS partners with the Kern County Behavioral Health and Recovery Services (KBHRS) to address the needs of members requiring specialty mental health services.

Vulnerable Subpopulations

KHS tailors its programs and services to address the unique needs of vulnerable groups, including:

- Seniors and Persons with Disabilities (SPDs): Older adults and individuals with disabilities require specialized care and enhanced care management services.
- Homeless Individuals: Outreach efforts target unsheltered populations, including street medicine initiatives to deliver care in nontraditional settings.
- Children and Adolescents: Programs focus on preventive care, developmental screenings, and health education for younger members.

Kern County ranks lower compared to other California counties for a variety of public health indicators. Kern County ranks in the bottom 10 California counties for age-adjusted death rates due to diabetes, Alzheimer's disease, coronary heart disease, chronic lower respiratory disease, homicide, and drug-induced deaths1. It is also among the bottom 10 California counties for the incidence of chlamydia, gonorrhea among people 15-44 years old, congenital syphilis, primary and secondary syphilis, infant mortality, and persons under 18 in poverty.

In Kern County's most recent Community Health Assessment, asthma and other respiratory diseases were identified as the top community health problems. According to the California Health Interview Survey, 15.7% of the Kern County population has been diagnosed with asthma. In 2019, the emergency department (ED) rate due to asthma was 46.1 per 100,000 compared to the state average of 42.6 per 100,000. Black/African American people in Kern County experience asthma disparities as demonstrated by their asthma ED visit rate of 181.5 per 100,000 people. This rate is more than four times the rate of the next highest racial/ethnic group in Kern County and more than double the rate of any age group in the county.

Other health disparities identified within Kern County include the teen birth rate (25.9 per 1,000 live births) which was more than double the state average (12.5 per 1,000 live births); the percentage of all pregnancies accessing early prenatal care which was below the state average (KC-79.6%; CA-85.1%); and the obesity rate which was 35.5% compared to 30.3 for California.

Regarding mental health, Kern County's age-adjusted mortality rate due to suicide is 13.5 per 100,000 which is higher than the state averages (CA-10.7 per 100,000).

In accordance with the World Health Organization definition of social determinants of health, (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.

The improvement of long-term health outcomes, particularly for populations experiencing the greatest inequities in health over time, requires a shift in focus to the upstream factors that are the underlying causes of ill health (Harris County Public Health: Health Equity Policy, 2015). Such health inequities include disparate rates of disease, disability, and premature death. A shift to upstream (Appendix A) factors provides all individuals, regardless of socioeconomic or environmental conditions, the opportunity to attain their full health potential.

Addressing health disparities among identified populations is a priority of KHS. To ensure robust insights regarding disparities, KHS leverages the External Quality Review (EQR) Technical Report, and the KHS Population Needs Assessment. An annual analysis of the EQR is used to identify specific disparities and/or targeted areas of focus to incorporate into strategies to improve member satisfaction, close gaps in care, and highlight other specific needs

for the KHS population. KHS utilizes the EQR recommendations to develop strategies that impact the timeliness and quality of services provided to members as well as barriers to accessing preventive and other health care services. The KHS PNA uses internal and external data to identify and assess vulnerable member groups by race or ethnicity, age, sex, language, and other member characteristics, including cultural and linguistic needs. The KHS PNA builds upon previous needs assessments and uses various data collection methods and sources. The goal of the PNA is to improve health outcomes for KHS members and ensure that KHS is meeting the needs of its members through:

1. Identification of member health needs and health disparities.
2. Evaluation of current health education (HE), cultural and linguistic (C&L), and quality improvement (QI) activities and available resources to address identified concerns; and
3. Implementation of targeted strategies for HE, C&L, and QI programs and services to address member needs.

Population Health Management (PHM) services (i.e., basic population health management, enhanced care management, etc.) are offered to all KHS members, and provided in a manner to address member needs and preferences and address health disparities.

Opportunities for Improvement

KHS leverages insights from its annual Population Needs Assessment to identify gaps in care and develop targeted interventions. Key opportunities include:

- Expanding provider networks to improve access in underserved areas.
- Reducing health disparities by addressing inequities in chronic disease management and preventive care.
- Enhancing member engagement through culturally competent health education and communication strategies.
- Strengthening partnerships with community organizations to address SDOH and improve overall member well-being.

II. QIHEP Overview

A. QIHEP Purpose

The KHS Quality Improvement Health Equity Program (QIHEP) is a written description of the overall scope and responsibilities of the program. The QIHEP actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.

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

The mission of the KHS Health Equity Program is to improve the health and well-being of the community through the delivery of trusted, high quality, cost-effective, and accessible health to all members regardless of race/ethnicity, language spoken, or their cultural/personal preferences. In partnership with the county KHS serves, the goal is to offer whole person-centered care that reflects the best practices available today. KHS's program is built on a foundation of dedication to trusted messaging, high-quality care, culturally sensitive engagement with members, regular collaboration with community partners, continuous improvement, and service by working together with providers. KHS acknowledges an ongoing shared responsibility with its providers, facilities, community stakeholders and other provider organizations to deliver trusted, effective, and timely care and services for its members.

At a high level, the program seeks to emulate the guidance found in the Department of Health Care Services' 2022 Comprehensive Quality Strategy, which summarizes the state's goal of helping Medi-Cal members achieve longer, healthier, and happier lives through both clinical health care services and non-clinical services. This program integrates clinical and non-clinical services to create a holistic healthcare environment, improving member health outcomes. Disparate impacts from the COVID-19 pandemic have underscored the need for urgency and the necessity of building partnerships with trusted community stakeholders to increase trust with members. These two areas of providing additional non-clinical supports and increasing trust are key changes designed to catalyze different outcomes.

KHS staff are constantly evaluating member differences and preferences regarding race, ethnicity, culture, gender identity, sexual orientation, and language. Through its Quality Improvement Health Equity Program (QIHEP), KHS intends to implement standards on culturally and linguistically appropriate services to achieve the following key objectives:

- Respond to current and projected demographic changes in the populations served.
- Understand the impact of race, ethnicity, culture, gender identity, sexual orientation, and language in whole person health.
- Improve the quality of services and outcomes for members.

B. QIHEP Scope

KHS QIHEP is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. Again, it should be

noted that this expanded scope covers both clinically focused and non-clinically focused areas. Each of these defined areas of program scope include, but are not limited to, the following:

- Monitor and identify opportunities to monitor, evaluate, and take action to address needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
- Maintain a process and structure for quality improvement with contracting providers that includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and take action to support health equity.
- Oversee and direct processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
- Monitor and improve the quality and safety of clinical care for covered services for KHS members.
- Ensure members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).

This is accomplished through the development and maintenance of an interactive health care system that includes the following elements:

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

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

The scope of the QIHE Program includes the following elements:

1. The QIHE Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
    a. KHS does not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.
    b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QIHE Program reflects the population served and applies equally to covered medical and behavioral health services.
2. The QIHE Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings. New this year is the addition of street medicine providers. Street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be living.
3. The QIHE Program assessment activities encompass all diagnostic and therapeutic activities, and outcomes affecting members, including primary care and specialty practitioners, vision providers, behavioral health care providers, pharmaceutical services, preventive services, prenatal care, and family planning services in all applicable care settings, including emergency, inpatient, outpatient, and home health.
4. The QIHE Program evaluates quality of service, including the availability of practitioners, accessibility of services, coordination, and continuity of care. Member input is obtained through member participation on the Community Advisory Committee (CAC), grievances, and member satisfaction surveys.
5. The QIHE Program activities are integrated internally across appropriate KHS departments. This occurs through multi-departmental representation on the QI/UM Committee.
6. KHS and Kern County Department of Health jointly cover mental health care. It is arranged and covered, in part, by Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

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

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

As part of KHS' commitment to ensure the rights of our members to quality health care, the following six rights to Quality Health Care have been adopted:

1. Right to Needed Care
    - Accurately diagnosed and treated
    - Care is coordinated across all the doctors and specialists
2. Right to Equitable Care
    - All people, regardless of their gender, race, ethnicity, geographical location, or socioeconomic status receive the good quality health care they need
    - Developing culturally competent care; for example, by expanding medical translation services, after-hours appointment, mobile health clinics or telehealth, etc.
3. Right to Place of Care
    - Did the patient go to the right place for care?
    - Is the patient going to the ER or Urgent Care for primary care?
    - Is the patient transitioned to the right place for care?
4. Right to Timely Care
    - Timely access to care
    - How long did the patient have to wait to get health care appointments and telephone advise?
    - Is the patient up to date with their preventative care?
5. Right to Be Part of Your Care
    - Patients and their families are part of the care team and play a role in decisions.
    - Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.
6. Right to Safe Care
    - Conduct continuous quality assurance and improvement
    - Customer and provider satisfaction surveys or interviews
    - Chart audits
    - Site reviews
    - Administration of medications

The QIHEP scope includes regular needs assessments based on race/ethnicity, language, cultural preferences, health disparities, and stakeholder engagement. Again, it should be noted that this expanded scope covers both clinically focused and non-clinically focused areas. Each of these defined areas of program scope include, but are not limited to, the following:

- Quality Improvement – Understanding health disparities is critical to identify the differences in treatment provided to members of different racial/ethnic or cultural groups that are not justified by the underlying health conditions or treatment preferences of patients. KHS will implement multiple programs to monitor, assess, and improve healthcare services to reduce health disparities within its membership.
- Quality Performance – Identification of gaps in care, opportunities to support providers and members, and overall responsibility for high quality and equitable care for the members we serve. Quality Performance is comprised of site reviews, MCAS/HEDIS, performance improvement projects, and organizational initiatives related to quality.
- Health Education & Cultural Linguistics – Ensuring members have access to appropriate language services including bilingual services, oral interpretation, and written/sight translations as appropriate. The network providers have access to these services to ensure the members receive information in their preferred method.
- Population Health Management – Promoting meaningful engagement and partnerships with network providers, communities, public health agencies, and schools and community-based organizations (CBOs), to support the improvement of data sharing among delivery systems to identify and mitigate SDOH to reduce disparities and ensure that all members are connected to primary care, appropriate wellness, prevention, and disease management activities and to identify and connect those members who are at risk for developing complex health issues to more specialized services.
- Member Engagement – Engaging all key stakeholders is a very critical process to collect and evaluate feedback from members, practitioners, and other community groups. The information is collected through multiple avenues including Member Advisory Committees, ongoing surveys from members and practitioners, discussions with large provider groups, etc.
- Provider Network Management – Evaluating the network's cultural responsiveness is one of the key components of the health equity program. This includes the ability of practitioners and providers to understand the individual values, beliefs, and behaviors shaped by cultural factors of diverse groups. KHS educates providers and practitioners annually on how to consider and integrate these members preferences into the delivery of healthcare services.
- Utilization Management – Facilitating, communicating, and collaborating among members, practitioners, providers, and the organization, to support cooperation and appropriate utilization of health care benefits.

Monitoring and reporting under and over utilization trends to eliminate care variations within vulnerable populations and proactively closing gaps in the care continuum.

- Policies & Procedures – The following components are integrated into KHS' policies and procedures across multiple areas:
    - Community input and advisement on relevant cultural, linguistic and Seniors and Persons with Disabilities (SPD) awareness issues via the established Community Advisory Committee
    - A Population Needs Assessment is conducted periodically to assess the need for special initiatives regarding cultural competency, linguistic sensitivity, and SPD awareness issues among practitioners and members.
    - Best efforts will be made to recruit and retain staffing that is reflective of the membership.
    - Creative efforts will be made to increase partnership with vendors and community-based organizations (CBOs) that are reflective of the membership.
    - KHS staff and provider network will be provided with opportunities for training and tools to promote cultural competency, linguistic sensitivity, and SPD awareness.
    - KHS will participate with government, community and educational institutions in symposiums related to cultural competency, linguistic sensitivity, and SPD awareness.
    - KHS will maintain systems that readily identify language and ethnic specific member data.
    - Through grant programs, KHS gives preference to funding agencies that can provide culturally and linguistically appropriate services that are accessible to the membership and the community.

C. QIHEP Goals

KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. The QI Department annually evaluates program objectives and progress, making modifications based on guidance from the KHS Board of Directors. The results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QIHE Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.

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

Results of the annual evaluation are presented to the Executive Quality Improvement Health Equity Committee (EQIHEC) and Board of Directors.

KHS acknowledges that culture change is necessary to achieve its health equity vision. As such, the vision and goals include a combination of qualitative and quantitative metrics. Some efforts will be initiated simply because they align with KHS's values and are perceived as being the "right thing to do" for the organization. Other objectives will have discrete measurements that are directly connected to DHCS contract requirements or KHS's annual goals or strategic plan. Some may be a blend of values-based goals and contractual obligations. Populations of focus particularly include:

A. Members affected by Health Disparities,

B. Limited English Proficiency (LEP) Members,

C. Children with Special Health Care Needs,

D. Seniors and Persons with Disabilities,

E. Persons with chronic conditions.

Culture (values-based) goals:

• Provide leadership to staff and provider network to support the long-term culture change needed to address any identified health disparities.

• Invite all stakeholder groups (i.e., members, providers, staff, community stakeholders, contractors, subcontractors, etc.) to better understand and engage in health equity work because it belongs to all of us.

• Provide educational opportunities to all stakeholders (above). Trainings will be provided through multiple modalities including not limited to:

o Online self-education classes

o In-person coaching/training

o Live Webinars

o Dissemination of educational materials

• Support development, workforce diversity, and training that increase cultural sensitivity, cultural awareness, and cultural humility in KHS's staffing and provider network.

• Establish partnerships and collaborations with community-based organizations that elevate social and racial justice in the communities served.

• Continue to solicit and incorporate diverse stakeholder perspectives through surveys and stakeholder meetings.

Goals to Meet Member's Cultural and Linguistic Needs:

• Target 90% of members who utilized interpreting and translation services are "satisfied" as indicated in satisfaction survey results.

• Deliver 90% of translation and interpretation service requests before or on the requested due date.

• Resolve 100% of cultural and language related grievances within 30 business days.

Goals to Directly Address Health Disparities:

• Identify disparities in care for selected MCAS/HEDIS measures. These may include, but will not be limited to, the following:

o Well Child Care (i.e., Well child visits, childhood immunizations, etc.)

o Maternity Care (i.e., disparities for Black and Native American persons)

o Mental Health (i.e., maternal, and adolescent depression screenings, follow up for mental health and substance use disorder)

o Cancer Screenings (i.e., Breast, Cervical, and Colorectal)

o Management of Chronic Conditions (i.e., Diabetes, hypertension, asthma, etc.)

• Address at least one disparity in care in each of the groups mentioned in the bullet above. Reduce the disparity between the highest and lowest performing populations (with reasonable membership) by 5% by 2025. For example:

o Increase well child visits for Black children by 15% by 2025.

o Increase maternal depression screenings for Black mothers by 15% by 2025.

o Increase the rate of annual diabetes screening for members who speak an Asian language in comparison to English speaking patients.

o Increase equity of member involvement in treatment planning for Black Non-Hispanic (77%), Hispanic (66%), and other race/ethnic populations (64%) to 85% or higher on the member satisfaction survey.

• MCAS measures - KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2025. Results for the 2024 measures will be calculated and submitted in report year (RY) 2025. The measures are in the following table:

#	MEASURE	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
Behavioral Health Domain				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
Children's Health Domain				
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10-E	ECDS	Yes
5	Developmental Screening in the First Three Years of Life	DEV	Administrative	Yesiii
6	Immunizations for Adolescents: Combination 2*	IMA-2-E	ECDS	Yes
7	Lead Screening in Children	LSC	Hybrid/Admin**	Yes
8	Topical Fluoride for Children	TFL-CH	Administrative	Yesiii
9	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	Yes
Chronic Disease Management Domain				

11	Asthma Medication Ratio*	AMR	Administrative	Yes
12	Controlling High Blood Pressure*	CBP	Hybrid/Admin**	Yes
13	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	GSD	Hybrid/Admin**	Yes
Reproductive Domain				
14	Chlamydia Screening in Women	CHL	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid/Admin**	Yes
Cancer Prevention Domain				
17	Breast Cancer Screening*	BCS-E	ECDS	Yes
18	Cervical Cancer Screening	CCS-E	ECDS	Yes
Report only Measures to DHCS				
19	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No

22	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
23	Colorectal Cancer Screening*	COL-E	ECDS	No^^
24	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
25	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
26	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No^^
27	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No^^
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
30	Follow-Up After ED Visit for Substance Use – 7	FUA	Administrative	No

	days*			
31	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
35	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	No^^
36	Plan All-Cause Readmissions*	PCR ii	Administrative	No
37	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No^^

38	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No^^
39	Prenatal Immunization Status	PRS-E	ECDS	No^^
Long Term Care Report Only Measures to DHCS				
40	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative^	No
41	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*	SNF-HAI	Administrative^	No
42	Potentially Preventable 30- day Post-Discharge Readmission*	PPR	Administrative^	No

III. Authority and Responsibility

The organizational structure includes the following personnel and committees:

A. KHS Board of Directors (BOD)

The Kern Health System (KHS) Board of Directors (BOD) has final authority and accountability for the KHS Quality Improvement Health Equity Program (QIHEP). The Board has delegated the responsibility for development and implementation of the QIHEP to the Executive Quality Improvement Health Equity Committee (EQIHEC). The EQIHEC is chaired by the KHS's Chief Medical Officer (CMO) and Co-Chaired by the KHS Health Equity Officer.

KHS's Board of Directors (BOD) is the governing body of the organization and has ultimate responsibility for the quality of care and service delivered by Kern Health Systems. The BOD:

- Approves the annual QIHEP description.
- Approves the annual quality management work plan which contains measures specific to the QIHEP.
- Reviews the annual QIHEP Evaluation.
- Reviews reports about QIHEP activities and measures as provided by the Quality Improvement Health Equity Committee (described below).
- Reviews and confirms the appropriate resources needed to implement the QIHEP recommended by the Quality Improvement Health Equity Committee.

B. Chief Executive Officer (CEO)

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

C. Chief Medical Officer (CMO)

KHS' Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the BOD and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QIHE Program and assigns authority for aspects of the program to the Chief Equity Officer and Quality Medical Director.

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

The CMO reports to the CEO and communicates directly with the Board of Directors. The CMO devotes the majority of the time to quality improvement activities.

The responsibilities of the CMO include:

- supervising the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Wellness & Prevention.
- supervising all QI activities performed by the Quality Improvement Department.
- providing direction for all medical aspects of KHS, preparation, implementation, and oversight of the QIHE Program, medical services management, resolution of medical disputes and grievances; and medical oversight on provider selection, provider coordination, and peer review.
- developing and implementing medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality. These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).
- providing direction to the EQIHEC and associated committees including PAC and Drug Utilization Review (DUR) Committee.
- providing assistance with study development and coordination of the QIHE Program in all areas to provide continued delivery of quality health care for members.
- assisting the Director of Provider Network Management with provider network development
- communicating with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.
- providing oversight for the development and ongoing revision of the Provider Policy and Procedure Manual related to health care services.
- executing, maintaining, and updating a yearly QIHE Program for KHS and an annual summary of the QIHE Program activities to be presented to the Board of Directors.
- assuring timely resolution of medical disputes and grievances.
- working with the appropriate departments to develop culturally and linguistically appropriate member and provider materials that identify benefits, services, and quality expectations of KHS.
- providing continuous assessment of monitoring activities, direction for member, provider education, and coordination of information across all levels of the QIHE Program and among KHS functional areas and staff.
- providing direction for internal and external QIHE Program functions, and supervision of KHS staff including:
    - Application of the QIHE Program by KHS staff and contracting providers
    - Participation in provider quality activities, as necessary

- Monitoring and oversight of provider QIHE Programs, activities, and processes
- Oversight of KHS delegated and non-delegated credentialing and recredentialing activities
- Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care
- Monitoring and oversight of any delegated UM activities
- Supervision of Health Services staff involved in the QIHE Program, including: Director of Quality Improvement, Director of Wellness & Prevention and Cultural & Linguistics Services, Population Health Management (PHM) Director, Utilization Management (UM) Director, Pharmacy Director, and other related staff
- Supervision of all Quality Improvement Activities performed by the QI Department
- Monitoring covered medical and behavioral health care provided to ensure they meet industry and community standards for acceptable medical care
- Active participation in the functioning of the plan grievance procedures

D. Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer oversees development, implementation, review and revision of health equity policies and procedures; maintains the QIHEP description and work plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between Kern Health Systems and any regulatory agencies on health equity issues and programs. The CHEO sits on the EQIHEC and provides health equity perspective for all non-clinical areas; the CHEO seat may not be delegated. The CHEO oversees the development, evaluation, and/or revision of the QIHEP description. The CHEO also oversees how health equity is embedded into the KHS culture for all non-clinical aspects (i.e., marketing, member engagement, member services, community supports, etc.).

E. Chief Operating Officer (COO)

Under direction of the CEO, plans, directs, monitors, coordinates, interprets, and administers all functional activities and policies related to Claims, Member Services, and AIS/Compliance departments. The COO is responsible for directing all activities of the Claims, Provider Relations, Member Services, and AIS/Compliance departments for a Knox-Keene Act-licensed health maintenance organization. COO maintains authority for setting policies and procedures for the departments, which are consistent with the policies and procedures set by the KHS Board of Directors and the CEO and fall in compliance with regulatory requirements. Executive is responsible for and has decision making authority regarding the organization in the absence of the CEO.

F. Quality Improvement Medical Director

The Medical Director of Quality must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The Medical Director will provide clinical leadership and guidance in the development and measurement of the strategic approach to quality, performance improvement, and patient satisfaction, and safety. As determined by the plan CMO, the Medical Director assists in short- and long-range program planning, total quality management including quality improvement, and external relationships, as well as develops and implements systems and procedures for all medical components of health plan operations.

In collaboration with the CMO and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and EQIHEC. Additionally, he or she represents the health plan on various committees and routinely reports to the Board of Directors on credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets.

Under direction of the Chief Medical Officer:

- Serve as a member of the following committees of the KHS Board of Directors: EQIHEC, PAC, P&T/DUR, Quality Improvement Committee, and Grievance Committee.
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS.
- Is responsible for reviewing and managing utilization of health care services at all levels of care to achieve high quality outcomes in the most cost-effective manner.
- Provides clinical leadership to the clinical departments staff and works collaboratively with the directors of the other Departments of KHS to ensure compliance with the contractual and regulatory requirements.
- Provide clinical support and education to the provider network in support of standards of care and evidence-based medicine and use of clinical criteria in decision management.
- Represents KHS in the medical community and in general community public relations.
- Participates in the implementation of the KHS Credentialing Program.
- Responsible for Review and identification of area for improvement and provide clinical leadership in the implementation of KHS Quality Improvement Plan and the Utilization Management Plan.
- Lead and/or attend and actively participate in meetings and committees as assigned by the CMO.

- Actively Participates as a member of the Health Services management team.
- Performs duties and responsibilities identified for the Medical Director under the Quality Improvement Plan, the Utilization Management Plan.

G. Behavioral Health Provider

The Behavioral Health Provider is a participating BH provider with an MD or PhD in Psychology and is licensed to practice in California. The Behavioral Provider is involved in all behavioral health aspects of the QI and UM Programs and advises the BHAC Committee aimed at improving behavioral healthcare services. Responsibilities include acting as the chairperson in the KHS Behavioral Health Advisory Committee (BHAC), reports to EQIHEC and provides reports on the key BHAC monitoring activities including but not limited to:

- Exchange of information between PCPs and behavioral health specialists.
- Coordination between KHS and Kern County Managed Behavioral Health Organization (MBHO) and certified SUD providers for substance use disorder services to promote continuity of care.
- Supervision of diagnosis, treatment, and referral for members with co-existing medical and behavioral conditions.
- Collaboration with pharmacy for the use of psycho-pharmaceutical medications.
- Identification of social determinants of health, and other potential barriers to receiving BH care, including access.
- Actively participating in the BHAC Committee and related subcommittees in collaboration with the CMO.
- Establishing QI and UM policies and procedures relating to behavioral healthcare.
- Participating in quality activities related to continuity and coordination of care between medical and BH practitioners.

H. Executive Quality Improvement Health Equity Committee (EQIHEC)

The EQIHEC provides overall direction for the continuous improvement process and monitors that activities are consistent with KHS's strategic goals and priorities. The EQIHEC addresses equity, quality, and safety, of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues from prior years, and conducts an annual evaluation of the overall effectiveness of the Quality Improvement Health Equity Program (QIHEP) and its progress toward influencing network-wide safe clinical practices. The QIHEP utilizes a population management approach to members, providers, and the community, and collaborates with Local, State, and Federal Public Health Agencies and Programs.

The EQIHEC consists of actively participating clinical and non-clinical providers. The physicians are voting members for clinical decision making. The QIHEC is comprised of internal and community participants. This process promotes an interdisciplinary and interdepartmental and community approach and drives actions when opportunities for improvement are identified.

The EQIHEC members consist of:

- Community Attendees:
    - 2 Participating Primary Care Physicians 2 Participating Specialty Physicians
    - 1 Federally Qualified Health Center (FQHC) Provider
    - 2 CAC members 1-Member of Board of Directors consumer & 1-community consumer 1 Pharmacy Provider
    - 1 Kern County Public Health Officer or Representative 1 Home Health/Hospice Provider
    - 1 DME Provider
- Internal KHS Attendees:
    - CMO
    - Health Equity Officer
    - Quality Improvement Medical Director
    - Quality Improvement Director
    - Quality Performance Director
    - Utilization Management Director
    - Population Health Management Director
    - BH Committee Behavioral Health Provider
    - KHS Chief Operating Officer (Grievances & Appeals)
    - P&T Committee Pharmacist
    - Public Policy Physician Advisory Committee Physician
    - Wellness & Prevention Director
    - Health Equity Manager
    - Provider Relations Director

The EQIHEC is required to meet at least four times annually and more frequently as determined. The activities of the EQIHEC and QI subcommittees providing information to the EQIHEC are formally documented in transcribed minutes, which summarize each agenda item, including deliberations, decisions, actions taken, recommendations and required follow-up. Key activities of the EQIHEC are the review and approval of the QIHE Program and Work-Plan, and QIHE quarterly and annual evaluations. The EQIHEC's findings and recommendations are reported quarterly by the CMO to the BOD.

The EQIHEC monitors and evaluates equity, quality, safety, appropriateness and outcomes of care and services to KHS members.

Activities:

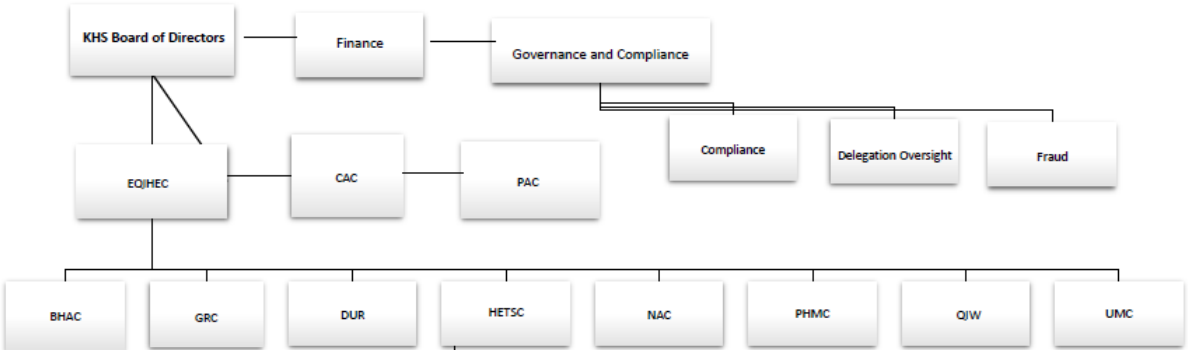
1. Formulates organization-wide improvement activities with QIHE subcommittee support.
2. Identifies appropriate performance measures, standards, and opportunities for performance improvement,
3. Assures QIHE Program activities are compliant with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, and NCQA,
4. Evaluates contract-specific interventions and outcomes.
5. Identifies actions to improve quality and prioritize based on analysis and significance; and indicate how the Committee determines these actions to ensure satisfactory outcomes,
6. Works closely with the IT Department for collection of data strategy and analytics to effectively analyze data related to the goals and objectives and establish performance goals to monitor improvement,
7. Ensures all departments can align project goals and map out responsibilities and deadlines prior to project implementation,
8. Ensures outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks,
9. Reviews the analysis and evaluation of QIHE activities of subcommittees and identifies needed actions and ensures follow up as appropriate,
10. Ensures that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions,
11. Reviews and modify the QIHE program description, annual QIHE Work Plan, quarterly work plan reports and annual evaluation of the QIHE program as necessary to maintain goals and priorities,
12. Communicates the quality health equity improvement process to practitioners/providers and members through appropriate persons and venues,
13. Ensures that the information available to the Plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services,
14. Ensures the annual HEDIS, CAHPS and Health Outcomes Survey (HOS) submissions are delivered according to technical specifications and deadlines,
15. Support and assist practitioners and providers to improve safety within their practices,
16. Design and implement strategies to improve compliance,
17. Develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines,

18. Meets healthcare industry standards of practice,
19. Improves quality, safety, and equity of care and service to members,
20. Conducts facility site and medical record reviews to ensure and support safe and effective provision of equitable clinical service,
21. Reviews, evaluates, and makes recommendations regarding oversight of delegated activities, such as audit findings, trending, and reports.

I. Quality Subcommittees

There are multiple KHS sub-committees in place to support the QIHEC and QIHEP objectives and goals. The activities of the quality subcommittees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. This information is reported at a minimum quarterly to the QIHEC in the format of formal reports.

Committee Structure



1. Behavioral Health Advisory Committee (BHAC)

KHS' responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County Medi-Cal Behavioral Organization manages severe mental health impairment referred to as Specialty Mental Health Services. In for substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi- Cal beneficiaries under the age of 21.

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee to the EQIHEC and is charged with facilitating collaborative coordination of medical and behavioral health and substance use disorder services between KHS and Kern County MBHO and Certified SUD providers caring for KHS members with the goal to maintain continuity and reduce barriers to appropriate initial and continuity of care.

The BHAC is chaired by a KHS credentialed and participating behavioral health provider with an M.D. or Psychologist. Committee attendees include community providers and stakeholders, and internal KHS departmental staff in the Population Health Management, Utilization Management, Health Equity, Pharmacy, and Quality Improvement Departments.

The committee meets at a minimum four (4) times a year. The key activities of the committee include:

a. Methods to exchange information and data between KHS the MBHO, Certified SUD Providers, PCP, and Specialists.
b. Appropriate diagnosis, treatment, and referral for members with coexisting medical, behavioral and SUDs for all levels of care.
c. Management of treatment, access, and follow-up care for members with coexisting medical, behavioral and SUDs for all levels of care.
d. Appropriate use of psycho-pharmaceuticals meds.
e. Addressing access to care barriers, health inequities, social determinants of health, and cultural and linguistic needs differences for the BH and SUD populations.

All BHAC review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

2. Drug Utilization Review Committee (DUR)

The Drug Utilization Review (DUR) committee is a subcommittee that reports to the (EQIHEC). The DUR committee is comprised of KHS' CMO and Director of Pharmacy along with network pharmacists and providers in the community serving KHS members. The DUR is responsible for reviewing matters related to the use of medications provided to KHS members. The basic objectives are to provide appropriate medication management for members improving their health and safety (administered in the outpatient settings by physicians under KHS' Division of responsibility, assist with case management, and monitor for possible FWA). RX Medi-Cal retains responsibility for formulary drugs carved out to them by the DHCS. KHS may address alternatives, based on safety and efficacy, and to minimize therapeutic redundancies; for those drugs dispensed under the MCRx program.

Activities:

a. Pharmacy guidelines, and policies and procedures based on clinical evidence for those drugs under the medical benefit, often referred to as Physician Administered Drugs (PADs).
b. Pharmacy utilization safety measures.
c. Drug Utilization Review.
d. Review of reports to identify members and providers with potentially inappropriate/excessive utilization of medication therapy.

The DUR Committee meets at a minimum (four) times a year. All reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

3. Grievance Review Committee (GRC)

Kern Health System Grievance and Appeals Process pursuant to which a member, or a provider or Authorized Representative acting on behalf of a member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution. The Grievances and Appeals process addresses the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters. KHS maintains written records of each Grievance and Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations.

All complaints, grievances, investigations, follow-up, tracking, and trending reports are prepared by the KHS Quality Improvement Department and submitted to the Grievance and Appeals (G&A) Review Committee. This committee is a subcommittee of the EQIHEC. The G&A Review Committee meets at a minimum four (4) times a year.

Under the direction and oversight of the Chief Medical Officer (CMO) or physician designee, individual and aggregate data on member grievances and appeals is reviewed by the G&A Review Committee. The committee is charged with evaluating and analyzing G&A data to identify systemic patters of improper services denials and other trends impacting health care delivery to Members By implementing necessary changes and process improvements for any adverse trends identified.

Grievances may address, but are not limited to, the following issues:

a. Difficulty obtaining an appointment,
b. Customer service at the provider or practitioner office,
c. Billing issues,
d. Difficulty accessing specialists,

e. Facility Conditions,
f. Confidentiality issues,
g. Refusals of PCP to refer the member for care,
h. Cultural Issues.

Appeals may address, but are not limited to, the following issues:

a. Appeals of denied Treatment Authorization Requests (TAR),
b. Appeals of level-of-care determinations,
c. Appeals of KHS claims payment denials,
d. Appeals of primary care physician request for disenrollment.

All G&A review reports and discussions and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

4. Health Equity Transformation Steering Committee (HETSC)

The Health Equity Transformation Steering Committee (HETSC)is an internal committee established to ensure KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The committee is responsible for identification and management of equity efforts throughout the organization including the planning, organization, and the direction, of the Health Equity Program. The HETSC is charged with systematic analysis to identify root causes of health disparities impacting KHS members and collaborating across the organization, with providers, and with other community agencies to eradicate inequities for KHS members served. The HETSC reviews and updates relevant health equity policies and procedures and may review the annual Population Needs Assessment (PNA) to identify opportunities for advancing health equity, incorporating applicable findings into the QIHE program. The HETSC, shall monitor, evaluate, and take timely action to address necessary improvements in the quality and equity of care delivered by Network Providers in any setting, and take appropriate action to improve upon quality improvement and health equity goals.

This workgroup includes the areas of focus described below. Due to significant overlap and alignment, the KHS DEI/JEDI workgroup may serve as the steering workgroup for health equity.

1. Development of Internal Resources:
   - The focus is to provide learning opportunities and activities for staff that promote personal and professional growth and understanding around issues of social and racial justice, equity, diversity, inclusion, and cultural humility.
2. Provider Network Development:

- Focus is to assess specific regional needs and existing skills of the provider network around health equity and provide training, resources, and support to providers to help build on their professional skills and help ensure they provide culturally sensitive and equitable treatment to all members.

3. Member Advocacy & Community Engagement:
   - Primary focus is to identify and promote ways that members can be educated about and provide feedback regarding their experiences with providers, KHS, and other systems in which their health is affected. Member feedback will be utilized to inform strategies developed to advocate for members' needs. The secondary focus is to sponsor and or participate in community events that are geared toward social and racial justice, develop initiatives that engage the community, impact health disparities, and help erase the stigmas surrounding mental health and substance use.
4. Human Resources Enhancement:
   - The focus is to work on recruitment, retention, and promotion of a more diverse workforce, as well as to ensure KHS has a welcoming and inclusive environment for all employees. The HR department is responsible for creating, implementing, and overseeing DEI policies and practices that have a direct impact on the workforce and its stakeholders. Also, the HR department is committed to upholding the highest standards for prioritizing equitable and inclusive practices and ensuring that the organization is representative of the communities it serves. By working closely with all departments and stakeholders, this workgroup will partner with the HR department to help ensure that the organization is inclusive, equitable, and responsive to the needs of the employees and communities it serves.
5. Monitoring and Evaluation for Continuous Improvement:
   - Focus is to identify how effectively staff apply internal QIHEP policies and procedures. The policy workgroup will determine areas of staff development and training to ensure discrimination is not present through the application of policies and procedures.

The Health Equity Department Manager reports to the Health Equity Officer and is charged with overseeing the day-to-day operations of the Health Department and is responsible for organizing and preparing the HETSC agenda, minutes, reporting and committee activities for reporting to the Executive Quality Improvement Health Equity Committee (EQIHEC).

The HETSC has established objectives to address health disparities to include:

a. Increase the awareness of health equity and quality and implement strengthened, expanded and/or new health equity quality activities to support providers and members ultimately reducing health inequities within KHS' membership.
b. Ensure services provided to members promote equity and are free of implicit bias or discrimination.

c. Implement programs that address the causes of inequity that members and their communities experience, food insecurity, housing problems, tobacco use, and other concerns.
d. Analyze the existence of significant health care disparities in clinical areas.
e. Reduce health disparities among members by implementing targeted quality improvement programs.
f. Promote physician involvement in health equity/ disparities and activities.
g. Conduct focused groups or key informant interview with cultural or linguistic minority members to determine how to meet their needs.
h. Address social determinants of health.

5. Network Adequacy Committee (NAC)

The Network Adequacy Committee (NAC) shall advance the mission of Kern Health Systems (KHS) of improving the health status of our members through an integrated managed health care delivery system. The NAC will report to the KHS Executive Quality Improvement Health Equity Committee (EQIHEC) on KHS' monitoring activities, corrective actions, and regulatory requirements related to network access, availability, and adequacy.

Function – The functions of the NAC are as follows:

1. **Establish Network Standards**: Ensuring network accessibility standards (capacity/adequacy, appointment availability, geographic accessibility, etc.) align with Department Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) standards.
2. **Monitor Network Compliance:** Review monitoring activities conducted by the Plan to measure network compliance with established standards.
3. **Promote Health Equity**: Implement review processes that monitor network adequacy amongst diverse populations, focusing on equitable access to care across different demographic and geographic groups.
4. **Steer Continuous Improvement:** Provide feedback on proposed corrective actions and ensure they are appropriate to address identified issues. Track progress of active corrective action plans.

Composition – The NAC is delegated by the EQIHEC to monitor and report on network adequacy. The committee will make recommendations and report findings to the EQIHEC.

Cadance - The NAC will meet quarterly with additional meetings, as necessary.

6. Population Health Management Committee (PHMC)

KHS follows the NCQA definition for Population Health Management: "Population Health Management is a model of care that addresses individuals' health needs at all points along the continuum of care with a "Whole Person"

approach supported through participation, engagement, and targeted interventions for a defined population." The Population Health Management Committee oversees the Population Health Management (PHM) Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHM MOC is to maintain or improve the physical and psychosocial well- being of individuals and address health disparities through cost effective and tailored health solutions.

The PHMC is a collaborative group that engages business units from multiple KHS departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health. Each year a Population Needs Assessment is conducted by KHS. The annual PNA describes the overall health and social needs of KHS's membership by analyzing service utilization patterns, disease burden, and gaps in care of members, considering their risk level, geographic location, and age groups. PHMC members focus on strategies related to gaps identified in the PNA, addressing adverse patterns and outcomes to improve members' physical and psychosocial well-being through cost-effective and tailored solutions.

The following departments support the PHMC:

- Quality Improvement
- Quality Performance
- Utilization Management
- Member Services
- Behavioral Health
- Enhanced Care Management
- Health Equity
- Wellness and Prevention

These departments provide the analysis of service utilization patterns, disease burden, health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs, and other gaps in care for KHS members.

The following programs are incorporated into PHM and fall under the administration of the afore mentioned Departments:

- LTC & LTSS
- Major Organ Transplants
- Transitions of Care (TOC)

PHM works collaboratively with the following programs and Departments:

- California Children's Services (CCS)
- Enhanced Care Management (ECM)
- Community Support Services (CSS)
- Behavioral Health

The PHM strategy focuses on the "whole person" throughout the care continuum to:

- Provide wellness services and intervene on the highest-risk members,
- Improve clinical health outcomes,
- Promote efficient and coordinated health care utilization,
- Maintain cost effectiveness, and quality care,
- Improve access to essential medical, mental health, and social services,
- Improve access to affordable care,
- Ensure appropriate utilization of services,
- Improve coordination of care through an identified point of contact,
- Improve continuity of services for members across transitions in healthcare setting, providers, and health services.
- Improve access to preventive health services.
- Improve beneficiary health outcomes

Activities:

a. Responsibilities of the committee include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimizing programing, ensuring that PHM addresses health at all points on the continuum of care,
b. Ensures that the medical care provided meets the community standards for acceptable medical care,
c. Collaborates with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
d. Improve communications (exchange of information- data sharing) between primary care practitioners, specialists, behavioral health practitioners, and health delivery organizations and ancillary care provider,
e. Monitors appropriate use and monitoring of medications,
f. Incorporates Population Health Management Model into policies, procedures, and workflows,
g. Improving member access to primary and specialty care, ensuring members with complex health conditions receive appropriate service,

h. Identifies and reduces barriers to needed healthcare and social services for members with complex health conditions,
i. Improve member health status through the delivery of wellness and disease prevention services, programs, and resources by educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve, and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions,
j. Ensures continuity in treatment access and follow-up for members with co-occurring medical, behavioral health, and SUD conditions.
k. Promotes routine depression, anxiety, trauma-based care, and substance use disorder screenings are completed, and appropriate follow-up referrals are made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period.
l. Link members to ECM, CSS, SUD Providers and other community-based programs with comprehensive and holistic approaches.

7. Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. The Board of Directors delegates the CAC to provide input in the development of public policy activities for KHS. The committee makes recommendations and reports findings to the Board of Directors. The role of the CAC is to implement and maintain community linkages.

Function – The functions of the CAC are as follows:

1. Review changes in policy or procedures that affect KHS Members.
2. Provide updates on state policies or issues that affect Members.
3. Allow committee members to have input on issues that have an impact on KHS Members (i.e. marketing materials, KHS website including the web Provider Directory or Doctor Search, the Evidence of Coverage, brochures, flyers, Health Education materials, Radio/TV/Billboard advertisements, incentive ideas/items, etc.).
4. Allow committee members to share experiences that will help KHS improve how care is delivered.
5. Advise on educational and operational issues affecting members who speak a primary language other than English;
6. Advise on cultural and linguistic issues.

8. Quality Improvement Workgroup (QIW)

The focus of the QIW is on clinical quality, patient safety, and patient and provider experience in four functional areas: HEDIS/Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, Quality Improvement, and Network Clinical Oversight. The QIW will ensure KHS members receive quality health care by identifying and addressing outcomes that deviate from standards in the afore-mentioned committee responsibilities.

Activities:

1. Review and approve the QIHE Program Description, the annual Work Plan, and annual Evaluation of the work plan.
2. Ensure compliance with DHCS facility site review requirements.
3. Review aggregate data of potential quality of care issues (PQIs), identify areas of improvement, and oversee implementation of improvements.
4. Oversee KHS safety program.
5. Oversee the identification of quality-of-care trends and recommend corrective action as needed.
6. Monitor evidence-based care through the HEDIS and Managed Care Accountability Set (MCAS) audit and make recommendations for areas of improvement.
7. Review and discuss YTD quality improvement initiatives.
8. Monitor member satisfaction by reviewing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Outcomes and address measures of dissatisfaction.

9. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on the UM activities. The UM Committee supports the QIHEC around appropriate provision of medical services and provides recommendations for UM activities. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information with the involvement of appropriate, actively practicing practitioners; and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under and utilization patterns.

Activities:

a. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient, and ancillary services.
b. Ensure that UM decisions:

1) Are made independent of financial incentives or obligations.
2) Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management
3) Physician compensation plans do not include incentives for denial decisions.
4) Physician and UM decision designees are not rewarded for utilization review decisions.

c. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
d. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
e. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
f. Continually monitor and evaluate utilization practice patterns of staff and contracted practitioners and vendors and identify variations in care.
g. Review state regulatory oversight of LTC and CBAS facilities and develop and maintain a process to identify and work with Quality and Credentialing teams to address quality issues.
h. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
i. Facilitate and ensure continuity of care for members within and outside of KHS network.
j. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

J. QI Support Committees

1. Delegation Oversight Committee

The purpose of the Kern Health Systems (KHS) Delegation Oversight Committee (DOC) is to ensure adequate oversight of performance and adherence to regulatory contracts, requirements, and KHS standards related to subcontractors to which KHS delegates any plan-required function(s). This includes oversight of the entire spectrum, from pre-delegation auditing, monthly Joint Operating Meetings, routine oversight of delegate reporting and/or audits, and annual audits conducted by KHS Department leads and staff. The Compliance Department is the leader, facilitator, and coordinator of formal audits of Delegated Entities as outlined in the annual compliance and monitoring/auditing work plans.

KHS may choose to delegate Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Credentialing, Compliance, Claims, and other departments activities and responsibilities to qualified entities, where regulatorily allowed. The DOC is responsible to oversee the ongoing assessment of performance results to ensure contract and regulatory requirement adherence, as well as achieving business goals and outcomes to deliver quality outcomes for our members.

Duties and Responsibilities

1. Evaluate prospective delegated vendor's ability to perform the proposed delegated activities prior to delegation through a pre-delegation audit conducted by the relevant business areas.
2. Ensure KHS departments which delegate functions establish performance and reporting deliverables for departmental business needs designed to assess the effectiveness of health care delivery to members and compliance with regulatory requirements.
3. Review business owners' updates on monitoring and oversight activities and subcontractor performance, recommending action and providing feedback where necessary.
4. Assist Departments with establishing effective departmental auditing tools designed to measure and report delegated entity performance to ensure compliance with regulatory requirements.
5. Review results of all annual audits of delegated entities, as coordinated by the Compliance Department in accordance with the annual compliance, monitoring and auditing work plans.
6. In conjunction with the Delegation Oversight department, ensure KHS business owners perform all necessary oversight of the functions delegated as set forth in the written delegation agreement on behalf of KHS.
7. Review and evaluate delegated entity's performance, including business owner updates on monitoring and oversight activities presented to the DOC.
8. Assist with identifying opportunities for performance improvement and /or recommending corrective action plans as needed when a deficiency has been identified.
9. Review findings, recommended changes to contracts and policies, and requested initiatives or project updates by the delegate entity.
10. Make recommendations to the Chief Compliance and Fraud Prevention Officer, Compliance Committee, Contract Business Owners, Governance and Compliance Committee and/or Board of Directors regarding the compliance status of the delegated entity as it relates to compliance with regulatory requirements, performance, and/or other documented requirements.
11. Escalate outstanding issues from the DOC to the Compliance Committee and/or Kern Health Systems Board of Directors, as needed.
12. Recommend and provide oversight of corrective action plans (CAPs) to address deficiencies from initiation through CAP closure.

13. Propose sanctions up to and including the revocation and/or termination of delegation if the delegated entity's performance is inadequate and corrective action plans are not successful.

2. Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities to include, serving as the KHS Credentialing and Peer Review Committee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates the credentials of all current and prospective practitioners and providers to be added to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care.

PAC- Credentialing and Peer Review

The minutes are confidential, and information is protected under California Business and Professions Evidence Code 1157. In accordance with state law, minutes containing confidential peer review information will be redacted. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain credentialing standards, oversight of the credentialing program, delegated credentialing oversight, conducting performance monitoring from quality improvement activities and member complaints in the recredentialing decision making process for the KHS network of Participating Practitioners and Health Delivery Organizations. The PAC Committee establishes and maintains credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. The Credentialing Committee may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, patient type or patient's insurance coverage in which the practitioner specializes.

Activities:

a. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.
b. Promote continuous improvement in the quality of the care and service provided by the KHS Network Providers.
c. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
d. Provide guidance on the overall direction of the credentialing program.

e. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process.
f. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
g. Monitoring the reporting of Provider Preventable Conditions

PAC-Medical Technologies and Clinical Criteria Sets

a. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members.
b. Performs reviews of technologies for use by medical and behavioral staff in the utilization review process.
c. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations.
d. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.
e. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers;

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
2. Protection of member identifiable health information by ensuring members' protected health
   information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.
3. Providing oversight in strategies to reduce FWA in provider networks.

3. Compliance Committee

Kern Health Systems (KHS) is committed to the preservation and integrity of its mission through the enforcement of contractual, legal, ethical, and regulatory standards and guidelines. All KHS employees are expected to adhere to these governing laws, regulations, and ethical standards. Management is responsible for ensuring such compliance; therefore, compliance is an integral part of good organizational governance.

The establishment of the KHS Compliance Committee (Committee) through this Charter evidence KHS' commitment to the highest integrity and ethical standards, thereby supporting compliance with contractual obligations, all applicable laws, and regulations. The Compliance Committee is an oversight committee.

1. The Compliance Committee's responsibilities include, but are not limited to:

a. Determine the appropriate strategy and/or approach to promote compliance; to prevent, detect, and correct potential violations; and to advise the Compliance Officer accordingly.

b. Review and approve training related to Compliance and Fraud, Waste, or Abuse issues and ensure that training and education are effective and appropriately completed;

c. Review Fraud, Waste or Abuse Reports, including member and provider reported cases;

d. Review reported HIP AA Incidents, including prevention education;

e. Review Timely Access Reporting;

f. Review DHCS Attestation Reporting deliverables;

g. Review delegated entities to ensure their performance on delegated functions meet KHS standards;

h. Review internal and external audits reports and auditing tools, including reporting outcomes and remediation efforts. Address when there is risk of program non-compliance and/or potential FWA, and ensure CAPs are implemented and monitored for effectiveness;

i. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

j. Review reports from the Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

k. Monitor the Quality Improvement and Grievance Processes, including opportunities to improve quality and service through trend management;

l. Validate that KHS has appropriate and current compliance policies and procedures;

m. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

n. Oversee the implementation of applicable federal and state programs, including contractual, legal, and regulatory requirements, as they relate to compliance risk, and coordinate with the Compliance Officer to ensure the adequacy of the Compliance Program to manage the compliance oversite of programs; and

o. Respond and manage Ad Hoc issues.

2. In accordance with KHS Policy 4-40-P Corrective Action Plans, the Compliance Committee will monitor the issuance of Corrective Action Plans (CAPs) by the KHS Physician Advisory Committee (PAC). The Compliance Committee will also review tracking and trending concerns and make recommendations when deemed necessary.

3. In collaboration with the PAC, the Compliance Committee, shall evaluate the effectiveness of each CAP and make recommendations regarding ongoing monitoring activates to ensure continued compliance.

4. Health Equity Advisory Board

The Health Equity Advisory Board recruits racially, ethnically, and culturally diverse (including those from LGBTQI+ communities) people from various stakeholder groups across the County. These include, but are not limited to, general consumers from racial groups that make up KHS's members, Kern County health officer or a designated representative, County Human Services representatives, community advocates, and traditional and safety net providers. Advisory Board members focus on issues of diversity, equity, and inclusion in KHS procedures and metrics to improve health equity. They may:

- Participate in establishing public policy which is defined as acts performed by KHS or its employees and staff to assure comfort, dignity and convenience of patients who rely on KHS' facilities to provide health care services to them, their families, and the public.
- Review and make recommendations on marketing and member materials.
- Review and make recommendations on the complaints and grievance process.
- Review and make recommendations on member and provider satisfaction surveys.
- Review and make recommendations on activities related to Quality Improvement, educational, operational, and cultural competency issues affecting Limited English Proficiency (LEP) members.
- Review and make recommendations on staff & provider health equity related training
- Review and make recommendations on contracted vendors and CBOs.

5. Health Equity and Learning (HEAL)

The mission of the Provider HEAL Committee is to foster a collaborative environment among healthcare providers in Kern Health Systems, dedicated to advancing health equity. The purpose of the committee is to:

1. Solicit Feedback: Act as a platform for providers to share challenges faced in the field and gather feedback to address issues related to health equity to help inform the development of KHS's training offerings, programs and support for Provider Network
2. Resource Sharing: Facilitate the exchange of resources, funding opportunities, best practices, and innovative approaches to improve healthcare service delivery with a focus on health equity
3. Training and Development: Identify, develop, and promote opportunities for training and professional development to enhance providers' knowledge and skills in delivering equitable healthcare
4. Practice Expansion: Explore and discuss opportunities for expanding access and/or services that align with and support health equity initiatives

Composition

The HEAL reports to the Health Equity Steering and Transformation Committee.

Membership

1. Membership in the Provider HEAL Committee is open to all healthcare practices within Kern Health Systems network that express an interest in promoting health equity.
2. Membership is voluntary and may include healthcare professionals, administrators, and other relevant stakeholders.
3. Members are expected to actively contribute to the mission and objectives of the committee.

Meetings

1. The committee shall meet regularly, at least quarterly, either in person or virtually
2. Additional ad-hoc meetings may be called as necessary to address specific issues or opportunities.

6. Regional Advisory Committee (RAC)

The Regional Advisory Committee (RAC) is a quarterly meeting held in one city in each of the five regions of Kern County. Every quarter a topic is selected to discuss with Members and community stakeholders to learn strategies for improvement and challenges being faced. The meetings are open to everyone in the region and information gained from each region is synthesized to help inform gaps and best practices occurring throughout the county.

These finding are presented to the Health Equity Transformation Steering Committee (HETSC) for review and determination of action steps to address the needs of the county and services to Kern Family Health Care members.

IV. Organizational Structure and Resources

A. Clinical Oversight of QIHEP

Under the direction of the CMO, the Medical Directors are responsible for clinical oversight and management of the QI, UM, BH, Wellness and Prevention and PHM activities, participating in QIHEP for KHS and its Practitioners, and overseeing credentialing functions. Medical Directors must possess a valid Physician's and Surgeon's Certificate issued by the State of California and certification by one (1) of the American Specialty Boards. Principal accountabilities include:

1. Developing and implementing medical policy for Health Services department activities and QI functions;
2. Reviewing current medical practices ensuring that protocols are implemented and medical personnel of KHS follow rules of conduct;
3. Ensuring that assigned Members are provided health care services and medical attention at all locations;
4. Ensuring that medical care rendered by Practitioners meets applicable professional standards for acceptable medical care.

B. Quality Improvement Department (QI)

Quality Improvement Director

Under the direction of the Chief Medical Officer (CMO) and Quality Improvement (QI) Medical Director, the Director of Quality Improvement leads the development, implementation, and oversight of QI initiatives to enhance health outcomes and address health disparities within the Kern Health Systems (KHS) membership. The Director ensures alignment with the KHS Quality Management Plan, Medi-Cal contractual requirements, and NCQA accreditation standards while fostering a culture of continuous improvement.

Key responsibilities include:

- QI Program Development: Designs and implements programs that align with KHS's Health Equity and Quality Improvement goals, regulatory standards, and contractual obligations.
- Performance Monitoring & Reporting: Oversees data collection, medical record reviews, and analysis of key performance indicators to inform decision-making.

- Provider & Community Collaboration: Engages with contracted providers and external partners to drive QI initiatives, address disparities, and improve member health outcomes.
- Regulatory Compliance & Accreditation: Ensures compliance with Medi-Cal QI requirements, oversees credentialing, and leads efforts for accreditation preparedness.
- Interdepartmental Coordination: Facilitates collaboration across KHS departments and external agencies to integrate QI activities into organizational workflows.
- Leadership & Workforce Development: Provides mentorship to QI staff, ensuring professional growth and alignment with KHS's health equity objectives.

The Director of QI plays a pivotal role in advancing health equity by identifying disparities, implementing targeted interventions, and continuously improving healthcare quality across the KHS network.

NCQA Manager

The NCQA Manager, under the direction of the Director of Quality Improvement, ensures KHS maintains NCQA accreditation and compliance with State regulations related to the Quality Improvement Program. This role provides oversight for the successful completion of initial and renewal accreditation efforts and ensures ongoing alignment of KHS departments with NCQA standards, State certification, and contractual quality requirements.

Key responsibilities include:

- Accreditation & Regulatory Compliance: Leads the development, implementation, and coordination of policies, procedures, and workflows to meet NCQA, Medi-Cal, and Medicare D-SNP model of care requirements.
- Quality Program Support: Integrates NCQA standards and State regulations into QI processes, ensuring compliance across all KHS business areas.
- Policy & Process Development: Oversees the development and revision of accreditation and compliance policies, incorporating feedback from regulatory agencies.
- Cross-Departmental Collaboration: Works with KHS leadership and staff to embed quality improvement initiatives into organizational operations, supporting a culture of continuous improvement and health equity.

The NCQA Manager plays a critical role in maintaining KHS's commitment to quality, accreditation, and regulatory compliance, ensuring that all initiatives support health equity and member-centered care.

NCQA Accreditation Specialist

Under the direction of the NCQA Manager, the NCQA Accreditation Specialist supports the planning, execution, and maintenance of NCQA Health Plan and Health Equity Accreditation at Kern Health Systems (KHS). This role ensures

accreditation readiness by coordinating efforts across departments, following established guidelines, and maintaining a comprehensive NCQA accreditation work plan.

Key responsibilities include:

- Accreditation Readiness & Compliance: Assists in managing the NCQA accreditation process, ensuring adherence to standards, quality studies, and interventions that support regulatory compliance and health equity goals.
- Process Coordination & Monitoring: Leads interdepartmental coordination to support accreditation requirements, track progress, and facilitate corrective action plans.
- Quality & Performance Enhancement: Works to ensure outstanding clinical performance and a positive member experience, contributing to KHS's commitment to continuous quality improvement and equitable care.

The NCQA Accreditation Specialist plays an essential role in sustaining NCQA compliance, ensuring high-quality care delivery, and reinforcing KHS's mission to advance health equity and member well-being.

Quality Improvement Manager, RN

Under the direction of the Director of Quality Improvement, the Quality Manager ensures state, regulatory, and contractual compliance for the Quality Improvement (QI) Program.

Key responsibilities include:

- Regulatory & Audit Oversight: Manages delegation audits, and external quality reviews, ensuring compliance with Medi-Cal and contractual requirements.
- Quality Improvement Initiatives: Leads Improvement Plans, PIPs, and other targeted quality initiatives aimed at enhancing care delivery and patient outcomes.
- Operational Leadership: Applies clinical expertise and analytical skills to oversee the day-to-day operations of the QI team, driving data-informed strategies to improve performance and member health equity.

The Quality Manager plays a critical role in advancing quality improvement efforts, ensuring compliance, and supporting KHS's mission to enhance equitable and high-quality care.

Quality Improvement Supervisor, RN

The Quality Improvement (QI) Supervisor RN oversees the daily operations and activities of clinical and non-clinical staff within the QI Department, ensuring the effective management of clinical grievances, Potential Quality Issues (PQIs), Performance Improvement Projects (PIPs), and other key quality initiatives. This role involves providing leadership, guidance, and oversight to maintain compliance with regulatory requirements and drive continuous

improvement. The QI Supervisor collaborates closely with the QI Manager to optimize workflows, enhance efficiency, and support the successful execution of quality improvement initiatives.

Quality Improvement Nurse, RN

The QI Nurse assists in clinical activities related to monitoring, assessing, and improving performance in ambulatory and inpatient health care delivery or health care related services to Kern Health Systems (KHS) membership. The QI Nurse assists in the implementation of the KHS QI Program Plan by doing the following activities:

- Communicates with contracted providers regarding studies and audit findings,
- Delivers provider or member education in support of quality health care,
- Conducts medical record reviews and audits, and HEDIS or HEDIS-like chart reviews,
- Performs clinical investigation of potential quality of care issues and grievances and writes an effective clinical summary of the investigation for referral to a medical director,
- Develop and ensure completion of provider corrective action plans related to quality-of-care issues or regulatory or accreditation non-compliance,
- Develop and complete performance improvement projects aimed at improving member compliance with specific preventive health measures.

Quality Improvement Coordinator

Reporting to the Quality Manager, the Quality Improvement (QI) Coordinator plays a key role in data collection, record maintenance, and regulatory compliance support for the QI Program. This position is integral to Managed Care Accountability Set (MCAS) initiatives, intervention development, and provider site review activities.

Key responsibilities include:

- Data Collection & Reporting: Supports MCAS methodology, assists in data entry, report preparation, and ensures accurate documentation for QI activities.
- Regulatory & Compliance Support: Assists in medical record requests, record preparation, and QI interventions, ensuring readiness for audits and compliance with State and contractual requirements.
- Provider Site Review Assistance: Provides administrative support for facility site reviews and collaborates with internal departments and external agencies to facilitate QI initiatives.

The QI Coordinator plays a vital role in supporting quality improvement efforts, ensuring regulatory compliance, and assisting in the execution of data-driven health equity interventions within the QI Program.

C. Quality Performance Department (QP)

Senior Director of Contracting and Quality Performance

Under the direction of the Chief Operating Officer (COO) and Chief Medical Officer (CMO), the Senior Director of Contracting and Quality Performance (QP) is responsible for provider contracting, quality performance, and practice transformation initiatives at Kern Health Systems (KHS). This role ensures the integrity of provider agreements, value-based care initiatives, and quality improvement (QI) programs, aligning with regulatory, legal, and strategic business objectives.

Key responsibilities include:

- Contracting & Compliance: Develops and negotiates provider contracts, ensuring compliance with regulatory requirements, risk mitigation, and alignment with KHS's business needs.
- Quality & Performance Management: Oversees Pay-for-Performance (P4P) programs, Managed Care Accountability Set (MCAS) reporting, and provider QI initiatives to enhance provider engagement and healthcare quality.
- Practice Transformation & Value-Based Care: Supports providers in transitioning to value-based care models, leveraging health IT and data analytics to improve care delivery and health equity.
- Provider Network Efficiency & Financial Performance: Leads process improvements, rate development for provider contracts, and oversight of special provider funding distributions.
- Credentialing & Compliance Oversight: Ensures facility site review processes, credentialing standards, and provider compliance with contractual and legal requirements.

The Senior Director of Contracting and QP plays a critical role in driving provider network integrity, optimizing quality performance, and advancing health equity, ensuring that contracted providers deliver high-quality, culturally competent, and accessible care for KHS members.

Director of Quality Performance

Under the direction of the Senior Director of Contract and Quality Performance, the Director of Quality Performance is responsible for oversight, implementation, and management of new quality improvement initiatives specific to the Provider Network and membership. This includes being responsible for HEDIS and MCAS functions and collaborating and supporting providers to improve health outcomes related to those measures. The Director is also responsible for quality improvement initiatives related to Performance Improvement Projects (PIPs) and Facility Site Reviews (FSRs). The Director will communicate and coordinate with contract providers regarding required studies, participation, and improvement projects. Related duties include ongoing data collection, medical record reviews, report writing, and collaboration with other KHS departments, as well as outside agencies.

The Director of Quality Performance is responsible for HEDIS/MCAS and performance and site review components of the Quality Improvement Program. This position will be responsible for oversight of maintaining compliance with Medi-Cal contractual stipulations for the performance of KHS and KHS contracted providers. In addition, this person will be an effective contributor to the KHS business planning and fiscal processes.

Essential Functions include:

- Builds and develops collaborative relationships (internally and externally) vital to the success of programs.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Responsible for Quality Performance staff and processes.
- Work collaboratively with Senior Director and Provider Network team to develop physician practice performance profiling on HEDIS/MCAS/STAR metrics, identify opportunities for improvement, and support/manage change implementation.
- Establishes and maintains tracking and monitoring systems for health care quality improvement activities according to regulatory requirements, policies and procedures, and contractual agreements.
- Track and monitor the HEDIS/MCAS improvement operations.
- Identify opportunities and potential barriers in HEDIS/MCAS
- Research and documents current health care standards for use in performance improvement study design and methodologies related to health outcomes.
- Provides guidance, and oversight to staff regarding study design, methodology, data analysis and reporting of Quality performance improvement projects.
- Works with staff to achieve production, timeliness, accuracy, and quality of work.
- Remains current with Department of Health Care Services and Department of Managed Care policy implementation or revisions.
- Participates in the development, review and updating of policies and procedures.

- Manages and evaluates performance of department staff.
- Coordinates guidelines, studies, and performance improvement activities in concert with the utilization management, quality management, pharmacy services, and population health management teams.
- Remains current with HEDIS/MCAS requirements and participates in planning and implementation of methods to improve HEDIS/MCAS performance.
- Education of providers on HEDIS/MCAS and program goals.
- Ensures compliance with applicable regulatory and reporting requirements.
- Coordinates the regular and systematic review of all potential quality of care issues in accordance with state statute.
- Develops and analyzes reports to monitor and evaluate quality performance in meeting established goals.

Quality Performance Nurse, RN

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

MCAS/HEDIS Supervisor

The QP MCAS/HEDIS Supervisor is responsible for oversight and daily operations of KHS' MCAS/HEDIS performance. The Supervisor possesses a bachelor's degree or higher in Healthcare, Business, Data Science, Project Management, or related field. They have at least 2 years' experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years' experience in project management work. Under the direction of the Director, the Supervisor manages, plans, coordinates, and monitors Quality Special Programs including but not limited to:

- Annual Managed Care Accountability Set (MCAS) audit and measurement results submission.
- QI Department Strategic Goals and Projects, and Special Programs (such as member incentives

and engagement, DHCS-required project improvement plans, site reviews, etc.).

Quality Performance Operations Analyst

The QP Operations Analyst is responsible for reporting needs related to MCAS and site review reporting needs. The Analyst serves as the Subject Matter Expert (SME) for MCAS and HEDIS aspects of KHS' Quality Program.

Under the direction of the Supervisor and Director, this position provider oversight, management, and validation of data and reports submissions for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QP department, vendors, and internal KHS departments, such as IT.

Quality Performance Coordinator

The QP Coordinators are responsible for functions related to data collection, data entry, report preparation, maintenance, collaboration, and regulatory compliance support for the department. The coordinator serves as the liaison between the health plan and provider network for record retrieval, scheduling, and various departmental initiatives and interventions. Under the direction of the QP Director and/or Supervisor, the Coordinators perform Quality related duties, including but not limited to MCAS data collection, sorting, chasing, and analyzing medical records.

D. Health Equity Department

Chief Health Equity Officer (CHEO)

The Chief Health Equity Officer oversees development, implementation, review and revision of health equity policies and procedures; maintains the QIHEP description and work plan; coordinates implementation activities; and ensures reporting to the EQIHEC. The CHEO also serves as the primary liaison between Kern Health Systems and any regulatory agencies on health equity issues and programs. The CHEO sits on the EQIHEC and provides health equity perspective for all non-clinical areas; the CHEO seat may not be delegated. The CHEO oversees the development, evaluation, and/or revision of the QIHEP description. The CHEO also oversees how health equity is embedded into the KHS culture for all non-clinical aspects (i.e., marketing, member engagement, member services, community supports, etc.).

Health Equity Manager

The Health Equity Manager is responsible for the daily management of the QIHEP including development and management of projects and activities to expand and advance the delivery and quality of health equity measures,

cultural competency services, operational effectiveness through process improvement, contract execution, and monitoring. The Health Equity Manager supervises all staff directly working in the Health Equity Office (HEO).

Senior Health Equity Analyst

The Senior Health Equity Analyst will provide reports, data analytics, project management, process improvement, and data integrity based on the collection, association, compliance review, and interpretation of data and operational processes. The Senior Health Equity Analyst is responsible for developing a complete understanding of the stated and actual needs of Health Equity Office stakeholders (internal and external), not simply their expressed desires, through a methodical analytical process, identify and report gaps, and help develop solutions to address revealed findings. The Senior Health Equity Analyst assists the HEO in defining the technical and reporting needs of KHS's QIHEP and HETSC initiatives and may facilitate or govern analytical discussions between various groups.

Health Equity Project Coordinator

The Health Equity Project Coordinator coordinates and organizes projects for the Health Equity Office. Supports the successful implementation of projects within timelines for associated department assignments and tasks. This position also coordinates the functions of the EQIHEC and all subcommittees.

E. Appeals and Grievances

Member Grievances and Appeals System

KHS Member Grievance and Appeal system complies with the requirements set forth in the 42 Code of Federal Regulations Sections 438.228 and 438.400 – 424, 28 California Code of Regulations Sections 1300.68 and 1300.68.01, and 22 CCR Section 53858. KHS use all notice templates included in the All-Plan letter 21-011 and ensures timely written acknowledgement and a notice of resolution to the member as quickly as possible.

Grievances with a Potential Quality Issue (PQI) identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues are reviewed by the KHS CMO or their designee to determine the severity level and follow-up actions needed. All cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include tracking and trending a provider for additional PQIs and/or request(s) for a corrective action plan (CAP) for issues or concerns identified during review. The CMO or their designee may present select cases to the PAC for review and direction as needed.

KHS regularly analyzes grievance and appeals data to identify, investigate, report and act upon trends impacting health

care access and delivery to the members.

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

F. Credentialing

The Credentialing Department operates under the direction of the Deputy Director of Contracting and Quality Performance, who reports to the COO and is responsible for Provider Operations, including credentialing and re-credentialing functions, oversight for directly contracted Practitioners, Providers, and delegated IPAs, and resolving credentialing-related Provider issues.

Provider Operations, which includes Provider Contracting, Provider Network Management, Provider Relations, and Provider Training & Development, is committed to having a culturally competent and linguistically accessible network comprised of diverse providers who are knowledgeable and responsive to members' cultural practices and beliefs. This includes a commitment to identifying, assessing, and addressing behavioral health inequities to eliminate disparities and ensure access to healthcare for all members. Provider Operations contributions to organizational QIHE initiatives includes the management of providers' profile and demographic data analyses to that of the KHS members' cultural and linguistical needs.

G. Member Services

KHS implements and maintains written policies and procedures that set forth the Member's rights and responsibilities and shall communicate its policies to its Members, Providers, and, upon request, potential members. Members are also assured of their rights to confidentiality, right to advance directives, and rights to linguistic services.

H. Pharmacy Department

Safety Monitoring: Pharmacy will expand on the current monitoring of opioids/controlled substances as defined by the SUPPORT Act. Though previously managed via prospective Pharmacy Benefit Manager (PBM) rules, KHS will retrospectively review claims for possible action in regard to the Beer's list for geriatric members. KHS will also monitor drug recalls issued by the FDA or manufacturer. Currently for monitoring the potentially inappropriate use of opioids, either, high dose, those without naloxone, and/or in combination with other agents acting on the central nervous system such as benzodiazepines, and muscle relaxants, KHS sends notification letters to the physician on record to evaluate the appropriateness of the regimen for that member.

The Director of Pharmacy or designee participates in interdisciplinary teams weekly to discuss drug regimens of select members. KHS also sends letters to providers regarding drug profiles of members that have been identified as having drug duplications, interactions, and/or missing therapies.
Pharmacy is developing a series of report suites that will identify all HEDIS/MCAS measures we are held accountable for or will be added in the following year (2024). These reports identify members who are non-compliant for that measure, and we will be working with other depts to best close the gap. The approach will incorporate brining in the local pharmacies to help with outreach to the members and providers.

I. Population Health Department (PHM)

The Kern Health System (KHS) Population Health Management (PHM) Service will support whole-person care by integrating and aggregating historical administrative, medical, behavioral, dental, social service and program information from disparate sources. This integrated approach will drive risk-stratification, segmentation, tiering, assessment and screening processes, analytics, and reporting. By transforming raw data into actionable insights, PHM will identify opportunities for continuous quality improvement, reduce bias and error in decision-making. KHS will connect its members to the right services and supports at the right time and place depending on their needs and preferences.

In addition to data integration, PHM will facilitate meaningful engagement with network providers, public health agencies, schools, and community-based organizations (CBOs) to enhance data sharing across delivery systems. These partnerships will promote care coordination and help identify and mitigate social determinants of health (SDOH) that contribute to health disparities. Through these collaborative efforts, KHS aims to connect all members to primary care, preventive and wellness services, and disease management programs while ensuring members at risk for complex health issues are linked to specialized services.

PHM will also gather, share, and assess timely and accurate member data to identify efficient and effective opportunities for intervention. This will be achieved through data-driven risk stratification, predictive analytics, identification of care gaps, and standardized assessment processes. These tools will allow KHS to proactively identify members with rising health risks and provide personalized interventions to improve health outcomes and reduce health disparities.

KHS will support the unique needs of members population, including health and social needs (e.g., behavioral, developmental, physical, and oral health); Long-Term Services and Supports (LTSS) needs as well as health risks, rising risks, and health-related social needs due to social determinants of health (SDOH) in the Population Needs Assessment. KHS is committed to ongoing initiatives to deliver comprehensive, equitable care across its service areas.

J. Human Resources Department

The KHS Human Resources Department is dedicated to promoting diversity and inclusivity within the workforce. Comprised of Talent Acquisition, Employee Relations, Benefits and Wellness Programming, and Learning and Professional Development, the department is committed to implementing equitable and accessible recruiting, hiring, onboarding, professional development, and succession planning practices to ensure and sustain a diverse workforce. To enhance cultural and linguistic competency within the organization, the HR department prioritizes creating a culture of trust, empathy, and humility, guiding employees towards a deeper understanding of cultural and linguistic diversity in their daily work. The department will also work towards developing policies and leadership practices that continuously support diversity, equity, and inclusion in compliance with regulations, supportive of organizational values, and in pursuit of industry best practices. This will help the organization remain trusted and highly responsive to the needs of employees and the communities it serves.

1. Hiring Initiatives

As described in the KHS DEI Program charter, KHS is dedicated to building a workforce that is diverse, qualified, and engaged, and one that reflects the diversity of the communities KHS serves in Kern County. KHS strives to create a workplace environment that is safe, inclusive, and strengths-based, providing abundant opportunities for employees of all backgrounds, cultures, and linguistic abilities to belong and flourish. Human Resources and Hiring Managers are responsible for ensuring that recruiting, hiring, and succession planning practices are inclusive and reflect the demographic needs of the communities.

Commitment to health equity in hiring, recruiting, and succession planning includes posting job opportunities in inclusive language across a network of diversity job sites and job boards to help attract a more diverse workforce, including groups of underrepresented individuals. KHS also incorporates inclusive language into job descriptions, conducts panel interviews with members reflective of the community's diversity, and uses standardized assessment tools. KHS aims to create a diverse and inclusive workforce that can provide better services to all communities.

2. KHS Bilingual Workforce

Departments who employ staff members to provide linguistic services to the membership include Behavioral Health, Wellness & Prevention, Marketing, Member Engagement, Member Services, Utilization Management, Population Health Management, Enhanced Care Management, Community Support Services, Quality Improvement, and Pharmacy. All bilingual staff must pass a verbal bilingual assessment before being hired or during employment. Certificates of linguistic proficiency are monitored and maintained by the Cultural and Linguistic Team. For KHS staff who have received certification of bilingual proficiency, a copy of the certificate is kept in their personnel file with Human Resources.

KHS defines qualified bi-lingual staff as:

- Proficient in speaking and understanding a language other than English.
- Having a fundamental knowledge in a language other than English that includes the use and application of specialized vocabulary, terminology and phraseology, and concepts.
- Having the ability to communicate directly effectively, accurately, and impartially with members who have limited English proficiency.

KHS Member Services Bi-lingual Representative staff will only provide oral interpretation services and are prohibited from providing written translation, including editing, and proofreading translated documents, and sight translation services.

K. Provider Network Management (PNM)

The Provider Network Management (PNM) department is responsible for growing and overseeing the Plan's network of providers and is comprised of: Contracting, Credentialing, Provider Relations, Provider Grants, and Analytics and Regulatory Reporting. The Senior Director of Provider Network heads the PNM department. The Deputy Director of Provider Contracts reports to the Senior Director of Provider Network and oversees Contracting and Credentialing. The Deputy Director of Provider Network reports to the Senior Director of Provider Network and oversees Provider Relations, and Provider Grants, and Analytics and Regulatory Reporting.

The Contracting Team is comprised of a Provider Contracts Supervisor, Contract Specialists, Coordinators. The Contracting Team is responsible for contracting with providers within and adjacent to the network service area to ensure network adequacy for all specialty types. The Contracting department also works with contracted providers to negotiate rates and implement special programs. As needed the Contracting team will negotiate single-case, Letter of Agreements (LOAs) with out-of-network providers.

The Credentialing Team is comprised of a Credentialing Manager and five Credentialing Coordinators. The PNM Credentialing team monitors and tracks provider licenses, certificates, training, Medi-Cal enrollment, and other applicable provider requirements. The Credentialing team also aids in maintaining accurate provider data utilized within Plan's regulatory reporting and provider directory.

The Provider Relations Representative Team is comprised of a Provider Relations Supervisor and seven Provider Relations Representatives. The Provider Relations Representatives are the direct link between the Plan and the Provider. The Provider Representatives are responsible for provider communication and education and conduct

outreach to noncontracted providers for potential recruitment.

The Grants Team is comprised of a Grants Manager and a Grants Specialist. The Grants Team is responsible for developing grant programs and identifying and reaching out to providers who may qualify for certain grants from the Plan. The Grants team is responsible for creation and tracking of appropriate grant's milestones and goals. The KHS grant program works to financially aid and encourage innovative efforts to bring beneficial services to our community.

The PNM Analyst team is comprised of the Provider Network Manager, Provider Network Analytics Program Manager, and three Senior Provider Network Analysts. The PNM Analyst Team is responsible for, monitoring network accessibility, network-related regulatory reporting (DMHC Timely Access and Annual Network Review, DHCS Annual Network Certification), the Provider Satisfaction Survey and maintaining the provider directory (in conjunction with credentialing team).

Provider network accessibility is primarily monitored via the Provider Network Management, Quarterly Network Review. The Quarterly Network Review includes, but is not limited to an Access Grievance Review, Provider Accessibility Monitoring Survey, Geographic Accessibility Review, and Network Adequacy/Provider Counts. These reports track and monitor the Plan's regulatory compliance to standards such as: PCP to member and Physician to Member ratios, Appointment Availability, Provider Response times, Provider After-Hours availability, and In-Office wait times. The PNM Analytics Team monitors and tracks members' geographic access to PCP, Specialist, Non-Physician Mental Health, Specialty OB/GYN, and Hospital providers and confirms the geographic access is within regulatory standards. If any provider type/geographic region is not meeting regulatory standards, it is the responsibility the PNM Analytics Team to request an Alternative Access Standard and identify potential providers for recruitment/contracting activities. The PNM Analytics Team reviews Access Grievance data to determine if any provider, group, or specialty is experiencing the same access issue on a continuous basis. The Provider Relations Department provides routine reports of access study data for review and recommended action by the EQIHEC.

L. Utilization Management Department (UM)

Please refer to the Utilization Management Program (UMP) Description for Utilization Management activities and related UM activities. The UMP is a formal Document supported by clinical, operational, and administrative policies and procedures (P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current NCQA Standards and Guidelines. The UM documents are developed through the

involvement of actively involved KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c). The UM Director is a standing member of the EQIHE Committee.

M. Behavioral Health Department (BH)

The KHS responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County Medi-Cal Behavioral Organization manages severe mental health impairment referred to as Specialty Mental Health Services.

For substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

N. Wellness and Prevention Department- Cultural and linguistics (C&L) and Health Education (HE)

Please refer to the Program Descriptions for Cultural and Linguistics and Health Education for C&L and Health Education activities and related wellness and prevention activities.

The Wellness & Prevention Department is responsible for providing comprehensive, culturally, and linguistically appropriate wellness and prevention services with the intent of promoting health behaviors, improving health outcomes, reducing risk for disease and empowering Members to be active participants in their health care. The W&P department is headed by the Senior Director of Wellness & Prevention and is composed of four teams:

- Cultural & Linguistic Services – comprised of a Manager, Cultural & Linguistic Specialists, and a Cultural & Linguistics Coordinator to provide comprehensive, culturally, and linguistically appropriate competent services to plan members with improved access and health outcomes. These services include, but not limited to linguistic services, translation of written member information materials, training and education for staff, providers, and contracted vendors, and assessing, monitoring, and evaluating the Cultural & linguistics services provided by the Plan, providers, and contracted vendors.
- Community Health & Wellness – comprised of a Manager, Health Education Specialist and Lifestyle Coach to establish community-based health and wellness initiatives that promote health, prevent illness, and improve health literacy to vulnerable communities in Kern County.

- Member Wellness & Prevention (MWP) – comprised of a Manager, Health Educators, Health Education Specialists and Lifestyle Coaches to provide health education, wellness, and prevention programs, services, interventions using evidence-based programs directly to our members or through partnerships with partner organizations. Services are delivered through one on coaching, group classes, written material such as member newsletters, brochures, and other health education material. Partner with providers to enhance provider/patient interaction and increase knowledge of member health education needs. The MWP has oversight of the readability and suitability standards and member incentive programs.
- Wellness & Prevention Partnerships – comprised of a Manager, Program Manager and Program Liaisons to establish and foster relationships and promote preventive service benefits among community partners and providers, such as the local public health department and Women Infants and Children programs, in order to expand access and reach of health and wellness programs and services to members.

KHS is committed to delivering culturally and linguistically appropriate heath care services. Services will comply with Title VI of the Civil Rights Act of 1964, section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights), and APL 21-004. The Senior Director of Wellness and Prevention is a standing member of the EQIHEC.

O. Enhanced Care Management Department (ECM)

Please refer to the Enhanced Care Management Program Description for Enhanced Care Management activities and related ECM activities.

P. Community Support Services (CSS) Department

Please refer to the Community Support Services Program Description for CSS activities and related CSS activities.

Q. Business Intelligence (BI)

Functions include:

- Establish advanced health analytics to ensure that leadership has full purview into the population to improve individual experience of care; improve the health of the population while reducing per capital cost of care for populations.
- Create, manage, and continuously improve Corporate Key Performance Indicators (KPI's)
- Reduce operational silos and proactively manage and improve overall operations.
- Provide and validate standard metrics and information around process improved to ensure that

project goals, objectives, or Return on Investments (ROI) are achieved.

- Establish data governance over various systems to ensure that reliable data can be consumed for analytics and reporting.
- Manage all operational and regulatory reporting inventory for the organization.

R. Information System & Data Management

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments. KHS MIS has the capability to capture, edit, and utilize various data elements for both internal management use and to meet the data quality and timeliness requirements. These include DHCS' encounter data, network provider data, program data, and template data submissions and processes. MIS also has the ability to meet Population Health Management data integration requirements and is able to provide the requested data to DHCS and Centers for Medicare and Medicaid Services upon request.

KHS's Information Technology (IT) Division, comprising of Data Analytics, Information Security, Technical Support Services, and Operational Systems follows the culturally and linguistically appropriate business practices as outlined by KHS Leadership and Human Resources. IT provides new technologies, and enhancing existing systems, to ensure that all KHS staff can perform their work in a culturally competent environment. This includes, but is not limited to, offering technologies and tools compliant with ADA standards, assistive technologies, and website compliance. Data Analytics shall support the organization's QIHE operational initiatives by collecting, storing, analyzing demographic data and profiles of both KHS members and providers, conducting statistical analyses, and aid in the development and facilitation of assessments and surveys.

KHS (MIS) has the capacity to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks.

KHS MIS supports at a minimum:

- All Medi-Cal eligibility data.
- Information on members enrolled with Kern Health Systems.
- Provider claims status and payment data.
- Health care services delivery encounter data.
- Network provider data.
- Program data.
- Template data.

- Screening and assessment data.
- Referrals including tracking of referred services to follow up with Members to ensure that services were rendered.
- Electronic health records.
- Prior auth requests and specialty referral system.
- Care Management data.
- Care Coordination data.
- Financial information.
- Social drivers of health data.
- Grievance and appeal information.

S. Marketing

The Marketing Department operates under the direction of the Senior Director of Marketing, who reports to the Chief Health Equity Officer. The Marketing Department is responsible for conducting appropriate product and market research to support the development of marketing and Member communication plans for all products including Member materials (e.g., Member Newsletters, Evidence of Coverage, website, etc.). The Quality Improvement and Health Equity Departments work closely with the Marketing and Wellness & Prevention Departments to ensure that Member materials are implemented in a timely manner.

V. Role of Participating Providers

A. Provider Participation

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

- **Provider Information** – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.
- **Provider Cooperation** – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

- **Provider Performance** – KHS requires contracted providers to comply with DHCS' Managed Care Accountability Set (MCAS) and participate in quality-based initiatives aimed at improving, access, quality, and health equity for our members. Routine meetings are conducted with a subset of participating providers to ensure monitoring, communication, and supporting of achieving MPLs and maintaining high quality care.

B. Provider and Hospital Contracts

Participating provider and hospital contracts contain language that designates access for KHS to perform monitoring activities and require compliance with KHS QIHE Program activities, standards, and review system.

Provider contracts include provisions for the following:

a. An agreement to participate in the KHS QIHE Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.

b. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

c. Cooperation with the KHS QIHE Program including access to applicable records and information.

d. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.

Hospital contracts include provisions for the following:

a. An agreement to participate in the KHS QIHE Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.

b. Development of an ongoing QIHE Program to address the quality of care provided by the hospital including CAPs for identified quality issues.

c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

d. Cooperation with the KHS QIHE Program, including access to applicable records and information.

C. Conflict of Interest

Network practitioners serving on any QI and Health Equity program-related committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues. All required employees and committee participants sign a Conflict-of-Interest statement on an annual basis. Fiscal and clinical interests are separated. KHS and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

Confidentiality Statement

KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process.

VI. Program Documents

A. Work Plan

The annual QIHEP Work Plan is designed to target specific QIHEP activities, projects, tasks to be completed during the upcoming year, and monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QIHE Program, including accomplishments and impact on members. Evaluation and planning the QIHE Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

- The Work Plan is developed by the Quality Improvement and Health Equity Departments on an annual basis and is presented to the EQIHEC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
- The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care, and the quality of service provided to members.

- After review and approval of quality study results including action plans initiated by the EQIHEC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS Provider bulletins to contracting providers.
- The activities in the QIHE Work Plan are annually evaluated for effectiveness.
- QIHE Work Plan responsibilities are assigned to appropriate individuals.

Components of the QIHEP Work Plan:

- Quality and Safety of Clinical Care
- Quality of Service
- Member & Provider Satisfaction

B. Work Plan Evaluation

An annual evaluation of the QIHEP shall be prepared based on the activities presented to the EQIHEC during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation. The QIHEP evaluation shall also be reviewed by the BOD. The Chief Health Equity Officer, with support from the Chief Medical Officer and/or Directors of Quality, will develop an evaluation of the QIHEP based on activities that were presented to the EQIHEC and BOD during the calendar year. The EQIHEC reviews and approves the QIHEP evaluation.

The QIHEP evaluation includes the following:

- A description of completed and ongoing quality improvement activities.
- Trended performance data from indicators to assess quality of care and service.
- An analysis of demonstrated improvements in care and service.
- A thorough evaluation of the program structure and effectiveness of the QIHEP including progress toward influencing safe clinical practices throughout the network.
- Monitoring efforts of medical groups and other subcontractors to ensure that delegated functions meet cultural, linguistic and sensitivity standards.
- Evaluation of patterns/trends for member grievances and discrimination complaints related to cultural/linguistic and sensitivity issues.
- A thorough evaluation of progress on non-clinical goals (i.e., Human Resources, Marketing, Member Engagement, Community Engagement, etc.)

KHS will also utilize the following methods to conduct ongoing monitoring and evaluation of its cultural competency and SPD awareness programs and annual sensitivity, diversity, cultural competency and health equity training for all staff, providers, subcontractors, and downstream subcontractors at key points of contact:

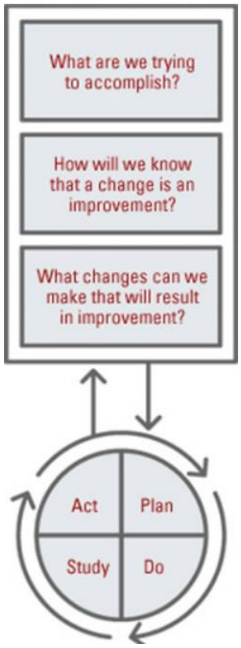
- Disenrollment data,
- MCAS/HEDIS results by race/ethnicity, language, and other demographic factors,
- Complaint and grievance reports,
- Member satisfaction survey results by race/ethnicity, language, and other demographic factors,
- Population Needs Assessments findings results by race/ethnicity, language, and other demographic factors,
- Performance Improvement Projects (PIPS),
- Health Education Activities Reports,
- Training attendance reports, attestations of training completion and/or completion of post-training quizzes.

VII. Quality Improvement Processes

A. KHS Quality Improvement (QI) Initiatives

1. Plan-Do-Study-Act Cycle

The QIHEP quality activities and studies are developed using the Plan-Do-Study-Act (PDSA) Model. The PDSA is an iterative, four-stage problem-solving model used for improving a process or carrying out change.



In accordance with the California Department of Health Care Services (DHCS) 2025 contract KHS will conduct quality studies, quality review activities, results, and assessments and submit the outcomes in reports to the DHCS in the reporting unit level and time frames as directed by DHCS.

2. Data Collection Methodology

KHS employs a structured data collection methodology designed to measure and improve healthcare quality and health equity outcomes. Data collection methods are determined based on the type of measure and available data sources, ensuring accuracy and reliability. Data validation is integral to this process, reinforcing the credibility of findings and supporting data-driven decision-making. Data is continuously collected, aggregated, and analyzed to monitor performance, identify disparities, and uncover opportunities for improvement. When performance gaps are identified, KHS implements targeted interventions with measurable goals. The effectiveness of these interventions is assessed through ongoing data analysis, ensuring that improvements are sustainable over time. If data indicates a need for a different approach, KHS re-evaluates strategies and adjusts action plans accordingly.

3. Measurement Process

KHS systematically monitors and evaluates quality improvement initiatives to assess their effectiveness and compliance with internal policies and external regulatory requirements. Performance is reviewed at least quarterly, with benchmarks and standards derived from:

- Nationally recognized clinical guidelines
- Peer-reviewed research
- Regulatory and contractual requirements
- Internal trend analyses
- State and federal quality measures

KHS uses these metrics to assess accessibility, availability, and equity in healthcare services, ensuring that interventions align with best practices and community needs.

4. Evaluation Process

A comprehensive evaluation framework guides KHS in assessing the effectiveness of Quality Improvement (QI) initiatives. Both quantitative and qualitative methodologies are employed:

- Quantitative Analysis: Benchmark comparisons, trend assessments, and statistical testing are used to evaluate the impact of QI initiatives.
- Qualitative Analysis: Root cause and barrier analyses are conducted collaboratively with key stakeholders to understand systemic challenges and identify sustainable solutions.

Cross-departmental collaboration ensures that evaluation findings inform future quality initiatives, driving continuous improvement in health outcomes.

5. Communication and Feedback

KHS fosters a culture of transparency and engagement through proactive communication with internal teams and external partners, including providers and stakeholders. Key communication channels include:

- Internal Education & Engagement: Staff meetings, committee updates, and training sessions on QI initiatives.
- Provider Communication: Newsletters, targeted mailings, KHS's provider portal, and direct outreach via quality visits.
- Performance Feedback: Providers receive actionable insights, including:
    1. Member-specific service and intervention lists
    2. Clinical guideline recommendations
    3. Performance data from HEDIS, CAHPS, and other quality measures
    4. Recognition for quality improvement achievements
    5. Compliance feedback based on audits, grievances, and utilization trends.

These communications reinforce accountability and foster a collaborative approach to quality improvement.

6. Improvement Processes

Performance indicators are used to identify quality concerns and disparities in care delivery. When deficiencies are detected, KHS initiates corrective actions, which may include:

- Provider-level remediation plans (Corrective Action Plans - CAPs)
- Enhanced provider education and technical assistance
- Temporary restrictions on new member assignments for non-compliant providers
- Delegation oversight adjustments
- Contract terminations for persistent non-compliance.

By integrating rigorous oversight, continuous evaluation, and data-driven decision-making, KHS ensures that quality improvement efforts translate into meaningful and sustainable healthcare enhancements for Medi-Cal members.

VIII. Quality Improvement Work Plan

A. Quality of Clinical Care

1. MCAS Measures

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

DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50th percentile based on outcomes published in the latest edition of NCQA's Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan's (MCP) compliance. When an MCP does not meet the 50th percentile or better for a measure, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2025. Results for the 2025 measures will be calculated and submitted in report year (RY) 2026. Please reference table on page 23 for list of MCAS measures.

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or that is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. Managed Care Plans are required to meet or exceed the performance levels set forth by Department Health Care Services (DHCS) as outlined in their contract.

2. Performance Improvement Projects (PIPs)

KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 36-month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project. The two new PIPS required by DHCS will include annual submissions for 3 years from 2023-2026. The framework for the new PIPs has been updated by DHCS to align with the CMS protocol.

<u>Clinical PIP:</u>

The new cycle of PIPs began in August 2023 and will run through 2026. The clinical PIP is focused on Health Equity,

specific to the W30 0-15 months African American population.

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions. QP will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders.

B. Safety of Clinical Care

1. Patient Safety Program

KHS recognizes that patient safety is a key component of delivering quality health care and focuses on promoting best practices that are aimed at improving patient safety. KHS engages Members and Providers to promote safety practices. KHS also focuses on reducing the risk of adverse events that can occur while providing medical care in different delivery settings. Some of the safety initiatives include:

1. Appropriate Medication Utilization
2. Review of Inpatient Admissions
    a. Readmissions
    b. Length of Stay
    c. Inappropriate Discharges
    d. Unexpected Mortalities
3. Provider Preventable Conditions (PPCs)
4. Potential Quality Issues (PQIs)
5. Initial Health Assessment Monitoring
6. Over-utilization and Under-utilization
7. Performance with healthcare outcomes and clinical processes
8. Adherence to clinical and preventive health guidelines
9. Effectiveness of chronic conditions, population health and care management programs

2. Potential Quality Issues (PQIs)

The QI Department reviews all Potential Quality Issues (PQIs) and adverse events involving practitioners and providers. Areas of review include primary and specialty care, hospitals, long-term care (LTC) facilities, skilled nursing facilities (SNF), and transportation providers. All identified PQIs are referred to the QI Department for investigation and evaluation, ensuring timely and appropriate actions are taken to address potential concerns. The

Medical Director oversees the process, ensuring alignment with recognized standards of care evaluating all cases and referring matters to the EQIHEC and/or Physician Advisory Committee for further assessment, as necessary.

3. Facility Site Review, Medical Record and Physical Accessibility Reviews

Facility site and medical record reviews are performed before a provider is awarded participation privileges and every three years thereafter. As part of the facility review, KHS QP Nurses review for the following potential safety issues:

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

In collaboration with other Kern County Health Plans for Site Reviews KHS coordinates, as described in APL 22-017, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.

4. Credentialing and Recredentialing

KHS maintains a comprehensive pre-contractual and post-contractual assessment and monitoring system to ensure that contracting providers have the capacity and capability to perform required functions. The pre-contractual assessment requires providers seeking to contract with KHS to complete a detailed document covering key areas such as health care delivery systems— including clinical safety, access and waiting times, referral tracking, medical records, and health education— as well as credentialing information. Post-contractual monitoring includes ongoing evaluation to ensure continued compliance with contractual requirements, quality standards, and regulatory guidelines. Specific policies outline the standards, tools, and processes used to support these activities, ensuring accountability and quality in provider credentialing and recredentialing.

C. Quality of Service

1. Grievance and Appeals

KHS monitors performance areas affecting Member experience. KHS has established categories and quantifiable standards to evaluate grievances received by Members. All grievances are categorized in several different categories

including but not limited to the following: continuity of care, geographic access, language access, provider availability, timely access, discrimination, care coordination, and quality of care. The organization's goal is to resolve all grievances within thirty (30) days of receipt. KHS grievances and appeals data is presented on a quarterly basis to the EQIHEC and PAC as needed. KHS goal is to maintain the overall complaint rate below thresholds as established by regulatory agencies such as DHCS, DMHC, and CMS.

2. Access to Care

The Plan maintains ongoing monitoring efforts to ensure its network is able to provide appropriate access to health care services, in line with regulatory standards and member needs. The Plan's Provider Network Management department utilizes appointment availability surveys, capacity/adequacy analysis, grievance reviews, provider/member mapping, and other tools to conduct Plan monitoring; these efforts are presented to the Plan's Network Adequacy Committee (NAC) and EQIHEC on a quarterly basis. Areas monitored include, but are not limited to: appointment availability, access to after-hours-care, time, and distance (geographic) accessibility, provider type availability, and network capacity.

D. Member and Provider Satisfaction

Member Satisfaction

KHS conducts a comprehensive CAHPS survey and analysis annually to assess Member satisfaction with the services and care received. CAHPS is a set of standardized surveys that ask health care consumers to report on and evaluate their care experience. The survey focuses on key areas like getting care needed; getting appointments to PCPs and Specialty Care Providers (SCPs); satisfaction with KHS and its Practitioners; and other key areas of the Plan operations. CAHPS surveys serve as a means to provide usable information about quality of care received by the Members. KHS uses this tool as one of its key instruments to identify opportunities for improvement. As part of the annual evaluation, KHS reviews the CAHPS results to identify relative strengths and weaknesses in performance, determines where improvement is needed, and tracks progress with interventions over time.

Provider Satisfaction

KHS monitors performance areas affecting provider satisfaction annually and submits the results to DHCS and CMS. This study assesses the satisfaction experienced by KHS's network of PCPs, SCPs, and Behavioral Health Providers. Information obtained from these surveys allow plans to measure how well they are meeting their Providers' expectations and needs. This study examines the satisfaction of the Provider network in the following areas: overall satisfaction, all other plans, finance issues, utilization and quality management network, coordination of care, pharmacy, Health Plan Call Center Service Staff, and Provider relations. Based on the data collected, KHS reports

the findings to the QIW and EQIHEC. The committees review the findings and make recommendations on potential opportunities for improvements.

E. Addressing Cultural, Ethnic, Racial and Linguistic Needs of Members

Integrated KHS Resources and Documents Utilized to Support the QIHE Program:

Population Needs Assessment

The Wellness & Prevention Department conducts population needs assessment of KHS' members to determine health education and cultural/linguistic needs. The Population Needs Assessment will be updated every year for the duration of the contract with DHCS. The contents of the Population Needs Assessment will define the goals and objectives, data sources and methodology, member demographics, member health status, disease prevalence and gap analysis, health education and cultural and linguistic service needs, and key recommendations, planned actions and conclusions. (APL19-011). KHS uses the PNA to inform its QIHEP priorities and share pertinent information regarding the PNA findings and the identified targeted strategies with its providers.

Population Health Model of Care

The KHS Population Health Management (PHM) Model of Care (MOC) is to provide a strategic road map defining the approach towards the provision of healthcare and preventative services and focuses on collaborative partnerships with providers to assist in delivering high-quality care to all members in a timely and efficient manner while reducing costs. The PHM MOC is designed to better coordinate member's care and utilize various data sources to draw insights on how to address each member's individual needs and make hospitals and clinics more accessible and effective.

PHM is a proactive, data-driven strategy focused on improving the health of a given population by a defined network of financially linked providers, achieved in partnership with the community (Health Catalyst, 2020). The Primary Care Physician (PCP) forms the backbone of PHM. The PCP is the signal caller who identifies problems early through various clinical and socio-behavioral screenings and refers patients to specialists. At the same time, KHS provides support to the PCP to ensure the patient receives high-quality, comprehensive health care in a timely manner. The Director of PHM is a standing Member of the Health Equity Transformation Steering Committee.

Diversity, Equity, and Inclusion and Health Equity Education and Training

KHS does not delegate health equity activities. Providers are required to actively participate and comply with Health Equity activities. To support this expectation, KHS provides annual training to employees, contracted staff, providers, sub-contractors, and downstream subcontractors at key points of contact on sensitivity, diversity, cultural

competency, effective communication, health equity, and inclusion relating to members. Training will promote access and delivery of services in a culturally competent manner to all members and potential members regardless of their sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation or identification with any other persons or groups defined in Penal Code 422.56. Training will consider structural and institutional racism, heath inequities and its impact on members, staff, providers, subcontractors, and downstream subcontractors. Trainings will include, but not be limited to topics such as:

- Beliefs about illness and health for identified cultural groups within KHS' membership and Kern County,
- Need for gender affirming care,
- Methods for interacting with providers and the health care structure,
- Traditional home remedies that may impact provider recommended treatment plans,
- Skills and practices regarding culture-related health care issues of the membership,
- How cultural competency relates to quality of care and access to care,
- Appropriate use and provision of interpreters,
- Translation process of written informing documents,
- Health literacy,
- PNA findings and identified targeted strategies,
- Culturally and linguistically appropriate community resources,
- Required completion of Continuing Medical Education on cultural competency and implicit bias.

IX. External Audits/Regulatory Audits and Delegation Oversight

A. Auditing and Monitoring Activities

Enforcement/Compliance: The Director of Quality Improvement is responsible for monitoring and oversight of the QIHE Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in policies. Compliance activities not under the oversight of QI are the responsibility of the Compliance Department.

Medical Reviews and Audits by Regulatory Agencies – The KHS Director of Compliance & Regulatory Affairs, in collaboration with the CHSO and the Director of Quality Improvement manages KHS medical reviews and medical audits

by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QIHE Program. CAPs for medical matters are approved and monitored by the EQIHEC.

B. Delegation

KHS delegates quality improvement activities as follows:

1. VSP – delegation of QI processes with oversight through the EQIHEC.

X. Conflict of Interest

All members of the Equity, Quality Improvement, and Health Equity Committee (EQIHEC) and its subcommittees are required to review and sign a Conflict of Interest Statement, affirming their commitment to ethical decision-making. Committee members must disclose any potential conflicts of interest and recuse themselves from discussions and voting on matters where they have a direct or indirect interest. Individuals personally involved in the care or service provided to a patient, or in an event or finding undergoing quality evaluation, may not vote or render a decision regarding the appropriateness of such care. By signing the Conflict of Interest Statement, members agree to abide by its terms, ensuring transparency and integrity in the committee's decision-making process.

XI. Confidentiality

All members, participating staff, and guests of the EQIHEC Committee and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hire. Confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Member's Right to Confidentiality:

KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. The EQIHEC Committee reviews

practices regarding the collection, use and disclosure of medical information.

XII. Information Security

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to all KHS contracted providers and KHS staff. HIPAA information is posted on the KHS website. Ongoing mandatory education is required annually for all staff.

XIII. Communication of Quality and Health Equity Activities

Results of performance improvement activities are communicated to the appropriate department, and/or multidisciplinary committee as determined by the nature of the activity. The EQIHEC subcommittees report their summarized information to the EQIHEC quarterly to facilitate communication along the continuum of care. The EQIHEC reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. EQIHEC participants are responsible for communicating pertinent, non-confidential QIHE issues to all members of KHS staff. Communication of QIHE trends to KHS contracted entities, members, practitioners and providers is through the following:

- Practitioner participation in the EQIHEC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Practitioner and member newsletters regarding relevant QIHE program topics
- The QIHEP description, available to providers and members on the KHS website. This includes QIHEP goals, processes and outcomes as they relate to member care and service.

- Annual practitioner education through provider relations and the Provider Manual

XIV. Annual Evaluation

Annual Evaluation of the KHS Quality Improvement Health Equity Program

On an annual basis, KHS evaluates the effectiveness and progress of the QIHE Program and Work Plan, and updates the program as needed. The CMO, with assistance from the Quality Improvement Medical Director, Director of QI, Pharmacy Director, Director of Wellness & Prevention, Director of Marketing, Director of Member Services, Senior Director of Contracting & QP and Director of QP, documents a yearly summary of all completed and ongoing QIHE Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

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

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

2025 Quality - Health Equity Program Description

Kern Health Systems

Effective Date: January 1, 2025

_____ Date _____

Chief Executive Officer

Emily Duran

_____ Date _____

Chief Medical Officer

_____ Date _____

Chief Health Equity Officer

_____ Date _____

Chief Operations Officer

_____ Date _____

Medical Director of Quality Improvement

_____ Date _____

Director of Quality Improvement

_____ Date _____

Senior Director of Contracting & Quality Performance

_____ Date _____

Director of Quality Performance

_____ Date _____

Senior Director of Wellness and Prevention

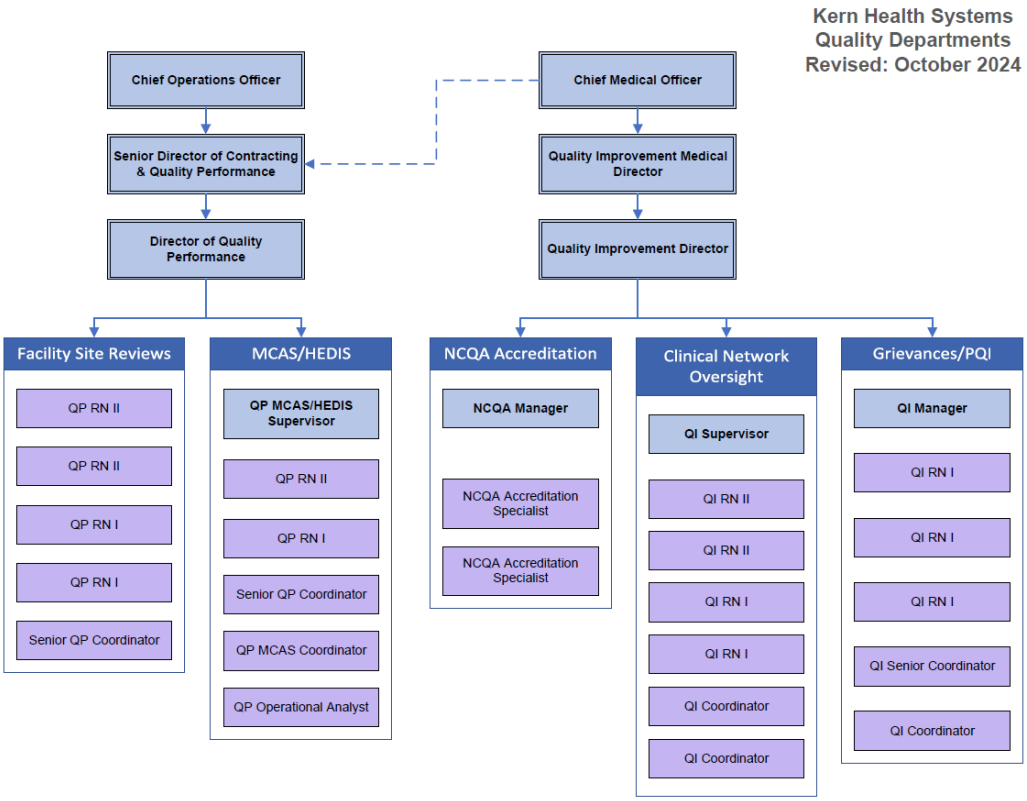
_____ Date _____

Director of Population Health Management

XV. Appendix

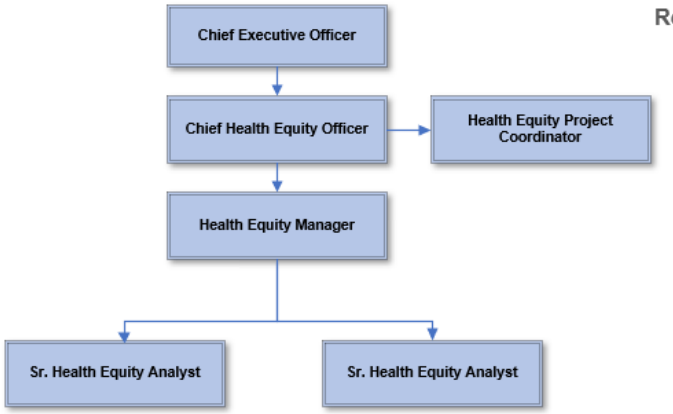
Appendix A: Population Needs Assessment October 2024

Appendix B: Quality Departments Organization Structure



Appendix C: Health Equity Office Organization Structure

Kern Health Systems
Health Equity Office
Revised: December 2024



Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
I. Quality Program Structure							
NCQA 1D	QIHE Governance	Conduct quarterly EQIHEC Meetings	No issues identified	Meet quorum of voting members at every meeting		12/31/2025	Quality Improvement Director & Health Equity Manager
NCQA 1C	Annual QI Evaluation of 2024	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director
NCQA 1A	2025 Quality Improvement Health Equity Program Description	QIHE Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	QI and HE Programs were previously two separate documents.	Annual approval by the EQIHEC and the BOD	Combine QI and HE Program documents and update for 2025	4/17/2025	Quality Improvement Director & Health Equity Manager
NCQA 1B	2025 Annual Quality Improvement Health Equity Work Plan	Yearly planned objectives and activities	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director
DHCS	Policies and Procedures	Annual review of KHS Quality Improvement P&Ps	No issues identified	100% of policies reviewed and updated as needed		12/31/2025	Quality Improvement Director
NCQA	NCQA Health Plan Accreditation	Attain Health Plan Accreditation	Initial Accreditation	Attain Full Health Plan Accreditation by 1/1/2026		12/31/2025	Quality Improvement Director
NCQA	NCQA Health Equity Accreditation	Attain Health Equity Accreditation	Initial Accreditation	Attain Full Health Equity Accreditation by 1/1/2026		12/31/2025	Health Equity Manager
II. Quality of Clinical Care							
DHCS	MCAS Measures	AMR	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	BCS	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CHL	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CCS	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CIS-10	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	CBP	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	DEV	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	IMA-2	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	LSC	Not Meeting MPL	Meet minimum performance levels (MPLs)	QI Senior Coordinators reached out to Top 10 provider that have less than 150 members to complete Lead Screening in Children before the 2 years of age (LSC)	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	FUA-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	FUM-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	HBD	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	PPC-Pre	Met MPL for MY2022/RY2023. Did not meet MPL for MY2023/RY 2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
DHCS	MCAS Measures	PPC-Post	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	TFL-CH	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	W30(0-15M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	W30(15-30M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	MCAS Measures	WCV	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director
DHCS	Clinical PIP: Focus on Health Equity, specific to the W30 0-15 months African American Population	2023-2026 performance improvement project (PIP) overseen by HSAG focused on increasing the number of children ages 0 - 15 months old with completing an annual well care visit.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.		12/31/2025	Quality Performance Director
DHCS	Non-Clinical PIP: Specific to FUA and FUM measures	2023-2026 performance improvement project (PIP) overseen by HSAG focused on improving Behavioral Health measures throug provider notivications with in 7-days of the ER visit.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG		12/31/2025	Quality Performance Director
IHI/DHCS	Health Equity Sprint Collaborative	Completion of well-care visits for African-American babies and children for W30 and WCV MCAS measures	Did not meet MPL for WCV or W30	Utilize MY2023 data to develop strategic provider partnerships to improve compliance for targeted population	2 provider partnerships and 1 CBO partnership in support of well-care visits	4/1/2025	Quality Performance Director
III. Safety of Clinical Care							
	Patient Safety Program/Clinical Network Oversight	Conduct Quarterly Audits of select measures (IHA, Lead Screening, etc.)	Baseline monitoring. No system of tracking provider performances.	Conduct quarterly monitoring of provider performance	Conduct quarterly monitoring of provider performance	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	Monitoring of PQI volume month over month	No issues identified	<30/month	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by Provider	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by ethnicity, english as a second language, sexual orientation, gender identity	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Potential Quality of Care Issue (PQI)	Timeliness of resolution	No issues identified	Within 120 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director
DHCS	Facility Site Review	Conduct on site reviews at the time of initial credentialing or contracting, and every three years thereafter, as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program	Issues were identified in Critical Elements while conducting FSR.	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coorninator will schedule and complete all PARS due 2025	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1. Emergency contact not documented 2. Dental/Oral Assessment not documented 3. HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director
	Drug Utilization Review	Treatment Authorization Request (TAR)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director
	Drug Utilization Review	Physician Administered Drugs (PAD)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No QOC trends for provider re-credentialing in 2024 to prevent moving forward from a QI perspective	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review 3 years	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Credentialing Manager
IV. Quality of Service							
DHCS	Grievance & Appeals	Timeliness of acknowledgement letters	No issues identified	90% Within 5 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
DHCS	Grievance & Appeals	Timeliness of resolution	No issues identified	90% within 30 calendar days and 72 hours for expedites	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
DHCS	Access to Care - PCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Access to Care - PCP	Routine Care - 10 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Access to Care - SCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Access to Care - SCP	Routine Care - 15 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director
DHCS	Telephone Access to Member Services	Speed of Answer	No issues identified	< 30 seconds	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
DHCS	Telephone Access to Member Services	Call abandonment rate	No issues identified	< 5%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director
V. Member Experience							
	CAHPS Survey	Adult and Child Medicad Survey	Getting Needed Care scored lowest in the Adult Survey	Monitor CAHPS Resutls and establish basline for Getting Care needed measure	Trending report on CAHPS results by survey questions	12/31/2025	Member Engagement Manager

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff
VI. Provider Engagement							
	Provider Satisfaction Survey	Would Recommend	No issues identified	Maintain 98th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director
	Provider Satisfaction Survey	Utilization and Quality Management	No issues identified	Maintain 97th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director
	Provider Satisfaction Survey	Degree to which the plan covers and encourages preventive care and wellness	No issues identified	Maintain 96th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director
	Provider Education	Host at least one educational conference for Providers	No issues identified	Host one educational conference for Providers	Medical Management of Obesity for Primary Care Providers Conference	11/30/2025	Quality Improvement Medical Director

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Louie Iturriria, Senior Director of Marketing and Member Engagement

SUBJECT: Blackhawk Network, Inc. Contract Extension

DATE: April 17, 2025

Background

In July 2022, Kern Health Systems (KHS) entered into an agreement with Blackhawk Network, Inc. (BHN) to support member engagement and incentive programs. BHN provides KHS with prepaid card distribution and gift card processing solutions that enhance participation in wellness initiatives.

KHS determined that its members would benefit from an improved fulfillment experience with a VISA reloadable rewards program and contracted with InComm, whose platform offers these services. The current process issues a separate gift card for each completed program benefit. The InComm platform allows rewards to be loaded onto a single reusable VISA card. This provides a more convenient experience for members and streamlines fulfillment by reducing distribution time and administrative overhead. Additionally, the InComm solution is expected to be more cost-effective over time due to decreased processing and mailing costs.

The InComm contract was approved by the Board of Directors on February 15, 2024. KHS is working diligently to ensure full regulatory compliance and alignment with internal operational readiness, which will support a smoother and more successful implementation. KHS is in the process of transitioning to the new platform; however, regulatory approval of the contract is still pending. To ensure uninterrupted member rewards fulfillment, KHS must extend the current contract with BHN until the new vendor receives state approval and the transition to InComm is successfully completed.

Discussion

The current agreement between KHS and BHN is set to expire on June 30, 2025. To maintain uninterrupted service, KHS intends to extend the agreement on a time and materials basis through June 30, 2026. This extension ensures that BHN will fulfill prepaid reward card orders, including servicing cardholders and delivering all related services, until the new awarded vendor, InComm, is fully operational for the Gift Cards program. During this transition period, the vendor will ensure uninterrupted support and service to maintain smooth operations.

Financial Impact

Cost for one (1) year extension with BHN from July 1, 2025, to June 30, 2026 with an additional amount of $287,400 for administrative costs in budgeted expenses. Raising the total aggregate not-to-exceed amount from $195,000 up to $482,400 for the Member Rewards Program.

Requested Action

Approve; Authorizing the CEO to amend the contract with Blackhawk Network, Inc. to extend the term for an additional one (1) year and increasing the not-to-exceed amount by $287,400 for a new not-to-exceed amount of $482,400.

Attachment A

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: ME Department Head: Louie Iturriria Contract Owner: Lela Criswell

Vendor Name: Blackhawk Network, Inc. Contact name & e-mail: Tina Tellado, tina.tellado@bhn.com

What services will this vendor provide to KHS? Vendor will provide with prepaid reward card orders, including servicing cardholders, and provide associated services.

Description of Contract	
Type of Agreement: Professional Services ☒ Contract ☐ Purchase ☐ New agreement ☐ Continuation of Agreement ☐ Addendum ☒ Amendment No. 3 ☐ Retroactive Agreement	Background: Blackhawk Network (BHN) is a rewards benefit fulfillment vendor used by KHS to fulfill retail gift card rewards for members who qualify. KHS has been doing business with BHN to fulfill member gift card rewards since 2022. KHS determined that its members would benefit from a better fulfillment experience with a Visa reloadable rewards fulfillment and contracted with InComm whose platform provides this service. KHS is in progress of cutting over to the new platform but must await regulatory approval of the contract with InComm and its call center vendor, Convey, before proceeding. Therefore, KHS must extend the current contract with BHN to allow member rewards fulfillment to continue until the new fulfillment vendor is approved by state regulators and we can successfully cutover to the InComm platform. Brief Explanation: The vendor will fulfill prepaid reward card orders, including servicing cardholders and delivering all related services, until the new awarded vendor, InComm, is fully operational for the Gift Cards program. During this transition period, the vendor will ensure uninterrupted support and service to maintain smooth operations.
☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)* Brief vendor selection justification:	
☒ Sole source – no competitive process can be performed. Brief reason for sole source: KHS has an ongoing agreement for gift cards until InComm fully takes over these services.	
☐ Conflict of Interest Form is required for this Contract	
☐ HIPAA Business Associate Agreement is required for this Contract	

Form updated 6/12/23

Attachment A

☐ Subcontractor Disclosure of Ownership and Control form is required for this Contract

Fiscal Impact

KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☒ NO	☐ YES
Capital project	☒ NO	☐ YES

Project type: _____

Budgeted Cost Center 410 GL# 5645

Maximum cost of this agreement not to exceed: $287,400

Notes: Not to exceed amount is for administration fees (card and shipping cost).

Contract Terms and Conditions

Effective date: 7/1/2025 Termination date: 6/302026

Explain extension provisions, termination conditions and required notice: _____

Approvals

Compliance DMHC/DHCS Review:

Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

4/11/25

Date

Contract Owner:

Approved by Louie Iturria

Department Head

per Contract meeting 3/27/25

Date

Purchasing:

Director of Procurement and Facilities

4/1/2025

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

4/3/25

Date

Recommended by the Executive Committee:

Chief Operating Officer

Date

IT Approval:

Chief Information Officer or IT Director

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Form updated 6/12/23

Attachment A

Board of Directors approval is required on all contracts over $100,000 if/ not budgeted and $200,000 if budgeted.

_____
KHS Board Chairman

_____
Date

Form updated 6/12/23

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Louie Iturriria, Senior Director of Marketing and Member Engagement

SUBJECT: Relay Network Texting Solution Contract Extension

DATE: April 17, 2025

Background

In 2020, Kern Health Systems (KHS) received approval from the Department of Health Care Services (DHCS) to utilize Relay Network's platform for texting Kern Family Health Care (KFHC) members as part of outreach programs. This initiative was designed to integrate text messaging into our campaign management programs, enhancing member communication. To ensure ongoing compliance with DHCS regulatory requirements, KHS established an annual contract to regularly assess our needs. On February 20, 2025, the Board approved the selection of mPulse as the new vendor for the Member and Provider Portal which includes a texting solution.

Discussion

Our current agreement with Relay Network is set to expire on May 31, 2025. The implementation with the new Member and Provider Portal, mPulse, is actively underway and additional time is needed to ensure technical integration, staff training, and regulatory alignment. To maintain uninterrupted service, we intend to extend our contract with Relay Network for an additional seven months, with a new contract end date of December 31, 2025. This extension will allow us to continue utilizing Relay Network's platform, as we implement the texting solution within our new Member and Provider Portal.

Financial Impact

The cost for a seven (7) month extension with Relay Network from June 1, 2025 to December 31, 2025 includes an additional amount of $100,000 in budgeted expenses for the texting solution. This will increase the total aggregate not-to-exceed amount from $399,998 to $499,998.

Requested Action

Approve; Authorizing the CEO to amend the contract with Relay Network to extend the term for an additional seven (7) months and increasing the not-to-exceed amount by $100,000 for a new not-to-exceed amount of $499,998.

Attachment A

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: Marketing Department Head: Louie Iturriria

Vendor Name: Relay Network Contact name & e-mail: Nate Asbell, nasbell@relaynetwork.com

What services will this vendor provide to KHS? Relay Network will provide KHS with unlimited texting messaging services for all Active Wires for KHS members for seven (7) months.

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☐ New agreement ☐ Continuation of Agreement ☐ Addendum ☒ Amendment No. 2 ☐ Retroactive Agreement	Background: In 2020, Kern Health Systems (KHS) received approval from the Department of Health Care Services (DHCS) to utilize Relay Network's platform for texting Kern Family Health Care (KFHC) members as part of outreach programs. This initiative was designed to integrate text messaging into our campaign management programs, enhancing member communication. To ensure ongoing compliance with DHCS regulatory requirements, KHS established an annual contract to regularly assess our needs. On February 20, 2025, the Board approved the selection of mPulse as the new vendor for the Member and Provider Portal which includes a texting solution. Brief Explanation: Current agreement with Relay Network will expire on May 31, 2025. The implementation with the new Member and Provider Portal, mPulse, is actively underway and additional time is needed to ensure technical integration, staff training, and regulatory alignment. To maintain uninterrupted service, we intend to extend our contract with Relay Network for an additional seven months.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification: Currently have an ongoing contract with the vendor.

☒ Sole source – no competitive process can be performed.

Brief reason for sole source: Currently have ongoing contract with the vendor.

Form updated 01/02/25

Attachment A

☐ Conflict of Interest Form is required for this Contract

☒ HIPAA Business Associate Agreement is required for this Contract

☐ Subcontractor Disclosure of Ownership and Control form is required for this Contract

Fiscal Impact

KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget ☐ NO ☒ YES

Will this require additional funds? ☒ NO ☐ YES

Capital project ☒ NO ☐ YES

Project type: ____

Budgeted Cost Center 225 GL# 5407

Maximum cost of this agreement not to exceed: $100,000

Notes: ____

Contract Terms and Conditions

Effective date: 6/1/2024 Termination date: 12/31/2025

Explain extension provisions, termination conditions and required notice: ____

Approvals

Compliance DMHC/DHCS Review:

Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

4/3/25

Date

Contract Owner:

Department Head

4/2/25

Date

Purchasing:

Director of Procurement and Facilities

4/2/2025

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

4/3/25

Date

Recommended by the Executive Committee:

Chief Operating Officer

Date

Form updated 01/02/25

Attachment A

IT Approval:	**Chief Executive Officer Approval:**
Chief Information Officer or IT Director	Chief Executive Officer
4/2/25 Date	Date

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

KHS Board Chairman

Date

Form updated 01/02/25

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Cesar Delgado, Deputy Chief Information Officer

SUBJECT: Renewal for Software and Hardware Support for the Rubrik Disaster and Recovery Solution with e360

DATE: April 17, 2025

Background

In August 2018, Kern Health Systems (KHS) obtained approval from the Board of Directors (Board) to procure hardware and support for the Rubrik Backup and Recovery solution. KHS strategically harnesses the power of Rubrik's robust backup and recovery solution, alongside the Microsoft 365 (M365) premium support, to safeguard all critical production data efficiently. This integrated approach ensures maximum efficiency and resilience in KHS's data management infrastructure. KHS leverages Rubrik's Backup and recovery solution for all its critical production data. In March of 2025, KHS issued a formal Request for Quote for the renewal of the maintenance and support for the Rubrik Backup and Recovery Solution. Only one bid was received, and e360 was selected as the awarded vendor.

Discussion

e360 will provide KHS with maintenance and support for the Rubrik backup and recovery solution for eighteen (18) months. The Rubrik backup and recovery solution provides KHS with a scalable and resilient data protection strategy, ensuring the security and integrity of all critical production data. The integrated approach with M365 premium support enhances operational efficiency and safeguards key business systems. The proposed renewal ensures continued protection of KHS's critical data assets, maintaining compliance and operational continuity. This renewal will allow KHS to sustain a robust backup and recovery infrastructure, supporting the organization's long-term data management strategy.

Financial Impact

Cost for an eighteen (18) month renewal not to exceed $285,565 in budgeted expenses.

Requested Action

Approve; Authorizing the CEO to sign, enter into, and/or amend a new contract with e360 for a not-to-exceed amount of $285,565.

Attachment A

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: IT

Department Head: Cesar Delgado

Vendor Name: E360

Contact name & e-mail: AnneMarie.Junior@e360.com

What services will this vendor provide to KHS? E360 will be providing KHS with support and maintenance for our R6000s appliance

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☒ New agreement ☐ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background KHS leverages Rubrik backup and data recovery solution for all of its critical data. E360 will provide KHS with premium hardware support for our R6000S appliances, ensuring both hardware support and maintenance for the production environment. Brief Explanation: E360 will be providing KHS with support and maintenance for out R6000s appliance
☒ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8 11-1, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)* Brief vendor selection justification: KHS Published an RFQ for the services. E360 was the only vendor that participated in this process	
☐ Sole source – no competitive process can be performed. Brief reason for sole source:	
☐ Conflict of Interest Form is required for this Contract	
☐ HIPAA Business Associate Agreement is required for this Contract	
☐ Subcontractor Disclosure of Ownership and Control form is required for this Contract	
Fiscal Impact	

Form updated 01/02/24

Attachment A

KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☒ NO	☐ YES
Capital project	☒ NO	☐ YES

Project type:

Budgeted Cost Center: 225 GL# 5304

Maximum cost of this agreement not to exceed: $285,565

Notes:

Contract Terms and Conditions

Effective date: 4/29/2025 Termination date: 10/31/2026

Explain extension provisions, termination conditions and required notice: Full amount due at time of executions.

Approvals

Compliance DMHC/DHCS Review:

Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

4/3/25

Date

Contract Owner:

Department Head

4-2-2025

Date

Purchasing:

Director of Procurement and Facilities

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

4/3/25

Date

Recommended by the Executive Committee:

Chief Operating Officer

Date

IT Approval:

Chief Information Officer or IT Director

4/3/25

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Form updated 01/02/24

Attachment A

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

_____

KHS Board Chairman

_____

Date

Form updated 01/02/24

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Cesar Delgado, Deputy Chief Information Officer

SUBJECT: Request for Approval to increase the Not-to-Exceed amount with Cognizant

DATE: April 17, 2025

Background

In August 2024, Kern Health Systems (KHS) obtained approval from the Board of Directors (Board) to renew the core software solution with Cognizant TriZetto Software Group, Inc., formally known as TriZetto Corporation, which also provides QNXT, a product under the TriZetto brand, for processing eligibility, provider contracts, authorizations, claims, and payments. QNXT remains a Cognizant-owned solution, supported through its TriZetto healthcare technology portfolio, ensuring continuity and stability for our core operations.

Discussion

Cognizant TriZetto Software Group, Inc. will provide KHS with multiple services. These services include:

1) $0 Change request to extend an upgrade project
2) 24x7 emergency support for a planned upgrade to the core system
3) Training through TriZetto University to enhance our team's expertise
4) IT assessment project to evaluate system performance and security
5) Code integration for data purging to streamline system maintenance and compliance
6) Zelis integration to improve payment processes.

To ensure continuity, it is necessary to seek Board approval to amend the current renewal contract to include the above additional requests as well as Board approval for increasing the not to exceed amount (NTE) from $6,445,522 to $6,607,387.

The financial impact associated with each additional request to amend the Agreement are as follows:

Agreement Name	Cost	Term	Total Cost
Change Request	$ -	4 Weeks	$ -
24x7 Upgrade Emergency Support	$ 5,450	3 Days	$ 5,450
TriZetto University	$ 10,000	1 Year	$ 10,000
Technology Assessment	$ 23,105	8 Weeks	$ 23,105
Data Purge	$ 58,810	4 Months	$ 58,810
Zelis Integration	$ 21,500	3 Years	$ 64,500
		Total Request	**$ 161,865**
		Previous Board Approval	$ 6,445,522
		New NTE	***$ 6,607,387***

Details Regarding Additional Requests to Amend the Agreement as Follows:

(1) $0 Change Request: 1 month date extension on upgrade to system.

(2) 24x7 Upgrade Emergency Support: Support for three (3) days to ensure the upgrade does not fail and to troubleshoot on demand if needed.

(3) TriZetto University: Online training hub for (5) user licenses.

(4) Technology Assessment: Cognizant will conduct a technical assessment to address system performance challenges in online and batching processes, reviewing KHS' setup and recommending improvements in preparation for a proposed data purge.

(5) Data Purge: QNXT Archival Framework Custom Solution is a code that will delete, and archive claims and call tracking data based on Client defined retention criteria.

(6) Zelis Integration: The Zelis Payment integration into QNXT allows claims to be verified in real-time against Zelis' payment integrity rules and algorithms. This integration helps identify and prevent inaccurate claims payments, supporting cost containment and compliance with regulatory requirements.

Fiscal Impact

Based on the additional contracts described above, the original Cognizant contract value will increase by $161,865 for a new not to exceed amount of $6,607,387.

Requested Action

Approve; Authorizing the CEO to amend the Cognizant contract and increasing the not-to-exceed amount by $161,865 from $6,445,522 to $6,607,387 for the remaining term of the contract, which is through September 10, 2029.

1-4

Attachment A

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: IT Department Head: Cesar Delgado

Vendor Name: Cognizant TriZetto Software Group, Inc Contact name & e-mail: christopher.donahue@cognizant.com

What services will this vendor provide to KHS? Cognizant will be providing KHS with the a $0 Project Change Request, 24x7 Weekend Upgrade, five user license for TriZetto University for training and a Technology Assessment.

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☒ New agreement ☐ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background: $0 Change Request: 1 month date extension on upgrade to system 24x7 Upgrade Emergency Support: Support for three days to ensure the upgrade does not fail and to troubleshoot on demand if needed TriZetto University: Online training hub for (5) user licenses. Technology Assessment: Cognizant will conduct a technical assessment to address system performance challenges in online and batching processes, reviewing KHS' setup and recommending improvements in preparation for a proposed data purge. Brief Explanation: Cognizant will be providing KHS with the a $0 PRC, 24x7 Weekend Upgrade, 5 TriZetto University for training and a Technology Assessment

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification: ____

☒ Sole source – no competitive process can be performed.

Brief reason for sole source: Ongoing contract with vendor for QNXT Claims Adjudication Systems

Form updated 01/02/24

Attachment A

☐ Conflict of Interest Form is required for this Contract

☐ HIPAA Business Associate Agreement is required for this Contract

☐ Subcontractor Disclosure of Ownership and Control form is required for this Contract

Fiscal Impact

KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☐ NO	☒ YES
Capital project	☒ NO	☐ YES

Project type:

Budgeted Cost Center: 225 GL# 5400 QNXT

Maximum cost of this agreement not to exceed: $38,555

Notes:

Contract Terms and Conditions

Effective date: 4/18/2025 Termination date: 4/17/2026

Explain extension provisions, termination conditions and required notice: ____

Approvals

Compliance DMHC/DHCS Review:

Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

4/3/25

Date

Contract Owner:

Department Head

4-2-2025

Date

Purchasing:

Director of Procurement and Facilities

Date

Reviewed as to Budget:

Robert Franklin

Chief Financial Officer or Controller

4/3/25

Date

Recommended by the Executive Committee:

Chief Operating Officer

Date

Form updated 01/02/24

Attachment A

IT Approval:	**Chief Executive Officer Approval:**
Chief Information Officer or IT Director	Chief Executive Officer
4/2/25 Date	Date

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

KHS Board Chairman

Date

Form updated 01/02/24

5

Attachment A

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: IT Department Head: Cesar Delgado

Vendor Name: Cognizant TriZetto Software Group, Inc Contact name & e-mail: christopher.donahue@cognizant.com

What services will this vendor provide to Cognizant will provide KHS with the QNXT Archival Framework Custom Solution, a specialized code designed to delete and archive claims, for system maintenance and ensuring compliance.

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☒ New agreement ☐ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background: The QNXT Archival Framework Custom Solution is a tailored software code developed to streamline the management of claims and call tracking data. It enables the deletion and archiving of records according to specific retention criteria defined by the client, ensuring efficient data handling and regulatory compliance. Brief Explanation: Cognizant will provide KHS with the QNXT Archival Framework Custom Solution, a specialized code designed to delete and archive claims, for system maintenance and ensuring compliance.
☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*	
Brief vendor selection justification: ____	
☒ Sole source – no competitive process can be performed.	
Brief reason for sole source: Ongoing contract with vendor for QNXT Claims Adjudication Systems	
☐ Conflict of Interest Form is required for this Contract	
☐ HIPAA Business Associate Agreement is required for this Contract	
☐ Subcontractor Disclosure of Ownership and Control form is required for this Contract	
Fiscal Impact	
KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget ☐ NO ☒ YES	

Form updated 01/02/24

Attachment A

Will this require additional funds?	☐ NO	☒ YES
Capital project	☒ NO	☐ YES

Project type:

Budgeted Cost Center: 225 GL# 5400 QNXT

Maximum cost of this agreement not to exceed: $58,810

Notes:

Contract Terms and Conditions

Effective date: 4/18/2025 Termination date: 8/20/2025

Explain extension provisions, termination conditions and required notice: ____

Approvals

Compliance DMHC/DHCS Review:

Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

4/3/25

Date

Contract Owner:

Department Head

4-2-2025

Date

Purchasing:

Director of Procurement and Facilities

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

4/3/25

Date

Recommended by the Executive Committee:

Chief Operating Officer

Date

IT Approval:

Chief Information Officer or IT Director

4/2/25

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Form updated 01/02/24

Attachment A

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

_____

KHS Board Chairman

_____

Date

Form updated 01/02/24

Attachment A

6

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: IT Department Head: Cesar Delgado

Vendor Name: Cognizant TriZetto Software Group, Inc Contact name & e-mail: christopher.donahue@cognizant.com

What services will this vendor provide to KHS? Cognizant will provide KHS with Zelis Payment integrity Interface management Services for three-years term.

Description of Contract	
Type of Agreement: Software ☒ Contract ☐ Purchase ☐ New agreement ☒ Continuation of Agreement ☐ Addendum ☐ Amendment No. ____ ☐ Retroactive Agreement	Background: In 2019, Cognizant provided KHS with the integration module to interface the QNXT Claims Adjudication System with the Zelis software. Zelis is providing KHS with a secondary claims editing software that will evaluate claims post-adjudication and pre-payment to ensure claims are processed appropriately. This will reduce the number of claims overpaid that lead to disputes. This is the annual renewal for the services. Brief Explanation: Conizant will provide KHS with Zelis Payment Integrity Interface Management Services for a three-year term
☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-1, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)* Brief vendor selection justification:	
☒ Sole source – no competitive process can be performed. Brief reason for sole source: Ongoing contract with vendor for QNXT Claims Adjudication Systems	
☐ Conflict of Interest Form is required for this Contract	
☐ HIPAA Business Associate Agreement is required for this Contract	
☐ Subcontractor Disclosure of Ownership and Control form is required for this Contract	
Fiscal Impact	

Form updated 01/02/24

Attachment A

KHS Governing Board previously approved this expense in KHS' FY 2024 Administrative Budget	☐ NO	☒ YES
Will this require additional funds?	☐ NO	☒ YES
Capital project	☒ NO	☐ YES

Project type:

Budgeted Cost Center: 225 GL# 5400 QNXT

Maximum cost of this agreement not to exceed: $64,500

Notes:

Contract Terms and Conditions

Effective date: 4/18/2025 Termination date: 4/17/2028

Explain extension provisions, termination conditions and required notice:

Approvals

Compliance DMHC/DHCS Review:

Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs

Date

Legal Review:

Legal Counsel

4/3/25

Date

Contract Owner:

Department Head

4-2-2025

Date

Purchasing:

Director of Procurement and Facilities

Date

Reviewed as to Budget:

Chief Financial Officer or Controller

4/3/25

Date

Recommended by the Executive Committee:

Chief Operating Officer

Date

IT Approval:

Chief Information Officer or IT Director

4/2/25

Date

Chief Executive Officer Approval:

Chief Executive Officer

Date

Form updated 01/02/24

Attachment A

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

_____
KHS Board Chairman

_____
Date

Form updated 01/02/24

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: December 2024 Financial Results

DATE: April 17, 2025

The December results reflect a $3.7 million increase in Net Position which is a $3.3 million favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $31.3 million favorable variance primarily due to:

   A) $7.8 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $15.5 million favorable variance due to receiving Amended CY 2024 Rates from DHCS on December 30, 2024.

   C) $5.1 million favorable variance in MCO Tax Premium primarily due to receiving revised MCO Tax information from DHCS on September 24, 2024 offset against an unfavorable variance included in the MCO Tax Expense line item on the Income Statement for the same amount.

   D) $2.7 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated rate information from DHCS for Calendar Year 2024 offset against amounts included in 2F below.

2) Total Medical Costs reflect a $20.3 million unfavorable variance primarily due to:

   A) $8.4 million unfavorable variance in Physician Services is primarily due to higher-than-expected utilization ($3.5 million) and higher-than-expected Targeted Rate Increases ("TRI") amounts allocated to PCP, Specialty and Urgent Care services ($4.9 million). As previously reported, we began paying TRI amounts in May and believed it was necessary to increase our accruals for these categories of expenses. This amount is offset against amounts included Other Professional Services included in 2B (2) below.

   B) $4.5 million favorable variance in Other Professional Services primarily due from:

      1) $1.0 million favorable variance from lower-than-expected utilization of Autism services over the last several months.

      2) $3.2 million favorable variance in Other Professional Services primarily due to lowering our accruals for TRI expenses offset against amounts included in 2A above.

C) $10.7 million unfavorable variance in Inpatient primarily due to higher-than-expected utilization over the last several months.

D) $2.6 million unfavorable variance in Outpatient Hospital primarily due to higher-than-expected utilization over the last several months.

E) $5.4 million unfavorable variance in Other Medical primarily from:

1) $3.3 million unfavorable variance in Ambulance and Non-emergency Medical Transportation ("NEMT") due to higher-than-expected utilization of NEMT services over the last several months by our members.

2) $1.4 million favorable variance in Utilization and Quality Review Expenses primarily due to a true-up in interpretation service expenses based on total invoice amounts which included portions of expenses being reimbursed by CSV.

3) $2.7 million unfavorable variance in CalAim Incentive Programs primarily due to Community Support Service program expenses.

F) $2.7 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rate information from DHCS for Calendar Year 2024 offset against amounts included in 1D above.

G) $5.1 million favorable variance in IBNR, Incentive, Paid Claims Adjustment primarily due to DHCS finalizing the CY 2023 ECM Risk Corridor calculation and reimbursing KHS for additional expenses paid by KHS above the ECM Risk Corridor amount.

3) Total Administrative Expenses reflect a $2.6 million unfavorable variance primarily due to:

A) $1.2 million unfavorable variance in Purchased Services primarily due to an increase in annual system maintenance costs related to the member and provider portal ($.4 million) and additional expenses related to outside IT professional services ($.5 million).

B) $1.3 million unfavorable variance in Administrative Expense Adjustment primarily relating to the CalPERS Net Pension True-Up Adjustment for the period July 1, 2023 to June 30, 2024 required under GASB 68.

The December Medical Loss Ratio is 89.7% which is favorable to the 92.4% budgeted amount. The December Administrative Expense Ratio is 6.8% which is unfavorable to the 6.0% budgeted amount for the reasons described in Item 3 above.

The results for the 12 months ended December 31, 2024 reflect a Net Decrease in Net Position of $46.6 million. This is a $52.6 million unfavorable variance to the budget and includes approximately $20.3 million of favorable adjustments from the prior year and approximately $30 million of unfavorable retroactive revenue rate adjustments for the current year. The year-to-date Medical Loss Ratio is 96.5% which is unfavorable to the 92.4% budgeted amount.

KERN HEALTH SYSTEMS

Financial Packet
December 2024

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

MEDI-CAL
STATEMENT OF NET POSITION
AS OF DECEMBER 31, 2024

ASSETS	December	November	Increase/ (Decrease)
Cash and Cash Equivalents	373,410,870	290,603,485	82,807,385
Short-Term Investments	247,563,428	248,319,881	(756,453)
Premiums Receivable	94,538,232	85,151,264	9,386,968
Premiums Receivable - MCO Tax	220,308,074	205,657,276	14,650,798
Premiums Receivable - Hospital Directed Payments	555,715,451	530,980,235	24,735,216
Interest Receivable	176,203	118,708	57,495
Provider Advance Payment	164,826	866,432	(701,605)
Other Receivables	2,268,069	3,799,514	(1,531,445)
Prepaid Expenses & Other Current Assets	8,059,338	7,285,329	774,009
Total Current Assets	1,502,204,491	1,372,782,122	129,422,369
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,198,965	1,206,604	(7,638)
Computer Equipment - Net	19,936,024	15,765,298	4,170,725
Building and Improvements - Net	33,068,590	32,352,593	715,997
Capital Projects In Process	961,113	5,399,966	(4,438,853)
Total Capital Assets	59,255,398	58,815,167	440,230
Restricted Assets	300,000	300,000	-
Officer Life Insurance Receivables	1,697,061	1,637,454	59,607
SBITA Asset	8,875,096	6,799,897	2,075,199
Total Long-Term Assets	10,872,157	8,737,351	2,134,806
Deferred Outflow of Resources	6,846,742	8,814,061	(1,967,319)
Total Assets and Deferred Outflows of Resources	1,579,178,788	1,449,148,702	130,030,086
CURRENT LIABILITIES			
Accrued Salaries and Benefits	7,409,952	8,180,684	(770,732)
Accrued Other Operating Expenses	7,098,000	6,899,742	198,259
MCO Tax Payable	369,406,327	309,603,050	59,803,278
Claims Payable (Reported)	28,423,171	5,466,650	22,956,521
IBNR - Inpatient Claims	88,377,546	80,246,804	8,130,742
IBNR - Physician Claims	22,243,104	17,386,564	4,856,540
IBNR - Accrued Other Medical	36,014,471	40,521,333	(4,506,863)
Risk Pool and Withholds Payable	7,021,376	6,414,716	606,660
Allowance for Claims Processing Expense	4,779,517	3,824,312	955,205
Other Liabilities	97,589,870	88,366,922	9,222,948
SBITA Liability – Current portion	2,217,189	2,617,467	(400,278)
Accrued Hospital Directed Payments	557,216,591	532,481,319	24,735,273
Total Current Liabilities	1,227,797,115	1,102,009,563	125,787,552
NONCURRENT LIABILITIES			
Net Pension Liability	12,251,788	12,965,462	(713,674)
SBITA Liability, net of current portion	5,491,541	4,182,430	1,309,111
Total NonCurrent Liabilities	17,743,329	17,147,892	595,437
Deferred Inflow of Resources	70,705	158,303	(87,598)
NET POSITION:			
Net Position at Beginning of Year	380,188,379	380,188,379	-
Increase (Decrease) in Net Position - Current Year	(46,620,740)	(50,355,434)	3,734,694
Total Net Position	333,567,639	329,832,944	3,734,694
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	1,579,178,788	1,449,148,702	130,030,086

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION
FOR THE MONTH ENDED DECEMBER 31, 2024

	December	Budget	Variance	Year to Date	Budget	Variance
Family Members	241,863	245,644	(3,781)	2,927,497	2,953,727	(26,230)
Expansion Members	114,572	111,811	2,761	1,379,210	1,359,731	19,479
SPD Members	23,376	19,927	3,449	274,891	242,123	32,768
LTC Members	523	555	(32)	6,175	6,657	(482)
Other Members	24,106	24,164	(58)	278,468	289,962	(11,494)
Total Members - MCAL	404,440	402,100	2,340	4,866,241	4,852,200	14,041
REVENUES						
Medicaid - Family and Other	63,457,995	53,049,076	10,408,920	670,418,785	637,768,621	32,650,164
Medicaid - Expansion Members	54,963,125	44,880,044	10,083,081	545,984,526	545,785,591	198,934
Medicaid - SPD Members	24,524,681	20,956,459	3,568,222	279,586,636	254,632,507	24,954,129
Medicaid - LTC Members	4,180,989	4,470,309	(289,320)	49,603,603	53,643,704	(4,040,101)
Premium - MCO Tax	50,161,540	45,027,158	5,134,382	709,635,614	543,349,356	166,286,258
Premium - Hospital Directed Payments	24,742,689	22,010,929	2,731,760	295,492,005	266,382,897	29,109,107
Investment Earnings And Other Income	2,179,759	2,079,480	100,279	31,141,833	25,000,000	6,141,833
Reinsurance Recoveries	-	112,588	(112,588)	-	1,358,616	(1,358,616)
Rate Adjustments - Hospital Directed Payments	(7,417)	-	(7,417)	(6,733,769)	-	(6,733,769)
Rate/Income Adjustments	(312,962)	-	(312,962)	653,366	-	653,366
Total Revenues	223,890,400	192,586,042	31,304,358	2,575,782,598	2,327,921,293	247,861,305
EXPENSES						
MEDICAL COSTS						
Physician Services	37,607,514	29,168,936	(8,438,578)	414,119,273	352,496,045	(61,623,228)
Other Professional Services	10,811,656	15,303,061	4,491,405	111,598,083	184,920,099	73,322,016
Emergency Room	6,048,961	6,508,395	459,434	77,890,977	78,632,250	741,273
Inpatient	38,706,469	27,959,779	(10,746,690)	396,082,677	338,580,290	(57,502,387)
Reinsurance Expense	112,548	112,588	40	1,346,512	1,358,616	12,104
Outpatient Hospital	15,505,363	12,905,465	(2,599,898)	176,969,664	156,273,105	(20,696,559)
Other Medical	28,832,240	23,417,481	(5,414,759)	357,834,737	282,720,597	(75,114,140)
Pay for Performance Quality Incentive	606,660	603,150	(3,510)	7,302,318	7,278,300	(24,018)
Risk Corridor Expense	430,817	-	(430,817)	1,172,922	-	(1,172,922)
Hospital Directed Payments	24,742,689	22,010,929	(2,731,760)	295,492,005	266,382,897	(29,109,107)
Hospital Directed Payment Adjustment	(7,417)	-	7,417	(3,851,969)	-	3,851,969
Non-Claims Expense Adjustment	1,931	-	(1,931)	(5,449,472)	-	5,449,472
IBNR, Incentive, Paid Claims Adjustment	(5,075,723)	-	5,075,723	(17,046,128)	-	17,046,128
Total Medical Costs	158,323,708	137,989,785	(20,333,924)	1,813,461,599	1,668,642,200	(144,819,400)
GROSS MARGIN	65,566,692	54,596,257	10,970,434	762,320,998	659,279,093	103,041,905
ADMINISTRATIVE COSTS						
Compensation	4,393,765	4,142,126	(251,639)	44,813,525	49,955,506	5,141,981
Purchased Services	2,949,925	1,739,891	(1,210,034)	23,748,172	20,878,690	(2,869,482)
Supplies	309,304	372,344	63,040	2,887,797	4,468,133	1,580,335
Depreciation	661,433	710,921	49,488	8,560,631	8,531,055	(29,576)
Other Administrative Expenses	533,629	554,843	21,214	6,797,014	6,658,117	(138,897)
Administrative Expense Adjustment	1,233,038	(43,839)	(1,276,877)	1,347,830	(526,074)	(1,873,903)
Total Administrative Expenses	10,081,094	7,476,286	(2,604,808)	88,154,968	89,965,427	1,810,459
TOTAL EXPENSES	168,404,802	145,466,071	(22,938,732)	1,901,616,568	1,758,607,627	(143,008,941)
OPERATING INCOME (LOSS) BEFORE TAX	55,485,598	47,119,972	8,365,626	674,166,030	569,313,666	104,852,364
MCO TAX	50,161,540	45,027,158	(5,134,382)	709,635,614	543,349,356	(166,286,258)
OPERATING INCOME (LOSS) NET OF TAX	5,324,058	2,092,814	3,231,244	(35,469,584)	25,964,310	(61,433,894)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	(1,430,186)	(826,876)	(603,310)	(9,962,561)	(10,000,000)	37,439
D-SNP Expenses	(159,177)	(826,876)	667,699	(1,188,595)	(10,000,000)	8,811,405
Total Non-Operating Revenue (Expense)	(1,589,363)	(1,653,752)	64,389	(11,151,156)	(20,000,000)	8,848,844
NET INCREASE (DECREASE) IN NET POSITION	3,734,694	439,062	3,295,633	(46,620,740)	5,964,310	(52,585,050)
MEDICAL LOSS RATIO	89.7%	92.4%	2.7%	96.5%	92.4%	-4.1%
ADMINISTRATIVE EXPENSE RATIO	6.8%	6.0%	-0.8%	5.6%	5.9%	0.3%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED DECEMBER 31, 2024

	December	Budget	Variance	Year to Date	Budget	Variance
Family Members	241,863	245,644	(3,781)	2,927,497	2,953,727	(26,230)
Expansion Members	114,572	111,811	2,761	1,379,210	1,359,731	19,479
SPD Members	23,376	19,927	3,449	274,891	242,123	32,768
LTC Members	523	555	(32)	6,175	6,657	(482)
Other Members	24,106	24,164	(58)	278,468	289,962	(11,494)
Total Members - MCAL	404,440	402,100	2,340	4,866,241	4,852,200	14,041
REVENUES						
Medicaid - Family and Other	238.59	196.62	41.97	209.12	196.62	12.50
Medicaid - Expansion Members	479.73	401.39	78.33	395.87	401.39	(5.52)
Medicaid - SPD Members	1,049.14	1,051.67	(2.53)	1,017.08	1,051.67	(34.58)
Medicaid - LTC Members	7,994.24	8,058.24	(64.00)	8,032.97	8,058.24	(25.27)
Premium - MCO Tax	2,080.87	1,863.44	217.44	2,548.36	1,873.86	674.49
Premium - Hospital Directed Payments	61.18	54.74	6.44	60.72	54.90	5.82
Investment Earnings And Other Income	5.39	5.17	0.22	6.40	5.15	1.25
Reinsurance Recoveries	-	0.28	(0.28)	-	0.28	(0.28)
Rate Adjustments - Hospital Directed Payments	(0.02)	-	(0.02)	(1.38)	-	(1.38)
Rate/Income Adjustments	(0.77)	-	(0.77)	0.13	-	0.13
Total Revenues	553.58	478.95	74.63	529.32	479.77	49.55
EXPENSES						
MEDICAL COSTS						
Physician Services	92.99	72.54	(20.45)	85.10	72.65	(12.45)
Other Professional Services	26.73	38.06	11.33	22.93	38.11	15.18
Emergency Room	14.96	16.19	1.23	16.01	16.21	0.20
Inpatient	95.70	69.53	(26.17)	81.39	69.78	(11.62)
Reinsurance Expense	0.28	0.28	0.00	0.28	0.28	0.00
Outpatient Hospital	38.34	32.10	(6.24)	36.37	32.21	(4.16)
Other Medical	71.29	58.24	(13.05)	73.53	58.27	(15.27)
Pay for Performance Quality Incentive	1.50	1.50	(0.00)	1.50	1.50	(0.00)
Risk Corridor Expense	1.07	-	(1.07)	0.24	-	(0.24)
Hospital Directed Payments	61.18	54.74	(6.44)	60.72	54.90	(5.82)
Hospital Directed Payment Adjustment	(0.02)	-	0.02	(0.79)	-	0.79
Non-Claims Expense Adjustment	0.00	-	(0.00)	(1.12)	-	1.12
IBNR, Incentive, Paid Claims Adjustment	(12.55)	-	12.55	(3.50)	-	3.50
Total Medical Costs	391.46	343.17	(48.29)	372.66	343.89	(28.77)
GROSS MARGIN	162.12	135.78	26.34	156.66	135.87	20.78
ADMINISTRATIVE COSTS						
Compensation	10.86	10.30	(0.56)	9.21	10.30	1.09
Purchased Services	7.29	4.33	(2.97)	4.88	4.30	(0.58)
Supplies	0.76	0.93	0.16	0.59	0.92	0.33
Depreciation	1.64	1.77	0.13	1.76	1.76	(0.00)
Other Administrative Expenses	1.32	1.38	0.06	1.40	1.37	(0.02)
Administrative Expense Adjustment	3.05	(0.11)	(3.16)	0.28	(0.11)	(0.39)
Total Administrative Expenses	24.93	18.59	(6.33)	18.12	18.54	0.43
TOTAL EXPENSES	416.39	361.77	(54.62)	390.78	362.44	(28.34)
OPERATING INCOME (LOSS) BEFORE TAX	137.19	117.18	20.01	138.54	117.33	21.21
MCO TAX	124.03	111.98	(12.05)	145.83	111.98	(33.85)
OPERATING INCOME (LOSS) NET OF TAX	13.16	5.20	7.96	(7.29)	5.35	(12.64)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	(0.39)	(2.06)	1.66	(0.24)	(2.06)	1.82
D-SNP Expenses	(3.54)	(2.06)	(1.48)	(2.05)	(2.06)	0.01
Total Non-Operating Revenue (Expense)	(3.93)	(4.11)	0.18	(2.29)	(4.12)	1.83
NET INCREASE (DECREASE) IN NET POSITION	9.23	1.09	8.14	(9.58)	1.23	(10.81)
MEDICAL LOSS RATIO	-20.8%	-20.0%	0.8%	-15.0%	-19.9%	-4.9%
ADMINISTRATIVE EXPENSE RATIO	-1.6%	-1.3%	0.3%	-0.9%	-1.3%	-0.4%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS
FOR THE MONTH ENDED DECEMBER 31, 2024

	2023 - Q4	2024 - Q1	2024 - Q2	2024 - Q3	Rolling 4-Quarter Totals	CURRENT QUARTER 2024 - Q4
Total Members - MCAL	1,038,591	1,234,656	1,217,132	1,204,552	4,694,931	1,209,901
REVENUES						
Medicaid - Family and Other	119,336,194	163,114,742	168,098,248	157,352,051	607,901,235	181,853,744
Medicaid - Expansion Members	97,694,167	142,141,972	141,387,639	115,764,407	496,988,185	146,690,508
Medicaid - SPD Members	59,165,633	70,643,949	72,382,078	63,945,176	266,136,837	72,615,432
Medicaid - LTC Members	9,599,451	12,120,676	12,644,500	12,158,979	46,523,606	12,679,447
Premium - MCO Tax	375,849,146	118,164,689	118,164,689	304,000,610	916,179,134	169,305,625
Premium - Hospital Directed Payments	63,752,178	74,715,152	73,085,162	73,636,849	285,189,341	74,054,842
Investment Earnings And Other Income	9,031,183	6,526,452	7,627,603	10,624,397	33,809,635	6,363,381
Rate Adjustments - Hospital Directed Payments	(26,268,027)	2,628,208	(467,208)	(8,849,506)	(32,956,532)	(45,264)
Rate/Income Adjustments	495,587	3,361,928	(5,047,999)	2,310,217	1,119,733	29,220
Total Revenues	708,655,511	593,417,768	587,874,713	730,943,182	2,620,891,174	663,546,935
EXPENSES						
MEDICAL COSTS						
Physician Services	61,076,433	93,110,533	102,259,757	100,828,569	357,275,292	117,920,414
Other Professional Services	19,381,164	37,861,872	28,897,182	27,259,189	113,399,406	17,579,841
Emergency Room	15,523,588	19,266,762	19,274,640	19,085,229	73,150,218	20,264,346
Inpatient	79,244,732	91,080,658	97,071,689	98,069,526	365,466,605	109,860,804
Reinsurance Expense	190,133	324,349	347,257	337,661	1,199,400	337,245
Outpatient Hospital	40,939,501	44,304,385	41,034,136	46,542,079	172,820,101	45,089,064
Other Medical	79,194,627	80,881,278	88,283,888	93,132,007	341,491,800	95,537,563
Pay for Performance Quality Incentive	1,555,236	1,851,974	1,825,698	1,809,795	7,042,703	1,814,852
Risk Corridor Expense	-	-	-	2,133,095	2,133,095	(960,173)
Hospital Directed Payments	63,752,178	74,715,152	73,085,162	73,636,849	285,189,341	74,054,842
Hospital Directed Payment Adjustment	(26,330,241)	2,663,543	18,927	(6,489,175)	(30,136,947)	(45,264)
Non-Claims Expense Adjustment	1,571,341	356,533	(22,398)	(4,294,448)	(2,388,972)	(1,489,159)
IBNR, Incentive, Paid Claims Adjustment	1,506,238	622,759	(7,444,944)	(6,331,814)	(11,647,762)	(3,892,128)
Total Medical Costs	337,604,928	447,039,796	444,630,994	445,718,563	1,674,994,280	476,072,247
GROSS MARGIN	371,050,583	146,377,973	143,243,720	285,224,619	945,896,894	187,474,687
ADMINISTRATIVE COSTS						
Compensation	13,584,268	10,509,085	10,907,085	11,047,726	46,048,164	12,349,629
Purchased Services	5,339,166	5,448,763	5,076,649	6,652,421	22,516,999	6,570,339
Supplies	680,996	764,751	722,573	707,109	2,875,429	693,365
Depreciation	2,099,363	2,040,936	2,164,109	2,283,774	8,588,182	2,071,812
Other Administrative Expenses	1,406,817	1,644,704	1,714,820	1,588,772	6,355,113	1,848,717
Administrative Expense Adjustment	1,580,132	96,938	22,381	(2,309)	1,697,142	1,230,820
Total Administrative Expenses	24,690,742	20,505,176	20,607,617	22,277,493	88,081,029	24,764,681
TOTAL EXPENSES	362,295,670	467,544,972	465,238,611	467,996,056	1,763,075,309	500,836,928
OPERATING INCOME (LOSS) BEFORE TAX	346,359,841	125,872,796	122,636,102	262,947,125	857,815,865	162,710,007
MCO TAX	376,495,887	118,164,689	118,164,689	304,000,610	916,825,875	169,305,625
OPERATING INCOME (LOSS) NET OF TAX	(30,136,046)	7,708,107	4,471,413	(41,053,485)	(59,010,011)	(6,595,619)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	25,418	(1,329,860)	(2,537,763)	(1,419,027)	(5,261,231)	(4,675,912)
D-SNP Expenses	(1,480,051)	(877,356)	(951,808)	169,913	(3,139,302)	470,656
Total Non-Operating Revenue (Expense)	(1,454,633)	(2,207,215)	(3,489,571)	(1,249,113)	(8,400,533)	(4,205,257)
NET INCREASE (DECREASE) IN NET POSITION	(31,590,679)	5,500,891	981,842	(42,302,598)	(67,410,544)	(10,800,875)
MEDICAL LOSS RATIO	101.6%	92.9%	93.6%	104.5%	97.8%	95.7%
ADMINISTRATIVE EXPENSE RATIO	8.4%	5.2%	5.2%	6.2%	6.1%	5.9%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS PMPM
FOR THE MONTH ENDED DECEMBER 31, 2024

	2023 - Q4	2024 - Q1	2024 - Q2	2024 - Q3	Rolling Quarter Totals	CURRENT QUARTER 2024 - Q4
Total Members - MCAL	1,038,591	1,234,656	1,217,132	1,204,552	3,490,379	1,209,901
REVENUES						
Medicaid - Family and Other	172.27	201.11	209.43	197.64	195.94	228.42
Medicaid - Expansion Members	338.10	401.13	409.54	343.25	374.86	428.47
Medicaid - SPD Members	1,063.71	1,042.58	1,068.92	918.92	1,020.92	1,039.89
Medicaid - LTC Members	7,447.21	8,123.78	8,200.06	7,764.35	7,900.09	8,050.44
Premium - MCO Tax	361.88	95.71	97.08	252.38	195.14	139.93
Premium - Hospital Directed Payments	61.38	60.51	60.05	61.13	60.74	61.21
Investment Earnings And Other Income	8.70	5.29	6.27	8.82	7.20	5.26
Rate Adjustments - Hospital Directed Payments	(25.29)	2.13	(0.38)	(7.35)	(7.02)	(0.04)
Rate/Income Adjustments	0.48	2.72	(4.15)	1.92	0.24	0.02
Total Revenues	682.32	480.63	483.00	606.82	558.24	548.43
EXPENSES						
MEDICAL COSTS						
Physician Services	58.81	75.41	84.02	83.71	76.10	97.46
Other Professional Services	18.66	30.67	23.74	22.63	24.15	14.53
Emergency Room	14.95	15.60	15.84	15.84	15.58	16.75
Inpatient	76.30	73.77	79.75	81.42	77.84	90.80
Reinsurance Expense	0.18	0.26	0.29	0.28	0.26	0.28
Outpatient Hospital	39.42	35.88	33.71	38.64	36.81	37.27
Other Medical	76.25	65.51	72.53	77.32	72.74	78.96
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.50	1.50
Risk Corridor Expense	-	-	-	1.77	0.45	(0.79)
Hospital Directed Payments	61.38	60.51	60.05	61.13	60.74	61.21
Hospital Directed Payment Adjustment	(25.35)	2.16	0.02	(5.39)	(6.42)	(0.04)
Non-Claims Expense Adjustment	1.51	0.29	(0.02)	(3.57)	(0.51)	(1.23)
IBNR, Incentive, Paid Claims Adjustment	1.45	0.50	(6.12)	(5.26)	(2.48)	(3.22)
Total Medical Costs	325.06	362.08	365.31	370.03	356.77	393.48
GROSS MARGIN	357.26	118.56	117.69	236.79	201.47	154.95
ADMINISTRATIVE COSTS						
Compensation	13.08	8.51	8.96	9.17	9.81	10.21
Purchased Services	5.14	4.41	4.17	5.52	4.80	5.43
Supplies	0.66	0.62	0.59	0.59	0.61	0.57
Depreciation	2.02	1.65	1.78	1.90	1.83	1.71
Other Administrative Expenses	1.35	1.33	1.41	1.32	1.35	1.53
Administrative Expense Adjustment	1.52	0.08	0.02	(0.00)	0.36	1.02
Total Administrative Expenses	23.77	16.61	16.93	18.49	18.76	20.47
TOTAL EXPENSES	348.83	378.68	382.24	388.52	375.53	413.95
OPERATING INCOME (LOSS) BEFORE TAX	333.49	101.95	100.76	218.29	182.71	134.48
MCO TAX	362.51	95.71	97.08	252.38	195.28	139.93
OPERATING INCOME (LOSS) NET OF TAX	(29.02)	6.24	3.67	(34.08)	(12.57)	(5.45)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	0.02	(1.08)	(2.09)	(1.18)	(1.12)	(3.86)
D-SNP Expenses	(1.43)	(0.71)	(0.78)	0.14	(0.67)	0.39
Total Non-Operating Revenue (Expense)	(1.40)	(1.79)	(2.87)	(1.04)	(1.79)	(3.48)
NET INCREASE (DECREASE) IN NET POSITION	(30.42)	4.46	0.81	(35.12)	(14.36)	(8.93)
MEDICAL LOSS RATIO	101.6%	92.9%	93.6%	104.5%	97.8%	95.7%
ADMINISTRATIVE EXPENSE RATIO	8.4%	5.2%	5.2%	6.2%	6.1%	5.9%

KERN HEALTH SYSTEMS

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
ROLLING 6 MONTHS
FOR THE MONTH ENDED DECEMBER 31, 2024

	JUNE 2024	JULY 2024	AUGUST 2024	SEPTEMBER 2024	OCTOBER 2024	NOVEMBER 2024	Prior 6 Month YTD	DECEMBER 2024
Total Members - MCAL	403,695	402,008	400,588	401,956	402,241	403,220	2,413,708	404,440
REVENUES								
Medicaid - Family and Other	54,454,738	54,814,574	55,394,125	47,143,352	55,766,852	62,628,897	330,202,537	63,457,995
Medicaid - Expansion Members	45,412,795	45,242,639	44,943,353	25,578,416	44,274,896	47,452,486	252,904,584	54,963,125
Medicaid - SPD Members	24,185,884	24,362,723	24,068,270	15,514,183	23,582,809	24,507,942	136,221,812	24,524,681
Medicaid - LTC Members	4,461,566	4,316,218	4,169,310	3,673,451	4,161,018	4,337,441	25,119,004	4,180,989
Premium - MCO Tax	39,388,230	39,388,230	39,388,230	225,224,150	59,470,965	59,673,120	462,532,925	50,161,540
Premium - Hospital Directed Payments	25,339,960	24,576,449	24,409,832	24,650,569	24,613,116	24,699,036	148,288,962	24,742,689
Investment Earnings And Other Income	2,584,498	3,396,336	3,597,586	3,630,475	2,035,919	2,147,703	17,392,517	2,179,759
Rate Adjustments - Hospital Directed Payments	(457,542)	(6,686,334)	5,409	(2,168,580)	(55,251)	17,404	(9,344,895)	(7,417)
Rate/Income Adjustments	3,282,276	594,484	117,732	1,598,001	102,639	239,543	5,934,676	(312,962)
Total Revenues	198,652,406	190,005,318	196,093,846	344,844,017	213,952,963	225,703,571	1,369,252,122	223,890,400
EXPENSES								
MEDICAL COSTS								
Physician Services	36,554,096	32,448,391	34,358,210	34,021,968	42,641,203	37,671,697	217,695,565	37,607,514
Other Professional Services	9,148,831	8,910,610	9,280,419	9,068,160	(3,203,582)	9,971,766	43,176,204	10,811,656
Emergency Room	6,665,692	6,362,602	6,439,132	6,283,494	7,576,830	6,638,555	39,966,306	6,048,961
Inpatient	32,758,876	32,835,724	32,643,856	32,589,946	33,979,229	37,175,106	201,982,737	38,706,469
Reinsurance Expense	110,398	113,134	111,965	112,562	111,767	112,931	672,757	112,548
Outpatient Hospital	13,499,596	16,572,741	15,115,990	14,853,348	15,182,189	14,401,513	89,625,376	15,505,363
Other Medical	29,527,118	28,667,716	31,087,518	33,376,773	34,893,013	31,812,311	189,364,449	28,832,240
Pay for Performance Quality Incentive	605,543	603,012	603,849	602,934	603,362	604,830	3,623,529	606,660
Risk Corridor Expense	-	-	-	2,133,095	(1,390,990)	-	742,105	430,817
Hospital Directed Payments	25,339,960	24,576,449	24,409,832	24,650,569	24,613,116	24,699,036	148,288,962	24,742,689
Hospital Directed Payment Adjustment	(20,001)	(6,679,802)	5,409	185,219	(55,251)	17,404	(6,547,023)	(7,417)
Non-Claims Expense Adjustment	(59,596)	1,831	(3,882,116)	(414,162)	(329)	(1,490,761)	(5,845,134)	1,931
IBNR, Incentive, Paid Claims Adjustment	(3,427,580)	(2,330,513)	(2,153,708)	(1,847,593)	905,899	277,697	(8,575,798)	(5,075,723)
Total Medical Costs	150,702,934	142,081,895	148,020,355	155,616,313	155,856,455	161,892,084	914,170,036	158,323,708
GROSS MARGIN	47,949,472	47,923,423	48,073,491	189,227,704	58,096,509	63,811,487	455,082,087	65,566,692
ADMINISTRATIVE COSTS								
Compensation	3,543,998	3,719,030	3,883,154	3,445,542	3,800,976	4,154,887	22,547,588	4,393,765
Purchased Services	1,609,874	2,266,065	2,446,404	1,939,952	1,959,335	1,661,091	11,882,721	2,949,925
Supplies	399,825	406,426	102,708	197,976	250,386	133,675	1,490,994	309,304
Depreciation	704,955	704,955	703,523	875,296	718,614	691,764	4,399,108	661,433
Other Administrative Expenses	489,373	608,392	453,737	526,643	706,468	608,620	3,393,233	533,629
Administrative Expense Adjustment	47,630	-	(2,444)	135	0	(2,230)	43,091	1,233,038
Total Administrative Expenses	6,795,655	7,704,868	7,587,082	6,985,543	7,435,779	7,247,808	43,756,736	10,081,094
TOTAL EXPENSES	157,498,590	149,786,762	155,607,437	162,601,856	163,292,234	169,139,892	957,926,771	168,404,802
OPERATING INCOME (LOSS) BEFORE TAX	41,153,817	40,218,556	40,486,409	182,242,161	50,660,730	56,563,679	411,325,351	55,485,598
MCO TAX	39,388,230	39,388,230	39,388,230	225,224,150	59,470,965	59,673,120	462,532,925	50,161,540
OPERATING INCOME (LOSS) NET OF TAX	1,765,587	830,326	1,098,179	(42,981,989)	(8,810,236)	(3,109,441)	(51,207,574)	5,324,058
NON-OPERATING REVENUE (EXPENSE)								
Total Non-Operating Revenue (Expense)	(1,631,585)	(507,411)	(235,639)	(506,063)	(1,781,820)	(834,074)	(5,496,592)	(1,589,363)
NET INCREASE (DECREASE) IN NET POSITION	134,002	322,915	862,540	(43,488,053)	(10,592,056)	(3,943,514)	(56,704,166)	3,734,694
MEDICAL LOSS RATIO	93.3%	93.6%	93.4%	134.6%	101.1%	97.1%	100.6%	89.7%
ADMINISTRATIVE EXPENSE RATIO	5.1%	5.8%	5.7%	7.2%	5.7%	5.1%	5.7%	6.8%

KERN HEALTH SYSTEMS

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
PMPM ROLLING 6 MONTHS
FOR THE MONTH ENDED DECEMBER 31, 2024

	JUNE 2024	JULY 2024	AUGUST 2024	SEPTEMBER 2024	OCTOBER 2024	NOVEMBER 2024	6 Month Prior YTD	DECEMBER 2024
Total Members - MCAL	403,695	402,008	400,588	401,956	402,241	403,220	2,413,708	404,440
REVENUES								
Medicaid - Family and Other	203.33	205.51	208.04	177.79	210.36	236.28	207.28	239.73
Medicaid - Expansion Members	394.31	398.75	399.18	226.08	390.42	414.85	372.73	492.79
Medicaid - SPD Members	1,083.31	1,060.22	1,063.41	670.71	1,016.41	1,054.01	979.87	1,029.45
Medicaid - LTC Members	8,629.72	8,190.17	8,002.51	7,023.81	7,850.98	8,309.27	7,986.96	8,009.56
Premium - MCO Tax	97.57	97.98	98.33	560.32	147.85	147.99	191.63	124.03
Premium - Hospital Directed Payments	62.77	61.13	60.94	61.33	61.19	61.25	61.44	61.18
Investment Earnings And Other Income	6.40	8.45	8.98	9.03	5.06	5.33	7.21	5.39
Rate Adjustments - Hospital Directed Payments	(1.13)	(16.63)	0.01	(5.40)	(0.14)	0.04	(3.87)	(0.02)
Rate/Income Adjustments	8.13	1.48	0.29	3.98	0.26	0.59	2.46	(0.77)
Total Revenues	492.09	472.64	489.52	857.91	531.90	559.75	567.28	553.58
EXPENSES								
MEDICAL COSTS								
Physician Services	90.55	80.72	85.77	84.64	106.01	93.43	90.19	92.99
Other Professional Services	22.66	22.17	23.17	22.56	(7.96)	24.73	17.89	26.73
Emergency Room	16.51	15.83	16.07	15.63	18.84	16.46	16.56	14.96
Inpatient	81.15	81.68	81.49	81.08	84.47	92.20	83.68	95.70
Reinsurance Expense	0.27	0.28	0.28	0.28	0.28	0.28	0.28	0.28
Outpatient Hospital	33.44	41.22	37.73	36.95	37.74	35.72	37.13	38.34
Other Medical	73.14	71.31	77.60	83.04	86.75	78.90	78.45	71.29
Pay for Performance Quality Incentive	1.50	1.50	1.51	1.50	1.50	1.50	1.50	1.50
Risk Corridor Expense	-	-	-	5.31	(3.46)	-	0.31	1.07
Hospital Directed Payments	62.77	61.13	60.94	61.33	61.19	61.25	61.44	61.18
Hospital Directed Payment Adjustment	(0.05)	(16.62)	0.01	0.46	(0.14)	0.04	(2.71)	(0.02)
Non-Claims Expense Adjustment	(0.15)	0.00	(9.69)	(1.03)	(0.00)	(3.70)	(2.42)	0.00
IBNR, Incentive, Paid Claims Adjustment	(8.49)	(5.80)	(5.38)	(4.60)	2.25	0.69	(3.55)	(12.55)
Total Medical Costs	373.31	353.43	369.51	387.15	387.47	401.50	378.74	391.46
GROSS MARGIN	118.78	119.21	120.01	470.77	144.43	158.25	188.54	162.12
ADMINISTRATIVE COSTS								
Compensation	8.78	9.25	9.69	8.57	9.45	10.30	9.34	10.86
Purchased Services	3.99	5.64	6.11	4.83	4.87	4.12	4.92	7.29
Supplies	0.99	1.01	0.26	0.49	0.62	0.33	0.62	0.76
Depreciation	1.75	1.75	1.76	2.18	1.79	1.72	1.82	1.64
Other Administrative Expenses	1.21	1.51	1.13	1.31	1.76	1.51	1.41	1.32
Administrative Expense Adjustment	0.12	-	(0.01)	0.00	0.00	(0.01)	0.02	3.05
Total Administrative Expenses	16.83	19.17	18.94	17.38	18.49	17.97	18.13	24.93
TOTAL EXPENSES	390.14	372.60	388.45	404.53	405.96	419.47	396.87	416.39
OPERATING INCOME (LOSS) BEFORE TAX	101.94	100.04	101.07	453.39	125.95	140.28	170.41	137.19
MCO TAX	97.57	97.98	98.33	560.32	147.85	147.99	191.63	124.03
OPERATING INCOME (LOSS) NET OF TAX	4.37	2.07	2.74	(106.93)	(21.90)	(7.71)	(21.22)	13.16
NON-OPERATING REVENUE (EXPENSE)								
Provider Grants/CalAIM/Home Heath	(3.08)	(1.09)	(1.48)	(0.97)	(6.56)	(1.50)	(2.45)	(3.54)
D-SNP Expenses	(0.96)	(0.17)	0.89	(0.29)	2.13	(0.57)	0.17	(0.39)
Total Non-Operating Revenue (Expense)	(4.04)	(1.26)	(0.59)	(1.26)	(4.43)	(2.07)	(2.28)	(3.93)
NET INCREASE (DECREASE) IN NET POSITION	0.33	0.80	2.15	(108.19)	(26.33)	(9.78)	(23.49)	9.23
MEDICAL LOSS RATIO	93.3%	93.6%	93.4%	134.6%	101.1%	97.1%	100.6%	89.7%
ADMINISTRATIVE EXPENSE RATIO	5.1%	5.8%	5.7%	7.2%	5.7%	5.1%	5.7%	6.8%

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2024

	December	Budget	Variance	Year to Date	Budget	Variance
REVENUES						
Premium - Medi-Cal	55,822,462	46,402,489	9,419,974	574,640,440	557,861,765	16,778,675
Premium - Maternity Kick	4,287,419	3,264,152	1,023,267	40,847,615	39,242,411	1,605,203
Premium - Enhanced Care Management	1,631,673	1,383,051	248,621	17,202,141	16,627,370	574,771
Premium - Major Organ Transplant	263,452	237,700	25,752	3,110,694	2,857,681	253,012
Premium - Provider Enhancement	1,174,962	1,084,021	90,941	14,011,780	13,032,361	979,418
Premium - GEMT	181,319	187,108	(5,789)	2,203,622	2,249,455	(45,832)
Premium - Cal AIM	0	332,665	(332,665)	8,559,982	3,999,372	4,560,610
Premium - Student Behavioral Health Incentive	-	157,891	(157,891)	1,704,218	1,898,205	(193,987)
Premium - Housing and Homelessness Incentive	-	-	-	6,395,468	-	6,395,468
Premium - Equity & Practice Transformation	-	-	-	569,537	-	569,537
Premium - Distinct Part Nursing Facility	239	-	239	2,734	-	2,734
Other	96,470	-	96,470	1,170,555	-	1,170,555
TOTAL MEDICAID - FAMILY & OTHER	63,457,995	53,049,076	10,408,920	670,418,785	637,768,621	32,650,164
Premium - Medi-Cal	51,740,111	41,406,918	10,333,193	500,009,099	503,548,951	(3,539,851)
Premium - Maternity Kick	434,986	422,753	12,233	5,192,870	5,141,089	51,781
Premium - Enhanced Care Management	1,680,951	1,585,202	95,749	20,129,337	19,277,620	851,717
Premium - Major Organ Transplant	429,734	414,707	15,027	5,139,392	5,043,244	96,148
Premium - Provider Enhancement	375,382	354,794	20,588	4,474,820	4,314,646	160,174
Premium - GEMT	255,996	262,662	(6,665)	3,080,135	3,194,227	(114,092)
Premium - Cal AIM	(0)	293,640	(293,640)	3,693,947	3,570,951	122,996
Premium - Student Behavioral Health Incentive	-	139,369	(139,369)	728,532	1,694,865	(966,332)
Premium - Housing and Homelessness Incentive	-	-	-	2,739,905	-	2,739,905
Premium - Equity & Practice Transformation	-	-	-	243,998	-	243,998
Premium - Distinct Part Nursing Facility	3	-	3	81	-	81
Other	45,962	-	45,962	552,410	-	552,410
TOTAL MEDICAID - EXPANSION MEMBERS	54,963,125	44,880,044	10,083,081	545,984,526	545,785,591	198,934
Premium - Medi-Cal	23,129,759	19,583,522	3,546,237	261,924,688	237,950,566	23,974,122
Premium - Enhanced Care Management	885,012	727,727	157,284	10,303,196	8,842,288	1,460,908
Premium - Major Organ Transplant	315,632	263,364	52,269	3,624,186	3,200,013	424,173
Premium - Provider Enhancement	28,652	24,705	3,947	334,844	300,179	34,665
Premium - GEMT	165,627	147,909	17,718	1,931,570	1,797,177	134,393
Premium - Cal AIM	-	141,888	(141,888)	750,906	1,724,020	(973,114)
Premium - Student Behavioral Health Incentive	-	67,344	(67,344)	144,653	818,264	(673,611)
Premium - Housing and Homelessness Incentive	-	-	-	525,772	-	525,772
Premium - Equity & Practice Transformation	-	-	-	46,822	-	46,822
Premium - Distinct Part Nursing Facility	-	-	-	-	-	-
Other	-	-	-	-	-	-
TOTAL MEDICAID - SPD MEMBERS	24,524,681	20,956,459	3,568,222	279,586,636	254,632,507	24,954,129
Premium - Medi-Cal	4,152,888	4,395,083	(242,195)	49,235,832	52,740,998	(3,505,166)
Premium - Enhanced Care Management	9,622	10,315	(693)	114,507	123,779	(9,272)
Premium - Major Organ Transplant	14,196	15,235	(1,040)	169,151	182,823	(13,672)
Premium - Provider Enhancement	4	4	(1)	48	53	(5)
Premium - GEMT	3,257	3,176	81	39,301	38,112	1,190
Premium - Cal AIM	(0)	31,530	(31,530)	16,858	378,360	(361,502)
Premium - Student Behavioral Health Incentive	-	14,965	(14,965)	3,230	179,579	(176,350)
Premium - Housing and Homelessness Incentive	-	-	-	11,558	-	11,558
Premium - Equity & Practice Transformation	-	-	-	1,029	-	1,029
Premium - Distinct Part Nursing Facility	1,022	-	1,022	12,089	-	12,089
Other	-	-	-	-	-	-
TOTAL MEDICAID - LTC MEMBERS	4,180,989	4,470,309	(289,320)	49,603,603	53,643,704	(4,040,101)

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2024

KERN HEALTH SYSTEMS

REVENUES	January	February	March	April	May	June	July	August	September	October	November	December	Year to Date
Premium - Medi-Cal	47,241,506	48,947,162	49,229,878	48,457,890	45,604,186	48,268,333	48,440,858	48,131,710	39,944,804	47,187,381	47,364,268	55,822,462	574,640,440
Premium - Maternity Kick	2,781,366	2,862,736	2,796,161	3,040,270	3,173,420	2,907,119	3,321,365	4,231,227	3,323,673	4,552,613	3,570,246	4,287,419	40,847,615
Premium - Enhanced Care Management	1,360,425	1,373,690	1,369,893	1,329,522	1,080,066	1,437,528	1,324,442	1,315,508	2,161,904	1,407,300	1,410,189	1,631,673	17,202,141
Premium - Major Organ Transplant	242,912	264,248	268,461	260,651	203,323	289,608	263,632	262,300	264,484	263,074	264,549	263,452	3,110,694
Premium - Cal AIM	-	-	-	-	-	-	-	-	-	-	8,559,982	0	8,559,982
Premium - Provider Enhancement	1,115,725	1,189,379	1,203,274	1,179,009	1,008,150	1,255,995	1,180,759	1,172,208	1,180,202	1,171,910	1,180,207	1,174,962	14,011,780
Premium - GEMT	187,833	192,364	192,415	187,592	158,941	198,874	185,899	184,380	169,297	182,217	182,492	181,319	2,203,622
Premium - Student Behavioral Health Incentive	-	-	-	798,493	-	-	-	-	-	905,724	-	-	1,704,218
Premium - Housing and Homelessness Incentive	-	-	-	6,395,468	-	-	-	-	-	-	-	-	6,395,468
Premium - Equity & Practice Transformation	-	-	-	569,537	-	-	-	-	-	-	-	-	569,537
Premium - Distinct Part Nursing Facility	-	-	-	-	-	-	-	-	2,025	234	236	239	2,734
Other	97,449	98,860	99,005	98,756	98,236	97,279	97,619	96,791	96,962	96,399	96,728	96,470	1,170,555
TOTAL MEDICAID - FAMILY & OTHER	53,027,216	54,928,439	55,159,087	62,317,189	51,326,322	54,454,738	54,814,574	55,394,125	47,143,352	55,766,852	62,628,897	63,457,995	670,418,785
Premium - Medi-Cal	43,459,690	44,508,533	44,016,473	43,567,402	43,005,883	42,475,755	42,240,002	42,088,885	21,913,683	40,481,897	40,510,785	51,740,111	500,009,099
Premium - Maternity Kick	576,986	710,136	503,013	325,479	281,096	258,904	340,274	199,726	403,958	659,799	498,515	434,986	5,192,870
Premium - Enhanced Care Management	1,651,191	1,664,324	1,642,575	1,626,006	1,605,210	1,579,736	1,569,286	1,564,662	2,242,374	1,650,725	1,652,298	1,680,951	20,129,337
Premium - Major Organ Transplant	432,007	442,199	437,523	433,298	427,929	422,778	420,674	419,415	422,787	425,365	425,682	429,734	5,139,392
Premium - Cal AIM	-	-	-	-	-	-	-	-	-	-	3,693,947	(0)	3,693,947
Premium - Provider Enhancement	373,632	384,099	380,389	376,842	372,278	368,239	366,657	365,604	368,793	371,296	371,608	375,382	4,474,820
Premium - GEMT	271,454	274,545	271,386	268,943	265,767	261,970	260,625	260,108	181,442	253,823	254,076	255,996	3,080,135
Premium - Student Behavioral Health Incentive	-	-	-	342,085	-	-	-	-	-	386,447	-	-	728,532
Premium - Housing and Homelessness Incentive	-	-	-	2,739,905	-	-	-	-	-	-	-	-	2,739,905
Premium - Equity & Practice Transformation	-	-	-	243,998	-	-	-	-	-	-	-	-	243,998
Premium - Distinct Part Nursing Facility	-	-	-	-	-	-	-	-	71	4	4	3	81
Other	46,893	47,755	47,171	46,671	46,053	45,413	45,122	44,952	45,308	45,540	45,572	45,962	552,410
TOTAL MEDICAID - EXPANSION MEMBERS	46,811,852	48,031,590	47,298,530	49,970,629	46,004,215	45,412,795	45,242,639	44,943,353	25,578,416	44,274,896	47,452,486	54,963,125	545,984,526
Premium - Medi-Cal	22,135,884	22,247,086	22,395,301	22,414,824	22,542,535	22,863,443	23,030,954	22,753,177	13,902,698	22,134,559	22,374,467	23,129,759	261,924,688
Premium - Enhanced Care Management	802,416	805,446	810,071	809,677	813,823	825,377	830,598	819,178	1,158,208	868,382	875,009	885,012	10,303,196
Premium - Major Organ Transplant	289,069	291,313	293,840	294,966	297,016	301,270	304,130	301,571	310,765	309,714	314,901	315,632	3,624,186
Premium - Cal AIM	-	-	-	-	-	-	-	-	-	-	750,906	-	750,906
Premium - Provider Enhancement	27,257	27,350	27,490	27,471	27,602	27,999	28,168	27,768	28,496	28,198	28,393	28,652	334,844
Premium - GEMT	163,069	163,702	164,656	164,596	165,447	167,796	168,873	166,576	114,017	162,947	164,265	165,627	1,931,570
Premium - Student Behavioral Health Incentive	-	-	-	65,644	-	-	-	-	-	79,009	-	-	144,653
Premium - Housing and Homelessness Incentive	-	-	-	525,772	-	-	-	-	-	-	-	-	525,772
Premium - Equity & Practice Transformation	-	-	-	46,822	-	-	-	-	-	-	-	-	46,822
Premium - Distinct Part Nursing Facility	-	-	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL MEDICAID - SPD MEMBERS	23,417,694	23,534,898	23,691,358	24,349,771	23,846,423	24,185,884	24,362,723	24,068,270	15,514,183	23,582,809	24,507,942	24,524,681	279,586,636
Premium - Medi-Cal	3,950,994	4,064,582	4,029,135	4,021,131	4,096,164	4,433,079	4,288,666	4,143,142	3,633,618	4,130,690	4,291,742	4,152,888	49,235,832
Premium - Enhanced Care Management	9,002	9,285	9,206	9,179	9,347	10,145	9,808	9,445	9,897	9,613	9,959	9,622	114,507
Premium - Major Organ Transplant	13,131	13,656	13,568	13,567	13,823	15,086	14,595	13,905	14,648	14,396	14,580	14,196	169,151
Premium - Cal AIM	-	-	-	-	-	-	-	-	-	-	16,858	(0)	16,858
Premium - Provider Enhancement	3	4	4	4	4	5	5	4	4	5	4	4	48
Premium - GEMT	2,536	2,779	2,790	2,814	2,870	3,252	3,145	2,814	6,278	3,543	3,222	3,257	39,301
Premium - Student Behavioral Health Incentive	-	-	-	1,443	-	-	-	-	-	1,786	-	-	3,230
Premium - Housing and Homelessness Incentive	-	-	-	11,558	-	-	-	-	-	-	-	-	11,558
Premium - Equity & Practice Transformation	-	-	-	1,029	-	-	-	-	-	-	-	-	1,029
Premium - Distinct Part Nursing Facility	-	-	-	-	-	-	-	-	9,006	985	1,076	1,022	12,089
Other	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL MEDICAID - LTC MEMBERS	3,975,666	4,090,307	4,054,703	4,060,726	4,122,208	4,461,566	4,316,218	4,169,310	3,673,451	4,161,018	4,337,441	4,180,989	49,603,603

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2024

	December	Budget	Variance	Year to Date	Budget	Variance
Physician Services						
Primary Care Physician Services	13,154,853	5,633,703	(7,521,150)	99,245,195	67,985,617	(31,259,578)
Referral Specialty Services	16,790,442	20,859,099	4,068,657	267,462,619	252,221,873	(15,240,746)
Urgent Care & After Hours Advice	7,652,920	2,666,834	(4,986,086)	47,301,659	32,178,755	(15,122,904)
Hospital Admitting Team	9,300	9,300	-	109,800	109,800	-
Total Physician Services	37,607,514	29,168,936	(8,438,578)	414,119,273	352,496,045	(61,623,228)
Other Professional Services						
Vision Service Capitation	348,348	341,785	(6,563)	3,939,332	4,124,370	185,038
221 - Business Intelligence	207,122	155,852	(51,270)	1,956,588	1,885,041	(71,547)
310 - Health Servcies - Utilization Management	985,552	1,118,215	132,663	9,213,805	13,524,844	4,311,039
311 - Health Services - Quality Improvement	300,958	337,507	36,549	2,458,751	4,082,160	1,623,409
312 - Health Services Education	418,048	385,653	(32,396)	3,429,027	4,664,479	1,235,452
313 - Pharmacy	153,516	136,317	(17,199)	1,361,491	1,648,757	287,266
314 - Enhanced Care Management	514,363	423,316	(91,047)	4,064,242	5,120,025	1,055,784
316 - Population Health Management	758,532	657,382	(101,150)	6,369,718	7,951,057	1,581,339
317 - In Lieu of Services	172,304	138,390	(33,914)	1,323,729	1,673,835	350,106
321 - Homeless Management Information Services	55,415	33,088	(22,327)	420,310	400,201	(20,109)
330 - Member Services	1,391,344	1,064,119	(327,225)	12,533,615	12,870,550	336,934
331 - Member Outreach	133,836	337,613	203,778	643,085	4,083,442	3,440,358
410 - Member Engagement	60,973	76,052	15,079	710,860	919,850	208,990
601 - Behavioral Health	216,559	170,694	(45,865)	1,560,693	2,064,545	503,852
602 - Quality & Health Equity	73,431	74,157	726	876,775	896,933	20,158
604 - Clinical Operations, Strategy, and Analytics	165,365	128,513	(36,852)	1,251,148	1,554,372	303,224
Behavior Health Treatment	2,725,646	3,755,007	1,029,361	32,041,409	45,271,283	13,229,874
Mental Health Services	420,104	1,071,527	651,423	5,334,049	12,999,919	7,665,870
Other Professional Services	1,710,240	4,897,874	3,187,634	22,109,456	59,184,437	37,074,981
Total Other Professional Services	10,811,656	15,303,061	4,491,405	111,598,083	184,920,099	73,322,016
Emergency Room	6,048,961	6,508,395	459,434	77,890,977	78,632,250	741,273
Inpatient Hospital	38,706,469	27,959,779	(10,746,690)	396,082,677	338,580,290	(57,502,387)
Reinsurance Expense Premium	112,548	112,588	40	1,346,512	1,358,616	12,104
Outpatient Hospital	15,505,363	12,905,465	(2,599,898)	176,969,664	156,273,105	(20,696,559)
Other Medical						
Ambulance and NEMT	6,074,222	2,766,167	(3,308,055)	59,152,782	33,438,319	(25,714,463)
Home Health Services & CBAS	895,972	869,064	(26,908)	14,830,583	10,524,433	(4,306,150)
Utilization and Quality Review Expenses	327,962	1,723,824	1,395,862	14,046,044	20,849,703	6,803,659
Long Term/SNF/Hospice	8,540,610	9,011,678	471,069	130,063,302	108,455,009	(21,608,292)
Provider Enhancement Expense - Prop. 56	1,500,410	1,780,391	279,981	17,877,636	16,764,877	(1,112,759)
Provider Enhancement Expense - GEMT	606,199	180,770	(425,430)	7,254,629	6,915,022	(339,607)
Enhanced Care Management	4,409,061	3,545,731	(863,330)	45,364,722	42,928,489	(2,436,233)
Major Organ Transplant	980,471	884,455	(96,016)	11,550,643	10,719,574	(831,069)
Cal AIM Incentive Programs	3,494,095	759,737	(2,734,359)	29,895,342	9,189,068	(20,706,274)
Student Behavioral Health Incentive	-	360,590	360,590	1,159,360	4,361,367	3,202,007
Housing and Homelessness Incentive	-	-	-	4,164,729	-	(4,164,729)
Equity & Practice Transformation Expense	-	-	-	321,366	-	(321,366)
Distinct Part Nursing Facility Expense	1,264	-	(1,264)	14,904	-	(14,904)
DME/Rebates	2,001,973	1,535,074	(466,899)	22,138,696	18,574,736	(3,563,960)
Total Other Medical	28,832,240	23,417,481	(5,414,759)	357,834,737	282,720,597	(75,114,140)
Pay for Performance Quality Incentive	606,660	603,150	(3,510)	7,302,318	7,278,300	(24,018)
Risk Corridor Expense	430,817	-	(430,817)	1,172,922	-	(1,172,922)
Hospital Directed Payments	24,742,689	22,010,929	(2,731,760)	295,492,005	266,382,897	(29,109,107)
Hospital Directed Payment Adjustment	(7,417)	-	7,417	(3,851,969)	-	3,851,969
Non-Claims Expense Adjustment	1,931	-	(1,931)	(5,449,472)	-	5,449,472
IBNR, Incentive, Paid Claims Adjustment	(5,075,723)	-	5,075,723	(17,046,128)	-	17,046,128
Total Medical Costs	158,323,708	137,989,785	(20,333,924)	1,813,461,599	1,668,642,200	(144,819,400)

* MEDICAL COSTS PER DMHC REGULATIONS

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2024

	December	Budget	Variance	Year to Date	Budget	Variance
TOTAL MEMBERS - MCAL	404,440	402,100	2,340	4,866,241	4,852,200	14,041
Physician Services						
Primary Care Physician Services	32.53	14.01	(18.52)	20.39	14.01	(6.38)
Referral Specialty Services	41.52	51.88	10.36	54.96	51.98	(2.98)
Urgent Care & After Hours Advice	18.92	6.63	(12.29)	9.72	6.63	(3.09)
Hospital Admitting Team	0.02	0.02	0.00	0.02	0.02	0.00
Total Physician Services	92.99	72.54	(20.45)	85.10	72.65	(12.45)
Other Professional Services						
Vision Service Capitation	0.86	0.85	(0.01)	0.81	0.85	0.04
221 - Business Intelligence	0.51	0.39	(0.12)	0.40	0.39	(0.01)
310 - Health Servcies - Utilization Management	2.44	2.78	0.34	1.89	2.79	0.89
311 - Health Services - Quality Improvement	0.74	0.84	0.10	0.51	0.84	0.34
312 - Health Services Education	1.03	0.96	(0.07)	0.70	0.96	0.26
313 - Pharmacy	0.38	0.34	(0.04)	0.28	0.34	0.06
314 - Enhanced Care Management	1.27	1.05	(0.22)	0.84	1.06	0.22
316 - Population Health Management	1.88	1.63	(0.24)	1.31	1.64	0.33
317 - In Lieu of Services	0.43	0.34	(0.08)	0.27	0.34	0.07
321 - Homeless Management Information Services	0.14	0.08	(0.05)	0.09	0.08	(0.00)
330 - Member Services	3.44	2.65	(0.79)	2.58	2.65	0.08
331 - Member Outreach	0.33	0.84	0.51	0.13	0.84	0.71
410 - Member Engagement	0.15	0.19	0.04	0.15	0.19	0.04
601 - Behavioral Health	0.54	0.42	(0.11)	0.32	0.43	0.10
602 - Quality & Health Equity	0.18	0.18	0.00	0.18	0.18	0.00
604 - Clinical Operations, Strategy, and Analytics	0.41	0.32	(0.09)	0.26	0.32	0.06
Behavior Health Treatment	6.74	9.34	2.60	6.58	9.33	2.75
Mental Health Services	1.04	2.66	1.63	1.10	2.68	1.58
Other Professional Services	4.23	12.18	7.95	4.54	12.20	7.65
Total Other Professional Services	26.73	38.06	11.33	22.93	38.11	15.18
Emergency Room	14.96	16.19	1.23	16.01	16.21	0.20
Inpatient Hospital	95.70	69.53	(26.17)	81.39	69.78	(11.62)
Reinsurance Expense Premium	0.28	0.28	0.00	0.28	0.28	0.00
Outpatient Hospital	38.34	32.10	(6.24)	36.37	32.21	(4.16)
Other Medical						
Ambulance and NEMT	15.02	6.88	(8.14)	12.16	6.89	(5.26)
Home Health Services & CBAS	2.22	2.16	(0.05)	3.05	2.17	(0.88)
Utilization and Quality Review Expenses	0.81	4.29	3.48	2.89	4.30	1.41
Long Term/SNF/Hospice	21.12	22.41	1.29	26.73	22.35	(4.38)
Provider Enhancement Expense - Prop. 56	3.71	4.43	0.72	3.67	3.46	(0.22)
Provider Enhancement Expense - GEMT	1.50	0.45	(1.05)	1.49	1.43	(0.07)
Enhanced Care Management	10.90	8.82	(2.08)	9.32	8.85	(0.48)
Major Organ Transplant	2.42	2.20	(0.22)	2.37	2.21	(0.16)
Cal AIM Incentive Programs	8.64	1.89	(6.75)	6.14	1.89	(4.25)
Student Behavioral Health Incentive	-	0.90	0.90	0.24	0.90	0.66
Housing and Homelessness Incentive	-	-	-	0.86	-	(0.86)
Equity & Practice Transformation Expense	-	-	-	0.07	-	(0.07)
Distinct Part Nursing Facility Expense	0.00	-	(0.00)	0.00	-	(0.00)
DME/Rebates	4.95	3.82	(1.13)	4.55	3.83	(0.72)
Total Other Medical	71.29	58.24	(13.05)	73.53	58.27	(15.27)
Pay for Performance Quality Incentive	1.50	1.50	(0.00)	1.50	1.50	(0.00)
Risk Corridor Expense	1.07	-	(1.07)	0.24	-	(0.24)
Hospital Directed Payments	61.18	54.74	(6.44)	60.72	54.90	(5.82)
Hospital Directed Payment Adjustment	(0.02)	-	0.02	(0.79)	-	0.79
Non-Claims Expense Adjustment	0.00	-	(0.00)	(1.12)	-	1.12
IBNR, Incentive, Paid Claims Adjustment	(12.55)	-	12.55	(3.50)	-	3.50
Total Medical Costs	391.46	343.17	(48.29)	372.66	343.89	(28.77)

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2024

KERN HEALTH SYSTEMS

	January	February	March	April	May	June	July	August	September	October	November	December	Year to Date
Physician Services													
Primary Care Physician Services	6,499,076	6,559,994	7,176,252	8,439,162	7,656,483	10,560,497	4,814,529	6,586,511	6,536,360	5,921,529	15,339,949	13,154,853	99,245,195
Referral Specialty Services	21,255,092	22,977,486	20,309,856	21,606,841	21,227,905	22,534,971	24,157,015	24,334,504	24,186,802	28,485,057	19,596,647	16,790,442	267,462,619
Urgent Care & After Hours Advice	2,319,250	3,179,640	2,806,586	2,687,879	4,069,091	3,449,628	3,467,547	3,427,895	3,289,806	8,225,316	2,726,101	7,652,920	47,301,659
Hospital Admitting Team	9,300	8,700	9,300	9,000	9,300	9,000	9,300	9,300	9,000	9,300	9,000	9,300	109,800
Total Physician Services	30,082,718	32,725,820	30,301,995	32,742,882	32,962,778	36,554,096	32,448,391	34,358,210	34,021,968	42,641,203	37,671,697	37,607,514	414,119,273
Other Professional Services													
Vision Service Capitation	140,322	296,413	344,110	359,517	404,063	339,399	343,443	339,893	341,707	339,293	342,825	348,348	3,939,332
221 - Business Intelligence	166,419	154,838	154,693	149,676	157,920	164,059	162,549	93,397	170,932	173,297	201,686	207,122	1,956,588
310 - Health Servcies - Utilization Management	852,585	802,658	800,584	810,297	790,917	700,035	698,997	669,680	652,308	701,001	749,192	985,552	9,213,805
311 - Health Services - Quality Improvement	240,989	241,505	131,143	25,469	194,860	181,920	202,485	217,662	217,269	264,934	239,558	300,958	2,458,751
312 - Health Services Education	238,074	244,710	246,020	243,125	259,637	263,229	286,717	282,077	302,858	307,327	337,204	418,048	3,429,027
313 - Pharmacy	117,253	108,343	102,637	102,244	111,483	107,476	102,845	112,041	109,561	115,772	118,322	153,516	1,361,491
314 - Enhanced Care Management	296,401	292,841	287,850	309,036	318,231	301,102	332,277	343,316	338,260	358,890	371,674	514,363	4,064,242
316 - Population Health Management	495,663	471,064	489,719	503,611	532,764	469,214	507,513	529,689	511,968	554,856	545,125	758,532	6,369,718
317 - In Lieu of Services	88,658	84,311	80,050	94,979	105,477	95,152	117,324	119,643	110,397	125,854	129,580	172,304	1,323,729
321 - Homeless Management Information Services	-	9,044	676	101,045	26,625	30,523	37,075	37,682	41,115	39,330	41,780	55,415	420,310
330 - Member Services	996,071	988,648	974,384	1,059,971	1,115,929	914,815	1,092,015	1,055,537	981,352	995,963	967,586	1,391,344	12,533,615
410 - Member Engagement	68,866	68,715	62,767	70,719	55,899	53,496	45,774	55,207	46,888	61,979	59,579	60,973	710,860
601 - Behavioral Health	63,991	79,219	103,195	113,713	138,092	134,174	137,330	136,230	131,794	145,630	160,766	216,559	1,560,693
602 - Quality & Health Equity	76,057	71,516	71,726	71,420	73,359	72,782	67,412	72,107	71,525	70,009	85,432	73,431	876,775
604 - Clinical Operations, Strategy, and Analytics	77,153	69,408	82,369	83,076	79,230	90,449	102,114	113,575	113,657	144,430	130,321	165,365	1,251,148
Behavior Health Treatment	3,612,672	1,051,116	3,458,567	1,308,993	2,602,725	2,931,009	2,668,314	2,863,238	2,674,105	3,269,050	2,875,975	2,725,646	32,041,409
Mental Health Services	1,525,645	620,225	1,069,857	826,611	393,105	330,088	173,541	343,978	450,090	(1,482,154)	662,960	420,104	5,334,049
Other Professional Services	4,642,734	5,211,408	4,823,947	4,258,014	1,813,653	1,904,534	1,762,191	1,826,761	1,736,929	(9,464,178)	1,883,223	1,710,240	22,109,456
Total Other Professional Services	13,699,554	10,865,981	13,296,336	10,516,696	9,231,655	9,148,831	8,910,610	9,280,419	9,068,160	(3,203,582)	9,971,766	10,811,656	111,598,083
Emergency Room	6,905,833	6,114,762	6,246,167	6,286,018	6,322,930	6,665,692	6,362,602	6,439,132	6,283,494	7,576,830	6,638,555	6,048,961	77,890,977
Inpatient Hospital	30,185,040	29,579,215	31,316,403	33,608,353	30,704,459	32,758,876	32,835,724	32,643,856	32,589,946	33,979,229	37,175,106	38,706,469	396,082,677
Reinsurance Expense Premium	96,765	98,519	129,066	118,429	118,429	110,398	113,134	111,965	112,562	111,767	112,931	112,548	1,346,512
Outpatient Hospital	13,495,747	15,812,073	14,996,564	14,993,746	12,540,794	13,499,596	16,572,741	15,115,990	14,853,348	15,182,189	14,401,513	15,505,363	176,969,664
Other Medical													
Ambulance and NEMT	3,214,531	3,869,951	4,117,183	4,046,350	4,886,538	4,694,674	4,700,022	5,617,091	5,700,653	6,236,286	5,995,280	6,074,222	59,152,782
Home Health Services & CBAS	821,583	1,260,395	1,162,579	1,286,263	1,383,467	1,803,391	1,254,827	1,371,979	1,307,115	1,019,232	1,263,781	895,972	14,830,583
Utilization and Quality Review Expenses	778,360	1,419,906	764,904	659,673	1,094,286	1,057,105	1,593,640	1,413,209	1,606,585	2,230,594	1,099,821	327,962	14,046,044
Long Term/SNF/Hospice	8,782,404	11,938,647	10,174,399	11,100,770	11,407,241	11,520,690	10,338,299	11,587,366	11,456,571	10,694,224	12,522,080	8,540,610	130,063,302
Provider Enhancement Expense - Prop. 56	1,440,786	1,520,790	1,530,599	1,504,160	1,337,631	1,569,564	1,493,732	1,487,305	1,498,620	1,492,839	1,501,201	1,500,410	17,877,636
Provider Enhancement Expense - GEMT	697,353	720,314	727,161	758,687	923,611	813,870	1,021,009	374,123	732,408	1,050,507	(1,170,614)	606,199	7,254,629
Enhanced Care Management	3,631,882	3,736,622	3,563,643	3,585,665	3,333,024	3,660,671	3,445,004	3,420,931	5,191,340	3,636,796	3,750,082	4,409,061	45,364,722
Major Organ Transplant	928,263	960,846	962,722	952,357	894,987	1,132,655	795,627	947,331	962,050	961,922	1,071,412	980,471	11,550,643
Cal AIM Incentive Programs	1,210,017	1,499,955	1,042,387	3,055,050	2,549,702	1,503,170	2,048,408	2,646,828	2,919,047	4,113,393	3,813,290	3,494,095	29,895,342
Housing and Homelessness Incentive	516,672	1,955,761	401,264	409,983	271,034	-	-	410,015	200,000	-	-	-	4,164,729
Equity & Practice Transformation Expense	-	-	-	-	-	-	-	-	-	321,366	-	-	321,366
Distinct Part Nursing Facility Expense	-	-	-	-	-	-	-	-	11,102	1,222	1,316	1,264	14,904
DME/Rebates	1,444,613	2,282,835	1,801,951	1,636,974	1,679,318	1,771,328	1,977,148	1,811,340	1,791,282	1,975,272	1,964,662	2,001,973	22,138,696
Total Other Medical	23,466,463	31,166,022	26,248,792	28,995,931	29,760,839	29,527,118	28,667,716	31,087,518	33,376,773	34,893,013	31,812,311	28,832,240	357,834,737
Pay for Performance Quality Incentive	607,242	620,847	623,885	611,412	608,744	605,543	603,012	603,849	602,934	603,362	604,830	606,660	7,302,318
Risk Corridor Expense	-	-	-	-	-	-	-	-	2,133,095	(1,390,990)	-	430,817	1,172,922
Hospital Directed Payments	24,282,372	24,917,058	25,515,722	24,754,858	22,990,345	25,339,960	24,576,449	24,409,832	24,650,569	24,613,116	24,699,036	24,742,689	295,492,005
Hospital Directed Payment Adjustment	42,165	2,395,027	226,351	134,240	(95,313)	(20,001)	(6,679,802)	5,409	185,219	(55,251)	17,404	(7,417)	(3,851,969)
Non-Claims Expense Adjustment	141,502	115,821	99,211	74,266	(37,068)	(59,596)	1,831	(3,882,116)	(414,162)	(329)	(1,490,761)	1,931	(5,449,472)
IBNR, Incentive, Paid Claims Adjustment	164,572	329,680	128,506	(929,497)	(3,087,868)	(3,427,580)	(2,330,513)	(2,153,708)	(1,847,593)	905,899	277,697	(5,075,723)	(17,046,128)
Total Medical Costs	143,169,973	154,740,825	149,128,998	151,907,335	142,020,725	150,702,934	142,081,895	148,020,355	155,616,313	155,856,455	161,892,084	158,323,708	1,813,461,599

* MEDICAL COSTS PER DMHC REGULATIONS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2024

KERN HEALTH SYSTEMS

	January	February	March	April	May	June	July	August	September	October	November	December	Year to Date
Physician Services													
Primary Care Physician Services	16.05	15.85	17.25	20.70	18.87	26.16	11.98	16.44	16.26	14.72	38.04	32.53	20.39
Referral Specialty Services	52.50	55.51	48.83	53.01	52.31	55.82	60.09	60.75	60.17	70.82	48.60	41.52	54.96
Urgent Care & After Hours Advice	5.73	7.68	6.75	6.59	10.03	8.55	8.63	8.56	8.18	20.45	6.76	18.92	9.72
Hospital Admitting Team	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02
Total Physician Services	74.31	79.07	72.85	80.33	81.22	90.55	80.72	85.77	84.64	106.01	93.43	92.99	85.10
Other Professional Services													
Vision Service Capitation	0.35	0.72	0.83	0.88	1.00	0.84	0.85	0.85	0.85	0.84	0.85	0.86	0.81
221 - Business Intelligence	0.41	0.37	0.37	0.37	0.39	0.41	0.40	0.23	0.43	0.43	0.50	0.51	0.40
310 - Health Servcies - Utilization Management	2.11	1.94	1.92	1.99	1.95	1.73	1.74	1.67	1.62	1.74	1.86	2.44	1.89
311 - Health Services - Quality Improvement	0.60	0.58	0.32	0.06	0.48	0.45	0.50	0.54	0.54	0.66	0.59	0.74	0.51
312 - Health Services Education	0.59	0.59	0.59	0.60	0.64	0.65	0.71	0.70	0.75	0.76	0.84	1.03	0.70
313 - Pharmacy	0.29	0.26	0.25	0.25	0.27	0.27	0.26	0.28	0.27	0.29	0.29	0.38	0.28
314 - Enhanced Care Management	0.73	0.71	0.69	0.76	0.78	0.75	0.83	0.86	0.84	0.89	0.92	1.27	0.84
316 - Population Health Management	1.22	1.14	1.18	1.24	1.31	1.16	1.26	1.32	1.27	1.38	1.35	1.88	1.31
317 - In Lieu of Services	0.22	0.20	0.19	0.23	0.26	0.24	0.29	0.30	0.27	0.31	0.32	0.43	0.27
330 - Member Services	2.46	2.39	2.34	2.60	2.75	2.27	2.72	2.63	2.44	2.48	2.40	3.44	2.58
410 - Member Engagement	0.17	0.17	0.15	0.17	0.14	0.13	0.11	0.14	0.12	0.15	0.15	0.15	0.15
601 - Behavioral Health	0.16	0.19	0.25	0.28	0.34	0.33	0.34	0.34	0.33	0.36	0.40	0.54	0.32
602 - Quality & Health Equity	0.19	0.17	0.17	0.18	0.18	0.18	0.17	0.18	0.18	0.17	0.21	0.18	0.18
604 - Clinical Operations, Strategy, and Analytics	0.19	0.17	0.20	0.20	0.20	0.22	0.25	0.28	0.28	0.36	0.32	0.41	0.26
Behavior Health Treatment	8.92	2.54	8.32	3.21	6.41	7.26	6.64	7.15	6.65	8.13	7.13	6.74	6.58
Mental Health Services	3.77	1.50	2.57	2.03	0.97	0.82	0.43	0.86	1.12	(3.68)	1.64	1.04	1.10
Other Professional Services	11.47	12.59	11.60	10.45	4.47	4.72	4.38	4.56	4.32	(23.53)	4.67	4.23	4.54
Total Other Professional Services	33.84	26.25	31.97	25.80	22.75	22.66	22.17	23.17	22.56	(7.96)	24.73	26.73	22.93
Emergency Room	17.06	14.77	15.02	15.42	15.58	16.51	15.83	16.07	15.63	18.84	16.46	14.96	16.01
Inpatient Hospital	74.56	71.46	75.29	82.45	75.66	81.15	81.68	81.49	81.08	84.47	92.20	95.70	81.39
Reinsurance Expense Premium	0.24	0.24	0.31	0.29	0.29	0.27	0.28	0.28	0.28	0.28	0.28	0.28	0.28
Outpatient Hospital	33.34	38.20	36.06	36.78	30.90	33.44	41.22	37.73	36.95	37.74	35.72	38.34	36.37
Other Medical													
Ambulance and NEMT	7.94	9.35	9.90	9.93	12.04	11.63	11.69	14.02	14.18	15.50	14.87	15.02	12.16
Home Health Services & CBAS	2.03	3.05	2.80	3.16	3.41	4.47	3.12	3.42	3.25	2.53	3.13	2.22	3.05
Utilization and Quality Review Expenses	1.92	3.43	1.84	1.62	2.70	2.62	3.96	3.53	4.00	5.55	2.73	0.81	2.89
Long Term/SNF/Hospice	21.69	28.84	24.46	27.23	28.11	28.54	25.72	28.93	28.50	26.59	31.06	21.12	26.73
Provider Enhancement Expense - Prop. 56	3.56	3.67	3.68	3.69	3.30	3.89	3.72	3.71	3.73	3.71	3.72	3.71	3.67
Provider Enhancement Expense - GEMT	1.72	1.74	1.75	1.86	2.28	2.02	2.54	0.93	1.82	2.61	(2.90)	1.50	1.49
Enhanced Care Management	8.97	9.03	8.57	8.80	8.21	9.07	8.57	8.54	12.92	9.04	9.30	10.90	9.32
Major Organ Transplant	2.29	2.32	2.31	2.34	2.21	2.81	1.98	2.36	2.39	2.39	2.66	2.42	2.37
Cal AIM Incentive Programs	2.99	3.62	2.51	7.50	6.28	3.72	5.10	6.61	7.26	10.23	9.46	8.64	6.14
Student Behavioral Health Incentive	-	-	-	-	-	-	-	-	-	2.88	-	-	0.24
Housing and Homelessness Incentive	1.28	4.73	0.96	1.01	0.67	-	-	1.02	0.50	-	-	-	0.86
Equity & Practice Transformation Expense	-	-	-	-	-	-	-	-	-	0.80	-	-	0.07
Distinct Part Nursing Facility Expense	-	-	-	-	-	-	-	-	0.03	0.00	0.00	0.00	0.00
DME/Rebates	3.57	5.52	4.33	4.02	4.14	4.39	4.92	4.52	4.46	4.91	4.87	4.95	0.00
Total Other Medical	57.97	75.30	63.11	71.14	73.33	73.14	71.31	77.60	83.04	86.75	78.90	71.29	68.99
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.50	1.50	1.50	1.51	1.50	1.50	1.50	1.50	-
Risk Corridor Expense	-	-	-	-	-	-	-	-	5.31	(3.46)	-	1.07	1.50
Hospital Directed Payments	59.98	60.20	61.35	60.73	56.65	62.77	61.13	60.94	61.33	61.19	61.25	61.18	0.24
Hospital Directed Payment Adjustment	0.10	5.79	0.54	0.33	(0.23)	(0.05)	(16.62)	0.01	0.46	(0.14)	0.04	(0.02)	60.72
Non-Claims Expense Adjustment	0.35	0.28	0.24	0.18	(0.09)	(0.15)	0.00	(9.69)	(1.03)	(0.00)	(3.70)	0.00	(0.79)
IBNR, Incentive, Paid Claims Adjustment	0.41	0.80	0.31	(2.28)	(7.61)	(8.49)	(5.80)	(5.38)	(4.60)	2.25	0.69	(12.55)	(1.12)
Total Medical Costs	353.65	373.86	358.55	372.68	349.95	373.31	353.43	369.51	387.15	387.47	401.50	391.46	371.62

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED DECEMBER 31, 2024

KERN HEALTH SYSTEMS

	December	Budget	Variance	Year to Date	Budget	Variance
110 - Executive	750,179	531,130	(219,048)	7,547,381	6,623,564	(923,816)
112 - Government Relations	43,854	47,358	3,504	634,366	568,295	(66,071)
210 - Accounting	612,923	351,597	(261,325)	4,004,668	4,219,168	214,500
220 - Management Information Systems (MIS)	300,585	276,982	(23,602)	4,052,136	3,323,788	(728,348)
221 - Business Intelligence	306,500	202,179	(104,322)	3,290,683	2,426,147	(864,536)
222 - MIS Development	359,025	381,923	22,898	4,255,568	4,583,078	327,511
223 - Enterprise Configuration	290,342	178,406	(111,936)	2,743,173	2,140,868	(602,305)
225 - Infrastructure	1,104,707	859,136	(245,571)	8,968,376	10,309,630	1,341,254
226 - Technical Administrative Services	80,573	220,111	139,539	1,609,098	2,641,338	1,032,240
230 - Claims	1,030,123	795,470	(234,653)	9,512,668	9,545,634	32,967
240 - Project Development	712,426	417,789	(294,636)	4,420,892	5,013,473	592,581
310 - Health Services - Utilization Management	21,645	55,322	33,676	324,359	663,860	339,501
311 - Health Services - Quality Improvement	10,073	45,141	35,068	80,365	541,691	461,326
312 - Health Services - Education	(1,623)	357	1,980	740	4,280	3,540
313 - Pharmacy	10,397	38,333	27,936	138,464	460,000	321,536
314 - Enhanced Care Management	14,277	24,753	10,477	367,162	297,039	(70,123)
316 - Population Health Management	(41,750)	2,975	44,725	(36,108)	35,700	71,807
317 - Community Support Services	1,605	1,625	20	2,416	19,500	17,084
318 - Housing & Homeless Incentive Program (HHIP)	-	-	-	(0)	-	0
319 - CAL AIM Incentive Payment Program (IPP)	-	-	-	12	-	(12)
320 - Provider Network Management	341,333	325,800	(15,532)	3,358,707	3,909,605	550,898
321 - Homeless Management Information Services	(11,963)	896	12,859	(9,456)	10,750	20,206
322 - Delegation & Oversight	76,878	31,116	(45,762)	665,350	373,397	(291,953)
330 - Member Services	324,034	272,551	(51,483)	2,674,167	3,270,614	596,446
331 - Member Outreach	(2,203)	-	2,203	(2,203)	-	2,203
340 - Corporate Services	1,049,260	1,034,659	(14,600)	12,247,458	12,415,912	168,454
360 - Audit & Investigative Services	205,747	241,240	35,493	2,628,621	2,894,880	266,259
410 - Member Engagement	81,231	100,456	19,225	818,319	1,205,471	387,152
420 - Sales/Marketing/Public Relations	288,729	270,104	(18,626)	3,194,723	3,241,245	46,522
510 - Human Resourses	436,259	464,570	28,311	5,414,342	5,574,841	160,499
520 - Legal	3,770	-	(3,770)	3,770	-	(3,770)
601 - Behavioral Health	136	1,779	1,643	28,634	21,350	(7,284)
602 - Quality & Health Equity	54,092	40,769	(13,323)	391,380	489,227	97,848
604 - Clinical Operations, Strategy & Analytics	(1,043)	479	1,522	(1,043)	5,750	6,793
605 - Quality Performance	395,938	305,117	(90,821)	3,477,964	3,661,408	183,443
Administrative Expense Adjustment	1,233,038	(43,839)	(1,276,877)	1,347,818	(526,074)	(1,873,891)
Total Administrative Expenses	10,081,094	7,476,286	(2,604,808)	88,154,968	89,965,427	1,810,459

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED DECEMBER 31, 2024

KERN HEALTH SYSTEMS

	January	February	March	April	May	June	July	August	September	October	November	December	YTD TOTALS
110 - Executive	624,355	577,007	603,344	648,716	539,284	580,943	711,301	798,056	453,299	587,079	673,817	750,179	7,547,381
112 - Government Relations	68,770	45,458	47,484	87,379	45,680	47,575	47,612	49,875	40,735	50,819	59,127	43,854	634,366
210 - Accounting	304,846	303,886	292,257	252,083	318,893	293,744	282,315	313,691	446,987	225,507	357,538	612,923	4,004,668
220 - Management Information Systems (MIS)	391,965	262,588	237,010	146,132	253,670	336,226	372,267	488,182	436,888	429,044	397,578	300,585	4,052,136
221 - Business Intelligence	269,666	199,076	187,188	165,837	228,645	197,729	360,364	474,405	227,722	325,055	348,494	306,500	3,290,683
222 - MIS Development	377,641	315,894	321,173	281,395	395,954	355,456	337,554	358,888	351,618	369,822	431,148	359,025	4,255,568
223 - Enterprise Configuration	174,793	155,969	171,033	161,377	180,934	136,019	266,274	408,183	263,228	252,129	282,892	290,342	2,743,173
225 - Infrastructure	617,597	874,756	639,101	642,546	760,253	834,263	815,160	608,118	702,793	710,147	658,937	1,104,707	8,968,376
226 - Technical Administrative Services	49,489	108,635	117,698	325,913	126,222	172,900	180,639	205,076	91,727	98,706	51,522	80,573	1,609,098
230 - Claims	819,584	766,126	717,167	701,834	775,174	698,241	869,709	769,883	731,866	845,900	787,061	1,030,123	9,512,668
240 - Project Development	347,377	265,411	322,425	313,084	371,811	303,949	348,056	381,627	313,617	395,729	345,380	712,426	4,420,892
310 - Health Services - Utilization Management	30,997	29,562	29,327	29,768	28,807	26,129	25,555	24,524	24,076	25,962	28,006	21,645	324,359
311 - Health Services - Quality Improvement	8,514	7,726	4,159	858	6,234	5,820	7,001	6,963	6,951	9,146	6,921	10,073	80,365
312 - Health Services - Education	341	138	436	581	-	-	243	137	-	45	444	(1,623)	740
313 - Pharmacy	21,270	10,500	10,861	10,822	10,500	10,500	10,500	10,500	10,500	10,932	11,182	10,397	138,464
314 - Enhanced Care Management	44,036	43,641	48,782	54,522	24,778	55,043	25,259	6,064	16,154	17,501	17,106	14,277	367,162
316 - Population Health Management	656	700	1,145	-	-	999	-	-	1,121	962	60	(41,750)	(36,108)
317 - Community Support Services	34	-	280	25	-	94	-	224	78	77	-	1,605	2,416
318 - Housing & Homeless Incentive Program (HHIP	3	12	(16)	1	-	-	-	-	-	-	-	-	(0)
319 - CAL AIM Incentive Payment Program (IPP)	22,503	12,348	2,057	(36,908)	-	0	-	-	-	-	12	-	12
320 - Provider Network Management	386,421	336,270	234,388	95,804	284,140	250,781	276,996	260,789	267,867	321,249	302,668	341,333	3,358,707
322 - Delegation & Oversight	21,948	20,301	29,846	95,971	39,170	37,054	52,664	68,721	67,406	72,728	82,665	76,878	665,350
330 - Member Services	667,205	268,918	162,283	166,335	135,344	143,090	159,911	143,624	133,829	204,775	164,820	324,034	2,674,167
340 - Corporate Services	1,024,905	966,025	929,506	977,234	1,148,873	959,922	1,002,122	960,105	1,185,328	1,029,693	1,014,486	1,049,260	12,247,458
360 - Audit & Investigative Services	195,508	186,054	187,655	202,574	244,557	223,461	226,650	212,147	204,729	295,722	243,819	205,747	2,628,621
410 - Member Engagement	76,778	80,429	69,534	82,742	63,776	65,519	52,063	63,155	47,464	70,643	64,986	81,231	818,319
420 - Sales/Marketing/Public Relations	177,987	306,155	176,484	267,848	246,762	228,632	593,890	194,985	217,603	284,138	211,510	288,729	3,194,723
510 - Human Resources	447,072	430,722	409,608	641,247	485,837	462,781	389,991	466,695	398,713	467,583	377,835	436,259	5,414,342
520 - Legal	-	-	-	-	-	-	-	-	-	-	-	3,770	3,770
601 - Behavioral Health	43	-	167	22,281	63	-	57	5,616	-	272	-	136	28,634
602 - Quality & Health Equity	40,103	59,304	81,243	(38,694)	14,311	59,557	8,554	11,040	62,219	29,420	10,230	54,092	391,380
604 - Clinical Operations, Strategy & Analytics	-	-	-	-	-	-	-	-	-	-	-	(1,043)	(1,043)
605 - Quality Performance	143,642	106,967	277,993	525,434	282,798	261,599	282,161	297,054	280,925	304,693	318,760	395,938	3,477,964
Administrative Expense Adjustment	258,024	(160,374)	(712)	(28,014)	2,765	47,630	-	(2,444)	135	-	(2,230)	1,233,038	1,347,818
Total Administrative Expenses	7,614,072	6,580,201	6,310,903	6,796,727	7,015,235	6,795,655	7,704,868	7,587,082	6,985,543	7,435,779	7,247,808	10,081,094	88,154,968

KHS - GROUP HEALTH PLAN
STATEMENT OF NET POSITION
AS OF DECEMBER 31, 2024

ASSETS	December 2024	November 2024	Increase/ (Decrease)
Cash and Cash Equivalents	1,231,217	1,234,173	(2,956)
Interest Receivable	14,264	9,600	4,664
Other Receivable	125	125	-
Total Current Assets	1,245,606	1,243,898	1,708
CURRENT LIABILITIES			
Other Liabilities	-	-	-
Total Current Liabilities	-	-	-
NET POSITION:			
Net Position at Beginning of Year	1,183,678	1,183,678	-
Increase (Decrease) in Net Position - Current Year	61,928	60,220	1,708
Total Net Position	1,245,606	1,243,898	1,708
TOTAL LIABILITIES AND NET POSITION	1,245,606	1,243,898	1,708

KHS - GROUP HEALTH PLAN
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED DECEMBER 31, 2024

	December	Budget	Variance	Year to Date	Budget	Variance
REVENUES						
Premium	-	-	-	-	-	-
Interest	4,664	-	4,664	54,831	-	54,831
Other Investment Income	(2,956)	-	(2,956)	7,097	-	7,097
Total Revenues	1,708	-	1,708	61,928	-	61,928
EXPENSES						
MEDICAL COSTS						
IBNR and Paid Claims Adjustment	-	-	-	-	-	-
Total Medical Costs	-	-	-	-	-	-
GROSS MARGIN	1,708	-	1,708	61,928	-	61,928
ADMINISTRATIVE COSTS						
Management Fee Expense and Other Admin Exp	-	-	-	-	-	-
Total Administrative Expenses	-	-	-	-	-	-
TOTAL EXPENSES	-	-	-	-	-	-
OPERATING INCOME (LOSS) BEFORE TAX	1,708	-	1,708	61,928	-	61,928
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	-	-	-	-	-	-
NET INCREASE (DECREASE) IN NET POSITION	1,708	-	1,708	61,928	-	61,928
MEDICAL LOSS RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ADMINISTRATIVE EXPENSE RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

MEDI-CAL	2024 MEMBER MONTHS	JAN'24	FEB'24	MAR'24	APR'24	MAY'24	JUN'24	JUL'24	AUG'24	SEP'24	OCT'24	NOV'24	DEC'24
ADULT AND FAMILY													
ADULT (SEE COMMENT)	***889,287***	73,352	78,663	78,717	63,272	74,432	74,454	74,349	74,525	74,469	74,571	74,017	74,466
CHILD	***2,032,871***	169,496	168,966	173,240	181,718	169,847	169,044	168,098	165,943	166,556	166,430	166,688	166,845
SUB-TOTAL ADULT & FAMILY	***2,922,158***	***242,848***	***247,629***	***251,957***	***244,990***	***244,279***	***243,498***	***242,447***	***240,468***	***241,025***	***241,001***	***240,705***	***241,311***
OTHER MEMBERS													
PARTIAL DUALS - FAMILY	***7,575***	774	770	790	694	629	601	551	588	581	526	522	549
PARTIAL DUALS - CHILD	***0***	0	0	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	***46***	6	5	5	3	5	4	7	1	3	2	2	3
BCCTP - TABACCO SETTLEMENT	***0***	0	0	0	0	0	0	0	0	0	0	0	0
FULL DUALS (SPD)													
SPD FULL DUALS	***276,476***	21,544	22,475	22,251	22,380	22,903	22,959	23,243	23,651	23,555	23,576	23,833	24,106
SUBTOTAL OTHER MEMBERS	***284,097***	***22,324***	***23,250***	***23,046***	***23,077***	***23,537***	***23,564***	***23,801***	***24,240***	***24,139***	***24,104***	***24,357***	***24,658***
TOTAL FAMILY & OTHER	***3,206,255***	***265,172***	***270,879***	***275,003***	***268,067***	***267,816***	***267,062***	***266,248***	***264,708***	***265,164***	***265,105***	***265,062***	***265,969***
SDP MEMBERS													
SPD (AGED AND DISABLED)	***274,601***	21,942	23,209	22,608	22,438	22,326	22,645	22,649	23,823	23,131	23,202	23,252	23,376
TOTAL CLASSIC MEMBERS	***3,480,856***	***287,114***	***294,088***	***297,611***	***290,505***	***290,142***	***289,707***	***288,897***	***288,531***	***288,295***	***288,307***	***288,314***	***289,345***
ACA OE - MEDI-CAL OPTIONAL EXPANSION													
ACA Expansion Adult-Citizen	***1,370,259***	115,850	117,787	116,589	115,661	*114,198*	*112,827*	*112,212*	*111,077*	*112,749*	*113,034*	*114,044*	*114,231*
EXPANSION DUALS	***8,951***	*1,382*	*1,517*	*1,226*	944	*972*	634	*378*	*458*	*389*	*370*	*340*	*341*
TOTAL ACA OE	***1,379,210***	***117,232***	***119,304***	***117,815***	***116,605***	***115,170***	***113,461***	***112,590***	***111,535***	***113,138***	***113,404***	***114,384***	***114,572***
LONG TERM CARE (LTC)													
LTC	***598***	38	49	47	46	53	57	52	55	57	50	39	55
LTC DUALS	***5,577***	451	457	450	452	464	470	469	467	466	480	483	468
TOTAL LTC	***6,175***	***489***	***506***	***497***	***498***	***517***	***527***	***521***	***522***	***523***	***530***	***522***	***523***
GRAND TOTAL	***4,866,241***	***404,835***	***413,898***	***415,923***	***407,608***	***405,829***	***403,695***	***402,008***	***400,588***	***401,956***	***402,241***	***403,220***	***404,440***

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: January 2025 Financial Results

DATE: April 17, 2025

The January results reflect a $.1 million Net Increase in Net Position which is a $2.1 million unfavorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $137.1 million favorable variance primarily due to:

   A) $1.6 million unfavorable variance in SPD Premium Revenues primarily due to California becoming a Medicare Part A Buy-In State effective January 1, 2025. Qualifying Medi-Cal members, who are enrolled in Medicare Part B only, were automatically enrolled into Medicare Part A Buy-In by the Department of Health Care Services ("DHCS"). The rate received for members who have Part A **and** Part B ($488 pmpm) is less than the rate for members who have Part B **only** ($1,130 pmpm), however, Medicare will now become primary for medical expenses associated with the members having both Part A and Part B.

   B) $35.5 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated rate information from DHCS on February 28, 2025 for Calendar Year 2025 offset against amounts included in 2B below.

   C) $103.1 million favorable variance in Rate Adjustments - Hospital Directed Payments primarily due to receiving updated rate information from DHCS on February 28, 2025 for Calendar Year 2024 offset against amounts included in 2C below.

2) Total Medical Costs reflect a $141.1 million unfavorable variance primarily due to:

   A) $1.3 million unfavorable variance in Other Medical primarily due to higher-than-expected utilization of Non-emergency Medical Transportation ("NEMT") services by our members.

   B) $35.5 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rate information from DHCS on February 28, 2025 for Calendar Year 2025 offset against amounts included in 1B above.

   C) $103.1 million unfavorable variance in Hospital Directed Payment Adjustment primarily due to receiving updated rate information from DHCS on February 28, 2025 for Calendar Year 2024 offset against amounts included in 1C above.

The January Medical Loss Ratio is 94.2% which is unfavorable to the 91.8% budgeted amount. The January Administrative Expense Ratio is 5.3% which is favorable to the 5.8% budgeted amount.

KERN HEALTH SYSTEMS

Financial Packet
January 2025

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

MEDI-CAL
STATEMENT OF NET POSITION
AS OF JANUARY 31, 2025

ASSETS	January	December	Increase/ (Decrease)
Cash and Cash Equivalents	278,027,418	373,410,870	(95,383,453)
Short-Term Investments	232,603,895	247,563,428	(14,959,532)
Premiums Receivable	107,011,488	94,538,232	12,473,256
Premiums Receivable - MCO Tax	237,793,180	220,308,074	17,485,106
Premiums Receivable - Hospital Directed Payments	718,681,637	555,715,451	162,966,186
Interest Receivable	59,709	176,203	(116,494)
Provider Advance Payment	163,740	164,826	(1,086)
Other Receivables	2,087,139	2,268,069	(180,930)
Prepaid Expenses & Other Current Assets	10,049,396	8,059,338	1,990,059
Total Current Assets	1,586,477,603	1,502,204,491	84,273,112
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,170,544	1,198,965	(28,421)
Computer Equipment - Net	19,230,067	19,936,024	(705,956)
Building and Improvements - Net	32,990,534	33,068,590	(78,056)
Capital Projects In Process	968,826	961,113	7,714
Total Capital Assets	58,450,678	59,255,398	(804,719)
Restricted Assets	300,000	300,000	-
Life Insurance Receivables	4,097,061	1,697,061	2,400,000
SBITA Asset	8,875,096	8,875,096	-
Total Long-Term Assets	13,272,157	10,872,157	2,400,000
Deferred Outflow of Resources	6,846,742	6,846,742	-
Total Assets and Deferred Outflows of Resources	1,665,047,180	1,579,178,788	85,868,392
CURRENT LIABILITIES			
Accrued Salaries and Benefits	9,239,642	7,409,952	1,829,691
Accrued Other Operating Expenses	6,084,680	7,098,000	(1,013,320)
MCO Tax Payable	314,015,919	369,406,327	(55,390,408)
Claims Payable (Reported)	21,412,078	28,423,171	(7,011,093)
IBNR - Inpatient Claims	72,565,839	88,377,546	(15,811,707)
IBNR - Physician Claims	26,784,933	22,243,104	4,541,828
IBNR - Accrued Other Medical	33,256,833	36,014,471	(2,757,638)
Risk Pool and Withholds Payable	7,628,037	7,021,376	606,662
Allowance for Claims Processing Expense	4,779,517	4,779,517	-
Other Liabilities	95,220,144	97,589,870	(2,369,726)
SBITA Liability – Current portion	2,217,189	2,217,189	-
Accrued Hospital Directed Payments	720,182,631	557,216,591	162,966,039
Total Current Liabilities	1,313,387,443	1,227,797,115	85,590,328
NONCURRENT LIABILITIES			
Net Pension Liability	12,401,788	12,251,788	150,000
SBITA Liability, net of current portion	5,491,541	5,491,541	-
Total NonCurrent Liabilities	17,893,329	17,743,329	150,000
Deferred Inflow of Resources	70,705	70,705	-
NET POSITION:			
Net Position at Beginning of Year	333,567,639	380,188,379	(46,620,740)
Increase (Decrease) in Net Position - Current Year	128,064	(46,620,740)	46,748,804
Total Net Position	333,695,702	333,567,639	128,064
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	1,665,047,180	1,579,178,788	85,868,392

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Budget	Variance	Year to Date	Budget	Variance
Family Members	242,422	243,000	(578)	242,422	243,000	(578)
Expansion Members	114,640	113,000	1,640	114,640	113,000	1,640
SPD Members	47,379	47,000	379	47,379	47,000	379
Total Members - MCAL	404,441	403,000	1,441	404,441	403,000	1,441
REVENUES						
Medicaid - Family and Other	54,779,472	54,840,976	(61,504)	54,779,472	54,840,976	(61,504)
Medicaid - Expansion Members	48,572,760	47,912,766	659,994	48,572,760	47,912,766	659,994
Medicaid - SPD Members	38,799,459	40,402,462	(1,603,003)	38,799,459	40,402,462	(1,603,003)
Medicaid - LTC Members	-	-	-	-	-	-
Premium - MCO Tax	59,136,301	59,639,970	(503,669)	59,136,301	59,639,970	(503,669)
Premium - Hospital Directed Payments	59,831,392	24,307,910	35,523,482	59,831,392	24,307,910	35,523,482
Investment Earnings And Other Income	1,729,314	1,991,718	(262,403)	1,729,314	1,991,718	(262,403)
Reinsurance Recoveries	-	273,046	(273,046)	-	273,046	(273,046)
Rate Adjustments - Hospital Directed Payments	103,134,648	-	103,134,648	103,134,648	-	103,134,648
Rate/Income Adjustments	520,492	-	520,492	520,492	-	520,492
Total Revenues	366,503,837	229,368,848	137,134,989	366,503,837	229,368,848	137,134,989
EXPENSES						
MEDICAL COSTS						
Physician Services	36,132,491	36,705,204	572,714	36,132,491	36,705,204	572,714
Other Professional Services	11,445,798	10,830,950	(614,849)	11,445,798	10,830,950	(614,849)
Emergency Room	7,289,728	6,778,581	(511,147)	7,289,728	6,778,581	(511,147)
Inpatient	33,857,875	33,932,293	74,418	33,857,875	33,932,293	74,418
Reinsurance Expense	269,619	273,046	3,427	269,619	273,046	3,427
Outpatient Hospital	16,019,765	15,406,417	(613,348)	16,019,765	15,406,417	(613,348)
Other Medical	30,295,617	28,995,240	(1,300,377)	30,295,617	28,995,240	(1,300,377)
Pay for Performance Quality Incentive	606,662	604,508	(2,153)	606,662	604,508	(2,153)
Risk Corridor Expense	-	-	-	-	-	-
Hospital Directed Payments	59,831,392	24,307,910	(35,523,482)	59,831,392	24,307,910	(35,523,482)
Hospital Directed Payment Adjustment	103,134,648	-	(103,134,648)	103,134,648	-	(103,134,648)
Non-Claims Expense Adjustment	15,749	-	(15,749)	15,749	-	(15,749)
IBNR, Incentive, Paid Claims Adjustment	22,696	-	(22,696)	22,696	-	(22,696)
Total Medical Costs	298,922,038	157,834,150	(141,087,888)	298,922,038	157,834,150	(141,087,888)
GROSS MARGIN	67,581,799	71,534,698	(3,952,899)	67,581,799	71,534,698	(3,952,899)
ADMINISTRATIVE COSTS						
Compensation	4,200,484	4,223,117	22,633	4,200,484	4,223,117	22,633
Purchased Services	1,498,800	2,343,143	844,343	1,498,800	2,343,143	844,343
Supplies	95,074	244,079	149,005	95,074	244,079	149,005
Depreciation	812,433	766,752	(45,681)	812,433	766,752	(45,681)
Other Administrative Expenses	883,740	672,406	(211,334)	883,740	672,406	(211,334)
Administrative Expense Adjustment	202,969	200,000	(2,969)	202,969	200,000	(2,969)
Total Administrative Expenses	7,693,499	8,449,496	755,997	7,693,499	8,449,496	755,997
TOTAL EXPENSES	306,615,537	166,283,646	(140,331,891)	306,615,537	166,283,646	(140,331,891)
OPERATING INCOME (LOSS) BEFORE TAX	59,888,301	63,085,202	(3,196,902)	59,888,301	63,085,202	(3,196,902)
MCO TAX	59,136,301	59,639,970	503,669	59,136,301	59,639,970	503,669
OPERATING INCOME (LOSS) NET OF TAX	751,999	3,445,232	(2,693,233)	751,999	3,445,232	(2,693,233)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	(387,871)	(829,736)	441,865	(387,871)	(829,736)	441,865
D-SNP Expenses	(236,065)	(398,710)	162,646	(236,065)	(398,710)	162,646
Total Non-Operating Revenue (Expense)	(623,936)	(1,228,446)	604,511	(623,936)	(1,228,446)	604,511
NET INCREASE (DECREASE) IN NET POSITION	128,064	2,216,786	(2,088,722)	128,064	2,216,786	(2,088,722)
MEDICAL LOSS RATIO	94.2%	91.8%	-2.3%	94.2%	91.8%	-2.3%
ADMINISTRATIVE EXPENSE RATIO	5.3%	5.8%	0.5%	5.3%	5.8%	0.5%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Budget	Variance	Year to Date	Budget	Variance
Family Members	242,422	243,000	(578)	242,422	243,000	(578)
Expansion Members	114,640	113,000	1,640	114,640	113,000	1,640
SPD Members	47,379	47,000	379	47,379	47,000	379
Total Members - MCAL	404,441	403,000	1,441	404,441	403,000	1,441
REVENUES						
Medicaid - Family and Other	225.97	225.68	0.28	225.97	225.68	0.28
Medicaid - Expansion Members	423.70	424.01	(0.31)	423.70	424.01	(0.31)
Medicaid - SPD Members	818.92	859.63	(40.71)	818.92	859.63	(40.71)
Medicaid - LTC Members	-	-	-	-	-	-
Premium - MCO Tax	146.22	147.99	(1.77)	146.22	147.99	(1.77)
Premium - Hospital Directed Payments	147.94	60.32	87.62	147.94	60.32	87.62
Investment Earnings And Other Income	4.28	4.94	(0.67)	4.28	4.94	(0.67)
Reinsurance Recoveries	-	0.68	(0.68)	-	0.68	(0.68)
Rate Adjustments - Hospital Directed Payments	255.01	-	255.01	255.01	-	255.01
Rate/Income Adjustments	1.29	-	1.29	1.29	-	1.29
Total Revenues	906.20	569.15	337.05	906.20	569.15	337.05
EXPENSES						
MEDICAL COSTS						
Physician Services	89.34	91.08	1.74	89.34	91.08	1.74
Other Professional Services	28.30	26.88	(1.42)	28.30	26.88	(1.42)
Emergency Room	18.02	16.82	(1.20)	18.02	16.82	(1.20)
Inpatient	83.72	84.20	0.48	83.72	84.20	0.48
Reinsurance Expense	0.67	0.68	0.01	0.67	0.68	0.01
Outpatient Hospital	39.61	38.23	(1.38)	39.61	38.23	(1.38)
Other Medical	74.91	71.95	(2.96)	74.91	71.95	(2.96)
Pay for Performance Quality Incentive	1.50	1.50	0.00	1.50	1.50	0.00
Hospital Directed Payments	147.94	60.32	(87.62)	147.94	60.32	(87.62)
Hospital Directed Payment Adjustment	255.01	-	(255.01)	255.01	-	(255.01)
Non-Claims Expense Adjustment	0.04	-	(0.04)	0.04	-	(0.04)
IBNR, Incentive, Paid Claims Adjustment	0.06	-	(0.06)	0.06	-	(0.06)
Total Medical Costs	739.10	391.65	(347.45)	739.10	391.65	(347.45)
GROSS MARGIN	167.10	177.51	(10.41)	167.10	177.51	(10.41)
ADMINISTRATIVE COSTS						
Compensation	10.39	10.48	0.09	10.39	10.48	0.09
Purchased Services	3.71	5.81	2.11	3.71	5.81	2.11
Supplies	0.24	0.61	0.37	0.24	0.61	0.37
Depreciation	2.01	1.90	(0.11)	2.01	1.90	(0.11)
Other Administrative Expenses	2.19	1.67	(0.52)	2.19	1.67	(0.52)
Administrative Expense Adjustment	0.50	0.50	(0.01)	0.50	0.50	(0.01)
Total Administrative Expenses	19.02	20.97	1.94	19.02	20.97	1.94
TOTAL EXPENSES	758.12	412.61	(345.51)	758.12	412.61	(345.51)
OPERATING INCOME (LOSS) BEFORE TAX	148.08	156.54	(8.46)	148.08	156.54	(8.46)
MCO TAX	146.22	147.99	1.77	146.22	147.99	1.77
OPERATING INCOME (LOSS) NET OF TAX	1.86	8.55	(6.69)	1.86	8.55	(6.69)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	(0.58)	(2.06)	1.48	(0.58)	(2.06)	1.48
D-SNP Expenses	(0.96)	(0.99)	0.03	(0.96)	(0.99)	0.03
Total Non-Operating Revenue (Expense)	(1.54)	(3.05)	1.51	(1.54)	(3.05)	1.51
NET INCREASE (DECREASE) IN NET POSITION	0.32	5.50	(5.18)	0.32	5.50	(5.18)
MEDICAL LOSS RATIO	94.2%	91.8%	-2.3%	94.2%	91.8%	-2.3%
ADMINISTRATIVE EXPENSE RATIO	5.3%	5.8%	0.5%	5.3%	5.8%	0.5%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS
FOR THE MONTH ENDED JANUARY 31, 2025

	2024 - Q1	2024 - Q2	2024 - Q3	2024 - Q4	Rolling 4-Quarter Totals	CURRENT QUARTER 2025 - Q1
Total Members - MCAL	1,234,656	1,217,132	1,204,552	1,209,901	4,866,241	404,441
REVENUES						
Medicaid - Family and Other	163,114,742	168,098,248	157,352,051	181,853,744	670,418,785	54,779,472
Medicaid - Expansion Members	142,141,972	141,387,639	115,764,407	146,690,508	545,984,526	48,572,760
Medicaid - SPD Members	70,643,949	72,382,078	63,945,176	72,615,432	279,586,636	38,799,459
Medicaid - LTC Members	12,120,676	12,644,500	12,158,979	12,679,447	49,603,603	-
Premium - MCO Tax	118,164,689	118,164,689	304,000,610	169,305,625	709,635,614	59,136,301
Premium - Hospital Directed Payments	74,715,152	73,085,162	73,636,849	74,054,842	295,492,005	59,831,392
Investment Earnings And Other Income	6,526,452	7,627,603	10,624,397	6,363,381	31,141,833	1,729,314
Reinsurance Recoveries	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	2,628,208	(467,208)	(8,849,506)	(45,264)	(6,733,769)	103,134,648
Rate/Income Adjustments	3,361,928	(5,047,999)	2,310,217	29,220	653,366	520,492
Total Revenues	593,417,768	587,874,713	730,943,182	663,546,935	2,575,782,598	366,503,837
EXPENSES						
MEDICAL COSTS						
Physician Services	93,110,533	102,259,757	100,828,569	117,920,414	414,119,273	36,132,491
Other Professional Services	37,861,872	28,897,182	27,259,189	17,579,841	111,598,083	11,445,798
Emergency Room	19,266,762	19,274,640	19,085,229	20,264,346	77,890,977	7,289,728
Inpatient	91,080,658	97,071,689	98,069,526	109,860,804	396,082,677	33,857,875
Reinsurance Expense	324,349	347,257	337,661	337,245	1,346,512	269,619
Outpatient Hospital	44,304,385	41,034,136	46,542,079	45,089,064	176,969,664	16,019,765
Other Medical	80,881,278	88,283,888	93,132,007	95,537,563	357,834,737	30,295,617
Pay for Performance Quality Incentive	1,851,974	1,825,698	1,809,795	1,814,852	7,302,318	606,662
Risk Corridor Expense	-	-	2,133,095	(960,173)	1,172,922	-
Hospital Directed Payments	74,715,152	73,085,162	73,636,849	74,054,842	295,492,005	59,831,392
Hospital Directed Payment Adjustment	2,663,543	18,927	(6,489,175)	(45,264)	(3,851,969)	103,134,648
Non-Claims Expense Adjustment	356,533	(22,398)	(4,294,448)	(1,489,159)	(5,449,472)	15,749
IBNR, Incentive, Paid Claims Adjustment	622,759	(7,444,944)	(6,331,814)	(3,892,128)	(17,046,128)	22,696
Total Medical Costs	447,039,796	444,630,994	445,718,563	476,072,247	1,813,461,599	298,922,038
GROSS MARGIN	146,377,973	143,243,720	285,224,619	187,474,687	762,320,998	67,581,799
ADMINISTRATIVE COSTS						
Compensation	10,509,085	10,907,085	11,047,726	12,349,629	44,813,525	4,200,484
Purchased Services	5,448,763	5,076,649	6,652,421	6,570,351	23,748,184	1,498,800
Supplies	764,751	722,573	707,109	693,365	2,887,797	95,074
Depreciation	2,040,936	2,164,109	2,283,774	2,071,812	8,560,631	812,433
Other Administrative Expenses	1,644,704	1,714,820	1,588,772	1,848,717	6,797,014	883,740
Administrative Expense Adjustment	96,938	22,381	(2,309)	1,230,808	1,347,818	202,969
Total Administrative Expenses	20,505,176	20,607,617	22,277,493	24,764,681	88,154,968	7,693,499
TOTAL EXPENSES	467,544,972	465,238,611	467,996,056	500,836,928	1,901,616,568	306,615,537
OPERATING INCOME (LOSS) BEFORE TAX	125,872,796	122,636,102	262,947,125	162,710,007	674,166,030	59,888,301
MCO TAX	118,164,689	118,164,689	304,000,610	169,305,625	709,635,614	59,136,301
OPERATING INCOME (LOSS) NET OF TAX	7,708,107	4,471,413	(41,053,485)	(6,595,619)	(35,469,584)	751,999
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	(2,207,215)	(3,489,571)	(1,249,113)	(4,205,257)	(11,151,156)	(623,936)
NET INCREASE (DECREASE) IN NET POSITION	5,500,891	981,842	(42,302,598)	(10,800,875)	(46,620,740)	128,064
MEDICAL LOSS RATIO	92.9%	93.6%	104.5%	95.7%	96.5%	94.2%
ADMINISTRATIVE EXPENSE RATIO	5.2%	5.2%	6.2%	5.9%	5.6%	5.3%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS PMPM
FOR THE MONTH ENDED JANUARY 31, 2025

	2024 - Q1	2024 - Q2	2024 - Q3	2024 - Q4	Rolling Quarter Totals	CURRENT QUARTER 2025 - Q1
Total Members - MCAL	1,234,656	1,217,132	1,204,552	1,209,901	4,866,241	404,441
REVENUES						
Medicaid - Family and Other	201.11	209.43	197.65	228.42	209.12	225.97
Medicaid - Expansion Members	401.13	409.54	343.25	428.47	395.87	423.70
Medicaid - SPD Members	1,042.58	1,068.92	918.71	1,039.89	1,017.02	818.92
Medicaid - LTC Members	8,123.78	8,200.06	7,764.35	8,050.44	8,032.97	-
Premium - MCO Tax	95.71	97.08	252.38	139.93	145.83	146.22
Premium - Hospital Directed Payments	60.51	60.05	61.13	61.21	60.72	147.94
Investment Earnings And Other Income	5.29	6.27	8.82	5.26	6.40	4.28
Rate Adjustments - Hospital Directed Payments	2.13	(0.38)	(7.35)	(0.04)	(1.38)	255.01
Rate/Income Adjustments	2.72	(4.15)	1.92	0.02	0.13	1.29
Total Revenues	480.63	483.00	606.82	548.43	529.32	906.20
EXPENSES						
MEDICAL COSTS						
Physician Services	75.41	84.02	83.71	97.46	85.10	89.34
Other Professional Services	30.67	23.74	22.63	14.53	22.93	28.30
Emergency Room	15.60	15.84	15.84	16.75	16.01	18.02
Inpatient	73.77	79.75	81.42	90.80	81.39	83.72
Reinsurance Expense	0.26	0.29	0.28	0.28	0.28	0.67
Outpatient Hospital	35.88	33.71	38.64	37.27	36.37	39.61
Other Medical	65.51	72.53	77.32	78.96	73.53	74.91
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.50	1.50
Hospital Directed Payments	60.51	60.05	61.13	61.21	60.72	147.94
Hospital Directed Payment Adjustment	2.16	0.02	(5.39)	(0.04)	(0.79)	255.01
Non-Claims Expense Adjustment	0.29	(0.02)	(3.57)	(1.23)	(1.12)	0.04
IBNR, Incentive, Paid Claims Adjustment	0.50	(6.12)	(5.26)	(3.22)	(3.50)	0.06
Total Medical Costs	362.08	365.31	370.03	393.48	372.66	739.10
GROSS MARGIN	118.56	117.69	236.79	154.95	156.66	167.10
ADMINISTRATIVE COSTS						
Compensation	8.51	8.96	9.17	10.21	9.21	10.39
Purchased Services	4.41	4.17	5.52	5.43	4.88	3.71
Supplies	0.62	0.59	0.59	0.57	0.59	0.24
Depreciation	1.65	1.78	1.90	1.71	1.76	2.01
Other Administrative Expenses	1.33	1.41	1.32	1.53	1.40	2.19
Administrative Expense Adjustment	0.08	0.02	(0.00)	1.02	0.28	0.50
Total Administrative Expenses	16.61	16.93	18.49	20.47	18.12	19.02
TOTAL EXPENSES	378.68	382.24	388.52	413.95	390.78	758.12
OPERATING INCOME (LOSS) BEFORE TAX	101.95	100.76	218.29	134.48	138.54	148.08
MCO TAX	95.71	97.08	252.38	139.93	145.83	146.22
OPERATING INCOME (LOSS) NET OF TAX	6.24	3.67	(34.08)	(5.45)	(7.29)	1.86
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	(1.79)	(2.87)	(1.04)	(3.48)	(2.29)	(1.54)
NET INCREASE (DECREASE) IN NET POSITION	4.46	0.81	(35.12)	(8.93)	(9.58)	0.32
MEDICAL LOSS RATIO	92.9%	93.6%	104.5%	95.7%	96.5%	94.2%
ADMINISTRATIVE EXPENSE RATIO	5.2%	5.2%	6.2%	5.9%	5.6%	5.3%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
ROLLING 6 MONTHS
FOR THE MONTH ENDED JANUARY 31, 2025

	JULY 2024	AUGUST 2024	SEPTEMBER 2024	OCTOBER 2024	NOVEMBER 2024	DECEMBER 2024	Prior 6 Month YTD	JANUARY 2025
Total Members - MCAL	402,008	400,588	401,956	402,241	403,549	404,440	2,414,782	404,441
REVENUES								
Medicaid - Family and Other	54,814,574	55,394,125	47,143,352	55,766,852	62,628,897	63,457,995	339,205,795	54,779,472
Medicaid - Expansion Members	45,242,639	44,943,353	25,578,416	44,274,896	47,452,486	54,963,125	262,454,915	48,572,760
Medicaid - SPD Members	24,362,723	24,068,270	15,514,183	23,582,809	24,507,942	24,524,681	136,560,608	38,799,459
Medicaid - LTC Members	4,316,218	4,169,310	3,673,451	4,161,018	4,337,441	4,180,989	24,838,426	-
Premium - MCO Tax	39,388,230	39,388,230	225,224,150	59,470,965	59,673,120	50,161,540	473,306,235	59,136,301
Premium - Hospital Directed Payments	24,576,449	24,409,832	24,650,569	24,613,116	24,699,036	24,742,689	147,691,691	59,831,392
Investment Earnings And Other Income	3,396,336	3,597,586	3,630,475	2,035,919	2,147,703	2,179,759	16,987,778	1,729,314
Reinsurance Recoveries	-	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	(6,686,334)	5,409	(2,168,580)	(55,251)	17,404	(7,417)	(8,894,770)	103,134,648
Rate/Income Adjustments	594,484	117,732	1,598,001	102,639	239,543	(312,962)	2,339,438	520,492
Total Revenues	190,005,318	196,093,846	344,844,017	213,952,963	225,703,571	223,890,400	1,394,490,116	366,503,837
EXPENSES								
MEDICAL COSTS								
Physician Services	32,448,391	34,358,210	34,021,968	42,641,203	37,671,697	37,607,514	218,748,983	36,132,491
Other Professional Services	8,910,610	9,280,419	9,068,160	(3,203,582)	9,971,766	10,811,656	44,839,030	11,445,798
Emergency Room	6,362,602	6,439,132	6,283,494	7,576,830	6,638,555	6,048,961	39,349,575	7,289,728
Inpatient	32,835,724	32,643,856	32,589,946	33,979,229	37,175,106	38,706,469	207,930,330	33,857,875
Reinsurance Expense	113,134	111,965	112,562	111,767	112,931	112,548	674,906	269,619
Outpatient Hospital	16,572,741	15,115,990	14,853,348	15,182,189	14,401,513	15,505,363	91,631,143	16,019,765
Other Medical	28,667,716	31,087,518	33,376,773	34,893,013	31,812,311	28,832,240	188,669,571	30,295,617
Pay for Performance Quality Incentive	603,012	603,849	602,934	603,362	604,830	606,660	3,624,647	606,662
Risk Corridor Expense	-	-	2,133,095	(1,390,990)	-	430,817	1,172,922	-
Hospital Directed Payments	24,576,449	24,409,832	24,650,569	24,613,116	24,699,036	24,742,689	147,691,691	59,831,392
Hospital Directed Payment Adjustment	(6,679,802)	5,409	185,219	(55,251)	17,404	(7,417)	(6,534,439)	103,134,648
Non-Claims Expense Adjustment	1,831	(3,882,116)	(414,162)	(329)	(1,490,761)	1,931	(5,783,607)	15,749
IBNR, Incentive, Paid Claims Adjustment	(2,330,513)	(2,153,708)	(1,847,593)	905,899	277,697	(5,075,723)	(10,223,942)	22,696
Total Medical Costs	142,081,895	148,020,355	155,616,313	155,856,455	161,892,084	158,323,708	921,790,810	298,922,038
GROSS MARGIN	47,923,423	48,073,491	189,227,704	58,096,509	63,811,487	65,566,692	472,699,306	67,581,799
ADMINISTRATIVE COSTS								
Compensation	3,719,030	3,883,154	3,445,542	3,800,976	4,154,887	4,393,765	23,397,355	4,200,484
Purchased Services	2,266,065	2,446,404	1,939,952	1,959,335	1,661,091	2,949,925	13,222,771	1,498,800
Supplies	406,426	102,708	197,976	250,386	133,675	309,304	1,400,474	95,074
Depreciation	704,955	703,523	875,296	718,614	691,764	661,433	4,355,586	812,433
Other Administrative Expenses	608,392	453,737	526,643	706,468	608,620	533,629	3,437,489	883,740
Administrative Expense Adjustment	-	(2,444)	135	0	(2,230)	1,233,038	1,228,499	202,969
Total Administrative Expenses	7,704,868	7,587,082	6,985,543	7,435,779	7,247,808	10,081,094	47,042,174	7,693,499
TOTAL EXPENSES	149,786,762	155,607,437	162,601,856	163,292,234	169,139,892	168,404,802	968,832,984	306,615,537
OPERATING INCOME (LOSS) BEFORE TAX	40,218,556	40,486,409	182,242,161	50,660,730	56,563,679	55,485,598	425,657,132	59,888,301
MCO TAX	39,388,230	39,388,230	225,224,150	59,470,965	59,673,120	50,161,540	473,306,235	59,136,301
OPERATING INCOME (LOSS) NET OF TAX	830,326	1,098,179	(42,981,989)	(8,810,236)	(3,109,441)	5,324,058	(47,649,103)	751,999
NON-OPERATING REVENUE (EXPENSE)								
Total Non-Operating Revenue (Expense)	(507,411)	(235,639)	(506,063)	(1,781,820)	(834,074)	(1,589,363)	(5,454,370)	(623,936)
NET INCREASE (DECREASE) IN NET POSITION	322,915	862,540	(43,488,053)	(10,592,056)	(3,943,514)	3,734,694	(53,103,473)	128,064
MEDICAL LOSS RATIO	93.6%	93.4%	134.6%	101.1%	97.1%	89.7%	99.8%	94.2%
ADMINISTRATIVE EXPENSE RATIO	5.8%	5.7%	7.2%	5.7%	5.1%	6.8%	6.0%	5.3%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
PMPM ROLLING 6 MONTHS
FOR THE MONTH ENDED JANUARY 31, 2025

KERN HEALTH SYSTEMS

	JULY 2024	AUGUST 2024	SEPTEMBER 2024	OCTOBER 2024	NOVEMBER 2024	DECEMBER 2024	6 Month Prior YTD	JANUARY 2025
Total Members - MCAL	402,008	400,588	401,956	402,241	403,549	404,440	2,414,782	404,441
REVENUES								
Medicaid - Family and Other	205.88	209.27	177.79	210.36	236.28	238.59	213.03	225.97
Medicaid - Expansion Members	401.84	402.95	226.08	390.42	414.85	479.73	386.18	423.70
Medicaid - SPD Members	1,075.66	1,010.30	670.71	1,016.41	1,054.01	1,049.14	979.40	818.92
Medicaid - LTC Members	8,284.49	7,987.18	7,023.81	7,850.98	8,309.27	7,994.24	7,907.81	-
Premium - MCO Tax	97.98	98.33	560.32	147.85	147.87	124.03	196.00	146.22
Premium - Hospital Directed Payments	61.13	60.94	61.33	61.19	61.20	61.18	61.16	147.94
Investment Earnings And Other Income	8.45	8.98	9.03	5.06	5.32	5.39	7.03	4.28
Rate Adjustments - Hospital Directed Payments	(16.63)	0.01	(5.40)	(0.14)	0.04	(0.02)	(3.68)	255.01
Rate/Income Adjustments	1.48	0.29	3.98	0.26	0.59	(0.77)	0.97	1.29
Total Revenues	472.64	489.52	857.91	531.90	559.30	553.58	577.48	906.20
EXPENSES								
MEDICAL COSTS								
Physician Services	80.72	85.77	84.64	106.01	93.35	92.99	90.59	89.34
Other Professional Services	22.17	23.17	22.56	(7.96)	24.71	26.73	18.57	28.30
Emergency Room	15.83	16.07	15.63	18.84	16.45	14.96	16.30	18.02
Inpatient	81.68	81.49	81.08	84.47	92.12	95.70	86.11	83.72
Reinsurance Expense	0.28	0.28	0.28	0.28	0.28	0.28	0.28	0.67
Outpatient Hospital	41.22	37.73	36.95	37.74	35.69	38.34	37.95	39.61
Other Medical	71.31	77.60	83.04	86.75	78.83	71.29	78.13	74.91
Pay for Performance Quality Incentive	1.50	1.51	1.50	1.50	1.50	1.50	1.50	1.50
Hospital Directed Payments	61.13	60.94	61.33	61.19	61.20	61.18	61.16	147.94
Hospital Directed Payment Adjustment	(16.62)	0.01	0.46	(0.14)	0.04	(0.02)	(2.71)	255.01
Non-Claims Expense Adjustment	0.00	(9.69)	(1.03)	(0.00)	(3.69)	0.00	(2.40)	0.04
IBNR, Incentive, Paid Claims Adjustment	(5.80)	(5.38)	(4.60)	2.25	0.69	(12.55)	(4.23)	0.06
Total Medical Costs	353.43	369.51	387.15	387.47	401.17	391.46	381.73	739.10
GROSS MARGIN	119.21	120.01	470.77	144.43	158.13	162.12	195.75	167.10
ADMINISTRATIVE COSTS								
Compensation	9.25	9.69	8.57	9.45	10.30	10.86	9.69	10.39
Purchased Services	5.64	6.11	4.83	4.87	4.12	7.29	5.48	3.71
Supplies	1.01	0.26	0.49	0.62	0.33	0.76	0.58	0.24
Depreciation	1.75	1.76	2.18	1.79	1.71	1.64	1.80	2.01
Other Administrative Expenses	1.51	1.13	1.31	1.76	1.51	1.32	1.42	2.19
Administrative Expense Adjustment	-	(0.01)	0.00	0.00	(0.01)	3.05	0.51	0.50
Total Administrative Expenses	19.17	18.94	17.38	18.49	17.96	24.93	19.48	19.02
TOTAL EXPENSES	372.60	388.45	404.53	405.96	419.13	416.39	401.21	758.12
OPERATING INCOME (LOSS) BEFORE TAX	100.04	101.07	453.39	125.95	140.17	137.19	176.27	148.08
MCO TAX	97.98	98.33	560.32	147.85	147.87	124.03	196.00	146.22
OPERATING INCOME (LOSS) NET OF TAX	2.07	2.74	(106.93)	(21.90)	(7.71)	13.16	(19.73)	1.86
NON-OPERATING REVENUE (EXPENSE)								
Total Non-Operating Revenue (Expense)	(1.26)	(0.59)	(1.26)	(4.43)	(2.07)	(3.93)	(2.26)	(1.54)
NET INCREASE (DECREASE) IN NET POSITION	0.80	2.15	(108.19)	(26.33)	(9.77)	9.23	(21.99)	0.32
MEDICAL LOSS RATIO	93.6%	93.4%	134.6%	101.1%	97.1%	89.7%	99.8%	94.2%
ADMINISTRATIVE EXPENSE RATIO	5.8%	5.7%	7.2%	5.7%	5.1%	6.8%	6.0%	5.3%

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Budget	Variance	Year to Date	Budget	Variance
REVENUES						
Premium - Medi-Cal	47,363,308	48,069,532	(706,224)	47,363,308	48,069,532	(706,224)
Premium - Maternity Kick	3,443,250	3,340,876	102,374	3,443,250	3,340,876	102,374
Premium - Enhanced Care Management	2,125,064	1,743,563	381,501	2,125,064	1,743,563	381,501
Premium - Major Organ Transplant	160,356	236,180	(75,824)	160,356	236,180	(75,824)
Premium - Provider Enhancement	1,429,771	1,162,803	266,967	1,429,771	1,162,803	266,967
Premium - GEMT	160,977	181,103	(20,126)	160,977	181,103	(20,126)
Premium - Cal AIM	-	-	-	-	-	-
Premium - Student Behavioral Health Incentive	-	-	-	-	-	-
Premium - Housing and Homelessness Incentive	-	-	-	-	-	-
Premium - Equity & Practice Transformation	-	-	-	-	-	-
Premium - Distinct Part Nursing Facility	-	-	-	-	-	-
Other	96,746	106,920	(10,174)	96,746	106,920	(10,174)
TOTAL MEDICAID - FAMILY & OTHER	54,779,472	54,840,976	(61,504)	54,779,472	54,840,976	(61,504)
Premium - Medi-Cal	44,855,744	44,592,454	263,290	44,855,744	44,592,454	263,290
Premium - Maternity Kick	564,968	442,636	122,332	564,968	442,636	122,332
Premium - Enhanced Care Management	2,153,257	1,778,641	374,616	2,153,257	1,778,641	374,616
Premium - Major Organ Transplant	285,237	422,945	(137,708)	285,237	422,945	(137,708)
Premium - Provider Enhancement	430,414	364,845	65,569	430,414	364,845	65,569
Premium - GEMT	236,976	261,525	(24,549)	236,976	261,525	(24,549)
Premium - Cal AIM	-	-	-	-	-	-
Premium - Student Behavioral Health Incentive	-	-	-	-	-	-
Premium - Housing and Homelessness Incentive	-	-	-	-	-	-
Premium - Equity & Practice Transformation	-	-	-	-	-	-
Premium - Distinct Part Nursing Facility	-	-	-	-	-	-
Other	46,164	49,720	(3,556)	46,164	49,720	(3,556)
TOTAL MEDICAID - EXPANSION MEMBERS	48,572,760	47,912,766	659,994	48,572,760	47,912,766	659,994
Premium - Medi-Cal	37,081,984	38,844,033	(1,762,049)	37,081,984	38,844,033	(1,762,049)
Premium - Enhanced Care Management	1,403,572	1,014,864	388,708	1,403,572	1,014,864	388,708
Premium - Major Organ Transplant	125,409	341,085	(215,676)	125,409	341,085	(215,676)
Premium - Provider Enhancement	35,647	28,525	7,122	35,647	28,525	7,122
Premium - GEMT	151,476	173,842	(22,366)	151,476	173,842	(22,366)
Premium - Cal AIM	-	-	-	-	-	-
Premium - Student Behavioral Health Incentive	-	-	-	-	-	-
Premium - Housing and Homelessness Incentive	-	-	-	-	-	-
Premium - Equity & Practice Transformation	-	-	-	-	-	-
Premium - Distinct Part Nursing Facility	1,259	-	1,259	1,259	-	1,259
Other	112	112	-	112	112	-
TOTAL MEDICAID - SPD MEMBERS	38,799,459	40,402,462	(1,603,003)	38,799,459	40,402,462	(1,603,003)

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Year to Date
REVENUES		
Premium - Medi-Cal	47,363,308	47,363,308
Premium - Maternity Kick	3,443,250	3,443,250
Premium - Enhanced Care Management	2,125,064	2,125,064
Premium - Major Organ Transplant	160,356	160,356
Premium - Provider Enhancement	1,429,771	1,429,771
Premium - GEMT	160,977	160,977
Premium - Cal AIM	-	-
Premium - Student Behavioral Health Incentive	-	-
Premium - Housing and Homelessness Incentive	-	-
Premium - Equity & Practice Transformation	-	-
Premium - Distinct Part Nursing Facility	-	-
Other	96,746	96,746
TOTAL MEDICAID - FAMILY & OTHER	54,779,472	54,779,472
Premium - Medi-Cal	44,855,744	44,855,744
Premium - Maternity Kick	564,968	564,968
Premium - Enhanced Care Management	2,153,257	2,153,257
Premium - Major Organ Transplant	285,237	285,237
Premium - Provider Enhancement	430,414	430,414
Premium - GEMT	236,976	236,976
Premium - Cal AIM	-	-
Premium - Student Behavioral Health Incentive	-	-
Premium - Housing and Homelessness Incentive	-	-
Premium - Equity & Practice Transformation	-	-
Premium - Distinct Part Nursing Facility	-	-
Other	46,164	46,164
TOTAL MEDICAID - EXPANSION MEMBERS	48,572,760	48,572,760
Premium - Medi-Cal	37,081,984	37,081,984
Premium - Enhanced Care Management	1,403,572	1,403,572
Premium - Major Organ Transplant	125,409	125,409
Premium - Provider Enhancement	35,647	35,647
Premium - GEMT	151,476	151,476
Premium - Cal AIM	-	-
Premium - Student Behavioral Health Incentive	-	-
Premium - Housing and Homelessness Incentive	-	-
Premium - Equity & Practice Transformation	-	-
Premium - Distinct Part Nursing Facility	1,259	1,259
Other	112	112
TOTAL MEDICAID - SPD MEMBERS	38,799,459	38,799,459

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Budget	Variance	Year to Date	Budget	Variance
Physician Services						
Primary Care Physician Services	6,633,777	8,104,707	1,470,930	6,633,777	8,104,707	1,470,930
Referral Specialty Services	25,541,006	24,793,615	(747,391)	25,541,006	24,793,615	(747,391)
Urgent Care & After Hours Advice	3,948,407	3,797,582	(150,826)	3,948,407	3,797,582	(150,826)
Hospital Admitting Team	9,300	9,300	-	9,300	9,300	-
Total Physician Services	36,132,491	36,705,204	572,714	36,132,491	36,705,204	572,714
Other Professional Services						
Vision Service Capitation	344,606	362,700	18,094	344,606	362,700	18,094
221 - Business Intelligence	211,963	192,767	(19,197)	211,963	192,767	(19,197)
310 - Health Servcies - Utilization Management	826,640	774,403	(52,237)	826,640	774,403	(52,237)
311 - Health Services - Quality Improvement	306,121	285,794	(20,327)	306,121	285,794	(20,327)
312 - Health Services Education	321,705	356,025	34,319	321,705	356,025	34,319
313 - Pharmacy	140,301	127,750	(12,551)	140,301	127,750	(12,551)
314 - Enhanced Care Management	411,824	395,113	(16,711)	411,824	395,113	(16,711)
316 - Population Health Management	593,720	609,948	16,228	593,720	609,948	16,228
317 - In Lieu of Services	134,223	130,077	(4,147)	134,223	130,077	(4,147)
321 - Homeless Management Information Services	44,251	42,524	(1,727)	44,251	42,524	(1,727)
330 - Member Services	1,080,746	1,086,008	5,261	1,080,746	1,086,008	5,261
331 - Member Outreach	83,414	251,939	168,525	83,414	251,939	168,525
410 - Member Engagement	59,841	105,462	45,621	59,841	105,462	45,621
601 - Behavioral Health	170,807	176,756	5,949	170,807	176,756	5,949
602 - Quality & Health Equity	82,237	82,029	(208)	82,237	82,029	(208)
604 - Clinical Operations, Strategy, and Analytics	142,213	134,693	(7,520)	142,213	134,693	(7,520)
605 - Quality Performance	154,331	186,664	32,333	154,331	186,664	32,333
Behavior Health Treatment	3,181,908	2,817,797	(364,111)	3,181,908	2,817,797	(364,111)
Mental Health Services	974,251	677,548	(296,703)	974,251	677,548	(296,703)
Other Professional Services	2,180,697	2,034,956	(145,740)	2,180,697	2,034,956	(145,740)
Total Other Professional Services	11,445,798	10,830,950	(614,849)	11,445,798	10,830,950	(614,849)
Emergency Room	7,289,728	6,778,581	(511,147)	7,289,728	6,778,581	(511,147)
Inpatient Hospital	33,857,875	33,932,293	74,418	33,857,875	33,932,293	74,418
Reinsurance Expense Premium	269,619	273,046	3,427	269,619	273,046	3,427
Outpatient Hospital	16,019,765	15,406,417	(613,348)	16,019,765	15,406,417	(613,348)
Other Medical						
Ambulance and NEMT	5,965,805	5,043,028	(922,776)	5,965,805	5,043,028	(922,776)
Home Health Services & CBAS	1,636,266	1,318,326	(317,940)	1,636,266	1,318,326	(317,940)
Utilization and Quality Review Expenses	936,126	1,811,792	875,665	936,126	1,811,792	875,665
Long Term/SNF/Hospice	10,523,545	11,515,130	991,586	10,523,545	11,515,130	991,586
Provider Enhancement Expense - Prop. 56	1,801,039	1,643,514	(157,525)	1,801,039	1,478,365	(322,675)
Provider Enhancement Expense - GEMT	549,430	420,497	(128,933)	549,430	585,646	36,217
Enhanced Care Management	5,134,027	4,310,215	(823,813)	5,134,027	4,310,215	(823,813)
Community Support Services	590,845	-	(590,845)	590,845	-	(590,845)
Major Organ Transplant	542,452	950,199	407,747	542,452	950,199	407,747
Cal AIM Incentive Programs	275,000	-	(275,000)	275,000	-	(275,000)
Student Behavioral Health Incentive	-	-	-	-	-	-
Housing and Homelessness Incentive	-	-	-	-	-	-
Distinct Part Nursing Facility Expense	1,259	-	(1,259)	1,259	-	(1,259)
Equity & Practice Transformation Expense	-	-	-	-	-	-
DME/Rebates	2,339,823	1,982,539	(357,284)	2,339,823	1,982,539	(357,284)
Total Other Medical	30,295,617	28,995,240	(1,300,377)	30,295,617	28,995,240	(1,300,377)
Pay for Performance Quality Incentive	606,662	604,508	(2,153)	606,662	604,508	(2,153)
Risk Corridor Expense	-	-	-	-	-	-
Hospital Directed Payments	59,831,392	24,307,910	(35,523,482)	59,831,392	24,307,910	(35,523,482)
Hospital Directed Payment Adjustment	103,134,648	-	(103,134,648)	103,134,648	-	(103,134,648)
Non-Claims Expense Adjustment	15,749	-	(15,749)	15,749	-	(15,749)
IBNR, Incentive, Paid Claims Adjustment	22,696	-	(22,696)	22,696	-	(22,696)
Total Medical Costs	298,922,038	157,834,150	(141,087,888)	298,922,038	157,834,150	(141,087,888)

* MEDICAL COSTS PER DMHC REGULATIONS

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Budget	Variance	Year to Date	Budget	Variance
TOTAL MEMBERS - MCAL	404,441	403,000	1,441	404,441	403,000	1,441
Physician Services						
Primary Care Physician Services	16.40	20.11	3.71	16.40	20.11	3.71
Referral Specialty Services	63.15	61.52	(1.63)	63.15	61.52	(1.63)
Urgent Care & After Hours Advice	9.76	9.42	(0.34)	9.76	9.42	(0.34)
Hospital Admitting Team	0.02	0.02	0.00	0.02	0.02	0.00
Total Physician Services	89.34	91.08	1.74	89.34	91.08	1.74
Other Professional Services						
Vision Service Capitation	0.85	0.90	0.05	0.85	0.90	0.05
221 - Business Intelligence	0.52	0.48	(0.05)	0.52	0.48	(0.05)
310 - Health Servcies - Utilization Management	2.04	1.92	(0.12)	2.04	1.92	(0.12)
311 - Health Services - Quality Improvement	0.76	0.71	(0.05)	0.76	0.71	(0.05)
312 - Health Services Education	0.80	0.88	0.09	0.80	0.88	0.09
313 - Pharmacy	0.35	0.32	(0.03)	0.35	0.32	(0.03)
314 - Enhanced Care Management	1.02	0.98	(0.04)	1.02	0.98	(0.04)
316 - Population Health Management	1.47	1.51	0.05	1.47	1.51	0.05
317 - In Lieu of Services	0.33	0.32	(0.01)	0.33	0.32	(0.01)
321 - Homeless Management Information Services	0.11	0.11	(0.00)	0.11	0.11	(0.00)
330 - Member Services	2.67	2.69	0.02	2.67	2.69	0.02
331 - Member Outreach	0.21	0.63	0.42	0.21	0.63	0.42
410 - Member Engagement	0.15	0.26	0.11	0.15	0.26	0.11
601 - Behavioral Health	0.42	0.44	0.02	0.42	0.44	0.02
602 - Quality & Health Equity	0.20	0.20	0.00	0.20	0.20	0.00
604 - Clinical Operations, Strategy, and Analytics	0.35	0.33	(0.02)	0.35	0.33	(0.02)
605 - Quality Performance	0.38	0.46	0.08	0.38	0.46	0.08
Behavior Health Treatment	7.87	6.99	(0.88)	7.87	6.99	(0.88)
Mental Health Services	2.41	1.68	(0.73)	2.41	1.68	(0.73)
Other Professional Services	5.39	5.05	(0.34)	5.39	5.05	(0.34)
Total Other Professional Services	28.30	26.88	(1.42)	28.30	26.88	(1.42)
Emergency Room	18.02	16.82	(1.20)	18.02	16.82	(1.20)
Inpatient Hospital	83.72	84.20	0.48	83.72	84.20	0.48
Reinsurance Expense Premium	0.67	0.68	0.01	0.67	0.68	0.01
Outpatient Hospital	39.61	38.23	(1.38)	39.61	38.23	(1.38)
Other Medical						
Ambulance and NEMT	14.75	12.51	(2.24)	14.75	12.51	(2.24)
Home Health Services & CBAS	4.05	3.27	(0.77)	4.05	3.27	(0.77)
Utilization and Quality Review Expenses	2.31	4.50	2.18	2.31	4.50	2.18
Long Term/SNF/Hospice	26.02	28.57	2.55	26.02	28.57	2.55
Provider Enhancement Expense - Prop. 56	4.45	4.08	(0.37)	4.45	3.67	(0.78)
Provider Enhancement Expense - GEMT	1.36	1.04	(0.32)	1.36	1.45	0.09
Enhanced Care Management	12.69	10.70	(2.00)	12.69	10.70	(2.00)
Major Organ Transplant	1.34	2.36	1.02	1.34	2.36	1.02
Cal AIM Incentive Programs	0.68	-	(0.68)	0.68	-	(0.68)
Student Behavioral Health Incentive	-	-	-	-	-	-
Housing and Homelessness Incentive	-	-	-	-	-	-
Distinct Part Nursing Facility Expense	0.00	-	(0.00)	0.00	-	(0.00)
DME/Rebates	5.79	4.92	(0.87)	5.79	4.92	(0.87)
Total Other Medical	73.45	71.95	(1.50)	73.45	71.95	(1.50)
Pay for Performance Quality Incentive	1.50	1.50	0.00	1.50	1.50	0.00
Hospital Directed Payments	147.94	60.32	(87.62)	147.94	60.32	(87.62)
Hospital Directed Payment Adjustment	255.01	-	(255.01)	255.01	-	(255.01)
Non-Claims Expense Adjustment	0.04	-	(0.04)	0.04	-	(0.04)
IBNR, Incentive, Paid Claims Adjustment	0.06	-	(0.06)	0.06	-	(0.06)
Total Medical Costs	737.64	391.65	(345.99)	737.64	391.65	(345.99)

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Year to Date
Physician Services		
Primary Care Physician Services	6,633,777	6,633,777
Referral Specialty Services	25,541,006	25,541,006
Urgent Care & After Hours Advice	3,948,407	3,948,407
Hospital Admitting Team	9,300	9,300
Total Physician Services	36,132,491	36,132,491
Other Professional Services		
Vision Service Capitation	344,606	344,606
221 - Business Intelligence	211,963	211,963
310 - Health Servcies - Utilization Management	826,640	826,640
311 - Health Services - Quality Improvement	306,121	306,121
312 - Health Services Education	321,705	321,705
313 - Pharmacy	140,301	140,301
314 - Enhanced Care Management	411,824	411,824
316 - Population Health Management	593,720	593,720
317 - In Lieu of Services	134,223	134,223
321 - Homeless Management Information Services	44,251	44,251
330 - Member Services	1,080,746	1,080,746
331 - Member Outreach	83,414	83,414
410 - Member Engagement	59,841	59,841
601 - Behavioral Health	170,807	170,807
602 - Quality & Health Equity	82,237	82,237
604 - Clinical Operations, Strategy, and Analytics	142,213	142,213
605 - Quality Performance	154,331	154,331
Behavior Health Treatment	3,181,908	3,181,908
Mental Health Services	974,251	974,251
Other Professional Services	2,180,697	2,180,697
Total Other Professional Services	11,445,798	11,445,798
Emergency Room	7,289,728	7,289,728
Inpatient Hospital	33,857,875	33,857,875
Reinsurance Expense Premium	269,619	269,619
Outpatient Hospital	16,019,765	16,019,765
Other Medical		
Ambulance and NEMT	5,965,805	5,965,805
Home Health Services & CBAS	1,636,266	1,636,266
Utilization and Quality Review Expenses	936,126	936,126
Long Term/SNF/Hospice	10,523,545	10,523,545
Provider Enhancement Expense - Prop. 56	1,801,039	1,801,039
Provider Enhancement Expense - GEMT	549,430	549,430
Enhanced Care Management	5,134,027	5,134,027
Community Support Services	590,845	590,845
Major Organ Transplant	542,452	542,452
Cal AIM Incentive Programs	275,000	275,000
Student Behavioral Health Incentive	-	-
Housing and Homelessness Incentive	-	-
Distinct Part Nursing Facility Expense	1,259	1,259
Equity & Practice Transformation Expense	-	-
DME/Rebates	2,339,823	2,339,823
Total Other Medical	30,295,617	30,295,617
Pay for Performance Quality Incentive	606,662	606,662
Risk Corridor Expense	-	-
Hospital Directed Payments	59,831,392	59,831,392
Hospital Directed Payment Adjustment	103,134,648	103,134,648
Non-Claims Expense Adjustment	15,749	15,749
IBNR, Incentive, Paid Claims Adjustment	22,696	22,696
Total Medical Costs	298,922,038	298,922,038

* MEDICAL COSTS PER DMHC REGULATIONS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Year to Date
Physician Services		
Primary Care Physician Services	16.40	16.40
Referral Specialty Services	63.15	63.15
Urgent Care & After Hours Advice	9.76	9.76
Hospital Admitting Team	0.02	0.02
Total Physician Services	89.34	89.34
Other Professional Services		
Vision Service Capitation	0.85	0.85
221 - Business Intelligence	0.52	0.52
310 - Health Servcies - Utilization Management	2.04	2.04
311 - Health Services - Quality Improvement	0.76	0.76
312 - Health Services Education	0.80	0.80
313 - Pharmacy	0.35	0.35
314 - Enhanced Care Management	1.02	1.02
316 - Population Health Management	1.47	1.47
317 - In Lieu of Services	0.33	0.33
321 - Homeless Management Information Services	0.11	0.11
330 - Member Services	2.67	2.67
410 - Member Engagement	0.15	0.15
601 - Behavioral Health	0.42	0.42
602 - Quality & Health Equity	0.20	0.20
604 - Clinical Operations, Strategy, and Analytics	0.35	0.35
605 - Quality Performance	0.38	0.38
Behavior Health Treatment	7.87	7.87
Mental Health Services	2.41	2.41
Other Professional Services	5.39	5.39
Total Other Professional Services	28.30	28.30
Emergency Room	18.02	18.02
Inpatient Hospital	83.72	83.72
Reinsurance Expense Premium	0.67	0.67
Outpatient Hospital	39.61	39.61
Other Medical		
Ambulance and NEMT	14.75	14.75
Home Health Services & CBAS	4.05	4.05
Utilization and Quality Review Expenses	2.31	2.31
Long Term/SNF/Hospice	26.02	26.02
Provider Enhancement Expense - Prop. 56	4.45	4.45
Provider Enhancement Expense - GEMT	1.36	1.36
Enhanced Care Management	12.69	12.69
Community Support Services	1.34	1.34
Major Organ Transplant	1.34	1.34
Cal AIM Incentive Programs	0.68	0.68
Housing and Homelessness Incentive	-	-
Distinct Part Nursing Facility Expense	0.00	0.00
DME	5.79	5.79
Total Other Medical	74.79	74.79
Pay for Performance Quality Incentive	1.50	1.50
Risk Corridor Expense	-	-
Hospital Directed Payments	147.94	147.94
Hospital Directed Payment Adjustment	255.01	255.01
Non-Claims Expense Adjustment	0.04	0.04
IBNR, Incentive, Paid Claims Adjustment	0.06	0.06
Total Medical Costs	738.98	738.98

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED JANUARY 31, 2025

KERN HEALTH SYSTEMS

	January	Budget	Variance	Year to Date	Budget	Variance
110 - Executive	682,639	650,390	(32,249)	682,639	650,390	(32,249)
112 - Government Relations	64,745	62,942	(1,803)	64,745	62,942	(1,803)
210 - Accounting	373,730	370,068	(3,662)	373,730	370,068	(3,662)
220 - Management Information Systems (MIS)	354,906	508,775	153,869	354,906	508,775	153,869
221 - Business Intelligence	288,258	246,484	(41,774)	288,258	246,484	(41,774)
222 - MIS Development	390,138	515,722	125,584	390,138	515,722	125,584
223 - Enterprise Configuration	233,790	321,789	87,999	233,790	321,789	87,999
224 - Cyber Security	31,621	43,744	12,122	31,621	43,744	12,122
225 - Infrastructure	767,910	1,140,153	372,243	767,910	1,140,153	372,243
226 - Technical Administrative Services	70,628	94,102	23,474	70,628	94,102	23,474
230 - Claims	885,033	823,337	(61,696)	885,033	823,337	(61,696)
240 - Project Development	214,035	216,007	1,972	214,035	216,007	1,972
310 - Health Services - Utilization Management	30,019	50,148	20,129	30,019	50,148	20,129
311 - Health Services - Quality Improvement	(15,100)	11,596	26,696	(15,100)	11,596	26,696
312 - Health Services - Education	-	648	648	-	648	648
313 - Pharmacy	10,795	11,450	655	10,795	11,450	655
314 - Enhanced Care Management	18,954	22,583	3,628	18,954	22,583	3,628
316 - Population Health Management	103	2,454	2,352	103	2,454	2,352
317 - Community Support Services	-	3,150	3,150	-	3,150	3,150
318 - Housing & Homeless Incentive Program (HHIP)	-	-	-	-	-	-
319 - CAL AIM Incentive Payment Program (IPP)	-	-	-	-	-	-
320 - Provider Network Management	297,212	326,776	29,564	297,212	326,776	29,564
321 - Homeless Management Information Services	73	1,854	1,781	73	1,854	1,781
322 - Delegation & Oversight	50,538	30,422	(20,117)	50,538	30,422	(20,117)
330 - Member Services	174,446	229,310	54,864	174,446	229,310	54,864
331 - Member Outreach	-	-	-	-	-	-
340 - Corporate Services	1,085,693	1,128,044	42,351	1,085,693	1,128,044	42,351
360 - Audit & Investigative Services	286,424	306,189	19,765	286,424	306,189	19,765
410 - Member Engagement	67,809	62,873	(4,936)	67,809	62,873	(4,936)
420 - Sales/Marketing/Public Relations	139,774	329,532	189,757	139,774	329,532	189,757
510 - Human Resourses	727,474	460,498	(266,976)	727,474	460,498	(266,976)
520 - Legal	35,231	122,824	87,593	35,231	122,824	87,593
601 - Behavioral Health	307	3,350	3,043	307	3,350	3,043
602 - Quality & Health Equity	10,624	35,573	24,949	10,624	35,573	24,949
604 - Clinical Operations, Strategy & Analytics	-	662	662	-	662	662
605 - Quality Performance	212,721	116,048	(96,673)	212,721	116,048	(96,673)
Administrative Expense Adjustment	202,969	200,000	(2,969)	202,969	200,000	(2,969)
Total Administrative Expenses	7,693,499	8,449,496	755,997	7,693,499	8,449,496	755,997

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED JANUARY 31, 2025

	January	YTD TOTALS
110 - Executive	682,639	682,639
112 - Government Relations	64,745	64,745
210 - Accounting	373,730	373,730
220 - Management Information Systems (MIS)	354,906	354,906
221 - Business Intelligence	288,258	288,258
222 - MIS Development	390,138	390,138
223 - Enterprise Configuration	233,790	233,790
224 - Cyber Security	31,621	31,621
225 - Infrastructure	767,910	767,910
226 - Technical Administrative Services	70,628	70,628
230 - Claims	885,033	885,033
240 - Project Development	214,035	214,035
310 - Health Services - Utilization Management	30,019	30,019
311 - Health Services - Quality Improvement	(15,100)	(15,100)
312 - Health Services - Education	-	-
313 - Pharmacy	10,795	10,795
314 - Enhanced Care Management	18,954	18,954
316 - Population Health Management	103	103
317 - Community Support Services	-	-
318 - Housing & Homeless Incentive Program (HHIP)	-	-
319 - CAL AIM Incentive Payment Program (IPP)	-	-
320 - Provider Network Management	297,212	297,212
322 - Delegation & Oversight	50,538	50,538
330 - Member Services	174,446	174,446
340 - Corporate Services	1,085,693	1,085,693
360 - Audit & Investigative Services	286,424	286,424
410 - Member Engagement	67,809	67,809
420 - Sales/Marketing/Public Relations	139,774	139,774
510 - Human Resourses	727,474	727,474
520 - Legal	35,231	35,231
601 - Behavioral Health	307	307
602 - Quality & Health Equity	10,624	10,624
605 - Quality Performance	212,721	212,721
Administrative Expense Adjustment	202,969	202,969
Total Administrative Expenses	7,693,499	7,693,499

KHS - GROUP HEALTH PLAN
STATEMENT OF NET POSITION
AS OF JANUARY 31, 2025

ASSETS	January 2025	December 2024	Increase/ (Decrease)
Cash and Cash Equivalents	1,245,481	1,231,217	14,264
Interest Receivable	4,700	14,264	(9,564)
Other Receivable	125	125	-
Total Current Assets	1,250,306	1,245,606	4,700
CURRENT LIABILITIES			
Other Liabilities	-	-	-
Total Current Liabilities	-	-	-
NET POSITION:			
Net Position at Beginning of Year	1,245,606	1,183,678	61,928
Increase (Decrease) in Net Position - Current Year	4,700	61,928	(57,228)
Total Net Position	1,250,306	1,245,606	4,700
TOTAL LIABILITIES AND NET POSITION	1,250,306	1,245,606	4,700

KHS - GROUP HEALTH PLAN
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2025

	January	Budget	Variance	Year to Date	Budget	Variance
REVENUES						
Premium	-	-	-	-	-	-
Interest	4,700	-	4,700	4,700	-	4,700
Other Investment Income	-	-	-	-	-	-
Total Revenues	4,700	-	4,700	4,700	-	4,700
EXPENSES						
MEDICAL COSTS						
IBNR and Paid Claims Adjustment	-	-	-	-	-	-
Total Medical Costs	-	-	-	-	-	-
GROSS MARGIN	4,700	-	4,700	4,700	-	4,700
ADMINISTRATIVE COSTS						
Management Fee Expense and Other Admin Exp	-	-	-	-	-	-
Total Administrative Expenses	-	-	-	-	-	-
TOTAL EXPENSES	-	-	-	-	-	-
OPERATING INCOME (LOSS) BEFORE TAX	4,700	-	4,700	4,700	-	4,700
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	-	-	-	-	-	-
NET INCREASE (DECREASE) IN NET POSITION	4,700	-	4,700	4,700	-	4,700
MEDICAL LOSS RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ADMINISTRATIVE EXPENSE RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

MEDI-CAL	2025 MEMBER MONTHS	JAN'25	FEB'25	MAR'25	APR'25	MAY'25	JUN'25	JUL'25	AUG'25	SEP'25	OCT'25	NOV'25	DEC'25
ADULT AND FAMILY													
ADULT (SEE COMMENT)	**74,604**	74,604	0	0	0	0	0	0	0	0	0	0	0
CHILD	**167,252**	167,252	0	0	0	0	0	0	0	0	0	0	0
SUB-TOTAL ADULT & FAMILY	**241,856**	**241,856**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
OTHER MEMBERS													
FULL DUALS - FAMILY	**566**	566	0	0	0	0	0	0	0	0	0	0	0
FULL DUALS - CHILD	**0**	0	0	0	0	0	0	0	0	0	0	0	0
SUBTOTAL OTHER MEMBERS	**23,840**	**566**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FAMILY	**265,696**	**242,422**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SPD MEMBERS													
SPD (AGED AND DISABLED)	**23,226**	23,226	0	0	0	0	0	0	0	0	0	0	0
OTHER MEMBERS													
BCCTP - TABACCO SETTLEMENT	**0**	0	0	0	0	0	0	0	0	0	0	0	0
FULL DUALS - BCCTP	**2**	2	0	0	0	0	0	0	0	0	0	0	0
SPD FULL DUALS	**23,272**	23,272	0	0	0	0	0	0	0	0	0	0	0
EXPANDION FULL DUALS	**366**	*366*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
LONG TERM CARE (LTC)													
LTC	**48**	48	0	0	0	0	0	0	0	0	0	0	0
LTC DUALS	**465**	465	0	0	0	0	0	0	0	0	0	0	0
TOTAL LTC	**513**	**513**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL SPD	**47,379**	**47,379**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ACA OE - MEDI-CAL OPTIONAL EXPANSION													
ACA Expansion Adult-Citizen	**114,640**	*114,640*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
TOTAL EXPANSION	**114,640**	**114,640**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CLASSIC MEMBERS	**288,922**	**404,441**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
GRAND TOTAL	**404,075**	**404,441**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: Reports on Accounts Payable, Administrative Contracts and IT Technology Consulting Resources

DATE: April 17, 2025

Attached for your review are the following items:

1) Accounts Payable Vendor Report listing of payments over $20,000 for the months of December 2024 and January 2025.

2) Administrative Contract Report listing of contracts between $50,000 and $200,000 for the months of December 2024 and January 2025.

3) IT Technology Consulting Resources Report for the period ending December 31, 2024.

Requested Action

Receive and File.

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5466	ZIPARI, INC ****	1,127,911.82	1,150,911.82	JUN. 2024-DEC. 2025 MEMBER-PROVIDER PORTAL SUBSCRIPTION	MIS INFRASTRUCTURE
T1045	KAISER FOUNDATION HEALTH - HMO	889,624.10	10,267,478.33	DEC. 2024 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T1845	DEPARTMENT OF MANAGED HEALTH CARE	691,298.03	1,458,980.85	2024-2025 FINAL INSTALLMENT ANNL ASSESSMENT	ADMINISTRATION
T1408	DELL MARKETING L.P.	560,267.64	2,538,530.27	YR 3 EA TRUE UP & (46) LAPTOPS	MIS INFRASTRUCTURE
T4350	COMPUTER ENTERPRISE	515,680.93	6,945,125.54	OCT. & NOV. 2024 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T1180	LANGUAGE LINE SERVICES INC.	449,647.19	2,570,538.13	SEPT. & OCT. 2024 INTERPRETATION SERVICES	HEALTH SERVICES - WELLNESS & PREVENTION
T2704	MCG HEALTH LLC. ****	407,949.16	1,642,229.93	ANNUAL HEALTH CARE MANAGEMENT & SOFTWARE LICENSE	UTILIZATION MANAGEMENT
T4737	TEKSYSTEMS, INC.	188,292.00	3,371,028.05	NOV. 2024 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T5022	SVAM INTERNATIONAL INC	165,903.00	1,441,444.50	OCT. & NOV. 2024 PROFESSIONAL SERVICES	MIS ADMINISTRATION
T4733	UNITED STAFFING ASSOCIATES	147,637.25	1,187,881.80	OCT. & NOV. 2024 TEMPORARY HELP - (16) MS: (4) ME	VARIOUS
T5337	CAZADOR CONSULTING GROUP INC	127,654.40	1,359,160.65	OCT. & NOV. 2024 TEMPORARY HELP - (1) ACC: (16) MS: (1) ME: (1) HR	VARIOUS
T5292	ALL'S WELL HEALTH CARE SERVICES	118,905.47	1,135,351.54	OCT. & NOV. 2024 TEMPORARY HELP - QI: (2), UM: (8), PHM (1)	VARIOUS
WT/ACH	USPS ****	90,000.00	90,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5684	REBELLIS GROUP LLC	85,293.80	907,111.33	OCT. & NOV. 2024 PROFESSIONAL SERVICES	MEDICARE
T3011	OFFICE ALLY, INC	70,126.56	747,587.21	NOV. 2024 EDI CLAIMS	CLAIMS

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC ****	62,824.69	2,481,391.81	OCT. & NOV. 2024 PROFESSIONAL SERVICES & EDI CLAIMS	MIS INFRASTRUCTURE/CLAIMS
T5313	HEALTH LITERACY INNOVATIONS, LLC ****	61,850.00	61,850.00	HEALTH LITERACY ADVISOR ANNUAL LICENSE RENEWAL	MIS INFRASTRUCTURE
T5886	US POSTAL SERVICE	60,000.00	360,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5658	THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	59,642.32	702,201.95	DEC. 2024 VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T5564	CLARISHEALTH, INC	57,822.39	929,103.69	NOV. 2024 CONSULTING SERVICES	ADMINISTRATION
T4657	DAPONDE SIMPSON ROWE PC ****	50,142.50	371,454.50	SEPT. & OCT. 2024 LEGAL SERVICES	ADMINISTRATION
T5963	ANTAGE INCORPORATED	49,200.00	296,831.20	NOV. 2024 PROFESSIONAL SERVICES	MIS ADMINISTRATION
T2967	DEPARTMENT OF HEALTH CARE SERVICES ****	49,000.00	287,000.00	YEAR 2023 MONETARY SANCTION	ADMINISTRATION
T5890	DELTA DENTAL OF CALIFORNIA	47,633.77	549,536.18	DEC. 2024 EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM	VARIOUS
T1128	HALL LETTER SHOP, INC ****	45,431.35	304,043.68	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS & ENVELOPES	VARIOUS
T4452	WELLS FARGO ACH	44,045.42	421,681.73	ACH- MISC CREDIT CARD PURCHASES	VARIOUS
T5509	NGUYEN CAO LUU-TRONG ****	42,000.00	275,250.00	OCT. 2024 CONSULTING SERVICES	HEALTH SERVICES - UTILIZATION MANAGEMENT
T4914	ART COUNCIL OF KERN ****	39,600.00	44,600.00	COMMUNITY HEALTH GRANT	COMMUNITY GRANTS
T4237	FLUIDEDGE CONSULTING, INC.	39,442.50	590,157.50	NOV. 2024 CONSULTING SERVICES	VARIOUS
T5435	TEGRIA SERVICES GROUP - US, INC	39,200.00	536,987.50	NOV. 2024 CONSULTING SERVICES	BUSINESS INTELLIGENCE/PROJECT MANAGEMENT
T5420	PAYPRO ACH	37,534.76	441,263.35	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5930	DAYFORCE US, INC ****	32,898.40	311,288.80	NOV. 2024 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5863	MANNA HAGOS ****	30,717.00	130,702.50	SEPT., OCT., & NOV. 2024 PROFESSIONAL SERVICES	HEALTH SERVICES - UTILIZATION MANAGEMENT
T2458	HEALTHCARE FINANCIAL, INC.	30,000.00	401,597.97	OCT. & NOV. 2024 CONSULTING	ADMINISTRATION
T3088	GLEN BROWN CONSULTING	29,362.50	562,162.50	NOV. 2024 CONSULTING	CAPITAL PROJECT
T5520	BG HEALTHCARE CONSULTING, INC	29,025.00	415,445.00	NOV. 2024 SERVICES	HEALTH SERVICES - QUALITY MGMT. & POP. HEALTH MGMT.
T6179	BPM LLP	27,052.14	67,630.35	CONSULTING SERVICES - ERP SOFTWARE ADVISORY	CAPITAL PROJECT
T2167	PG&E	26,932.86	365,061.19	NOV. 2024 UTILITIES	CORPORATE SERVICES
T5882	RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC ****	26,290.00	210,769.78	NOV. 2024 JANITORIAL SERVICES	CORPORATE SERVICES
T4227	FREESTYLE EVENTS SERVICES INC ****	23,902.00	83,115.90	WINTER WELLNESS WONDERLAND EVENT	HUMAN RESOURCES
		6,677,740.95			
	TOTAL VENDORS OVER $20,000	6,677,740.95			
	TOTAL VENDORS UNDER $20,000	622,906.29			
	TOTAL VENDOR EXPENSES- DECEMBER	**$ 7,300,647.24**			

Note:
****New vendors over $20,000 for the month of December

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	10,267,478.33	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE	6,945,125.54	PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T4737	TEKSYSTEMS, INC.	3,371,028.05	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T1180	LANGUAGE LINE SERVICES INC	2,570,538.13	INTERPRETATION SERVICES	HEALTH SERVICES - WELLNESS & PREVENTION
T1408	DELL MARKETING L.P.	2,538,530.27	COMPUTER EQUIPMENT & SOFTWARE MAINTENANCE	MIS INFRASTRUCTURE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC	2,481,391.81	PROFESSIONAL SERVICES & ANNUAL LICENSING	VARIOUS
T5452/WT	BLACKHAWK ENGAGEMENT SOLUTIONS INC	1,873,679.30	PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM	HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI
T2704	MCG HEALTH LLC	1,642,229.93	ANNUAL HEALTH CARE MANAGEMENT & SOFTWARE LICENSE	UTILIZATION MANAGEMENT
T1845	DEPARTMENT OF MANAGED HEALTH CARE	1,458,980.85	2024-2025 MCAL ANNUAL ASSESSMENT & YR 2022 MONETARY SANCTION	ADMINISTRATION
T5022	SVAM INTERNATIONAL INC	1,441,444.50	PROFESSIONAL SERVICES	MIS ADMINISTRATION
T2686	ALLIANT INSURANCE SERVICES INC.	1,434,276.47	2024 -2025 INSURANCE PREMIUMS	ADMINISTRATION
T3130	OPTUMINSIGHT, INC	1,416,456.00	ANNUAL LICENSE SOFTWARE	MIS INFRASTRUCTURE
T4699	ZEOMEGA, INC	1,413,206.12	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T5337	CAZADOR CONSULTING GROUP INC	1,359,160.65	TEMPORARY HELP	VARIOUS
T4733	UNITED STAFFING ASSOCIATES	1,187,881.80	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
T5466	ZIPARI, INC	1,150,911.82	JAN-JUN MEMBER-PROVIDER SUBSCRIPTION & PROVIDER DIRECTORY UPDATES	MIS INFRASTRUCTURE
T5292	ALL'S WELL HEALTH CARE SERVICES	1,135,351.54	TEMPORARY HELP	VARIOUS
T5564	CLARISHEALTH, INC	929,103.69	DRG AUDIT RECOVERIES	ADMINISTRATION
T5111	ENTISYS 360, E360	916,448.92	NUTANIX ACROPOLIS SOFTWARE LICENSE	MIS INFRASTRUCTURE
T5684	REBELLIS GROUP LLC	907,111.33	MAPD BUSINESS CONSULTING	MEDICARE
T3011	OFFICE ALLY, INC	747,587.21	EDI CLAIM PROCESSING	CLAIMS
T5658	THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	702,201.95	VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T3022	MICROSOFT CORPORATION	612,498.75	CONSULTING SERVICES	ENTERPRISE CONFIGURATION
T4237	FLUIDEDGE CONSULTING, INC	590,157.50	CONSULTING SERVICES	VARIOUS
T5865	HARTE-HANKS RESPONSE MANAGEMENT/AUSTIN, INC	579,932.01	2024 SALESFORCE LICENSE FEES-CUSTOMER CARE CONTACT CENTER	MEMBER SERVICES
T5877	TGN CONSULTING LLC	564,073.17	FRONT LINES ACTIVATION & EXECUTIVE COACHING	HUMAN RESOURCES
T3088	GLEN BROWN CONSULTING	562,162.50	CONSULTING SERVICES	CAPITAL PROJECT
T5890	DELTA DENTAL OF CALIFORNIA	549,536.18	EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T2918	STINSON'S	539,256.07	OFFICE SUPPLIES	VARIOUS
T5435	TEGRIA SERVICES GROUP - US, INC	536,987.50	PROFESSIONAL SERVICES	HEALTH SERVICES - UM

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4460	PAYSPAN, INC	498,721.08	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T5340	GARTNER INC	446,955.00	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	HUMAN RESOURCES
T5420	PAYPRO ACH	441,263.35	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5155	A-C ELECTRIC COMPANY	425,423.85	CARPORT SOLAR PROJECT	CAPITAL PROJECT
T4452	WELLS FARGO	421,681.73	ACH- MISC CREDIT CARD PURCHASES	VARIOUS
T5520	BG HEALTHCARE CONSULTING, INC	415,445.00	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T5907	DIAMOND PEAK CONSTRUCTION	404,759.00	MAIL ROOM REDESIGN & WALL REPAIR NEAR GENERATOR AREA	CAPITAL/CORPORATE SERVICES
T2458	HEALTHCARE FINANCIAL, INC	401,597.97	CONSULTING SERVICES	ADMINISTRATION
T4657	DAPONDE SIMPSON ROWE PC	371,454.50	LEGAL FEES	VARIOUS
T2167	PG&E	365,061.19	UTILITIES	CORPORATE SERVICES
T5886	US POSTAL SERVICE	360,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T4331	COTIVITI, INC	334,327.73	PROFESSIONAL SERVICES	HEALTH SERVICES - QI
T3449	CDW GOVERNMENT	311,347.92	FORTINET RENEWAL & ADOBE LICENSES	MIS INFRASTRUCTURE
T5930	DAYFORCE US, INC	311,288.80	SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T1128	HALL LETTER SHOP	304,043.68	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS & ENVELOPES	VARIOUS

KERN·HEALTH SYSTEMS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5963	ANTAGE INCORPORATED	296,831.20	PROFESSIONAL SERVICES	ENTERPRISE DEVELOPMENT
T2967	DEPARTMENT OF HEALTH CARE SERVICES	287,000.00	2024-2025 1ST INSTALLMENT MCAL ANNUAL ASSESSMENT & 2021 MEDICAL MCAS PERFORMANCE MEASUREMENT MONETARY SANCTION	ADMINISTRATION
T5757	BITFOCUS, INC	285,946.95	ENTERPRISE SOFTWARE LICENSING & DATA MODELING	CAPITAL PROJECT
T2584	UNITED STATES POSTAL SVC - HASLER	280,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5509	NGUYEN CAO LUU-TRONG	275,250.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T2413	TREK IMAGING INC	258,384.90	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T5344	SIGNATURE STAFF RESOURCES LLC	239,710.00	2023 & 2024 PROFESSIONAL SERVICES	PROJECT MGMNT/CAPITAL PROJECT
T4501	ALLIED UNIVERSAL SECURITY SERVICES	236,763.42	ONSITE SECURITY	CORPORATE SERVICES
T4024	QUADIENT INC	226,079.53	MAIL INSERTER, METER RENTAL & SOFTWARE SUPPORT	CAPITAL PROJECT/CORPORATE SERVICES
T4695	EDIFECS, INC.	221,605.25	ANNL LICENSE RENEWAL TRANSACTION MANAGEMENT LICENSES	MIS INFRASTRUCTURE
T5121	TPX COMMUNICATIONS	221,306.12	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T5026	TEL-TEC SECURITY SYSTEMS	220,403.12	SECURITY MAINTENANCE & UPGRADES	CAPITAL/ CORPORATE SERVICES
T4353	TWE SOLUTIONS, INC	213,364.31	JUNIPER QFX SWITCHES & LICENSES	MIS INFRASTRUCTURE
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	213,187.50	PROFESSIONAL SERVICES	HEALTH SERVICES - UM

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5882	RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC	210,769.78	BUILDING IMPROVEMENT/MAINTENANCE	CORPORATE SERVICES
T4484	JACOBSON SOLUTIONS	208,050.12	TEMPORARY HELP	HEALTH SERVICES - UM
T1183	MILLIMAN USA	206,468.25	CY2022/2023 TNE & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T1272	COFFEY COMMUNICATIONS INC	206,236.82	MEMBER NEWSLETTER/WEBSITE IMPLEMENTATION	HEALTH SERVICES - WELLNESS & PREVENTION/MEDIA & ADVERTISING
T2469	DST HEALTH SOLUTIONS, LLC	200,350.00	ANNUAL ACG LICENSE & SUPPORT	BUSINESS INTELLIGENCE
T5742	MICHAEL NGUYEN	200,000.00	PROFESSIONAL SERVICES	QUALITY & HEALTH EQUITY
T5329	RELAY NETWORK, LLC	199,999.44	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T1022	UNUM LIFE INSURANCE CO.	198,825.78	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T2941	KERN PRINT SERVICES INC	192,295.59	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T5751	EXCELL HCA, LLC	190,774.00	PROFESSIONAL SERVICES	PROJECT MANAGEMENT
T2955	DELTA ELECTRIC INC.	188,130.00	BUILDING IMPROVEMENT/MAINTENANCE	CORPORATE SERVICES
T6127	MANIFEST MEDEX	184,905.83	YR 1 OF 3 HIE SUBSCRIPTION FEE	CAPITAL PROJECT
T2969	AMERICAN BUSINESS MACHINES INC	184,295.73	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T4985	CYBERCODERS, INC	171,781.25	PROFESSIONAL SERVICES	MIS ADMINISTRATION

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	168,744.18	PMPY DUES 2024-2025	ADMINISTRATION
T5583	THE MIHALIK GROUP, LLC	158,940.00	NCQA TRAINING	HEALTH SERVICES - QI
T5738	INSURICA - WALTER MORTENSEN INSURANCE	150,147.00	WORKERS COMP PREMIUM 2024-2025	ADMINISTRATION
T5931	SPROUT SOCIAL, INC	145,264.00	12 MONTHS OF SOCIAL MEDIA VIGILANCE & MANAGEMENT	CAPITAL PROJECT
T1005	COLONIAL LIFE & ACCIDENT	143,665.48	LIFE INSURANCE PREMIUM	VARIOUS
T4708	WAKELY CONSULTING GROUP, LLC FRMLY HEALTH MANAGEMENT ASSOCIATES, INC.	136,591.22	PROFESSIONAL SERVICES	ADMINISTRATION
T4503	VISION SERVICE PLAN	131,716.95	EMPLOYEE HEALTH BENEFITS	VARIOUS
T5863	MANNA HAGOS	130,702.50	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T4165	SHI INTERNATIONAL CO.	129,349.74	NETWORK SWITCHES WITH SUPPORT	MIS INFRASTRUCTURE/CAPITAL PROJECT
T2726	DST PHARMACY SOLUTIONS, INC	126,000.00	PHARMACY CLAIMS	PHARMACY
T4785	COMMGAP	121,331.25	INTERPRETATION SERVICES	HEALTH SERVICES - WELLNESS & PREVENTION
T5562	JDM SOLUTIONS INC.	119,040.00	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T2961	SOLUTION BENCH, LLC	118,220.00	M-FILES SOFTWARE ANNUAL RENEWAL	MIS INFRASTRUCTURE
T4514	A.J. KLEIN, INC T. DENATALE, B. GOLDNER	117,905.77	LEGAL FEES	ADMINISTRATION

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2509	UNITED STATES POSTAL SERVICE	116,095.96	PERMIT 162 MEMBER NEWSLETTER POSTAGE	HEALTH SERVICES - WELLNESS & PREVENTION
T5494	LDP ASSOCIATES, INC.	115,770.99	YEAR 1 OF 3 UPS BATTERY SUPPORT	MIS INFRASTRUCTURE
T5571	GHA TECHNOLOGIES INC	109,938.26	FORTINET SECURITY	MIS INFRASTRUCTURE
T5941	CORDELL KEY	108,630.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T4563	SPH ANALYTICS	102,242.00	HEDIS CAHPS, ECM & PROVIDER SATISFACTION SURVEY	VARIOUS
T6054	WEBMD IGNITE	101,694.30	HEALTHWISE LICENSE FEES 2024	HEALTH SERVICES - WELLNESS & PREVENTION
T5467	MOSS ADAMS LLP	99,142.00	CLAIMS AUDIT TOOL ENHANCEMENT	CLAIMS
T5778	CONTOUR DATA SOLUTIONS, LLC	98,000.00	ANNUAL DATA SOLUTIONS	CAPITAL PROJECT
T2446	AT&T MOBILITY	97,916.19	CELLULAR PHONE/INTERNET USAGE	MIS INFRASTRUCTURE
T4217	CONTEXT 4 HEALTHCARE, INC	97,775.15	ANNL RENEWAL AMA FEES 6/2024-6/2025	MIS INFRASTRUCTURE - QNXT
T5291	PINNACLE RECRUITMENT SERVICES LLC	97,451.23	TEMPORARY HELP	VARIOUS
T5298	TOTALMED, INC	97,322.24	TEMPORARY HELP	VARIOUS
T5850	SERRANO ADVISORS LLC	96,300.00	PROFESSIONAL SERVICES	ENHANCED CARE MANAGEMENT
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	92,500.00	2024 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T5967	SAI360 INC	91,846.25	REGULATORY COMPLIANCE & BEST PRACTICES POLICY MANAGEMENT MODULES	CAPITAL PROJECT

KERN·HEALTH SYSTEMS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
WT/ACH	USPS ****	90,000.00	KHS POSTAL ONE/EPS ACCOUNT FUNDS	CORPORATE SERVICES
T1655	KERN,KKXX,KISV,KGEO,KGFM,KEBT,KZOZ,KKJG,KVEC,KSTT,KRQK,KPAT,	89,465.00	RADIO ADVERTISING	SALES/MARKETING/PUBLIC RELATIONS
T4265	SIERRA SCHOOL EQUIPMENT COMPANY	85,287.69	BOARDROOM FURNITURE	CORPORATE SERVICES
T5400	CENTRO DE UNIDAD POPULAR BENITO JUAREZ, INC.	85,000.00	GRANT FUNDING	COMMUNITY GRANTS
T5319	CITIUSTECH INC	84,999.00	FAST+ ANNUAL MAINTENANCE & SUPPORT	MIS INFRASTRUCTURE
T4963	LINKEDIN CORPORATION	84,018.50	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T4216	NEXSTAR BROADCASTING INC	83,525.00	ADVERTISEMENT - MEDIA	MARKETING
T4227	FREESTYLE EVENTS SERVICES INC	83,115.90	AUDIO SERVICES CONNECT FORUM & SPRING GALA EVENT	ADMINISTRATION/HUMAN RESOURCES
T5538/WT	OCTOPAI B.I. LTD	74,496.00	ANNUAL RENEWAL - METADATA PLATFORM	BUSINESS INTELLIGENCE
T5550	CHARTER COMMUNICATIONS OPERATING, LLC	73,371.03	INTERNET SERVICES	MIS INFRASTRUCTURE
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	73,000.00	2023 AUDIT FEES	FINANCE
T2933	SIERRA PRINTERS, INC	71,941.66	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T3986	JACQUELYN S. FRANKLIN-WARD	69,320.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T6179	BPM LLP	67,630.35	ERP SOFTWARE ADVISORY	CAPITAL PROJECT
T6100	SYMPLR	67,512.48	SOFTWARE LICENSE 2024/2025	HEALTH SERVICES - UTIL REVIEW

KERN·HEALTH SYSTEMS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5201	JAC SERVICES, INC	64,891.50	AIR CONDITIONING PM SERVICES	CORPORATE SERVICES
T4792	KP LLC	63,899.18	PROVIDER DIRECTORIES	PROVIDER NETWORK MANAGEMENT
T5313	HEALTH LITERACY INNOVATIONS, LLC ****	61,850.00	HEALTH LITERACY ADVISOR ANNL LICENSE RENEWAL	MIS INFRASTRUCTURE
T4607	AGILITY RECOVERY SOLUTIONS INC.	60,707.24	PROFESSIONAL SERVICES	CORPORATE SERVICES
T2441	LAURA J. BREZINSKI	60,000.00	MARKETING MATERIALS	MARKETING
T4182	THE LAMAR COMPANIES	59,308.92	OUTDOOR ADVERTISEMENT - BILLBOARDS	ADVERTISING
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	58,771.00	2024 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	56,887.96	2023 & 2024 EDI CLAIM PROCESSING	CLAIMS
T4228	THE SSI GROUP, LLC	56,115.80	2023 & 2024 EDI CLAIM PROCESSING	CLAIMS
T1650	UNIVISION TELEVISION GROUP	53,327.00	ADVERTISEMENT - MEDIA	SALES/MARKETING/PUBLIC RELATIONS
T1861	CERIDIAN HCM, INC.	53,039.29	MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T5398	GOLDEN EMPIRE GLEANERS	50,908.80	FOOD BASKETS FOR MEMBERS	ENHANCED CARE MANAGEMENT
T1986	BOYS AND GIRLS CLUB OF KERN COUNTY	50,292.00	BRIDGING THE TRANSPORTATION GAP FUNDING	GRANTS
T5109	RAND EMPLOYMENT SOLUTIONS	50,141.07	TEMPORARY HELP	VARIOUS
T5696	ASA GLOBAL HEALTHCARE SERVICES PC	47,500.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5802	MOTOR VEHICLE NETWORK	47,430.00	DMV ADVERTISING OCT. 2024-OCT. 2024	SALES/MARKETING/PUBLIC RELATIONS
T4195	SCRIPPS MEDIA, INC DBA KERO-TV	46,660.00	ADVERTISEMENT - MEDIA	MARKETING
T1091	CLINICA SIERRA VISTA	46,610.12	2024 INTERPRETATION FEES - CSV	HEALTH SERVICES - WELLNESS & PREVENTION
T3001	MERCER	46,500.00	2024 COMPENSATION STUDY	ADMINISTRATION
T5421	PREMIER ACCESS INSURANCE COMPANY	46,074.50	EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	44,890.00	ADVERTISEMENT - MEDIA	MARKETING
T5783	TELADOC HEALTH INC	44,712.00	EMPLOYEE MENTAL HEALTH PREMIUM	VARIOUS
T4914	ART COUNCIL OF KERN ****	44,600.00	ARTS4 REHABILITATION GRANT OCT 2024	COMMUNITY GRANTS
T5846	MOKSHA PSYCHOTHERAPY & COMMUNITY HEALTH CONSULTING INC	44,187.50	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T2580	GOLDEN EMPIRE TRANSIT DISTRICT	44,000.00	MARKETING -BUS ADVERTISING	SALES/MARKETING/PUBLIC RELATIONS
T5843	SEVEN OAKS COUNTRY CLUB	43,841.25	PROVIDER DINNER EVENT & Q2 FORUM	PROVIDER NETWORK MANAGEMENT
T3081	ST. VINCENT DE PAUL STORE, INC.	43,405.62	GRANT FUNDING	COMMUNITY GRANTS
T1097	NCQA	43,019.00	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	HEALTH SERVICES - QI
T5759	SHELLBY ROSE P DUMLAO	42,668.50	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T4993	LEGALSHIELD	42,430.95	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5653	SUN OUTDOOR ADVERTISTING LLC	40,500.00	HOSTED SOFTWARE RENEWAL	MIS INFRASTRUCTURE
T5851	ABSORB SOFTWARE NORTH AMERICA, LLC	40,193.64	DAYFORCE LEARNING LICENSE	MIS INFRASTRUCTURE
T5376	KCHCC	38,250.00	SPONSORSHIPS	SALES/MARKETING/PUBLIC RELATIONS
T2869	COMMUNITY ACTION PARTNERSHIP OF KERN	38,200.00	SPRING GRANTS & MEMBER ENGAGEMENT	SALES/MARKETING/PUBLIC RELATIONS/ CORPORATE SERVICES
T5779	COMMUNITY ACTION PARTNERSHIP OF KERN FOUNDATION	38,000.00	SPONSORSHIPS	SALES/MARKETING/PUBLIC RELATIONS
T5119	PACIFIC WEST SOUND PROFESSIONAL AUDIO & DESIGN INC	37,830.88	INSTALL & RELOCATE PROJECTORS/SMARTBOARDS	CORPORATE SERVICES
T1347	ADVANCED DATA STORAGE	37,379.55	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T2376	ROBIN PLUMB	37,280.00	CONSULTING SERVICES	FINANCE
T5791	WEINTRAUB TOBIN	37,086.50	LEGAL SERVICES	ADMINISTRATION
T5592	BRAND CO MARKETING	36,875.93	WEB HOSTING, RECRUITMENT & COMPANY STORE SUPPLIES	HUMAN RESOURCES
T3972	JOURNEY AIR CONDITIONING CO., INC.	36,157.00	HVAC RECONFIGURATION OF MAILROOM, 3RD & 4TH FLOOR	CAPITAL PROJECT
T5743	INTEL AGREE, COLABS	35,650.00	INTEL AGREE SUBSCRIPTION YEAR 2 OF 3	MIS INFRASTRUCTURE
T6121	JACKSON UTILIZATION MANAGEMENT CONSULTING	35,455.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UTIL REVIEW
T2641	MARANATHA GARDENING & LANDSCAPING, INC.	35,280.00	2024 BUILDING MAINTENANCE	CORPORATE SERVICE
T2562	CACTUS SOFTWARE LLC	33,506.15	2024 CREDENTIALING LICENSE & SUPPORT	MIS INFRASTRUCTURE

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5762	SCREENVISION MEDIA	33,489.65	CINEMA ADVERTISING	SALES/MARKETING/PUBLIC RELATIONS
T5436	THE BEACON STUDIOS, LLC	33,110.00	VIDEO SERVICES	SALES/MARKETING/PUBLIC RELATIONS
T1172	BUCK OWENS PRODUCTIONS	33,085.00	RADIO ADVERTISING	SALES/MARKETING/PUBLIC RELATIONS
T2787	SAGE SOFTWARE. INC	33,019.32	SAGE 300 LICENSE RENEWAL - FINANCE SOFTWARE	FINANCE
T4259	SKARPHOL ASSOCIATES	32,798.04	BUILDING IMPROVEMENT -REMODELING & NEW OFFICES	CAPITAL PROJECT
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	32,068.08	2023 & 2024 EDI CLAIM PROCESSING	CLAIMS
T5130	BUILDING ELECTRONIC CONTROLS, INC.	30,484.34	FIRE ALARM EXPANSION & INSTALLATION	CAPITAL PROJECT/CORPORATE SERVICES
T4934	APPLE INC.	30,291.38	IPADS, IPHONES & POWER ADAPTERS	MIS INFRASTRUCTURE/CAPITAL
T4230	COFFEE BREAK SERVICE, INC.	30,225.70	COFFEE SUPPLIES	CORPORATE SERVICES
T4577	LA CAMPESINA, KBDS, KUFW, KMYX, KSEA, KBHH, KYLI, KCEC, KNAI	30,020.00	RADIO ADVERTISING	SALES/MARKETING/PUBLIC RELATIONS
T2793	AMERICAN MANAGEMENT ASSOCIATION ****	29,724.37	TRAINING FOR ESSENTIALS OF PROJECT MANAGEMENT	PROJECT MANAGEMENT
T5434	CHARGEPOINT, INC	29,400.00	5 YR EV CHARGER MAINTENANCE	CORPORATE SERVICES
T4417	KAISER FOUNDATION HEALTH PLAN - OR	29,310.84	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T5936	AXIOS HQ INC	28,800.00	AI COMMUNICATION SOFTWARE LICENSING	CAPITAL PROJECT
T4731	GO TO TECHNOLOGIES, INC	28,560.00	INTERNET SERVICES	MIS INFRASTRUCTURE

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5741	HEALTHWISE, INCORPORATED	28,402.23	MEMBER SELF MANAGEMENT TOOLS	HEALTH SERVICES - WELLNESS & PREVENTION
T4920	OTIS ELEVATOR COMPANY	27,863.66	ELEVATOR MAINTENANCE & SERVICE CALLS	CORPORATE SERVICES
T2578	AMERICAN STROKE ASSOC/AMERICAN HEART ASSOC WESTERN STATES	27,500.00	SPONSORSHIP KERN CPRA, GRFW & HEART WALK	MARKETING
T4544	BARNES WEALTH MANAGEMENT GROUP	27,040.00	RETIREMENT PLAN CONSULTANTS	ADMINISTRATION
T1007	FEDERAL EXPRESS CORP.	26,698.47	SHIPPING SERVICES	VARIOUS
T4424	GUROCK SOFTWARE GmbH	26,565.97	TESTRAIL SOFTWARE RENEWAL	MIS INFRASTRUCTURE
T5887	PREPARIS INC	26,118.46	DISASTER REOVERY	CORPORATE SERVICES
T4983	SDL LIMITED	25,895.00	TRANSLATION TOOL LICENSES SEP. 2024-SEP. 2024	MIS INFRASTRUCTURE
T6183	ZOHO CORPORATION	25,600.00	2 YR SUBSCRIPTION MANAGE ENGINE OP MANAGER	MIS INFRASTRUCTURE
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	25,559.67	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5977	IMAGENET, LLC	25,500.00	OCR SERVICES	CAPITAL PROJECT
T5536	CALIFORNIA STATE UNIVERSITY BAKERSFIELD FOUNDATION	25,000.00	2024 SCHOOL SCHOLARSHIPS	SALES/MARKETING/PUBLIC RELATIONS
T3084	KERN COUNTY-COUNTY COUNSEL	24,804.80	LEGAL SERVICES	ADMINISTRATION
T5486	ALLIED GENERAL CONTRACTORS, INC	24,800.00	BUILDING IMPROVEMENT/MAINTENANCE	CORPORATE SERVICES
T1957	FRIENDS OF MERCY FOUNDATION	24,200.00	SPONSORSHIPS	SALES/MARKETING/PUBLIC RELATIONS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4249	LOTUS BAKERSFIELD CORP	24,200.00	SPANISH RADIO ADVERTISING	SALES/MARKETING/PUBLIC RELATIONS
T3118	AMERICAN ACADEMY HOLDINGS LLC dba AAPC	23,563.40	CPC & MEDICAL HEALTHCARE TERMINOLOGY TRAINING	CLAIMS
T5260	HD DYNAMICS SOFTWARE SOLUTIONS, CORP	22,750.00	PROFESSIONAL SERVICES	PROVIDER NETWORK MANAGEMENT
T3055	FIRST 5 KERN ****	22,343.67	CHILD PASSENGER SAFETY TECHNICIAN TRANING SERVICES & IMMUNIZATION COALITION PARENT SURVEY SPONSORSHIP	HEALTH SERVICES - WELLNESS & PREVENTION
T2601	RLH FIRE PROTECTION, INC.	22,311.00	OFFICE SPRINKLER INSPECTIONS	CORPORATE SERVICES
T4605	KERNVILLE UNION SCHOOL DISTRICT	22,208.00	SCHOOL WELLNESS GRANT	COMMUNITY GRANTS
T5986	ABSOLUTE DRYWALL, INC	21,870.00	BLUE ZONES WELLNESS GARDEN	CORPORATE SERVICES
T4466	MENTORS MOVING & STORAGE ****	21,594.76	OFF SITE STORAGE	CORPORATE SERVICES
T4521	PAYSCALE, INC	21,420.00	COMPENSATION STUDY YR 1 OF 3	HUMAN RESOURCES
T5615	HAPPY WHOLE YOU, INC	21,355.11	2024 CUSTOM PROGRAMS	HUMAN RESOURCES
T5701	THE GRANGER NETWORK LLC	21,146.71	SUPERVISOR BOOTCAMP	HUMAN RESOURCES
T5391	INDEED, INC	21,074.79	GLOBAL SMART SOURCING SUBSCRIPTION	HUMAN RESOURCES
T5408	MARY HARRIS	20,825.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T5191	PACWEST DIRECT	20,676.25	MAIL SERVICES	CORPORATE SERVICES
T6040	KARLEN & PANICI BREWING LLC	20,333.75	SPRING GALA CATERING	HUMAN RESOURCES

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5159	AT&T CORP ****	20,275.32	INTERNET SERVICES	MIS INFRASTRUCTURE
T4585	DELANO UNION SCHOOL DISTRICT ****	20,064.00	OFFICE RENT FOR MEMBER ENGAGEMENT & SCHOOL WELLNESS GRANT	CORPORATE SERVICES/HEALTH SERVICES - WELLNESS & PREVENTION
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT	20,000.00	SCHOOL WELLNESS GRANT	COMMUNITY GRANTS
		72,379,999.44		
	TOTAL VENDORS OVER $20,000	72,379,999.44		
	TOTAL VENDORS UNDER $20,000	2,930,851.76		
	TOTAL VENDOR EXPENSES- DECEMBER	**$ 75,310,851.20**		

Note:
****New vendors over $20,000 for the month of December

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January AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T1408	DELL MARKETING L.P.	1,581,177.42	ANNUAL VLA ENTERPRISE LICENSE/ EA RENEWAL & (88) LAPTOPS	MIS INFRASTRUCTURE
T3130	OPTUMINSIGHT, INC	855,290.00	ANNUAL CLAIMS EDIT SOFTWARE LICENSE - YR 3 OF 5	MIS INFRASTRUCTURE
T4350	COMPUTER ENTERPRISE	456,320.81	DEC. 2024 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T5340	GARTNER INC	386,099.99	EXECUTIVE PROGRAM LICENSE & 2025 ON SITE TRAINING	TECHNICAL ADMINISTRATIVE SERVICES/HUMAN RESOURCES
T4737	TEKSYSTEMS, INC.	239,401.00	DEC. 2024 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T1180	LANGUAGE LINE SERVICES INC.	229,292.36	NOV. 2024 INTERPRETATION SERVICES	HEALTH SERVICES - WELLNESS & PREVENTION
WT/ACH	BCI HOLDINGS	207,156.39	JAN. 2025 EMPLOYEE HMO HEALTH BENEFITS PREMIUM & RX CLAIMS	VARIOUS
WT/ACH	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	200,000.00	PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM	HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES - QI
T4963	LINKEDIN CORPORATION	142,532.00	2025 LEARNING HUB YR 1 OF 2, RECRUITMENT JOB SLOTS YR 1 OF 3	HUMAN RESOURCES
T4460	PAYSPAN, INC	142,156.20	NOV. & DEC. 2024 ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC	126,618.78	NOV. & DEC. 2024 PROFESSIONAL SERVICES & EDI CLAIMS	MIS INFRASTRUCTURE/CLAIMS
T5877	TGN CONSULTING LLC	123,008.95	LEADERSHIP DEVELOPMENT CONSULTING	HUMAN RESOURCES
T1097	NCQA	122,349.00	POPULATION HEALTH PROGRAM ACCREDITATION	HEALTH SERVICES - QI
T4514	A.J. KLEIN, INC T. DENATALE, B. GOLDNER	98,602.53	JAN. - DEC. 2024 LEGAL FEES	ADMINISTRATION
T5684	REBELLIS GROUP LLC	91,806.64	NOV. 2024 PROFESSIONAL SERVICES	MEDICARE
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	85,000.00	2025 ANNUAL MEMBER DUES	ADMINISTRATION
T5292	ALL'S WELL HEALTH CARE SERVICES	80,738.91	NOV. & DEC. 2024 TEMPORARY HELP - UM: (13)	VARIOUS
T5571	GHA TECHNOLOGIES INC	80,374.17	FORTINET-FORTIGATE SECURITY APPLIANCES SUPPORT AND MAINTENANCE	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

January AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T6218	CLOUDERA, INC	77,940.10	ANNUAL RENEWAL - METADATA PLATFORM	BUSINESS INTELLIGENCE
T2413	TREK IMAGING INC	77,930.81	MARKETING PROMOTIONAL SUPPLIES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T1272	COFFEY COMMUNICATIONS INC.	77,466.57	WINTER ISSUE OF FAMILY HEALTH	HEALTH SERVICES - WELLNESS & PREVENTION
T1128	HALL LETTER SHOP, INC	66,267.21	M-CAL RENEWALS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS & ENVELOPES	VARIOUS
T3011	OFFICE ALLY, INC	64,369.41	DEC. 2024 EDI CLAIMS	CLAIMS
T5658	THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	63,621.63	JAN. 2025 VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T4708	WAKELY CONSULTING GROUP, LLC	63,467.50	AUG. - NOV. 2024 PROFESSIONAL SERVICES	FINANCE
T5886	US POSTAL SERVICE	60,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
WT/ACH	USPS	60,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5564	CLARISHEALTH, INC	57,816.28	DEC. 2024 CONSULTING SERVICES	ADMINISTRATION
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	56,656.00	2025 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T5337	CAZADOR CONSULTING GROUP INC	55,750.44	DEC. 2024 TEMPORARY HELP - (1) PHM: (22) MS: (1) ME: (1) HE	VARIOUS
T5882	RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC	53,355.00	DEC. 2024 & JAN. 2025 JANITORIAL SERVICES	CORPORATE SERVICES
T5890	DELTA DENTAL OF CALIFORNIA	51,677.71	JAN. 2025 EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM	VARIOUS
T4733	UNITED STAFFING ASSOCIATES	49,367.16	DEC. 2024 TEMPORARY HELP - (9) MS: (3) ME	VARIOUS
WT/ACH	PAYPRO ACH	47,382.96	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T4237	CITIUS HEALTHCARE CONSULTING, LLC	45,262.50	DEC. 2024 CONSULTING SERVICES	VARIOUS
T5509	NGUYEN CAO LUU-TRONG	42,900.00	NOV. 2024 CONSULTING SERVICES	HEALTH SERVICES - UTILIZATION MANAGEMENT
T6142	GREAT PLACE TO WORK INSTITUTE, INC	41,995.00	EMPLOYEE ENGAGEMENT SURVEY ACCELERATE PACKAGE	HUMAN RESOURCES

KERN·HEALTH SYSTEMS

January AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T2584	UNITED STATES POSTAL SVC. - HASLER	40,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T6100	SYMPLR	35,515.73	ANNUAL CREDENTIALING AND SOFTWARE LICENSE	HEALTH SERVICES - UTIL REVIEW
T5321	TYK TECHNOLOGIES LTD	34,000.00	SELF MANAGED ARCHITECTURE PLAN 2024/2025	MIS INFRASTRUCTURE
T3088	GLEN BROWN CONSULTING	31,387.50	DEC. 2024 CONSULTING	CAPITAL PROJECT
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	30,000.00	PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM	HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES - QI
T4501	ALLIED UNIVERSAL SECURITY SERVICES	29,401.98	DEC. 2024-JAN. 2025 ONSITE SECURITY	CORPORATE SERVICES
T5738	INSURICA - WALTER MORTENSEN INSURANCE	28,406.00	2023-2024 WORKERS COMPENSATION AUDIT	ADMINISTRATION
T6179	BPM LLP	27,052.14	CONSULTING SERVICES - ERP SOFTWARE ADVISORY	CAPITAL PROJECT
T4452	WELLS FARGO ACH	25,423.03	ACH- JAN MISC CREDIT CARD PURCHASES	VARIOUS
T2167	PG&E	24,627.63	DEC. 2024 UTILITIES	CORPORATE SERVICES
T4731	GO TO TECHNOLOGIES, INC	22,737.00	LOGMEIN RESCUE SUBSCRIPTION 2.2025-1.2026	MIS INFRASTRUCTURE
T4934	APPLE INC.	22,229.90	(4) MACBOOKS, MAGIC MOUSE & MAGIC KEYBOARDS	CAPITAL PROJECT
T5319	CITIUSTECH INC.	21,250.00	FAST + MAINTENANCE & SUBSCRIPTION Q3 2024	MIS INFRASTRUCTURE
T5318	CANONICAL GROUP LIMITED	20,720.00	(35) UBUNTU PRO LICENSES 10.2024-9.2025	MIS INFRASTRUCTURE
T5988	WASCO UNION HIGH SCHOOL DISTRICT	20,000.00	SCHOOL WELLNESS GRANT 2025-2026	HEALTH SERVICES - WELLNESS & PREVENTION
		6,773,902.34		
	TOTAL VENDORS OVER $20,000	6,773,902.34		
	TOTAL VENDORS UNDER $20,000	730,800.74		
	TOTAL VENDOR EXPENSES- JANUARY	**$ 7,504,703.08**		

Note:
****New vendors over $20,000 for the month of January

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
January 2024							
Press Ganey/SPH Analytics	$81,696.00	Yes	ECM	Loni Hill-Pirtle	ECM Member Satisfaction Survey	1/1/2024	12/31/2026
Michael Nguyen	$197,500.00	Yes	HE	Traco Matthews	Health Equity Strategic Guidance and Cultural Insights Services	1/1/2024	12/31/2024
Harte Hanks	$198,064.00	Yes	MS	Nate Scott	Up to (3,200) New Member Welcome calls	1/1/2024	12/31/2024
Entysis360	$51,837.28	Yes	IT	Richard Pruitt	(52) licenses for VMware maintenance & technical support	1/1/2024	12/31/2024
GHA Technologies	$71,550.61	Yes	IT	Richard Pruitt	Fotinet-Fortigate Maintenance & Support for Security Appliances	1/1/2024	12/31/2024
Gartner	$189,765.00	Yes	IT	Richard Pruitt	Executive Program Leadership licenses (3)	1/1/2024	12/31/2024
Moss Adams	$143,334.50	Yes	CLM	Robin Dow-Morales	Claims Audit Tool	1/1/2024	12/31/2026
The Granger Network	$198,800.00	Yes	HR	Alan Avery	Front Lines Activation and Manager Bootcamp	1/1/2024	6/30/2024
BG Healthcare	$199,000.00	Yes	QI	Dr. Martha Tasinga	Consulting services for the QI dept	1/1/2024	12/31/2024
BG Healthcare	$199,000.00	Yes	PHM	Michelle Curiouso	Consulting services for the PHM dept	1/1/2024	12/31/2024
HD Dynamics	$50,000.00	Yes	PNM	Amisha Pannu	Consulting services for CRM process	1/2/2024	12/31/2024
Poppyrock	$120,000.00	Yes	MRKT	Louie Iturriria	KHS & KFHC Graphic Design	1/2/2024	12/31/2025
CEI	$199,920.00	Yes	COSA	Josh Hosch	Business Analyst for UM team	1/2/2024	12/31/2024
Reliable Janitorial	$199,008.00	Yes	CS	Andrea Hylton	Janitorial services	1/11/2024	1/10/2025
CAQH	$50,000.00	Yes	PNM	Amisha Pannu	Acess to real-time Provider applications (ProView)	1/25/2024	1/24/2025
CDW-G	$67,761.50	Yes	IT	Richard Pruitt	All Adobe licenses annual renewal (257)	1/26/2024	1/25/2025
TEKSystems	$78,000.00	Yes	HR	Devin Brown	HRIS Analyst for HR DEPT	1/30/2024	7/30/2024
February 2024							
Clinica Sierra Vista	$145,000.00	Yes	HE	Isabel Silva	MOU	2/1/2024	1/31/2025
BG Healthcare	$81,000.00	Yes	UM	Dr. Tasinga	Consulting services for the UM dept	2/6/2024	5/5/2024
Diligent Corporation	$50,000.00	Yes	CPL	Deborah Murr	Compliance Training Material	2/7/2024	2/6/2027
SPH Analytics	$63,809.00	Yes	BH	Melinda Santiago	ECHO 3.0 (Behavioral Health) Satisfactions Survey	2/7/2024	2/6/2027
Coffey Communications	$170,000.00	Yes	HE	Isabel Silva	Printing of Member Newsletters	2/15/2024	2/14/2025
CDW-G	$111,495.80	Yes	IT	Richard Pruitt	Nutanix renewal co-termed	2/17/2024	1/23/2026
Sprout Social	$145,264.00	Yes	MRKT	Louie Iturriria	Social Media Vigilance software	2/23/2024	2/25/2025
Axios HQ	$59,040.00	Yes	MRKT	Louie Iturriria	Internal AI Communication Software for Marketing team	2/23/2024	2/22/2026
LanguageLine	$90,000.00	Yes	HE	Isabel Silva	Interpreting services	2/28/2024	2/27/2025
March 2024							
Gartner	$184,800.00	Yes	HR	Devin Brown	Gartner Advisory licenses for HR team	3/1/2024	2/28/2025
Serrano Advisors	$119,000.00	Yes	ECM	Dr. Tasinga	Staff Augmentation Services	3/1/2024	8/31/2024
TEKSystems	$198,432.00	Yes	COSA	Josh Hosch	One (1) Solution Architect & Analyst Resouece	3/4/2024	12/31/2024
HMA	$199,000.00	Yes	Acct	Veronica Barker	Actuarial services (RTD, Rate Analyst, & SDR's)	3/6/2024	3/5/2025
TEKSystems	$193,752.00	Yes	UM	Dr. Tasinga	Reports & Dashboard Analyst for UM dept.	3/18/2024	12/31/2024
Dell	$65,909.11	Yes	IT	Richard Pruitt	Dell 5540 laptops (30) & monitors (32)	3/25/2024	3/23/2028
SAI360	$159,070.00	Yes	CPL	Deb Murr	Policy Management Platform	3/28/2024	3/27/2026
April 2024							
Coffey Communications	$92,944.00	Yes	MRKT	Louie Iturriria	Digital renewal agreement for KHS website	4/1/2024	3/31/2026
Imagenet	$197,000.00	Yes	CLM	Robin Dow-Morales	OCR services	4/4/2024	4/3/2027
The SSI Group	$70,000.00	Yes	CLM	Robin Dow-Morales	EDI Claims & Electronic Remittance	4/4/2024	4/5/2026
Dell	$78,927.60	Yes	IT	Richard Pruitt	Microsoft Defender for Servers Standard P2 Node	4/16/2024	12/31/2024
Dell	$61,480.00	Yes	IT	Richard Pruitt	Dell monitors (50) & Laptops (25)	4/24/2024	4/24/2028

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
Entysis360	$162,227.40	Yes	IT	Richard Pruitt	Rubrik renewal of premium support for enterprise edition software and hardware for a co-term	4/29/2024	4/28/2025
May 2024							
BG Healthcare	$118,000.00	Yes	UM	Dr. Tasinga	Consulting services for UM team	5/6/2024	12/31/2024
June 2024							
Relay Network	$199,999.00	Yes	IT	Richard Pruitt	Mobile Communication Platform, Unlimited Texting	6/1/2024	5/31/2025
The Granger Network	$197,500.00	Yes	HR	Devin Brown	Advance Leadership Development	6/1/2024	1/31/2025
Milliman	$199,000.00	Yes	ACCT	Veronica Barker	Actuarial Services	6/1/2024	5/31/2025
Context4 Healthcare	$97,775.15	Yes	IT	Richard Pruitt	ICD-10 Coding software	6/27/2024	6/27/2025
HMA	$30,681.00	Yes	PNM	Amisha Pannu	Timely Access Validation renewal	6/1/2024	5/31/2025
Bitfocus	$190,692.67	Yes	IT	Richard Pruitt	Clarity Human Services SaaS	6/22/2024	6/21/2025
TWE Solutions	$101,040.00	Yes	IT	Richard Pruitt	24x7 Security Monitoring	6/23/2024	6/22/2025
SS&C	$73,500.00	Yes	PHARM	Bruce Wearda	Rx Claims Processing	6/1/2024	12/31/2024
LDP	$122,850.00	Yes	CS	Andrea Hylton	UPS Battery Replacement & Service Plan	6/21/2024	6/20/2027
Ignite Healthwise	$146,062.26	Yes	HE	Isabel Silva	Care Management & Digital Experience w/ Patient Instructions Add-on	6/5/2024	6/4/2025
Caravel	$189,365.00	Yes	ACCT	Veronica Barker	Financial Advisory Services	6/25/2024	6/24/2026
Dell	$186,443.39	Yes	IT	Richard Pruitt	Microsoft Unified Enterprise Support	6/15/2024	6/14/2025
July 2024							
California Health Collaborativ	$84,000.00	Yes	HE	Isabel Silva	Diabetes Prevention and Diabetes Empowerment and Education Program (DEEP & DPP)	7/1/2024	6/30/2025
Bakersfield American Indian H	$90,000.00	Yes	HE	Isabel Silva	MCP Tribal Liaison	7/1/2024	6/30/2025
Commgap	$190,000.00	Yes	HE	Isabel Silva	In-person interpreting services	7/6/2024	7/5/2026
JDM	$119,040.00	Yes	HE	Richard Pruitt	Data Extraction & Transformation Solution	7/1/2024	6/30/2025
Solution Bench	$190,000.00	Yes	IT	Richard Pruitt	M-Files Subscription Base Licensing	7/24/2024	7/23/2026
August 2024							
The Granger Network	$198,750.00	Yes	HR	Devin Brown	Leadership Development and Consulting Services	8/1/2024	7/31/2025
Blackhawk	$65,000.00	Yes	ME	Lela Criswell	Member Gift cards, Amendment	8/7/2024	12/31/2024
Symplr	$67,512.48	Yes	UM	Dr Tasinga	Knowledge library for new medical procedures	8/1/2024	7/31/2027
Preparis	$107,093.84	Yes	CS	Andrea Hylton	Increase to Preparis alerts	8/19/2024	12/27/2026
September 2024							
Gartner	$72,390.00	Yes	Comp	Deb Murr	Gartner Compliance Licenses	9/1/2024	8/31/2025
The Periscope Group	$162,000.00	Yes	UM	Christine Pence	In-home Assesment Visits to Members	9/5/2024	9/4/2025
Clearlink	$180,400.00	Yes	UM	Christine Pence	Consulting Services	9/6/2024	Until exhausted
Pathfinder	$92,000.00	Yes	IT	Joe Orlando	3rd Party Risk Assessment	9/16/2024	9/15/2025
Tek Systems	$77,100.00	Yes	IT	Joe Orlando	ITSM Assessment	9/23/2024	12/6/2024
RWS	$72,685.00	Yes	IT	Joe Orlando	Translation Tool- cloud based	9/24/2024	9/23/2027
October 2024							
Maranatha Landscaping	$88,200.00	Yes	CS	Andrea Hylton	Landscaping and Garedning Services	10/17/2024	10/16/2027
AT&T	$97,404.00	Yes	IT	Joe Orlando	Secondary Azure	10/18/2024	10/17/2027
GHA Technologies	$66,322.99	Yes	IT	Cesar Delgado	Fontinet Fortigate Renewal	10/31/2024	12/31/2025
November 2024							
Payscale	$64,260.00	Yes	HR	Devin Brown	Compensation Study and Salary Analytics	11/24/2024	11/23/2027
Tel-Tec	$52,680.00	Yes	CS	Andrea Hylton	Annual Service and Monitoring Agreement for three years	11/1/2024	10/31/2027
The Granger Network	$198,000.00	Yes	HR	Devin Brown	2025 Readiness	11/21/2024	9/30/2025

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
ADS	$110,100.00	Yes	CS	Andrea Hylton	Storage management and onsite shredding	11/1/2024	10/31/2026
Blackhawk	$130,000.00	Yes	ME	Louie Iturriria	Gift Cards, Amendment for extension	11/1/2024	6/30/2025
Health Literacy	$61,850.00	Yes	IT	Darin Moore	Health Literacy adviser tool	11/11/2024	11/10/2025
Dell	$56,381.57	Yes	IT	Cesar Delgado	(13) Developer laptops	11/25/2024	11/24/2028
December 2024							
SPH Analytics	$60,900.00	Yes	HE	Isabel Silva	Translation Services Member Satisfaction Survey	12/10/2024	12/9/2026
Dell	$56,381.57	Yes	IT	Cesar Delgado	(13) Developer laptops	11/25/2024	11/24/2028
BDO	$71,500.00	Yes	IT	Cesar Delgado	Data Governance assessment	12/9/2024	2/3/2025
CitiusTech	$102,575.00	Yes	IT	Cesar Delgado	FHIR System	12/15/2024	12/15/2025
January 2025							
LinkedIn	$180,900.00	Yes	HR	Devin Brown	Online Training Course Lincenses	1/1/2025	12/31/2026
LinkedIn	$188,659.83	Yes	HR	Devin Brown	Hiring Enterprise Program	1/1/2025	1/1/2028
MetaStar	$56,700.00	Yes	QP	Kailey Collier	NCQA HEDIS Compliance Audit	1/1/2025	12/31/2027
Cloudera	$77,940.10	Yes	IT	Cesar Delgado	Data Lineage Software	1/1/2025	12/31/2025
Gartner	$184,800.00	Yes	HR	Devin Brown	HR licensing	1/1/2025	12/31/2025
Aobe	$89,807.52	Yes	IT	Cesar Delgado	Pro DC, Photoshp, Indesign, etc.	1/27/2025	12/26/2026

2024 PROJECT CONSULTING PROFESSIONAL SERVICES																			
ITEM	PROJECT	CAP/EXP	BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD TOTAL	REMAINING BALANCE
1	Member Engagement Platform	CAP	$ 2,078,861	$ 49,106	$ 434,335	$ 43,576	$ 67,939	$ 107,616	$ 96,594	$ 115,174	$ 89,982	$ 64,820	$ 61,429	$ 35,280	$ 37,240	$ 1,203,088	$ 875,773
2	DSNP	CAP	$ 4,232,682	$ 24,075	$ 23,625	$ 18,675	$ 22,193	$ 26,025	$ 22,050	$ 24,638	$ 10,725	$ 23,813	$ 9,563	$ 21,428	$ 18,375	$ 245,183	$ 3,987,499
3	HIE	CAP	$ 1,250,870	$ 18,000	$ 32,152	$ 45,024	$ 25,168	$ 24,024	$ 22,880	$ 24,024	$ 24,453	$ 22,880	$ 25,168	$ 20,592	$ -	$ 284,365	$ 966,505
4	Artifical Intelligence	CAP	$ 534,560	$ 29,496	$ 29,411	$ 31,378	$ 31,509	$ 31,290	$ 28,008	$ 28,271	$ 29,846	$ 28,621	$ 33,960	$ 24,595	$ 25,207	$ 351,591	$ 182,969
5	PHI Data Visibility & Security	CAP	$ 588,016	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 588,016
6	CBO Electronic Medical Record System	CAP	$ 777,550	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 777,550
7	Policy Management System	CAP	$ 267,280	$ -	$ -	$ -	$ 22,000	$ 2,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 24,000	$ 243,280
8	Accounting System Review	CAP	$ 245,898	$ 20,875	$ 19,250	$ 18,372	$ 19,250	$ 21,750	$ 16,188	$ 20,375	$ 18,563	$ 19,875	$ 21,250	$ 1,000	$ -	$ 196,747	$ 49,151
	CAPITAL TOTALS		**$ 9,975,716**	**$ 141,552**	**$ 538,773**	**$ 157,024**	**$ 188,058**	**$ 212,705**	**$ 185,720**	**$ 212,481**	**$ 173,568**	**$ 160,008**	**$ 151,369**	**$ 102,894**	**$ 80,822**	**$ 2,304,973**	**$ 7,670,744**
9	IT Staff Augmentation	EXP	$ 1,388,680	$ 658,391	$ 669,659	$ 747,729	$ 768,752	$ 785,756	$ 660,557	$ 703,801	$ 678,919	$ 632,317	$ 619,956	$ 509,269	$ 430,382	$ 7,865,489	$ (6,476,809)
10	PM Staff Augmentation	EXP	$ 3,770,964	$ 241,543	$ 219,591	$ 212,689	$ 234,970	$ 246,493	$ 205,888	$ 274,871	$ 314,300	$ 249,660	$ 251,849	$ 196,445	$ 167,143	$ 2,815,440	$ 955,524
11	DSNP Staff Augmentation	EXP	$ 4,252,032	$ 21,769	$ 22,915	$ 23,345	$ 24,777	$ 24,419	$ 20,767	$ 23,345	$ 23,775	$ 22,772	$ 26,352	$ 20,051	$ 21,197	$ 275,484	$ 3,976,548
12	NCQA (The Mihalik Group)	EXP	$ 350,000	$ 23,408	$ 16,703	$ 11,520	$ 8,418	$ 7,260	$ 11,003	$ 12,898	$ 13,605	$ 8,613	$ 10,498	$ 17,435	$ 17,585	$ 158,943	$ 191,058
13	DSNP (Rebellis)	EXP	$ 4,300,000	$ 956	$ 16,413	$ 49,164	$ 38,069	$ 43,988	$ 42,831	$ 68,493	$ 35,156	$ 57,169	$ 77,006	$ 103,068	$ 157,400	$ 689,713	$ 3,610,287
	OPERATING EXPENSE TOTALS		**$ 14,061,676**	**$ 946,067**	**$ 945,280**	**$ 1,044,447**	**$ 1,074,985**	**$ 1,107,916**	**$ 941,046**	**$ 1,083,408**	**$ 1,065,755**	**$ 970,530**	**$ 985,661**	**$ 846,267**	**$ 793,707**	**$ 11,805,068**	**$ 2,256,608**

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
April 17, 2025

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 03/05/2025 (4)				
Latha Madhavan, MD dba: AV Bridges Mental Health	Mental Health	1331 W Ave J Ste. 101A Lancaster CA		Retro-Eff 3/1/2025
ChildNet Youth and Family Services	ECM Case Management	2131 Mars Court Bakersfield CA		4/1/2025
Gabriel Arevalo Carranza dba: G and A Non-Medical Transportation	Transportation	4920 Elysium St. Bakersfield CA		4/1/2025
Purposeful Mobility LLC	Transportation	5701 Truxtun Ave Ste 220 Bakersfield CA		4/1/2025
PAC 04/02/2025 (10)				
EduCare ABA Solutions LLC dba: EduCare ABA Solutions	ABA Provider	2616 Vyn Dr. Bakersfield CA	Existing Provider: E. Barrientos-Ramirez BCBA	Retro-Eff 4/1/2025
Stephanie Prince LCSW dba: Stephanie Prince MSW LCSW Counseling and Therapy Services	Mental Health	2012 E Street Bakersfield CA		Retro-Eff 4/1/2025
Affordable Medical Transport Inc dba: AMT	Transportation	6100 Goldstone Dr Bakersfield CA		5/1/2025
Empress Medical Transportation	Transportation	9815 Fort Sanders Ave Bakersfield CA		5/1/2025
FirstCare Solutions Inc. dba: FirstCare Pharmacy	DME & Pharmacy	5410 Stockdale Hwy Unit B Bakersfield CA		5/1/2025
Hand Rehab Pros Antelope Valley	Occupational Therapy	38925 Trade Center Dr, Unit H Palmdale CA		5/1/2025
HCM Med Transport	Transportation	43700 17th St West Ste 202 Lancaster CA		5/1/2025
Whitney Guerrero MD INC	General Surgery	2021 22nd St Bakersfield CA	Existing Provider: Whitney Guerrero MD	5/1/2025
Shoreline Diagnostics LLC	Laboratory	175 Technology Drive Ste. 100 Irvine CA		5/1/2025
Loula Perinatal Health Services of California LLC	Doula	2261 Market St Ste. 10561 San Francisco CA		5/1/2025
Kern Psychiatric Health & Wellness Center	CSS	2204 Q Street Bakersfield CA		5/1/2025

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
April 17, 2025

Legal Name DBA	Specialty	Address	Comments	Contract Term Date
John E Heess MD Inc	Anesthesiology	2400 Bahamas Dr Ste 100 Bakersfield CA	Provider is now working for another in network Group	3/23/2025
Philip Rosenthal MD PC	Neurosurgeon	2323 16th Street Ste 503 Bakersfield, CA 93301	KHS termination	3/7/2025
PharMedQuest Pharmacy Services Inc	Pharmacy	8787 Hall Road, Lamont and 2000 Physicians Blvd, Bakersfield	Pharmacies were bought out by Clinica Sierra Vista	2/10/2025
Kern Cardiology Medical Group Inc.	Cardiology	4000 Physicians Blvd Bldg E Ste. 101 Bakersfield CA	Physician Retired - New Ownership under VIPMD	2/8/2025
LJMP LP dba: Capri in the Desert	Congregate Living Facility	44726 Cerisa Street	KHS Termination non-response to recredentialing	2/28/2025
Medical Diagnostic Laboratory, LLC	Specialty Lab	1330 Arrow Highway	KHS Termination non-response to inquiries and offices closed	3/14/2025
Oak Hills Medical Corporation	Specialty	5020 Commerce Drive Bakersfield CA	New Ownership under Silver Summit Medical Group	3/18/2025
STJ LP dba: Sorrento in the Desert	Congregate Living Facility	3833 E Avenue R-12	KHS Termination non-response to recredentialing	2/28/2025

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Chief Compliance and Fraud Prevention Officer Report

DATE: April 17, 2025

BACKGROUND

Kern Health Systems (KHS) is required to implement an effective Compliance Program that meets the regulatory requirements set forth in both the Department of Health Care Services (DHCS) contract and the Department of Managed Health Care (DMHC) Knox-Keene license.

The principles outlined in the regulatory guidelines are applicable to all KHS relevant decisions, situations, communications, and developments that align with requirements defined by the Office of Inspector General (OIG). The Governing Board is required to exercise reasonable oversight with respect to the implementation and effectiveness of the Compliance program.

DISCUSSION

Regulatory filings, e.g., reports, financial data, quality performance, and surveys are filed in response to new services, programs, and oversight requirements that are mandated under our contract and license. Currently, KHS is on track to meet or exceed the number of filings completed in 2024.

Privacy Protections and Fraud Prevention remain a key focus for KHS's Compliance department. Suspected violations are promptly investigated and reported to DHCS for probable violations of policies, regulations, statutes, or program requirements.

For Q1 2025, the Compliance Department investigated 74 allegations of privacy concerns, with four (4) forwarded to DHCS for review, with one (1) determined to be a non-breach and three (3) remain under review with DHCS. The Compliance department has investigated 189 suspected fraud, waste, and abuse allegations, which represents a 45% increase for the same time period in 2024. Services not rendered and excessive or unnecessary services represent many of the provider cases reviewed, while transportation and identity theft represent most member cases reviewed.

The Compliance Department conducts internal audits and monitoring activities related to determine organizational alignment to all regulatory and contractual obligations and conducts risk analysis to prioritize remediation plans if warranted. In the first quarter of 2025, Compliance conducted internal audits of Exempt, Expedited, and Standard Grievances (a previous audit finding), and the Provider Manual content. The reports are currently under review by the Business Owners after which the internal audit reports will be finalized.

Department of Managed Health Care (DMHC)

The final report for the 2022 DMHC Medical Audit was received in October 2024. Compliance continues to meet with stakeholders regarding deficiencies to prepare for the DMHC follow up survey anticipated in November 2025 to validate corrective actions for identified findings, including any follow up from the Office of Enforcement.

The DMHC is currently conducting the 2024 DMHC Audit of Fiscal and Administrative Affairs which began on 04/07/2025 for financial reports for the quarter ended September 30, 2024.

Department of Health Care Services (DHCS)

The DHCS 2023 Limited Scope Medical Audit and Focused Audit for Transportation/Behavioral Health closed five of the seven findings with a Corrective Action Plan (CAP) update submitted to DHCS on 1/25/2025. KHS is currently awaiting closure or additional requests from DHCS.

The DHCS 2024 Medical Survey completed on 12/20/2024. The Plan received the Preliminary Audit Reports, reporting **no findings for the audit period** for both our main DHCS contract and the state supported services contract.

Dual Special Needs Plan (DSNP)

The Center for Medicare and Medicaid Services (CMS) applications were submitted on 02/10/2025 in preparation for implementation of KHS's Medicare DSNP line of business in January 2026. Notifications were received advising of no deficiencies on the Medicare Part C Application and D-SNP Application. The Notice of intent to deny or approval from CMS for the DSNP product is anticipated late April 2025.

On 03/07/2025, DHCS advised there were no deficiencies identified in the Model of Care submitted for state review. The Model of Care remains under review by NCQA for CMS with anticipated KHS notification to be received in April 2025. All other implementation activities remain active.

This report provides an overview of the January 2025 through March 2025 KHS Compliance Program activities with the corresponding updates.

REQUESTED ACTION

Receive and file.

Compliance
Key Performance Indicators
April 2025

KERN HEALTH SYSTEMS

Compliance Communications

Department of Managed Health Care (DMHC)

- 2022 DMHC Medical Audit
  - Awaiting further communication from DMHC
  - Efforts ongoing to ensure readiness for follow up audit in November.
- 2024 DMHC Audit of Fiscal and Administrative Affairs
  - Onsite (Virtual) sessions begin 04/07/2025

Department of Health Care Services (DHCS)

- 2023 Limited Scope Medical Audit and Focused Audit:
  - Awaiting follow up or closure from DHCS on Corrective Action Plan.
  - DHCS acknowledged receipt of 01/25/2025 CAP update and confirmed no additional questions; however, awaiting further communication.
- 2024 Medical Survey notification received from DHCS:
  - Preliminary Audit Reports received, with no findings or deficiencies identified for the main or state supported services contracts.
  - Exit Conference held 04/02/2025.
  - Awaiting receipt of Final Report.

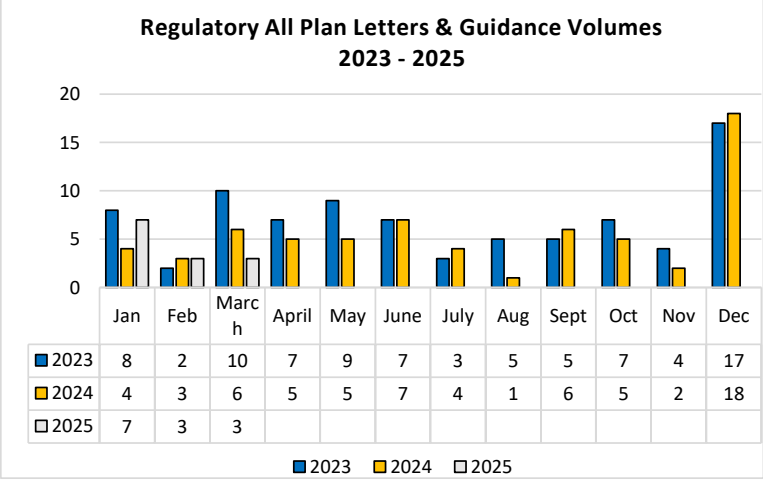
DSNP:

- CMS notifications received advising of no deficiencies on Medicare Part C Application and D-SNP Application. One small deficiency identified on CMS Part D Application regarding first-tier, downstream, and related entity organization chart submitted. Corrected and resubmitted on 03/13/2025.
- Notice of intent to deny or approval anticipated late April.
- On 03/07/2025, DHCS advised no deficiencies in the Model of Care submitted for state review. Model of Care still under review by NCQA for CMS; anticipated notification to be received in April.
- Implementation activities ongoing.

Compliance Capsules:

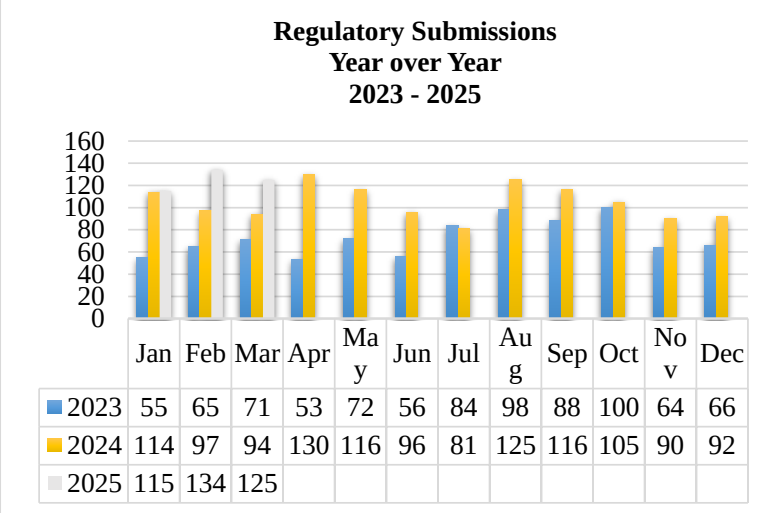
- February: Stakeholder Responsibilities
- March: Compliance Program

All Plan Letter (APLs) & Guidance Letters

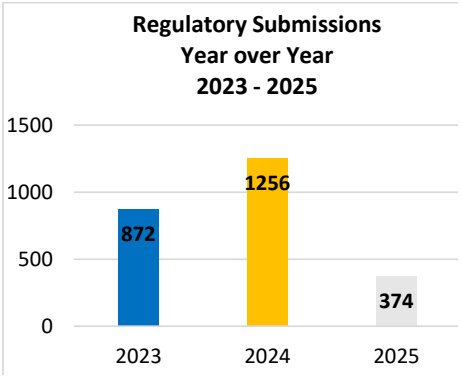


All Plan Letters & Guidance Letters Received		
2023	2024	2025
83	66	14

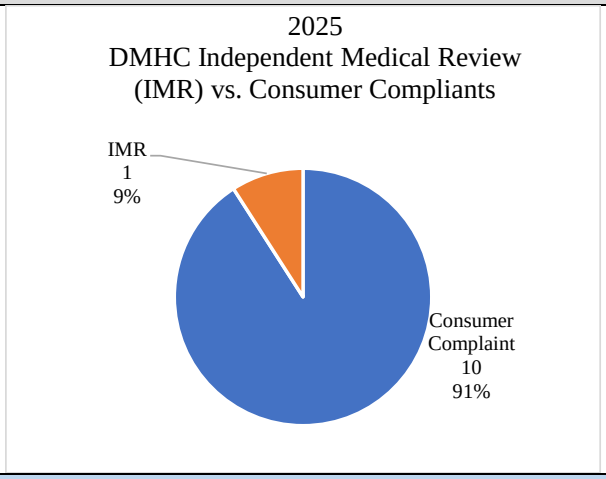
Regulatory Reports & Filings



Regulatory Submissions		
Regulatory Agency	**February 2025**	**March 2025**
DHCS	119	112
DMHC	15	13
Total	**134**	**125**



DMHC Consumer Complaints & Independent Medical Reviews (IMR)



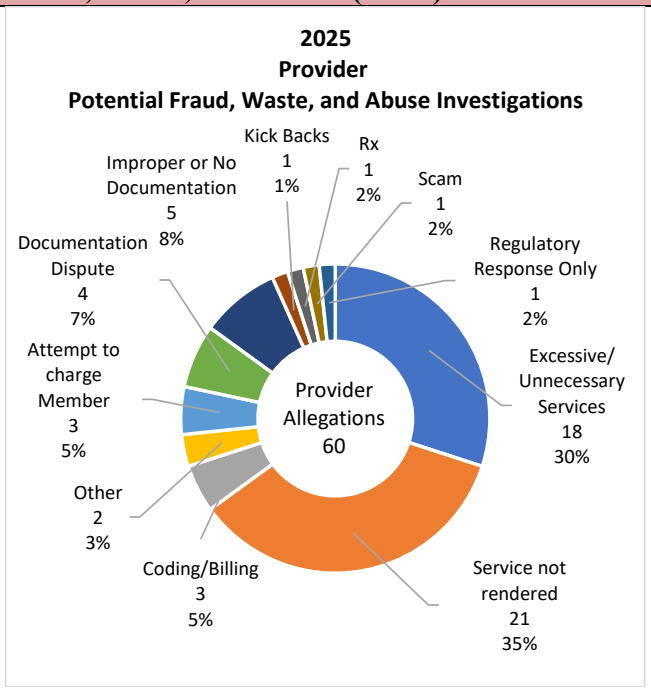
Decision	KHS Response	DMHC Response
Upheld	6	8
Overturned	3	0
Return to Plan (Grievance Process not completed prior to DMHC complaint)	1	0
Services Never Denied	1	0
In Process	0	3
Grand Total	11	11

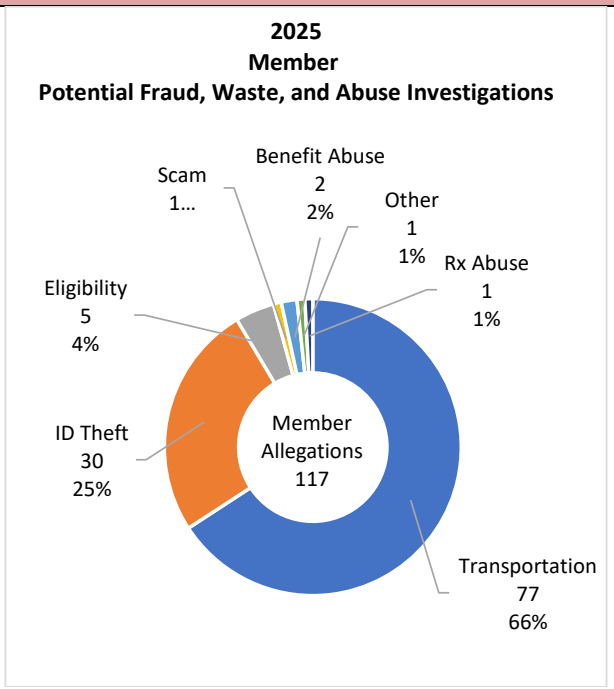
HIPPA Breach Activity

Summary of potential Protected Health Information (PHI) disclosures for January 16th through March 15, 2025: 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).

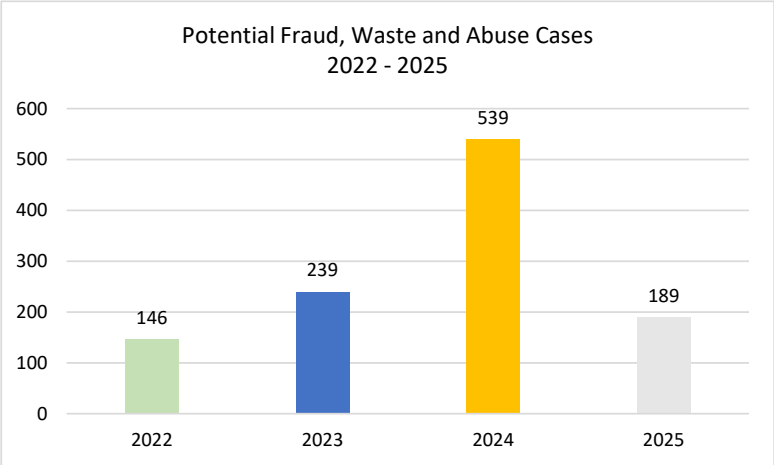
During the time from January 16th to March 15th, 2025, the Compliance Department investigated and reviewed seventy-four (74) allegations of privacy concerns and four (4) of the cases were sent to the State for their review. The DHCS closed one (1) of the cases and determined these to be a non-breach incident. There are three (3) cases that are still under review by the State.

Fraud, Waste, and Abuse (FWA)





2025 Potential FWA cases through March = 45% increase over same time period in 2024:



All Plan Letters (APLs) & Guidance Letters
01/16/2025 – 03/31/2025

Department of Health Care Services (DHCS)

APL 25-004 Community Reinvestment (Issued 2/7/2025)	This APL provides the Plan with guidance regarding the Plan's Contract requirements that the Plan reinvest a minimum level of their net income into their local communities.
APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats (Issued 2/12/2025)	This APL informs the Plan of the dataset that identifies the threshold and concentration languages in which, at a minimum, the Plan must provide written translated Member information.

Department of Managed Health Care (DMHC)	
APL 25-005 Southern California Fires and Flexibilities to Impacted Providers (Issued 3/19/2025)	This APL provides guidance on Health and Safety Code section 1368.7 that allows DMHC and the Plan to take actions to help mitigate the impact to enrollees and providers in Los Angeles and/or Ventura Counties who were displaced by the fires.
APL 25-007 Assembly Bill 3275 Guidance (Claim Reimbursement) (Issued 4/1/2025)	This APL under the Knox-Keene Health Care Service Plan Act of 1975, as amended is to provide guidance to the Plan on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026.
Internal Audit and Monitoring Activity	
The Compliance Department conducts internal audits and monitoring activities related to regulatory All Plan Letters, guidance, previous regulatory audit findings, and contractual obligations. From the published requirements, the Compliance Department conducts a risk analysis and identifies those that pose a higher degree of risk to the Plan. In the first quarter of 2025, Compliance conducted internal audits of Exempt, Expedited, and Standard Grievances (previous audit findings), and the Provider Manual; reports are currently under review by the Business Owners after which the internal audits will be finalized. In addition, delegation audits of American Logistics, Carenet, and VSP are being finalized. Audits of Utilization Management Notice of Action (NOA) denials, Notice of Appeal Resolutions (NAR), and Concurrent Inpatient Reviews (DMHC audit finding) have also begun in the second quarter.	
Regulatory Reports & Filings	
Regulatory Reports & Filings **Submission to Government Agencies**	KHS is required to submit various types of information to both DHCS and DMHC with cadences ranging from daily, weekly, monthly, quarterly, or annually. In some cases, KHS are required under statute or regulation to submit reports or documentation to establish initial or ongoing compliance with the law (e.g., timely access reporting, financial reporting). In other cases, plans are required to submit reports or documentation when they are planning to make an operational, business, product, or other change that affects the scope or applicability of their license. Additionally, key personnel and Board member filings are required to allow the regulatory agencies to review and advise on the individuals who provide leadership at KHS as well as the makeup of our Board of Directors. These submissions often reflect an amendment or material modification to the plan's license and, in some cases, are subject to Department approval prior to making the requested change to plan operations.
Regulatory Submission Volume	Regulatory submissions to both DHCS and DMHC continue to increase annually. As demonstrated in the graphs above, submissions to date continue to increase steadily year over year. Volumes are anticipated to significantly increase further due to the introduction of the Dual Special Needs Plan (D-SNP).

DMHC Consumer Complaints & Independent Medical Reviews

KHS addresses and tracks enrollee complaints and requests for independent medical review (IMR) received from the DMHC. For January through March 2025, a total of eleven (11) Consumer Complaints/IMRs were received, of which seven (7) were closed following KHS' response; one (1) was sent on for Independent Medical Review; and three (3) are pending DMHC review.

Fraud, Waste, and Abuse (FWA)

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. In 2024, the Compliance Department received 554 reported cases of alleged fraud, waste, or abuse, of which 309 were reported to DHCS. In 2024, the volume was 230% of the 2023 volume, with almost four times the number received in 2022, and more cases in a single year than the two previous years combined. For 2025, the volumes continue to trend up, with 45% more cases received in the first quarter of 2025 when compared to the first quarter of 2024.

DHCS Medical Audits

Limited Scope Medical Audit and Focused Transportation/Behavioral Health Audit – 2023:

DHCS conducted a routine limited scope medical survey and a focused Transportation/Behavioral Health audit of KHS in November/December 2023. The survey period covered 11/01/2022 – 10/31/2023:

- For the Focused Audit on Behavioral Health and Transportation, the final audit report was received on 08/30/2024.
    - The findings included four (4) items under Behavioral Health, and three (3) under Transportation.
        - The Behavioral Health findings are related to the coordination with the specialty mental health and substance use disorder benefits, which are carved out from KHS Medi-Cal benefits. During the audit period, KHS had already created a separate Behavioral Health Department and implemented corrective actions; however, since some of these actions were implemented during the audit period, DHCS still documented findings.
        - The Transportation preliminary findings were focused on our oversight and monitoring to ensure members receive door-to-door service, we are monitoring no show rates, and monitoring level of service modifications.
    - Corrective Action Plan (CAP) submitted to DHCS 10/07/2024, with thirty (33) actions taken across the seven (7) findings
        - DHCS accepted twenty-three (23) of the proposed corrective actions; and requested additional information for ten (10).
    - DHCS advised they did not have any further requests, and an additional submission was not required following the CAP update submission on 01/25/2025. KHS is currently awaiting closure or additional requests from DHCS.

DHCS Routine Medical Audit – 2024:

DHCS received the official notification of the Routine Medical Audit on 10/03/2024.

- Pre-Audit deliverables were submitted to DHCS on 10/31/2024.
- Numerous subsequent requests were received and submitted to DHCS timely.
- The "on site" interview portions of the audit were conducted virtually from 12/09/2024 – 12/20/2024.
- A preliminary exit conference was held on 12/20/2024, with DHCS verbally reporting potential findings (approximately 9), primarily related to Utilization Management and Grievance processing and notifications.
- The Plan received the Preliminary Audit Reports, reporting no findings for the audit period for both our main DHCS contract and the state supported services contract.
- An Exit Conference was held on 04/02/2025 and KHS is awaiting receipt of the final audit reports.

DMHC Routine Medical Audits

DMHC Routine Medical Audit – 2022/2023:

DMHC conducted a routine audit of KHS in January 2023. The audit period covered 09/01/2020 – 08/31/2022. The Audit Report was received on 03/07/2024.

- DMHC issued the final audit report on 10/08/2024
    - Four (4) of the twenty-four (24) findings from the preliminary report were removed from the final report.
    - Any supporting documentation KHS submitted after 04/21/2024 was not considered in issuance of the final report.
    - Of the twenty (20) findings in the final report:
        - Four (4) were considered 'corrected'.
        - Sixteen (16) were determined to be "not corrected". Although DMHC recognized steps were taken to correct the deficiencies, the effectiveness of the corrective actions will be re-assessed in a follow up survey, which will be conducted in November 2025.

            Four (4) findings are being referred to the Office of Enforcement:

            - The Plan fails to consistently ensure its delegate complies with required utilization management notification standards.
            - The Plan failed to consistently demonstrate that for concurrent review denials, care was not discontinued until the enrollee's treating provider had been notified and agreed to an appropriate care plan. Section 1367.01(h)(3).
            - The Plan inappropriately denies post-stabilization care and is operating at variance with policies filed with the Department.
            - The Plan improperly denied payment for emergency services and treatment. Section 1371.4(b) and (c).
    - Two (2) – not able to remediate as these were pharmacy-related and Pharmacy is now carved out
- Compliance continues to meet with stakeholders regarding deficiencies to prepare for follow up from the Office of Enforcement.
- Compliance is in the process of developing the auditing and monitoring plan for 2025, which will include audits of the DMHC deficiencies to ensure compliance prior to the follow up survey, currently targeted for 11/10/2025.
- No additional communication has been received from DMHC to date.

DMHC Audit of Fiscal and Administrative Affairs (Financial Audit) – 2024:

- Entrance letter received 10/30/2024
- Deliverables submitted timely on 01/27/2025
- Onsite (Virtual) scheduled to begin 04/07/2025

KERN HEALTH SYSTEMS

Compliance Capsule – February 2025

Business Stakeholder Roles & Responsibilities

Understanding your roles and responsibilities fosters a collaborative work environment. Compliance is always available for guidance, although knowing and fulfilling your responsibilities is essential for our success. This not only reinforces the importance of teamwork, but also offers a tangible reference to enhance understanding and implementation of the task assigned. For additional details on how Stakeholders and Compliance collaborate, please refer to the table below.

Stakeholder responsibilities for regulatory submissions:

- Review the regulatory calendar routinely for upcoming submissions: 2025 Regulatory Calendar.xlsx
- **Review "Reminder" emails when they are received**
  - By reviewing the first reminder sent and advising the team of any concerns or questions related to the required submission, we can clarify or remediate as needed in advance of the due date.
- **Ensure accuracy of submissions**
  - By carefully reviewing the data within, the naming convention, completion of review tools, attestations, etc. (as applicable based on submission), we can avoid rework or resubmissions.
- **Submit deliverables timely**

Stakeholder responsibilities for policies:

- Draft/update policies to ensure alignment with regulatory requirements and organizational practices
- Redline to track changes
- Review policies against regulations, All Plan Letters, DHCS Contract, and regulatory tools (when applicable):
  - DHCS All Plan Letters
  - DMHC All Plan Letters
  - Knox Keene Act
  - P:__Compliance\DHCS Contract
- **Perform a quality review of the updates, including numbering, grammar, formatting, etc.**
- If referencing responsibilities of other departments, review with the appropriate business stakeholder
- Transfer policies from the "old" policy format to the "new" policy format and formatting upon revisions of policies on the previous form.

KHS Policy Template_ v1.docx

- Reach out to Compliance, PolicyTeam@khs-net.com, prior to revision to request the appropriate version of the policy to update
- **Return updated policies within 10 days**
- Ensure any new policies created for DHCS Operational Readiness and/or NCQA are sent to Compliance
- Conduct annual policy reviews to identify gaps, needed changes, and potential refinement opportunities

Stakeholder responsibilities for audits:

- Ensure timely submission of deliverables, both to Compliance and to our regulators
- Coordinate with other business owners when needed for your own deliverable
- Ensure accuracy of deliverables
- Ensure the deliverable provides the information requested

For more information about stakeholder roles & responsibilities, or any Compliance questions, please reach out to Deborah Murr, Chief Compliance & Fraud Prevention Officer, or Jane MacAdam, Director of Compliance & Regulatory Affairs.

KERN HEALTH SYSTEMS

Compliance Capsule – March 2025

The 7 Elements of a Compliance Program

A comprehensive compliance program is essential for organizations to ensure adherence to legal, regulatory, and ethical standards. It provides a structured framework to prevent, detect, and address potential violations, safeguarding the organization's integrity and reputation. The seven key elements of a compliance program serve as a guide to effectively manage compliance risks and promote a culture of accountability. These elements, when implemented properly, help organizations create an environment that supports lawful practices, transparency, and proactive risk management. This framework includes establishing clear policies, effective training, strong internal controls, and ongoing monitoring, among other critical components.

The 7 Elements of a Compliance Program:

1. **Written Policies and Procedures:**
   - Establish clear, accessible, and comprehensive guidelines for conduct, ensuring all personnel are aware of their compliance obligations.
2. **Designate a Compliance Officer/Committee:**
   - Have a dedicated compliance officer or committee to oversee the program and provide guidance.
3. **Training and Education:**
   - Conduct regular training to educate employees on compliance policies, ethical conduct, and potential risks.
4. **Effective Lines of Communication:**
   - Create safe channels for employees to report concerns or ask questions without fear of retaliation.
5. **Internal Monitoring and Auditing:**
   - Regularly monitor and audit the compliance program to identify potential issues and ensure effectiveness.
6. **Enforce Standards through Disciplinary Guidelines:**
   - Establish well-publicized disciplinary guidelines outlining consequences for non-compliance.
7. **Prompt Response and Corrective Action:**
   - Ensure all allegations of non-compliance are addressed promptly and that corrective action is taken, when needed.

KHS' Compliance Guide, Compliance Program Description, and Code of Conduct provide further details on these elements and more!

More information about the seven elements and our full compliance program description is posted to our external website and can also be found on our KHS intranet.

For more information about stakeholder roles & responsibilities, or any Compliance questions, please reach out to Deborah Murr, Chief Compliance & Fraud Prevention Officer, or Jane MacAdam, Director of Compliance & Regulatory Affairs.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

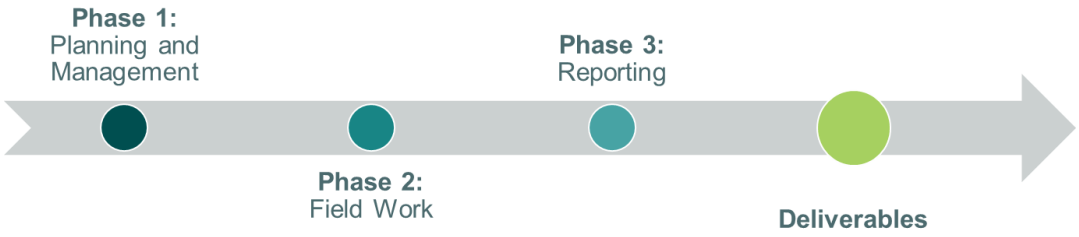
SUBJECT: Enterprise Risk Management Project Update

DATE: April 17, 2025

BACKGROUND

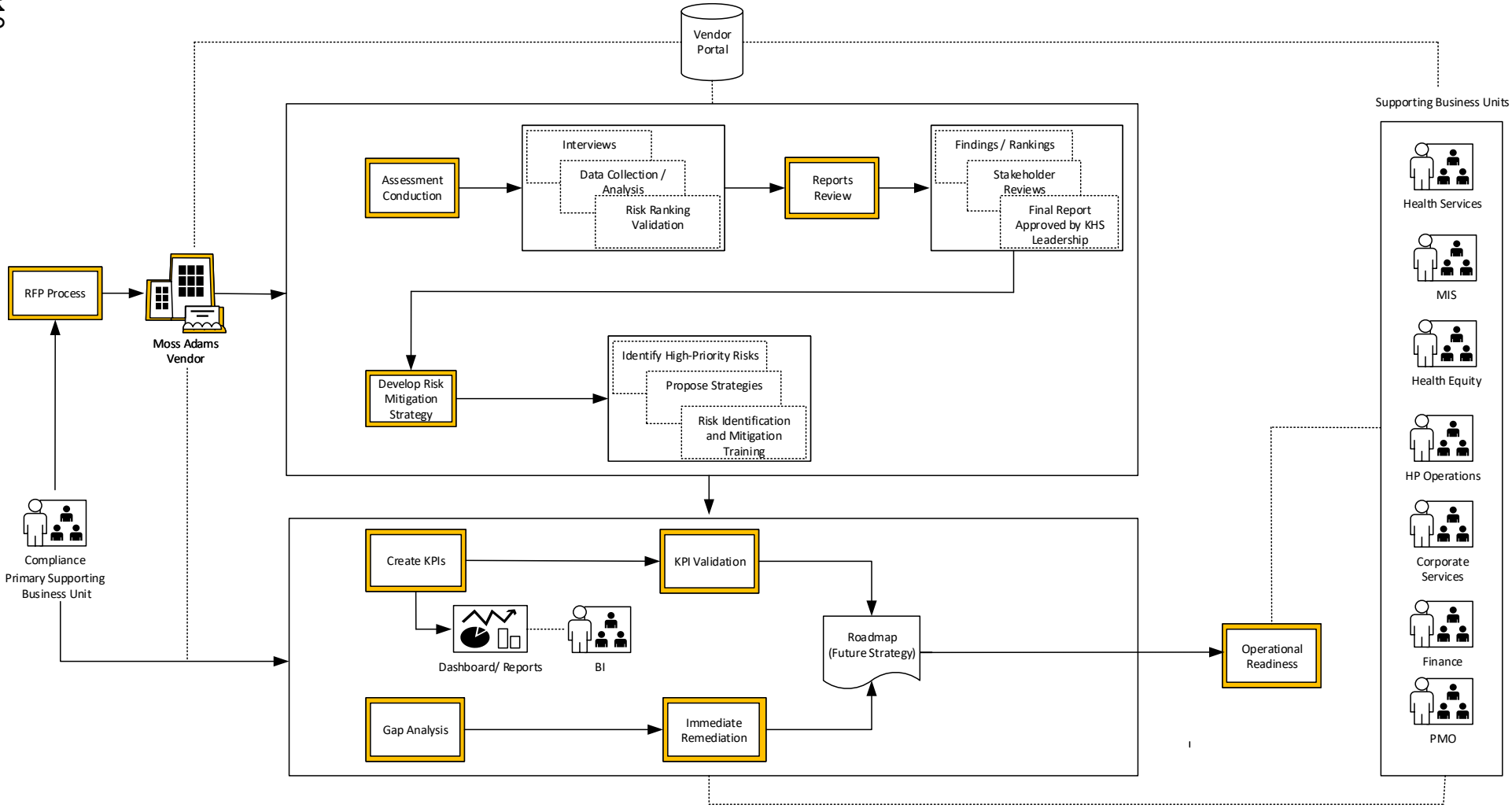
In December 2024, the Kern Health Systems HS Compliance Department received Board of Directors approval to conduct an Enterprise Risk Management Assessment Project to strategically identify, assess, and prepare for potential harm that may interfere with an organization's operations and objectives. Moss Adams and KHS Compliance staff initiated Phase 1 of 3 for the project on February 4, 2025.

Establishing an Enterprise Risk Management (ERM) program will provide the knowledge and framework to identify and evaluate emerging through design and launching a program that combines existing risk management practices, provides an explanation in familiar terms of how enterprise risk management will benefit KHS, and facilitate conversations around the topic of risk for all stakeholders.



REQUESTED ACTION

Receive and File the Enterprise Risk Management Project Update.



Data Information Knowledge Action Business Intelligence	Description Enterprise Risk Management Assessment	Customer / Project Compliance	Kern Family Health Care The Friendly Face Of Kern Health Systems
		Author Mauricio Osorio	Date Revised 02/06/2025
			Page 1 of 1

Enterprise-Wide Risk Assessment Example Timeline

Tasks	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Week 16	Week 17	Week 18
Kickoff Meeting																		
Status Updates																		
Receive Initially Requested Documentation																		
Develop Risk Universe																		
Meeting to Discuss Risk Universe and Finalize																		
Schedule individual stakeholder and group session meetings																		
Hold individual leadership and group session meetings																		
Provide initial ranked universe based on individual and group sessions																		
Meeting to discuss initial ranked universe																		
Identify risk owners																		
Schedule meetings with risk owners to discuss controls																		
Conduct meetings with risk owners																		
Apply control reliance and present updated risk ranked universe																		
Meeting to discuss updated risk ranked universe																		

Major Deliverables (EPIC)	**Major Deliverable Requirements (What and Why)**	**Requirement Details (Specifics)**
Data exchange (example)	*ABC department requires multiple data files from XYZ so that we can manage members*	*1 daily Membership file - inbound*
Conduct Assessment	Regulatory Framework Alignment	Review OIG/DOJ guidelines and other applicable regulations to ensure the ERM framework complies with them. Adjust ERM strategies to align with these standards and address compliance needs.
	Gap Analysis	Conduct a thorough review of the current risk management environment. Document discrepancies between the existing processes and regulatory requirements.
	Risk Identification and Categorization	Identify existing risks across KHS domains. Categorize risks based on their impact and probability. Align risks with regulatory impact areas for prioritization.

	Scenario Analysis and Testing	Conduct scenario analysis for high-risk events. Test organizational readiness and response to those events.
	Internal Controls Assessment	Conduct a thorough review of internal controls. Test internal controls to evaluate their effectiveness.
Review Reports	Policy and Procedure Review	Review and assess current policies and procedures. Identify and address any gaps or deficiencies in regulatory compliance.
	Risk Reporting and Communication	Assess current risk reporting systems and communication channels. Ensure reports meet regulatory standards and are accessible to stakeholders.
	Third-Party Risk Management	Assess the third-party risk management processes. Evaluate compliance with regulatory standards in vendor oversight.
	Documentation and Audit Readiness	Document all ERM processes and strategies. Ensure documentation meets audit and regulatory standards.
	Prioritization of Gaps	Rank identified gaps based on severity, impact on compliance, operations, and financial risk. Use a risk scoring system to prioritize mitigation actions.

Develop Risk Mitigation Strategy	Mitigation Strategy Development	Develop actionable strategies for each identified gap. Ensure strategies are aligned with regulatory requirements and best practices.
	Resource Allocation	Review resource allocation for risk management. Ensure adequate resources are available for mitigation actions.
	Integration with Strategic Goals	Align risk management strategies with KHS's organizational goals. Ensure that ERM is integrated into overall strategic planning.
Create/Develop Key Performance Indicators (KPIs)	Risk Appetite and Tolerance	Review KHS's risk appetite and tolerance levels. Ensure these levels are consistent with regulatory standards and organizational goals.
	Monitoring and Continuous Improvement	Implement ongoing monitoring mechanisms for ERM. Develop a continuous improvement plan based on monitoring results.
	Risk Culture Evaluation	Assess organizational risk culture. Identify gaps in awareness, communication, and propose solutions.

Integration	Integration with Strategic Goals	Align risk management strategies with KHS's organizational goals. Ensure that ERM is integrated into overall strategic planning.
	Stakeholder Engagement	Hold meetings with stakeholders from relevant departments to discuss gaps and strategies. Ensure alignment between departments for unified risk management
	Training and Awareness Programs	Evaluate current training programs. Propose enhancements based on identified gaps.
Systems	Data Quality and Accessibility	Review data sources used in risk management. Assess quality and accessibility for decision-making.
	Risk Reporting and Communication	Assess current risk reporting systems and communication channels. Ensure reports meet regulatory standards and are accessible to stakeholders.
	Monitoring and Continuous Improvement	Implement ongoing monitoring mechanisms for ERM. Develop a continuous improvement plan based on monitoring results.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Proposed Draft Ticket Distribution Policy

DATE: April 17, 2025

BACKGROUND

The purpose of a Ticket Distribution Policy (Policy) is to ensure that all tickets and/or passes that Kern Health Systems (KHS) receives from public and private entities and individuals are distributed in furtherance of governmental and/or public purposes as required pursuant to Fair Political Practices Commission (FPPC) Regulation Section 18944.1.

This new policy conforms to the requirements of Regulation 18944.1, and it increases the ability of KHS to distribute tickets to qualifying community organizations, in line with the actual distribution of tickets. It takes into consideration best practices for ticket distribution and reporting that are consistent with the previous and ongoing distribution of tickets. Specifically, tickets covered by the policy include gratuitously provided to KHS by an outside source and distributed to KHS Representatives or purchased by KHS and distributed to KHS Representatives.

REQUESTED ACTION

Receive and File.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Ticket Distribution Policy	**Policy #**	14.xxxx
Policy Owner	Compliance	**Original Effective Date**	xx/2025
Revision Effective Date		**Approval Date**	
Line of Business	☒ Medi-Cal ☐ Medicare		

I. PURPOSE

The purpose of this Ticket Distribution Policy (Policy) is to ensure that all tickets and/or passes that Kern Health Systems (KHS) receives from public and private entities and individuals are distributed in furtherance of governmental and/or public purposes as required pursuant to Fair Political Practices Commission (FPPC) Regulation Section 18944.1.

This Policy conforms to the requirements of Regulation 18944.1, and it increases the ability of KHS to distribute tickets to qualifying community organizations, in line with the actual distribution of tickets. It takes into consideration best practices for ticket distribution and reporting that are consistent with the previous and ongoing distribution of tickets.

II. POLICY

A. **Tickets Covered by this Policy**

1. Gratuitously provided to KHS by an outside source and distributed by the Ticket Coordinator to KHS Representatives; and

2. Purchased by KHS = and distributed by the Ticket Coordinator to KHS Representatives.

B. Limitations and Exclusions

1. This Policy shall only apply to KHS's distribution of Tickets to, or at the behest of, a KHS Representative. Consideration of equal or greater value shall be presumed if the Tickets are distributed pursuant to this Policy.
2. This Policy shall apply only to Tickets to entertainment, amusement, recreational, or similar events and functions that further a public purpose in accordance with title 2, section 18944.1, of the California Code of Regulations. Tickets that are distributed as provided in this policy will

not result in a gift to the KHS Representative who receives the tickets.

2. This Policy shall apply only if (i) the Ticket is not earmarked by the original source of the Ticket for use by the specific KHS Representative who uses the Ticket, (ii) the Ticket Coordinator accepts the Ticket on behalf of KHS, (iii) the Ticket is provided by the Ticket Coordinator to a KHS Representative or at the behest of a KHS Representative, and (iv) the Ticket Coordinator determines in his/her sole discretion which Representative may use the Ticket.

3. This Policy shall not apply to any other item of value provided to KHS or KHS Representative unless the item is provided to all members of the public with the same class of Ticket, such as food and beverages. Any other benefits may be reportable on the KHS Representative's Form 700 and be subject to state law and FPPC regulations related to gifts to public Representatives.

4. This Policy does not apply to up to two ticket(s) or other admission to political fundraising event or non-profit (501(c)(3) exempt organization fundraisers that are provided directly to the KHS Representative for use by the KHS Representative and one other guest and does not involve KHS. Such tickets or admissions are not considered gifts or income in accordance with FPPC Regulation 18946.4.

5. This Policy does not apply to any Ticket received by a KHS Representative that:
   (a) The KHS Representative treats as income consistent with applicable state and federal income tax laws and regulations and KHS reports the distribution of the Ticket as income to the KHS Representative; or
   (b) For which the KHS Representative pays the fair market value, or for which the KHS Representative reimburses the original source of the Ticket in accordance with FPPC Regulations, or for which the KHS Representative pays or reimburses KHS for the fair market value; or
   (c) Is a "gift" to the KHS Representative in accordance with FPPC Regulations whether or not the KHS Representative reports the gift on the KHS Representative's Form 700.

6. This Policy does not apply to a Ticket provided to a KHS Representative for his or her admission to an event at which the KHS Representative performs a ceremonial role or function on behalf of KHS. Such Tickets are exempt from disclosure or reporting requirements under FPPC Regulations in effect as of the date of the adoption of this policy.

C. Ticket Distribution for Public Purposes

The distribution of any Ticket by KHS to, or at the behest of, a KHS Representative shall further a public purpose as defined below, or as otherwise considered and approved by the KHS Board of Directors where not listed herein. KHS may accomplish one or more of the following public purposes through the distribution of Tickets to, or at the behest of, a KHS Representative:

1. Support or promotion of KHS.
2. Sponsorships of events, activities, or programs of KHS.
3. Support or promotion of local nonprofit health care related charitable organizations and foundations.

4. Sponsorships of events, activities, or programs of local nonprofit health care related charitable organizations and foundations.
5. Sponsorship, promotion, or increasing public exposure to and awareness of the KHS's mission to promote good health to the staff, members, providers, and community partners of KHS.
6. Sponsorships or promotion of special events in accordance with a KHS contract.
7. Representation or promotion of KHS recognition, visibility, and/or profile on local, state, or federal levels.
8. Recognizing or rewarding meritorious service of a KHS Representative or employee with a Ticket for their personal use, including to support general employee morale and retention, except if the KHS Representative is a member of the governing body, the chief administrative officer of the agency, political appointee, or department head.

D. Purchase of Tickets or Passes

KHS Representatives may request the Ticket Coordinator purchase up to two (2) tickets in accordance with the public purposes of this Policy for use by the KHS Representative, and an immediate family member (spouse or dependent child), or one other person.

E. Transfer, Sale, and Reimbursement Prohibitions

The transfer by any KHS Representative of any Ticket, distributed to such KHS Representative pursuant to this Policy, to any other person, except to one guest or members of the KHS Representative's Immediate Family for their personal use, is prohibited. No person receiving a Ticket pursuant to this Policy shall be permitted to sell, receive reimbursement for the value of, or further transfer any Ticket.

F. Return of Tickets

Any KHS Representative or any member of KHS Representative's Immediate Family, or any person or entity receiving a Ticket at the behest of any KHS Representative, may return any unused Ticket to the Ticket Coordinator for redistribution pursuant to this Policy, provided such Ticket(s) is/are returned prior to the event taking place. A KHS Representative is not required to report on Form 802 any Ticket returned pursuant to this Section prior to the event taking place. Any Ticket returned unused but after the event has taken place shall be deemed to have been used by the recipient and reported as such on Form 802.

G. Website Posting

This Policy and all completed FPPC Form 802s, or a summary of the information on the Form 802, shall be posted on KHS's website in a prominent fashion within thirty (30) days after the Ticket distribution.

H. Reporting

.
KHS shall report the distribution of a Ticket as required by title 2, section 18944.1, of the California

Code of Regulations.

III. DEFINITIONS

TERMS	DEFINITIONS
Organization	Shall mean Kern Health Systems (KHS)
Organization Representative	Shall mean and refer to Kern Health System's "public Representatives" as that term is defined by Government Code Section 82048 and FPPC Regulation Section 18701, as these sections are amended from time to time.
FPPC	Shall mean the California Fair Political Practices Commission.
FPPC Regulations	Shall mean the regulations of the FPPC set forth in Title 2, Division 6, of the California Code of Regulations.
Immediate Family	Shall have the same meaning as set forth in Government Code Section 82029 as the same may be amended from time to time. As of the date of adoption of this Policy, the term "Immediate Family" is defined in Section 82029 as the Representative's spouse and dependent children.
Policy	Shall mean this Ticket Distribution Policy.
Fair Market Value	Shall mean "fair market value" as defined in title 2, section 18946, of the California Code of Regulations, as it now exists or as it may be amended in the future.
Ticket/Pass	Shall mean a "ticket or pass" as that term is defined in FPPC Regulation 18944.1, as amended from time to time, but which currently defines a "ticket or pass" as access, entry, or admission to a facility, event, show or performance for an entertainment, amusement, recreational, or similar purpose for which similar tickets or passes are sold to the public to view, listen to, or otherwise take advantage of the attraction or activity for which the ticket is sold. "Ticket" includes a "pass" as defined in this section, so that wherever this Policy uses the term "ticket," it means both tickets and passes. A ticket includes any benefits that the ticket provides.
Ticket Coordinator	Shall be Kern Health System's CEO or their designee who shall be the Agency Head responsible for implementing this policy, distributing tickets in accordance with this policy and completing and posting the FPPC Form 802.

IV. PROCEDURES

A. Applicability

1. A ticket not covered by this policy may be subject to separate disclosure requirements and the annual gift limit under the California Political Reform Act and related regulations. A KHS Representative who receives or behests a ticket not covered by this policy is solely responsible for determining, and complying with, all reporting requirements and the annual gift limit applicable to such ticket.

2. This Policy applies only to the benefits that the KHS Representative receives from the ticket that are provided to all members of the public with the same class of ticket. If the KHS Representative receives benefits, such as food and beverages, that are not provided to all members of the public with the same class of ticket, then the KHS Representative shall treat those benefits as gifts unless the KHS Representative provides consideration of equal or greater value for the benefits.

3. The use of tickets is a privilege extended by KHS and not the right of any person to whom the privilege may from time to time be extended.

V. ATTACHMENTS

Attachment A:
Attachment B:
Attachment C:
Attachment D:

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	California Code of Regulations Title 2 Sections 18944.1; 18942.3
Regulatory	California Code of Regulations Title 2, section 18946
Choose an item.	

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective			
Revised			

Retired			

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure:

Last approved version:

Reason for Creation:

Director Approval		
Title	**Signature**	**Date Approved**

Date posted to public drive: _____

Date posted to website ("P" policies only) : _____

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Readily Artificial Intelligence Tool

DATE: April 17, 2025

BACKGROUND

Kern Health System operates in a complex regulatory environment that requires constant vigilance to ensure alignment with California's Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC) All Plan Letters (APLs), Centers for Medicare and Medicaid Services (CMS), Health Plan Management System (HPMS) Memos, and federal and state laws. Keeping up with the volume and frequency of regulatory updates is a daunting task, often requiring extensive manual effort to interpret, track, and implement requirements across the organization.

Readily, an AI-powered compliance tool streamlines these processes by automatically monitoring, categorizing, and analyzing new regulatory communications, providing actionable insights in real-time. The tool will assist the compliance and other operational departments to prioritize critical updates and avoid costly delays or missed deadlines.

Readily is a robust solution for managing audit tracking and responding efficiently to inquiries. AI can centralize audit data, flag potential risks, and predict gaps based on historical trends, enabling a proactive approach to compliance. By integrating with existing systems, the tool can improve operational efficiency, reduce human error, and provide a scalable solution to meet increasing regulatory demands.

REQUESTED ACTION

Approve.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Jake Hall, Senior Director of Contracting and Quality Performance

SUBJECT: Managed Care Accountability Set Update

DATE: April 17, 2025

Background

The Managed Care Accountability Set (MCAS) is a California specific, focused subset of HEDIS (Health Effectiveness Data Information Set) measures that DHCS and DMHC uses to evaluate managed care plan performance. These measures include well child visits, adolescent vaccinations, breast cancer screenings, Diabetes monitoring, blood pressure control, and a host of other preventative care services. The measures are categorized into various "domains" such as Chronic Disease Management, Behavioral Health, Cancer Prevention, Women, and Children's domains. The QP team is responsible for plan monitoring and oversight of MCAS performance annually, as well as evaluation of ongoing MCAS activities. This overview provides an update on our annual MCAS audit progress, 2025 year to date performance, and a comparison of 2025 versus 2024 performance.

Discussion

See attached PowerPoint Presentation.

Fiscal Impact

The fiscal impact of not achieving and maintaining satisfactory MCAS rates may be severe to the health plan. This includes sanctions which may come in the form of monetary fines, reduction in default assignment, reduction in membership, and ultimately revocation of the plan from the Medi-Cal program. Another cost is utilization and increased costs of care associated with the lack of preventive care, that turns preventable conditions into chronic conditions. The ultimate cost is paid by the membership in the form of reduced health status and diminished quality of life. Access to high quality and equitable care is what MCAS drives, and what we as a plan are striving to deliver to the more than 400,000 lives we cover.

Requested Action

Receive and File.

Quality Performance

MCAS

Jake Hall
Senior Director of Contracting and Quality Performance

KERN HEALTH SYSTEMS

2025 YTD Performance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
78.86%	46.08%	28.57%	47.25%	13.04%	37.50%
HITS FOR MPL (44)	*HITS FOR MPL 1,315*	*HITS FOR MPL 10,825*	*HITS FOR MPL 6,579*	*HITS FOR MPL 3,124*	*HITS FOR MPL 1,077*
MPL: 66.24% Over MPL by 12.62% AMR is not held to MPL.	MPL: 52.68% Under MPL by 6.60%	MPL: 64.48% Under MPL by 35.91%	MPL: 57.11% Under MPL by 9.86%	MPL: 35.70% Under MPL by 22.66%	MPL: 55.95% Under MPL by 18.45%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
13.71%	19.55%	17.22%	96.01%	27.07%	68.97%
HITS FOR MPL 933	*HITS FOR MPL 44*	*HITS FOR MPL 65*	*HITS FOR MPL 14,258*	*HITS FOR MPL 611*	*HITS FOR MPL (347)*
MPL: 27.49% Under MPL by 13.78%	MPL: 36.18% Under MPL by 16.63%	MPL: 53.82% Under MPL by 36.60%	MPL: 33.33% Under MPL by 62.68% Inverted Measure	MPL: 34.30% Under MPL by 7.23%	MPL: 63.84% Over MPL by 5.13%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
60.21%	59.45%	20.97%	27.20%	59.33%	8.82%
HITS FOR MPL 506	*HITS FOR MPL 634*	*HITS FOR MPL (3,356)*	*HITS FOR MPL 1,479*	*HITS FOR MPL 716*	*HITS FOR MPL 61,103*
MPL: 80.23% Under MPL by 20.02%	MPL: 84.55% Under MPL by 25.10%	MPL: 19.00% Over MPL by 1.97%	MPL: 60.38% Under MPL by 33.18%	MPL: 69.43% Under MPL by 10.10%	MPL: 48.07% Under MPL by 39.25%

- Meeting MPL for 3 measures
- 2 of 3 in children's domain
- Reflective of YTD admin data only

KERN HEALTH SYSTEMS

2025 Trending Performance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
78.86%	46.08%	28.57%	47.25%	13.04%	37.50%
HITS FOR MPL (44)	HITS FOR MPL 1,315	HITS FOR MPL 10,825	HITS FOR MPL 6,579	HITS FOR MPL 3,124	HITS FOR MPL 1,077
+3.16 % change Mar'24 75.70%	-1.35 % change Mar'24 47.44%	+3.53 % change Mar'24 25.05%	+9.02 % change Mar'24 38.23%	+1.18 % change Mar'24 11.86%	+2.27 % change Mar'24 35.23%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
13.71%	19.55%	17.22%	96.01%	27.07%	68.97%
HITS FOR MPL 933	HITS FOR MPL 44	HITS FOR MPL 65	HITS FOR MPL 14,258	HITS FOR MPL 611	HITS FOR MPL (347)
+1.54 % change Mar'24 12.17%	-0.72 % change Mar'24 20.27%	-4.65 % change Mar'24 21.88%	-10.05 % change Mar'24 85.96%	+3.99 % change Mar'24 23.08%	+8.92 % change Mar'24 60.05%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
60.21%	59.45%	20.97%	27.20%	59.33%	8.82%
HITS FOR MPL 506	HITS FOR MPL 634	HITS FOR MPL (3,356)	HITS FOR MPL 1,479	HITS FOR MPL 716	HITS FOR MPL 61,103
+2.73 % change Mar'24 57.47%	+30.78 % change Mar'24 28.68%	+0.33 % change Mar'24 20.65%	-6.83 % change Mar'24 34.04%	+2.46 % change Mar'24 56.86%	-1.76 % change Mar'24 10.59%

- Improving in 13 of 18 measures compared to same time last year

KERN HEALTH SYSTEMS

MY2024 Audit Update

Hybrid Measures Held to MPL

CCS	CIS-10	GSD*	CBP	IMA-2	PPC-Pre	PPC-Post	LSC
55.72	24.09	34.55	59.85	36.50	85.89	82.00	66.42
MPL: 57.18	MPL: 27.49	MPL: 33.33	MPL: 64.48	MPL: 34.3	MPL: 84.55	MPL: 80.23	MPL: 63.84
Diff: -1.46	Diff: -3.40	Diff: -1.22	Diff: -4.63	Diff: 2.20	Diff: 1.34	Diff: 1.77	Diff: 2.58
Hits Needed: 7	Hits Needed: 14	Hits Needed: 6	Hits Needed: 20	Hits Needed: 0	Hits Needed: 0	Hits Needed: 0	Hits Needed: 0

Admin Measures Held to MPL

AMR	BCS-E	CHL	DEV	FUA	FUM	TFL-CH	W30(0-15M)
75.53	58.79	56.86	30.33	28.60	17.77	18.69	45.88
MPL: 66.24	MPL: 52.68	MPL: 55.95	MPL: 35.70	MPL: 36.18	MPL: 53.82	MPL: 19.00	MPL: 60.38
Diff: 9.29	Diff: 6.11	Diff: 0.91	Diff: -5.37	Diff: -7.58	Diff: -36.05	Diff: -0.31	Diff: -14.50
Hits Needed: 0	Hits Needed: 0	Hits Needed: 0	Hits Needed: 722	Hits Needed: 134	Hits Needed: 360	Hits Needed: 476	Hits Needed: 434

W30(15-30M)	WCV
69.00	50.49
MPL: 69.43	MPL: 51.81
Diff: -0.43	Diff: -1.32
Hits Needed: 25	Hits Needed: 1,852

Indicates KHS did not met MPL
Indicates KHS need 5% or less to met MPL
Indicates KHS met or exceeded MPL
Indicates KHS met or exceeded HPL

Note: 'Hits Needed' is the number of compliant members needed to reach MPL

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

- Currently meeting MPL for 7 of 18 measures
- Within 5% of MPL for 5 additional measures
- 55% of charts reviewed to date
- Pending 2 lag runs to capture additional admin data
- On track to exceed MY2023 performance


You + Us = a better day!
Thank you!
KERN HEALTH
SYSTEMS

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Martha Tasinga, MD, MPH, MBA

SUBJECT: Chief Medical Officer Report

DATE: April 17, 2025

BACKGROUND

The Chief Medical Officer's presentation highlights utilization trends and key clinical focus areas 2023 through 2024. Physician services, inpatient care, and outpatient services are experiencing sustained higher-than-projected utilization, largely driven by chronic and complex medical conditions.

Included is Attachments A – H with the detailed medical management performance dashboard.

REQUESTED ACTION

Receive and File.

KERN HEALTH SYSTEMS

MARTHA TASINGA MD.MPH.MBA

APRIL 17,2025

CHIEF MEDICAL OFFICER REPORT

PHYSICIAN SERVICES UTILIZATION

- Increase in utilization which started in August 2023 continued through 2024. Contributing factors

- SPDs continuing to use more professional services than projected.
- Cost per professional visits is higher than projected for all AID codes
- Top diagnosis for utilization of physicians' services
  - Wellness visits
  - hypertension
  - Diabetes
  - Chronic kidney disease

Refer to **Attachment A & E** for full Detail

PHYSICIAN SERVICES:

OUTPATIENT VISITS PER 1,000 PER MEMBER/MONTH

Aid Group	2023	2024	% INCREASE year over year
SPD	2082	2209	6
Expansion	729	1012	38.8
Family/others	696	788	13.3

Refer to **Attachment A & E** for full Detail

INPATIENT SERVICES

- **Admits per 1,000 per member per month was higher in 2024 when compared to 2023 is higher than in for all Aid codes**
- **The cost per admit continues to be stable**
- **The PMPM for all inpatient services is within projections**
- **Top 4 reasons for inpatient stays continue to be related to pregnancy and delivery**
- **Other sepsis was second reason for in patient admission in January 2024**
- **Inpatient stays are at Kern Medical with BMH a close second**

Refer to **Attachment A & E** for full Detail

TOP 10 INPATIENT DIAGNOSIS

- **In 2023, services related to pregnancy, delivery, and related complications (.80/1,000 admissions) accounted top reason for inpatient utilization.**
- **In 2024; Disorders of the brain NOS, traumatic brain injury, encephalopathy, sequela for cerebrovascular disease and Alzheimer, dementia and Other disorders of muscle, wasting and atrophy unspecified multiple sites are number 1 reason for acute hospital stay at 1.19/per 1,000 admissions to acute hospital.**
- **These are the patients that families can not take care of them, the facilities LTC do not accept these patient because of the behavioral issues and risk associated with them. They remain in acute care hospitals because there is no place to send them to.**
- **Our focus in 2025 is to continue increasing access to outpatient services to manage chronic conditions and prevent deterioration leading to acute hospital stays.**
- **We will be working with our partners to identify facilities in our community that can take care of this growing number of our members who are not appropriate for conventional Post acute facilities because of behavioral issues.**

Refer to **Attachment B & F** for full Detail

POST ACUTE UTILIZATION 2024

- Skilled Nursing Facilities
  - Admissions 3.00/1,000 members (no change)
  - ALOS 14.33 days/1,000 (20.67 in 2023)

- Long-term Acute(LTAC)
  - Admits 3.0/1,000 (no change from 2023)
  - ALOS 409.33/1,000 (491.33/1,000 in 2023)
  - No possibility for discharge to lower level of care
  - No advanced directives
  - Families not willing to make members No CODE

- Acute rehab
  - Admits 1/1,000 (no change)
  - ALOS 5.00/1,000 (4 in 2023)

HOSPITAL OUTPATIENT UTILIZATION

VISIT PER 1,000 PER MEMBER/MONTH

These are services provided in the outpatient section of the hospital. However, it also includes patients who are admitted to the hospital for observation usually less than 2 days LOS

Utilization of these services is higher than projected but in line with projections for the other AID codes.

Top diagnosis for utilization of these services in descending order

- Sepsis
- Other urinary tract infection
- Chronic Kidney/end stage kidney disease
- Hypertension

Refer to **Attachment C & G** for full Detail

HOSPITAL OUTPATIENT UTILIZATION

AID GROUP	2023	2024	% Increase year over year
SPD	93	103	10.7
Expansion	47	49	4.2
Family/Others	28	31	10.7

Refer to **Attachment C & G** for full Detail

EMERGENCY ROOM VISITS

- Despite slight increases in utilization for all AID codes, utilization remains below projections
- Majority of ER visits are at BMH
- Top diagnoses for ED visit in descending order of frequency
  - Other unspecified acute respiratory disease
  - Chest pain
  - Abdominal and pelvic pain
  - Urinary tract infection

Refer to **Attachment D & H** for full Detail

EMERGENCY ROOM:
VISIT PER 1,000 PER MEMBER/MONTH

AID group	2023	2024
SPD	64	66(3.1% increase)
Expansion	33	34(3.0% increase)
Family/others	23	24(4.3% increase)

Refer to **Attachment D & H** for full Detail

QUSTIONS?

THANK YOU

Martha Tasinga, MD
Chief Medical Officer

KERN HEALTH SYSTEMS

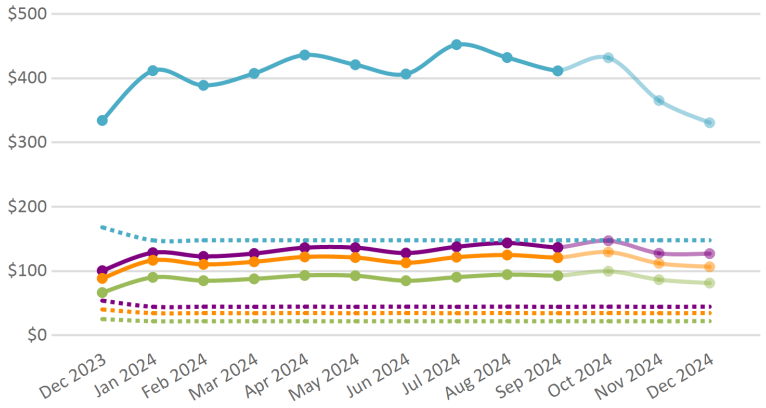
Governed Reporting System

Physician Services

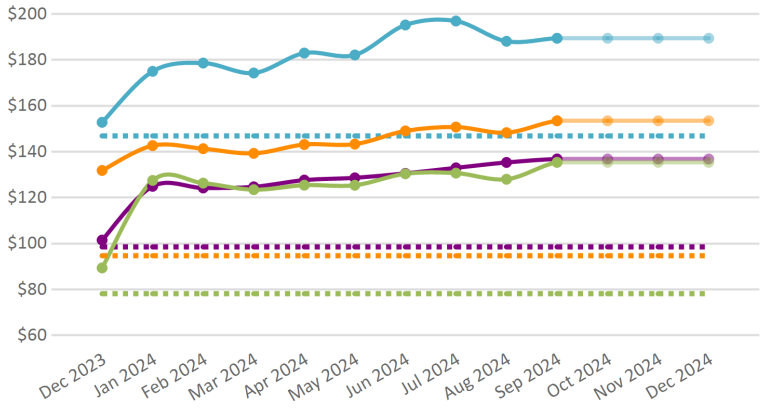
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

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

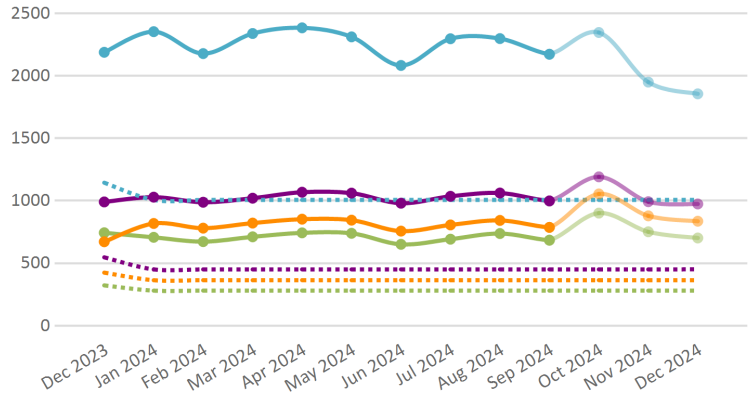
Professional Services Incurred by Aid Group PMPM



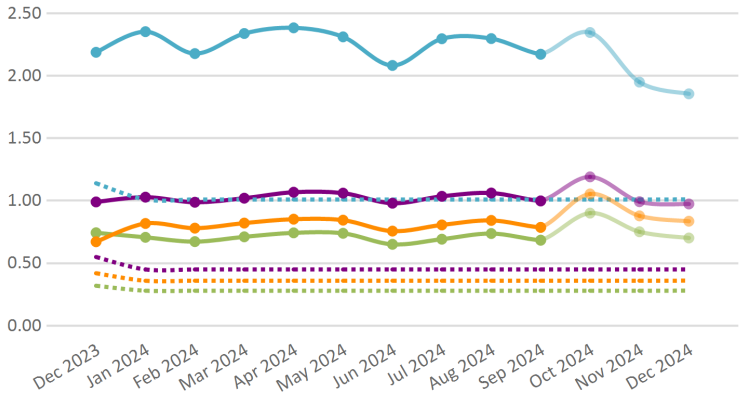
Cost per Professional Service Visit by Aid Group



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



Professional Service Visits per Member per Month by Aid Group



Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

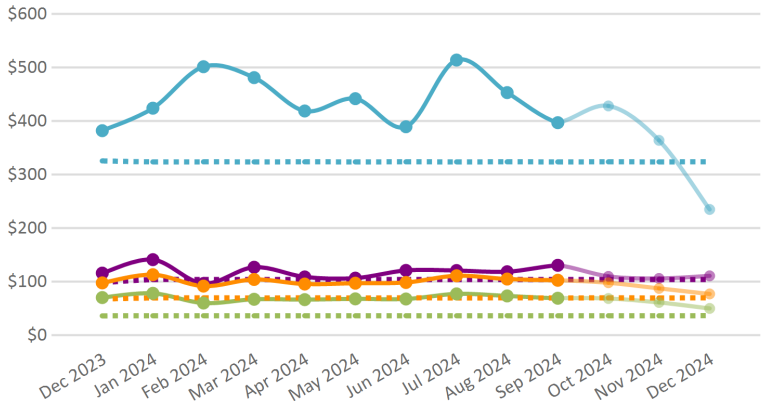
Governed Reporting System

Inpatient

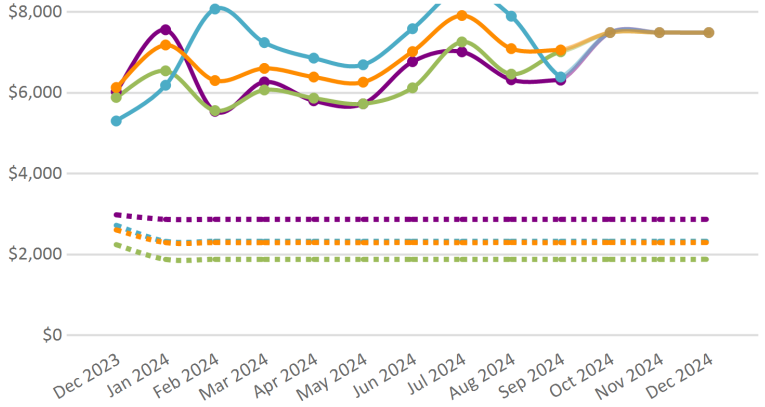
(Includes: Inpatient Hospital Claims)

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

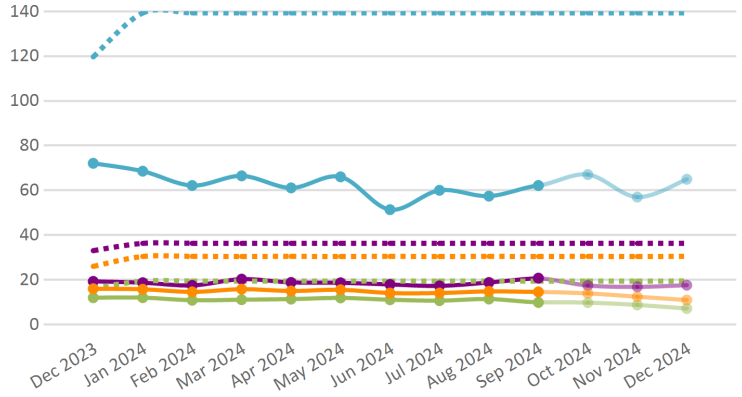
Inpatient Services Incurred by Aid Group PMPM



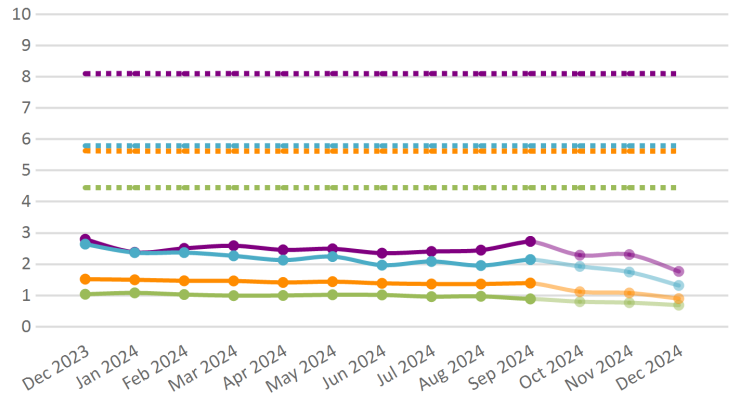
Cost Per Bed Day by Aid Group



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



Average Length of Stay in Days by Aid Group



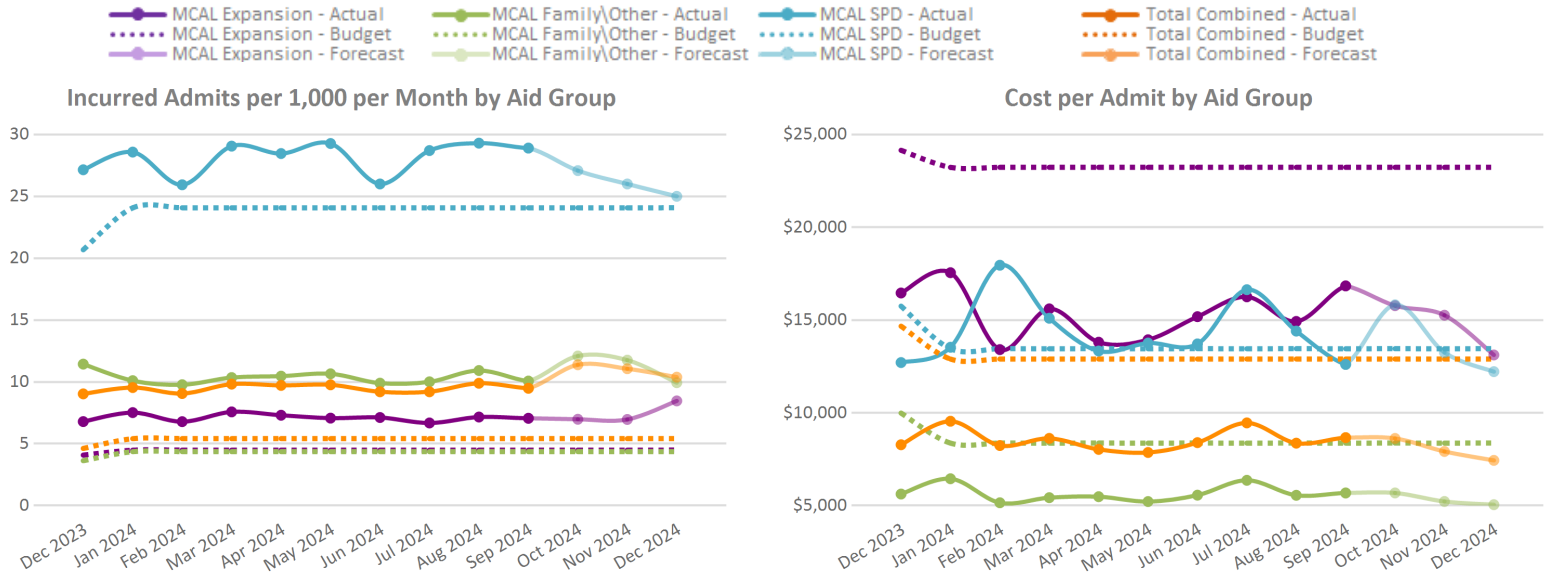
Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient

(Includes: Inpatient Hospital Claims)



Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

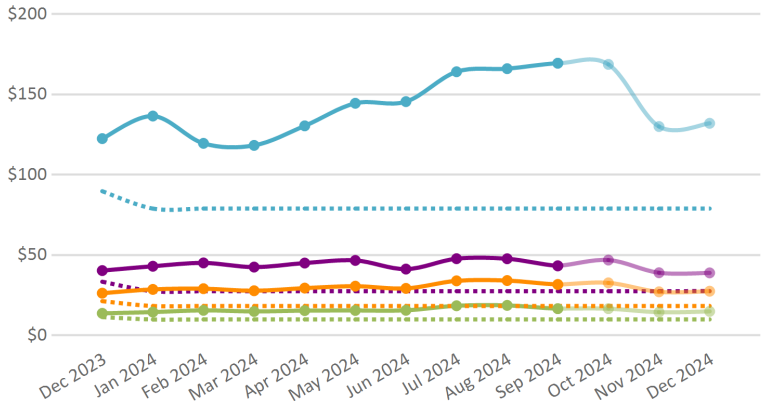
Governed Reporting System

Outpatient Hospital

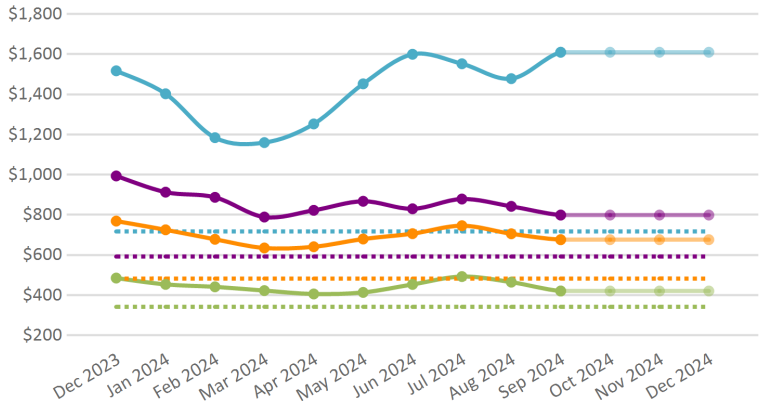
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

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

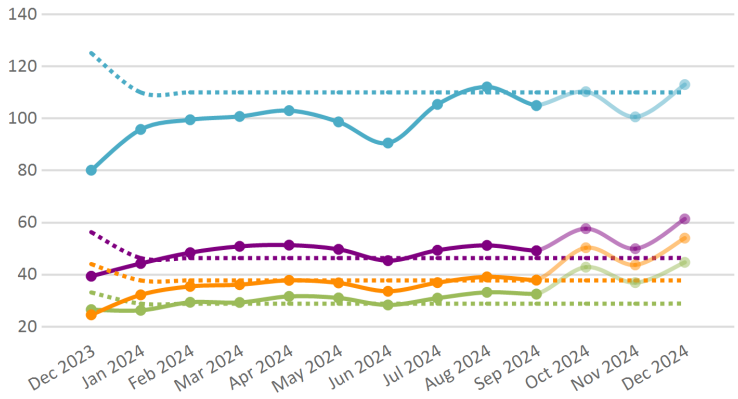
Outpatient Services Incurred by Aid Group PMPM



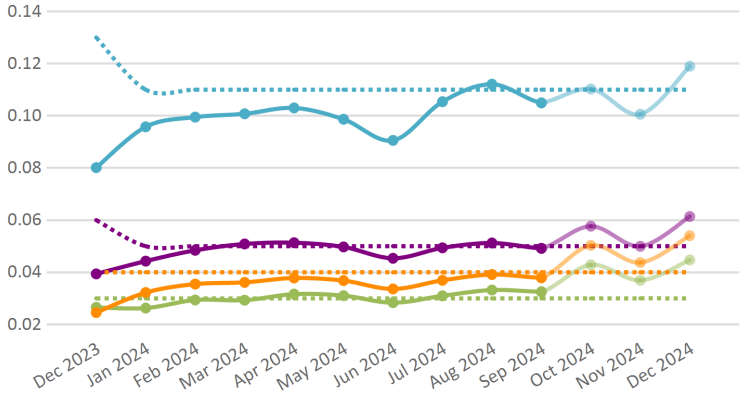
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



Outpatient Visits per Member per Month by Aid Group

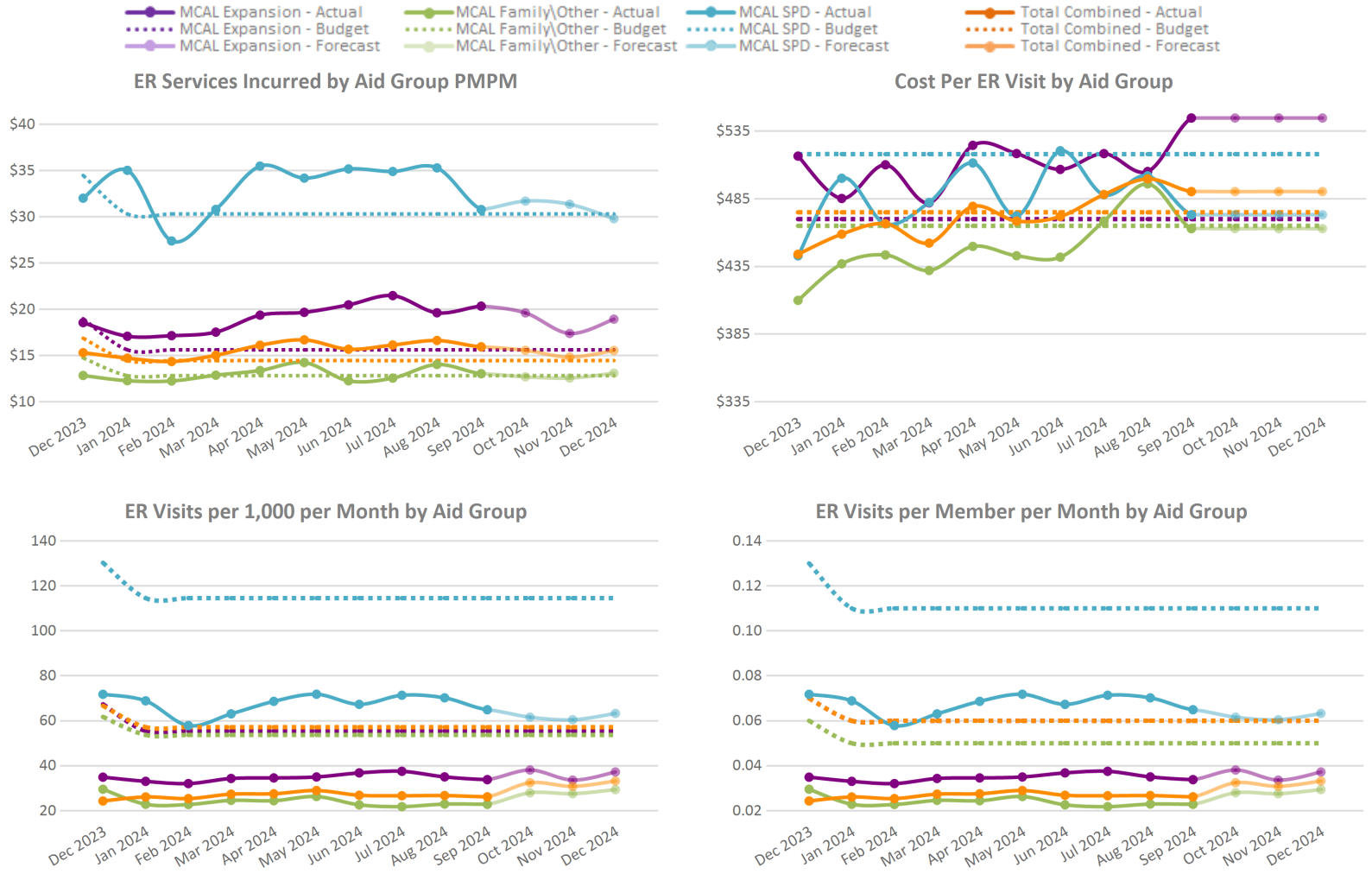


Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Room



Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

Governed Reporting System

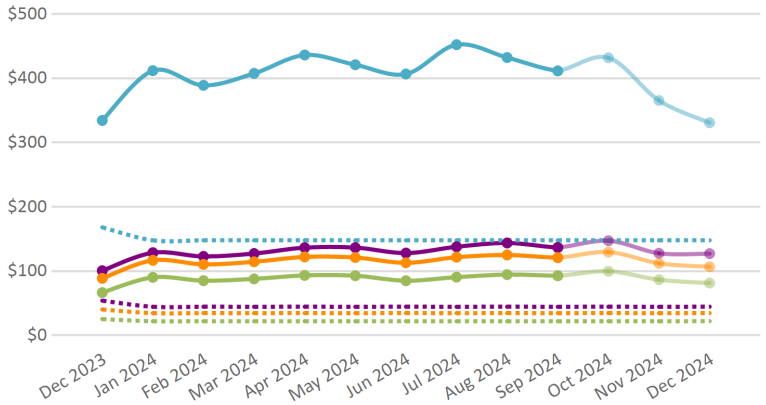
Attachment E

Physician Services

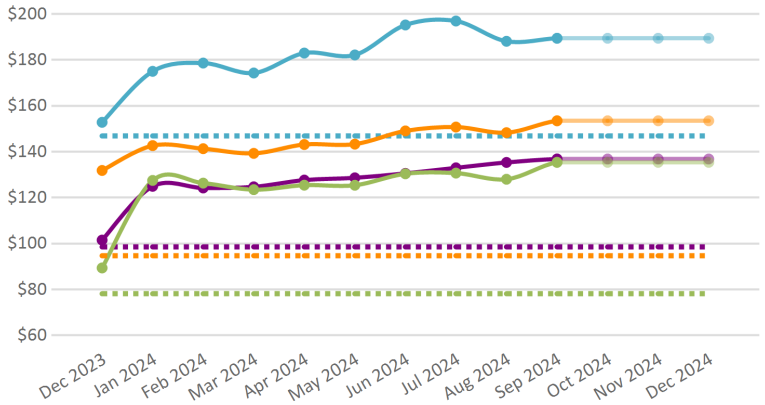
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

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

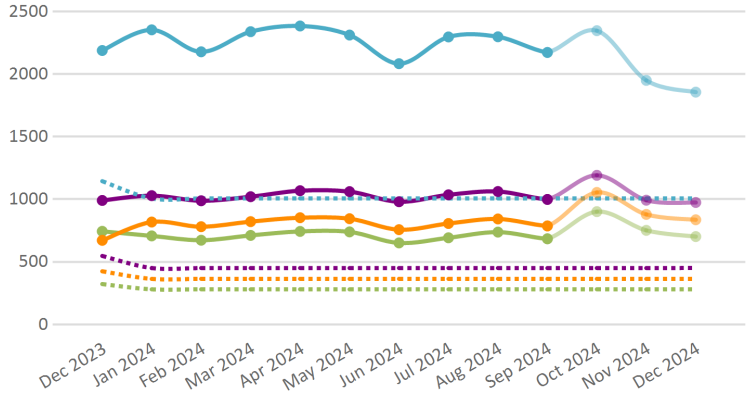
Professional Services Incurred by Aid Group PMPM



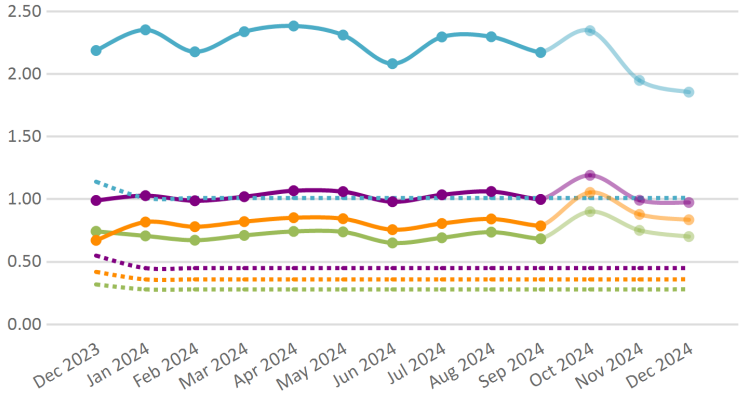
Cost per Professional Service Visit by Aid Group



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



Professional Service Visits per Member per Month by Aid Group



Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

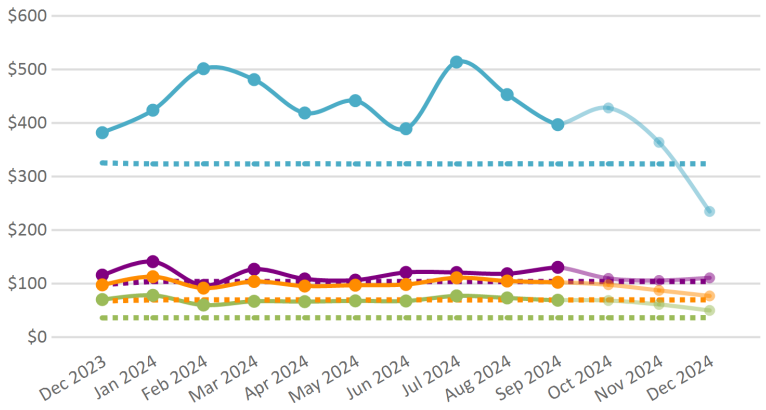
Governed Reporting System

Inpatient

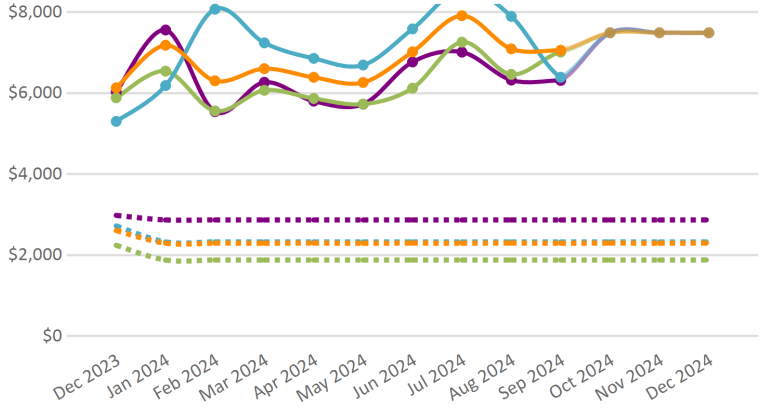
(Includes: Inpatient Hospital Claims)

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

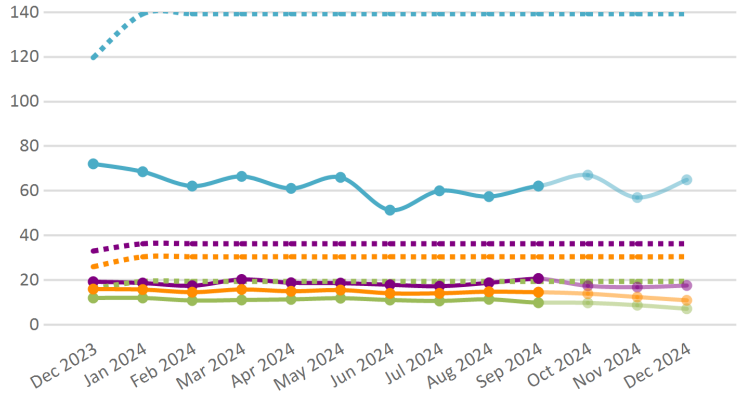
Inpatient Services Incurred by Aid Group PMPM



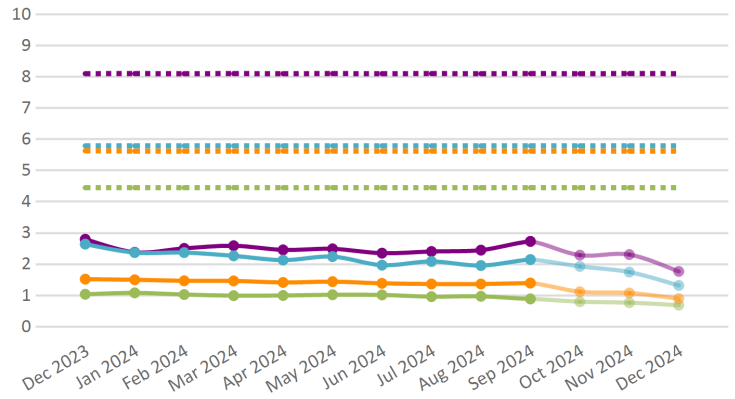
Cost Per Bed Day by Aid Group



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



Average Length of Stay in Days by Aid Group



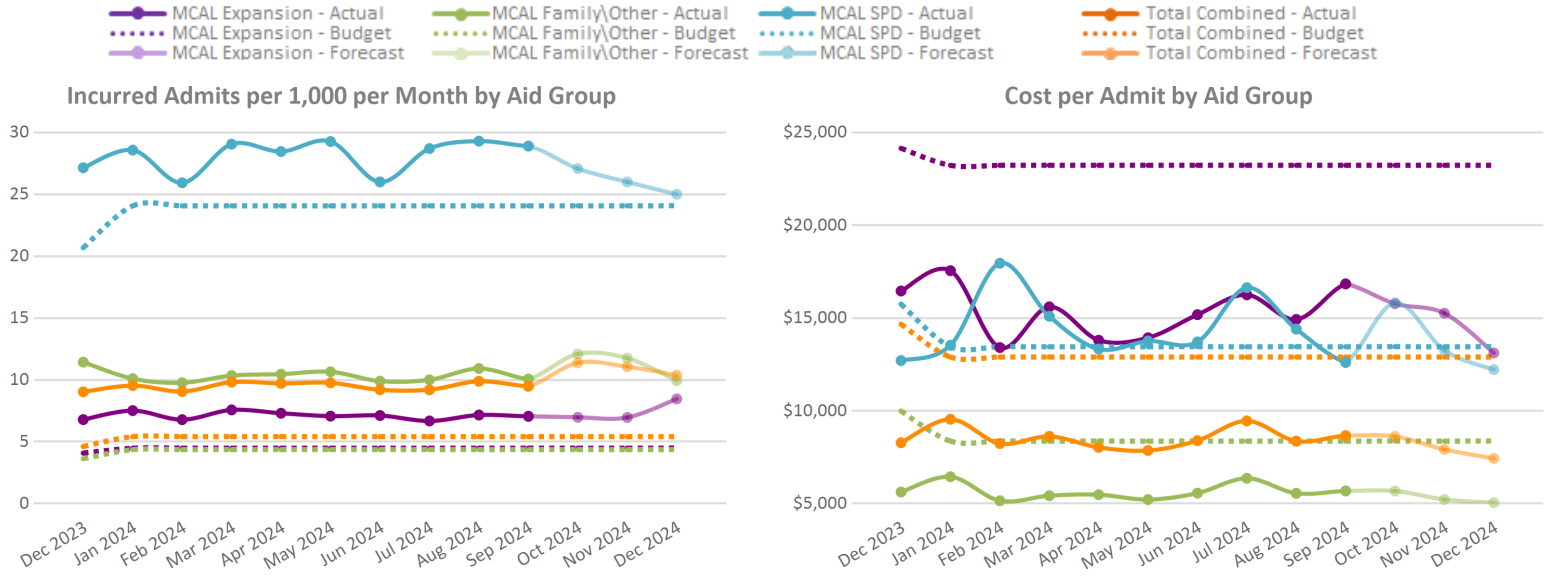
Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient

(Includes: Inpatient Hospital Claims)



Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

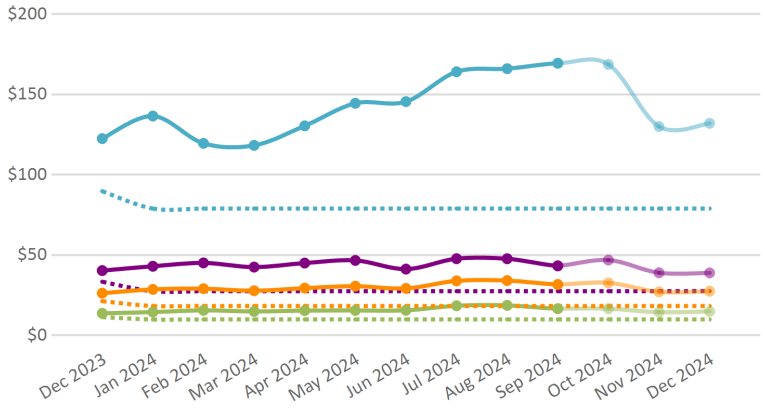
Governed Reporting System

Outpatient Hospital

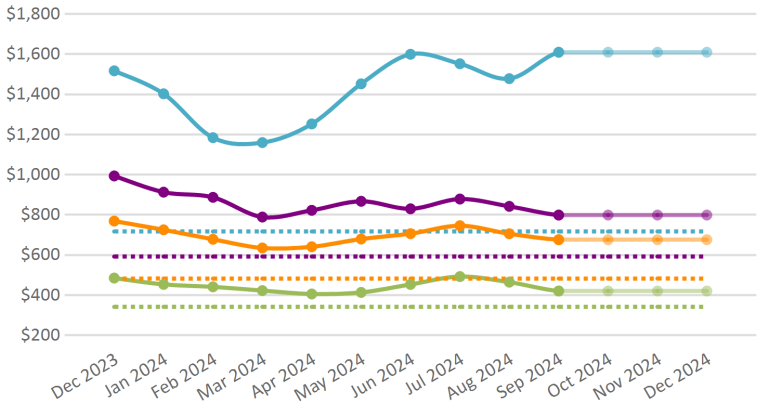
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

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

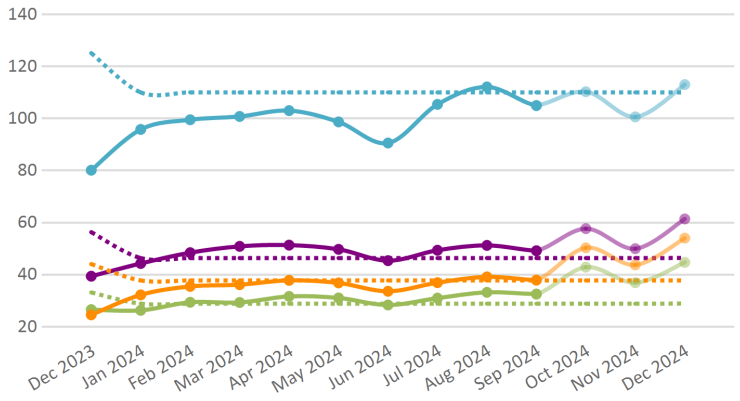
Outpatient Services Incurred by Aid Group PMPM



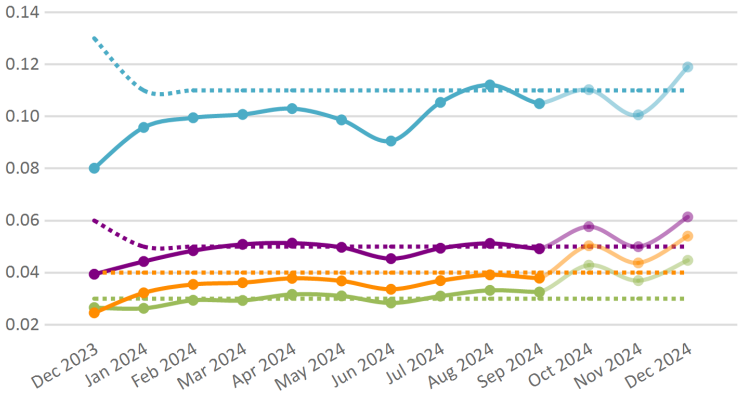
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



Outpatient Visits per Member per Month by Aid Group

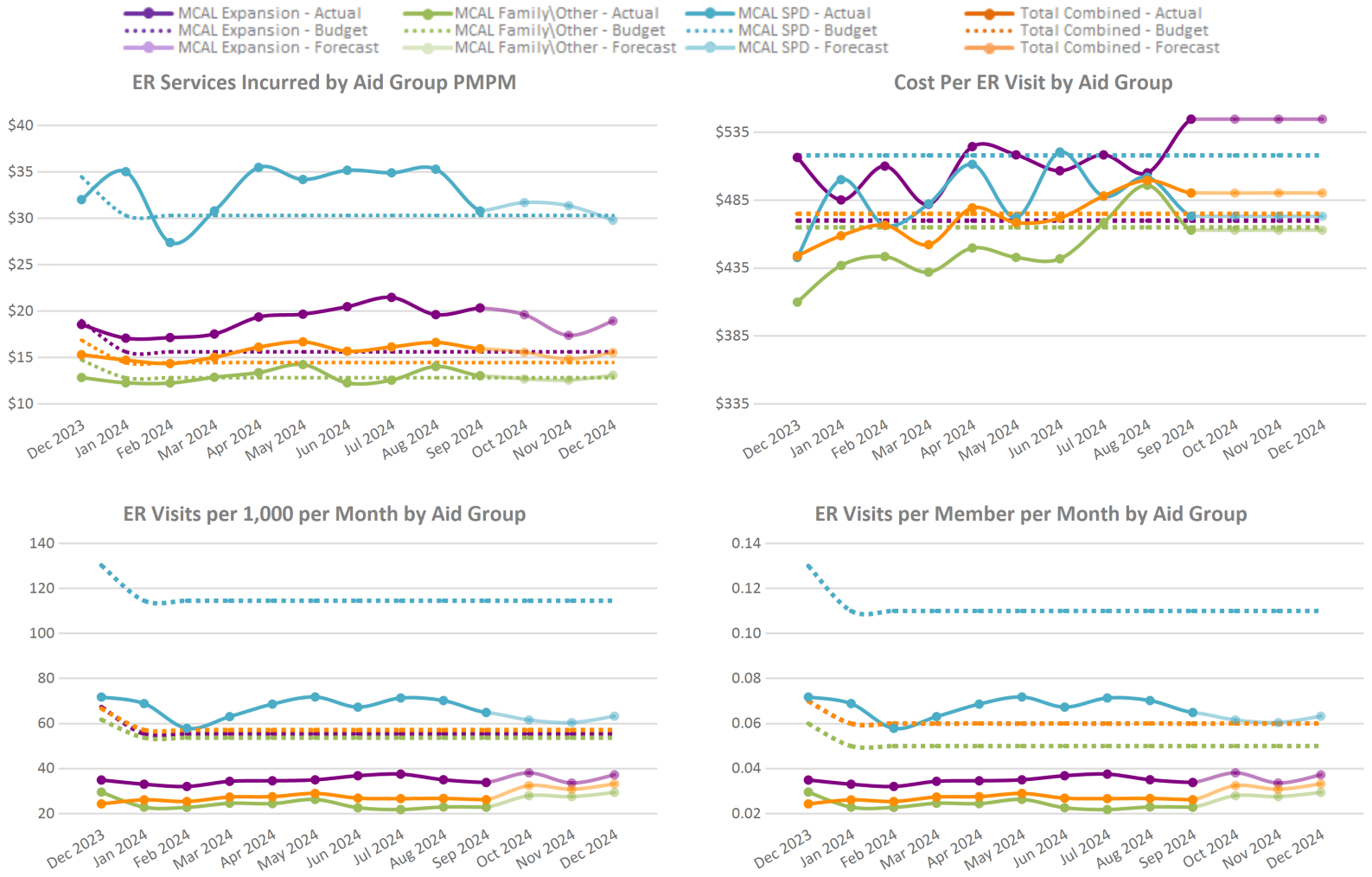


Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Room



Services provided through: 12/31/2024 Claims Paid through: 1/31/2025

KERN HEALTH SYSTEMS

BOARD OF DIRECTOR'S MEETING

2025

Chief Executive Officer's Report

Emily Duran

April 17, 2025

KHS CORPORATE STRATEGIC PLAN

The KHS Strategic Plan defines the organization's priority areas and serves as a roadmap for 2023–2025. **Attachment A: Strategic Plan Status Report: Q1 2025** provides a summary of key accomplishments from the fourth quarter of 2024. The organization's forward-looking focus. Overall, KHS continues to make steady progress toward achieving its strategic goals, as detailed in the attachment.

DHCS Medical Audit Success

We are proud to report that Kern Health Systems received zero findings in the 2024 Department of Health Care Services (DHCS) medical audit—an outstanding and rare achievement. This result reflects our organization's unwavering commitment to excellence, compliance, and member-focused care.

The audit, which reviewed performance and regulatory adherence over the period of November 1, 2023 through October 31, 2024, is a comprehensive evaluation of how well we meet state regulations and Medi-Cal managed care contract requirements. We are pleased to share that the audit concluded with no documented compliance issues in any of the reviewed areas.

This exceptional outcome is both a significant milestone and a testament to our strong internal processes, accountability, and quality-driven culture. At KHS, compliance is not a one-time task—it is a continuous journey. We remain dedicated to improving, learning, and upholding the trust of our members, partners, and community.

MEDICARE D-SNP

Background

The CalAIM initiative focuses on transforming Medi-Cal to reduce health disparities, improve health outcomes, and enhance care delivery, particularly for the most vulnerable populations. Dual-eligible members, who qualify for both Medicare and Medi-Cal, often face complex healthcare needs and coordination challenges, which led to the creation of Dual Special Needs Plans (D-SNPs). These Medicare Advantage plans provide tailored care coordination and wrap-around services for this population. In alignment with CalAIM's January 1, 2026, timeline, KHS will implement a D-SNP line of business to integrate care across both programs, requiring significant regulatory compliance, new internal infrastructure, and process development.

Update: KHS posted an RFP for supplemental benefits and is in the final stages of selecting which supplemental benefits to offer. Work efforts to implement the D-SNP line of business have begun, leveraging our administrative services partner, and our consultants. KHS is working closely with Milliman, to prepare and submit our bid to CMS in June.

LEGISLSTIVE SUMMARY

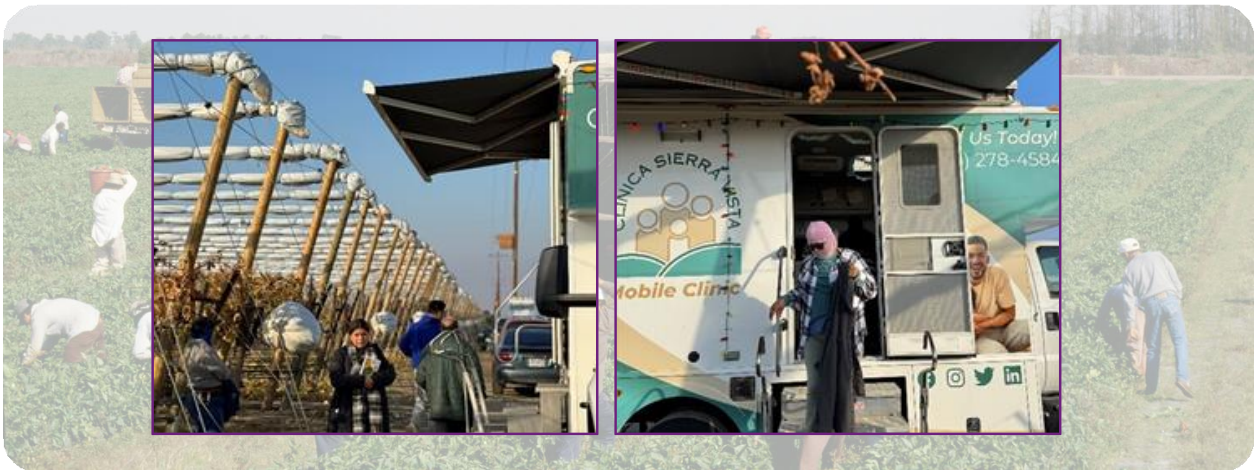
Federal – In February 2025, the House of Representatives approved a budget resolution that proposes substantial adjustments to federal spending. This resolution aims to reduce the federal deficit and may lead to significant alterations in Medicaid funding over the next decade, with target reductions of at least $880 billion over ten years. The Senate passed their own resolution in February with much smaller funding impacts. The Senate and House are expected to hammer out their differences on the budget resolution in early April. Assuming a joint budget resolution is adopted, the next step would include relevant policy committee discussions on specific proposals. The outcome of any policy proposal agreement could adversely affect Medicaid coverage and access to care for members in Kern County. Since January, our staff and leadership have been actively engaging with our local congressional delegation in Kern and with representatives in Washington D.C. to emphasize the importance of Medicaid and the potential impacts of these proposed adjustments on the Kern County economy and communities. Moving forward, our staff will continue to collaborate with our Federal Trade Association (ACAP) to analyze any new developments in Medicaid policy and continue to advocate on the importance of Medicaid in our communities.

State – As California approaches the May Revision of the state budget for 2025, several key factors and themes are influencing the fiscal landscape. The January draft budget initially projected a "modest" surplus of $16.9 billion. However, the California Legislative Analyst's Office (LAO) later estimated a $2 billion deficit, indicating that the budget is effectively balanced – a notable improvement from last year's significant deficit. At the time, the Governor and the Legislature stressed the importance of fiscal prudence as they acknowledged the potential for substantial changes to the budget based on federal developments. Since then, uncertainty has increased due to a severe natural disaster; wildfires that destroyed over 16k homes in Southern California. Additionally, in recent weeks, the Governor has requested $3.4 billion loan from lawmakers to cover essential "critical" payments for Medi-Cal. Furthermore, the Department of Health Care Services (DHCS) has sought an additional $2.8 billion from the legislature to ensure that Medi-Cal is sustained through the end of the fiscal year. As we approach the May revision, we anticipate more clarity regarding next year's budget. Our staff will continue to collaborate with our State Trade Associations to ensure that our plans are adequately represented in the forthcoming budget discussions related to Medi-Cal. Our staff is also monitoring pertinent bills and analyzing their potential impacts. The month of April consists of many policy committee hearings in the State Legislature, leading up to some committee deadlines in early May. The 2025 bill tracking document can be found under **Attachment B: Bill Tracking.**

GRANTS AND STRATEGIC INITIATIVES 2023 – 2025

Community-Based Initiative & Quality Grant:

All 15 Community Based Organizations (CBO's) have initiated projects aligned with their scope of work. Four (4) of the 15 organizations have completed their projects, while the remaining are on track to finish by November 2025. KHS would like to highlight California Farmwork Foundation's (CFF) goals under this initiative. The goal is to implement mobile health services at rural farm worksites to provide mobile health services from vaccinations, blood pressure screenings to Medi-Cal renewal education through a cultural competency lens. Providing services to this population is essential, as they play a critical role in sustaining the local agricultural economy but often face limited access to healthcare, social services, and resources necessary for overall well-being. Addressing their unique needs helps promote health equity, improves quality of life, and supports a healthier, more resilient community. The project is ongoing with a few challenges such as the immigration raids that happened earlier this quarter in Kern County, which caused the volume of patients to decrease, however, KHS is working closely with the organization for next steps. In addition to this collaboration, Clinica Sierra Vista (CSV) and Omni Family Health are anticipating launching new mobile units in quarter 2 of 2025 that will help increase access to vulnerable communities in Kern County.



Recruitment and Retention (R&R) Grant:

The R&R grant has played a crucial role in increasing access to care, strengthening the provider network, and improving health outcomes for our members. Though we have seen significant strides through the R&R Grant there have been several challenges observed. The rural nature of the region has limited recruitment success and providers continue to struggle with attracting healthcare professionals to Kern County. Many providers have expressed a desire to shift funding focus from recruitment efforts to retention strategies to better sustain their workforce. Additionally, some awardees have attempted to recruit clinicians already within the network, which does not expand the overall provider pool and reduces the intended impact of the grant.

KHS has successfully recruited 30 new providers and retained 26, including much-needed primary care, mental health, and specialty care providers. To highlight a few of the successes, Clinica Sierra Vista (CSV) recruited a new Endocrinologist and a Geriatrics Provider to the Kern Family Health Care (KFHC) network. Kern Medical (KM\) has recruited an Invasive Cardiologist and an Ear, Nose, & Throat (ENT) specialist into the network. The behavioral health network expanded services through additions of psychiatric providers and mid-levels, Behavioral Certified Behavior Analyst (BCBA), and licensed marriage and family therapist. ACE Eyecare recruited a new optometrist and Terrio Physical Therapy has recruited two (2) new physical therapists into the network.

It is crucial to concurrently prioritize local nursing and residency expansions through the Healthcare Workforce Expansion Grant as hiring and retaining providers unfamiliar with Kern County's rural landscape has proven challenging. Despite ongoing challenges, our recruitment and retention efforts have already strengthened the provider network, and we remain optimistic about continued progress in 2025. We will continue monitoring progress and provide further recommendations as we gather additional data.

RECRUITMENT & RETENTION	SINCE LAST CEO REPORT	AS OF 12/15/2024
Physician Recruitment under R&R	4	30
Physician Retainment under R&R	3	26
Transportation Services Rendered Kern Valley Healthcare District	308	2,661

Healthcare Workforce Initiative:

All nine (9) organizations have successfully executed their contracts and initiated projects. KHS is excited to share that Dignity Health - Bakersfield Memorial Hospital (BMH) has successfully matched with a class of 10 medical school graduates who will be joining the Graduate Medical Education (GME) program. Eight of the individuals are from California and two are right here in Bakersfield! KHS would also like to share pictures specific to the contract milestones to showcase construction progress of the physical campus; the hospital is on track to meet remaining milestones around capital infrastructure.

Dignity Health
Bakersfield Memorial Hospital Class of 2028
Internal Medicine Residents

Sai Manoj Reddy Narava, MD
Cupertino, CA

Hasrat Bir Singh Maan, MD
Ravneet Kaur, MD
Lathrop, CA

Ikleel Moshref, MD
Aabra Meer, MD
Bakersfield, CA

Ikleel Moshref, MD
Aabra Meer, MD
Bakersfield, CA

Amir Najafi, MD
Woodland Hills, CA

Khondekar Adnon, MD
Canoga Park, CA

Arian Azmian, DO
Mission Viejo, CA

Dignity Health – Bakersfield Memorial Hospital
Residents Physical Campus Progress

INCENTIVE PAYMENT PROGRAM FUNDING

Background

The CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of Enhanced Care Management (ECM) and Community Supports (CSS) by incentivizing managed care plans (MCPs) to invest in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and pro mote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports. IPP Program Year 1 and Year 2 have been successfully completed, Year 3 is currently active with estimated completion dates of March 2025. Once all three years have been completed, a final summary of IPP will be presented to the Board of Directors.

IPP Program Year 3 | January 1, 2024 – June 30, 2024

A total of nine (9) providers and CBOs were contracted in IPP PY3 funding for Enhanced Care Management and Community Support Services. Be Finally Free, Clinica Sierra Vista (CSV) Baker and CSV Lamont, Kern Psychiatric Health and Wellness, Unity Care, and The Open Door Network have successfully completed their milestones. The grants team is currently auditing final documents for the remaining milestones for Bakersfield American Indian Health Project (BAIHP), California Action Partnership of Kern (CAPK), and Habitat for Humanity Golden Empire (HFHGE).

IPP Next Steps:

For the remaining three organizations, the grants team will be conducting audits and working with the KHS finance team to finalize payments by end of April 2025. The team will begin working on a final presentation for all IPP Programs.

KHS APRIL 2025 ENROLLMENT:

Member Age	
0-5	12%
18-Jun	30%
19-44	35%
45-64	17%
65+	6%

Ethnicity	
Hispanic	64%
Caucasian	15%
No Valid Data	11%
African American	6%
Asian Indian	2%
Filipino	1%
Other	1%

Language	
English	66%
Spanish	33%
Other	1%

Percentage Increase in Membership from previous month

	Enrollment Type						
	FAMILY-ADULT	FAMILY-CHILD	FAMILY-OTHERS'	Seniors & Persons with Disabilities (SPDs)	Adult Expansion	Long Term Care	Total KHS Medi-Cal Managed Care Enrollment
2025-03	74,812	167,960	25,461	20,341	115,889	512	404,975
2025-04	74,426	167,495	25,374	20,306	116,017	509	404,127
% Change	-0.5%	-0.3%	-0.3%	-0.2%	0.1%	-0.6%	-0.2%

Enrollment Update: The Kern County Department of Human Services continues their "automated discontinuance process" for Medi-Cal Redeterminations when beneficiaries do not complete the Annual Eligibility Redetermination process

COMMUNITY EVENTS

KHS will share sponsorship in the following events in April and May:

Organization Name	Event Name	Purpose	Donated Amount
The Open Door Network	Reimagine	Help homeless families in crisis stabilize, obtain permanent housing, and become self-sufficient. The Open Door Network partnered with Kern Family Health Care to open the Reimagined Hope House.	$5,000
Kern Economic Development Foundation	Career & STEM 2025 Expo	Kern County employers gather at the Career Technical Education Center (CTEC) in Bakersfield to engage with thousands of middle and high school students from throughout the county.	$1,500
Global Family Care Network	Best of Bakersfield Annual Gala	Work to prevent and intercept child trafficking and systematic abuse and provide long-term and family-based care for children who are victims of commercial sexual exploitation and other forms of abuse.	$3,500
Bakersfield Sikh Women's Association	8th Annual Sikh Women's Association 5K Run/walk	All proceeds go to deserving students who need a helping hand to pursue their dreams of earning a college degree. Donation will directly support their college aspirations, empowering them to achieve their dreams.	$5,000
ADAKC	ADAKC's Annual Golf Classic	Help improve the lives of Kern County residents on the Alzheimer's journey by providing adult day care services, support groups, and educational classes.	$800

Organization Name	Event Name	Purpose	Donated Amount
Flood Bakersfield Ministries	Golden Gala	Proceeds will go towards reaching out to those in the community struggling with homelessness.	$5,000
The Leukemia & Lymphoma Society, Inc.	Bakersfield Campaign Grand Finale Celebration	Support thousands of youth and adults in their fight against blood cancers.	$5,000
South Fork Middle School	Mustang Color Run	Support the school's color run raising money to purchase physical education and athletics program equipment.	$200
H.E.A.R.T.S. Connection	Autism on the Run	Raise awareness, acceptance, and inclusion for individuals with Autism.	$1,500
Noel Alexandria Foundation	4th Annual A Day with the Angels	Raise awareness and provide free resources to families affected by pregnancy and infant loss.	$1,000
The Mission at Kern County	5th Annual Spring Gala	Support The Mission at Kern County in serving the homeless community.	$5,000
McFarland USA Foundation	McFarland USA 5K Run / Grape Festival	Support the 5k and 10k run and the Grape Festival event celebrating the spirit of community and fitness.	$1,000
Valley Fever Institute at Kern Medical	Valley Fever Walk	Raise awareness about Valley Fever and its impact on the community while supporting programs and research at the Valley Fever Institute at Kern Medical.	$10,000
Kiwanis Club of Taft Foundation	Bike Rodeo	Donation will go towards the purchase of 50 bikes and helmets.	$3,000
United Way of Central Eastern California	3rd Annual Charity Classic Golf Tournament	Support Healthy Minds and Bodies programs along with early childhood literacy and education programs.	$650
California Living Museum Foundation	KEEP CALM Jamboree	Proceeds benefit Kern County Superintendent of Schools' two outdoor education programs - CALM and Camp KEEP.	$5,000
JJ's Legacy	15th Annual Golf Classic & Gala	Support educating about the importance of organ, eye, and tissue donations, increasing the number of registered donors, and providing compassionate support to donor and recipient families.	$6,000
Greater Tehachapi Chamber of Commerce	Tehachapi Wind Festival	An event that celebrates the wind in Tehachapi and features kite flying contests, delicious food, vendors, and games.	$500
Be Finally Free	Interesting Men Who Cook	Support this non-profit organization's mission to restore and equip individuals affected by addiction, crime, incarceration, and poverty.	$1,000
Bakersfield North Rotary Foundation	French Connection	Support charities in the greater Bakersfield area, particularly those serving children and youth, along with the club sponsored Interact and Rotaract Clubs.	$1,500
Keep Bakersfield Beautiful	Great American Cleanup	The Keep America Beautiful Great American Cleanup™ (GAC) is one of the largest community service events in the nation. Keep Bakersfield Beautiful (KBB) volunteers choose to hold this locally in April.	$1,000
Kern Economic Development Corporation	Kern County 2025 Economic Summit	Support their goal to create a strong and diverse economy in Kern County.	$2,500

Organization Name	Event Name	Purpose	Donated Amount
North of the River Chamber of Commerce	Golf Tournament	Support the NOR Education Community Fund to offer scholarships for all high schools in North Bakersfield.	$1,500
Redwood Elementary (Shafter)	Spring Festival Color Run	This event aims to recognize the commitment and perseverance of students in maintaining excellent attendance, which is a significant part of their academic success.	$500
Court Appointed Special Advocates of Kern County	CASA Derby Party	Support their mission of giving abused and neglected children a caring and highly trained advocate.	$3,000
Bakersfield Memorial Hospital Foundation	Larry Carr Memorial Golf Tournament	Proceeds support the Lauren Small Children's Center at Bakersfield Memorial Hospital.	$2,500
League of Dreams, Inc	Night of Illusion	Directly contribute to the League of Dreams' mission of fostering inclusion, empowerment, and joy through sports.	$2,500
Richland School District	Annual Resource Fair	Donations will go towards the planning of the annual Resource Fair to promote healthy lifestyles and improve the community's overall health.	$500
Morning Star Fresh Food Ministry	Annual Banquet	Provide fresh food to feed families in need in the Bakersfield community and equip local churches, non-profits, and distribution sites to provide an open door with a box of fresh food.	$3,500
Children First Campaign	2025 East Bakersfield Festival	Support the creation of prosperous communities by ensuring that all children live in healthy, safe, and nurturing neighborhoods that promote academic achievement and success.	$4,000
First 5 Kern	ACEs - Building Community Resilience Conference	Support conference that addresses Adverse Childhood Experiences (ACEs) through education, collaboration, and resilience-building strategies.	$2,500
City of Wasco	Annual Bike Rodeo	A Bike Rodeo ensures children are using safe equipment and teaches bicycle traffic safety skills. There will be helmets given away, a free bike raffle, and bike accessory prizes for participants.	$2,000
Bakersfield Ronald McDonald House	Walk for Kids	The walk is designed to raise funds and awareness for the services and programs provided by the BRMH - comfort, care and support to children and families in Southern California.	$2,500

KHS will also participate in the following events in April and May:

Organization Name	Event Name	Location	Date	Time
Greenfield Family Resource Center	Health & Safety Fiesta	725 Capitola Dr., Bakersfield	4/3/2025	3:30pm - 6:30pm
Panama Buena Vista Union School District	3rd Annual Parent Resource Fair	8000 Akers Rd., Bakersfield	4/3/2025	4:30pm - 6:30pm

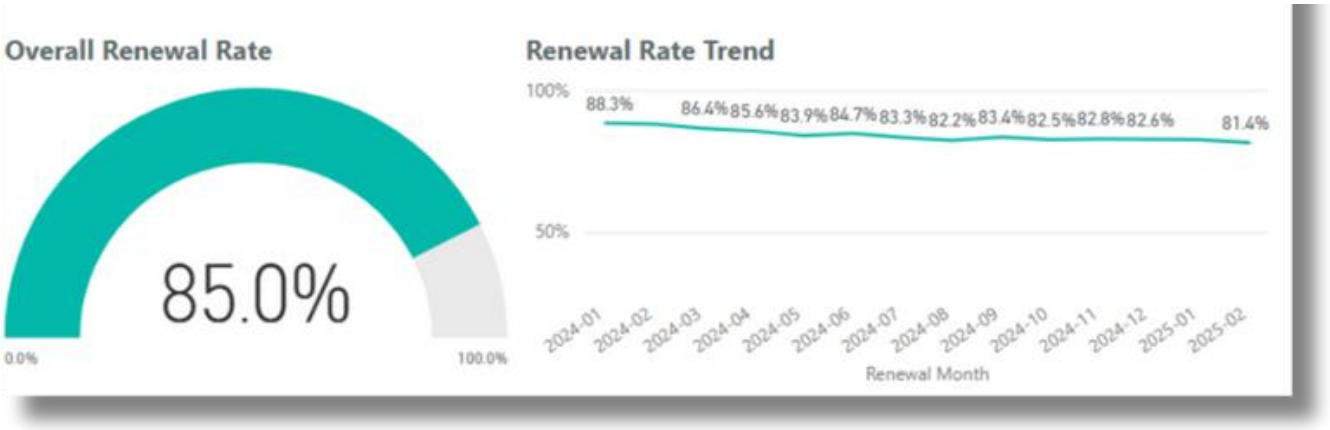
Organization Name	Event Name	Location	Date	Time
Sikh Women's Association Bakersfield	8th Annual Sikh Women's 5K Run/Walk	11200 Stockdale Hwy Bakersfield, Ca 93311	4/5/2025	8:00am - 12:00pm
Kern Autism Network, Inc.	5th Annual Autism Awareness Car Parade & Family Festival	3400 21st St., Bakersfield	4/5/2025	10:00am - 1:00pm
McWilliams & Walden, Inc	Hope & Help Resource Fair	816 E. 21St., Bakersfield	4/5/2025	9:00am - 2:00pm
Kern County Outreach	Walk for Hope	316 Baker St., Bakersfield	4/5/2025	10:00am - 1:30pm
Grimmway Farms	Health and Benefits Fair	1142 S P St., Bakersfield	4/6/2025	12:00pm - 5:00pm
Community Action Partnership of Kern	Spring Festival	3300 Redlands Dr. Bakersfield, CA 93306	4/8/2025	10:00am - 12:00pm
Bakersfield College	BC Rising Scholars 3rd Annual Resource Fair	1801 Panorama Dr., Bakersfield	4/9/2025	9:30am - 1:30pm
The Yoga & Birth Advocate	Black Maternal Health Symposium	9001 Stockdale Hwy., Bakersfield	4/10/2025	10:00am - 5:00pm
Bakersfield Adult School	Resource Fair	501 S. Mt. Vernon Ave., Bakersfield	4/11/2025	11:00am - 12:30pm
Bakersfield Recreation & Parks	Spring Eggstravaganza	1000 S. Owens., Bakersfield	4/11/2025	2:00pm - 4:00pm
Children's Choice	Annual Easter Event	2350 White Ln., Bakersfield	4/12/2025	11:00am - 2:00pm
Love From Above Community	The Easter Showdown	2207 Brundage Ln., Bakersfield	4/12/2025	11:00am - 3:00pm
Kern County Public Health	Know Your Numbers	10300 San Diego St., Lamont	4/15/2025	3:00pm - 4:00pm
First Presbyterian Church	Food Pantry	1705 17th St., Bakersfield	4/17/2025	7:30am - 9:00am
Bakersfield Kern Regional Homeless Collaborative	Homeless Outreach Resource Fair	3201 F St., Bakersfield	4/17/2025	9:30am - 12:00pm
Vision y Compromiso	Mujer Completa - Menopausia y Salud Hormonal	4550 California Ave. Suite 310, Bakersfield	4/17/2025	8:30am - 1:30pm
Bear Mountain Recreation	Easter Egg Hunt & Resource Fair	Digiorgio Park - 685 South Hill, Arvin	4/18/2025	4:00pm - 6:00pm
Bear Mountain Recreation	Easter Egg Hunt	Bear Mountain Park - 10300 San Diego St., Lamont	4/19/2025	10:00am - 2:15pm
GBLA	12th Annual Fair Housing Conference	801 Truxtun Ave., Bakersfield	4/30/2025	9:00am - 3:00pm
Kern County Superintendent of Schools	Mental Health Awareness Fair	300 E. Truxtun Ave. Ste A, Bakersfield	5/1/2025	5:00pm - 7:00pm

Organization Name	Event Name	Location	Date	Time
Casa Loma Elementary	Spring Carnival	525 E. Casa Loma Dr., Bakersfield	5/2/2025	5:00pm - 7:30pm
Bakersfield College, Arvin Educational Center	Cinco de Mayo Showcase	1001 Varsity Rd., Arvin	5/5/2025	2:00pm - 5:00pm
Kern County Public Health	Know Your Numbers	2070 Veneto St., Delano	5/6/2025	5:00pm - 6:00pm
Wasco Union Elementary School	TK Kindergarten Enrollment Fair	600 Griffith Ave., Wasco	5/8/2025	5:00pm - 7:00pm
CSUB	Expungement Clinic	2204 Q St., Bakersfield	5/9/2025	9:00am - 3:30pm
Ridgeview Parent & Family Center	Mental Health Awareness Resource Fair	8501 Stine Rd., Bakersfield	5/12/2025	5:00pm - 7:00pm
Kern County Human Services	Employee Resource Fair	100 E. California Ave., Bakersfield	5/16/2025	9:00am - 12:00pm

Medi-Cal Renewal Updates

KHS continues direct outreach activities to members who must complete the Medi-Cal renewal process or those in a hold status who have 90 days (from disenrollment date) to complete their renewal to be retroactively enrolled to their disenrollment date. Member communications include: text messages, mail, phone calls, and the KFHC Member Portal. KHS also continues working with providers, local Medi-Cal enrollment entities, and community-based organizations to support the correct completion of renewal applications

Below are Medi-Cal Redetermination Trending Rates.



KHS Media Clips

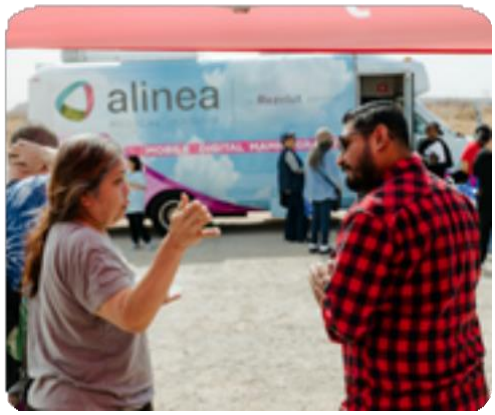
We compiled local media coverage that KHS received in October 2024 – November 2024. Please see **Attachment C: Public Relations and Publicity Media Clips.**

KHS MEMBER ENGAGEMENT | COMMUNITY HIGHLIGHTS

California City Wellness Fair

Kern Family Health Care recently hosted the California City Wellness Fair, a powerful demonstration of our commitment to expanding access to care in rural and underserved areas of Kern County. Recognizing a growing need in the East Kern region, our Quality Performance, Marketing, and Member Engagement teams joined forces to develop an event focused on closing care gaps—particularly in California City and neighboring communities.

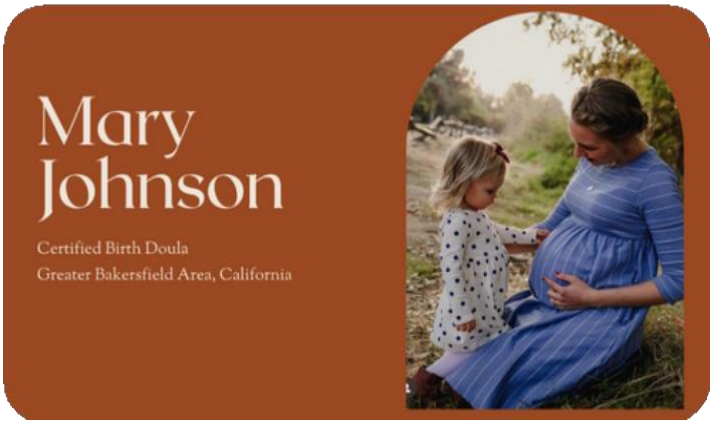
Through this collaborative effort, residents received free health services including mammograms, cervical cancer screenings, A1C tests, and well-child visits. In partnership with Safe Haven Kids' League, the event also fostered community connection with engaging family activities. The fair exemplified our core value of Collaboration and showcased what's possible when departments unite behind a shared mission. This initiative not only improved health outcomes but also reinforced KFHC's presence and trust in the East Kern region.

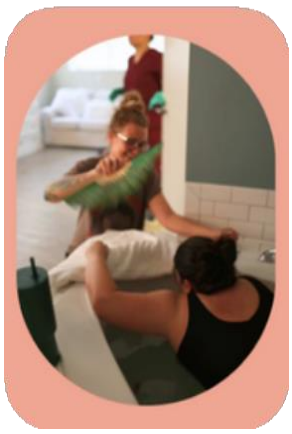


Elevating Provider Partnerships: A Doula's Perspective on KFHC Support

Mary Johnson, owner of Your Doula Mary, is a full-spectrum doula who has been passionately supporting families through pregnancy and birth for over seven years. Her personal journey as a mother and surrogate has deeply informed her practice, and she now serves local Medi-Cal members full-time. Mary recently expressed her sincere appreciation for the way Kern Family Health Care (KFHC) has partnered with doulas like herself—calling our support respectful, efficient, and truly member-focused.

In her own words, Mary described KFHC as her "first experience dealing with managed care plans" and noted it has been exceptional. She highlighted the smooth onboarding process, responsive coordination, and timely payments, contrasting it with the frustrating and unsupported experiences she's had with other health plans. Her feedback underscores the meaningful impact our team is making—not just for members, but for the dedicated community providers who serve them. KFHC's commitment to accessible, compassionate care is truly being recognized and felt.





McFarland Gym Pilot

KHS has established a partnership with Iron Valley Fitness to launch a pilot wellness program aimed at fostering healthier behaviors, increasing physical activity, and enhancing the overall well-being of participating KHS members. The program is designed to assess the viability of implementing a gym membership benefit across all members to kick off and enhance their wellness and preventive health journey. Eligible KHS members residing in McFarland will have the opportunity to enroll in a free 3-month gym membership to the McFarland Iron Valley Fitness facility in McFarland. This membership provides access to the gym facility, exercise equipment, and professional trainer support.

As part of the program, Iron Valley Fitness will offer the following to participating KHS members:

- A comprehensive gym tour.
- A personalized 30-day workout plan tailored to individual needs.
- Progress evaluations at 30, 60, and 90 days through onsite weigh-ins.
- Regular text messages highlighting essential KHS benefits, wellness tips, and motivational reminders to maintain gym attendance.

This collaboration reflects KHS's dedication to promoting the health and wellness of its members while strengthening ties with the local business community. By leveraging the expertise and resources of Iron Valley Fitness, KHS aims to support members in achieving sustainable lifestyle improvements and overall better health outcomes. The insights gathered from this pilot will help guide a broader decision on implementing a gym membership benefit for members and reinforces KHS's commitment to keeping members healthy through approaches that enhance wellness through community-focused partnerships.

Birthing Care Pathway - DHCS

On December 15, 2023, the Centers for Medicare & Medicaid Services (CMS) announced the new Transforming Maternal Health (TMaH) Model. The TMaH Model will implement evidence-informed interventions within a value-based payment (VBP) framework, reimbursing providers based on patient health outcomes and quality of care, rather than the volume of services provided.

In August of 2024, Kern Health Systems was chosen to help implement the TMaH model in California. The Plan provided the DHCS, Department of Health Care Services, with the "Kern Health Systems Information Request Template for DHCS TMaH Application," which provided data regarding the Plan's In-Network Hospitals with Licensed Obstetrical Units, the ACOG Level of Maternal Care for those Units, and Average Number of Medicaid/CHIP-financed births over CY 2021 – CY 2023, along with additional data relating to Maternal Health provided by the Plan.

In January 2025, the Centers for Medicare & Medicaid Services (CMS) announced California as one of 15 states selected for the federal ten-year Transforming Maternal Health (TMaH) Model and awarded DHCS $17 million in federal funding to implement it. DHCS determined it would implement TMaH in five Central Valley counties, with Kern County being selected as one of the chosen counties. The other counties to be chosen were: Kings, Tulare, Fresno, and Madera.

On February 5, 2025, DHCS visited Kern County to share with local maternity providers, CalAIM/ECM/CS providers working with maternity populations, hospitals, other maternity partners, such as the Bakersfield American Indian Project about the goals of the Birthing Care Pathway, key highlights from the Birthing Care Pathway Report, and how the TMaH Model will complement and bolster DHCS' work to strengthen the state's health care delivery system, improve maternal health outcomes, and reduce disparities. A panel discussion was held with maternity care experts representing diverse perspectives, followed by a structured question and answer session to encourage input from attendees. During this visit they toured a few of the local hospitals, Kern Medical Center and Bakersfield Memorial Hospital, to access their birthing centers and learn about their daily operational processes.

The Plan continues to provide the DHCS with additional information relating to Maternal Health. Most recently, the Plan provided data to the DHCS in February relating to the Plan's members who live in one of the five TMaH Counties (99.3%) and members who live in California but not in one of the five TMaH Counties (0.5%). The Plan also provided data regarding Plan births occurring in the five TMaH Counties (14,903 from 2021-2023) and births within California but outside the five TMaH Counties (294 from 2021-2023).

COMMUNITY HEALTH - YOUTH PARTNERSHIPS

Voices Unlocked: Healing Youth Through Arts & Expression

Kern Health Systems (KHS) continues to deepen its commitment to improving the health and wellbeing of our community's youth through the newly launched Community Health Partnership (CHP) program. This initiative strengthens local support systems by investing in grassroots organizations that are making a real difference in the lives of children and young adults—particularly those impacted by homelessness, incarceration, and lack of access to afterschool enrichment.

Among the standout partnerships in 2024, KHS joined forces with the Arts Council of Kern to expand the Art4Rehabilitation (A4R) program. Piloted in 2023–24, A4R offers a creative outlet for youth at APEX and Crossroads Juvenile Detention Centers. Through Hip-Hop, music production, literary, and visual arts, participants are guided in building behavioral, emotional, and social skills that support their long-term health and success.

Building Cultural Capital in our NEXT Generation

For many students from underserved communities, this experience could be their first exposure to higher education, a fine dining experience, and live symphonic music, sparking inspiration and broadening their view of what's possible.

Each BSO NEXT concert event will begin with a tour of a local college—Bakersfield College, CSUB, or Taft College—designed to show students a pathway to their own future. They'll then enjoy a fine dining experience at a local restaurant before attending a live performance by the Bakersfield Symphony Orchestra at The Dignity Health Theater.

To deepen their appreciation, students will participate in an interactive pre-concert lecture that introduces the music they'll hear, enhancing their understanding and connection to the art form.

By offering these experiences to 600 students, most from rural and Title 1 schools, we aim to inspire their imaginations, expand their horizons, and cultivate a lifelong connection to the arts. It's heartbreaking that many youth wouldn't be exposed to the arts due to their socio-economic status.

We will further support by encouraging staff to volunteer and accompany KFHC members, giving us an opportunity to learn first-hand what they learned and how the experiences helped them. Staff will also rally around this project by fundraising to purchase clothes for our members who participate. Together, we will promote healing through the arts and motivation to pursue higher education.

KHS ORGANIZATIONAL HIGHLIGHTS

KHS Connect Week - Strengthening Alignment Through Engagement

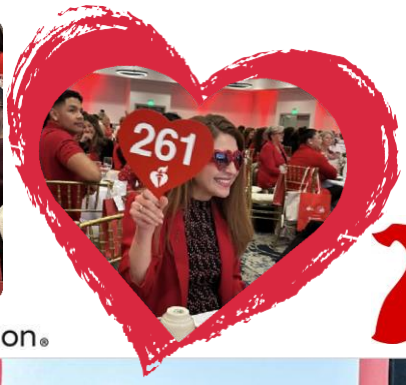
Kern Family Health Care proudly hosted its inaugural Connect Week, a strategic initiative designed to align staff with our organizational mission, 2025 goals, and core values. Each day focused on a specific core value—Excellence, Integrity, Equity, Collaboration, Compassion, and Innovation—creating an intentional opportunity for employees to reflect on how their work supports our collective vision. Through presentations, team-based activities, and value-driven dialogue, employees across all departments gained clarity on our strategic direction and their role in advancing it.

While elements of fun and recognition were woven into the experience to foster team spirit, the true impact of Connect Week was its ability to unite the organization around shared purpose. The week reinforced our commitment to transparent communication, continuous learning, and a workplace culture rooted in our values—ensuring our entire team is equipped and inspired to help Kern Family Health Care grow stronger and serve our members better in 2025 and beyond.

KHS Leadership at the Forefront of Women's Heart Health

Kern Family Health Care was honored to sponsor the American Heart Association's Go Red for Women Luncheon—an impactful event dedicated to raising awareness and support for women's heart health. The luncheon brought together local healthcare leaders, advocates, and community members to advance education and action against cardiovascular disease, the leading cause of death among women.

In a proud moment for KHS, our CEO Emily Duran was announced as the Chair of the 2026 Go Red for Women campaign, solidifying our organization's commitment to this life-saving cause. Emily joins current team member Maritza Jimenez, who continues her second year of leadership on the event's planning committee. Their involvement demonstrates KHS's dedication not only to community health but also to empowering women through advocacy and education. We look forward to supporting the movement in the years ahead and congratulate Emily and Maritza on representing KHS with such purpose and passion



American Heart Association.

Go Red for women.

Attachment A

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2025

Goal 1	
Goal Name | Description	**Quality and Equity** Deliver exceptional quality outcomes and health equity for KHS members
Strategy 1	Increase overall quality with a drive toward achieving Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps.
Accomplishments	• The annual MCAS audit is underway for Measurement Year 2024. Current YTD administrative rates reflect meeting MPL for 7 measures and within 5% MPL for 7 additional measures. Demonstrating improvement in 13 MCAS measures. • Mobile Unit partnerships established with more than 15 school districts across the county and expanding. • Routine data exchange established with two additional providers to promote real-time insight of MCAS performance. • Two interventions established with two local PCPs focused on well-care visits for children and adolescents. • Strike Team was re-established in March with a dedicated focus on member engagement. Initial development is underway.
Strategy 2	Meet National Committee for Quality Assurance (NCQA) standards and work toward accreditation.
Accomplishments	• Mock audit file reviews completed for Utilization Management, Population Health Management and Credentialing. • Finalizing operationalization of updated policies and procedures. Bookmarking and annotating of evidence for NCQA surveys. • Uploading HPA survey evidence into the NCQA survey tool for 4/8/25 Health Plan Accreditation survey date. • Continued configuration efforts for regulatory software to leverage for on-going monitoring of NCQA standard compliance.
Strategy 3	Further maturity of the organization's Health Equity programs under the direction of the Chief Health Equity Officer.
Accomplishments	• Continuing to develop and launch comprehensive KHS Doula Training, Onboarding & Support program resulting in 11 contracted Doulas. Successfully supported DHCS visit for the Transforming Maternal Health (TMaH) Model Press Conference, hosting tours and sharing about the 2025 Doula Lanyard Pilot Program with Memorial Hospital. • Launched Kern Health Equity Fellows Program with BC and supported BC MESA Stem & Pre-Health Conference. • Received Committee approval of 2025 QIHE Program Description & associated workplans. • Received DHCS approval for training curriculum per All Plan Letter 24-016, submitted TGI curriculum for DHCS & DHMC approval, completed initial SOGI training.

Strategic Plan Status Report: Q1 2025

Goal 2	
Goal Name | Description	**Workforce** Develop initiatives for the recruitment and retention of both internal and external workforce needed to fulfill KHS' mission
Strategy 1	Identify Provider Network needs and gaps to inform target areas and approaches.
Accomplishments	• The Q1 2025 Network Adequacy Committee (NAC) meeting was held on February 27, 2025. NAC oversees the Plan's accessibility monitoring and network expansion efforts by establishing network standards, monitoring compliance, promoting health equity, and driving continuous improvement. During the meeting, the group discussed accessibility challenges identified in Central and East Kern through Plan monitoring efforts. Provider shortages were noted as a contributing factor to East Kern's accessibility issues. • In Q1 2025, the Provider Network Management and Contracting departments worked to complete the provider network adequacy portions of the Plan's initial D-SNP contract filing. CMS geographic access standards differ from those used by state regulatory bodies (DHCS, DMHC), which the Plan typically follows, requiring a new geographic accessibility analysis. Through this analysis, the Plan identified potential provider gaps in certain geographic regions in relation to CMS geographic access standards.
Strategy 2	Strengthen and expand the KHS provider network through innovative and effective recruitment and retention programs.
Accomplishments	• KHS continues to prioritize both local nursing and residency expansions through the Healthcare Workforce Expansion Initiative, especially as recruiting and retaining providers who are familiar with the unique needs of Kern County's rural communities remains a challenge. Despite these ongoing difficulties, our recruitment and retention efforts have already made significant strides in strengthening the provider network. Through these efforts, KHS has successfully recruited 30 new providers and retained 26.
Strategy 3	Identify business needs and gaps in current workforce to inform target areas and approaches.
Accomplishments	• Drafting has begun on initiatives focused on leadership development, succession planning, and enhancing our employee value proposition. • The equity adjustments related to the Mercer compensation study were completed in January.
Strategy 4	Meet the growing operational demands of the organization by creating recruitment and retention programs for internal staffing and leadership needs.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2025

Accomplishments	• The self-funded health plan with Blue Shield of CA was successfully implemented and went into effect January 1, 2025. The transition was completed smoothly and on schedule, ensuring continuous coverage and support for our employees. • The Talent Acquisition team has been working with Delegation Oversight since February on positions and job descriptions related to Medicare staffing. We currently have 5 positions open for Delegation Oversight.

Strategic Plan Status Report: Q1 2025

Goal 3	
Goal Name | Description	**CalAIM** Continue to develop, implement, and grow the programs and policies included under DHCS' CalAIM initiative
Strategy 1	Continued growth and maturity of existing CalAIM programs – Population Health Management, Enhanced Care Management, Community Supports, and Long-Term Care.
Accomplishments	• Launched two (2) new ECM program providers in Quarter 1, bringing the total number of ECM program provider sites to 40 overall currently. CityServe began providing ECM services as of February 1, 2025, and Kern Bridges Youth Homes (KBYH) began providing ECM services as of March 1, 2025. The exciting news is that KBYH is not only providing services in Bakersfield, but they are also providing services in Ridgecrest for all populations of focus. These program providers are community-based organizations (CBOs); the focus has been to continue to diversify the KHS ECM program and ensure that we have specialty program providers in place to serve all populations of focus. • Community Supports team was able to onboard two new Community Based Organizations to offer Community Support services. The Mission of Kern County will provide the Housing Trio services: Navigation, Deposits, and Sustainability. Pathway Assisted Living will offer Nursing Facility Transition and Community Transition Services. • Population Health Management team continued the growth and development of several key programs. The Homebound Program is currently in the contracting phase, with an expected launch date of May 1, 2025. The department has also recently established a team of nurses to follow up with members who utilize the KHS Nurse Advice Line, ensuring they receive ongoing support and resources to maintain their health. The team has also initiated discussions with various cardiologists to explore potential partnerships in developing a comprehensive, holistic care program for members diagnosed with heart failure.
Strategy 2	Strengthen Existing and Establish New Community Partnerships to Support CalAIM.
Accomplishments	• Four out of the 15 organizations participating in the "Community-Based Initiative" grant program have successfully completed their projects and the remaining 11 are on track to meet the November 2025 completion deadline. These organizations have made a meaningful impact by addressing pressing community needs. Their efforts include improving access to healthcare, promoting education on healthy eating habits, distributing food and clothing, collaborating with local organizations to host health fairs, and expanding mobile health services at our rural underserved areas of Kern County. • Team continued to attend, support, and participate in the CalAIM PATH HC2 Collaborative meetings monthly along with our local Managed Care plans including Anthem Blue Cross and Kaiser Permanente. The team also participated in and provided support for the quarterly in-person CalAIM PATH HC2 Collaborative meeting that took place at Bakersfield College.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2025

	• Progress reports for Q4 were submitted and approved by DHCS and KHS is currently preparing the Q1 2025 progress report. The MOUs with Kern County Probations and CAPK WIC have been signed. An amendment to the MOU with Kern County Public Health was requested by DHCS and it is scheduled for board of supervisors' approval on 4/8/25. KHS partnered with Anthem and Kaiser to create a MCP training and education curriculum for CAPK and CSV WIC and have plans to create similar training material for Kern County Public Health and Kern County Probations in Q2. Quarterly MOU meetings with First 5 Kern began in March and IHSS has agreed to begin redline reviews of the MOU. Kern Regional Center MOU is under review by their new administrator and the Child Welfare MOU is on hold until additional guidance from the state is provided.
Strategy 3	Ongoing collaboration between KHS staff and the Department of Health Care Services (DHCS) on the development and implementation of future CalAIM initiatives.
Accomplishments	• The ECM Leadership Team continued to build and maintain monthly collaborative meetings with the Kern County Probation Department, Kern County Sheriff Department, Kern Behavioral Health and Recovery Services, Kern County Department of Human Services, Kern Medical, the California Department of Corrections and Rehabilitation, and our local Managed Care plans including Anthem Blue Cross and Kaiser Permanente, for the purposes of collaborating and maintaining relationships regarding the implementation of the Justice-Involved Initiative/pre-release services in Kern County. Both the Kern County Probation Department and the Kern County Sheriff Office plan to go live with pre-release services for all county juvenile and adult facilities in Kern County as of July 1, 2025. • CDC-R went live with pre-release services for all prisons throughout California as of February 1, 2025. CDC-R has transitioned to now meeting with all MCPs throughout the state and while services have gone live, workflows and data sharing continue to be a work in progress overall. • PHM is closely monitoring updates on the implementation of Medi-Cal Connect, tentatively scheduled to launch in July 2025. DHCS has rolled out an opportunity for health plans to participate as Advisors and Champions. The initiative focuses on improving health information sharing, increasing service access, and reducing care fragmentation to enhance health outcomes, especially for individuals with complex healthcare needs. • The development of Transitional Rent, Closed-Loop Referrals and data sharing files is ongoing. In February 2025 DHCS released refinements for four of the Community Supports Services: Nursing Facility Transition/Diversion, Community Transition, Asthma Remediation and Medically Tailored Meals. Refinements for the housing trio have been discussed; however, nothing concrete has been provided yet. Other changes include refinements to Recuperative Care and Short-Term Hospitalization. Community Supports Services (CSS) actively participates in monthly technical assistance meetings with DHCS to enhance service implementation and collaborates with LHPC to identify and share best practices.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2025

Goal 4	
Goal Name | Description	**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 1	Development of the long-term D-SNP strategy and implementation roadmap.
Accomplishments	• The contract with the administrative services partner has been executed and approved by both DMHC and DHCS. • The contract with the Pharmacy Benefit Manager (PBM) has also been executed and approved by both DMHC and DHCS. • Finalized the Model of Care, including California specific requirements. • Submitted the CMS H contract application which included the executed PBM and administrative services subcontractor contracts in addition to the Model of Care.
Strategy 2	Analysis of the appropriate market factors to maximize the competitiveness of the product.
Accomplishments	• Supplemental benefits RFP was completed, and interviews have been held with potential vendors. KHS has identified targeted populations for development of a marketing strategy.
Strategy 3	Design and implementation of an efficient Medicare D-SNP offering with competitive advantages, leveraging KHS innovation and new business/new product development capabilities.
Accomplishments	• Kicked off the Medicare D-SNP operational and implementation project, aligning internal teams and delegate partner on key objectives and timelines. • Revised 2025 resource estimates to ensure accurate budgeting and optimal allocation for the D-SNP projects. • Kicked off the Pharmacy Benefit Manager (PBM) implementation project for Medicare part D. • Launched future-state design efforts in partnership with the delegate partner to ensure operational alignment and readiness.

Strategic Plan Status Report: Q1 2025

Goal 5	
Goal Name | Description	**Behavioral Health** Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions
Strategy 1	Development and maturity of an internal Behavioral Health Department.
Accomplishments	• Created Policies and Procedures (P&P) for Minor Consent services. Implementing the related workflow within KHS systems and the Provider Portal ensuring that the process is seamless and integrated. • Continued to improve data reporting capabilities, focusing on better identifying trends, performance gaps, and areas for improvement. • Collaborative work to define requirements for the BHT (Behavioral Health Treatment)/ABA (Applied Behavioral Analysis) workflow. • Enhancing the Provider Portal including adding a Behavioral Health (BH) tab to the member profile, which will provide comprehensive information about the member's BH history, utilization, health records, gaps in care, and member engagement.
Strategy 2	Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS).
Accomplishments	• There was an increase in the availability of several key mental health provider types in the network: Licensed Marriage and Family Therapists (LMFT) increased from 77 to 96 providers, Licensed Clinical Social Workers (LCSW) increased from 106 to 122 providers, Psychiatrists increased from 109 to 124 providers. • Continuous efforts have been made with the provider network to address existing gaps, particularly in the areas of Applied Behavioral Analysis (ABA) providers and in-person providers.
Strategy 3	Communication and coordination with County Behavioral Health regarding DHCS requirements.
Accomplishments	• A monthly Care Coordination meeting was established between the Managed Care Plan (MCP) and the Mental Health Plan (MHP). This meeting focuses on addressing issues related to the Transition of Care (TOC) process, with the goal of ensuring accuracy in documentation to properly support requests for step-down services. • Continued work on the implementation of the Memorandum of Understanding (MOU) between the MHP and the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Strategic Plan Status Report: Q1 2025

	• Active ongoing efforts are in place to automate the data exchange with Kern Behavioral Health and Recovery Services (KBHRS). This exchange is critical for improving the flow of information, ensuring accurate and timely data for program evaluation, and supporting compliance with DHCS requirements. • The team worked closely with Kern BHRS to obtain encounter data for the 2024 Managed Care Accountability Set (MCAS) Follow-Up After Hospitalization for Mental Illness (FUA) and Follow-Up After Emergency Department Visit for Mental Illness (FUM) measures. This data is crucial for meeting DHCS quality reporting requirements and assessing performance in key behavioral health areas.
Strategy 4	Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment (MAT) services.
Accomplishments	• Successfully initiated the 2025 Behavioral Health project, which will focus on integrating MAT services as part of the overarching goal. This marked the formal start of the project work related to MAT implementation. • Finalized a high-level roadmap for the establishment of Behavioral Health (BH) programs, including MAT services, to ensure that MAT will be fully integrated into broader BH initiatives. • Created comprehensive deliverables, outlining the critical requirements and details for the work involved in MAT implementation. • Outreach to a Primary Care Provider (PCP) offering MAT services to explore collaboration opportunities that bridge the gap between PCPs and MAT services, ensuring effective partnerships for service delivery. • Exploring collaboration opportunities with other Local Health Plans focused on best practices for establishing standards of care, as well as clinical oversight and monitoring of Medication-Assisted Treatment (MAT) programs.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2025

Goal 6	
Goal Name | Description	**Member Engagement** Increase member engagement in their health care
Strategy 1	Identify and implement innovative and effective offerings designed to engage members more in their health care.
Accomplishments	• East Kern (Mojave based) Member Engagement Representative (MER) expanded reach to Boron and may play an active role in a community event. • Worked with Wellness & Prevention to send wellness topics of the month to members via text messages. • Provided support organizing the California City Wellness event and handed out gift cards to members who completed a qualifying health event.
Strategy 2:	Work with internal staff and external partners to develop strategies that ensure continuity of coverage for our members.
Accomplishments	• Continue to perform live outreach and text message campaigns. • Member and Community Engagement Representatives continue to hand out informational flyers at events. • Community Enrollment Navigators continue to assist members at various locations with Medi-Cal Renewals.
Strategy 3:	Leverage convenient technology to enhance the effectiveness of engagement and suit members' needs.
Accomplishments	• New Member Rewards Program that will implement a Visa-type reloadable card is expected to go-live by July 2025 and include a portal for members to track their rewards. • Text message automation project - completed the design of enhancements to the scheduling website/workflow. • CRM process improvement use-case designs are completed – demographic updates, call tracking, and ID card button.

Strategic Plan Status Report: Q1 2025

Goal 7	
Goal Name | Description	**KHS Foundation** Explore the opportunity for KHS to create a non-profit foundation to further its mission in the community
Strategy 2	Begin collaboration with law firm on the corporate formation documents and finalize the development phase of the foundation.
Accomplishments	• The foundation committee will meet in Q2 of 2025 to begin key operation activities.

Attachment B

Bill Tracking:

Title	Description	Status
AB 29	This bill would require the department, as part of its above-described duties, to include (1) community-based organizations and local health jurisdictions that provide health services through community health workers and (2) doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to require these providers to make clinical or other appropriate referrals, as specified, as a condition of payment for conducting ACEs trauma screenings. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would also require the department to update its internet website and the ACEs Aware internet website to reflect the addition of the Medi-Cal providers described above as authorized to provide ACEs screenings. The bill would authorize the department to implement, interpret, or make specific these provisions by means of a provider manual, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB29	03/20/25 - Re-referred to Com. on Health.

AB 37	Existing law establishes the California Workforce Development Board as the body responsible for assisting the Governor in the development, oversight, and continuous improvement of California's workforce investment system and the alignment of the education and workforce investment systems to the needs of the 21st century economy and workforce. Existing law requires the board to assist the Governor in certain activities, including the review and technical assistance of statewide policies, programs, and recommendations to support workforce development systems in the state, as specified. This bill would require the board to study how to expand the workforce of mental health service providers who provide services to homeless persons. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB37	03/17/25 - Re-referred to Com. on L. & E.
AB 45	This bill would state the intent of the Legislature to enact legislation to make it unlawful to geofence an entity that provides in-person health care services and to prohibit health care providers from releasing medical research information related to an individual seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on another state's laws that interfere with a person's rights under the Reproductive Privacy Act. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB45	12/03/24 - From printer. May be heard in committee January 2.

AB 50	Existing law, the Pharmacy Law, establishes in the Department of Consumer Affairs the California State Board of Pharmacy to license and regulate the practice of pharmacy. Exiting law requires a pharmacist, when furnishing self-administered hormonal contraceptives, to follow specified standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. Existing law requires those standardized procedures or protocols to require that the patient use a self-screening tool that will identify related patient risk factors and that require the pharmacist to refer the patient for appropriate follow-up care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical follow-up, and other appropriate information. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would make related conforming changes. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB50	02/18/25 - Referred to Coms. on B. & P. and Health.

AB 55	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth certain criteria for Medi-Cal reimbursement to alternative birth centers for facility-related delivery costs. Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement provisions described above, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. The bill would delete the above-described proximity requirement and instead require a written policy for hospital transfer, as provided. The bill would also make a technical change to an obsolete reference within a related provision. By creating a new requirement for an alternative birth center or a primary care clinic that provides services as an alternative birth center, the violation of which is a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB55	02/26/25 - Re-referred to Com. on Health.
AB 96	Existing law required the Department of Health Care Access and Information, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs. Existing law requires the department, as part of developing those requirements, to, among other things, determine the necessary curriculum to meet certificate program objectives. Existing law defines “community health worker” for these purposes to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing	02/12/25 - Re-referred to Com. on Health.

	law specifies that "community health worker" include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other non-licensed health workers with the qualifications developed by the department. This bill would also specify for these purposes that a "community health worker" includes a peer support specialist and would deem a certified peer support specialist to have satisfied all education and training requirements developed by the department for certification as a community health worker. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB96	
AB 220	Existing law requires the department to establish a subacute care program in health facilities, as specified, to be available to patients in health facilities who meet subacute care criteria. Existing law requires that medical necessity for pediatric subacute care be substantiated by specified conditions. Existing regulations require a treatment authorization request for each admission to a subacute unit. This bill would require a health facility that provides pediatric subacute or adult subacute care services pursuant to these provisions to submit with a treatment authorization request, including an electronic treatment authorization request, a specified form when requesting authorization for subacute care services. The bill would prohibit a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity for pediatric subacute or adult subacute care services with a condition or standard not enumerated in those forms. The bill would require the department to develop and implement procedures, and authorize the department to impose sanctions, to ensure that a Medi-Cal managed care plan complies with these provisions. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB220	02/03/25 - Referred to Com. on Health.

AB 242	Existing law establishes the continuously appropriated Genetic Disease Testing Fund (GDTF), consisting of fees paid for newborn screening tests, and states the intent of the Legislature that all costs of the genetic disease testing program be fully supported by fees paid for newborn screening tests, which are deposited in the GDTF. Existing law also authorizes moneys in the GDTF to be used for the expansion of the Genetic Disease Branch Screening Information System to include cystic fibrosis, biotinidase, severe combined immunodeficiency (SCID), adrenoleukodystrophy (ALD), and any other disease that is detectable in blood samples, as specified, and exempts the expansion of contracts for this purpose from certain provisions of the Public Contract Code, the Government Code, and the State Administrative Manual, as specified. This bill would require the department to expand statewide screening of newborns to include screening for Duchenne muscular dystrophy as soon as possible, but no later than January 1, 2027. By expanding the purposes for which moneys from the GDTF may be expended, this bill would make an appropriation. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB242	03/20/25 - In committee: Hearing postponed by committee.
AB 257	This bill would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a telehealth and other virtual services specialty care network that is designed to serve patients of safety-net providers consisting of qualifying providers, defined to include, among others, rural health clinics and community health centers. The bill would authorize the focus of the project to include increasing access to behavioral and maternal health services and additional specialties prioritized by the agency. The bill would state the intent of the Legislature that implementation of the demonstration project would facilitate compliance with any applicable network adequacy standards.	02/10/25 - Referred to Com. on Health.

	The bill would require the demonstration project to include a grant program to award funding to grantees, as defined, that meet specified conditions relating to specialist networks and health information technology. Under the bill, the purpose of the grant program would be to achieve certain objectives, including, among others, reducing structural barriers to access experienced by patients, improving cost-effectiveness, and optimizing utilization. The bill would require a grantee to evaluate its performance on the objectives and to submit a report of its findings to the agency. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB257	
AB 260	This bill would repeal those unconstitutional provisions and delete obsolete references to criminal abortion penalties. The bill would make technical changes to provisions authorizing abortion for incarcerated and committed persons. (5) Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law regulates the department's certification of enrolled Medi-Cal providers. Under existing law, in-person, face-to-face contact is not required to provide services under the Medi-Cal program, as specified, but existing law generally prohibits a provider from establishing a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic synchronous interaction, remote patient monitoring, or other virtual communication modalities. This bill would require the department to update the Medi-Cal provider enrollment requirement and procedures for remote service providers who offer reproductive health care services exclusively through telehealth modalities, as specified, and to permit the use of a cellular telephone as the primary business phone for reproductive health care providers. The bill would authorize a health care provider to establish a new patient relationship using asynchronous store and forward if the visit	03/18/25 - Re-referred to Com. on Health.

	is related to reproductive health care services and meets specified requirements. This bill would prohibit a health care service plan contract or a group or individual disability insurance policy or certificate that covers prescription drugs from limiting or excluding coverage for brand name or generic mifepristone, regardless of its FDA approval status or solely on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA or that varies from an approved risk evaluation and mitigation strategy, except if the state deems it necessary to address an imminent health or safety concern. The bill would prohibit a plan or insurer from contracting with a health care services provider to terminate or nonrenewal the contract or otherwise penalize the provider, or from discriminating against a licensed provider, for manufacturing, transporting, or engaging in certain other acts relating to mifepristone or other medication abortion drugs that are lawful in California. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB260	
AB 278	Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law establishes the Health Care Affordability Board to establish, among other things, a statewide health care cost target and the standards necessary to meet exemptions from health care cost targets or submitting data to the office. Existing law authorizes the office to establish advisory or technical committees, as necessary, in order to support the board's decision-making.	02/10/25 - Referred to Com. on Health.

	This bill would require the board, on or before June 1, 2026, to establish a Patient Advocate Advisory Standing Committee, as specified, that is required to publicly meet, and receive public comments, at least 4 times annually. The bill would require the committee to include specified data from the meetings to the board as part of its annual report. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB278	
AB 280	This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.	02/10/25 - Referred to Com. on Health.

	On or before January 1, 2026, this bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to use to request directory information from providers and to establish a methodology and processes to ensure accuracy of provider directories and consistency with other laws, regulations, or standards. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB280	
AB 302	Existing law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act punishes a violation of its provisions that results in economic loss or personal injury to a patient as a misdemeanor. Existing law requires a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by law or if the disclosure is compelled by, among other things, a court order or a search warrant lawfully issued to a governmental law enforcement agency. This bill would instead require a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by California law. The bill would revise the disclosure requirement relating to a court order to require disclosure if compelled by a California state court pursuant to an order of that court or a court order from another state based on another state's law so long as that law does not interfere with California law, as specified. The bill would revise the disclosure requirement relating to a search warrant to require disclosure if compelled by a warrant from another state based on another state's law so long as that law does not interfere with California law. By narrowing the exceptions for disclosing medical information, and thereby expanding the crime of violating the act, this bill would	01/24/25 - From printer. May be heard in committee February 23.

	impose a state-mandated local program. This bill would delete the exceptions allowing disclosure pursuant to an express authorization by a patient, enrollee, or subscriber. By expanding prohibitions against disclosing medical information, and thereby expanding the crime of violating the act, this bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB302	
AB 315	Existing law sets forth provisions for the implementation of the Nursing Facility/Acute Hospital Transition and Diversion Waiver, which is the predecessor of the Home and Community-Based Alternatives (HCBA) Waiver, for purposes of providing care management services to individuals who are at risk of nursing facility or institutional placement. This bill would recast those provisions to refer to the HCBA Waiver. The bill would delete a provision authorizing the expansion of the number of waiver slots up to 5,000 additional slots, and would instead require the enrollment of all eligible individuals who apply for the HCBA Waiver. The bill would require the department, by March 1, 2026, to seek any necessary amendments to the waiver to ensure that there is sufficient capacity to enroll all eligible individuals who are currently on a waiting list for the waiver, as specified. The bill would require the department, by March 1, 2026, to submit a rate study to the appropriate fiscal and policy committees of the Legislature addressing the sustainability, quality, and transparency of rates for the HCBA Waiver. The bill would require that the study include an assessment of the effectiveness of the methods used to pay for services under the waiver, with consideration of certain factors. The bill would make related legislative findings. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202520260AB315	02/10/25 - Referred to Com. on Health.

AB 322	Existing law establishes the State Department of Education in state government, and vests the department with specified powers and duties relating to the state's public school system, including encouraging and assisting school districts to improve and monitor the health of their pupils. Existing law requires the department, as part of that assistance, to provide information and guidance to schools that request the information and guidance to establish "Health Days" to provide screenings for common health problems among pupils. This bill would require the department to include county offices of education and charter schools in the above-described provisions. The bill would require the department to encourage school districts, county offices of education, and charter schools to participate in programs that offer reimbursement for school-based health services and school-based mental health services, as provided. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB322	03/13/25 - From committee: Do pass and re-refer to Com. on APPR. with recommend ation: To Consent Calendar. (Ayes 8. Noes 0.) (March 12). Re-referred to Com. on APPR.
AB 346	Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with specified services in order to permit them to remain in their own homes and avoid institutionalization. Existing law defines supportive services for purposes of the IHSS program to include those necessary paramedical services that are ordered by a licensed health care professional, which persons could provide for themselves, but for their functional limitations. Existing law requires an applicant for, or recipient of, in-home supportive services, as a condition of receiving these services, to obtain a certification from a licensed health care professional declaring that the applicant or recipient is unable to perform some activities of daily living independently, and that without services to assist the applicant or recipient with activities of daily living, the applicant or recipient is at risk of placement in out-of-home care, and defines a licensed health care professional to mean an individual licensed in California by the appropriate California regulatory agency, acting within the scope of their license or certificate as defined in the Business	02/18/25 - Referred to Com. on HUM. S.

	and Professions Code. This bill would instead define "licensed health care professional" for those purposes to mean any person who engages in acts that are the subject of licensure or regulation under specified provisions of the Business and Professions Code or under any initiative act referred to in those specified provisions. The bill would also clarify that as a condition of receiving paramedical services, an applicant or recipient is required to obtain a certification from a licensed health care professional, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB346	
AB 348	Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services, as specified. The MHSA establishes the Mental Health Services Fund, a continuously appropriated fund, which is administered by the State Department of Health Care Services (department), to fund specified county mental health programs. Existing law, the Behavioral Health Services Act (BHSA), a legislative act amending the MHSA that was approved by the voters as Proposition 1 at the March 5, 2024, statewide primary election, recast the MHSA by, among other things, renaming the fund to the Behavioral Health Services Fund and reallocating how moneys from that fund may be spent. The BHSA requires each county to establish and administer a full-service partnership program that includes, among other things, outpatient behavioral health services, as specified, and housing interventions. This bill would establish criteria for an individual with a serious mental illness to be presumptively eligible for a full-service partnership, including, among other things, the person is transitioning to the community after 6 months or more in the state prison or county jail. The bill would specify that a county is not required to enroll an individual who meets that presumptive eligibility criteria if doing so would exceed full-	02/18/25 - Referred to Com. on Health.

	service partnership funding. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB348	
AB 350	Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including certain dental services, that are rendered by Medi-Cal enrolled providers. Under existing law, silver diamine fluoride treatments are a covered benefit for eligible children 0 to 6 years of age, inclusive, as specified, and application of fluoride or other appropriate fluoride treatment is covered for children 17 years of age and under. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of age. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB350	02/18/25 - Referred to Com. on Health.

AB 384	This bill, the California Mental Health Protection Act, would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for mental health and substance use disorders from requiring prior authorization (1) for an enrollee or insured to be admitted for medically necessary 24-hour care in inpatient settings for mental health and substance use disorders, as specified, and (2) for any medically necessary health care services provided to an enrollee or insured while admitted for that care. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violations of these provisions. This bill would prohibit requiring prior authorization under the Medi-Cal program (1) for admission for medically necessary 24-hour care in inpatient settings for mental health and substance use disorders, as specified, and (2) for any medically necessary health care services provided to a beneficiary while admitted for that care. The bill would authorize the Director of the State Department of Health Care Services to terminate a contract with, or impose sanctions on, an entity that violates these provisions. The bill would condition implementation of these provisions on the availability of federal financial participation and the receipt of any necessary federal approvals. For purposes of these provisions, this bill would provide that 24-hour care in inpatient settings includes, among other things, a general acute care hospital and an acute psychiatric hospital, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB384	03/18/25 - Re-referred to Com. on Health.

AB 403	Under existing law, community health worker (CHW) services are a covered Medi-Cal benefit subject to any necessary federal approvals. CHW is defined as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees with regard to the CHW services benefit, as specified. Existing law requires the department to inform stakeholders about implementation of the benefit. This bill would require the department to annually conduct an analysis of the CHW services benefit, submit the analysis to the Legislature, and publish the analysis on the department's internet website, with the first analysis due July 1, 2027. The bill would require the analysis to include, at a minimum, an assessment of the above-described outreach and education efforts conducted by each Medi-Cal managed care plan, an assessment of the CHW benefit utilization and services, a demographic disaggregation of CHWs providing the CHW benefit and the Medi-Cal beneficiaries receiving services, and data on Medi-Cal reimbursements for CHW services billed to the department, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB403	03/18/25 - Re-referred to Com. on Health.

AB 432	This bill would instead require the board, in determining its continuing education requirements, to include a course in menopausal mental or physical health. The bill would require physicians who have a patient population composed of 25% or more of women to complete a mandatory continuing medical education course in perimenopause, menopause, and postmenopausal care. (2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2026, to include coverage for evaluation and treatment options for perimenopause and menopause. The bill would require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB432	03/10/25 - Re-referred to Coms. on B. & P. and Health pursuant to Assembly Rule 96.

AB 489	Existing law establishes various healing arts boards within the Department of Consumer Affairs that license and regulate various healing arts licensees. Existing laws, including, among others, the Medical Practice Act and the Dental Practice Act, make it a crime for a person who is not licensed as a specified health care professional to use certain words, letters, and phrases or any other terms that imply that they are authorized to practice that profession. This bill would make provisions of law that prohibit the use of specified terms, letters, or phrases to falsely indicate or imply possession of a license or certificate to practice a health care profession, as defined, enforceable against an entity who develops or deploys artificial intelligence technology that uses one or more of those terms, letters, or phrases in its advertising or functionality. The bill would prohibit the use by AI technology of certain terms, letters, or phrases that indicate or imply that the advice or care being provided through AI is being provided by a natural person with the appropriated health care license or certificate. This bill would make a violation of these provisions subject to the jurisdiction of the appropriate health care profession board, and would make each use of a prohibited term, letter, or phrase punishable as a separate violation. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB489	03/17/25 - Referred to Coms. on B. & P. and P. & C.P.
AB 510	This bill would, upon request, require that an appeal or grievance regarding a decision by a health care service plan or disability insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, be reviewed by a licensed physician who is competent to evaluate the specific clinical issues involved in the health care service being requested, and of the same or similar specialty as the requesting provider. The bill, notwithstanding the above-described timelines, would require these reviews to occur within 2 business days, or if an enrollee or insured faces an imminent and serious threat to their health, within a timely	02/24/25 - Referred to Com. on Health.

	fashion appropriate for the nature of the enrollee's or insured's condition, as specified. If a health care service plan or disability insurer fails to meet those timelines, the bill would deem the prior authorization request as approved and supersede any prior delay, denial, or modification. The bill would make conforming changes to related provisions. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB510	
AB 512	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. For a request prior to or concurrent with the provision of health care services, existing law requires utilization review decisions to be made within 5 business days from the plan's or insurer's receipt of the information reasonably necessary and requested by the plan or insurer to make the determination, or within 72 hours if the enrollee or insured faces an imminent and serious threat to their health or the normal timeframe would be detrimental to their life or health, as specified. This bill would shorten the timeline for prior authorization requests to no more than 48 hours for standard requests or 24 hours for urgent requests from the plan's or insurer's receipt of the information reasonably necessary and requested by the plan or insurer to make the determination. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202520260AB512	02/24/25 - Referred to Com. on Health.

AB 517	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed $1,250. Under the bill, a treatment authorization request for repair or replacement of a CRT-powered wheelchair would not require an individual prescription or documentation of medical necessity from the treating practitioner if the CRT-powered wheelchair has already been approved for use by the patient. For repair of a CRT-powered wheelchair, the bill would require the supplier to document and maintain records of the items being repaired, the reason for the repair, and the labor details, as specified, with the information being subject to a post payment audit by the department. The bill would set forth other recording requirements for the supplier. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB517	02/24/25 - Referred to Com. on Health.

AB 530	This bill would extend the operation of those standards indefinitely. The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks. Under this bill, the use of telehealth providers to meet time or distance standards would not absolve the managed care plan of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. The bill would set forth other related provisions with regard to the use of telehealth. This bill would recast those provisions and would specify, under both circumstances, that there be an appropriate level of care and access that is consistent with professionally recognized standards of practice, with a departmental determination that the alternative access standards will not have a detrimental impact on the health of enrollees. The bill would make other changes to the procedure for a managed care plan to submit a previously approved alternative access standard request. This bill would require that the evaluation be performed using a direct testing method and an examination of complaints data, as specified. This bill would expand the scope of the definition for "specialist" to include providers of immunology, urology, and sleep medicine, among other additional areas of medicine. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB530	03/05/25 - Referred to Com. on HEALTH.

AB 539	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides that a health care service plan or a health insurer that authorizes a specific type of treatment by a health care provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This bill would require a prior authorization for a health care service by a health care service plan or a health insurer to remain valid for a period of at least one year from the date of approval. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202520260AB539	02/24/25 - Referred to Com. on Health.
AB 543	This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports. The bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness for purposes of full-scope Medi-Cal benefits without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons.	03/24/25 - In committee: Hearing postponed by committee.

	The bill would require a Medi-Cal managed care plan to allow a beneficiary who is experiencing homelessness to seek Medi-Cal covered services directly from any participating Medi-Cal provider off the premises of the provider's site. The bill would impose related reimbursement requirements on a managed care plan and the department. The bill would authorize a managed care plan to establish reasonable requirements governing participation in the plan network, if protocols and network participation requirements are consistent with the goal of authorizing services to Medi-Cal beneficiaries who are experiencing homelessness. The bill would require a managed care plan to provide a beneficiary with the ability to inform the managed care plan online, in person, or via telephone that the beneficiary is experiencing homelessness. The bill would require the department to inform a managed care plan if a beneficiary has indicated that they are experiencing homelessness based on information furnished on the Medi-Cal application. The bill would require the department to ensure that the Medi-Cal program and the California Statewide Automated Welfare System (CalSAWS) mutually share data on the status of Medi-Cal applicants or beneficiaries experiencing homelessness, including through codes relating to unsheltered status, to the extent not in conflict with privacy laws. The bill would require the coordination to enable a person applying for the Medi-Cal program to identify that they are experiencing homelessness. The bill would condition implementation of the above-described provisions on receipt of any necessary federal approvals and the availability of federal financial participation. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB543	

AB 546	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to include coverage for portable high-efficiency particulate air (HEPA) purifiers and filters for enrollees or insureds who are pregnant or diagnosed with asthma or chronic obstructive pulmonary disease. The bill would prohibit a portable HEPA purifier and filter covered pursuant to these provisions from being subject to a deductible, coinsurance, or copayment requirement. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202520260AB546	02/24/25 - Referred to Com. on Health.
AB 618	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing Medi-Cal provisions, behavioral health services, including specialty mental health services and substance use disorder treatment, are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program, and the Drug Medi-Cal organized delivery system (DMC-ODS) program, as specified. This bill would require each Medi-Cal managed care plan, county specialty mental health plan, Drug Medi-Cal certified program, and DMC-ODS program to electronically provide	02/14/25 - From printer. May be heard in committee March 16.

	data for members of the respective entities to support member care. The bill would require the department to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027, in compliance with privacy laws. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB618	
AB 636	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Under existing law, incontinence medical supplies are covered by the Medi-Cal program. This bill would establish diapers as a covered Medi-Cal benefit for a child greater than 3 years of age who has been diagnosed with a condition, as specified, that contributes to incontinence, and for an individual under 21 years of age if necessary to correct or ameliorate a condition pursuant to certain federal standards. The bill would limit the provided diapers to an appropriate supply based on the diagnosed condition and the age of the Medi-Cal beneficiary. The bill would require the department to seek any necessary federal approvals to implement these provisions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and an appropriation by the Legislature. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB636	03/17/25 - Re-referred to Com. on Health.

AB 669	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage and are issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. On and after January 1, 2027, this bill would prohibit concurrent or retrospective review of medical necessity for the first 28 days of an inpatient substance use disorder stay during each plan or policy year, and would prohibit retrospective review of medical necessity for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder, but would require specified review for day 29 and days thereafter of that stay or service. On and after January 1, 2027, the bill would prohibit the imposition of prior authorization or other prospective utilization management requirements for outpatient prescription drugs to treat substance use disorder that are determined medically necessary by the enrollee's or insured's physician, psychologist, or psychiatrist. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB669	03/03/25 - Referred to Com. on Health.

AB 676	Existing law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors. Under the bill, those factors would include, among others, the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB676	03/03/25 - Referred to Com. on Health.
AB 682	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a plan to submit financial statements to the Director of Managed Health Care at specified times. Existing law provides for the regulation of health insurers by the Department of Insurance and requires a health insurer or multiple employer welfare arrangement to annually report specified information to the department. This bill would require the above-described reports to include specified information for each month, including the total	03/03/25 - Referred to Com. on Health.

	number of claims processed, adjudicated, denied, or partially denied. Because a violation of this requirement by a health care service plan would be a crime, the bill would create a state-mandated local program. The bill would require each department to publish on its internet website monthly claims denial information for each plan or insurer. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB682	
AB 688	Under existing law, in-person, face-to-face contact is not required under the Medi-Cal program when covered health care services are provided by video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Existing law required the department, on or before January 1, 2023, to develop a research and evaluation plan that, among other things, proposes strategies to analyze the relationship between telehealth and access to care, quality of care, and Medi-Cal program costs, utilization, and program integrity. The department created that plan in December of 2022 and published the Biennial Telehealth Utilization Report in April of 2024. This bill, the Telehealth for All Act of 2025, would require the department, commencing in 2028 and every 2 years thereafter, to use Medi-Cal data and other data sources available to the department to produce analyses in a publicly available Medi-Cal telehealth utilization report. The bill would authorize the department to include those analyses in each of the department's Biennial Telehealth Utilization Reports, as specified. The bill would require the analyses to address telehealth access and utilization data, including various metrics on telehealth visits and claims, disaggregated by geographic,	03/26/25 - From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (March 25). Re-referred to Com. on APPR.

	demographic, and social determinants of health categories to identify disparities. The bill would require the department to identify additional data elements for inclusion in future reports to help to identify and address access-to-care issues or provide greater insight into utilization of telehealth modalities. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB688	
AB 787	Existing law requires specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures. This bill would require a full service health care service plan, specialized mental health plan, health insurer, or specialized mental health insurer to include in its provider directory or directories a statement at the top of the directory advising an enrollee or insured to contact the plan or insurer for assistance in finding an in-network provider. The bill would require the plan or insurer to respond within 24 hours if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB787	03/18/25 - Re-referred to Com. on Health.

AB 804	Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024. This bill would delete the requirement for the department to complete that analysis, and instead would make housing support services for specified populations a covered Medi-Cal benefit when the Legislature has made an appropriation for purposes of the housing support services. The bill would require the department to seek federal approval for the housing support services benefit, as specified. Under the bill, subject to an appropriation by the Legislature, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness. Under the bill, the services would include housing transition navigation services, housing deposits, and housing tenancy sustaining services, as defined. The bill would authorize the department to implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or similar instruction, and to enter into exclusive or nonexclusive contracts, or amend existing contracts for its purposes, as specified. The bill would authorize these provisions to be modified by the department to the extent necessary to meet the requirements of federal law or regulations, to obtain federal approval, or to enhance the probability that federal approval can be obtained, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB804	03/03/25 - Referred to Com. on Health.

AB 843	This bill would require a health care service plan or health insurer to take reasonable steps to provide meaningful access to each individual with limited English proficiency, including companions with limited English proficiency, eligible to receive services or likely to be directly affected by its programs and activities. The bill would require a health care service plan or health insurer to offer a qualified interpreter or to utilize a qualified translator when interpretation or translation services are required, as specified. The bill would prohibit a health care service plan or health insurer from requiring an individual with limited English proficiency to provide or pay for the costs of their own interpreter. The bill would require a health care service plan or health insurer to comply with specified requirements when providing remote interpreting services. The bill would make a health care service plan or health insurer that violates these provisions liable for civil penalties, as specified. This bill would authorize a health care service plan or health insurer to satisfy the notice requirement by taking reasonable steps to inform the enrollee or insured of any required actions, including by providing a sight translation of a document. This bill would require a health care service plan or health insurer to also provide the information regarding the availability of language assistance services, as described above, (A) when specified forms are provided, (B) in clear and prominent physical locations, as specified, and (C) upon request. This bill would require a health care service plan or health insurer to additionally report to the applicable department on internal policies and procedures relating to language access, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB843	03/26/25 - From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (March 25). Re-referred to Com. on APPR.

AB 877	Existing law provides for the regulation of community care facilities that provide nonmedical care, including residential facilities, short-term residential therapeutic programs, and group homes by the State Department of Social Services. Existing law requires the care and supervision provided by a short-term residential therapeutic program or group home to be nonmedical, except as otherwise permitted by law. This bill would require the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to prepare and send one letter to each chief financial officer of a health care service plan, health insurer, or Medi-Cal managed care plan that provides coverage, including out-of-network benefits, in California for substance use disorder in residential facilities, as defined. The bill would require the letter to include, among other things, a statement informing the plan or insurer that substance use disorder treatment in licensed and certified residential facilities is almost exclusively nonmedical, with rare exceptions. The bill would authorize the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to consult with each other and would require those departments to consult with the State Department of Social Services, when preparing the contents of the letter. The bill would require the letters to be sent on or before an unspecified date. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB877	03/03/25 - Referred to Com. on Health

AB 951	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB951	03/26/25 - From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (March 25). Re-referred to Com. on APPR.
AB 974	Under this bill, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, the department would be required to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services. The bill would authorize a Medi-Cal managed care plan to	03/25/25 - Re-referred to Com. on Health.

	require a letter of agreement, or a similar agreement, under either of the following circumstances: (1) if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified, or (2) if an enrollee requires a covered service and meets the requirements for continuity of care or the completion of covered services through a Medi-Cal managed care plan pursuant to specified provisions under existing law regarding services by a terminated or nonparticipating provider. The bill would require the department to solicit input from specified stakeholders regarding the coordination of payment for services between Medi-Cal enrollees' other commercial health care coverage and their Medi-Cal managed care plans, with a specific emphasis on Medi-Cal recipients receiving regional center services. The bill would require the department to include an item on the agenda of the first meeting of the Medi-Cal Managed Care Advisory Committee of 2026 to discuss this topic and, within 6 months of the advisory committee meeting, take the actions that it deems necessary to provide clarification regarding the conditions for billing plans to providers that render services to enrollees who also have other health care coverage. The bill would specify the intent of the Legislature that the department offer educational resources to an enrollee who needs assistance with understanding continuity of care and coordinating Medi-Cal and their other health care coverage when requested by the enrollee. The bill would require the department, annually from 2026 through 2029, to update the legislative health committees on the effectiveness of implementing these provisions. The bill would authorize the department to implement these provisions through plan letters or similar instructions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB974	

AB 980	Under existing law, a health care service plan or managed care entity has a duty of ordinary care to arrange for the provision of medically necessary health care services to its subscribers or enrollees and is liable for all harm legally caused by its failure to exercise that ordinary care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee and the subscriber or enrollee suffers substantial harm, as defined. This bill would define "medically necessary health care service" for purposes of the above-described provision to mean legally prescribed medical care that is reasonable and comports with the medical community standard. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB980	03/26/25 - In committee: Set, first hearing. Hearing canceled at the request of author.
AB 1012	Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to an individual who does not have satisfactory immigrant status if they are otherwise eligible for those benefits, as specified. This bill would create the Serving Our Seniors Fund, would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits, and would transfer funds previously appropriated for the provision of Medi-Cal benefits to those individuals to that fund. The bill would	02/21/25 - From printer. May be heard in committee March 23.

	appropriate the moneys in that fund to the State Department of Health Care Services to restore and maintain payments for Medicare Part B premiums for eligible individuals. By making the moneys available without regard to fiscal years, the bill would create a continuous appropriation. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB1012	
AB 1018	This bill would generally regulate the development and deployment of an automated decision system (ADS) used to make consequential decisions, as defined. The bill would define "automated decision system" to mean a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decision-making and materially impacts natural persons. This bill would require a developer of a covered ADS, as defined, to take certain actions, including conduct performance evaluations of the covered ADS and provide deployers to whom the developer transfers the covered ADS with certain information, including the results of those performance evaluations. This bill would, beginning January 1, 2027, require a deployer of a covered ADS to take certain actions, including provide certain disclosures to a subject of a consequential decision made or facilitated by the covered ADS, provide the subject an opportunity to opt out of the use of the covered ADS, provide the subject with an opportunity to appeal the outcome of the consequential decision, and submit the covered ADS to third-party audits, as prescribed. This bill would prescribe requirements for a third party to audit a covered ADS, as prescribed. This bill would require a developer, deployer, or auditor to, within 30 days of receiving a request from the Attorney General, provide an unredacted copy of the performance evaluation or disparate impact assessment prepared pursuant	03/10/25 - Referred to Coms. on P. & C.P. and JUD.

	to the bill to the Attorney General and would exempt those records from the California Public Records Act. This bill would authorize certain public entities, including the Attorney General, to bring a specified civil action for noncompliance. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB1018	
AB 1041	Health care coverage: physician and provider credentials- This bill would require those departments to review specified credentialing requirements and adopt regulations to establish minimum standards or policies and processes that can streamline and reduce redundancy and delay in physician credentialing. The bill would also require those departments to adopt regulations to develop, on or before July 1, 2027, a standardized credentialing form to be used by health care service plans and health insurers for credentialing and recredentialing purposes. The bill would require every health care service plan or health insurer to use the standardized credentialing form on and after July 1, 2027, or six months after the form is completed, whichever is later. The bill would require those departments to update the form every three years, or as necessary to comply with changes in laws, regulations, and guidelines, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB1041	03/10/25 - Referred to Com. on Health.

AB 1161	This bill would require the State Department of Social Services, for purposes of CalWORKs, CalFresh, CFAP, IHSS, and CAPI, and the State Department of Health Care Services, for Medi-Cal purposes, to provide continuous eligibility for the applicable programs to a recipient or beneficiary who has been displaced by, or who has otherwise been affected by, a state of emergency or a health emergency, as described above. Under the bill, the continuous eligibility would maintain a recipient's or beneficiary's current scope of benefits under the applicable program for at least 90 calendar days starting from the proclamation or declaration, whichever one is later, and would continue through at least the conclusion of the proclamation or declaration, whichever one is later. The bill would require the 2 departments to implement the continuous eligibility through automated programming of eligibility systems, with notifications, as specified. The bill would require a county to immediately restore eligibility for the applicable program for any recipient or beneficiary whose eligibility was discontinued and who informs the county that they have been impacted as described above, without requesting any further verifications from the recipient or beneficiary. In the case of CalWORKs, CalFresh, CFAP, IHSS, and CAPI, if a recipient fails to submit a semiannual report or an annual redetermination or recertification of eligibility, if applicable, the bill would require the county to determine that the recipient had good cause for failing to submit that information. The bill would set forth related provisions for the county, the State Department of Social Services, and the Director of Social Services. The bill would authorize the Director of Social Services or the Director of Health Care Services to issue county directives regarding compliance with these provisions. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB1161	03/10/25 - Referred to Coms. on HUM. S. and Health.

AB 1328	This bill would require the Medi-Cal fee-for-service reimbursement rates for nonemergency ambulance transports and for interfacility ambulance transports, as defined, to be 100% of the amounts set forth in the federal Medicare ambulance fee schedule for the appropriate level of service billed, as specified. Under this bill, the reimbursement rate for interfacility ambulance transports, in an emergency context, would not affect the calculation of the quality assurance fee rate. Under the bill, the calculation of the quality assurance fee rate would be based on the methodology and reimbursement rate in effect as of January 1, 2025. The bill would make conforming changes to related provisions. Existing law authorizes the Director of Health Care Services to modify or make adjustments to any methodology or fee amount under these provisions to the extent necessary to meet federal requirements or to obtain federal approval. If a modification or adjustment is needed to meet federal requirements, this bill would require the director to recalculate and reduce the add-on amount as necessary, and would prohibit the director from reducing the Medi-Cal fee-for-service reimbursement rates for nonemergency ambulance transports or interfacility ambulance transports. Under this bill, whenever the medical necessity of an ambulance transport needs to be certified for purposes of Medi-Cal coverage, a nonphysician would be authorized to complete that certification in place of a physician, and the nonphysician would be authorized to do so with a signature in electronic format or any other format, to the extent authorized by the above-described federal regulations or their successor. The bill would require the department to revise and update the Medi-Cal provider manual or any guidance, as applicable, to implement this provision. This bill would require the department to revise and update the above-described regulatory provision in order to allow medical transportation providers to document mileage in their	03/25/25 - Re-referred to Com. on Health.

	records through other mechanisms, including vehicle Global Positioning System (GPS) tracking, digital mapping software, or another reasonable mechanism identified by the department, as specified, in addition to the option of odometer readings. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB1328	
AB 1386	Existing law establishes the licensure and regulation of health facilities by the State Department of Public Health, including, among others, general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Existing law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Existing regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. This bill would, beginning ____, include perinatal services as a basic service. The bill would require, on or before ____, the department to establish a process to approve or deny a "perinatal service compliance plan" to meet the requirement to provide perinatal services. The bill would require, on or before ____, any general acute care hospital that does not provide perinatal services to submit a "perinatal service compliance plan to the department, with specified information. By expanding the scope of a crime, this bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB1386	03/13/25 - Referred to Com. on Health.

SB 7	This bill would require an employer, or a vendor engaged by the employer, to provide a written notice that an ADS, for the purpose of making employment-related decisions, is in use at the workplace to all workers that will be directly or indirectly affected by the ADS, as specified. The bill would require the employer or vendor to maintain a list of all ADS currently in use and would require the notice to include the updated list. The bill would prohibit an employer or vendor from using an ADS that does certain functions and would limit the purposes and manner in which an ADS may be used to make decisions. The bill would require an employer to allow a worker to access data collected or used by an ADS and to correct errors in data, as specified. This bill would require an employer or vendor to provide a written notice to a worker that has been affected by an employment-related decision made by an ADS, and provide that worker with a form or a link to an electronic form to appeal the decision within 30 days of the notification. The bill would require an employer or vendor to respond to an appeal within 14 business days, designate a human reviewer who meets specified criteria to objectively evaluate all evidence, and rectify the decision within 21 business days if the human reviewer determines that the employment-related decision should be overturned. This bill would prohibit an employer from discharging, threatening to discharge, demoting, suspending, or in any manner discriminating or retaliating against any worker for taking certain actions asserting their rights under the bill. The bill would require the Labor Commissioner to enforce the bill's provisions, as specified, and would authorize a public prosecutor or any worker who has suffered a violation or their representative to bring a civil action. The bill would set forth specified types of relief that a plaintiff may seek and that an employer that violates these provisions is subject to, including a $500 civil penalty per violation. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB7	03/26/25 - Set for hearing April 9.

SB 32	This bill would state the intent of the Legislature to enact legislation relating to menopause that ensures patients experiencing menopause have access to health care providers who are well equipped to offer effective treatments and support and to promote greater awareness and education within the medical community to address gaps in care. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202520260SB32	12/03/24 - From printer. May be heard in committee January 2.
SB 242	This bill would delete the exclusion of otherwise qualified applicants who have end stage renal disease, thereby making the specified Medicare supplement benefit plans available to those individuals. The bill, on and after January 1, 2026, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare supplement coverage available from an issuer, as specified. The bill would require the open enrollment period to be a guaranteed issue period. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB242	02/14/25 - Referred to Com. on HEALTH.

SB 246	This bill would require the department, subject to any necessary federal approvals and the availability of federal financial participation, to make additional Medi-Cal payments to district and municipal public hospitals (DMPHs), defined as non-designated public hospitals, and to their affiliated government entities, in recognition of the Medi-Cal managed care share of GME costs. Under the bill, these payments would be made in a manner consistent with the methodology for GME payments to DPHs and their affiliated government entities and would consist of the above-described direct and indirect GME payment components. The bill would authorize the department to seek federal approval for other forms of GME payments to DMPHs and their affiliated government entities, as specified. Under the bill, the nonfederal share of payments under these provisions would consist of voluntary IGTs of funds provided by DMPHs or their affiliated government entities, or other eligible public entities, to the extent permitted under certain federal regulations and other applicable federal Medicaid laws, and with no state General Fund moneys being used to fund the nonfederal share of payments. The bill would establish the DMPH GME Special Fund, with moneys deposited being continuously appropriated to the department for purposes of these provisions. The bill would require the department to seek any necessary federal approvals for GME payments, effective no sooner than January 1, 2026. The bill would authorize the Director of Health Care Services to modify the requirements set forth in these provisions to the extent necessary to meet federal requirements or to maximize federal financial participation, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB246	03/17/25 - Set for hearing April 2.

SB 278	This bill would additionally authorize state public health agency HIV surveillance staff to disclose the information to State Department of Health Care Services staff, followed by authorized disclosures to the Medi-call managed care plan if applicable, the HIV-positive person who is the subject of the record, and the designated health care provider, for the purpose of proactively offering and coordinating care and treatment services to the person or for the purpose of administering quality improvement programs, as specified, designed to improve HIV care for Medi-Cal beneficiaries. The bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to develop a mechanism by which a Medi-Cal beneficiary would be authorized to opt out of the disclosure of personally identifying information in public health records relating to HIV or AIDS to State Department of Health Care Services staff or the Medi-Cal managed care plan for the above-described purposes. The bill would make a conforming change to a related provision regarding authorized disclosure of HIV test results for the purpose of administering quality improvement programs under Medi-Cal as described above. The bill would make certain clarifying or declaratory statements in relation to those provisions. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB278	03/26/25 - From committee: Do pass and re-refer to Com. on JUD. with recommend ation: To consent calendar. (Ayes 10. Noes 0.) (March 26). Re-referred to Com. on JUD.

SB 250	Existing federal Medicaid law requires the state to publish an online directory of physicians and, at state option, other providers, as specified. Existing state law sets forth Medi-Cal managed care provisions relating to a Medi-Cal applicant or beneficiary being informed of the health care options available regarding methods of receiving Medi-Cal benefits, including through certain provider directories. The department has administratively created an online provider directory through an internet website known as Medi-Cal Managed Care Health Care Options. This bill would require, as part of the health care options information posted by the department, in the provider directory that lists accepted Medi-Cal managed care plans, through the Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, that the directory include skilled nursing facilities as one of the available searchable provider types. The bill would require that this provision be implemented in conjunction with implementation of the above-described provisions. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB250	02/03/25 - From printer. May be acted upon on or after March 2.

SB 306	Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers. This bill would prohibit a health care service plan or health insurer from imposing prior authorizations, as defined, on a covered health care service for a period of one year beginning on April first of the current calendar year, if specified conditions exist, including that the health care service plan approved 90% or more of the requests for a covered service in the prior calendar year. The bill would also require a health care service plan or health insurer to list any covered services exempted from prior authorization on their internet website by March 15 of each calendar year. The bill would also clarify how to calculate a plan or insurer's approval rate for purposes of determining whether a service may be exempted from prior authorization. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB306	02/19/25 - Referred to Com. on HEALTH.

SB-324	Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to elect to cover community supports, as specified. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services. This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to give preference to contracting with community providers, as defined, whenever those providers are available in the respective county and have experience in providing the applicable ECM or community support. Existing law requires the department to develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of ECM or community supports. This bill would expressly include providers of ECM or community supports within the consultation process and would additionally require the department to develop standardized and streamlined templates to be used by managed care plans, as specified, and to develop guidance to allow community providers to subcontract with other community providers. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB324	02/19/25 - Referred to Com. on HEALTH.
SB-338	This bill would establish the Mobile Health for Rural Communities Pilot Program and require the State Department of Health Care Services to administer the program to expand access to health services for farmworkers in rural communities. The bill would require the department, among other things, to deploy mobile units, as defined, in 2 rural counties based on farmworker population and access to health care. Under the bill, the mobile units would include, at a minimum, computers, Wi-Fi, cubicles for virtual visits, and exam rooms for telemedicine. The bill would require the	02/19/25 - Referred to Com. on HEALTH.

	department, on or before January 1, 2027, to report the outcomes of the program to the Legislature. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB338	
SB 339	Existing law prohibits Medi-Cal reimbursement to providers for clinical laboratory or laboratory services from exceeding the lowest of the following: (1) the amount billed; (2) the charge to the general public; (3) 100% of the lowest maximum allowance established by the federal Medicare Program; or (4) a reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying. This bill would carve out, from the above-described provision, Medi-Cal reimbursement to providers for clinical laboratory or laboratory services related to the diagnosis and treatment of sexually transmitted infections, and would apply the above-described threshold but excluding the reimbursement rate described in paragraph (4). The bill would exempt data on those services from certain data-reporting requirements that are applicable to the reimbursement rate described in paragraph (4). This bill would require the department to make available to the public a dataset, as specified, of the deidentified raw data reported pursuant to the above-described data-reporting requirements by any applicable laboratory service providers that reported a volume greater than 10 tests for the data-collection period. The bill would require the department to publish the associated dataset coincident with publishing updated reimbursement rates. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB339	03/17/25 - Set for hearing April 2.

SB 402	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism and defines "behavioral health treatment" to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional. Existing law defines "qualified autism service provider," "qualified autism service professional," and "qualified autism service paraprofessional" for those purposes. Those definitions are contained in the Health and Safety Code and the Insurance Code. This bill would move those definitions to the Business and Professions Code. The bill would also make technical and conforming changes. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB402	03/18/25 - Set for hearing April 21.

SB 418	Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would prohibit a subscriber, enrollee, policyholder, or insured from being excluded from enrollment or participation in, being denied the benefits of, or being subjected to discrimination by, any health care service plan or health insurer licensed in this state, on the basis of race, color, national origin, age, disability, or sex. The bill would define discrimination on the basis of sex for those purposes to include, among other things, sex characteristics, including intersex traits, pregnancy, and gender identity. The bill would prohibit a health care service plan or health insurer from taking specified actions relating to providing access to health programs and activities, including, but not limited to, denying or limiting health care services to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded. The bill would prohibit a health care service plan or health insurer,, specified circumstances, from taking various actions, including, but not limited to, denying, canceling, limiting, or refusing to issue or renew health care service plan enrollment, health insurance coverage coverage, or other health-related coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, disability, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB418	04/01/25 - Set for hearing April 22 in JUD. pending receipt.

SB 439	Existing law establishes the Health Care Benefits Fund to support the University of California's implementation of the California Health Benefit Review Program. Under the program, the University of California assesses legislation proposing to repeal or mandate a benefit or service requirement on health care insurance plans or health insurers. Under the program, the University of California provides a written analysis that includes, among other data, financial impacts of legislation on publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program. Existing law imposes an annual charge on health care service plans and health insurers for the 2022–23 to 2026–27 fiscal years, inclusive, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment on health care service plans and health insurers from exceeding $2,200,000. Under existing law, the fund and the program become inoperative on July 1, 2027, and are repealed as of January 1, 2028. This bill would extend the operation of the California Health Benefit Review Program and the Health Care Benefits Fund through July 1, 2032, and would authorize the continued assessment of the annual charge on health care service plans and health insurers for that purpose for the 2026–27 to 2032–33 fiscal years, inclusive. The bill would increase the allowable total annual assessment on health care service plans and health insurers to $3,200,000. The bill would remove the Healthy Families Program as an example of the publicly funded state health insurance programs within an analysis of financial impacts of legislation. This bill would make these provisions inoperative on July 1, 2032, and would repeal it as of January 1, 2033. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB439	02/26/25 - Referred to Com. on HEALTH.

SB 497	This bill would additionally prohibit a provider of health care, a health care service plan, or a contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or gender-affirming mental health care in response to a criminal or civil action, including a foreign subpoena, based on another state's law that interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care. The bill would also prohibit a provider of health care, health care service plan, contractor, or employer from cooperating with or providing medical information to an individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care, as specified. The bill would prohibit these entities from releasing medical information related to sensitive services, as defined, in response to a foreign subpoena that is based on a violation of another state's laws authorizing a criminal action against a person or entity for provision or receipt of legally protected health care activity, as defined. The bill would also generally prohibit the issuance of a subpoena based on a violation of another state's law that interferes with a person's right to seek or obtain gender-affirming health care or gender-affirming mental health care, as specified. This bill would prohibit a state or local agency or employee, appointee, officer, contractor, or official or any other person acting on behalf of a public agency from providing any CURES data or expend any resources in furtherance of any interstate investigation or proceeding seeking to impose civil, criminal, or disciplinary liability upon the provision or receipt of legally protected health care activity, as defined. The bill would prohibit out-of-state law enforcement from having access to CURES data through the interstate data sharing hub and would require a warrant, subpoena, or court order for a law enforcement agency to obtain information from CURES as part of a criminal investigation. This bill would make it a misdemeanor for a person to access	03/20/25 - Set for hearing April 8.

	the CURES database when not authorized by law, and would make it a misdemeanor for a person who is authorized to access the database to knowingly furnish information from the CURES database to a person who is not authorized by law to receive that information. By creating new crimes, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB49	
SB 503	Existing law requires a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider, employee, or other appropriate person. Existing law exempts from this requirement a communication read and reviewed by a human licensed or certified health care provider. This bill would require the Department of Health Care Access and Information and the Department of Technology to establish an advisory board related to the use of artificial intelligence in health care services. The bill would require the advisory board to perform specified duties, including, but not limited to, developing a standardized testing system with criteria for developers to test AI models or AI systems for biased impacts. The bill would require developers of AI models or AI systems, in conjunction with health facilities, clinics, physician's offices, or offices of a group practice, to test for biased impacts in the outputs produced by the specified AI model or AI system based on the health facility's patient population, as specified. The bill would authorize developers to use the standardized testing system developed by the board to certify their AI models or AI systems. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB503	03/25/25 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS

SB 508	Existing law authorizes a person licensed as a physician and surgeon in another state, as specified, to deliver health care via telehealth to an eligible patient, as defined. Existing law defines "eligible patient" as a person who, among other requirements, has a life-threatening disease or condition, as defined, and has not been accepted to participate in the clinical trial nearest to their home for the immediately life-threatening disease or condition, as specified, or in the medical judgment of a physician and surgeon, as defined, it is unreasonable for the patient to participate in that clinical trial due to the patient's current condition and state of disease. This bill would expand the life-threatening disease requirement of an eligible patient to include a person who has been diagnosed with any stage of cancer and would provide that cancer patients are not subject to the clinical trial requirement, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB50	03/18/25 - Set for hearing April 7.

SB 528	This bill would require the department, subject to an appropriation, to expand any existing state-only-funded health programs, including, but not limited to, the State-Only Family Planning Program, to provide to Medi-Cal beneficiaries certain services or benefits that are otherwise covered under the Medi-Cal program but for any lack of, elimination of, reduction in, or limitation on, federal financial participation. For purposes of the expansion above, the bill would require the department to determine the services or benefits, which may include, but are not limited to, abortion and gender-affirming care, based on the levels of federal financial participation, as specified. (2) This bill would, subject to an appropriation, require the California Health and Human Services Agency to develop a new program, or to expand an existing state program, as applicable, to provide certain services or benefits that are otherwise covered under the Medi-Cal program but for any lack of, elimination of, reduction in, or limitation on, federal financial participation. Under the bill, these services or benefits would not be limited to the population of Medi-Cal beneficiaries. The bill would require the agency to determine the services or benefits, which may include, but are not limited to, abortion, family planning, and gender-affirming care, based on the needs of target populations and the levels of federal financial participation, as specified. (3) The bill would authorize expansion of the State-Only Family Planning Program, subject to an appropriation, to facilitate implementation of the provisions described in paragraphs (1) and (2), as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB528	03/25/25 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.

SB 530	The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks. This bill would recast those provisions and would specify, under both circumstances, that there be an appropriate level of care and access that is consistent with professionally recognized standards of practice, with a departmental determination that the alternative access standards will not have a detrimental impact on the health of enrollees. The bill would require the department to consider the sufficiency of payment rates offered by the Medi-Cal managed care plan to the provider type or for the service type when evaluating requests for the utilization of alterative access standards. The bill would also require the department to publish, and periodically update as necessary, the criteria for evaluation and authorizing alternative access standards under the above-described provisions, as specified. The bill would make other changes to the procedure for a managed care plan to submit a previously approved alternative access standard request. This bill would require that the evaluation be performed using a direct testing method and an examination of complaints data, as specified. The bill would, effective for contract periods commencing on or after January 1, 2026, additionally require the report to include, for each of the preceding 3 years, the number and percentage of enrollees that are subject to an approved alternative access standard, and the number and percentage of alternative access standards requested, approved, and denied, as specified. This bill would expand the scope of the definition for "specialist" to include providers of immunology, urology, and sleep medicine, among other additional areas of medicine. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB530	03/26/25 - Set for hearing April 9.

SB 626	This bill would modify the term “maternal mental health condition” to “perinatal mental health condition” and additionally include in its definition a mental health condition that occurs during the perinatal period. The bill would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a maternal perinatal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists. This bill would modify the term “maternal mental health” to “perinatal mental health” and additionally include in its definition a mental health condition that occurs during the perinatal period, as specified. The bill would instead require the above-described program to include perinatal mental health screening to be conducted during pregnancy and during the postpartum and perinatal periods according to clinical guidelines from the American College of Obstetricians and Gynecologists. The bill would require a health care service plan or health insurer to provide case management and care coordination for an enrollee or insured during the perinatal period. The bill would require a plan or insurers to annually report the utilization and outcomes of case management services to the appropriate department and to post that reported information to its internet website. The bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for at least one medication and one digital therapeutic for maternal perinatal mental health, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB626	03/24/25 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

SB 660	This bill would require the center, on or before January 1, 2026, and subject to an appropriation in the annual Budget Act, to take over the establishment, implementation, and all of the functions related to the California Health and Human Services Data Exchange Framework, including the data sharing agreement and policies and procedures, from the agency. The bill would expand the California Health and Human Services Data Exchange Framework to include social services information. The bill would expand the entities that are specifically required to execute a data sharing agreement with the California Health and Human Services Data Exchange Framework and authorize the center to determine other categories of entities required to execute a data sharing agreement. The bill would require the center, no later than July 1, 2025, to establish a process to designate qualified health information organizations as data sharing intermediaries that have demonstrated their ability to meet requirements of the California Health and Human Services Data Exchange Framework. The bill would require the center to annually report to the Legislature on the California Health and Human Services Data Exchange Framework, including compliance with data sharing agreements. The bill would expand the membership of the stakeholder advisory group and also establish the CalHHS Data Exchange Board as a separate entity from the stakeholder advisory group. The board would be composed of 12 members who are appointed or serve ex officio. The board, among other things, would be required to review, modify, and approve modifications to the California Health and Human Services Data Exchange Framework data sharing agreement and any new policies and procedures developed by the center. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB660	03/05/25 - Referred to Com. on HEALTH.

SB 812	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a schoolsite. This bill would additionally require a contract or policy that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a qualified youth drop-in center. Because a violation of this requirement relative to health care service plans would be a crime, the bill would create a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB812	03/12/25 - Referred to Com. on HEALTH.

Kern Family Health Care

Public Relations and Publicity
Media Clips Report
February 2025-March 2025

Features

Living History: Personal Stories and Community Celebrations of Black Heritage
By: KGET Studio 17 | February 24, 2025

"As Black History Month continues, the significance of storytelling in preserving history and shaping the future remains at the forefront of community conversations. On Studio 17, Lilli Parker of the Bakersfield Senior Center and Traco Matthews of **Kern Family Healthcare** shared how personal stories and cultural traditions help keep Black history alive." **Click here to read more.**

Shaping Tomorrow's Leaders: How Faith and Education Drive Change in Kern County
By: KGET Studio 17 | February 24, 2025

"The discussion also touched on healthcare advancements in Kern County, including CSUB's new Doctor of Nursing Practice (DNP) degree, supported by **Kern Family Health Care.** Dr. Harper explained the program's potential impact: "We have a shortage of specialized doctors and nurses. This program is essential for improving healthcare outcomes and addressing our community's needs." Dr. Harper reinforced CSUB's commitment to being Kern County's University, ensuring accessibility, innovation, and inclusivity for all. "Our goal is to be the first choice for every high school graduate and a hub for industry and community growth," he said." **Click here to read more.**

Kern Health Meets Residents at Library
By: The Mountain Enterprise | March 28, 2025

"On March 21, 2025, members of **Kern Health Systems (KHS)** met with community members at the Frazier Park Library as part of an outreach event to discuss behavioral health needs of the mountain communities. Members of the Mountain Communities Family Resource Center (MCFRC) were present, including Executive Director Jessica Hernandez and Community..." **Click here to read more.**

Mentions

Art lends focus to mental health festival in Wasco
By: The Bakersfield Californian | March 27, 2025

"Sponsors that have contributed to the festival include Strata Credit Union, Rotary Club of Wasco, the Knights of Columbus, Kern Family Health Care, Wasco Elks Lodge and Grocery Outlet." **Click here to read more.**

End of Document

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***FEBRUARY 5, 2025***
CALL TO ORDER: ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD – Network Provider, Cardiology	Miguel Lascano – Network Provider, OB/GYN Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	Hasmukh Amin, MD – Network Provider, Pediatrics David Hair, MD - Network Provider, Ophthalmology Ashok Parmar, MD– Network Provider, Pain Medicine		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Jake Hall, Deputy Director of Contracting Amy Daniel, Executive Administrative Yolanda Herrera, Credentialing Manager (REMOTE)	Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:02 AM.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of December 4, 2024 for review and approval.	☑ **ACTION**: Dr. Lascano moved to approve minutes of December 4, 2024, seconded by Dr. Patel. Motion carried.	*2/5/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 12/26/2024 and 02/03/2025:** [redacted] **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **02/05/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted]	☑ **ACTION:** [redacted] ☑ **ACTION:** [redacted]	*2/5/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted] **RECREDENTIALING REPORT** **Recredentialing Providers Lists Dated 02/05/2025.** Recredentialing files meeting clean file review were accepted as presented with no additional questions or alternative actions. There were no comprehensive reviews for recredentialing. Dr. [redacted]		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NEW VENDOR CONTRACTS New Vendor Contracts List Dated February 20, 2025, were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** Yolanda Herrera, KHS Credentialing Manager reported on the January and February 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. [redacted]	☑ ACTION: [redacted]	2/5/25
	[redacted]	☑ ACTION: [redacted]	2/5/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Delegated Credentialing 2024 Annual Oversight Reports Yolanda Herrera KHS Credentialing Manager informed the committee of the results of the 2024 Annual Oversight Reporting for the following delegated provider groups: • **KHS utilized the Health Industry Collaborative Efforts Delegated Credentialing Shared Audit process in lieu of conducting our own. The results identified compliant credentialing programs with no opportunities for improvement as well as no findings of unauthorized credentialing system or file modifications:** 1. CHLA Medical Group (NCQA Accredited: No / CVO Andros Accredited Expires 8/26/25) **Audit Type:** HICE CA Shared Audit Tool Performed 7/26/2024 by Cigna **Audit Score**: 100% **Credentialing System Controls**: Reports dated 6/2/23-6/2/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified 2. UCLA Medical Group (NCQA Accredited: Yes / Expires: 8/14/2026) **Audit Type:** HICE CA Shared Audit Tool Performed 9/30/2024 by HealthNet **Audit Score**: 100% **Credentialing System Controls**: Reports dated 7/1/23-6/30/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified 3. USC Care Medical Group (NCQA Accredited: No) **Audit Type:** HICE CA Shared Audit Tool Performed 11/18/2024 by Aetna **Audit Score**: 100% **Credentialing System Controls**: Reports dated 8/1/23-	☑ **ACTION**: Dr. Lascano moved to approve the Delegated Credentialing 2024 Annual Oversight Report for CHLA Medical Group, UCLA Medical Group, USC Care Medical Group, Child Net (Valley Children's), Vision Services Plan and American Logistics as presented, seconded by Dr. Patel. Motion carried.	2/5/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	9/30/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified 4. Child Net (aka: Valley Children's Hospital) (NCQA Accredited: No) **Audit Type:** HICE CA Shared Audit Tool Performed 10/21/2024 by Kaiser **Audit Score**: 100% **Credentialing System Controls**: Reports dated 9/12/23-10/2/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified • **Desk-top audit was conducted for the following delegated group. The results identified compliant credentialing programs with no opportunities for improvement as well as no findings of unauthorized credentialing system or file modifications:** 5. Vision Service Plan (aka: VSP) (NCQA Accredited: Yes / Expires: 1/27/26) **Audit Type:** KHS Desk-top Audit Performed on 8/16/2024 by Yolanda Herrera KHS Credentialing Manager. **Audit Score**: 100% **Credentialing System Controls**: Reports dated Q1 2023-Q4 2024 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified • **Desk-top audit was conducted for the following delegated group. The file review was not applicable as AL is an administrative only vendor for coordinating transportation scheduling. KHS credentials all transportation vendors with a direct contract between KHS and the vendor. There was a**		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	minor opportunity for improvement to AL's Policy #3 to include required language from APL 22-013 DHCS Screening and Enrollment requirements. 6. American Logistics (aka: AL Transportation Admin) (NCQA Accredited: N/A) **Audit Type:** KHS Desk-top Audit Performed on 12/10/2024 by Yolanda Herrera KHS Credentialing Manager. **Audit Score**: 99% **Credentialing System Controls**: not applicable. **Opportunity for Improvement:** AL P&P #3 Medi-Cal Policy dated 10.17.2022 is missing required language on Page 3 specific to the denied or lack of DHCS Medi-Cal FFS enrollment requirements. Corrective Action Plan requested: Update P&P #3 Due within 90-days upon notification by KHS Compliance.		
	KHS Credentialing System Controls 2024 Annual Report Yolanda Herrera KHS Credentialing Manager presented the 2024 Annual Credentialing System Controls Report. As required by NCQA Credentialing Standards for Credentialing System Controls Oversight, at least annually, KHS monitors compliance with its credentialing controls Policy and Procedure. The annual review was conducted by monitoring the following: 1. Identifying all modifications to credentialing and recredentialing information that did not meet KHS's policy and procedure for modifications, if any; 2. Analyzing all instances of modifications that did not meet KHS's policy and procedures, if any; 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters, if applicable. **Audit Results**: The Credentialing System can identify all modifications made in the system. Monthly Reports are received (Credentialing@khs-net.com) and Cred Mgr reviews all system modifications by authorized personnel and by modification type:	☑ **ACTION**: Dr. Lascano moved to approve the 2024 Annual Credentialing System Controls Report as presented, seconded by Dr. Patel. Motion carried.	2/5/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	insert, update and deletions. There were no unauthorized modifications found in the credentialing system database during the date range reviewed. Additionally, a sampling 5%, of 28 Initials files and 25 Recredentialing e-files were reviewed for inappropriate documentation or updates based on information integrity assessment indicators for 2025. During this sampling, there were no inappropriate documentation or updates identified in the sampled files reviewed. System modification for January - December 2024 did not reveal any unauthorized personnel making any inappropriate changes to the credentialing system database. The 58 electronic file sample reviews also did not reveal any inappropriate documentation or updates that do not align with our KHS System Controls current Policy, no falsification of credentialing dates, no fraudulently altering or creating documents for any required activity.		
	KHS 2024 Annual Confidentiality and Non-Discriminatory Monitoring Report Yolanda Herrera KHS Credentialing Manager presented the 2024 Annual Confidentiality and Non-Discriminatory Monitoring Report. For 2024, KHS PNM Credentialing processed a combined 1,055 credentialing and recredentialing provider files. There were no providers denied network participation and 72-applications withdrawn for various reasons. **Monitoring Activities:** • Policy and Procedure 23.05-P Credentialing Program is reviewed annually and states that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient's insurance coverage (e.g., Medicaid) in which the practitioner specializes **(P&P Approval dates: 10/3/2024)** • Effective February 7, 2024, to affirm compliance, the voting members of the Physician Advisory Committee sign a	☑ **ACTION**: Dr. Lascano moved to approve the 2024 Annual Confidentiality and Non-Discriminatory Monitoring Report as presented, seconded by Dr. Patel. Motion carried.	2/5/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	confidentiality and non-discrimination statement. **Signatures obtained for 2025, remote members will be sent the confidentiality and non-discrimination statement via email for signature and return.** • During 2024, there were no reports made to the Credentialing Manager alleging discrimination at the credentialing or recredentialing level while applications were in-process, denied or approved. The Non-Discrimination Annual Summary is a detailed review of provider demographics by age, gender, and specialty type. There were no outliers identified to indicate a discriminatory practice in the KHS Credentialing Program.		
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process and anticipates completion in 1st Quarter 2025.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	*Pending*
NEW BUSINESS	**Pharmacy Criteria** Bruce Wearda presented the Pharmacy criteria submitted for approval under pharmaceutical covered medical benefit as follows: • Somatostatin Analogs; Amphotericin B; Amyloidosis; Asthma Monoclonal Antibody; Beremagene Geperpavec; Fabry Disease; Gaucher Disease; Givosiran; Hyaluronic Acid; Immune Globulin; Infliximab; Myathenia Gravis; Nusinersen; Primary Hyperoxaluria Type 1	☑ **ACTION**: Dr. Patel moved to approve the Pharmacy criteria (listed below), seconded by Dr. Lascano. Motion carried.	*2/5/25*
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, March 5, 2025	Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 7:55 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

For Signature Only – Physician Advisory Committee Minutes 02/05/2025:

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

CA-25 B

KERN HEALTH SYSTEMS

COMMITTEE: ***Delegated Entity Oversight Committee***
DATE OF MEETING: ***February 10, 2025***
CALL TO ORDER: ***10:30 am by Jane MacAdam - Director of Compliance and Regulatory Affairs***

Members Present On-Site:	N/A	
Members Virtual Remote:	N/A	
Members Excused=E Absent=A	N/A	
Staff Present:	Linda Anchondo, Senior Program Manager Elia Bercian, Compliance Program Specialist Cynthia Cardona, Cultural and Linguistic Services Manager Michelle Curioso, Director of Population Health Management Sandeep Dhaliwal, Compliance Manager, Audits, and Investigations Misty Dominguez, Director of Health Services Special Programs Heather Fowler, Senior Regulatory and Government Program Manager Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement Elizabeth Johns, Compliance Analyst I Christina Kelly, Pharmacy Administrative and Support Supervisor Maninder Khalsa, Medical Director of Utilization Management Jane MacAdam, Director of Compliance and Regulatory Affairs Melissa McGuire, Senior Director of Delegation and Oversight Deborah Murr, Chief Compliance and Fraud Prevention Officer	Jessica Nguyen, Pharmacy Intern Greg Panero, Provider Network Analytics Program Manager Maria Parra, Member Services Manager Christine Pence, Senior Director for Health Services Cassandra Perez, Compliance Program Specialist Jeff Pollock, Regulatory and Government Program Manager Martha Quiroz, Member Services Manager Lizbeth Rodriguez, Delegation Oversight Business Analyst Amy Sanders, Member Services Manager Isabel Silva, Senior Director of Wellness and Prevention Ebeth Soliman, Member Services Supervisor Katie Sykes, Delegation Oversight Manager Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Jane MacAdam: **1. Action Items:** From 10/29/2024 Meeting; Minutes Attached	A. Compliance will update the verbiage in the Charter in section C. Duties and responsibilities, number 10. 1. Verbiage was update. 2. Final version reviewed. 3. No additional feedback during the meeting, but Members can send recommendations after the meeting.	**ACTION**: N/A	N/A
	B. Robin will add the Claims information in the format Compliance is requesting for the VSP Audit. 1. Completed	**ACTION**: N/A	Completed 10/29/2024
	C. Compliance will revisit the Request List for the CareNet Audit 1. See below under CareNet.	**ACTION**: N/A	Completed
	D. Jane and MS will discuss offline to determine how to approach AL's representatives offering/suggesting the lower modality before the next Committee meeting. 1. See below under AL.	**ACTION**: N/A	N/A
	E. Amy will send the AL Executive summary of the 3rd Quarter Door-to Door and Lower Modality 1. Amy and Jane will touch base.	**ACTION**: **1.** Jane and Amy will discuss the AL Executive summary	N/A
	F. Amy will add the action taken/conclusion and the vendor trending on the next AL report. 1. See below under AL.	**ACTION**: N/A	N/A
	G. Compliance is reviewing the DMHC Comment table regarding the ALLMED Contract and will respond to DMHC this week. 1. Submitted and the Plan received approval from DMHC for the ALLMED contract.	**ACTION**: N/A	Completed
2. Delegation Oversight Committee Charter	A. Review Updated Charter- Jane 1. Completed, see 1. (A.) above.	**ACTION**: N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
3. VSP	A. Delegation Oversight Audit Update- Jane MacAdam: 1. All Department have completed their summaries. a. Eleven (11) identified deficiencies across all areas. b. Thirteen (13) additional recommendations. 2. Jane finalized the report and will send it out to VSP and the Plan's Departments 3. Jane will reach out to Claims regarding one question. B. AB 1455 – Claims Timeliness- Jane MacAdam: 1. No concerns the 4th quarter. C. JOM Meeting Minutes- Katie Sykes: 1. Delegation Oversight (DO) is tracking action items, like the Member Promise Reporting Estimate and Eye Exam Provider Letter. 2. Jane and Isabel discussed VSP completing the reading level document. a. Katie will request the reading level information from VSP.	**ACTION**: **2.** Jane will send the VSP Audit results to VSP and the Plan's Departments **3.** Jane will reach out to Claims regarding one question on the Delegation Oversight Audit for VSP **4.** Katie will request the reading level information from VSP.	N/A
4. Health Dialog / Care Net	A. Transition - Katie Sykes: 1. There is a new Daily File –Development phase has been completed 2. Still receiving the old file and testing the new file. a. Soon we will be using the new file. B. Delegation Oversight / Pre-Delegation Audit- Jane MacAdam: 1. Deliverables due 02/14/2025 C. JOM Meeting Minutes - Katie Sykes: 1. Point of Contact changed at the end of January. a. Departmental representatives will be invited to the Meet and Greet with the new Point of Contact. 2. All open action items have been communicated with the new point of contact.	**ACTION**: N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
5. American Logistics (AL)	A. DHCS Focused Audit - Transportation CAP- Jane MacAdam: 1. Reviewed Results of internal monitoring 2. Submitted to DHCS on 1/25/2025, pending feedback a. Three (3) findings as part of the CAP i. No Shows ii. Lower Modality iii. Door-to-Door B. Delegation Oversight Audit: Katie Sykes/Ebeth Soliman /Martha Quiroz 1. No Show: a. Monitoring for NEMT and NMT b. Monthly reporting for the next two (2) years i. There is a No Show and a Grievance tab on the report 1) Katie's recommendation is to also have a specific tab for the No Show related to Grievances tab too. ii. AL will ask for the assigned Driver's name for oversight iii. KHS will provide an overview of the Q4 findings to AL management c. DO will continue to monitor with Member Services (MS) support. 2. Lower Modality: a. Each month we are requesting thirty (30) audio calls from October, November, and December to verify that the Member is the one requesting the Lower Modality, rather than the AL agent recommending it. ii. October- Five (5) out of thirty (30) trips, the Member did not request to lower their own modality iii. November: Nine (9) out of thirty (30) trips, the Member did not request to lower their own modality. iv. December: pending a response b. There are standing orders for Curb-to-Curb. The orders were established, but the original order is beyond the expiration date to review the recording. i. We sent them thirty (30) call requests and AL only return three (3), due to the original call expiration. 1) The Plan requested a different set of twenty-seven (27) calls for review. i. The recordings are saved for 18 months c. Amy and Martha discussed that a Secret Shopper Call check-ins would be beneficial d. Katie discussed adding to the process flow the timeliness of getting information from AL. We can discuss with AL and mutually agree to a timeline. i. Example: Initial request, five (5) business days later follow-up, then three (3) business day later follow-up.	**ACTION**: 5. KHS will provide an overview of the Q4 findings to AL management 6. Martha and Greg will have a breakout session to discuss creating a Provider Bulletin regarding the Door-to-Door requirements. 7. Martha will schedule a meeting with Compliance to discuss the results of the Internal Focused Audit.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
5. American Logistics (AL) Cont.	ii. Also, set a performance threshold. 3. Door-to-Door: a. Calling random members to see if they receive or was asked if they needed door-to-door. i. October-All random members did receive Door-to-Door when needed. ii. November- One (1) member did not receive it. iii. December- All random members did receive Door-to-Door when needed. b. KHS will provide the "Lesson Learned" training to internal employees conducting the survey. c. Transportation Providers will need to know what the expectations are for Door-To-Door i. Martha and Greg will have a breakout session to discuss creating a Provider Bulletin regarding the Door-to-Door requirements. d. MS had one concern regarding the Internal Focused Audit with AL. Martha will schedule a meeting		
	C. JOM Meeting Minutes - Katie Sykes: 1. New report has additions 2. The Plan clarified milage reimbursements guidelines. 3. Discussed an internal process for Members to lower their modality without going through the Provider a. Example: Waive or withdraw their PCS form. 4. Improving the LOA process.		
6. Transportation Committee	A. Overview / Updates - Katie Sykes: 1. Agenda requests go out on the 10th of each month	**ACTION**: N/A	
7. Language Line	A. JOM Meeting Minutes - Katie Sykes: 1. No open Items	**ACTION**: N/A	N/A
	B. Contract Update 1. The contract ends in February 2. The new contract is going to the Board meeting on February 21 and will also be presented to the Finance Committee.		
	C. Performance Monitoring Summary Q 4 1. Their average speed of answer is four (4) seconds, language connect time. 2. Four (4) seconds for Spanish 3. 20 seconds for the next nine (9) languages 4. 22 seconds for all languages		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
8. AllMed	A. Contract Update - Jane MacAdam: 1. The Contract was approved by the Regulators. 2. Christine Pence discussed the Implementation status: AllMed is reviewing 10 a day, then UM is reviewing their review. a. There are some inconsistencies we are working on. b. The Plan is meeting with AllMed three (3) times a week, daily meetings with the Nurses, meeting with their Providers as needed. c. There have been four (4) HIPAA breaches that were identified and sent to Compliance. d. In the future, we will have formal quarterly JOM and Audits.	**ACTION**: N/A	N/A
9. DSNP	A. Delegation Update – Jane MacAdam 1. Execute two contracts a. Universal Healthcare- for Medical b. PBM- for Pharmacy 2. Launching January 1, 2026 3. Received approval from DMHC and filed with DHCS	**ACTION**: N/A	N/A
10. Monitoring / Auditing Results	A. Call Center: Maria Parra 1. AL- 4th-Quarter had a slight increase of abandonment rate. a. Answer rate was at 79.9 % and it should be at 80%. b. For them not having staff, they are doing fine. The Plan addressed it and hope moving forward it will not be a problem. i. In JOM, AL shared that they did not hire as much staff as they should have for December, due to a process discussed for members to call in advance to book transportation trip 72 hours. 1) The process did not move forward and was removed. 2) AL planned that would go into effect and their call volume would decrease. AL acknowledged and informed the Plan that their staff is back to where it should be to manage calls 2. Argus- Do not have concerns. 3. Harte Hanks a. Went into a new contract with Harte Hanks b. Their SLA has been changed based on the new contract; they will now be performing based on what they are contracted to do which is outbound calls. The change will take effect next quarter. c. Per Katie, in January 2025, they met their metrics.	**ACTION**: N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
10. Monitoring / Auditing Results	4. CareNet a. 4th Quarter has improved, b. Their ASA for November was slightly over 30%, at 32%. c. In December they had short period of calls transferred and they managed to meet SLA's 5. Payspan a. 4th Q- the ASA was over 30% but met other areas, so they scored 90/100 and they continue to meet monthly. b. If they meet overall 75% or better throughout the month, they meet criteria, based on contract. c. Katie and Maria discussed Payspan. An email was sent to the Payspan team asking for justification for their average speed of answer, for providers calling, not members. Their answer is pending 6. VSP-No concerns, they met all their SLA's.		
	B. Cultural Linguistics Q4 – Cynthia Cardona 1. Bilingual Staff Call Audit: a. 30 Spanish calls audited b. 100% did not have difficulty communicating with members in a non-English language 2. Post Call Surveys a. 9,943 Spanish Post Call Surveys b. 97% of Members are satisfied with the linguistic performance of bilingual staff 3. Vendor Bilingual Call Audits: a. American Logistics (ALC) b. Vision Services Provider (VSP) c. Harte Hanks i. 91 Spanish Audio Call Audits ii. 98% of Bilingual staff did not have difficulty communicating with members in a non-English language 4. LLS Interpreter Call Monitoring Audit a. 30 OPI Interpreter Service Calls b. 100% of LL's Audited calls met expectations 5. Satisfaction Surveys: a. Member Onsite Interpreting	**ACTION:** N/A	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
10. Monitoring / Auditing Results Cont.	i. Thirty (30) members surveyed ii. 100% reported "Strongly Agreed" satisfaction b. Member OPI/VRI Interpreting i. Thirty (30) members surveyed ii. 100% reported "Strongly Agreed" satisfaction c. Member Translations i. Thirty-two (32) Members surveyed ii. 99% "Very Satisfied" Satisfaction iii. Six (6) Members reported not receiving an NOA/GTL Translation d. KHS Staff OPI Satisfaction i. 129 KHS Staff Surveyed ii. 98% "Strongly Agreed" Satisfaction with LLS 6. Per Cynthia Cardona, reached out to Maria Parra regarding the six (6) members not receiving NOA/GTL Translation and Maria did respond. a. Letters were resent to members that did not receive them. Per Maria Parra, one member reported that they did not receive the NOA/GTL Translation, however research was conducted, and it was found that an English letter was mailed out to member on October 3rd and then a Spanish letter was mailed out to member on October 14th. Per Maria, there was record that the letters were mailed.		
	C. Delegated Credentialing-Yolanda Herrera 1. End of year tertiary facility a. CHLA b. UCLA c. USC d. Child Net AKA Valley Children's i. We utilize the HICE industry collaborative effort shared audit, there were no opportunity for improvement, they all passed. 2. VSP -Desk top audit a. VSP is inclusive of credentialing filing review. They passed at 100% with no opportunity of improvement. 3. AL- Desk top audit a. There was one opportunity for improvement that they update their language on policy #3. There was missing language from the APL for screening and enrollment. b. Once received, Yolanda will verify that the policy is updated with the correct	**ACTION**: N/A	

	language.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
10. Monitoring / Auditing Results Cont.	D. Transportation Provider Enrollment Monitoring - Yolanda Herrera: 1. No issues identified	**ACTION**: N/A	
Open Forum	A. Yolanda would like to speak with Jane regarding the NCQA audit. B. Compliance will move the Delegation oversight meeting from April 29 to a May date, the second month after the quarter	**ACTION**: 8. Jane and Yolanda will meet regarding the NCQA Audit 9. Compliance will move the cadence of the meeting to the second month after the quarter.	N/A
Next Meeting	Next meeting is scheduled for Thursday, May 22, 2025, 10:30 – 12:00 PM	N/A	N/A
ADJOURNMENT	The Committee adjourned at 11:49 am	N/A	N/A

KERN HEALTH SYSTEMS

COMMITTEE: ***HEALTH EQUITY TRANSFORMATION STEERING COMMITTEE (HETSC)***
DATE OF MEETING: ***February 11, 2025***
CALL TO ORDER: ***2:00pm - Pawan Gill, Health Equity Manager – CHAIR***

Staff Present:	• Jackie Byrd, Senior Marketing and Communications Specialist • Lela Criswell, Member Engagement Manager • Pawan Gill, Health Equity Manager • Anastasia Lester, Senior Health Equity Analyst • Finster Paul III, Manager of Community Health and Wellness • Cesar Chavez, HRIS and Analytics Manager • Magdee Hugais, Director of QI	• Marilu Rodriguez, Senior Health Equity Analyst • Melinda Santiago, Director of Behavioral Health • Adriana Salinas, Director of Community and Social Services • Nate Scott, Director of Member Services • Tiffany Chatman, Wellness & Prevention Manager	• Frankie Gonzalez, Employee Relations Manager • Vanessa Nevarez, Health Equity Coordinator • Amy Sanders, Member Services Manager • Maritza Jimenez, Community Engagement Supervisor • Jake Hall, Senior Director of Contracting and Quality Performance • Daisy Torrez, Member Engagement Supervisor
Staff Virtual:	• Michelle Curioso, Director of Population Health Management	• Cynthia Cardona, Cultural & Linguistics Services Manager	• Martha Quiroz, Member Services Manager

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
QUORUM	Attendance / Roll Call	N/A – Workshop-style Committee	N/A
CALL TO ORDER	Pawan Gill, Health Equity Manager and Chair called the meeting to order at 2:05pm.	N/A	N/A
COMMITTEE MINUTES	There were no previous minutes to approve.	N/A	N/A

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**1) JEDI Charter Revisions** • Pawan G. gave an update on the Justice, Equity, Diversity, and Inclusion (JEDI) Charter revisions where she announced Tiffany Chatman as the Vice Chairperson and Vanessa Nevarez as the point person for any inquiries from departments that would like to leverage JEDI services as you would for Health Equity in your program development. • Pawan G. announced that the JEDI Charter will be getting an addendum which includes committees using JEDI to help fill external seats to ensure diversity. Cesar C. asked what committees would have outside seats to be filled? Pawan G. gave Community Advisory Committee (CAC) and Executive Quality Improvement Health Equity Committee (EQIHEC) as examples. **2) 2025 HEO Workplan** • Pawan G. provided an update on the 2025 HEO Workplan which includes QI and Health Equity combining their program descriptions and workplans. • Pawan G. thanked those that added their program and activities to the spreadsheet that was circulated in 2024. **3) TGI/SOGI Training Update** • Pawan G. provided an update on the TGI (Transgender Intersex Identities) training requirement that is associated with Senate Bill 9-23 and APL 24-018.	• The JEDI Charter revisions will be presented to the EQIHEC in March for approval. • If anyone has an open seat on their committees start reaching out to JEDI now. • The combined program charter and workplans will be presented to the EQIHEC in March for approval. • Pawan G. will circulate the program and activities spreadsheet to all to remove any programs that have since ended that were added to the list last year. • Departments with member facing staff are to email list of names to Vanessas N.	N/A N/A N/A N/A N/A

	Pawan G. explained that the TGI training will look very similar to the SOGI (Sexual Orientation Gender Identity), required by NCQA, and that both will be happening beginning of March for employees that have direct contact with KFHC members. Pawan G. added that eventually, a DEI training will also be given. KHS was unable to combine the DEI training with the TGI and/or SOGI in year one.	• Share training dates with the L&D department to add to their calendar.	N/A
	4) EPT Update - Presentation • Marilu R. gave a presentation on the EPT (Equity and Practice Transformation) Payment Program which provided an overview of how providers receive their payments.	• Informational only.	N/A
	5) Doula Update – Presentation • Ana L. presented The Doula Journey and announced that doulas are now a provider benefit at KFHC. The presentation highlighted the benefits and challenges doulas face.	• Informational only.	

AGENDA ITEM	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ACTION	DATE RESOLVED
OPEN FORUM	Pawan opened the floor for announcements.	N/A	N/A
NEXT MEETING	Next meeting will be held Tuesday, May 13th, 2025, at 2:00pm.	N/A	N/A
ADJOURNMENT	The Committee adjourned at 2:55 pm. ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Coordinator***	N/A	N/A

For Signature Only – HETSC Minutes 02/11/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

CA-25 D

SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, February 14, 2025

8:30 A.M.

COMMITTEE RECONVENED

Members: Elliott, Bowers, McGlew, Turnipseed, Watson
ROLL CALL: 4 Present; 1 Absent – Bowers

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

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

DIRECTOR TURNIPSEED REPORTED ON HIS RECENT TRIP TO D.C. AND THE CONVERSATION HE HAD WITH U.S. CONGRESSMAN DAVID VALADAO

FINANCIAL MATTERS

CA-3) Minutes for Kern Health Systems Finance Committee meeting on December 13, 2024 - APPROVED
McGlew-Watson: 4 Ayes; 1 Absent - Bowers

4) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2024 (Fiscal Impact: None) – IRA COHEN, UBS FINANCIAL, HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-McGlew: 4 Ayes; 1 Absent - Bowers

5) Report on 2024 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Turnipseed: 4 Ayes; 1 Absent - Bowers

6) Report on 2024 Annual Travel Report (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-McGlew: 4 Ayes; 1 Absent - Bowers

7) Report on 2024 Annual Report of Disposed Assets (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: 4 Ayes; 1 Absent - Bowers

8) Special Requests for Funding by Local Community Partners and Providers (Fiscal Impact: $15,880,981; Not Budgeted; Discretionary) – MOTION TO ADOPT THE STRATEGY OF KHS STAFF FOR SIMILAR GRANT REQUESTS AND PROCEED WITH EVALUATING GRANT REQUEST IN NORMAL COURSE OF BUSINESS
McGlew-Watson: 4 Ayes; 1 Absent - Bowers

9) Proposed New Agreement with mPulse, for the Member and Provider Portal from March 1, 2025 through December 31, 2030 with a Not-to-Exceed amount of $5,966,116 over the term of the contract (Fiscal Impact: $5,966,116; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Watson: 4 Ayes; 1 Absent - Bowers

10) Proposed Contract Extension and Retroactive Approval with Language Line, for Language Interpretation services, from February 28, 2025 through February 27, 2028 and increasing the Not-to-Exceed by $11,678,000 over the term of the contract (Fiscal Impact: $11,678,000; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: 4 Ayes; 1 Absent - Bowers

11) Proposed Contract Extension with LifeSigns, for American Sign Language Interpreting Services, from February 23, 2025 through February 22, 2027 and increasing the Not-to-Exceed amount by $120,000 from $160,000 to $280,000 (Fiscal Impact: $120,000; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Turnipseed: 4 Ayes; 1 Absent - Bowers

12) Proposed Contract Extension with Coffey Communications, for the Member Newsletters, from February 15, 2025 through February 14, 2026 and increasing the Not-to-Exceed amount by $200,000 from $170,000 to $370,000 (Fiscal Impact: $200,000; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Watson: 3 Ayes; 2 Absent – McGlew, Bowers

DIRECTOR MCGLEW LEFT THE DAIS AT 9:16 AM AND RETURNED AT 9:19 AM; AFTER THE VOTE ON ITEM 12

13) Proposed Contract Extension with Ceridian, for the Payroll and HRIS services, from March 18, 2025 through March 17, 2027 and increasing the Not-to-Exceed amount by $772,224 from $648,000 to $1,420,224 (Fiscal Impact: $772,224; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew: 4 Ayes; 1 Absent - Bowers

14) Proposed Contract Extension with Change Healthcare, for Electronic Claims Processing, from February 20, 2025 through February 19, 2030 and increasing the Not-to-Exceed amount by $1,275,000 from $930,000 to $2,205,000 (Fiscal Impact: $1,275,000; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Turnipseed: 4 Ayes; 1 Absent - Bowers

15) Proposed Contract Extension with Health Management Associates, for Actuarial services, from March 1, 2025 through February 28, 2026 and increasing the Not-to-Exceed amount by $199,000 from $199,000 to $398,000 (Fiscal Impact: $199,000; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Turnipseed: 3 Ayes; 2 Absent – Watson, Bowers

DIRECTOR WATSON LEFT THE DAIS AT 9:26 AM AND RETURNED AT 9:28 AM; AFTER THE VOTE ON ITEM 15

16) Proposed Contract Extension with Milliman, for Actuarial services including D-SNP, from March 1, 2025 through December 31, 2026 and increasing the Not-to-Exceed amount by $750,000 from $762,000 to $1,512,000 (Fiscal Impact: $750,000; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Turnipseed: 4 Ayes; 1 Absent - Bowers

17) Report on Kern Health Systems financial statements for November 2024 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: 4 Ayes; 1 Absent - Bowers

18) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2024 and IT Technology Consulting Resources for the period ended November 30, 2024 (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew: 4 Ayes; 1 Absent - Bowers

ADJOURN TO FRIDAY, APRIL 11, 2025 AT 8:30 A.M.

CA-25 E

KERN HEALTH SYSTEMS

COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **FEBRUARY 24, 2025**
CALL TO ORDER: **6:32 P.M. BY DR. MARTHA TASINGA, CMO, CHAIR**

Members Present On-Site:	Alison Bell, PharmD – Geriatrics Dilbaugh Gehlawat, MD – Network Provider, Pediatrician Kimberly Hoffmann, PharmD – Psychiatric	Martha Tasinga, MD – KHS Chief Medical Officer Bruce Wearda, RPh – KHS Director of Pharmacy	
Members Virtual Remote:	James "Patrick" Person, RPh – Retail Abdolreza Saadabadi, MD – Network Provider, Psy.D.	Sarabjeet Singh, MD - Network Provider, Cardiology	
Members Excused=E Absent=A	Joseph Tran, PharmD – Specialty (A) Vasanthi Srinivas, MD – Network Provider, OB/GYN (E)		
Staff Present:	Amy Daniel, KHS Executive Health Srvs Coordinator	John Miller, MD, KHS Medical Director Sukhpreet Sidhu, MD, KHS Medical Director	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
APPROVAL OF MINUTES	The Committee's Chairperson, Bruce Wearda, RPh, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Dilbaugh Gehlawat moved to approve minutes of November 25, 2024, seconded by Alison Bell. 7 approved, 0 nays.	*02/24/25*
OLD BUSINESS	• None	N/A	
NEW BUSINESS	• Report of Plan Utilization Metrics Bruce Wearda reviewed this information with the committee. The committee had no further comments. • Educational Articles	Received and Filed.	*02/24/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2024 Immunization Update: COVID-19, Influenza, RSV, Pneumococcal, Polio, Meningococcal, HiB, HepB, and Mpox Dr. Gehlawat had some questions about how to bill for Vaccines for Children (VFC). VFC Programs were explained for both Pharmacy and Medical Billing. All vaccine billing was then further explained. • DUR General Topics 1. Medicare <u>D-SNP Application</u> Bruce Wearda announced that our DSNP application was submitted and accepted. Kim Hoffmann inquired about expected membership, formulary, and processing PA's. Dr. Tasinga shared a Medicare plan is complex, and it was hard to find partners that would meet CMS requirements and KHS' vision and goals. Bruce stated that our PBM for Medicare will be Med-Impact. They will be processing the prior-authorizations and managing the formulary. KHS will be monitoring these delegated functions. <u>IRA 2nd Round</u> The next 15 drugs that Medicare will negotiate prices was presented. Dr. Sarabjeet Singh had a question regarding weight loss drugs and what diagnosis are they covered under? Bruce explained the difference between weight loss and diabetes indications. The same drug could be used for both conditions but may only be covered for a specific condition. Rules for Medi-Cal and Medicare differ.	☑ **ACTION**: N/A	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2. CAHP Bruce shared the latest publication from California Association of Health Plans with the committee. 3. NCQA Dr. Kimberly Hoffmann asked what the importance of NCQA is, and why or why not have we not sought it previously. Dr. Tasinga answered that it was not required by Medi-Cal before and now it is.		
OPEN FORUM	Topics of discussion brought up were: • Kim Hoffmann revisited the structure and function regarding the P&T and formulary. • Dr. Gehlawat shared more insight on obesity in members 12 and up.	☑ **ACTION**: N/A	*02/24/25*
NEXT MEETING	Next meeting will be held Monday, May 19, 2025 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:35 pm.	☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. It was seconded by Dr. Dilbaugh Gehlawat. 8 Ayes, 0 Nays.	*02/24/25*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 02/24/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

CA-25 F

COMMITTEE: ***Fraud, Waste, and Abuse (FWA) Committee***
DATE OF MEETING: ***February 25, 2025***
CALL TO ORDER: ***3:00 pm by Jane MacAdam – Director of Compliance and Regulatory Affairs***

Members Present On-Site:	N/A	
Members Virtual Remote:	N/A	
Members Excused=E Absent=A	N/A	
Staff Present:	Brandon Bowe, Compliance Analyst Cynthia Cardona, Cultural and Linguistic Services Manager Sandeep Dhaliwal, Compliance Manager, Audits and Investigations Heather Fowler, Senior Regulatory and Government Program Manager Russell Hasting, PHM Manager of Case Management Yolanda Herrera, Credentialing Manager Loni Hill-Pirtle, Administrative Director, Enhanced Care Management Magdee Hugais, Director of Quality Improvement Jane MacAdam, Director of Compliance and Regulatory Affairs Elia Bercian, Compliance Specialist Veronica Barker, Controller Kathryn Castaneda, Compliance Analyst Dr. Maninder Khalsa, Medical Director, Utilization Management Amy Sanders, Executive Health Services Coordinator	Deborah Murr, Chief Compliance and Fraud Prevention Officer Jeff Pollock, Regulatory and Government Program Manager Heather Pruitt, Compliance Analyst Martha Quiroz, Member Services Manager Bruce Wearda, Director of Pharmacy Maria Parra, Member Services Manager James Winfrey, Deputy Director of Provider Network Karen Beale, Compliance Analyst Michelle Curioso, Director of Population Health Management Christina Kelly, Pharmacy Administrative and Support Supervisor Christine Pence, Senior Director of Health Services Nate Scott, Senior Director of Member Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Action Items from 11/04/2024	Communication regarding status of training ongoing – standing agenda item	*N/A*	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Meeting - Jane	A. FWA Training **Update:** Good progress has been made, however, there is a handful of employees that are still outstanding. Sandeep will be following up with those employees. There are 5 people that still have outstanding training for last year and a due date had been extended to today 02/25/2025. • 2 UM • 1 MIS • 1 Provider Contracting • 1 TBD B. Anti-Fraud Plan We have to submit an annual Anti-Fraud Plan and an annual Anti-Fraud Report to DMHC. It is included in the materials packet for your review. It outlines how we are structured, how our committees are comprised, policies and procedures, training, FWA monitoring and investigations, and reporting.	*N/A*	*N/A*
Telehealth Services	A. Telehealth Services Compliance has been seeing a lot of potential misuse of Telehealth appointments. Members are reporting allegations and during the investigation we are discovering that we are being billed for telehealth services that we should not be billed for. Included in the meeting materials are some guidelines on this topic. Potential solutions: o Claims Edits o Updates to Provider Manual o Provider bulletin Other?	☐ **ACTION:** James Winfrey will lead a work group to revise the Telehealth Policy and look at creating provider education.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CBAS	Eligibility Tool and UM approval process Seeing an increase in potential fraud cases. What can we do to improve the diagnosis/approval process?	Pending further discussion.	
Report	A. Member Services – Martha - Frequent Rider Report for July through October. 1. Members Researched in July - 93 a. Members with no or less than 3 FWA occurrences - 58 b. Members on Restriction – 1 c. Members Outreached – 34 d. Members Issued a Warning – 15 e. Members Restricted Pending Follow Up – 19 f. Members Restricted to Bus Passes – 1 2. Members Researched in August – 115 a. Members with no or less than 3 FWA occurrences – 69 b. Members on Restriction – 1 c. Members Outreached – 45 d. Members Issued a Warning – 16 e. Members Restricted Pending Follow Up – 29 f. Members Restricted to Bus Passes – 1 3. Members Researched in September - 92	N/A	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	g. Members with no or less than 3 FWA occurrences - 55 h. Members on Restriction – 2 i. Members Outreached – 35 j. Members Issued a Warning – 9 k. Members Restricted Pending Follow Up – 26 l. Members Restricted to Bus Passes – 2 4. Members Researched in October – 132 g. Members with no or less than 3 FWA occurrences – 70 h. Members on Restriction – 5 i. Members Outreached – 57 j. Members Issued a Warning – 16 k. Members Restricted Pending Follow Up – 41 l. Members Restricted to Bus Passes - 5		
	B. Credentialing - Provider Monitoring Reports We have transitioned to a new reporting spreadsheet that is for our active in network par providers, not the ones we do for non-par. On the new reporting spreadsheet, there were 2-3 providers, but none that rise to the level of fraud, waste and abuse. Any provider findings are reported to PAC and are reviewed with		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	PAC to the fullest extent. We continue to monitor them through whatever the licensing agency. Finds. In the conclusion of their investigation, whether that be a public reprimand, probation or the case being dropped, so those are all reviewed and managed through PAC, but none that need to be reported to fraud, waste and abuse.		
	C. Compliance – 1. Verification of Services The texting campaign was implemented in May to verify services with members. The texts are sent out on the 20th of each month. This is a DHCS contract requirement to show we have a method to verify that members are getting services for which we have been billed. We did pass this portion of our audit, so it seems to have all the requirements. The number of texts sent out each month is still being determined but you can see the text vs. response numbers for the first few cycles below: November - 488 texts sent, 69 responses – 14.14% December - 467 texts sent, 72 responses – 15.42% January - 463 texts sent, 99 responses – 21.38% 2. FWA Investigations Cases for 2024 are up twice the number of cases worked in 2023.	N/A	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	a. Cases for 2024 – 554 b. Cases submitted to DHCS: 309 – 56% i. 299 submitted timely – 97% ii. 10 submitted late – 3% c. Cases not submitted to DHCS: 245 – 44% 3. Six (6) cases were received in the 4th quarter beyond the required reporting period to DHCS. Five (5) did not require reporting to DHCS; one (1) was submitted to DHCS late. Compliance continues to address those received late with the Member Services team upon receipt 4. Calendar year 2024 FWA Allegations Member vs Provider a. Provider – 240 (43%) cases i. #1 FWA allegation – 77 Cases for services not rendered. ii. #2 FWA allegation – 62 cases for excessive/unnecessary services b. Member- 314 (57%) cases i. #1 FWA allegation - 211 cases for Transportation ii. #2 FWA allegation – 80 cases for ID theft		
OPEN FORUM	Open Forum or other Summary/Discussion made.	N/A	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEXT MEETING	Next meeting will be held Monday, May 5th, 2025.	N/A	*N/A*
ADJOURNMENT	The Committee adjourned at 4:23 pm.	N/A	*N/A*

KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***FEBRUARY 26, 2025***
CALL TO ORDER: ***12:07 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Ashok Parmar, MD –Specialist Pain Medicine	Parikshat Sharma, MD – Outpatient Specialist	
Members Virtual Remote:	Maninder Khalsa, MD – KHS UM Medical Director	Abdolreza Saadabadi, MD - Psychologist	Karan Srivastava, MD – Kern Medical
Members Excused=E Absent=A	Philipp Melendez, MD – OB/GYN (A)		
Staff Present:	Linda Corbin, Health Services Consultant (Remote) Amy Daniel, Executive Health Services Coordinator Dan Diaz, CCM Manager, RN Erin Endes, Health Services Manager (Remote)	Alma Garcia, NCQA Accreditation Specialist Amanda Gonzalez, Director of UM Loni Hill-Pirtle, Director of Enhanced Case Mgmt. Kulwant Kaur, UM Outpatient Clinical Supervisor RN	Steve Pocasangre, NCQA Accreditation Specialist Christine Pence, Senior Director for Health Services Melinda Santiago, Director of Behavioral Health Nate Scott, Director of Member Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met as the composition as described in the committee charter are still in development and recruiting participating providers.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:07 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of December 11, 2024 were presented for review and approval.	☑ **ACTION**: Dr. Parikshat Sharma moved to approve minutes of December 11, 2024, seconded by Dr. Ashok Parmar. Motion carried.	N/A
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Policy Review and Approval Dr. Khalsa informed the committee that the following policy and procedures were revised and sent out prior to committee meeting for review and approval. • Policy 3.07-P Vision Care (Review on HOLD) • Policy 3.16-P California Children's Services • Policy 3.26-P New Medical Technology • Policy 3.39-P Continuity of Care by Terminated Provider • Policy 30.55 Appropriate Non-Licensed UM Staff and Licensed Professionals Christine informed the members that Policy 3.07-P was not ready for review and will be presented at the next meeting. Members reviewed the policies presented and had no further discussion or input on these revisions and new policies.	☑ **ACTION**: Dr. Sharma moved to approve the policy and procedure revisions for 3.16, 3.26, 3.39, and 30.55 as presented, seconded by Dr. Saadabadi. Motion carried.	*2/26/25*
	UM Report 4th Quarter 2024 Dr. Khalsa presented the 4th 2024 UM Report. The following highlights were noted: • UM Timeliness of Decisions – KHS remains compliant at 98.8% for Urgent and 99% for Routine timelines. • UM Referral Notification is complaint at 100% • Outpatient Referrals – has increased to 100817 from last quarter which was 95657. • Adult & Pediatric Referrals – remain consistent in comparison to past quarters. • Denial Percentage – 4th Quarter is averaging 2.7% denied referrals. • IRR Q4 Results – All staff and Med Directors have successfully passed the required IRR testing with passing score of 95% or higher • Internal Auditing for 4th Quarter included delayed referrals from October 1 – December 31, 2024. Audit results were shared with UM Staff with appropriate staff reminders identified in this audit.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*2/26/25*

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS</th><th>RECOMMENDATIONS/ ACTION</th><th>DATE RESOLVED</th></tr>
<tr><td></td><td><u>UM/Internal Auditing Activities</u>

Christine Pence reported on the UM Auditing Activities that included monitoring the process of referrals that have been delayed by the UM Department. A review of 10 files were reviewed for the month of October – December 2024.

<table><tr><th></th><th>October</th><th>November</th><th>December</th></tr><tr><td>Total referrals for the month</td><td>37,663</td><td>30,180</td><td>31,392</td></tr><tr><td>Total referrals that were delayed</td><td>88</td><td>66</td><td>67</td></tr><tr><td>Percent of referrals delayed</td><td><1%</td><td><1%</td><td><1%</td></tr><tr><td>Audit sample size</td><td>10 referrals</td><td>10 referrals</td><td>10 referrals</td></tr></table>
Audit results were shared with UM Staff with appropriate staff reminders identified in this audit.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>2/26/25</td></tr>
<tr><td></td><td><u>HICE Reviews</u>

Christine Pence reported on the HICE Reviews which is the industry standard for monitoring UM Key Metrics. All metrics for UM passed which included: Inpatient Metrics, Referral/Requests Metrics, ER Metrics, Turnaround Time Metrics, and Behavioral Health Metrics.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>2/26/25</td></tr>
<tr><td></td><td><u>ALLMed Update</u>

Christine Pence reported that AllMed has started performing preservice reviews and appeals. KHS is monitoring their performance to ensure compliance with regulation and accreditation standards.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>2/26/25</td></tr>
<tr><td></td><td><u>2024 UM Workplan Evaluation</u>

Christine Pence reported on the 2024 UM Workplan Evaluation
The identified goals were all met and found to be compliant.
There were some noted interventions include policy updates, enhancement of letters to be clearer and more concise, UM daily monitoring processes, and JIVA improvements where indicated.</td><td>☑ ACTION: Dr. Sharma moved to approve the 2024 UM Workplan Evaluation as presented, seconded by Dr. Saadabadi. Motion carried</td><td>2/26/25</td></tr>
</table>

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2025 UM Workplan Christine Pence presented the 2025 UM Workplan. The Workplan goals were identified which will include the following: • Goal 1: Meet NCQA UM standards. Obtain at least an 80% for UM standard reviews and pass all must-pass UM standards • Goal 2: Ensure consistent application of medical necessity determination criteria by maintaining a Inter-rater reliability pass rate of 100% • Goal 3: Ensure 100% of potentially eligible cases will be identified and referred to California Children's Services (CCS) • Goal 4: Monitor UM review process to ensure compliance with regulatory standards. Maintain at least a 95% timeliness rate for regulatory required prior authorization requests Christine informed the members that the 2025 UM Program Description has been completed and submitted to DHCS and is pending review.	☑ **ACTION**: Dr. Sharma moved to approve the 2025 UM Workplan as presented, seconded by Dr. Saadabadi. Motion carried	*2/26/25*
OPEN FORUM	**Open Forum** There were no further open items presented for discussion or comment by the committee members. • **Committee Attestations**: members were asked to complete and sign UM Attestations for 2025.	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, May 14, 2025 at 12:00 PM	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:55 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*
AMENDMENT	1. Approval of 2025 UM Program Description 2. Approval of 2024 UM Workplan Evaluation Summary 3. Approval of additional Hierarchy Description	1. Approved electronically March 31, 2025 2. Approved electronically March 31, 2025 3. Approved electronically March 22, 2025	

For Signature Only – Utilization Management Committee Minutes 2/26/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***Compliance Committee - Q4, 2024***
DATE OF MEETING: ***February 28, 2025***
CALL TO ORDER: ***3:00 pm by Jane MacAdam - Director of Compliance and Regulatory Affairs***

Members Present On-Site:	N/A		
Members Virtual Remote:	N/A		
Members Excused= E Absent=A	N/A		
Staff Present:	Linda Anchondo, Compliance Program Manager Alan Avery, Chief Operating Officer Karen Beale, Compliance Analyst II Elia Bercian, Compliance Program Specialist Brandon Bowe, Compliance Analyst I Stephanie Camarena, Compliance Supervisor Flor Del Hoyo Galvan, Manager of Member Wellness & Prevention Sandeep Dhaliwal, Compliance Manager, Audits and Investigations Robin Dow-Morales, Director of Claims Heather Fowler, Compliance Manager Jared Harness, Compliance Analyst Russell Hasting, PHM Manager of Case Management Loni Hill-Pirtle, Director Enhanced Care Management Magdee Hugais, Director of Quality Improvement Elizabeth Johns, Compliance Analyst I Christina Kelly, Pharmacy Administrative and Support Supervisor Maninder Khalsa, Medical Director Utilization Management Jane MacAdam, Director of Compliance & Regulatory Affairs	Traco Matthews, Chief Health Equity Officer Melissa McGuire, Senior Director of Delegation and Oversight Deborah Murr, Chief Compliance and Fraud Prevention Officer Kristie Onaindia, Provider Relations Manager Greg Panero Christine Pence, Senior Director Health Services Cassandra Perez, Compliance Program Specialist Jeff Pollock, Regulatory and Government Program Manager Heather Pruitt, Compliance Analyst I Adriana Salinas, Director of Community & Social Services Amy Sanders, Member Services Manager Melinda Santiago Nate Scott, Director of Member Services Isabel Silva, Senior Director of Wellness and Prevention Bruce Wearda, Director of Pharmacy James Winfrey, Deputy Director of Provider Network	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
1. Action Items: Jane MacAdam (from 11/04/2024 Meeting; Minutes Attached)	A. Jiva Grievance Module update 1. Amy provided an update that it is in testing. a. Testing will be completed by the end of next week, 3/7/2025. b. The goal is to go live by mid-March.	N/A	N/A
	B. Retrospective Audits 1. These audits are starting next week 2. Compliance will be scheduling additional meetings on retrospective APLs. 3. At the next Compliance Committee meeting, we will discuss the retrospective audits.	☑ ***Action Item***: **1.** Compliance will schedule meetings on retrospective APLs and will discuss at the next Compliance Committee meeting.	N/A
2. 11/04/2024 Meeting Minutes: **Jane MacAdam**	A. Included in Packet	N/A	N/A
3. Governance & Compliance Committee Meetings: **Deb Murr**	A. Governance & Compliance Committee Meetings 1. The below documents were updated for 2025. a. Compliance Program Description i. This document pertains to Medi-Cal but will need to add Medicare documents too. b. Code of Conduct (draft previously shared) c. Employee Guide d. Anti-Fraud Plan	N/A	N/A
4. Enterprise Risk Management (ERM) : **Deb Murr/ Jane Macadam**	A. Enterprise Risk Management (ERM) Update 1. Moss Adams will be completing the first assessment, then the Plan will be completing the risk assessment in futures years.	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
5. Artificial Intelligence (AI): **Deb Murr**	A. Artificial Intelligence Update 1. Project Overview a. AI Executive Steering Committee was created. 2. Communication Plan 3. Communication Flow a. There will be an approval process for anything related to AI. It will need to be vetted through the AI Committee 4. Policy 70.84-I AI Executive Steering Committee 5. The Plan is in beta testing for an AI program called Readily. 6. Nate and Deb discussed the Government's view of AI. There is a concern when AI is used for discission making or generating documents that are not vetted by humans. 7. Robin and Deb discussed using AI for job descriptions or help with letter writing, for more detail/description. If the Plan is using an AI, like Chat GPT, send an inventory to Deb and Stephen to be reviewed. Robin will send her list. 8. Bruce, Deb, and Jane discussed the Vendors using AI. The plan has been conducting a security assessment on Vendors related to using AI. DMHC has release an APL related to this subject. 9. Traco discussed using AI for routine decisions, not complex discission making.	☑ ***Action Item***: 2. Robin to send her list of items that she uses AI with to Deb and Stephen to be reviewed.	N/A
6. Compliance Trainings: **Jane MacAdam**	**A. Compliance Trainings:** 1. Code of Conduct-2024 a. (20 Employees outstanding) 2. Cultural Competency-2024 a. (20 employees outstanding) 3. HIPAA-2024 a. (2 employees outstanding) 4. FWA-2024 a. (5 employees outstanding) 5. Nate and Jane discussed that Compliance is working with HR	☑ ***Action Item***: 3. Compliance will discuss with HR the training that shows not completed, but the employee has completed it.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	on sending automated reminders. 6. Robin and Jane discussed employees that have completed the trainings, but the system shows that they have not completed it. a. Compliance will discuss with HR about the training that shows not completed, but the employee has complete it 7. On a few occasions, when the due date passes for the training, it is no longer showing on the dashboard. HR must go back in an extend the due date to access the course when the due date passes.		
7. Compliance Dashboard: **Jane MacAdam**	A. Compliance Dashboard remains in development 1. Metrics published, but additional work not included in 2025 Project. 2. IRs to be submitted for drill downs originally requested to be worked on in maintenance.	N/A	N/A
8. Regulatory Audits: **Jane MacAdam**	A. 2023 DHCS Focused Audit (BH/Transportation): 1. Most recent CAP Response Submission 01/25/2025 2. DHCS has not closed the CAP but advised no additional questions at this time and no February submission due.	N/A	N/A
	B. 2023 DMHC Medical Audit: 1. Continued preparation for follow up audit and/or potential follow up from DMHC Office of Enforcement 2. Follow Up Audit scheduled for approximately 11/10/2025 based on DMHC Calendar (no communication to date from DMHC)	N/A	N/A
	C. 2024 DHCS Medical Audit 1. Preliminary Exit Conference held 12/20/2024 with approximately nine (9) verbally reported deficiencies. DHCS	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	still reviewing at that time, so report may contain additional findings. The Plan will have 15 days to respond. a. UM: i. Did not ensure 6th grade reading level ii. Did not send NOA to member within two (2) days; provider within 24 hours of decision iii. Did not document clear and concise reasons iv. Did not ensure criteria applied consistently 2. Appeals: a. Did not provide written notice of appeal extension when extending expedited appeal 3. Grievance: a. Did not provide acknowledgment letters within five (5) days b. Did not provide resolutions within thirty (30) days c. Quality of Care – did not ensure all QOC immediately referred to medical director for action. 4. Awaiting Preliminary Audit Report		
	D. 2024 DMHC Audit of KHS Fiscal and Administrative Affairs 1. Pre-Audit deliverables submitted timely, 01/27/2025 2. Claims and PDR Samples selected by DMHC with documentation due by 04/07/2025. 3. Virtual audit will begin 04/07/2025. 4. Jane and Nate discussed the LHPCs getting together to speak with the auditors on creating a matrix for grievances. a. Jane will discuss with the LHPC Compliance Officers work group. 5. Amy and Jane discussed the monthly Grievance Collaboration call that Amy has with sister Plans.	☑ ***Action Item***: 4. Jane will discuss with the LHPC Compliance Officers work group regarding the grievances matrix.	N/A
	E. HSAG Encounter Data Validation Audit (EDV) 1. 2023-2024 KHS Specific Appendix Received a. Unable to submit records for six (6) of the samples	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	b. We had some areas we did not meet; however, we improved in all categories over last year and were better than the statewide averages in all categories c. Met one (1) additional category over the previous year related to procedure codes. 2. 2024-2025 EDV Audit underway: a. 411 Samples b. 40% due by 04/11/2025 c. 100% due by 05/13/2025		
9. DSNP: **Jane MacAdam**	A. DSNP Update: 1. Medicare Service Area Expansion (SAE) submitted 08/31/2024; DMHC approved 11/12/2024 2. EAE D-SNP filing submitted to DMHC 11/15/2024; DMHC approved 02/06/2025 3. Delegated Contracts with MedImpact (PBM) and Universal Healthcare MSO (Administrative) approved by both regulators. 4. DSNP Applications submitted to CMS 02/10/2025. a. Will be hearing an answer from CMS in March. 5. Implementation and BID activities underway.	N/A	N/A
10. Reports: **Amy Sanders**	A. Member Services Quarterly Grievance Audits: Amy Sanders 1. 2024 Q4 goal is to audit thirty (30) case files per quarter/10 per month each quarter aiming for score of 90% or above. 2. Q4 Monthly audit average is 93.8% a. October 92.5 % b. November 94% c. December 95% 3. Trends Identified in DHCS 2024 audits is an alignment with the findings. a. Not sending the acknowledgement letters by the 5th day b. Not sending the appropriate acknowledgement letter or templates that are sent by DHCS. 4. Q4 goal of 90% met a. Individual scores are shared with the staff during their one on one b. Common deficiencies are shared with team members	☑ ***Action Item***: 5. MS will get with their team to discuss what can be done to get Grievances closed timely and to send letters timely.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	during the staff meeting to reduce number of errors. c. MS will get with their team to discuss what can be done to get Grievances closed timely and to send letters timely.		
Magdee Hugais	B. Quality Improvement: Magdee Hugais 1. IHA Audits a. Q4 findings: Audited 53 providers i. Eleven (11) providers scored under 79% b. Follow-up: Sent educational letters to all providers scoring 79% and below. c. Providers scoring 79% and below added to track and trend, Dr. Miller will reach out to these providers. 2. Exempt Grievance Audits a. Shared with MS/Grievance b. Achieved 100% for Q4 3. NAR Audits a. October: No findings b. November: Three (3) findings i. One (1)spelling error ii. One (1) readability issue iii. One (1) overall process issue c. December: 3 errors i. One (1) readability issue ii. One (1) process error iii. One (1) hierarchy error d. Follow-up: Internal team members addressed with corrective actions 4. Gold Card Audits a. Table is aggregated i. Centric Health: 100% ii. Comprehensive Cardiovascular: 100% iii. Dr. Hao Bui MD Inc.: 86% iii. Rheumatology Services Medical Group: 80% iv. Other providers (Referrals submitted to Kern Endocrine, Jasleen Duggal MD Inc.): 60%	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	b. Dr. Miller is still deciding on actions for low scores 5. CBCC Audits a. Achieved 100% 6. Lead Screening Audits a. One (1) provider with 80-89% overall score b. Seventeen (17) providers with 79% and/or less c. CAPS are pending d. Letters sent to each region e. Working on getting CAPS from Dr. Miller for those providers		
Christine Pence	C. UM Audits 1. Q4 internal audit results compared to Q1 to Q4 a. 9% increase in overall referrals process b. Reduction in the percentage of denied and delayed referrals (56 min) 2. 2024 improvements: a. Notifications mailed after 2 days of decision reduced by 93% (Q1: 4.6% late, Q4: 0.3% late) b. Errors within the NOA reduced by 43.4% (Q4: 3.7% NOA letters had an error) c. Missing citation or criteria reduced by 60% (Less than 2% in Q4) d. Entire process from start to finish errors reduced by 11% (Q4: 4.1% total) e. NOA language above 6th grade reading level reduced by 18%. 3. Jane and Christine discussed that the correct hierarchy is being used when reviewing criteria.	N/A	N/A
Flor Del Hoyo Galvan	D. Health Education: 1. Service Audit a. Areas at 100% i. Class starting on time ii. Member sign-in iii. Providing examples for topics, concepts, or myths	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	iv. Explaining and doing all planned activities b. Areas below 50% i. Covering SMART goals or objectives 2. Satisfaction Survey a. Presentation was interesting is just under 100% b. Facilitator was effective is just under 100% c. Satisfied with reward is just under 100% d. What did you like most about the class? Members appreciated: i. The delivery and tone of voice used by the instructors ii. Learning about eating habits, substitutions, and health topics was appreciated iii. The content was found to be relevant and informative, which made the classes easy to understand iv. Clear explanations and easy-to-understand material were highlighted v. The teaching techniques and presentation style were praised vi. The supportive environment and opportunity to connect with others were valued vii. Feeling supported and looked forward to attending the classes e. How could we improve the class? Members suggested: i. More information and engagement during the class ii. Additional content or topics to be covered iii. Changes in class structure or format iv. Ideas for providing incentives or rewards to participants 3. Class Effectiveness a. Asthma Education i. 73% Pre-test ii. 77% Post-test b. Fresh Start i. 56% Pre-test		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	ii. 84% Post-test c. Nutrition Education i. 79% Pre-test A+E ii. 85% Post-test A+E iii. 76% Pre-test EHBA iv. 92% Post-test EHBA d. Diabetes Prevention Program: Knowledge Gain i. 85% Pre-test ii. 96% Post-test e. Diabetes Management Program: Knowledge Gain i. 78% Pre-test ii. 85% Post-test f. Asthma Follow Up Call Results by Quarter i. 69% Q4 2023 ii. 75.8% Q1 2024 iii. 91.5% Q2 2024 iv. 77.3% Q3 2024 v. 84.1% Q4 2024 g. Diabetes Prevention Program: Weight Loss by Month (2024) i. 2.1% October ii. 2.1% November iii. 1.9% December h. Diabetes Management, Q4 2024 Average Weight Comparison at Class1 and Class 6 i. Class 1: 184 for Q3 ii. Class 6: 181 for Q3 iii. Average weight loss trend - 3% iv. Class 1: 219 for Q4 v. Class 2: 211 for Q4 vi. Average weight loss trend - 8%		
Jane MacAdam/ Isabel Silva	E. MOU Status 1. Per Jane, we provide quarterly and annual reports to our regulators which is included in the packets on the status of the MOU's and required MOU's. 2. Per Isabel, Executed MOU was submitted for the local health department to DHCS and received an AIR (Additional Information Request). Tiffany and her team are working through the AIR o prepare for re-submission. a. Per Jane, it was re-submitted back to DHCS in	☑ ***Action Item***: 5. Jane will add Tiffany Chatman to the cadence of the Compliance Committee meeting invite.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	November 2024 with the recommended redlines and requested for expedited review. DHCS just sent back the commentary in February 2025. Per Jane, currently working on re-submitting the Executed version. 3. Jane will add Tiffany Chatman to the cadence of the Compliance Committee meeting invite.		
Jane MacAdam	F. Compliance: Jane McAdam 1. All Plan Letters and Guidance Letters Received a. 66 in 2024 2. Regulatory Submissions a. 1256 in 2024 i. Robin Dow-Morales, wanted to know if Regulatory Submissions include both DHCS and DMHC, per Jane it includes both regulators 3. 2024 DMHC Independent Medical Review (IMR) vs. Consumer Complaints a. Consumer Complaint – 32 (58%) b. IMR – 23 (42%) i. Upheld – 32 (KHS) 29 (DMHC) ii. Overturned – 7 (KHS) 15 (DMHC) iii. Misdirected – 10 (KHS) 0 (DMHC) iv. Return to Plan – 4 (KHS) 7 (DMHC) v. Services Never Denied – 2 (KHS) 0 (DMHC) vi. In Process 0 (KHS) 4 (DMHC) vii. Grand Total: Fifty-five (55) 4. 2024 HIPAA Unauthorized Disclosure/Breach Initial Report Timeliness (24 Hours) a. Yes i. 98 (91%) b. No ii. 10 (9%) 5. 2024 HIPAA Unauthorized Disclosure/Breach Final Report Timeliness (10 Days) a. Yes i. 106 (99%)	N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	b. No ii. 1 (1%) 6. 2024 Breach Status a. Yes i. 2 (2%) b. No ii. 102 (94%) c. Unknown iii. 4 (4%) 7. Policy Status Report will be in the next meeting. 8. The next Committee meeting will have expanded reporting and might expand the meetings from 1.5 hours to 2 hours.		
Open Forum	No discussion	N/A	N/A
Next Meeting	Next meeting is scheduled for Wednesday, May 14, 2025: 3:00 – 4:30 PM	N/A	N/A
Adjournment	Meeting Adjournment 4:30pm	N/A	N/A

KERN HEALTH SYSTEMS

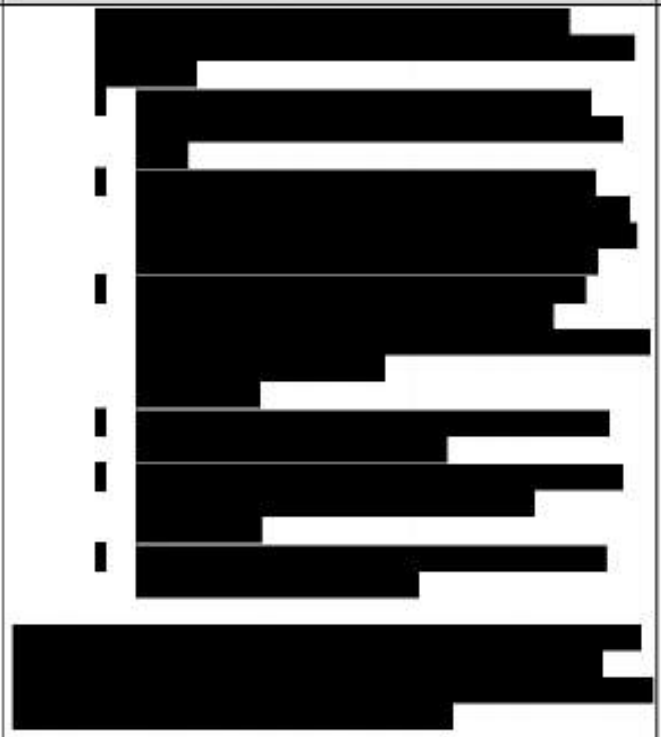
COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***MARCH 5, 2025***
CALL TO ORDER: ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Miguel Lascano – Network Provider, OB/GYN	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics David Hair, MD - Network Provider, Ophthalmology		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Alan Avery, Chief Operations Officer Michelle Curioso, Director of Population Health Amy Daniel, Executive Administrative Jake Hall, Deputy Director of Contracting	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:02 AM.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of February 5, 2025 for	☑ **ACTION**: Dr. Patel moved to approve minutes of February 5, 2025, seconded by Dr. Lascano. Motion carried.	3/5/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	review and approval.		
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 03/03/2025:** [redacted] **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **03/05/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers Lists Dated 03/05/2025.** Recredentialing files meeting clean file review, report dated 3/5/2025, were accepted as presented with no additional questions or	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 03/03/2025, and 03/05/2025, seconded by Dr. Lascano. Motion carried. ☑ **ACTION**: Dr. Patel moved to approve Comprehensive Reviews for BC & DL as listed, seconded by Dr. Lascano. Motion carried.	*3/5/25* *3/5/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	alternative actions. [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **March 5, 2025**, were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** [redacted]	☑ **ACTION:** [redacted]	3/5/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
			

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Delegated Credentialing 4th Quarter 2024 HICE Quarterly Reports Yolanda Herrera KHS Credentialing Manager informed the committee that the 4th Quarter 2024 HICE Delegated Oversight Reports have all been received and reviewed for CHLA Medical Group, ConferMED, Valley Children's Child Net, Vision Services Plan, UCLA Medical Group and USC Medical Group. Semi-Annual Rosters have also been received. During 4th Quarter 2024, delegates reported Credentialing Committee dates for initial credentialing, recredentialing and terminations. There were no significant changes in provider network that would affect KHS members. **There were no identified issues.**	☑ **ACTION**: Dr. Patel moved to approve the Delegated Credentialing 4th Quarter 2024 HICE Quarterly Reports for CHLA Medical Group, ConferMED, Valley Children's Child Net, Vision Services Plan, UCLA Medical Group and USC Medical Group as presented, seconded by Dr. Lascano. Motion carried.	3/5/25
	KHS Organizational Providers – Assessment Report Yolanda Herrera KHS Credentialing Manager presented the KHS Organizational Providers Assessment Report. This report is utilized to track and monitor organizations/facility providers are in good standing with state and federal regulatory bodies, accrediting bodies when applicable or have an onsite quality assessment if the provider is not accredited. KHS traditionally credentials the organizational/facility providers as part of the assessment and have been updating the assessment tool upon approval by PAC. KHS Credentialing Staff continue to monitor those organizations/facilities that exceed the 36-month validation as we strive to ensure the verification dates are conducted within the 36-months. KHS Credentialing Staff will recredential these organizations and facilities sooner to ensure the approval dates are at least every 34-months to ensure the verification dates are compliant.	☑ **ACTION**: Dr. Patel moved to approve the KHS Organizational Providers Assessment Report as presented, seconded by Dr. Parmar. Motion carried.	3/5/25
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	*Pending*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**PQI Threshold Methodology & Selection**: Magdee Hugais, Director of Quality Improvement presented the Potential Quality Issues (PQI) Threshold Methodology and selection criteria. The purpose is to provide a detailed justification for the selection of 0.99 PQI per 1000 interactions as the threshold for identifying underperforming providers in PQI analysis. This threshold supports Policy 2.70-I by outlining the statistical methodology, rationale, and expected impact of this threshold on provider performance evaluation. Providers with any Level 3 will continue to be brought to the PAC for review.	☑ **ACTION**: Dr. Patel moved to approve the PQI Threshold Methodology and Selection Criteria and Guidelines as presented, seconded by Dr. Lascano. Motion carried	*3/5/25*
	PQI Track and Trend Jan-Mar 2025 Magdee Hugais, Director of Quality Improvement presented the January – March PQI Track and Trend Reports. The report lists the providers who are currently on "Track and Trend" all of which are Level 1 (Potential for Harm) assigned severity level; however, there are no cases rising to PAC review. These providers will be monitored for 3-months and if no further issues, will then be removed. Most cases tend to be service type issue with the facility or staff member, and most are resolved with information letter and response. The clinical policy and procedure for Corrective Action Plans is in development and will outline this process.	☑ **ACTION**: Dr. Raju Patel moved to approve the PQI Track and Trend Report for January – March 2025 as presented, seconded by Dr. Miguel Lascano. Motion carried	*3/5/25*
	<u>Pharmacy Criteria</u> Bruce Wearda presented the Pharmacy criteria submitted for approval under pharmaceutical covered medical benefit as follows: • Abatacept • Certolizumab • Golimumab • Gonadotropin • Guselkumab • Inebilzumb • Lovotibeglogene • Mirikizumab	☑ **ACTION**: Dr. Raju Patel moved to approve the Pharmacy criteria (listed below), seconded by Dr. Ashok Parmar. Motion carried.	*3/5/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Neuromyelitis • Risankizumab • Rituximab • Tildakizumab • Tocilizumab • Ustekinumab • Vedolizumab		
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, April 2, 2025	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:03 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

For Signature Only – Physician Advisory Committee Minutes 03/05/2025:

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

CA-25 J

KERN HEALTH SYSTEMS

COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***March 18, 2025***
CALL TO ORDER: ***7:18 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Jennifer Ansolabehere, KC Public Health Satya Arya, MD - ENT. Danielle Colayco, PharmD – Komoto Martha Tasinga, KHS Chief Medical Officer	Allen Kennedy – Quality Team DME Michael Komin, MD – Komin Medical Group Chan Park, MD – Vanguard Family Medicine Philipp Melendez, MD – OB/GYN	Rukiyah Polk - CAC Chair Jasmine Ochoa – Health Equity Manager of Public Health Traco Matthews – KHS Chief Health Equity Officer (Non-Voting)
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Todd Jeffries – Bakersfield Community Healthcare (A)		
Staff Present:	Michelle Curioso - Director of Pop Health Management Pawan Gill - Health Equity Manager Sukhpreet Sidhu, MD - Pop Health Medical Director Anastasia Lester - Sr. Health Equity Analyst John Miller - Quality Improvement Medical Doctor Ann StoryGarza - Assistant General Counsel Amy Sanders - Member Services Manger	Magdee Hugais - Director of Quality Improvement Kailey Collier - Director of Quality Performance Maninder Khalsa - Medical Director Christine Pence - Senior Director of Health Services Nate Scott - Member Services Director Steven Kinnison - NCQA Manager Alma Garcia – NCQA Accreditation Specialist	Vanessa Nevarez - Health Equity Coordinator Greg Panero - Provider Network Analytics Abdolreza Saadabadi, MD - BH Medical Director Isabel Silva - Senior Director of Wellness & Prevention Melinda Santiago - Director of Behavioral Health Steve Pocasangre - NCQA Accreditation Specialist James Winfrey - Deputy Director of Provider Network

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	10 of 12 committee members present; Debra Cox and Todd Jeffries were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:18 am.	N/A	N/A
Public Presentation	Julie Skelton, RN, addressed the EQIHEC in public comment with serious concerns regarding treatment denials for cancer patients, particularly young Hispanic women and men. She cited repeated denials by KHS based on current NCG Health Ambulatory Criteria, despite patients meeting national guidelines, including cases involving personal or family history of breast cancer. Ms. Skelton emphasized that national guidelines allow for screenings starting at age 50 – or earlier if clinical requirements are met – and that these guidelines, which	• Dr. Tasinga will meet with the cancer center offline to discuss guidelines and criteria.	3/18/25

	certified providers are obligated to follow, should be added to KHS's criteria. She shared that these denials have led to delayed surgeries or the need for second surgeries. Dr. Tasinga acknowledged the concern and stated that many denials occur due to incomplete clinical information provided during the request process. She clarified that while NCG guidelines are nationally recognized, the guidelines reference by Ms. Skelton are not recognized by NCQA, which informs KHS policy. Dr. Tasinga committed to discussing the matter further offline with the cancer center.		

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • There were no committee announcements.		
Committee Minutes	**Approval of Minutes** CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes for approval.	**Action:** • Philipp M. first, Satya A. second. All aye's. Motion carried.	3/18/25
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** • CA-4) Behavioral Health Advisory Committee (BHAC) Minutes from January 15, 2025. • CA-5) Health Equity Transformation Steering Committee (HETSC) Minutes from February 11, 2025. • CA-6) Network Advisory Committee (NAC) Minutes from February 27, 2025. • CA-7) Pharmacy Drug Utilization Review (DUR) Minutes from November 25, 2025. • CA-8) Physician Advisory Committee (PAC) October 2, 2024, Redacted Summary of Proceedings. • CA-9) Physician Advisory Committee (PAC) November 6, 2024, Redacted Summary of Proceedings. • CA-10) Physician Advisory Committee (PAC) December 4, 2024, Redacted Summary of Proceedings. • CA-11) Population Health Management Committee	**Action:**	

	(PHMC) Minutes from December 4, 2024. • CA-12) Utilization Management Committee (UMC) Minutes from December 11, 2024. • CA-13) Quality Improvement Workgroup (QIW) Minutes from December 12, 2024. • CA-14) Quality Improvement Workgroup (QIW) Minutes from March 7, 2025. • CA-15) Wellness & Prevention (W&P) -Q3 2024 W&P Report -Q3 2024 C&L Report -Q4 2024 W&P Report -Q4 2024C&L Report • A motion to approve Consent Agenda Items was requested	• Satya A. first, Chan P. second. All aye's. Motion carried.	3/18/25
	16) Quality Improvement Workgroup (QIW) • Magdee H. presented an overview of the Quality Improvement Trilogy documents which consists of the 2024 Quality Program Evaluation, the 2025 Quality Improvement Health Equity Program Description, and the 2025 Quality Improvement Work Plan. These documents provide a comprehensive assessment of program performance, outline strategic priorities for the coming year, and establish measurable goals to enhance clinical care, service quality, and member experience. • Magdee H. presented the 2024 Quality Performance Evaluation. A motion to approve was requested. • Magdee H. presented the 2025 Quality/Health Equity Program Description. A motion to approve was requested. • Magdee H. presented the 2025 Quality Improvement Work Plan. A motion to approve was requested. **17) Quality Performance (QP)** • Kailey C. presented the Quality Performance Q1 2025 report which provides a summary of the quarterly	**Action:** • Informational only. • Allen K. first, Satya A. second. All aye's. Motion carried. • Satya A. first, Allen K second. All aye's. Motion carried. • Satya A. first, Chan P. second. All aye's. Motion carried. • Chan P. first, Satya A. second. All aye's. Motion carried.	3/18/25 3/18/25 3/18/25 3/18/25

	activities and outcomes for the department. A motion to approve was requested.		
	18) Health Equity Transformation Steering Committee (HETSC)		
	• Pawan G. presented the 2025 Health Equity Workplan. She explained that the Health Equity Program Description and the Health Equity Program Workplan were combined in 2025 to form the QIHE Program Description as mentioned by Magdee H. at the beginning of the EQIHEC meeting. A motion to approve was requested.	• Philipp M. first, Allen K. second. All aye's. Motion carried.	3/18/25
	• Pawan G. presented the updated JEDI Charter as it is an integral part of the Health Equity Office strategy. A motion to approve was requested.	• Jasmine O. first, Satya A. second. All aye's. Motion carried.	3/18/25
	• Pawan G. provided a Health Equity Division update to the committee which covered Health Equity trainings in 2025, Equity and Practice Transformation (EPT) and Doula updates.	• Informational only.	
	19) Behavioral Health Advisory Committee (BHAC)		
	• Melinda S. presented the Behavioral Health Department National Committee for Quality Assurance Continuity and Coordination Between Medical and Behavioral Health Care report. Melinda S. also shared that a Tribal Liaison, the Bakersfield American Indian Health Project (BAIHP), was invited to be on the BHAC to enhance health outcomes for American Indian and Alaska Native communities. Melinda S. asked the committee if they had any recommendations on how the Behavioral Health Department can meet their goal of 10% penetration rate (right now it is at 1%). Traco M. asked how our collaboration with Kern Behavioral Health Recovery Systems is. Melinda S. responded that she would share the collaboration data	• Jennifer A. first, Allen K. second. All aye's. Motion carried.	3/18/25

	at the third quarter EQIHEC meeting. A motion to approve the BHAC Q1 2025 report was requested.		
	20) Member Services		
	• Amy S. presented the Q4 2024 Operational Board Report that covers grievance trends. She stated that Q4 is historically slow and therefore dropped by 10%. A motion to approve was requested.	• Philipp M. first, Satya A. second. All aye's. Motion carried.	3/18/25
	• Amy S. presented the Q4 2024 Grievance Summary Report that provides the types of grievances that are received. Dr. Tasinga commented on the quality-of-care grievances stating that every call is a quality of care. A motion to approve was requested.	• Allen K. first, Satya A. second. All aye's. Motion carried.	3/18/25
	• Amy S. presented the Member Services Email Audit Summary Report which states that emails must achieve a monthly average score of 90% or higher and 100% of email must have a response within 1 business day; both conditions were met. A motion to approve was requested.	• Satya A. first, Jasmine O. second. All aye's. Motion carried.	3/18/25
		• Satya A. left the meeting at 8:27am.	3/18/25
	21) Utilization Management (UM)		
	• Dr. Khalsa presented the Q4 2024 UM report which contains a synopsis of both quantitative and qualitative analysis that reflect the performance of the UM department in Q4 2024. A motion to approve was requested.	• Philipp M. first, Allen K. second. All aye's. Motion carried.	3/18/25
	• Christine P. presented the 2024 UM Workplan Evaluation which provides an evaluation of the progress towards the goals and workplan from 2024. A motion to approve was requested.	• Philipp M. first, Chan P. second. All aye's. Motion carried.	3/18/25
	• Christine P. presented the 2025 UM Workplan that covers the success of the goals and planned interventions set by the UM department. A motion to approve was requested.	• Rukiyah P. first, Allen K. second. All aye's. Motion carried.	3/18/25

	• Christine P. presented the UM Department Hierarchy of Criteria Report which discloses that new technology reviews that do not have established criteria and guidelines will be reviewed using HAYES. If a new technology has not been evaluated by HAYES, then KHS will send the specific case for independent medical review for appropriateness of use. A motion to approve was requested.	• Philipp M. first, Allen K. second. All aye's. Motion carried.	3/18/25
	22) Network Adequacy Committee (NAC)		
	• Greg P. presented the NAC Q1 2025 report that provided an overview of the Plan's network adequacy standards, monitoring activities, findings, and process improvements. Greg P. asked the committee to comment on how the NAC can improve. A motion to approve was requested.	• No response was provided from the committee. • Philip M. first, Allen K. second. All aye's. Motion carried.	3/18/25 3/18/25
		• Philipp M. left the meeting at 8:55am.	3/18/25
	23) Pop Health Management (PHM)		
	• Michelle C. presented a report on Improving Mental Healthcare Access in East Kern County due to a previous discussion at EQIHEC regarding limited access to maternal healthcare in East Kern. The report includes findings from her SWOT analysis, along with feedback gathered from both internal and external partners. Additionally, the report includes recommendations for improving maternal health outcomes and reducing disparities in access to care. Michelle C. requested insight and feedback from the committee. A motion to approve was requested.	• No response was provided from the committee. • Jennifer A. first, Jasmine O. second. All aye's. Motion carried.	3/18/25 3/18/25

	24) Wellness & Prevention (W&P) • Isabel S. presented the 2024 Annual Wellness Report that summarizes department goals, objectives, and activities performed in 2024. Daniella C. asked what the departments success factors were. Isabel S. responded that partnering directly with parks and rec was the best success. Daniella C. asked how she can refer patients to the W&P activated and programs. Isabel S. responded that class locations such as the City of Delano are great about posting information. Additionally, there are flyers on the KHS website.	• Allen K. first, Danielle C. second. All aye's. Motion carried. • Chan P. left the meeting at 9:20am	3/18/25

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Open Forum	Traco M. gave an update on the DHCS Transforming Maternal Health Model Press Conference that took place at Bakersfield Memorial Hospital on February 5, 2025. The day consisted of a tour of the birthing center at Bakersfield Memorial, a tour of the Bakersfield American Indian Health Project facility, a tour of Kern Medical, and a discussion led by KHS with Kern County Public Health. The DHCS and CA Surgeon General were in attendance and so impressed by Kern County that they have demanded that all areas follow what we do.	Informational only.	N/A
Next Meeting	The next meeting will be held Tuesday, June 17, 2025, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:23am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	• Danielle C. first, Jennifer A. second. All aye's. Motion carried.	N/A

For Signature Only – EQIHEC Minutes 3/25/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

CA-25 K

KERN HEALTH SYSTEMS

COMMITTEE: COMMUNITY ADVISORY COMMITTEE (CAC)
DATE OF MEETING: March 25, 2025
CALL TO ORDER: 11:05 AM by Rukiyah Polk - Chair

Members Present:	*Rukiyah Polk* *Lourdes Bucher* *Evelin Torres-Islas* *Tammy Torres* *Jasmine Ochoa* *Beatriz Basulto* *Michelle Bravo* *Jay Tamsi* *Jennifer Wood-Slayton*	**Members Absent:**	*Rocio Castro* *Alyssa Olivera* *Mark McAlister* *Ashton Chase* *Jessika Lopez* *Nalasia Jewel*	**Staff Present:**	*Anastasia Lester, Senior Health Equity Analyst* *Isabel Silva, Senior Director of Wellness & Prevention* *Vanessa Nevarez, Health Equity Coordinator* *Amy Sanders, Member Services Manager* *Lela Criswell, Member Engagement Manager* *Moises Manzo, Cultural & Linguistics Specialist* *Tiffany Chatman, Wellness & Prevention Manager* *Nate Scott, Senior Director of Member Services* *Cynthia Jimenez, Cultural & Linguistics Specialist* *Cynthia Cardona, Cultural & Linguistic Manager*

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	9 committee members present; Rocio Castro, Alyssa Olivera, Mark McAlister, Ashton Chase, Jessika Lopez, and Nalasia Jewel were absent.	Committee quorum requirements met.	N/A
Call to Order	Rukiyah Polk, Chair, called meeting to order at 11:05 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Rukiyah gave the opportunity for member updates.		
	• Rukiyah P. provided key updates from the State Community Advisory Committee meeting that she attended as a Kern Family Health Care representative on February 19, 2025.	• Informational only.	N/A
	• The first update was the Governor's proposed 2025-26 budget which includes $296.1 billion for human and health services, with $193.4 billion allocated to DHCS. This funding supports ongoing efforts to transform Medi-Cal, expand behavioral health services, and improve access to care.	• Informational only.	N/A
	• The second update was that the Medi-Cal enrollment is projected to decline from 15 million to 14.5 million as redeterminations resume and pandemic flexibilities end. Additionally, potential changes in federal immigration policy may further impact enrollment.	• Informational only.	N/A
	• The third update is the huge shift in Enhanced Care Management (ECM) and Community Supports. These programs continue to expand, with ECM participation growing 53% year-over-year and 239,700 members benefiting from housing assistance, medically tailored meals, and recuperative care.	• Informational only.	N/A

KERN HEALTH SYSTEMS

	• The fourth update are the significant investments in the behavioral health infrastructure, launching the Bond BHCIP Program with $3.3 billion in funding for mental health facilities and services The rollout includes public listening sessions, phased policy guidance, and a full implementation deadline in July 2026.	• Informational only.	N/A
	• The fifth update is the focus on maternal health equity. The Birthing Care Pathway Initiative aims to reduce maternal mortality and severe complications, particularly in Black, American Indian, and Pacific Islander mothers. Key concerns include limited access to midwives and doulas, inadequate postpartum mental health care, and difficulties navigating Medi-Cal benefits. DHCS is working on policy reforms and stronger care coordination to improve maternal health outcomes.	• Informational only.	N/A
	• The sixth update is regarding the Children & Youth Behavioral Health Initiative (CYBHI) expansion on school-based mental health services by providing funding for psychologists, social workers, and peer mentors. However, challenges remain in navigating HIPAA and FERPA compliance while ensuring youth receive accessible and culturally competent mental health care.	• Informational only.	N/A
	• Lastly, the Long-Term Service & Supports (LTSS) Dashboard is being enhanced to provide better data transparency on Medi-Cal	• Informational only.	N/A

	utilization, quality of care, and member demographics.		
Committee Minutes	**Approval of Minutes** CA-3) The Committee's Chairperson, Rukiyah Polk, presented the CAC Minutes for approval.	**Action:** • Tammy T. first, Jasmine O second. All aye's. Motion carried.	3/25/25
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** CA-4) December 2024 Medi-Cal Membership Enrollment Report	N/A	N/A
	5) Grievance 4th Quarter 2024 Operation Board Update • Amy S. presented the Q4 2024 Operational Board Report that covers grievance trends. She stated that Q4 is historically slow and therefore dropped by 10%. 6) Grievance 4th Quarter 2024 Executive Summary Grievance • Amy S. presented the Q4 2024 Grievance Summary Report that provides the types of grievances that are received.	• Informational only. • Informational only.	N/A N/A

KERN HEALTH SYSTEMS

	7) Member Services – Email Audit Summary Report & Examples • Amy S. presented the Member Services Email Audit Summary Report which states that emails must achieve a monthly average score of 90% or higher and 100% of email must have a response within 1 business day; both conditions were met. Jennifer W. asked if there are other languages offered besides English and Amy S. responded that there are if they are requested. • Beatriz B. recommended that the KHS Member Services Department educate members more on where and how to view their benefits. Beatriz B. asked Amy S. if there is a "chat" option on the KHS website. Amy S. responded that may be available in the future. Amy S. added that there is an outreach team to help engage members if they need help. One way the outreach team assists is by contacting members if they are due for appointments. If members are signed up in the member portal, then they will receive health care reminders. Beatriz B. responded that members need help navigating the system and portal. She added that it is a fast-paced system so there continues to be less understanding and more education that needs to be provided. The system is intimidating. Lela C. asked Beatriz B. what the best way to educate	• Informational only. • Informational only.	N/A N/A

	members are based on her experience. Beatriz B. explained that she has the most success when she works with an individual or family one-on-one, in person, to show how to navigate the portal. Every family is different, with different needs, this method allows each family to really get to know all the benefits and keep their benefits private as opposed to using a discussion group method. Lela C. responded that KHS should expand their in-person presentations and that members can start to request one-on-one presentations if needed. Amy S. added that KHS has walk-in rooms specifically for one-on-one face time. Amy S. also added that when KHS does welcome calls to members, they are walked through the process of navigating the portal. Beatriz B. responded that the problem with walk-in rooms is the hours that they are available are not the hours the members are available. KHS should be available to members after hours as well. 8) CHIP/CHA • Jasmine O. presented an overview and breakdown of the Community Health Improvement Plan (CHIP) and the Community Health Assessment (CHA) 3-year plan. The presentation included the community	• Informational only.	N/A

KERN HEALTH SYSTEMS

	roadmap, community meetings held, and community surveys that have been conducted. • Tammy T. asked Jasmine O. when and how training is conducted. Jasmine O. responded that Kern County Public Health (KCPH) hosts symposiums as well as provides education through provider portals that have presentations and trainings for viewing. She added that the goal is to engage more frequently with symposiums and physically network with the community. • Rukiyah P. asked Jasmine O. how the current CHIP ensures that feedback from home-schooled families, non-English speakers, and rural communities are being incorporated effectively into the plan. Jasmine O. responded that the committee goes door to door to speak to communities. They also partner with others in the community to provide additional services and make resources publicly available. Partnerships allow them to reach communities they never have before. • Rukiyah P. asked Jasmine O. to share how the community's direct quotes and narratives from the CHA were used to shape the five priority areas and what specific metrics are being used to measure progress in the "Equitable Access to Services and Resources" priority area. Jasmine O. replied that survey responses received highlight the following issues: how to access care, materials not being in their	• Informational only. • Informational only. • Informational only.	N/A N/A N/A

	language, and feeling unseen. Jasmine O. added that all reports and data are visible online and that she will filter the data and share at the next CAC meeting. Jennifer W. added that she struggles with getting folks that don't have kids at Lamont Elementary to get the medical services they need. • Rukiyah P. asked Jasmine O. if there has been collaboration with community organizations like NAMI or ShePower to deliver targeted solutions for basic needs, behavioral health, and access issues. Jasmine O. responded that she has taken a personal approach to asking others if they need help and what others would like to see happen in their communities. She has sent personal emails to organizations such as NAMI and ShePower and asked if they can provide focus groups. • Rukiyah P. asked Jamine O. what structures are in place to regularly check in with the community during the 3-year CHIP timeline to adjust based on evolving needs, if there are any plans to expand the monthly education for providers to include lived-in experience panels or peer-led discussions, and what progress has been made toward expanding mobile clinics and supporting maternal care/doula access, as identified by the CHIP. Jasmine O. responded that each committee has sub committees that cover different areas and that they have prioritized training. She added that the	• Informational only. • Informational only.	N/A N/A

KERN HEALTH SYSTEMS

	Maternal Care Committee has fully launched, and that she wrote a grant for doula healthcare providers for $30k. 9) Cultural & Linguistic Activities Overview • Cynthia C. presented the Cultural & Linguistics department's services and activities which included satisfaction surveys and training resources. • Jennifer W. shared that she was speaking to a child at Lamont Elementary and the child mentioned having to interpret for his mom at the doctor. Jennifer W. asked Cynthia C. if KHS can improve the process so that children are no longer required to interpret this type of information. Cynthia C. responded that members preferred language is documented when their medical appointments are made. • Beatriz B. thanked KHS for doing a great job in hiring bilingual staff. She doesn't have to request a Spanish speaking employee because she already knows they will be bilingual. Beatriz B. added that when providers call to cancel an appointment with a patient, they are not offered language assistance. In the last month, she has received two last minute cancellations and has not been offered assistance. Cancellations are difficult for members because they take off work to attend which can affect the household. Amy S. replied	• Informational only. • Informational only. • Informational only.	N/A N/A N/A

	by saying those are the grievances Member Services wants to see to track and trend provider education. Corrective action is taken if continued. Amy S. added that she will get the provider information from Beatriz B. to internally come up with a plan to correct them.		
Next Meeting	The next meeting will be held Tuesday, June 24, 2025, at 11:00am.	N/A	N/A
Adjournment	The Committee adjourned at 12:09pm. ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	Tamme T. first, Lourdes B. second. All aye's. Motion carried.	N/A

CA-25 L

SUMMARY

GOVERNANCE AND COMPLIANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Thursday, March 27, 2025

8:30 A.M.

COMMITTEE RECONVENED

Members: Acharya, Hoffmann, Meave, Turnipseed
ROLL CALL: All Present

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 COMMITTEE 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 CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

ADJOURNED TO CLOSED SESSIOIN

CLOSED SESSION

1) Request for Closed Session regarding Audits and Investigation Update (Health and Safety Code Section 32106 & Welfare and Institutions Code Section 14087.38) – SEE RESULTS BELOW

8:45 A.M.

COMMITTEE RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 1 concerning Request for Closed Session regarding Audits and Investigation Update (Health and Safety Code Section 32106 & Welfare and Institutions Code Section 14087.38) – HEARD; NO REPORTABLE ACTION TAKEN

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

COMMITTEE MATTERS

4) Report on Kern Health Systems Enterprise Risk Management Project Update –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS

5) Report on Kern Health Systems Proposed Draft Ticket Distribution Policy –
RECEIVEDD AND FILE; REFERRED TO KHS BOARD OF DIRECTORS

6) Report on Kern Health Systems Artificial Intelligence Tool Readily (PandanAI)
(Fiscal Impact: Not to Exceed $100,000; Budgeted) -
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS

7) Report on Kern Health Systems Update Managed Care Accountability Set (MCAS)
(Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS

ADJOURN TO THURSDAY, MAY 29, 2025 AT 8:30 A.M.