KERN HEALTH SYSTEMS

REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, April 13, 2023
at
8:00 A.M.

At
Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, CA 93308

The public is invited.

For more information - please call (661) 664-5000.

AGENDA

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, April 13, 2023

8:00 A.M.

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

PLEASE SILENT CELL PHONES AND OTHER ELECTRONIC DEVICES DURING THE MEETING

BOARD TO RECONVENE

Directors: Watson, Thygerson, Patel, Martinez, Abernathy, Bowers, Garcia, Hoffmann, McGlew, Meave, Nilon, Patrick, Singh, 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 regarding contracts and contract negotiations by Kern Health Systems with providers (Government Code Section 54956.87) -

8:15 A.M.

BOARD TO RECONVENE

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

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

CA-6) Minutes for Kern Health Systems Board of Directors regular meeting on February 16, 2023 (Fiscal Impact: None) –
APPROVE

7) Kern County Board of Supervisors appointment of Jay Tamsi, 3rd District Community Representative, for term expiring June 30, 2023 and reappointment of John Nilon, 2nd District Community Representative, for term expiring April 21, 2026 (Fiscal Impact: None) –
RECEIVE AND FILE

8) Report by Daniells Phillips Vaughan & Bock on the audited financial statements of Kern Health Systems for the year ending December 31, 2022 (Fiscal Impact: None) –
APPROVE

9) Report on Kern Health Systems Corporate Compliance Plan (Fiscal Impact: None) –
RECEIVE AND FILE

10) Report on Kern Health Systems 2022 Employee Satisfaction Survey (Fiscal Impact: None) –
RECEIVE AND FILE

11) Report on Kern Health Systems 2022 Provider Satisfaction Survey (Fiscal Impact: None) –
RECEIVE AND FILE

12) Report on Kern Health Systems 2022 Member Satisfaction Survey (Fiscal Impact: None) –
RECEIVE AND FILE

CA-13) Report on Kern Health Systems Strategic Plan for 1st Quarter (Fiscal Impact: None) –
RECEIVE AND FILE

14) Proposed 2023 Budget changes relating to MCO Tax, Hospital Directed Payments and Proposition 56 Value Based Supplemental Payment Program (Fiscal Impact to Net Position: None) –
APPROVE

15) Report on Kern Health Systems Financial Statements for December 2022 and January 2023 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-16) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for December 2022 and January 2023 and IT Technology Consulting Resources for the period ended December 31, 2022 (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) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) –
RECEIVE AND FILE

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

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

CA-21) Proposed revisions to Policy 4.01-P, Credentialing Program (Fiscal Impact: None) –
APPROVE

CA-22) Proposed New Policy, HIV/AIDS Specialist Identification (Fiscal Impact: None) –
APPROVE

CA-23) Proposed New Policy, Ongoing Monitoring & Sanction Activity Review (Fiscal Impact: None) –
APPROVE

CA-24) Miscellaneous Documents –
RECEIVE AND FILE

A) Minutes for Kern Health Systems Finance Committee meeting on February 10, 2023
B) Minutes for Kern Health Systems Physician Advisory Committee meeting on February 1, 2023
C) Minutes for Kern Health Systems Physician Advisory Committee meeting on March 1, 2023

ADJOURN TO JUNE 15, 2023 AT 8:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY
Revised

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, December 15, 2022

8:00 A.M.

BOARD RECONVENED

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

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

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

BOARD ACTION SHOWN IN CAPS

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

ADJOURNED TO CLOSED SESSION
Patrick

CLOSED SESSION

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

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

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

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

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

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING NOVEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON AHMAD, CLARKE, DAQUIOAG, ELROD, PETERSEN, YALAMANCHILI; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON FERNANDEZ, HER, OUMA, TRAN, VUE; DIRECTOR MEAVE ABSTAINED FROM VOTING ON FERNANDEZ, HER, OUMA, TRAN, VUE
Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING DECEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON DORSCH, GARG, GUARNEROS, IGNACIO, MADZIARSKI, PASCUAL, SAMRA; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON BAKERSFIELD RECOVERY STATION, MING & H DRUGS, GILL, JOHNSON, MADZIARSKI, ONYIA, VIAMONTES; DIRECTOR MCGLEW ABSTAINED FROM VOTING ON KERN VALLEY HEALTHCARE DISTRICT D/P SNF; DIRECTOR MEAVE ABSTAINED FROM VOTING ON GILL, JOHNSON, ONYIA, VIAMONTES
Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING NOVEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON BEKAREV, BHANDOHAL, HUNTER, LEE, PALISPIS, RAMZAN, RIVERA; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON KOMOTO MEDICAL PHARMACY, PANSAWIRA, SANTOS; DIRECTOR MCGLEW ABSTAINED FROM VOTING ON FELIZARTA, MONGAR, PANSAWIRA, SANTOS, SPOHN-GROSS; DIRECTOR MEAVE ABSTAINED FROM VOTING ON DIXON
Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING DECEMBER 2022** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON LOPEZ, MACK, YANG; DIRECTOR BOWERS ABSTAINED FROM VOTING ON DUGGAL; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON AYALA-RODRIGUEZ, CHASE, MARTINEZ DUENAS, MCDERMOTT, ORNELAZ; DIRECTOR MCGLEW ABSTAINED FROM VOTING ON GUTZMAN; DIRECTOR MEAVE ABSTAINED FROM VOTING ON FONG BALART, AYALA-RODRIGUEZ, CHASE, MARTINEZ DUENAS, MCDERMOTT, ORNELAZ

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

DIRECTOR NILON REPORTED ON THE KHS COMPENSATION COMMITTEE MEETING HELD ON NOVEMBER 15TH AND INFORMED THE BOARD OF THE INFLATION STIPEND PAYMENT THAT WAS APPROVED TO BE DISBURSED TO KHS FULL TIME AND PART TIME EMPLOYEES. DIRECTOR NILON ALSO NOTED THAT THE KHS CEO DECLINED CONSIDERATION TO RECEIVE A STIPEND AND DID NOT RECEIVE AN INFLATION STIPEND PAYMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADJOURN TO FEBRUARY 16, 2023
Patel

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

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, February 16, 2023

8:00 A.M.

BOARD RECONVENED

Directors: Watson, Thygerson, Patel, Martinez, Abernathy, Bowers, Garcia, Hoffmann, McGlew, Meave, Nilon, Patrick, Singh, Turnipseed
ROLL CALL: 11 Present; 3 Absent – Patel, McGlew, Turnipseed

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

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

BOARD ACTION SHOWN IN CAPS

1) Board Resolution to Allow Virtual Board Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) - APPROVED
Patrick-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

ADJOURNED TO CLOSED SESSION
Patrick

CLOSED SESSION

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

8:15 A.M.

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING FEBRUARY 2023** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON MADHAVAN, VERDE; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON FALLS, IBAZEBO, KOGOUT, LUNDQUIST, VANLERBERG; DIRECTOR MEAVE ABSTAINED FROM VOTING ON FALLS, GEARHART, IBAZEBO, KOGOUT, LUNDQUIST, VANLERBERG
Item No. 2 concerning a Request for Closed Session regarding peer review PROVIDERS RECOMMENDED FOR **RECREDENTIALING FEBRUARY 2023** of a provider (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON BEKAREV, COBOS, KURAN, OJI, RUSSIN, SUTTER, ZUVERZA-CHAVARRIA; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON BARNES, ARREAZA, BELL, FARRER, NORTH CHESTER PHARMACY, PRIETO; DIRECTOR MEAVE ABSTAINED FROM VOTING ON ARREAZA, BELL, COBOS, PRIETO

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

DIRECTOR PATRICK REPORTED ON THE RECENT NEWSPAPER ARTICLE ON KHS CEO, EMILY DURAN AND ALSO REPORTED THAT EMILY WILL BE INDUCTED INTO THE CSUB ALUMNI HALL OF FAME

DIRECTOR THYGERSON REPORTED ON ATTENDING THE RIBBON-CUTTING CEREMONY LAST WEEK WITH EMILY DURAN AT THE BRUNDAGE LANE NAVIGATION CENTER AND THANKED KHS FOR FUNDING THE PROGRAM

DIRECTOR GARCIA THANKED KHS AND THE STAFF FOR SUPPORTING AND DONATING FUNDS TO OUR COMMUNITY

DIRECTOR NILON REQUESTED TO REMOVE ITEM 5 FROM THE CONSENT CALENDAR AND REPORTED ON THE REVISIONS TO BE MADE TO THE DECEMBER 15TH BOARD MINUTES

5) Minutes for Kern Health Systems Board of Directors regular meeting on December 15, 2022 (Fiscal Impact: None) – APPROVED
Nilon-Garcia: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

6) Appreciation recognition of Wayne Deats for 11 + years of dedicated service as a member of the Kern Health Systems Board of Directors (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Patrick: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

7) Appreciation recognition of Jeff Flores for his tenure of dedicated service as a member of the Kern Health Systems Board of Directors (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Garcia: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-8) Report on Kern Health Systems 2023 Utilization Management Program Work Plan and the Quality Improvement 2023 Work Plan (Fiscal Impact: None) – APPROVED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

9) Report on Kern Health Systems Managed Care Accountability Set (MCAS) Action Plan (Fiscal Impact: None) – APPROVED
Nilon-Meave: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

10) Review of Kern Health Systems Cyber Insurance Policy (Fiscal Impact: None) – CHRIS TOBIN, ALLIANT INSURANCE SERVICES, HEARD; RECEIVED AND FILED
Bowers-Garcia: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed,

CA-11) Report on Kern Health Systems 2022 Corporate Goals and Objectives Final Report (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-12) Proposed revisions to Policy 4.01-P, Credentialing (Fiscal Impact: None) – APPROVED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-13) Proposed revisions to Policy 4.47-P, Clinical Laboratory Improvements Amendments (Fiscal Impact: None) – APPROVED
Nilon-Bowers: 121Ayes; 3 Absent – Patel, McGlew, Turnipseed

14) Report on Kern Health Systems 2023-2025 Strategic Plan (Fiscal Impact: None) – RECEIVED AND FILED
Thygerson-Hoffmann: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-15) Report on Kern Health Systems 2023 Marketing and Community Outreach Campaign Plan (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-16) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2022 (Fiscal Impact: None) – RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-17) Report on 2022 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-18) Request to change the previously approved 2023 reinsurance carrier from HM Life Insurance back to the current 2022 carrier IOA Re (2023 Fiscal Impact: $1,122,917; $914,969 Budgeted; $207,948 Not Budgeted) –
APPROVED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-19) Report on 2022 Annual Travel Report (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-20) Report on 2022 Annual Report of Disposed Assets (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-21) Review of 2022 Budgeted Capital Projects scheduled to be completed in 2023 (Fiscal Impact: None) –
APPROVED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

22) Report on Kern Health Systems financial statements for November 2022 (Fiscal Impact: None) –
RECEIVED AND FILED
Patrick-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-23) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2022 and IT Technology Consulting Resources for the period ended November 30, 2022 (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-24) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) –
APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-25) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

CA-26) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) –
RECEIVED AND FILED
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

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

CA-28) Miscellaneous Documents –
RECEIVE AND FILE
Nilon-Bowers: 11 Ayes; 3 Absent – Patel, McGlew, Turnipseed

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

ADJOURN TO APRIL 13, 2023
Garcia

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

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Kristen Beall Watson, Chairman

Date: April 13, 2023

Re: Kern Health Systems Board of Directors Appointments

Background

On February 7, 2023, the Kern County Board of Supervisors appointed Jay Tamsi as Third District Community Representative to the Kern Health Systems Board of Directors. Mr. Tamsi replaces Jeff Flores following Supervisor Flores taking office in January as Kern County's newest elected member of the Board of Supervisors.

Also, on March 14, 2023, the Kern County Board of Supervisors reappointed John Nilon as Second District Community Representative to the Kern Health Systems Board of Directors.

The Board of Directors of Kern Health Systems welcomes our newest member, Mr. Tamsi and congratulates John Nilon on his reappointment.

The appointment letters and a complete roster of the Kern Health Systems Board are attached.

Requested Action

Receive and File.

BOARD OF SUPERVISORS
COUNTY OF KERN

KATHLEEN KRAUSE
CLERK OF THE BOARD OF SUPERVISORS
Kern County Administrative Center
1115 Truxtun Avenue, 5th Floor
Bakersfield, CA 93301
Telephone (661) 868-3585
TTY (800) 735-2929
www.kerncounty.com

February 7, 2023

Mr. Jay Tamsi

Dear Mr. Tamsi:

Congratulations on your appointment to the Kern Health Systems Board of Directors.

Enclosed please find the Oath of Office for your appointment as Third District Community Representative Member to the Kern Health Systems Board of Directors, term to expire June 30, 2023. You may take the Oath of Office in the office of the Clerk of the Board located in the Kern County Administrative Center, 1115 Truxtun Avenue, Fifth Floor, Bakersfield, or you may take it before a Notary Public in your vicinity. If the Oath is taken before a Notary Public, please ask the Notary to attach a Jurat. **The Oath must be administered and received by the Clerk of the Board before you can participate on the Kern Health Systems Board of Directors.**

For your convenience, a Form 700, Statement of Economic Interests, is enclosed. Please complete, sign and return the Form 700 to **Kern Health Systems no later than thirty (30) days from your date of appointment** to the Kern Health Systems Board of Directors.

Pursuant to State law, you are required to complete a course in ethics training approved by the Fair Political Practices Commission and Attorney General. You must receive the required training within one year of your appointment and every two years thereafter. Your Agency's Manager will provide information regarding training opportunities.

On behalf of the Kern County Board of Supervisors, I would like to extend our sincere appreciation for your commitment to serve on the Kern Health Systems Board of Directors. If my office can ever be of assistance to you, please call on us.

Sincerely,

Kathleen Krause

KATHLEEN KRAUSE
Clerk of the Board

KK
enclosures
cc: Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, CA 93308

BOARD OF SUPERVISORS
COUNTY OF KERN

SUPERVISORS

PHILLIP PETERS	District 1
ZACK SCRIVNER	District 2
JEFF FLORES	District 3
DAVID COUCH	District 4
LETICIA PEREZ	District 5

KATHLEEN KRAUSE
CLERK OF THE BOARD OF SUPERVISORS
Kern County Administrative Center
1115 Truxtun Avenue, 5th Floor
Bakersfield, CA 93301
Telephone (661) 868-3585
TTY (800) 735-2929
www.kerncounty.com

March 14, 2023

Mr. John Nilon

Dear Mr. Nilon:

Congratulations on your re-appointment to the Kern Health Systems Board of Directors.

Enclosed is the Official Appointment covering your re-appointment as Second District Community Representative Member to the Kern Health Systems Board of Directors, for the term expiring April 21, 2026.

Pursuant to State law, you are required to complete a course in ethics training approved by the Fair Political Practices Commission and Attorney General. You must receive the required training within one year of your appointment and every two years thereafter. Your Agency's Manager will provide information regarding training opportunities.

On behalf of the Kern County Board of Supervisors, I would like to extend our sincere appreciation for your commitment to serve on the Kern Health Systems Board of Directors. If my office can ever be of assistance to you, please call on us.

Sincerely,

Kathleen Krause

KATHLEEN KRAUSE
Clerk of the Board

cc: Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, CA 93308

BOARD OF SUPERVISORS
COUNTY OF KERN

SUPERVISORS

PHILLIP PETERS	District 1
ZACK SCRIVNER	District 2
JEFF FLORES	District 3
DAVID COUCH	District 4
LETICIA PEREZ	District 5

KATHLEEN KRAUSE
CLERK OF THE BOARD OF SUPERVISORS
Kern County Administrative Center
1115 Truxtun Avenue, 5th Floor
Bakersfield, CA 93301
Telephone (661) 868-3585
TTY (800) 735-2929
www.kerncounty.com

OFFICIAL APPOINTMENT
BOARD OF SUPERVISORS

STATE OF CALIFORNIA)
) ss.
County of Kern)

I, KATHLEEN KRAUSE, Clerk of the Board of Supervisors, County of Kern, State of California, do hereby certify that at a regular session of said Board held in and for said County of Kern, on March 14, 2023, John Nilon was duly appointed as Second District Community Representative Member to the Kern Health Systems Board of Directors for the term expiring April 21, 2026, in and for Kern County, State of California, as appears by the Official Records of said Board in my office.

IN WITNESS WHEREOF, I have hereunto affixed my hand and Seal of the Board of Supervisors of the County of Kern, State of California on March 14, 2023.

Kathleen Krause

KATHLEEN KRAUSE
Clerk of the Board of Supervisors

KERN HEALTH SYSTEMS

BOARD OF DIRECTORS

Kristen Beall Watson, Ed.D., ***Chairman***
Chief of Staff to the President,
California State University Bakersfield
3rd District Community Representative

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

1st District Community Representatives
1) Elsa Martinez, ***Treasurer***
Chief Financial Officer, County of Kern
2) Michael Bowers, Vice President of Public Affairs and Government Relations, Centric Healthcare

Traditional Medi-Cal Primary Care Representative (Metro Bakersfield)
Sarabjett Singh, M.D.
Centric Healthcare, Central Cardiology Medical Clinic

2nd District Community Representatives
1) John Nilon, Retired
2) Cathy Abernathy, Cathy Abernathy Consultants

Safety Net Care Provider Representative
Olga Meave, M.D.
Chief Executive Officer
Clinica Sierra Vista

3rd District Community Representatives
1) Kristen Beall Watson, Ed.D.
Chief of Staff to the President
California State University, Bakersfield
2) Jay Tamsi, President/CEO
Kern County Hispanic Chamber of Commerce

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

4th District Community Representatives
1) Barbara Patrick, Retired
2) Vacant

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

5th District Community Representatives
1) Alex Garcia, Councilmember, City of Wasco
2) Michael Turnipseed, Executive Director
Kern County Taxpayers Association

Kern Medical Representative
Scott Thygerson, ***Vice Chairman***
Chief Executive Officer
Kern Medical

Rev. 2.22.2023
By: S.Woods

KERN HEALTH SYSTEMS

To: **KHS Board of Directors**

From: **Robert Landis, CFO**

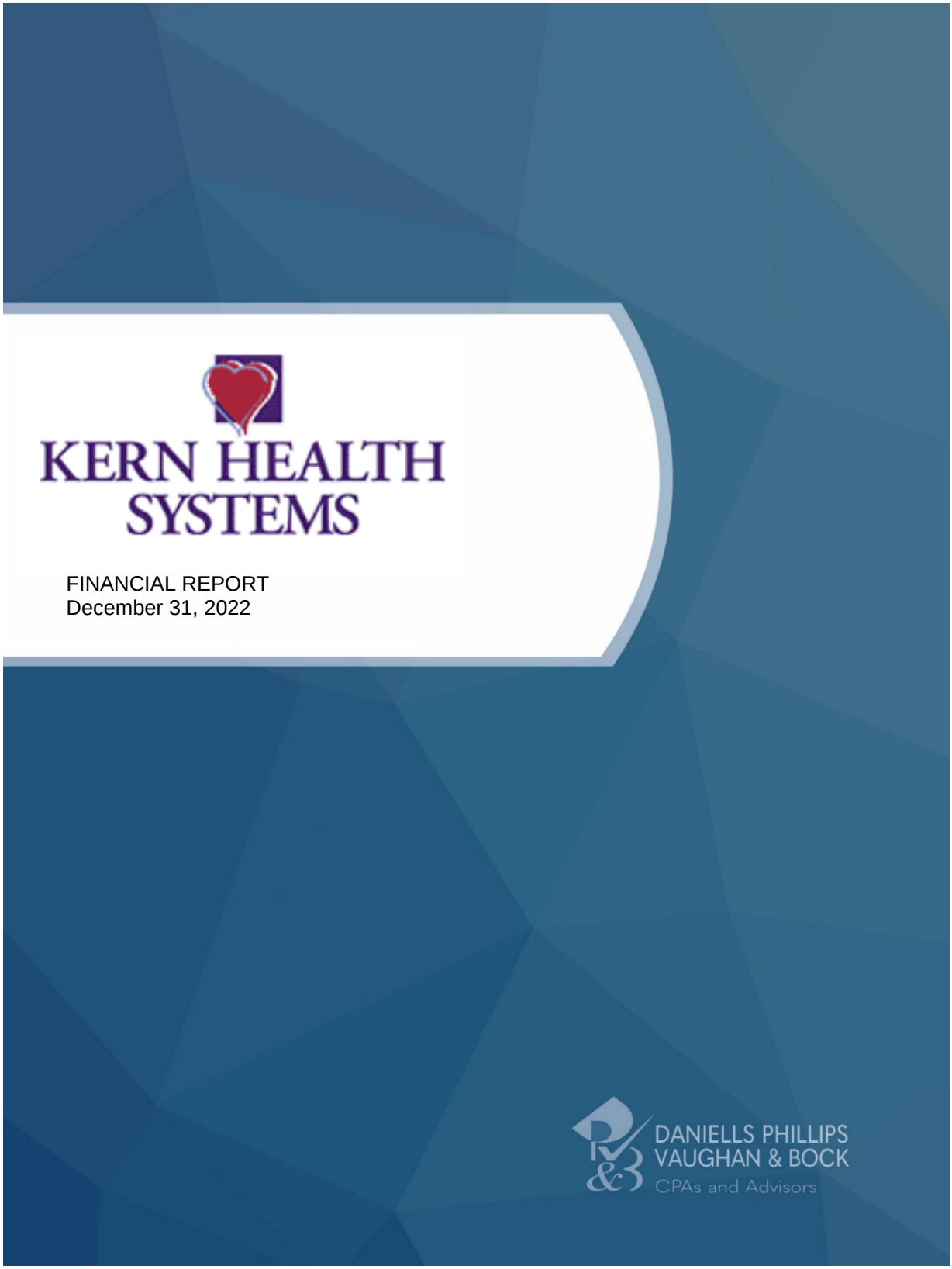
Date: **April 13, 2023**

Re: **Report by Daniells Phillips Vaughan & Bock Regarding the 2022 Audit**

Attached for your review are the December 31, 2022 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 Daniells Phillips Vaughan & Bock will be providing a report on the 2022 audit.

Requested Action

Approve.


KERN HEALTH SYSTEMS
FINANCIAL REPORT
December 31, 2022
DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

CONTENTS

DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

An independently owned member RSM US Alliance

Member of AICPA Division for Firms
Private Companies Practice Section

NANCY C. BELTON

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
Kern Health Systems
Bakersfield, California

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of **Kern Heath Systems**, as of and for the years ended December 31, 2022 and 2021, and the related notes to the financial statements, which collectively comprise **Kern Health System**'s basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of **Kern Health Systems**, as of December 31, 2022 and 2021, and the respective changes in financial position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* (*Government Auditing Standards*), issued by the Comptroller General of the United States. 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.

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**' ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

300 New Stine Road – Bakersfield, CA 93309 – Tel. 661.834.7411 – Fax.661.834.4389 – www. dpvb.com

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 and *Government Auditing Standards* 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 and *Government Auditing Standards*, 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.
- 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'** 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 management's discussion and analysis, schedules of proportionate share of the net pension (asset) liability and schedules of pension contributions on pages 4-13 and 43-46 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental 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 auditing standards generally accepted in the United States of America, 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 March 29, 2023 on our consideration of **Kern Health Systems**' 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**' 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**' internal control over financial reporting and compliance.

Daniells Phillips Vaughan & Bock

Bakersfield, California
March 29, 2023

KERN HEALTH SYSTEMS

Management's Discussion and 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, 2022 and 2021. 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 14.

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 2022 and 2021, 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 is one additional Medi-Cal health plan 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 two 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 2022 and 2021, KHS paid approximately 86% and 92%, respectively, of its revenue to providers.

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
- 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.

Financial Highlights:

- Our net position increased in 2022 by $71,279,986 or approximately 28.8% while in 2021 our net position increased by $20,390,142 or 9.0%.

- Our Medi-Cal enrollment growth showed an average monthly increase of approximately 32,100 members or 11.1% in 2022 compared to 2021. This compared to an average monthly increase of approximately 26,700 members or 10.2% in 2021 compared to 2020. The increase in average monthly membership was due largely to the State not performing Medi-Cal redeterminations as a result of the COVID-19 Public Health Emergency (PHE) and increased eligibility as a result of the ongoing PHE.

- We have a capitated arrangement required by the California Department of Health Care Services (DHCS) with another health plan which allows for that plan to provide health care services for assigned members. Assigned membership to this other health plan was 14,635 members at the end of 2022 compared to 12,692 members at the end of 2021. The premium revenue earned for this population was $33.5 million and $32.3 million for the years ended December 31, 2022 and 2021, respectively. As we have no obligation to provide care for this population, the Premiums earned amount reported for the years ended December 31, 2022 and 2021 is net of the $33.2 million and $32.2 million, respectively, of associated capitated expense and the member months shown have been adjusted to remove capitated member months.

- We reported an operating income of $74,571,133 or $19.35 PMPM in 2022 and operating income of $28,457,987 or $8.20 PMPM in 2021. The increase in operating income in 2022 is primarily due to increased membership in 2022 resulting from the paused Medi-Cal redetermination process. In addition, there was a decrease in Inpatient Hospital utilization on a per member per month basis in 2022 from 2021 attributed to reductions in admissions due to COVID-19 and the focus of KHS' medical management team to reduce hospital admissions and readmissions through the performance of case management.

- Managed Care Organization (MCO) Tax Revenues of $124,665,083 or $32.36 PMPM are included in premiums earned in 2022 and $119,594,632 or $34.48 PMPM in 2021. Beginning July 1, 2016, under Senate Bill X2-2, the MCO tax methodology changed from a 3.9375% of premium revenue to a fixed PMPM rate. The rate was $33.50 PMPM for the period January 1, 2022 to December 31, 2022 and $33.08 PMPM for the period January 1, 2021 to December 31, 2021. The tax amounts are based on projected membership and MCO expense is payable quarterly. MCO Tax Expense is reported as an operating expense and was $124,658,814 or $32.35 PMPM in 2022 and $112,821,118 or $32.53 PMPM in 2021.

- The net increase in nonoperating income of $4,776,698 between 2022 and 2021 is primarily attributable to a decrease in Community grant expense in 2022 compared to 2021. In 2021, KHS had increased the amounts of Community grants awarded to assist providers with the implementation of the requirements under the CalAIM initiative which began January 2022. Additionally, the increase in nonoperating income was the result of additional investment and other income earnings due to higher investment balances along with higher interest rates experienced by our investment portfolio in 2022 compared to 2021. We reported Community grant expense of $4,759,612 or $1.23 PMPM in 2022 compared to $7,895,437 or $2.28 PMPM in 2021. We reported investment and other income of $1,468,465 in 2022 or $0.38 PMPM and investment and other income (expense) of ($172,408) or ($0.05) PMPM in 2021.

- We continued with provider quality incentive programs and reported expenses of approximately $5.8 million in 2022 to reward providers who demonstrate improved Managed Care Accountability Set (MCAS) outcomes.

Operational Highlights:

Kern Health Systems experienced a transitional year with a change in leadership, increase in membership, and expanded areas of responsibility. While fulfilling our organizational mission and maintaining efficient operations, the following projects and activities were implemented in 2022:

- Members of our Board of Directors selected a new Chief Executive Officer and a successful transition of leadership occurred in July 2022.

- Telehealth services were expanded according to the DHCS guidance on telehealth flexibility for services rendered to KHS members for all covered benefits including behavioral health, home health, physical therapy, and autism therapy. KHS allowed both synchronous, interactive audio and telecommunications systems and asynchronous store and forward telecommunications systems, thereby allowing both virtual and telephonic communication. DHCS is now considering telehealth as a permanent benefit to provide an additional mode of service delivery to increase access and timeliness.

- As a part of the State's overarching home and community-based services (HCBS) spending plan, DHCS launched the Housing and Homelessness Incentive Program (HHIP). HHIP aims to prevent and reduce homelessness and housing instability and insecurity by addressing social determinants of health while improving health outcomes and accessibility to whole-person care for those who are a part of the Medi-Cal population and simultaneously experiencing or at risk of being homeless. KHS continues to work with contracted entities comprised of 13 network providers and community-based organizations to support 19 housing and homelessness service delivery projects. These projects range from Street Medicine, Mental and Behavioral Health Support Services, Prevention & Diversion, Non-Congregate Shelters & Expanding Emergency Shelters for Youth, Adults, and Families, and Permanent Housing for Youth, Adults, and Families. These projects demonstrated a commitment to address inequities and disparities in homeless populations and achieve equitable provision of wrap-around services for those who are disproportionately impacted by homelessness, are at-risk of homelessness, experiencing housing instability, and/or recidivated to homelessness.

- We implemented six (6) Community Supports Services, (CSS), Housing Transition Navigation, Housing Deposits, Housing Tenancy and Sustaining Services, Recuperative Care (Medical Respite), Asthma Remediation, and Short-Term Post Hospitalization Housing. Participated with a community-based organization network to coordinate resources to address social determinants of health.

- We expanded the Transitional Care Program focus to reduce preventable hospital readmissions, coordinate care, and address any unidentified needs during the post-acute discharge planning. Additionally, completed placement of a physician led team in local hospital to evaluate members and provide alternatives to admission as an Emergency Room Diversion program for the prevention of unnecessary admissions.

- We created a Population Health Management (PHM) program that addresses individuals' health needs across the continuum of care using tailored health solutions focusing on specific conditions such as Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Palliative Care, and Medication Therapy Management.

- We initiated a new School Wellness Grant Program cycle with seven (7) schools awarded within five (5) school districts. The goal of this program builds upon KHS' efforts to engage students, families and community partners in activities that promote and support the physical, social, emotional, and behavioral health and wellbeing of students and their families.

- We continued to implement virtual health education classes on Diabetes Prevention, Asthma Management, Nutrition Education and Tobacco Cessation Programs focused on lifestyle changes.

- We implemented Community Health Worker services under the KHS benefit coverage to administer preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health through screening and assessments, health navigation, and support and advocacy delivered to the member's home or other clinical setting.

- Planning was initiated to implement Doula services as a new preventative service under KHS benefit coverage on January 1, 2023. Doula services include personal support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience. This includes emotional and physical support, provided during pregnancy, labor, birth, and the postpartum period.

- Planning was initiated to implement Dyadic Services as a new preventative service under KHS benefit coverage on January 1, 2023. Dyadic services are a family-and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified, and that fosters access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health.

- We continued the Asthma Mitigation Project in partnership with the Central California Asthma Collaborative. Program is targeted at helping members with poorly controlled asthma better manage their disease to prevent emergency room visits and hospitalizations.

- We continued to offer the Baby Steps Program to educate pregnant and postpartum members on the importance of accessing timely and routine care. Monthly outreach calls and health guides are conducted which includes information on pregnancy milestones, resources. Considerations for the expansion of this program includes high-risk pregnancy management and education.

- We successfully developed and implemented COVID Vaccine Incentive Programs (both member and provider) that increased member awareness and promoted vaccinations with the goal of increasing the vaccination rates for our members.

- We implemented strategies to increase utilization of preventative care to achieve the revised targeted goals for the Managed Care Accountability Set (MCAS) measures. Such strategies include ongoing member and provider education, member outreach and use of provider and member incentives to encourage utilization of qualified preventative services under the Program.

- We transitioned all Major Organ Transplant financial and care coordination under KHS benefit structure with shared responsibilities between the Health Services departments (Utilization Management and Population Health).

- We restructured the Population Health Management department to include team focused approached to managing and coordinating services for Long Term Care, Complex and Basic Care Management, through a data driven risk stratification, predictive analytics, and standardized assessment process.

- We started readiness assessment of KHS' preparedness for both Health Plan and Health Equity accreditation through the National Committee for Quality Assurance (NCQA).

- We received NCQA certification of KHS' Health Effectiveness Data and Information Set (HEDIS) Compliance Audit.

- KHS convened with several stakeholders in Kern County, including local education and behavioral health agencies, to collectively identify specific school districts, student populations, and interventions to build infrastructure and support behavioral services on or near campuses. A county-wide Behavioral Health Needs Assessment and Project plan was submitted to DHCS for approval to secure $13.2 million over three years available under the Student Behavioral Health Incentive Program (SBHIP).

- We created training for Discrimination Review Committee to increase cultural sensitivity and awareness for participants.

- We processed an additional 400,000 claims in 2022 compared to 2021 volume without having a significant impact on staffing due to increased system efficiency.

- We successfully transitioned Mandatory Managed Care Enrollment members from Medi-Cal Fee-for-Service into KHS along with expanding our service area to Ridgecrest.

- We transitioned funding for Housing Case Management under the ECM-CSS program to afford KHS members an opportunity to exit homelessness and receive safe and affordable housing services. KHS has contracted with the Housing Authority of the County of Kern to be a Community Supports Provider for Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services.

- The enhanced Care Management (ECM) program went effective January 1, 2022 with nine HHP programs that transitioned to the ECM and the Kern Medical Whole Person Care Program that was transition to KHS as a new ECM program. We also transitioned the two distributive model ECM programs in which the KHS ECM staff was conducting the care coordination service.

- We implemented Phase 1 of the CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of Enhanced Care Management (ECM) and Community Support Services (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 promote health equity; achieve improvements in quality performance; and encourage take-up of Community Support Services. KHS approved $14.2 million dollars in incentive funds to expand our ECM and CSS programs.

- We administered several Alternative Payment Methodologies ("APM") within provider contracts that focus on quality care coordination and cost reduction strategies. KHS has realized reductions in utilization expenses along with reductions in readmissions.

- We migrated e-mail and other communications tools to the Microsoft Cloud to increase availability and reduce data center footprint.

- We purchased and started using Data Lineage tools to map all data sources for reporting and analytics transparency.

- We started the Member Engagement strategy and discovery session with Microsoft to build a roadmap for KHS to maximize member engagement opportunities more real-time.

- We continue to retire BizTalk (legacy EDI system) and migrate previously developed data transformations to the Edifecs platform.

- We processed and submitted 3,403,951 encounters to DHCS with a 99.98% acceptance rate with a value of $709,097,728.

- We donated over $224,000 in sponsorships to 88 different non-profits, community-based organizations, or community events. Since these community partners serve many of the same constituents, many of our members will receive assistance from our sponsorships.

- We awarded over $400,000 in grants to support seven public schools and 72 community organizations to implement both school-based and community-based programs throughout Kern County.

- We optimized the Kern County Workforce Innovation and Opportunity Act (WIOA) OJT Program completing the year as the top employer in the program for the third year in a row, completing 58 OJT contracts that resulted in $337,570 of returned wages to KHS in grant funds from the State of California.

- We successfully completed the KHS employee return to work project, post the height of the COVID pandemic.

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 increased in 2022 and 2021 by $71,279,986 and $20,390,142, respectively. Our Statements of Net Position as of December 31, 2022, 2021, and 2020 are as follows:

	2022	2021	2020
Assets			
Cash and cash equivalents	$ 99,137,387	$ 90,414,348	$ 74,866,934
Investments	317,979,108	195,789,809	169,078,187
Premiums receivable	102,277,912	113,480,033	97,593,440
Hospital directed payments receivable	436,815,601	318,427,442	195,667,272
Other current assets	6,253,364	10,266,007	5,169,830
Capital assets, net	64,448,762	65,520,345	68,655,076
Other assets	2,152,854	2,646,723	5,527,956
Total Assets	$1,029,064,988	$ 796,544,707	$ 616,558,695
Deferred Outflows of Resources	$ 8,154,860	$ 3,665,821	$ 3,018,341
Liabilities			
Accrued medical expenses payable	$ 227,819,775	$ 187,168,103	$ 153,291,888
Hospital directed payments payable	436,633,259	318,427,442	195,667,272
Accrued expenses	43,561,728	41,800,341	35,012,634
Net pension liability	10,218,206	-	8,432,377
Total Liabilities	$ 718,232,968	$ 547,395,886	$ 392,404,171
Deferred Inflows of Resources	$ 230,571	$ 5,338,319	$ 86,684
Net Position			
Net investment in capital assets	$ 64,448,762	$ 65,520,345	$ 68,655,076
Restricted	300,000	300,000	300,000
Unrestricted	254,007,547	181,655,978	158,131,105
Total Net Position	$ 318,756,309	$ 247,476,323	$ 227,086,181

KHS' net position for 2022, 2021, and 2020 exceeded all regulatory requirements for Tangible Net Equity (TNE).

Statements of Revenues, Expenses and Changes in Net Position

Operating results and changes in our net position show an increase in net position of $71,279,986 and $20,390,142 for the years ended December 31, 2022 and 2021, respectively. The increases are made up of various components as outlined below:

	2022	2021	2020	2022	2021	2020
Enrollment						
Total member months				4,017,909	3,611,036	3,266,674
Less non-risk capitated member months				(165,042)	(142,638)	(118,205)
Net member months				3,852,867	3,468,398	3,148,469
Average monthly members				321,072	289,033	262,372
				Per Member Per Month in Dollars *		
Operating Revenue						
Premiums earned	$ 1,122,478,180	$ 1,086,542,811	$ 936,247,761	$ 291.34	$ 313.27	$ 297.37
Hospital directed payments earned	264,306,595	243,729,688	56,137,431	68.60	70.27	17.83
Other operating revenue	497,807	-	261,987	0.13	-	0.07
Total operating revenue	1,387,282,582	1,330,272,499	992,647,179	360.07	383.54	315.27
Operating Expenses						
Medical and hospital	856,089,001	891,828,161	770,310,287	222.21	257.13	244.66
Hospital directed payments	264,639,751	242,717,835	55,897,946	68.69	69.98	17.75
MCO premium tax	124,658,814	112,821,118	100,919,574	32.35	32.53	32.05
Administrative	60,258,858	47,239,327	46,280,714	15.64	13.62	14.70
Depreciation	7,065,025	7,208,071	5,034,208	1.83	2.08	1.60
Total operating expenses	1,312,711,449	1,301,814,512	978,442,729	340.72	375.34	310.76
Operating income	74,571,133	28,457,987	14,204,450	19.35	8.20	4.51
Nonoperating Revenue (Expenses)						
Investment and other income (expense)	1,468,465	(172,408)	2,508,382	0.38	(0.05)	0.80
Community grants	(4,759,612)	(7,895,437)	(4,319,024)	(1.23)	(2.28)	(1.37)
Total nonoperating revenue (expenses)	(3,291,147)	(8,067,845)	(1,810,642)	(0.85)	(2.33)	(0.57)
Changes in net position	71,279,986	20,390,142	12,393,808	18.50	5.87	3.94
Net position, beginning	247,476,323	227,086,181	214,692,373	64.23	65.47	68.19
Net position, ending	$ 318,756,309	$ 247,476,323	$ 227,086,181	$ 82.73	$ 71.34	$ 72.13

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

Operating Income

The first component of the overall change in net position is our operating income. This is the difference between the premiums earned and the cost of medical services. We earned operating income for the years ended December 31, 2022 and 2021 of $74,571,133 and $28,457,987, respectively.

The primary components of the operating income for 2022 are:

- Premiums earned increased $35,935,369 which is a reduction of ($21.93) PMPM in 2022 from 2021. The increase in premiums earned is attributed to an increase in membership in 2022 from 2021 and from additional funding provided in 2022 for CalAIM Initiative programs and enhanced benefits. The decrease in PMPM in 2022 from 2021 is due to the DHCS carve out of the pharmacy benefit which became effective January 1, 2022 and resulted in a reduction of capitated base rates paid by member. For 2021, KHS recognized approximately $116.5 million in Pharmacy revenue and $3.3 in Hepatitis C supplemental kick revenue.

- The Medi-Cal average monthly membership increased by approximately 32,100 members or 11.1% over 2022.

- The medical and hospital services costs reduced by ($35,739,160) and ($34.92) PMPM between 2022 and 2021. This reduction is primarily attributed to the reduction of plan paid pharmacy expenses as of January 1, 2022. Pharmacy costs were reduced by approximately ($108.8) million in 2022 from 2021. In addition, there was a decrease in Inpatient Hospital utilization on a per member per month basis in 2022 from 2021 attributed to reductions in admissions due to COVID-19 and the focus of the KHS medical management team to reduce hospital admissions and readmissions through Case Management. The decrease in Pharmacy expense and Inpatient utilization was offset by an increase of approximately $33.8 million related to new program expenses for CalAIM Initiative Programs and enhanced benefits. The Medical Loss ratio was 86% in 2022 and 92% in 2021.

- Administrative expenses increased by $13,019,531 or an increase of $2.02 PMPM over 2021 which is attributed primarily to increased expenses in salaries and benefits, including expenses related to new employees hired throughout 2021 that experienced a full year of compensation in 2022, additional expense for our current year CalPERs adjustment, and expenses for new employees hired in 2022. Approximately 41 new positions were added in 2022 to address the growing needs of the organization, administer new State funded programs, and meet regulatory requirements. Administrative expense as a percentage of total Operation Revenue (excluding MCO tax revenue and Hospital directed payments earned) was 6.03% in 2022 compared to 4.89% in 2021.

Nonoperating Revenues and Expenses

Nonoperating revenues and expenses consist primarily of investment income and community grants. In 2022, the net nonoperating expense amount was attributed to Community Grant Expense of $4,759,612 or $1.23 PMPM.

KHS' Cash Flow

Changes in KHS' cash flows are consistent with changes in operating income and nonoperating revenues and expenses and are reflective of timing differences pertaining to payment of accrued medical services and paid rates.

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. We believe that the State and Federal Governments are committed to keeping these programs in place, but they will continue to look for budgetary savings through reductions in health care costs.

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.

KERN HEALTH SYSTEMS

STATEMENTS OF NET POSITION
December 31, 2022 and 2021

	2022	2021
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current Assets		
Cash and cash equivalents (Note 2)	**$ 99,137,387**	$ 90,414,348
Investments (Notes 2 and 3)	**317,979,108**	195,789,809
Premiums receivable	**102,277,912**	113,480,033
Hospital directed payments receivable (Note 4)	**436,815,601**	318,427,442
Other receivables (Note 5)	**2,192,269**	1,313,706
Prepaid expenses	**3,217,028**	3,883,568
Current portion of provider advances (Note 6)	**844,067**	5,068,733
Total current assets	**962,463,372**	728,377,639
Capital Assets (Note 7)		
Land	**4,090,706**	4,090,706
Buildings and improvements	**36,671,140**	36,671,140
Computer hardware and software	**46,916,577**	39,165,691
Furniture and equipment	**4,395,077**	4,422,937
Capital projects in process	**2,241,699**	4,580,047
	94,315,199	88,930,521
Less accumulated depreciation	**29,866,437**	23,410,176
	64,448,762	65,520,345
Other Assets		
Restricted investments (Notes 2, 3 and 11)	**300,000**	300,000
Provider advances, less current portion (Note 6)	**263,964**	-
Split dollar life insurance (Note 8)	**1,588,890**	1,653,011
Net pension asset (Note 12)	**-**	693,712
	2,152,854	2,646,723
Total assets	**1,029,064,988**	796,544,707
Deferred Outflows of Resources (Note 12)	**8,154,860**	3,665,821
Total assets and deferred outflows of resources	**$ 1,037,219,848**	$ 800,210,528

See Notes to Financial Statements.

	2022	2021
LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION		
Current Liabilities		
Accrued medical expenses payable (Note 9)	**$ 227,819,775**	$ 187,168,103
Hospital directed payments payable (Note 4)	**436,633,259**	318,427,442
Accrued expenses (Note 10)	**43,561,728**	41,800,341
Total current liabilities	**708,014,762**	547,395,886
Noncurrent Liabilities		
Net pension liability (Note 12)	**10,218,206**	-
Commitments and Contingencies (Note 14)		
Deferred Inflows of Resources (Note 12)	**230,571**	5,338,319
Net Position		
Net investment in capital assets	**64,448,762**	65,520,345
Restricted (Note 11)	**300,000**	300,000
Unrestricted	**254,007,547**	181,655,978
Total net position	**318,756,309**	247,476,323
Total liabilities, deferred inflows of resources and net position	**$ 1,037,219,848**	$ 800,210,528

KERN HEALTH SYSTEMS

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
Years Ended December 31, 2022 and 2021

	2022	2021
Operating Revenue		
Premiums earned	**$1,122,478,180**	$1,086,542,811
Hospital directed payments earned (Note 4)	**264,306,595**	243,729,688
Stop-loss insurance recoveries (Note 13)	**497,807**	-
Total operating revenue	**1,387,282,582**	1,330,272,499
Operating Expenses		
Medical and hospital	**856,089,001**	891,828,161
Hospital directed payments (Note 4)	**264,639,751**	242,717,835
MCO premium tax	**124,658,814**	112,821,118
Administrative	**60,258,858**	47,239,327
Depreciation	**7,065,025**	7,208,071
Total operating expenses	**1,312,711,449**	1,301,814,512
Operating income	**74,571,133**	28,457,987
Nonoperating Revenue (Expenses)		
Investment and other income (expense)	**1,468,465**	(172,408)
Community grants	**(4,759,612)**	(7,895,437)
Net nonoperating (expenses)	**(3,291,147)**	(8,067,845)
Change in net position	**71,279,986**	20,390,142
Net position, beginning	**247,476,323**	227,086,181
Net position, ending	**$ 318,756,309**	$ 247,476,323

See Notes to Financial Statements.

KERN HEALTH SYSTEMS

STATEMENTS OF CASH FLOWS
Years Ended December 31, 2022 and 2021

	2022	2021
Cash Flows From Operating Activities		
Premiums received	**$1,132,156,123**	$1,071,601,137
Hospital directed payments earned	**145,918,436**	120,969,518
Stop-loss insurance recoveries	**497,807**	-
Medical and hospital payments	**(815,437,329)**	(857,951,946)
Hospital directed payments paid	**(146,433,934)**	(119,957,665)
Administrative expenses paid	**(58,360,563)**	(50,847,730)
MCO premium tax expense paid	**(121,696,867)**	(109,824,001)
Net cash provided by operating activities	**136,643,673**	53,989,313
Cash Flows From Noncapital Financing Activities		
Community grants	**(4,759,612)**	(7,895,437)
Nonoperating income	**3,355**	240,724
Net cash (used in) noncapital financing activities	**(4,756,257)**	(7,654,713)
Cash Flows From Capital And Related Financing Activities		
Acquisition of capital assets -		
Net cash (used in) capital and related financing activities	**(6,115,997)**	(4,173,157)
Cash Flows From Investing Activities		
Net purchases of investments	**(1,537,065,555)**	(1,299,773,167)
Proceeds from maturities of investments	**1,416,117,352**	1,272,817,420
Payments received on provider advances	**3,835,702**	437,785
Proceeds (payments) from split dollar life insurance	**64,121**	(96,067)
Net cash (used in) investing activities	**(117,048,380)**	(26,614,029)
Net increase in cash and cash equivalents	**8,723,039**	15,547,414
Cash and cash equivalents:		
Beginning	**90,414,348**	74,866,934
Ending	**$ 99,137,387**	$ 90,414,348

See Notes to Financial Statements.

	2022	2021
Reconciliation of operating activities to net cash provided by operating activities		
Operating income	**$ 74,571,133**	$ 28,457,987
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation	**7,065,025**	7,208,071
Provision for allowance for doubtful provider advances	**125,000**	-
Changes in:		
Deferred outflows of resources	**(4,489,039)**	(647,480)
Net pension (asset) liability	**10,911,918**	(9,126,089)
Deferred inflows of resources	**(5,107,748)**	5,251,635
Changes in working capital components:		
(Increase) decrease in:		
Premiums receivable and other receivables	**10,670,127**	(16,158,417)
Hospital directed payments receivable	**(118,388,159)**	(122,760,170)
Prepaid expenses	**666,540**	(1,660,316)
Increase in:		
Accrued medical expenses payable	**40,651,672**	33,876,215
Hospital directed payments payable	**118,205,817**	122,760,170
Accrued expenses	**1,761,387**	6,787,707
Net cash provided by operating activities	**$ 136,643,673**	$ 53,989,313

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 Institutions 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.

Redeterminations: 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), this situation is expected to change. The Act allows states to restore eligibility verification and to terminate members deemed ineligible as early as April 1, 2023. The final outcome of the redetermination process is not known; however, KHS expects membership and premium revenues to decline once normal enrollment and renewal operations resume on April 1, 2023. KHS has been in close contact with local and state agencies to develop action plans designed to minimize potential disruption of care for its members. KHS has a team of employees ready to support our Medi-Cal eligible members to recertify their Medi-Cal eligibility status.

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 (asset) 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.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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:

	Years
Buildings and improvements	10-40
Computer hardware and software	5
Furniture and equipment	5

KHS' capitalization policy is to capitalize all items with a unit cost greater than $1,000 with the exception of computer software which has a per unit capitalization of $5,000 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 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 accordance with GASB Codification Section C60.

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 $33.5 million for 14,635 members assigned for the year ended December 31, 2022 and was $32.3 million for 12,692 members assigned for the year ended December 31, 2021. This contract is expected to end on December 31, 2023.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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. 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. Medi-Cal redeterminations had been paused since March 2020, originally tied to the COVID-19 public health emergency (PHE). The passage of the Consolidated Appropriations Act of 2023 in December 2022 allows for the resumption of Medi-Cal redeterminations as early as April 1, 2023. 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, 2022 and 2021 maternity kick payments in the amount of $40.1 million or 3.6% and $33.8 million or 3.1% respectively, of total premium revenue were recognized. KHS also receives premium revenue in the form of a "Behavioral Health Treatment kick payment" based on the utilization by its members diagnosed with specific Autism criteria. For the years ended December 31, 2022 and 2021 Behavioral Health Treatment payments in the amount of $18.3 million or 1.6% and $15.5 million or 1.4% respectively, of total premium revenue were recognized. Beginning in 2021, DHCS began a two-year Behavior Health Integration Incentive Program (BHI) in which funds are received for qualifying providers to assist in the improvement of physical and behavioral health outcomes and care delivery efficiency. For the years ended December 31, 2022 and 2021, BHI program payments in the amount of $4.5 million or 0.4% of total premium revenue were recognized for both years. As of January 1, 2022, KHS is no longer receiving additional kick payments for Hepatitis C or for the Health Homes Program. In 2021, KHS recognized $3.2 million or 0.3% of total premium revenue in Hepatitis C kick revenue and $9.4 million or 0.9% of total premium revenue in Health Homes kick revenue.

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 CPT procedure codes. For the years ended December 31, 2022 and 2021 Proposition 56 payments in the amount of $70.5 million or 6.2% and $70.9 million or 6.5%, respectively, of total premium revenue were recognized. 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, 2022 and 2021 GEMT payments in the amount of $7.0 million or 0.6% and $6.3 million or 0.6% 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, 2022 and 2021 KHS recognized a net reduction of $3.3 million or 0.3% and a net increase of $1.9 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 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) or expansion members.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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 per member per month basis (PMPM). 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: In 2009 California enacted the Managed Care Organization (MCO) tax under Senate Bill 78 (SB 78). Effective July 1, 2013, under Assembly Bill 1422 (AB 1422), the MCO tax rate was increased to 3.9375% and payable to the California State Board of Equalization. Premium taxes were assessed based on the premium revenue collected. Beginning July 1, 2016, under Senate Bill X2-2, the MCO tax rate is 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 year ended December 31, 2022, KHS recorded a liability of approximately $14.4 million payable to DHCS for MCO tax revenue received in excess of the required MCO tax expense for the period July 1, 2020, through December 31, 2022. The current MCO tax program sunset as of December 31, 2022 and was not approved by the California State Legislators for calendar year 2023.

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, 2022 and 2021, KHS received $41.1 million and $136.5 million, respectively, of supplemental 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, 2022 and 2021, as this pass-through amount does not meet the requirements for revenue recognition under Governmental Accounting Standards.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Advertising: KHS expenses advertising costs as they are incurred. Advertising expense totaled $643,790 and $699,398 for the years ended December 31, 2022 and 2021, respectively.

Subsequent events: KHS has evaluated subsequent events through March 29, 2023, the date on which the financial statements were available to be issued. There were no subsequent events identified by management which would require disclosure in the financial statements.

Authoritative pronouncements not yet adopted: In June 2017, the GASB issued Statement No. 87, *Leases*. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities.

The requirements of this Statement are effective for reporting periods beginning after December 15, 2022. Management is evaluating the impact of the implementation of this statement on their financial statements.

In June 2022, the GASB issued Statement No. 100, *Accounting Changes and Error Corrections – An Amendment of GASB Statement No. 62.* 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.

KERN HEALTH SYSTEMS

NOTES TO 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.

The requirements of this Statement are effective for accounting changes and error corrections made in fiscal years beginning after June 15, 2023, and all reporting periods thereafter. Earlier application is encouraged. Management is evaluating the impact of the implementation of this statement on their financial statements.

In June 2022, the GASB issued Statement No. 101, *Compensated Absences.* The objective of this Statement is to better meet the information needs of financial statement users by updating the recognition and measurement guidance for compensated absences. That objective is achieved by aligning the recognition and measurement guidance under a unified model and by amending certain previously required disclosures.

This Statement 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. Leave is attributable to services already rendered when an employee has performed the services required to earn the leave. Leave that accumulates is carried forward from the reporting period in which it is earned to a future reporting period during which it may be used for time off or otherwise paid or settled. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. However, leave that is more likely than not to be settled through conversion to defined benefit postemployment benefits should not be included in a liability for compensated absences.

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. This Statement also requires that a liability for specific types of compensated absences not be recognized until the leave is used.

This Statement also establishes guidance for measuring a liability for leave that has not been used, generally using an employee's pay rate as of the date of the financial statements. A liability for leave that has been used but not yet paid or settled should be measured at the amount of the cash payment or noncash settlement to be made. Certain salary-related payments that are directly and incrementally associated with payments for leave also should be included in the measurement of the liabilities.

With respect to financial statements prepared using the current financial resources measurement focus, this Statement requires that expenditures be recognized for the amount that normally would be liquidated with expendable available financial resources.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

This Statement amends the existing requirement to disclose the gross increases and decreases in a liability for compensated absences to allow governments to disclose only the net change in the liability (as long as they identify it as a net change). In addition, governments are no longer required to disclose which governmental funds typically have been used to liquidate the liability for compensated absences.

The requirements of this Statement are effective for fiscal years beginning after December 15, 2023, and all reporting periods thereafter. Earlier application is encouraged. Management is evaluating the impact of the implementation of this statement on their financial statements.

Note 2. Cash, Cash Equivalents and Investments

Cash, cash equivalents and investments at December 31, 2022 are classified in the accompanying financial statements as follows:

Cash and cash equivalents:		
Deposits		$ 1,859,330
Local Agency Investment Fund (LAIF) and money market funds		97,277,857
Cash on hand		200
Total cash and cash equivalents		$ 99,137,387
	Cost	Fair Value
Investments:		
Unrestricted:		
Corporate bonds and notes	$178,316,451	$176,494,361
Government agency bonds and notes	141,320,476	141,484,747
Total unrestricted	319,636,927	317,979,108
Restricted:		
Certificates of deposit	300,000	300,000
Total investments	$319,936,927	$318,279,108

Cash, cash equivalents and investments at December 31, 2021 are classified in the accompanying financial statements as follows:

Cash and cash equivalents:		
Deposits		$ 3,291,537
Local Agency Investment Fund (LAIF) and money market funds		87,122,611
Cash on hand		200
Total cash and cash equivalents		$ 90,414,348
	Cost	Fair Value
Investments:		
Unrestricted:		
Corporate bonds and notes	$ 72,356,848	$ 71,815,789
Government agency bonds and notes	123,990,134	123,974,020
Total unrestricted	196,346,982	195,789,809
Restricted:		
Certificates of deposit	300,000	300,000
Total investments	$196,646,982	$196,089,809

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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 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	Not 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	30%	(5)	A
Money Market Funds	5 years	20%	(4)	AAA
Mortgage or Asset-Backed Securities	5 years	20%	(6)	AAA
Variable and Floating Rate Securities	5 years	30%	5%	AAA
Local Agency Investment Fund (LAIF)	5 years	50%	5%	Not Rated

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

(1) May not exceed the 5% limit of any one commercial bank and may not exceed the 5% limit for any security on any bank.

(2) May not exceed more than 10% of the outstanding commercial paper of the issuing corporation.

(3) May not exceed 50% if maturity is less than or equal to 7 days; 25% if maturity is greater than 7 days.

(4) May not exceed more than 10% 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% 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 Local Agency Investment Fund (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% 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% of its total investments as of December 31, 2022 or 2021.

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% of the total amount deposited by the public agencies.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Cash Equivalents in State Investment Pool

KHS is a voluntary participant in the Local Agency Investment Fund (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 excluding LAIF, held by KHS at December 31, 2022 and 2021 are considered to be level 1 assets. LAIF funds are considered to be level 2 assets.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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 consolidated financial statements.

Note 4. Hospital Directed Payments

Beginning with the July 1, 2017 rating period, the Department of Health Care Services (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 Managed Care Plans (MCP), like KHS, to pay specified contracted Network Providers in accordance with terms approved by the Centers for Medicare & Medicaid Services (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 approximately $436.8 million and Hospital Directed payments payable of approximately $436.6 million reported as of December 31, 2022. For the year ended December 31, 2021 KHS accrued Hospital Directed Payments receivable of approximately $318.4 million and Hospital Directed Payments payable of approximately $318.4 million. The amount of premium revenue for Hospital Directed Payment programs recognized for the years ended December 31, 2022 and 2021 was approximately $264.3 million and $243.7 million, respectively, and is reported as part of operating revenues. Hospital Directed Payment expense obligations recognized for the years ended December 31, 2022 and 2021 were approximately $264.6 million and $242.7 million, respectively, and are reported as part of operating expenses. 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 at December 31, 2022 and 2021:

	2022	2021
Provider receivable	$ 1,603,931	$ -
Interest	389,179	42,610
Other	199,159	566,096
Pharmacy rebates	-	705,000
	$ 2,192,269	$ 1,313,706

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Note 6. Provider Advances

In April 2020 as part of the response to the COVID-19 pandemic and in an effort to support its network of providers of care for the more than 258,000 members served, KHS advanced $5.7 million under a COVID-19 Provider Financial Relief Program. Under the Program, provider advance payments were offered to select local network providers of up to 50% of their average 2019 monthly claim payments multiplied by three months. The no interest payment advances were aimed at providing financial assistance to those network providers experiencing financial hardships due to lower utilization of medical services as the result of the Governor's shelter in place order. Monthly repayments of provider advances began in September 2021 and are due on January 1, 2024. In the event of a program payment default, KHS has the right to offset amounts owed by providers against any future monies owed to the provider. As of December 31, 2022 and 2021, provider advances due to KHS totaled $1,108,031 and $5,068,733, respectively.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Note 7. Capital Assets

Capital asset activity for the years ended December 31, 2022 and 2021 is as follows:

	Balance January 1, 2022	Additions	Deletions	Transfers	Balance December 31, 2022
Capital Assets Not Being Depreciated:					
Land	$ 4,090,706	$ -	$ -	$ -	$ 4,090,706
Capital projects in progress	4,580,047	5,277,836	(120,000)	(7,496,184)	2,241,699
Subtotal	8,670,753	5,277,836	(120,000)	(7,496,184)	6,332,405
Capital Assets Being Depreciated:					
Buildings and improvements	36,671,140	-	-	-	36,671,140
Computer hardware and software	39,165,691	737,487	(464,543)	7,477,942	46,916,577
Furniture and equipment	4,422,937	100,674	(146,776)	18,242	4,395,077
Subtotal	80,259,768	838,161	(611,319)	7,496,184	87,982,794
Accumulated Depreciation:					
Buildings and improvements	2,042,639	913,303	-	-	2,955,942
Computer hardware and software	18,642,258	5,576,749	(461,954)	-	23,757,053
Furniture and equipment	2,725,279	574,973	(146,810)	-	3,153,442
Subtotal	23,410,176	7,065,025	(608,764)	-	29,866,437
Net Depreciable Capital Assets	56,849,592	(6,226,864)	(2,555)	7,496,184	58,116,357
Total Capital Assets	$ 65,520,345	$ (949,028)	$ (122,555)	$ -	$ 64,448,762

	Balance January 1, 2021	Additions	Deletions	Transfers	Balance December 31, 2021
Capital Assets Not Being Depreciated:					
Land	$ 4,090,706	$ -	$ -	$ -	$ 4,090,706
Capital projects in progress	12,183,359	3,995,302	(99,731)	(11,498,883)	4,580,047
Subtotal	16,274,065	3,995,302	(99,731)	(11,498,883)	8,670,753
Capital Assets Being Depreciated:					
Buildings and improvements	36,482,174	-	-	188,966	36,671,140
Computer hardware and software	27,854,345	150,872	(5,079)	11,165,553	39,165,691
Furniture and equipment	4,255,005	26,983	(3,415)	144,364	4,422,937
Subtotal	68,591,524	177,855	(8,494)	11,498,883	80,259,768
Accumulated Depreciation:					
Buildings and improvements	1,133,894	908,745	-	-	2,042,639
Computer hardware and software	12,943,051	5,704,200	(4,993)	-	18,642,258
Furniture and equipment	2,133,568	595,126	(3,415)	-	2,725,279
Subtotal	16,210,513	7,208,071	(8,408)	-	23,410,176
Net Depreciable Capital Assets	52,381,011	(7,030,216)	(86)	11,498,883	56,849,592
Total Capital Assets	$ 68,655,076	$ (3,034,914)	$ (99,817)	$ -	$ 65,520,345

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Note 8. 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 $774,526 upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $816,478 and $858,223 at December 31, 2022 and 2021, 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 $847,832 upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $772,412 and $794,788 at December 31, 2022 and 2021, respectively.

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

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 $16.2 million and $8.7 million of favorable prior year IBNR adjustments for the years ended December 31, 2022 and 2021, respectively, due to lower-than-expected utilization.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Proposition 56: 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 Department of Health Care Services (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. At December 31, 2022 and 2021 KHS has accrued $60.7 million and $48.1 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.

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 Medi-Cal managed care plans (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. At December 31, 2022 and 2021, KHS had accrued $25.5 million owed to the state for the rate period July 1, 2019 through December 31, 2020.

Accrued medical services and related claims adjustment expenses payable consist of the following at December 31, 2022 and 2021:

	2022	2021
Estimated incurred but not reported claims	$ 96,084,096	$ 82,747,978
Supplemental Proposition 56 provider payments	60,729,070	48,144,699
Bridge risk corridor	25,453,666	25,453,666
Claims payable	18,643,959	22,249,622
Enhanced Care Management (ECM) risk corridor	12,843,453	-
CalAIM Incentive	4,318,339	-
Provider performance quality incentive	3,505,791	5,023,866
Major Organ Transplant	3,381,437	-
Allowance for claims processing expense	2,831,842	2,389,766
Provider vaccine incentive	28,122	1,158,506
	$ 227,819,775	$ 187,168,103

Note 10. Accrued Expenses

Accrued expenses consist of the following at December 31, 2022 and 2021:

	2022	2021
MCO tax expense	$32,495,339	$ 29,533,392
Salaries and employee benefits	4,137,755	3,818,601
Other administrative expenses	3,932,626	1,863,208
Community grants payable	1,515,321	4,120,333
Non-operating passthrough liability	1,058,010	2,050,194
CalPERS employee and employer contributions	410,699	359,613
New building and construction	11,978	55,000
	$43,561,728	$ 41,800,341

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Note 11. Restricted Investments and Tangible Net Equity

As required by the State of California's Department of Managed Health Care, Section 1300.76.1, KHS has acquired certificates of deposit with three financial institutions totaling $300,000. 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 $100,000 each on January 31, 2024, June 5, 2024 and June 8, 2024.

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 approximately $50.8 million and $51.4 million at December 31, 2022 and 2021, respectively. KHS' tangible net equity was approximately $318.8 million and $247.5 million at December 31, 2022 and 2021, 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 five 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 at December 31, 2022 and 2021 are summarized as follows:

		2022		2021	
		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% @ 60	2% @ 60	2% @ 62	2% @ 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 % of eligible compensation	2%	2%	2%	2%	2%
Retirement employee contribution rates	7%	6.93%	6.75%	6.92%	6.75%
Required employer contribution rates	6.709% to 7.159%	8.65% to 8.630%	7.59% to 7.470%	8.794% to 8.650%	7.732% to 7.590%

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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, 2022 and 2021, the contributions recognized as part of pension expense were as follows:

	2022	2021
Contributions - employer	$ 3,516,567	$ 2,951,981
Contributions - employee (paid by employer)	$ -	$ -

Pension Liabilities, Pension Expenses, and Deferred Outflows/Inflows of Resources Related to Pensions

As of December 31, 2022, and 2021, KHS reported net pension (asset) liability for its proportionate share of the net pension (asset) liability of $10,218,206 and $(693,712), respectively.

KHS' fiduciary net pension as a percentage of KHS' total pension liability for the years ended December 31, 2022 and 2021 was 87% and 101%, respectively.

KHS' net pension (asset) liability is measured as the proportionate share of the net pension (asset) liability. The net pension (asset) liability is measured as of June 30, 2022, and the total pension liability used to calculate the net pension (asset) liability was determined by an actuarial valuation as of June 30, 2021 rolled forward to June 30, 2022 using standard update procedures. KHS' proportion of the net pension (asset) 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 (asset) liability as of June 30, 2022 and 2021 was as follows:

Proportion - June 30, 2021	0.3221%
Proportion - June 30, 2022	0.3664%
Change - Increase	0.0443%

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, 2021, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2020 rolled forward to June 30, 2021 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, 2021 and 2020 was as follows:

Proportion - June 30, 2020	0.2881%
Proportion - June 30, 2021	0.3221%
Change - Increase	0.0340%

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

For the years ended December 31, 2022 and 2021, KHS recognized pension expense of $5,608,106 and $963,272, respectively. At December 31, 2022 and 2021, KHS reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	2022		2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Pension contributions subsequent to the measurement date	$ 2,913,850	$ -	$ 2,980,058	$ -
Changes in assumptions	1,756,640	-	-	-
Differences between expected and actual experiences	344,261	230,571	685,763	-
Net differences between projected and actual earnings on pension plan investments	3,140,109	-	-	5,338,319
Total	$ 8,154,860	$ 230,571	$ 3,665,821	$ 5,338,319

$2,913,850 reported as deferred outflows of resources related to contributions subsequent to the measurement date will be recognized as an increase of the net pension (asset) in the year ending December 31, 2023. 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,	
2023	$ 1,306,743
2024	1,145,011
2025	638,087
2026	1,920,598
	$ 5,010,439

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Actuarial Methods and Assumptions: The total pension liabilities in the June 30, 2021 and 2020 actuarial valuations were determined using the following actuarial assumptions:

	2022	2021
Valuation date	June 30, 2021	June 30, 2020
Measurement date	June 30, 2022	June 30, 2021
Actuarial cost method	Entry-Age Normal Cost Method	
Actuarial assumptions:		
Discount rate	6.90%	7.15%
Inflation	2.30%	2.50%
Payroll growth	2.55%	2.75%
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% of Scale MP 2020 published by the Society of Actuaries.

Discount Rate: The discount rate used to measure the total pension liability was 6.90% and 7.15% as of June 30, 2021 and June 30, 2020, respectively. 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 6.90% and 7.15% as of June 30, 2021 and 2020, respectively, are adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 6.90% 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.

According to Paragraph 30 of Statement 68, the long-term discount rate should be determined without reduction for pension plan administrative expense. The 6.90% and 7.15% as of June 30, 2021 and June 30, 2020, respectively, 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% and 7.30% as of June 30, 2021 and 2020, respectively. Using this lower discount rate has resulted in a slightly higher Total Pension Liability and Net Pension (Asset) 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.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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	New Strategic Allocation	Long-Term Expected Rate of Return
Public Equity (a)	44.4%	9.4%
Private Equity	12.0%	13.5%
Income (a)	26.7%	2.3%
Real Assets	15.8%	9.2%
Total Fund (b)	4.2%	-
Financing and liquidity (c)	-3.3%	0.8%
Total	100%	

(a) Includes exposure from derivatives and repo borrowing used for Trust Level leverage liquidity.
(b) Includes subtotal and totals that may not sum due to rounding.
(c) Financing reflects derivatives financing and repo borrowing in Trust Level Synthetic Cap Weighted and Synthetic Treasury portfolios. Liquidity reflects net asset value of the Liquidity Segment.

Sensitivity of the Proportionate Share of the Net Pension (Asset) Liability to Changes in the Discount Rate: The following presents KHS' proportionate share of the net pension (asset) liability, calculated using the discount rate, as well as what KHS' proportionate share of the net pension (asset) 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:

	2022	2021
1% Decrease	5.90%	6.15%
Net Pension (Asset) Liability	$ 16,603,473	$ (1,656,732)
Current Discount Rate	6.90%	7.15%
Net Pension (Asset) Liability	$ 10,218,206	$ (693,712)
1% Increase	7.90%	8.15%
Net Pension Liability	$ 4,964,716	$ 102,403

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% of contributions made by KHS employees to their 457(b) plan up to a maximum of 6% 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% 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 $1,969,979 and $1,665,198 for the years ended December 31, 2022 and 2021, respectively.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Note 13. Stop-Loss Insurance

KHS purchases stop-loss insurance 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 the years ended December 31, 2022 and 2021 coverage provides reimbursement of approximately 90 and 95 percent, respectively, of the cost of each member's acute care hospital admission(s) in excess of the deductibles, up to a maximum payable of $2,000,000 per member per contract year.

For the years ended December 31, 2022 and 2021 the premium coverage is $0.18 and $0.29 per member per month (PMPM) respectively with no minimum annual premium requirement.

The deductible for each individual member was $350,000 and the Aggregate Specific Retention deductible was $0.13 PMPM, for the year ended December 31, 2022. The deductible for each individual member was $300,000 and the Aggregate Specific Retention deductible was $0.23 PMPM for the year ended December 31, 2021.

Stop-loss insurance premiums of $595,993 and $1,000,259 are included in medical and hospital expense for the years ended December 31, 2022 and 2021, respectively. Stop-loss insurance recoveries of $497,807 are included in operating revenue for the year ended December 31, 2022. There were no stop-loss insurance recoveries for the year ended December 31, 2021.

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.

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.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Pharmacy

Effective January 1, 2022, DHCS transitioned most Medi-Cal pharmacy benefits from managed care plans like KHS to fee-for-service ("FFS"). For the years ended December 31, 2022 and 2021, KHS recognized $0 and $116,469,893, respectively, in Pharmacy revenue and $0 and $3,224,445, respectively, in Hepatitis C supplemental kick revenue as part of its premium capitation which in total accounted for approximately 0% and 13.1%, respectively, of reported Premiums earned. For the years ended December 31, 2022 and 2021 KHS reported $228,371 and $107,035,326, respectively, in Pharmacy expense. Additionally, for the years ended December 31, 2022 and 2021 KHS reported $0 and $3,138,427 in Hepatitis C expenses and received $326,288 and $1,494,616, respectively from Pharmacy Rebates. For the years ended December 31, 2022 and 2021, total expenses for Pharmacy and Hepatitis C as a percent of reported Medical and hospital expenses, was less than 1% and approximately 12.2%, respectively.

COVID-19 Vaccination Incentive Program

Kern Health Systems embarked on an aggressive COVID-19 Vaccination Incentive Program that aligns with the Department of Health Care Service's initiative to materially increase vaccines among California's Medi-Cal population. This program focuses on identifying unvaccinated beneficiaries, educating them as to the vaccine's importance, increasing access to COVID-19 vaccination sites and providing incentives to encourage becoming vaccinated. Starting September 1, 2021 through February 28, 2022, KHS offered incentives to members who got fully vaccinated. Providers that were willing to enhance their efforts in getting their assigned members vaccination and became a vaccination site, were also incentivized. KHS also partnered with several community organizations and initiatives that focused on education and access to COVID 19 vaccinations in Kern County. For the year ended December 31, 2022 KHS reported additional Medi-Cal premium revenue of $2,827,860 related to Vaccine Incentive Programs and medical expense of $3,521,991. For the year ended December 31, 2021 KHS reported additional Medi-Cal premium revenue of $4,868,689 related to Vaccine Incentive Programs and medical expense of $3,585,718.

California Advancing and Innovating Medi-Cal (CalAIM) Program

Effective January 1, 2022, DHCS implemented California Advancing and Innovating Medi-Cal (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 Enhanced Care Management (ECM) and Community Support programs required significant investments in care management capabilities in which DHCS provided additional funding to Medi-Cal managed care plans. As of December 31, 2022, CalAIM initiative payments, including ECM funding and Housing and Homelessness Incentive Program funds, in the amount of $41.2 million or 3.7% of total premium revenue were recognized.

California Advancing and Innovating Medi-Cal (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.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

There are significant operational impacts to Medi-Cal Managed Care Plans (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, a proposal to carve-in Long Term Care to MCPs, a proposal requiring all MCPs 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, Housing and Homelessness Incentive Program to address homelessness as a social determinant of health and keeping individuals housed, and a proposal 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.

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 Managed Care Plans. Additionally, in 2022 and 2021 there were numerous temporary changes in regulatory requirements related to the COVID-19 Public Health Emergency (PHE). There could be significant budget pressure following the ending of the PHE due to reduced federal matching funds which could limit future rate increases or reduce benefits to our members.

While most conversations were on hold during the COVID-19 PHE, the Governor's administration and the legislature also continue to consider a single-payer healthcare system for California.

Information Technology

KHS is dependent on effective and secure enterprise commercial information systems that assist in 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 required 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 department is constantly engaged in the third-party contracts that govern these systems while reviewing technical architectures, third-party operational models, and the business continuity and disaster recovery solutions using private and public cloud systems. KHS continued to be impacted by COVID-19 and a hybrid workforce and telecommuting model. KHS has updated its support team and processes leveraging third-party solutions to continue its operations for this new telecommuting work model. The KHS information systems require an ongoing commitment of technical human resources to maintain, protect, and enhance existing systems while developing/purchasing new systems to keep pace with continuing changes in information processing technology and security, evolving systems and regulatory standards, changing customer requirements/regulatory changes, acquisitions, and increased security risks.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Encounter Data

KHS is required to submit complete and correct encounter data to DHCS. The accurate and timely 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 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.

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.

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. In a report issued on October 30, 2018 by the California State Auditor, the report indicated "questionable payments" for many counties throughout California, including Kern County. During the period January 1, 2014 through December 31, 2017 amounts of $10,421,757 relating to Managed Care Premiums and $2,854,656 relating to Fee For Service Payments for a total of $13,276,413 of payments by DHCS were identified for Kern County primarily due to beneficiaries being eligible on the DHCS eligibility system and not being eligible on the county agency eligibility system. During the first quarter of 2020, DHCS recouped approximately $563,000 relating to payments previously received by KHS for members that were determined to be deceased by DHCS. This amount was subtracted from KHS' 2019 revenues. There were no significant recoupments during the years ended December 31, 2022 or 2021 for deceased members but it remains unclear if any additional amounts will be recouped by DHCS from KHS. Accordingly, 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.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Bridge 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 managed care plans (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% of premiums. KHS is required to refund to the State amounts below 85%. The calculation of the 85% 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 managed care plan'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.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

As of December 31, 2022, 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.

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.

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% of the federal poverty line. The federal government paid 100% of the entire cost for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020, 95% in 2021, and 85% in 2022 For the years ended December 31, 2022 and 2021, KHS served an average of 89,749 and 75,684 Medi-Cal Expansion members per month, respectively, which generated revenues of approximately $365.0 million and $345.8 million, respectively.

Contract Commitment

In September 2014 KHS entered into a ten-year contract with a vendor to supply software, licensing, support and maintenance, including a migration process from the existing software. Expenses are paid annually and are subject to change based on changes to the Consumer Price Index and changes in membership. At December 31, 2022 the total future contract commitments are as follows:

Years ending December 31,	
2023	$ 386,142
2024	386,142
	$ 772,284

Note 15. Concentration of Revenue

KHS' operating revenue is primarily derived from the California Department of Health Care Services (DHCS). KHS' current contract term with DHCS is to provide health care services through December 31, 2023 and is subject to cancellation upon either party giving at least six months written notice. The contract is expected to be renewed for an additional five-year period. For the years ended December 31, 2022 and 2021 over 99% of KHS' total revenues were received from DHCS. Future levels of funding and premium rates received by KHS could be impacted by state and federal budgetary constraints.

REQUIRED SUPPLEMENTARY INFORMATION

KERN HEALTH SYSTEMS

SCHEDULES OF PROPORTIONATE SHARE OF THE NET PENSION (ASSET) LIABILITY
As of December 31, 2022

	2022	2021	2020
CalPERS - Miscellaneous Classic Plan- Last 10 Years*			
Proportion of the net pension liability	0.36636%	0.32206%	0.28810%
Proportionate share of the net pension (asset) liability	$ 10,218,206	$ (693,712)	$ 8,432,377
Covered - employee payroll	$ 21,002,601	$ 20,710,645	$ 19,428,164
Proportionate share of the net pension liability as a percentage of covered-employee payroll	48.65%	-3.35%	43.40%
Plan's fiduciary net position (in thousands)	$ 16,770,671	$ 18,065,792	$ 14,702,361
Plan fiduciary net position as a percentage of the total pension liability	78.19%	90.49%	77.71%
KHS' fiduciary net position as a percentage of KHS' total pension liability	87.00%	101.08%	88.20%

* Fiscal year 2015 was the first year of implementation, therefore only eight years are shown. 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 2022 through 2016 for the miscellaneous Classic Plan includes the Pepra Plan.

2019	2018	2017	2016	2015
0.26415%	0.23579%	0.21146%	0.19046%	0.17122%
$ 7,038,233	$ 5,865,463	$ 6,082,752	$ 4,769,187	$ 3,104,717
$ 19,020,118	$ 17,733,290	$ 17,150,840	$ 17,364,146	$ 9,949,051
37.00%	33.08%	35.47%	27.47%	31.21%
$ 13,979,687	$ 13,122,440	$ 12,074,500	$ 10,923,476	$ 10,896,036
77.73%	77.69%	75.39%	75.87%	79.89%
85.18%	85.27%	82.04%	82.61%	83.03%

KERN HEALTH SYSTEMS

SCHEDULES OF PROPORTIONATE SHARE OF THE NET PENSION (ASSET) LIABILITY
As of December 31, 2022

		2015
CalPERS - Miscellaneous PEPRA Plan - Last 10 Years **		
Proportion of the net pension liability		0.00362%
Proportionate share of the net pension 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%

** 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 SYSTEMS

SCHEDULES OF PENSION CONTRIBUTIONS
Year Ended December 31, 2022

	2022	2021	2020
CalPERS - Miscellaneous Classic Plan - Last 10 Years*			
Contractually required contribution (actuarially determined)	$ 3,516,567	$ 2,951,981	$ 2,536,160
Contributions in relation to the actuarially determined contributions	3,516,567	2,951,981	2,536,160
Contribution deficiency (excess)	$ -	$ -	$ -
Covered-employee payroll	$ 21,002,601	$ 20,710,645	$ 19,428,164
Contributions as a percentage of covered-employee payroll	16.74%	14.25%	13.05%
Notes to Schedule			
Valuation date:	June 30, 2021	June 30, 2020	June 30, 2019
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	22 years	23 years	24 years
Asset valuation method	5-year smoothed market		
Inflation	2.30%	2.50%	2.50%
Salary increases	2.55%	2.75%	2.75%
Investment rate of return (a)	7.00%	7.00%	7.15%
Retirement age	50 years and 5 years of service		
Mortality	(b)	(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% 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% of scale MP 2016.

* Fiscal year 2015 was the first year of implementation, therefore only eight years are shown. 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 2022 through 2016 for the miscellaneous Classic Plan includes the Pepra Plan.

2019	2018	2017	2016	2015
$ 2,074,974	$ 1,822,052	$ 1,625,952	$ 1,314,297	$ 841,252
2,074,974	1,822,052	1,625,952	1,314,297	841,252
$ -	$ -	$ -	$ -	$ -
$ 19,020,118	$ 17,733,690	$ 17,150,940	$ 17,364,146	$ 9,949,051
10.91%	10.27%	9.48%	7.57%	8.46%
June 30, 2018	June 30, 2017	June 30, 2016	June 30, 2015	June 30, 2014
Entry-Age Normal Cost Method				
Level percentage of assumed future payrolls				
25 years	26 years	27 years	28 years	29 years
5-year smoothed market				
2.50%	2.50%	2.75%	2.75%	2.75%
2.75%	2.75%	3.00%	3.00%	3.00%
7.15%	7.15%	7.15%	7.65%	7.50%
50 years and 5 years of service				
(c)	(c)	(c)	(c)	(c)

KERN HEALTH SYSTEMS

SCHEDULES OF PENSION CONTRIBUTIONS
Year Ended December 31, 2022

	2015
CalPERS - Miscellaneous PEPRA Plan - Last 10 Years*	
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	52 years and 5 years of service
Mortality	20 years of projected on-going 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.

OTHER INDEPENDENT AUDITOR'S REPORT

DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

An independently owned member RSM US Alliance

Member of AICPA Division for Firms
Private Companies Practice Section

NANCY C. BELTON

INDEPENDENT AUDITOR'S REPORT 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*

Board of Directors
Kern Health Systems
Bakersfield, California

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 Heath Systems**, as of and for the year ended December 31, 2022, and the related notes to the financial statements, which collectively comprise **Kern Health Systems**' basic financial statements, and have issued our report thereon dated March 29, 2023.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered **Kern Heath Systems**' 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**' internal control. Accordingly, we do not express an opinion on the effectiveness of **Kern Health Systems**' 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.

300 New Stine Road – Bakersfield, CA 93309 – Tel. 661.834.7411 – Fax.661.834.4389 – www. dpvb.com

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether **Kern Health Systems**' 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.

Daniells Phillips Vaughan & Bock

Bakersfield, California
March 29, 2023

KERN HEALTH SYSTEMS

Report to the Finance Committee
March 29, 2023

DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

An independently owned member RSM US Alliance

Member of AICPA Division for Firms
Private Companies Practice Section

Finance Committee
Kern Health Systems

Attention: Elsa Martinez, Finance Committee Chair

We are pleased to present this report related to our audit of the financial statements of **Kern Health Systems** for the year ended December 31,2022. This report summarizes certain matters required by professional standards to be communicated to you in your oversight responsibility for **Kern Health Systems**' financial reporting process.

This report is intended solely for the information and use of the Board of Directors, Finance Committee, and management and is not intended to be and should not be used by anyone other than these specified parties. It will be our pleasure to respond to any questions you have about this report. We appreciate the opportunity to continue to be of service to **Kern Health Systems**.

Daniells Phillips Vaughan & Bock

March 29, 2023

300 New Stine Road – Bakersfield, CA 93309 – Tel. 661.834.7411 – Fax.661.834.4389 – www. dpvb.com

Contents

Required Communications

Generally accepted auditing standards (AU-C 260, *The Auditor's Communication with Those Charged with Governance*) require the auditor to promote effective two-way communication between the auditor and those charged with governance. Consistent with this requirement, the following summarizes our responsibilities regarding the financial statement audit as well as observations arising from our audit that are significant and relevant to your responsibility to oversee the financial reporting process.

Area	Comments
Our Responsibilities with regard to the Financial Statement Audit	Our responsibilities under auditing standards generally accepted in the United States of America have been described to you in our arrangement letter dated December 5, 2022. Our audit of the financial statements does not relieve management or those charged with governance of their responsibilities, which are also described in that letter.
Overview of the Planned Scope and Timing of the Financial Statement Audit	We have issued a separate communication regarding the planned scope and timing of our audit and have discussed with you our identification of and planned audit response to significant risks of material misstatement.
Accounting Policies and Practices	**Preferability of Accounting Policies and Practices** Under generally accepted accounting principles, in certain circumstances, management may select among alternative accounting practices. In our view, in such circumstances, management has selected the preferable accounting practice. **Adoption of, or Change in, Accounting Policies** Management has the ultimate responsibility for the appropriateness of the accounting policies used by the Organization. The Organization did not adopt any significant new accounting policies nor have there been any changes in existing significant accounting policies during the current period. **Significant or Unusual Transactions** We did not identify any significant or unusual transactions or significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus. **Management's Judgments and Accounting Estimates** Summary information about the process used by management in formulating particularly sensitive accounting estimates and about our conclusions regarding the reasonableness of those estimates is in the attached "Summary of Significant Accounting Estimates".

Area	Comments
Audit Adjustments	Audit adjustments proposed by us and recorded by **Kern Heath Systems** are shown on the attached "Summary of Recorded Audit Adjustments".
Uncorrected Misstatements	We are not aware of any uncorrected misstatements other than misstatements that are clearly trivial.
Disagreements with Management	We encountered no disagreements with management over the application of significant accounting principles, the basis for management's judgments on any significant matters, the scope of the audit, or significant disclosures to be included in the financial statements.
Consultations with Other Accountants	We are not aware of any consultations management had with other accountants about accounting or auditing matters.
Significant Issues Discussed with Management	No significant issues arising from the audit were discussed with or were the subject of correspondence with management.
Significant Difficulties Encountered in Performing the Audit	We did not encounter any significant difficulties in dealing with management during the audit.
Certain Written Communications Between Management and Our Firm	Copies of significant written communications between our firm and the management of the Organization, including the representation letter provided to us by management, are attached as Exhibit A.

KERN HEALTH SYSTEMS

Summary of Significant Accounting Estimates
Year Ended December 31, 2022

Accounting estimates are an integral part of the preparation of financial statements and are based upon management's current judgment. The process used by management encompasses their knowledge and experience about past and current events and certain assumptions about future events. You may wish to monitor throughout the year the process used to determine and record these accounting estimates. The following describes the significant accounting estimates reflected in the Organization's December 31, 2022, financial statements:

Estimate	Accounting Policy	Basis for Our Conclusions on Reasonableness of Estimate
Estimated claims payable	Estimates are based on historical information for total claims received and paid	Estimate is in accordance with accounting principles generally accepted in the United States of America
Provider performance quality incentive liabilities	Estimates are based on historical information for total claims received and paid	Estimate is in accordance with accounting principles generally accepted in the United States of America
Incurred but not reported claims	Estimates are based on historical information for total claims received and paid	Estimate is in accordance with accounting principles generally accepted in the United States of America
Net pension asset/liability	Estimate is based on actuarial reports provided by CalPERS	Estimate is in accordance with accounting principles generally accepted in the United States of America
Expansion, enhanced care management and bridge risk corridor liabilities	Estimates are based on management's best estimate of medical loss ratio	Estimate is in accordance with accounting principles generally accepted in the United States of America

KERN HEALTH SYSTEMS

Summary of Recorded Audit Adjustments
Year Ended December 31, 2022

	Effect — Increase (Decrease)					
Description	**Assets - Premiums receivable**	**Liabilities - Accrued medical expenses payable**	**Equity**	**Revenue - Premiums earned**	**Expense - Medical and hospital**	**Net Income**
Net Income (Loss) Before Adjustments						$ 67,324,223
To reverse Housing and Homelessness Incentive Program revenue and related expenses for Program Year One year not earned and not expended at December 31, 2022	($6,770,892)	($9,624,339)	$ -	($6,770,892)	($9,624,339)	2,853,447
To reverse CalAIM Incentive Payment Program revenue and related expenses for Program Year One not earned and not expended at December 31, 2022	(7,136,107)	(8,238,423)	-	(7,136,107)	(8,238,423)	1,102,316
Total effect	($13,906,999)	($17,862,762)	$ -	($13,906,999)	($17,862,762)	$ 71,279,986

Exhibit A
Representation Letter

KERN HEALTH SYSTEMS

March 29, 2023

Daniells Phillips Vaughan & Bock
300 New Stine Road
Bakersfield, California 93309

This representation letter is provided in connection with your audits of the basic financial statements of **Kern Health Systems** (the Organization) as of December 31, 2022 and 2021, for the purpose of expressing an opinion on whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

We confirm, to the best of our knowledge and belief, that as of March 29, 2023:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated December 5, 2022, for the preparation and fair presentation of the financial statements referred to above 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 controls to prevent and detect fraud.

4. The methods, data, and significant assumptions used by us in making accounting estimates and their related disclosures are appropriate to achieve recognition, measurement, or disclosure that is reasonable in the context of U.S. GAAP, and reflect our judgment based on our knowledge and experience about past and current events, and our assumptions about conditions we expect to exist and courses of action we expect to take.

5. The methods, assumptions and data used to determine incurred but not reported claim liability, net pension liability, as well as the deferred outflows and deferred inflows of resources are as follows, and result in an estimate that is appropriate for financial statement measurement and disclosure purposes and have been consistently selected and applied in making the estimate: Significant judgments made in making the estimate have taken into account all relevant information of which we are aware. Appropriate specialized skills or expertise has been applied in making the estimate. The assumptions listed above properly reflect our intent and ability to carry out the specific courses of actions previously communicated to you on behalf of the Organization. All disclosures related to the estimate, including disclosures describing estimation uncertainty, are complete and reasonable in the context of U.S. GAAP. No subsequent events have occurred that would require adjustment to the estimate and related disclosures included in the financial statements.

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

6. Related-party transactions have been recorded in accordance with the economic substance of the transaction and appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

7. 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.

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

9. Management has followed applicable laws and regulations in adopting, approving and amending budgets.

10. Risk disclosures associated with deposit and investment securities and derivative transactions are presented in accordance with GASB requirements.

11. Provisions for uncollectible receivables have been properly identified and recorded.

12. Capital assets, including infrastructure, intangible assets, and right of use assets are properly capitalized, reported and, if applicable, depreciated.

13. Components of net position (net investment in capital assets, restricted, and unrestricted) and classifications of fund balance (nonspendable, restricted, committed, assigned, and unassigned) are properly classified and, if applicable, approved.

14. Revenues are appropriately classified in the statement of activities within program revenues, general revenues, contributions to term or permanent endowments, or contributions to permanent fund principal.

15. Expenses have been appropriately classified in or allocated to functions and programs in the statement of activities, and allocations have been made on a reasonable basis.

16. We have no direct or indirect legal or moral obligation for any debt of any organization, public or private, that is not disclosed in the financial statements.

17. We have complied with all aspects of laws, regulations and provisions of contracts and agreements that would have a material effect on the financial statements in the event of noncompliance. In connection therewith, we specifically represent that we are responsible for determining that we are not subject to the requirements of the Single Audit Act because we have not received, expended or otherwise been the beneficiary of the required amount of federal awards during the period of this audit.

18. We have no knowledge of any uncorrected misstatements in the financial statements.

19. With respect to the service of drafting the financial statements and providing guidance on new authoritative pronouncements performed in the course of the audit:

    a. We have made all management decisions and performed all management functions;

    b. We assigned an appropriate individual to oversee the services;

    c. We evaluated the adequacy and results of the services performed, and made an informed judgment on the results of the services performed;

d. We have accepted responsibility for the results of the services; and

e. We have accepted responsibility for all significant judgments and decisions that were made.

20. Management is responsible for making the accounting estimates included in the financial statements. Those estimates reflect management's judgment based on knowledge and experience about past and current events and assumptions about conditions management expects to exist and course of action they expect to take. These include:

a. Estimated adjustments to revenue, such as retroactive adjustments by the Department of Health Care Services;

b. Obligations related to third-party payer contracts, including risk sharing and contractual settlements;

c. Audit and other adjustments by the Department of Health Care Services;

d. Obligations related to providing future services under prepaid health care service contracts;

e. Medical malpractice obligations expected to be incurred with respect to services provided through December 31, 2022.

21. Data submitted to the Department of Health Care Services complies in all respects with applicable coding principles and laws and regulations (including those dealing with Medicare antifraud and abuse), and only reflect charges for services that were medically necessary, properly approved by regulatory bodies and properly rendered.

22. With respect to reports submitted to the Department of Health Care Services:

a. All required Medi-Care and similar reports have been filed;

b. Management is responsible for the accuracy and propriety of all reports filed;

c. All costs reflected on such reports are appropriate, allowable under applicable reimbursement rules and regulations, patient-related, and properly allocated;

d. The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations;

e. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

f. All items required to be disclosed, including disputed costs that are being claimed to establish a basis for a subsequent appeal, have been fully disclosed in the report;

g. Recorded settlements include differences between filed (and to be filed) reports and calculated settlements, which are necessary based upon historical experience or new or ambiguous regulations that may be subject to differing interpretations. While management believes the entity is entitled to all amounts claimed on the cost reports, management also believes the amounts of these differences are appropriate;

h. The specialist used by management in preparing medical services payable estimates and reserves had a sufficient level of competence and experience in cost reporting. Management recognizes responsibility for estimated settlement amounts and balances and, that all such amounts are fairly presented.

23. In addition, we believe that the actuarial assumptions and methods used by the actuary for funding purposes and for determining the IBNR accrual are appropriate in the circumstances. We did not give instructions, or cause any instructions to be given, to the 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 Organization's actuary.

Information Provided

24. 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 Organization's basic financial statements such as records, documentation and other matters.

    b. Additional information that you have requested from us for the purpose of the audits.

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

    d. Minutes of the meetings of the board of directors, finance committee, and management, or summaries of actions of recent meetings for which minutes have not yet been prepared.

25. All transactions have been recorded in the accounting records and are reflected in the basic financial statements.

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

27. It is our responsibility to establish and maintain internal control over financial reporting. One of the components of an entity's system of internal control is risk assessment. We hereby represent that our risk assessment process includes identification and assessment of risks of material misstatement due to fraud. We have shared with you our fraud risk assessment, including a description of the risks, our assessment of the magnitude and likelihood of misstatements arising from those risks, and the controls that we have designed and implemented in response to those risks.

28. We have no knowledge of allegations of fraud or suspected fraud affecting the Organization's basic financial statements involving:

    a. Management.

    b. Employees who have significant roles in internal control.

    c. Others where the fraud could have a material effect on the Organization's basic financial statements.

29. We have no knowledge of any allegations of fraud or suspected fraud affecting the Organization's primary government basic financial statements received in communications from employees, former employees, analysts, regulators, or others.

30. We have no knowledge of noncompliance or suspected noncompliance with laws and regulations.

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

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

33. We are aware of no significant deficiencies in internal control over financial reporting, including significant deficiencies or material weaknesses, in the design or operation of internal controls that could adversely affect the Organization's ability to record, process, summarize and report financial data.

34. There have been no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices.

35. We agree with the findings of the specialist in evaluating the incurred but not reported claim liability and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give instructions, or cause any instructions to be given, to the specialist 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 specialist.

36. We believe that the actuarial assumptions and methods used by the actuary for funding purposes and for determining accumulated plan benefits are appropriate in the circumstances. We did not give instructions, or cause any instructions to be given, to the actuary 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 plan's actuary.

37. The following have been made available to you:

    e. Contracts with all significant third-party party payers or other providers;

    f. Reports of regulatory examinations that are currently in process. Management is not aware of any allegations of noncompliance that should be considered for disclosure or as a basis for recording a loss contingency.

38. There are no:

    a. Violations or possible violations of laws or regulations, such as those related to the Medi-Care and Medi-Caid antifraud and abuse statutes, including but not limited to the Medi-Care and Medi-Caid Anti-Kickback Statute, Limitations on Certain Physician Referrals (the Stark law}, and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency.

    b. Communications, whether oral or written, from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction, including those related to the Medi-Care and Medicaid antifraud and abuse statutes, deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

39. During the course of your audits, you may have accumulated records containing data that should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us.

Supplementary Information

40. With respect to the management's discussion and analysis, schedules of proportionate share of the net pension (asset) liability and schedules of pension contributions presented as required by the Governmental Accounting Standards Board to supplement the basic financial statements:

    c. We acknowledge our responsibility for the presentation of such required supplementary information.

    d. We believe such required supplementary information is measured and presented in accordance with guidelines prescribed by U.S. GAAP.

    e. The methods of measurement or presentation have not changed from those used in the prior period.

Compliance Considerations

In connection with your audit conducted in accordance with *Government Auditing Standards,* we confirm that management:

41. Is responsible for the preparation and fair presentation of the financial statements in accordance with the applicable financial reporting framework.

42. Is responsible for compliance with the laws, regulations and provisions of contracts and grant agreements applicable to the auditee.

43. Is not aware of any instances of identified and suspected fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements that have a material effect on the financial statements.

44. Is responsible 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.

45. Acknowledges its responsibility for the design, implementation and maintenance of controls to prevent and detect fraud.

46. Has a process to track the status of audit findings and recommendations.

47. Is not aware of any investigations or legal proceedings that have been initiated with respect to the period under audit.

48. Acknowledges its responsibilities as it relates to non-audit services performed by the auditor, including that it assumes all management responsibilities; that it oversees the services by designating an individual, preferably within senior management, who possesses suitable skill, knowledge or experience; that it evaluates the adequacy and results of the services performed; and that it accepts responsibility for the results of the services.

Kern Health Systems

Emily Duran, Chief Executive Officer

Robert Landis, Chief Financial Officer

KERN HEALTH SYSTEMS

To: **KHS Board of Directors**

From: **Deborah Murr, MHA, BS-HCM, RN, Chief Compliance and Fraud Prevention Officer**

Date: **April 13, 2023**

Re: **2023 Compliance Program and Workplan**

Background

The Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC), requires organizations that participate as a California Med-Cal plan, to have a formal compliance program. Additionally, in response to the many laws, rules and regulations governing healthcare, e.g., federal and state false claims and whistleblower laws, KHS has established a comprehensive compliance program to help the organization achieve our commitment to adhere to the highest ethical standards of conduct in all business practices.

The focus of KHS's compliance program is to prevent fraud, waste, and abuse while at the same time advancing the mission of providing affordable and extraordinary primary and specialty care that adheres and aligns with to the regulatory requirements under the office of Inspector General (OIG). Our overall compliance efforts are aimed at prevention, detection, and resolution of variances through audits and monitoring activities to identify new or emerging risk.

Discussion

Annually, KHS prepares a workplan after reviewing the latest Department of Health Care Services (DHCS) and Department of Managed Care (DMHC) priorities, recent enforcement activities, recent internal and external audit findings and other relevant topics that necessitate additional scrutiny. Additionally, the workplan includes a list of areas that the Compliance Department will audit and monitor.

Violations of the organization's compliance program, failure to comply with applicable state or federal law, and other requirements of government health plans, and other types of misconduct may threaten KHS's status as a reliable, honest, and trustworthy provider, capable of participating in federal and state healthcare programs. Detected, but uncorrected, misconduct may seriously endanger the mission, reputation, and legal status of the organization.

Requested Action

Approve the 2023 Compliance Program and the 2023 Compliance Workplan.

2023 Compliance Program and Workplan Board of Directors

Deborah Murr, MHS, BS-HCM, RN

Chief Compliance and Fraud Prevention Officer

April 13, 2023

Agenda

- Purpose
- Compliance Program
- Compliance Workplan
- Next Steps

KERN HEALTH SYSTEMS

Purpose

As required under Department of Health Care Services contract and defined under Code of Federal Regulations 42 CFR section 438.608, KHS has established a comprehensive Compliance Program and Workplan, designed to outline the organizations commitment to our program integrity and processes.

KERN HEALTH SYSTEMS

Compliance Program

Key elements for an effective compliance program:

- Designation of a compliance officer and compliance committee
- Development of compliance policies and procedures, including standards of conduct and non-intimidation/retaliation
- Developing open lines of communication
- Appropriate training and education
- Internal monitoring and auditing
- Response to detected deficiencies
- Enforcement of disciplinary standards

KERN HEALTH SYSTEMS

Compliance Workplan

Dynamic living document outlining the Compliance departments' strategic approach to ensuring KHS complies with applicable state and/or federal law, and other requirements under KHS's contract and Knox-Keene license

- Organizational approach to compliance
- Activity timelines defined and tracked
- Participation in industry collaborative meetings
- Corrective Action Plan tracking

Detected, but uncorrected, misconduct may seriously endanger the mission, reputation, and legal status of the organization.

KERN HEALTH SYSTEMS

Compliance Workplan Activities

Activities monitored within the Workplan and outlined in the Program:

- Annual Review/Update of Compliance Documents and Written Policies and Procedures
- Compliance Committee
- Monitoring and Oversight (Internal/External)
- Regulatory Audits
- All Plan Letters (APL)
- Fraud, Waste, and Abuse (FWA) Committee
- HIPAA Privacy
- Delegation Oversight

KERN HEALTH SYSTEMS

Requested Board Action

Request KHS Board of Directors approval for the 2023 Compliance Program and the 2023 Compliance Workplan.

KERN HEALTH SYSTEMS

Questions

Deborah Murr, Chief Compliance and Fraud Prevention Officer

deborah.murr@khs-net.com

661/664-5141

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

Kern Family Health Care™

Kern Health Systems

2900 Buck Owens Blvd
Bakersfield CA 93308
661/664-5000

2023 CORPORATE COMPLIANCE PROGRAM

Table of Contents

Executive Summary

Why Have a Compliance Program

Kern Health System's Compliance Program is necessary because it:

- Stops fraud;
- Protects patient privacy;
- Nurtures an ethical culture;
- Prevents conflicts of interest;
- Ensures proper credentialing;
- Identifies and prevents waste;
- Furthers accurate billing and coding;
- Assists in obeying state and federal laws;
- Maintains and promotes high quality care; and
- Strives to promote the use of best practices in management and board governance.

Kern Health System Health's Compliance Program applies to:

- Vendors
- Contractors
- Consultants
- All staff no matter the title or position
- Board of Directors

What you must do:

- Act fairly;
- Act ethically;
- Act honestly;
- Act as a team;
- Report a conflict of interest that you may have;
- Treat patients and one another with respect at all times;
- Identify ways to do things better in your department and act; and
- Report problems immediately to your supervisor, directly to the Compliance Director and/or the Chief Compliance and Fraud Prevention Officer or take advantage of our anonymous compliance hotline options.

COMPLIANCE PROGRAM

I. INTRODUCTION

Kern Health System (KHS) d.b.a. Kern Family Health Care (KFHC) is the Local Initiative for the arrangement of medical, social, and behavioral health care for Medi-Cal enrollees in Kern County. KHS is a public agency formed under Section 14087.38 of the California Welfare and Institutions Code. KHS began full operations on September 1, 1996, under the Kern County Board of Supervisors. KHS serves more than 365,000 Medi-Cal participants in Kern County. Medi-Cal is a jointly funded, Federal-State health insurance program for certain low-income beneficiaries. KHS is committed to the mission of improving the health of members with an emphasis on prevention and access to quality healthcare services. KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to elevate the health status of all community members. with a commitment to health equity, diversity, and inclusion. We are strongly committed to and have a longstanding reputation for lawful and ethical conduct. We take pride in earning the trust of those we serve, government regulators and one another.

The Department of Health Care Services (DHCS), Department of Managed Health Care, and Knox Keene License, requires organizations that participate as California Med-Cal plan, to have a formal compliance program. The Unites States Department of Health and Human Services, Office of the Inspector General (OIG) requires Medi-Cal providers to have a compliance program as well. Additionally, in response to the many laws, rules and regulations governing healthcare, e.g., federal and state false claims and whistleblower laws, KHS has established a comprehensive compliance program to help the organization achieve our commitment to adhere to the highest ethical standards of conduct in all business practices.

One goal of KHS's compliance program is to prevent fraud, waste, and abuse while at the same time advancing the mission of providing affordable and extraordinary primary and specialty care. Our compliance efforts are aimed at prevention, detection, and resolution of variances.

The eight elements of the KHS's Compliance Plan are:

1. Written policies and procedures
2. Designation of a Compliance Officer/Committee
3. Training and education programs
4. Open lines of communication to the responsible compliance position
5. Disciplinary policies to encourage good faith participation
6. A system for routine identification of compliance risk areas

7. A system for responding to compliance issues

8. A policy of non-intimidation and non-retaliation for good faith participation in the compliance program

II. COMPLIANCE STRUCTURE

KHS's compliance program starts with its Board of Directors, who must assure the organization operates in compliance with applicable Federal, state, and local laws and regulations. The Board of Directors provide direction to our CEO, who sets the tone for the organization's compliance activities.

The Chief Compliance and Fraud Prevention Officer works to ensure the organization has the appropriate policies, procedures, and processes in place to minimize its risk and further the organization's mission to provide a holistic approach to services offerings while promoting equitable and timely access. In addition to the Chief Compliance and Fraud Prevention Officer, the Compliance Team consists of the Director of Compliance, a Compliance Manager, a Compliance Manager of Audits and Investigations, Compliance Analyst(s), Compliance Auditor, and Compliance Specialist. On a quarterly basis, the Chief Compliance and Fraud Prevention Officer and the Director of Compliance meet with the staff compliance committee and provide updates on the department's current and future activities.

How KHS's Compliance Program Aligns to OIG Standards

Eight Steps of Compliance							
Written Policies and Procedures	**Designation of a Compliance Officer/ Committee**	**Training and Education Programs**	**Open Lines of Communication**	**Disciplinary policies to encourage good faith participation**	**A system for routine identification of compliance risk areas**	**A system for responding to compliance issues**	**A policy of non-intimidation and non-retaliation**
• Fraud, Waste & Abuse, Anti-Kickback Statute, False Claims Act and Stark Law policies • Whistle Blower/ Non-retaliation policy • Clinical policies • HIPAA • Conflict of Interest • Exclusion screening	• Compliance Officer job description • Compliance Committee Chair • Oversight responsibility of the Program • Prepare an Annual Compliance Report	• Annual compliance training • Compliance on-boarding training • Monthly Spotlight • Department training events • Training at periodic all Staff meetings • Ad Hoc training inform and train on recent events	• Open door policy • Compliance Hotline: allows individuals to report perceived compliance issues anonymously either online, through email, fax or mail	• All members of organization are required to comply with applicable standards, laws, and procedures. • Supervisors and/or Managers are account-able for the foreseeable compliance failures of their subordinates	• Annual identification of top risks • Ongoing audit and monitoring activities • Ad hoc audits • Monthly exclusion screening • Maintain anonymous outside Hotline. • Annual risk assessment • Credentialing and peer review	• Internal investigations and reporting • Review of an Annual Conflict of Interest Disclosure Forms • Process for reporting and resolving incidents	• Whistleblower/ non-retaliation policy

III. WRITTEN POLICIES AND PROCEDURES

The written compliance policies and procedures provide a clear explanation of the organization's compliance and quality goals and provide clear and understandable mechanisms and procedures designed to achieve those goals in compliance with Federal, state, and other program requirements and standards. The organization has specific, individual policies for an array of matters ranging from proper documentation of services to whistle blower protections. In addition, the organization's policies and procedures are available online at the KHS's company site.

A. Conflict of Interest Policy and Disclosure Statement

KHS is required to ensure that it adheres to the highest standards of ethical conduct by identifying instances which an independent observer might reasonably conclude that the potential for individual or institutional conflict could influence decision making or carrying out responsibilities. KHS has a conflict of interest policy that is based upon full disclosure and appropriate management of any possible conflict of interest. The policy requires staff to conduct their business according to the highest ethical standards of conduct and to comply with all applicable laws.

KHS requires individuals to complete the annual conflict of interest disclosure form to assist in identifying and evaluating potential conflicts of interests. Individuals also are required to disclose any actual, potential, or perceived conflicts as they arise during their affiliation or employment with KHS. The forms are reviewed on an annual basis or when the need to complete the statement arises (new hires or changed circumstances). It is the responsibility of everyone to have a working knowledge of these policies and procedures and refer to them.

B. Other Written Policies and Procedures

Annual Work Plan

Every year, the Chief Compliance and Fraud Prevention Officer will prepare a Work Plan after reviewing the latest Department of Health Care Services (DHCS) and Department of Managed Care (DMHC) priorities, recent enforcement activities, recent internal and external audit findings and other relevant topics that necessitate additional scrutiny. Additionally, the Chief Compliance and Fraud Prevention Officer will obtain input from the Chief Executive Officer, the Director of Compliance, the staff Compliance Committee and various departments.

Additionally, the Work Plan includes a list of areas that the Compliance Department will audit and monitor. The Compliance Department may add additional monitoring audits to its duties in response to new and emerging risks.

The Compliance Department and audited departments will review the audit findings and develop audit responses to address findings. The parties will develop remediation plans and associated timelines. The Compliance Department will conduct follow-up on remediation activities and report progress to the Chief Executive Officer and the Chief Compliance and Fraud Prevention Officer. Additionally, the Compliance Department will coordinate external audits from state and other regulatory oversight organizations.

C. Ad Hoc Policy and Procedure Development

From time to time, the Compliance Department will work with other departments to develop and revise policies and procedures to reflect new legal requirements and new concerns that may arise.

IV. DESIGNATION OF A COMPLIANCE OFFICER AND/OR A COMPLIANCE COMMITTEE

DHCS requires KHS to designate a compliance officer to carry out and enforce compliance activities. The compliance officer should function as an independent and objective person that reviews and evaluates organizational compliance and privacy/confidentiality issues and concerns. The compliance officer's main duties include coordination and communication of the compliance plan; this involves planning, implementing, and monitoring the program.

A. Chief Compliance Officer

The responsibilities of the Chief Compliance Officer are:

- Chair the Compliance Committee and serve as a spokesperson for the Committee.
- Oversee and monitor the implementation of the compliance program.
- Report periodically to the Compliance Committee, the Chief Executive Officer and the Board of Directors on the progress of implementation of compliance initiatives, corrective actions and recommendations to reduce the vulnerability to allegations of fraud, waste, and abuse.
- Develop and distribute all written compliance policies and procedures to all affected employees.
- Periodically revise the program in light of changes in the needs of the organization and in the law; and changes in policies and procedures of government payer health plans and emerging threats.
- Develop, coordinate, and participate in a multifaceted educational and training program that focuses on the elements of the compliance program and seeks to ensure that all employees are knowledgeable of, and comply with, pertinent federal and state payer standards.

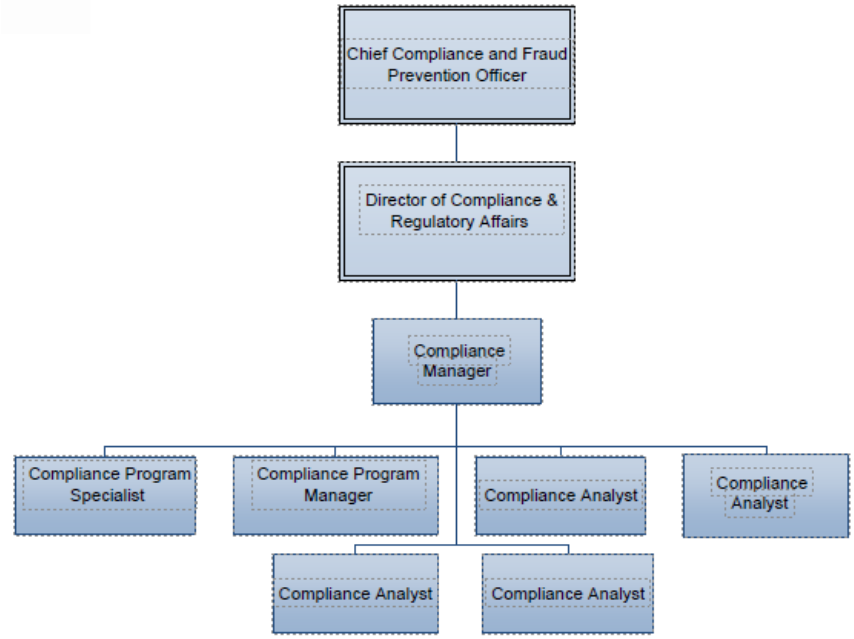
- Ensure that employees, vendors, and Board of Directors do not appear on any of the Federal or State “excluded, debarred or suspended” listings published by Medicare and Medicaid.
- Ensure that all Providers/Staff are informed of compliance program standards with respect to coding, billing, documentation, and marketing, etc.
- Assist in coordinating internal compliance review and monitoring activities, including annual or whenever necessary reviews of policies.
- Review the results of compliance audits, including internal reviews of compliance, independent reviews, and external compliance audits.
- Independently investigate and act on matters related to compliance, including the flexibility to design and coordinate internal investigations.
- Develop policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation. (See Whistleblower Policy)
- Interact with external legal counsel to discuss the Organization’s initiatives on regulatory compliance.
- Handle inquiries by employees, affiliates, members, and family members regarding compliance issues.

The Chief Compliance and Fraud Prevention Officer has the authority to review all documents and other information relative to compliance activities, including, but not limited to Human Resources/Personnel records, requisition forms, billing information, claims information, and records concerning marketing efforts and arrangements with vendors.

B. Compliance Department Organizational Structure

The Chief Compliance and Fraud Prevention Officer supervises the Director of Compliance. The Director of Compliance and Regulatory Affairs supervises the Compliance Manager. The Compliance Manager oversees the Compliance Program Manager, Compliance Analyst(s), Compliance Auditor, and compliance Specialist, and other positions which may be added based on the department’s identified operational needs.

Because the Chief Compliance and Fraud Prevention Officer is responsible for compliance oversight for all other departments of the organization, this position reports directly to the Chief Executive Officer to mitigate risk.



C. Compliance Committee

The Organization will designate a Compliance Committee to advise the Chief Compliance and Fraud Prevention Officer and assist in the implementation of the compliance program as needed. The Compliance Committee will consist of at least the Executive Officers and Departmental leadership. The Chief Compliance and Fraud Prevention Officer will also select designees representing other departments as needed.

The functions of the Compliance Committee are to:

- Analyze the organization's regulatory environment, the legal requirements with which it must comply, and specific risk areas.
- Assess existing policies and procedures that address risk areas for possible incorporation into the Compliance Program.
- Work within the organization's standards of conduct and policies and procedures to promote compliance.
- Recommend and monitor the development of internal systems and controls to implement standards, policies, and procedures as part of the daily operations.
- Determine the appropriate strategy/approach to promote compliance with the program and detection of any potential problems or violations.
- Develop a system to solicit, evaluate, and respond to complaints and problems.

V. CONDUCTING EFFECTIVE TRAINING AND EDUCATION

An effective Compliance Program is rooted in an active and adaptive education and training program. Active education and training is designed to teach each individual how to carry out their responsibilities effectively, efficiently and in compliance with statutory and regulatory compliance requirements. Adaptive education and training is designed to be responsive to the educational needs of the organization's workforce identified through internal and/or external reviews, audits, or compliance assessments or by government notices, alerts, and/or other advisory statements.

Inadequate training significantly increases the risks of compliance issues and possible violations of the applicable statutes and regulations. KHS requires all employees, contractors, and volunteers to attend specific training upon hire and on an annual and as needed basis thereafter. This will include training in federal and state statutes, regulations, program requirements, policies, code of conduct and corporate ethics. The training emphasizes KHS's commitment to compliance with these legal requirements and policies.

The training programs will include sessions highlighting KHS's Compliance Program, summaries of fraud and abuse laws, HIPAA regulations, policy and procedures that reflect current legal and program standards.

The Chief Compliance and Fraud Prevention Officer or other designated staff member will document the attendees, the subjects covered, and any materials distributed at the training sessions.

Basic training will include:

- Overview of the organization's regulatory environment
- Examples of fraud, waste, and abuse.
- Recent enforcement activities
- KHS's compliance structure
- Eight elements of compliance
- Location of compliance plan and policies and procedures on the KHS's SharePoint site and company website
- Key laws and regulations
- KHS's commitment to non-retaliation
- Compliance hotline information for making anonymous complaints
- Duty to report misconduct.

VI. DEVELOPING EFFECTIVE AND OPEN LINES OF COMMUNICATION

COMPLIANCE PROGRAM

A. Open Lines of Communication

Open lines of communication encourage everyone to express their compliance, quality, and other concerns and/or suggestions for improvement without fear of retaliation. Open communication is essential to maintaining an effective Compliance Program and enables the organization to learn about issues that may arise, generating faster responses and quicker fixes. Additionally, open communications allow KHS to address small problems before they become big ones.

Any potential problem or questionable practice which is, or is reasonably likely to be, in violation of, or inconsistent with, federal or state laws, rules, regulations, or directives or the organization rules or policies relative to the delivery of healthcare services, or the billing and collection of revenue derived from such services, and any associated requirements regarding documentation, coding, supervision, and other professional or business practices must be reported to the Chief Compliance and Fraud Prevention Officer.

Any person who has reason to believe that a potential problem or questionable practice is or may be in existence should report the circumstance to the Chief Compliance and Fraud Prevention Officer. Such reports may be made verbally or in writing and may be made on an anonymous basis. KHS utilizes an external vendor, Ethics Point, so that employees may anonymously report violations though the following mediums:

Online:	www.kernfamilyhealthcare.com FraudTeam@khs-net.com HIPAATeam@khs-net.com Compliance@khs-net.com
Phone:	Ethics Hotline 1(800) 500-0333
Mail:	Kern Health System Health c/o Chief Compliance and Fraud Prevention Officer, 2900 Buck Owens Blvd, Bakersfield CA 93308.

The Chief Compliance and Fraud Prevention Officer or designee will promptly document and investigate reported matters that suggest substantial violations of policies, regulations, statutes, or program requirements to determine their veracity.

The Chief Compliance and Fraud Prevention Officer will work closely with legal counsel who can provide guidance regarding complex legal and management issues.

B. Exit Interviews

VII. DISCIPLINARY GUIDELINES

All employees of KHS will be held accountable for failing to comply with applicable standards, laws, and procedures. Directors, Manages, and/or Supervisors will be held accountable for the foreseeable compliance failures of their subordinates.

The Director, Manager, or Supervisor will be responsible for taking appropriate disciplinary actions in the event an employee fails to comply with applicable regulations or policies. The disciplinary process for violations of compliance programs will be administered according to KHS protocols (generally oral warning, written warning, suspension without pay, and may lead to termination) depending upon the seriousness of the violation. The Chief Compliance and Fraud Prevention Officer is to be consulted and may consult legal counsel in determining the seriousness of the violation. However, the Chief Compliance and Fraud Prevention Officer should never be involved in imposing discipline.

If the deviation occurred due to legitimate, explainable reasons, the Chief Compliance and Fraud Prevention Officer and director/manager/supervisor may want to limit disciplinary action or take no action. If the deviation occurred because of improper procedures, misunderstanding of rules, including systemic problems, KHS should take immediate action to correct the problem.

When disciplinary action is warranted, it should be prompt and imposed according to written standards of disciplinary action established and defined within the Human Resources Personnel Manual.

Within 30 working days after receipt of an investigative report, the Director/Manager/Supervisor and/or Chief Human Resources Officer or their designee shall determine the action to be taken upon the matter and refer to the CEO for final recommendations. The action may include, without limitation, one or more of the following:

1) Dismissal of the matter.
2) Verbal counseling.
3) Issuing a warning, a letter of admonition, or a letter of reprimand.
4) Entering and monitoring of a formal corrective action plan. The corrective action plan may include requirements for individual or group remedial education and training, consultation, proctoring, and/or concurrent review.
5) Reduction, suspension, or revocation of clinical/assigned privileges.
6) Suspension or termination of employment.
7) Modification of assigned duties.
8) Reduction in the amount of salary compensation in parallel with demotion.

The CEO shall have the authority to, at any time, suspend summarily the involved employee or contractor's privileges or to summarily impose consultation, concurrent review, proctoring, or other conditions or restrictions on the assigned duties of the involved party in order to reduce the substantial likelihood of violation of standards of conduct.

VIII. AUDITING AND MONITORING

The Chief Compliance and Fraud Prevention Officer will conduct ongoing evaluations of compliance processes involving thorough monitoring and regular reporting to the KHS Executive leadership/officers.

The Chief Compliance and Fraud Prevention Officer will develop an annual audit plan that is designed to address KHS's key compliance risks, including but not limited to the Department of Health Care Services contract and the Department of Managed Care Knox-Keen license requirements. The audit work program steps will inquire into compliance with specific rules and policies that have been the focus of Medi-Cal regulatory agencies.

The Chief Compliance and Fraud Prevention Officer should be aware of patterns and trends in deviations identified by the audit that may indicate a systemic problem.

IX. RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

Violations of the organization's compliance program, failure to comply with applicable state or federal law, and other requirements of government health plans, and other types of misconduct may threaten KHS's status as a reliable, honest, and trustworthy provider, capable of participating in federal and state healthcare programs. Detected, but uncorrected, misconduct may seriously endanger the mission, reputation, and legal status of the organization. Consequently, upon reports or reasonable indications of suspected noncompliance, the Chief Compliance and Fraud Prevention Officer must initiate an investigation to determine whether a material violation of applicable laws or requirements has occurred.

The steps in the internal investigation may include interviews and a review of relevant documentation. Records of the investigation should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed, and the documents reviewed, results of the investigation, and the corrective actions implemented.

Additionally, the Chief Compliance and Fraud Prevention Officer must take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

If the results of the internal investigation identify a problem, the response may be immediate referral to criminal and/or civil law enforcement authorities, development of a corrective action plan, a report to the government, and submission of any overpayments, if applicable. If potential fraud or violations of the False Claims Act are involved, the Chief Compliance and Fraud Prevention Officer should report the potential violation to the Office of the Inspector General or the Department of Justice.

The CEO shall have the authority and responsibility to direct repayment to payers and the reporting of misconduct to enforcement authorities as is determined, in consultation with legal counsel, to be appropriate or required by applicable laws and rules.

If the CEO discovers credible evidence of misconduct and has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the Chief Compliance and Fraud Prevention Officer will promptly report the matter to the appropriate government authority within the required timeframe after determining that there is credible evidence of a violation.

When reporting misconduct to the government, the Chief Compliance and Fraud Prevention Officer should provide all evidence relevant to the potential violation of applicable federal or state laws and the potential cost impact.

X. NON-INTIMIDATION AND NON-RETALIATION POLICIES

The organization will protect whistle-blowers from retaliation. KHS will not retaliate against employees who, in good faith, have raised a complaint against some practice of the organization, or of another individual or entity with whom KHS has a business relationship, on the basis of a reasonable belief that the practice is in violation of law, or a clear mandate of public policy.

Staff, vendors, interns, contractors, and Board Members are obligated to report to the Chief Compliance and Fraud Prevention Officer any activity he or she believes to be inconsistent with KHS's policies or state and federal law. KHS has a Whistleblower policy which is intended to encourage and enable employees and others to raise serious concerns within the organization, prior to seeking resolution outside of the organization. The policy protects employees who in good faith reports an ethics violation from harassment, retaliation, or adverse employment consequence. Any employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. The Chief Compliance and Fraud Prevention Officer will notify the sender and acknowledge receipt of the reported violation or suspected violation within the required timeframes. All reports will be promptly investigated, and appropriate corrective action will be taken if warranted by the investigation.

XI. KERN HEALTH SYSTEM'S COMMITMENT TO COMPLIANCE

A. Standards of Conduct

KHS's employees are bound to comply, in all official acts and duties, with all applicable laws, rules, regulations, standards of conduct, including, but not limited to laws, rules, regulations, and directives of the federal government and the state of California, including KHS's rules and policies and procedures. These current and future standards of conduct are incorporated by reference in this Compliance Plan.

All candidates for employment shall undergo a reasonable and prudent background investigation, including a reference and criminal background check. Due diligence will be used in the recruitment and hiring process to prevent the appointment to positions with substantial discretionary authority, persons whose record (professional licensure, credentials, prior employment, criminal record or specific "exclusion" from Medi-Cal funded programs) gives reasonable cause to believe the individual has a propensity to fail to adhere to applicable standards of conduct.

All new employees will receive orientation and training in compliance policies and procedures. Participation in required training is a condition of employment. Failure to participate in required training may result in disciplinary actions, up to and including, termination of employment.

Every employee is asked to attest that they have received, read, and understood the contents of the compliance plan.

Every employee will receive an initial compliance orientation and periodic training updates in compliance protocols as they relate to the employee's individual duties.

Non-compliance with the plan or violations will result in sanctioning of the involved employee(s) up to, and including, termination of employment.

B. Member Rights

We treat our members with respect and dignity and provide care that is both necessary and appropriate. No distinction is made in the admission, transfer, discharge or care of individuals on the basis of race, creed, religion, national origin, gender, gender expression, sexual orientation, or disability. Clinical care is provided based on identified healthcare needs and Care Management is provided based on needs identified through a uniform assessment tool, and no treatment or action is undertaken without the informed consent of the patient or an authorized representative. Members are provided with a written statement of rights which conforms to all applicable laws, that ensure their autonomy and privacy are respected.

Employees involved in member's care are expected to know and comply with all applicable laws and regulations and our policies and procedures governing their particular program.

C. Personal Health Information/HIPAA

KHS collects and aggregates personal health information about our members to provide the best possible care. We realize the sensitive nature of this information and are committed to safeguarding our member's privacy.

The Chief Compliance and Fraud Prevention Officer is responsible for development and implementation of policies, procedures and educational programs that will ensure that KHS will continue to be compliant with the Privacy regulations and will also ensure that protected health information is secure.

To ensure that confidentiality is maintained, employees and their representatives must adhere to the following rules:

- Do not discuss protected health information (PHI)/ client information in public areas such as elevators, hallways, common gathering areas.
- Limit release of PHI/client information to the minimum reasonably necessary for the purpose of the disclosure.
- Do not disclose PHI without an appropriate consent signed by the member unless it is related to the person's care, payment of care, or health care operations of the organization. In an emergency, a member's consent may not be required when a healthcare provider treating the patient requests information, but the name and affiliation of the person requesting the information must be confirmed and documented in the medical record.
- Honor any restrictions on uses or disclosure of information placed by the member.
- Make sure PHI/member information stored in the computer system is properly secured.

- Be familiar with and comply with special confidentiality rules governing the disclosure of sensitive health care conditions, alcohol and substance abuse and behavioral/mental health treatment.

KHS maintains a Chief Information Officer who is responsible for the development and implementation of the policies and procedures required by the Security Rule.

The Chief Information Officer is responsible for ensuring Kern Health System engages in the following activities:

- Maintain appropriate security measures to ensure the confidentiality, integrity and availability of patients' electronic protected health information (EPHI).
- Adhere to applicable federal and state security laws and standards.
- Provide security training and orientation to all employees, volunteers, medical and professional staff.
- Comply with Security Policies including periodic risk assessments.
- Monitor access controls to EPHI to ensure appropriate access to authorized personnel.
- Maintain hardware and software with the appropriate patches and updates.
- Maintain a validation of compliance with the Data Security Standards, a set of security controls that businesses are required to implement to protect data.

D. Medical Necessity

KHS will take reasonable measures to ensure that only claims for services that are reasonable and necessary, given the member's condition/ client's needs are billed.

Documentation will support the determinations of medical necessity/member need when providing services.

KHS is aware that DHCS will only pay for services that meet the coverage criteria and are reasonable and necessary to treat or diagnose a suspected condition. Therefore, KHS's Providers will use prudent ordering practices.

In requesting diagnostic procedures or tests, KHS's Providers will make an independent medical necessity decision with regard a treatment plan. Documentation of findings and diagnoses will support the medical necessity of the service.

KHS's Providers understand that there may be limitations on services; therefore, the prior authorization process will be followed.

E. Billing

All claims for services submitted will correctly identify the services ordered.
Only those services that are performed and that meet payer criteria will be billed.

Intentionally or knowingly up coding (the selection of a code to maximize reimbursement when such code is not the most appropriate descriptor of the service offered) may result in disciplinary. KHS's providers must provide documentation to support services provided and billed based on clinical and behavioral findings and diagnoses.

Immediate disciplinary action, up to and including termination will be implemented for instances of intentional misrepresentation of any service if results in over billing.

All individuals who provide billing information and billing department employees who prepare or submit billing statements must comply with all applicable laws, rules and regulations and the organization's policies.

KHS will promptly return to payers any payments which we determine do not conform to our policies and applicable laws.

As healthcare providers, KHS's business involves reimbursement under government programs which require submission of certain reports of our costs of operations. KHS complies with all federal and state laws and regulations relating to cost reports, which define what costs are allowable and describe the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given the complexity of this area, all issues related to the completion and settlement of cost reports must be communicated through or coordinated with the Chief Financial Officer.

F. Compliance with Applicable Fraud Alerts

The Chief Compliance and Fraud Prevention Officer will review the Medi-Cal/Medicare Fraud Alerts.

The Chief Compliance and Fraud Prevention Officer will ensure that any conduct disparaged by the Fraud Alert is immediately ceased, implement corrective actions, and take reasonable actions to ensure that future violations do not occur.

G. Marketing

KHS will promote only honest, straightforward, fully informative, and non-deceptive marketing. We use marketing to educate the public, increase awareness of our services and recruit employees. All marketing materials must accurately describe

our services and programs. To ensure that no incorrect information is disseminated, employees must coordinate all marketing materials with and direct all media requests to the CEO or designee. KHS will only use and/or disclose any member protected health information for marketing activities if a written prior authorization is obtained.

H. Anti-Kickback/Inducements

KHS will not participate in nor condone the provision of inducements or receipt of kickbacks to gain business or influence referrals. KHS's Providers will consider the member's interests in offering referral for treatment, diagnostic, or service options.

Federal and state laws prohibit any form of kickback, bribe, or rebate, either directly or in directly, in cash or in kind, to induce the purchase or referral of goods, services or items paid for by Medicare or Medi-Cal.

Self-referral laws prohibit a Provider from referring a patient for certain types of health services to an entity with which the Provider or members of his or her immediate family has a financial relationship unless there is an applicable exception under the self-referral law.

Since violations of these laws may subject both KHS and the individual involved to civil and criminal penalties and exclusion from government-funded healthcare programs, all proposed transactions with healthcare providers must be reviewed with legal counsel.

Any employee involved in promoting or accepting kickbacks or offering inducements may be terminated immediately.

I. Relationships with Vendors and Suppliers

KHS is committed to employing the highest ethical standards in its relationships with vendors and suppliers with respect to source selection, negotiation, determination of contract awards, and administration of purchasing activities. All vendors and suppliers are to be selected solely based on objective criteria; personal relationships and friendships will play no part in the selection process. KHS does not knowingly contract or do business with a vendor that has been excluded from a government-funded healthcare program. Any vendor or suppler who has access to the organization's PHI and is not a covered entity, will be required to enter into a Business Associate Agreement to comply with applicable federal and state confidentiality and data protections rules, including HIPAA and 42 C.F.R. KHS will maintain a vendor review program for selecting and assessing the appropriate safeguards and security controls for key vendors.

J. Retention of Records/Documentation/Destruction

KHS will ensure that all records required by federal and/or state law are created and maintained. All records will be maintained as required under specific laws.

Documentation of compliance efforts will include staff meeting and committee minutes, audit reports, memoranda concerning compliance protocols, problems identified, and corrective actions taken, the results of any investigations, and documentation supportive of assessment findings, diagnoses, treatments, and plan of care.

Hard copy data that is not necessary or which the organization is no longer required to retain will be shredded and disposed of according to KHS policies.

K. Medical Record Documentation

Timely, accurate and complete documentation is important to clinical care. This documentation not only facilitates high quality care, but also serves to verify that billing is accurate as submitted.

KHS requires that Providers follow these documentation guidelines:

- The medical record is complete and organized.
- Documentation is timely
- The documentation of each encounter includes the reason for the encounter, any relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan of care, and date and legible identity of the observer.
- CPT and ICD-10 codes used for claims submission are supported by documentation in the medical record.
- Appropriate health risk factors are identified. The patient's progress, his or her response to treatment.
- Care management encounters will be documented

KHS will maintain a process for identifying and reviewing its billing and coding to ensure compliance with applicable state and federal requirements.

This plan has attempted to provide the foundation for development of an effective and cost-efficient compliance program.

COMPLIANCE PROGRAM

This Compliance Program may be altered or amended in writing only with the concurrence of the CEO, Chief Compliance and Fraud Prevention Officer and KHS's Compliance Committee.

Adoption of this Compliance Program has been approved and authorized as designated below, effective on_____.

Kern Health System Health, Inc.

By: _____Date: _____

KERN HEALTH SYSTEMS
2023
Compliance Program
Compliance Plan

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Compliance Plan									
A. Annual Review/Update of Compliance Documents and Written Policies and Procedures									
1. 2023 Compliance Plan	Create 2023 Compliance Plan and for Executive approval	3/31/2023	Director of Compliance		On Track	Draft submitted to CCO 03/29/2023			
1a. Obtain Board Approval	Obtain Board Approval of Compliance Plan	4/16/2023	Chief Compliance Officer		On Track				
2. Review/Update and Approval of Compliance Code of Conduct	Update Code of Conduct to align with 2024 DHCS Contract and obtain Board approval	5/22/2023	Director of Compliance		On Track				
2a. Obtain Board Approval of Compliance Code of Conduct	Obtain Board Approval of Compliance Code of Conduct	11/15/2023	Chief Compliance Officer		On Track				
3. Review/Update and Approval of Compliance Guide	Update Code of Conduct to align with 2024 DHCS Contract and obtain Board approval	5/22/2023	Director of Compliance		On Track				
3a. Obtain Compliance Committee Approval of Compliance Guide	Obtain Compliance Committee Approval of Compliance Guide	11/15/2023	Chief Compliance Officer		On Track				
4. Create 2023 Compliance Program	Create 2023 Compliance Program description and obtain Board approval	5/22/2023	Director of Compliance		On Track				
4a. Obtain Compliance Committee Approval of Compliance Program	Obtain Compliance Committee Approval of Compliance Program	11/15/2023	Chief Compliance Officer						
5. Coordinate Departmental Review/Update of all Policy and Procedures	Create schedule & ensure all policies	12/31/2023	Compliance Manager Compliance Analyst Compliance Specialist			Many reviews/updates underway as part of 2024 contract readiness			
5a. Create schedule and distribute to stakeholders	Create schedule for policy reviews and distribute	4/15/2023	Compliance Manager						
5b. Track to completion	All policies to be reviewed by end of year	12/31/2023	Compliance Manager Compliance Analyst Compliance Specialist						
5c. Report Policy Review Status in Compliance Committee Meetings	Provide quarterly update to Compliance Committee (number reviewed/to be reviewed by department)	2Q meeting and forward	Compliance Manager Compliance Analyst Compliance Specialist						
6. Review/Update Compliance Policy & Procedures	Review/Update all Compliance owned policy and procedures	9/30/2023	Director of Compliance Compliance Manager						
6a. Create Public versions of policies where needed (e.g. FWA, HIPAA)	Create public facing versions of identified policies (e.g. HIPAA; FWA; etc)	06/30/203	Director of Compliance Compliance Analyst						
6b. Finalize New HIPAA Privacy policies and procedures	Create missing privacy-related policies and procedures	6/30/2023	Director of Compliance Compliance Manager						
B. Compliance Committee and Oversight									
1. Conduct Committee Meetings at least quarterly									
1a. Conduct Compliance Committee meetings at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		On Track	Q1 Meetiing held 03/27/2023			
1b. Conduct Fraud, Waste, and Abuse Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		On Track				
1c. Conduct Delegation Oversight Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		On Track	Q1 Meeting held 03/24/2023			
2. Review/update Committee Charters at least annually	Review/Update Charters and obtain Committee Approvals								
2a. Compliance Committee	Review/Update Charter	04/30/2023	Chief Compliance Officer						
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	07/15/2023	Chief Compliance Officer						
2b. FWA Committee	Review/Update Charter	04/30/2023	Chief Compliance Officer						
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	07/15/2023	Chief Compliance Officer						
2c. Delegation Oversight Committee	Review/Update Charter	04/30/2023	Chief Compliance Officer						
2c.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	07/15/2023	Chief Compliance Officer						
3. Provide regular Compliance Updates to the Board of Directors	Distribute monthly Compliance Corner email communication by th 10th of each month	Bi-Monthly BOD Meetings	Chief Compliance and Fraud Prevention Officer/Director of Compliance		On Track	02/16/2023 BOD Update			
C. Effective Training and Education									
1. In coordination with HR, review/update Corporate Compliance Training									
1a. Compliance Training	Review/update Compliance Training	4/30/2023	Director of Compliance		On Track	In progress			
1b. Fraud, Waste, and Abuse Training	Review/Update FWA Training	4/30/2023	Director of Compliance		On Track				
1c. HIPAA/Privacy Training	Review/Update HIPAA/Privacy Training	4/30/2023	Director of Compliance		On Track				
2. In coordination with HR, track/report on completion of mandatory training (Compliance, FWA, HIPAA)	Track annual training to completion	12/30/2023	Director of Compliance (HR resource TBD)						
2a. Report training status in quarterly Compliance Committee Meetings	Report status of training completions, by department, in quarterly Compliance Committee Meetings	Quarterly	Director of Compliance (HR resource TBD)						
3. Review/Update New Hire Orientation Overview	Review/Update Compliance New Hire Orientation Overview	5/15/2023	Director of Compliance						
4. Compliance & Ethics Week	Plan and Execute activities for annual Compliance & Ethics Week	11/15/2023	Compliance Manager Compliance Team Members						
5. Establish Compliance Training for Subcontractors	Establish content and method for delegated entity/subcontractor Compliance training	10/31/2023	Compliance Manager Director of Compliance						
5a. Identify Delegated Entities/Subcontractors to receive training	Identify subcontractors to which Compliance Training applies	8/31/2023	Compliance Manager Director of Compliance						
5b. Implement Compliance Training for Subcontractors	Implement delegated entity/identified subcontractor training	12/31/2023	Compliance Manager Director of Compliance						

KERN HEALTH SYSTEMS
2023
Compliance Program
Compliance Plan

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
6. Review and provide feedback on content of Provider Manual	Review and continually expand upon content of Provider Manual for Compliance-related topics	Quarterly	Compliance Manager Director of Compliance		On Track	Compliance Manager Completed Review Director to review and submit to PNM			
7. Compliance distributes notifications to key stakeholders of any DHCS-related meeting/webinar/presentations	Receive, review, distribute regulatory updates regarding trainings, webinars, meetings to relevant stakeholders	Ongoing	Compliance Manager		On Track				
8. 2024 DHCS Contract Readiness Activities	Compliance coordinates with project team and key stakeholders on deliverables, AIRs, and implementation readiness	Ongoing	Director of Compliance Compliance Analyst		On Track				
9. Compliance key personnel attend regulatory-focused meetings:	Attend calls and report relevant updates to key stakeholders								
9a. LHPC call (weekly)		Weekly	Director of Compliance		On Track				
9b. CAHPS meeting (weekly)		Weekly	Manager of Compliance		On Track				
9c. DHCS Plan Call (including Payment Call) (weekly)		Weekly	Director of Compliance		On Track				
9d. DHCS topic-specific webinars/meetings (ad hoc)		As scheduled	Director of Compliance Compliance Manager		On Track				
9e. DMHC Roundtable Meetings (quarterly)		Quarterly	Director of Compliance		On Track				
9f. LHPC Compliance Officer Meetings (monthly)		Monthly	Chief Compliance Officer Director of Compliance		On Track				
9g. LHPC Compliance Officer Contract Readiness (bi-monthly)		Bi-Monthly	Chief Compliance Officer Director of Compliance		On Track				
D. Effective Lines of Communication									
1. Distribute Monthly "Compliance Corner" email communications	Distribute monthly Compliance Corner email communication by th 10th of each month	04/10/2023 - 12/10/2023	Compliance Manager Compliance Analysts						
2. Conduct Compliance Awareness Survey	Compliance will implement a compliance survey to obtain feedback from employees regarding various compliance topics such as training, retaliation, HIPAA, and the Compliance HelpLine. Such surveys evaluate how well the compliance program is functioning and identify areas that can be strengthened.	9/30/2023	Compliance Manager / Director of Compliance						
4. Focus at least one monthly Compliance Corner email on methods for communication with Compliance			Director of Compliance						
5. Compliance Updates			Director of Compliance						
5a. Compliance provide updates at monthly in Executive Officers Meeting			Director of Compliance						
5b. Compliance provides updates at least every-other-month in Operations Meeting									
6. Compliance continues to coordinate communication and hold meetings as needed regarding regulatory updates (APLs, emails, DHCS weekly meetings, etc.)			Compliance Manager Director of Compliance						
7. Participate in weekly Grievance & Appeals review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		On Track				
8, Participate in weekly Discriminations review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		On Track				
E. Well Publicized Disciplinary Standards									
1. In coordination with HR, ensure review of new hires against exclusionary databases and report out in Compliance Committee			Director of Compliance						
2. Incorporate further emphasis on disciplinary standards into Compliance materials, trainings, policies, and new hire orientation			Director of Compliance						
			Director of Compliance						
F. Routine Monitoring and Identification of Compliance Risks									
1. Complete Risk Assessments and incorporate into Compliance Auditing/Monitoring Plan		04/30/2023	Director of Compliance						
1a. 2022 APLs		04/30/2023	Director of Compliance						
1b. 2022 DHCS Medical Survey Findings		04/30/2023	Director of Compliance						
1c. 2023 DMHC Medical Survey Findings		04/30/2023	Director of Compliance						
1d. Prior Regulatory Audits		04/30/2023	Director of Compliance						
4. Establish Routine monthly Operational Reporting for Monitoring/Oversight/Identification of Potential Compliance Issues (e.g. Grievance timeliness)		04/30/2023	Director of Compliance			Has been added to 2024 Readiness project as acceptance criteria			
5. Based on final monitoring plan, report on items being monitored in quarterly Compliance Committee Meeting			Director of Compliance						
6. Based on final internal auditing plan, conduct and report out on all audits in the Compliance Committee Meeting (# TBD)			Director of Compliance						
			Director of Compliance						
G. Procedures and Systems for Prompt Response to Compliance Issues									
1. Create Compliance Issues Tracking Log		2/1/2023	Director of Compliance		On Track	Log created and 2023 items being tracked			
1a. Report on status of Compliance Issues in quarterly Compliance Committee Meetings		Q2, Q3, Q4 meetings	Director of Compliance Manager of Compliance						
2. Create Compliance Policy for Prompt Response to compliance Issues (include tracking mechanism, reporting, CAP process)		05/22/2023	Director of Compliance						
2a. Create Corrective Action Plan template for CAPs (internal/external)		05/22/2023	Director of Compliance						

KERN HEALTH SYSTEMS
2023
Compliance Program
Compliance Plan

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
2b. Report on status of CAPS in quarterly Compliance Committee Meetings		Q2, Q3, Q4 meetings	Director of Compliance						
			Director of Compliance						
H. Fraud, Waste, and Abuse (FWA)									
1. Attend Annual and Quarterly DOJ FWA Trainings		12/31/2023	Director of Compliance Chief Compliance Officer Compliance Analyst		On Track	Director of Compliance and Compliance Analyst attended in February	Scheduled to attend in San Francisco in May		
2. Review/Update Annual FWA Plan	Review, update, and submit annual FWA plan to DMHC	12/31/2023	Director of Compliance						
3. Facilitate FWA Data Mining Workgroup at least every other month	Facilitate workgroup meetings and prioritize		Director of Compliance						
3b. Identify and assess at least one FWA Data Mining Initiative per quarter			Director of Compliance / Compliance Analyst Data Mining Workgroup		On Track	* Impossible Visits and high-level E&M currently underway * Data refresh for transportation requested for 2nd quarter initiative	Transportation (ghost/duplicate trips)		
4. Conduct investigations regarding potential FWA and provide Updated FWA Reporting to FWA Committee									
I. Delegation Oversight						Part of Compliance Audit/Monitoring Plan			
1. Schedule & Coordinate Annual Delegation Oversight Audits									
1a. Kaiser		6/30/2023							
1b. VSP		7/31/2023							
1c. Stria		8/31/2023	Robin Dow-Morales - monthly Stria quality audit Director of Compliance						
1d. American Logistics (AL)		9/30/2023	Member Services Marketing						
1e. Health Dialog		6/30/2023	QI/UM			Identify additional elements that need to be audited (in progress)			
2. Determine additional Subcontractors to be audited (e.g. Interpreter; Health Education vendors; etc.) and develop schedule		4/30/2023	Director of Compliance (w/ Director of C&L/HE)						
3. Participate in delegated subcontractor joint operating meetings (JOM)									
3a. Kaiser									
3b. VSP									
3c. AL									
3d. Health Dialog									
4. Create delegation reporting and compliance plan in accordance with 2024 contract readiness requirements									
4a. Delegation Function Matrix		5/22/2023							
4b. Delegation Justification and Plan		5/22/2023							
4c. Contract Requirements Grid		5/22/2023							
5. Track Delegated Entity Compliance with APLs through APL grid attestation at least quarterly	Distribute APL grid to Kaiser and VSP; follow up as needed with subcontractors to complete; report out on status in Delegation Oversight Committee quarterly	Send by the 10th of each month	Compliance Manager						
5a. Report status of Delegates APL compliance quarterly	Report status in Delegation Oversight Committee meeting quarterly	Meeting schedule	Compliance Manager			2022 Grid distributed and responses received Q1 to be distributed by 04/10/2023			
5b. Determine how to incorporate other subcontractors and which subcontractors and begin distribution/tracking	Distribute APL grid and track to ensure responses received								

KERN HEALTH SYSTEMS

To: **KHS Board of Directors**

From: **Anita Martin, Chief Human Resources Officer**

Date: **April 13, 2023**

Re: **2022 Employee Engagement Survey Summary**

Background

On an annual basis, Kern Health Systems conducts an employee engagement survey to:

- Gauge overall employee satisfaction
- Identify factors which influence employee retention.
- Evaluate internal opportunities for enhancing employees work experience.
- Determine year to year trends to address concerns and celebrate progress.

We have just completed our eighth survey. This year's survey will be used to assess employee's satisfaction and work engagement with KHS. Included is the report with overall employee engagement results and a summary presentation.

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

Employee Satisfaction & Engagement Survey 2022

Anita Martin
Chief Human Resources Officer
April 13, 2023

Employee Feedback

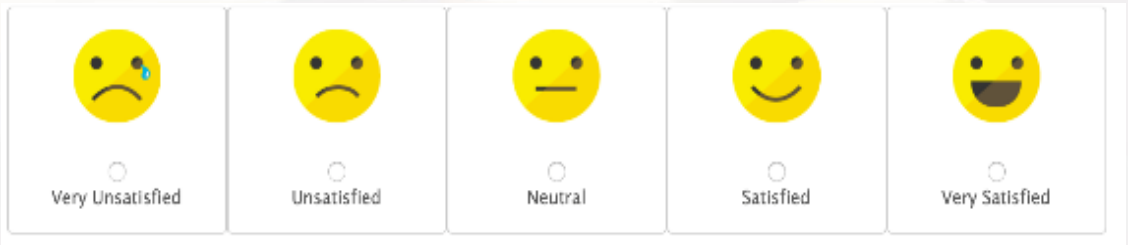
Response Rate:

82.9%

The response rate to the survey is the first indication of the level of employee engagement in the organization. Of 491 active employees, 407 employees responded for a response rate of 82.9%. As a general rule, rates higher than 50% suggest soundness, while rates lower than 30% may indicate problems. At 82.9%, the response rate is considered high. High rates mean that employees have an investment in the organization and are willing to contribute towards making improvements within the workplace. With this level of engagement, employees have high expectations from leadership to act on the survey results.

Scoring:

Responses are scored on a 5-point scale from Very Unsatisfied to Very Satisfied. The scale is as follows;



Employee Satisfaction

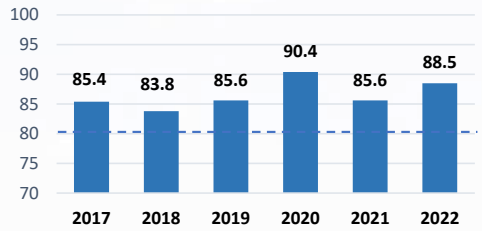
Similar items are grouped together, and their scores are averaged to produce sixteen construct measures. These constructs capture the concepts most utilized by leadership and drive organizational performance and engagement. Each Construct consists of two (2) to eight (8) questions and are grouped together to an average score for each construct.

Overall Satisfaction	Enthusiasm to come to work daily	Executive Team	Department Leadership	Corporate Culture	Pride
Corporate Communications	Department Communications	Career Development	Your Role at KHS	Rewards and Recognition	Teamwork and Collaboration
Immediate Supervisor	Diversity	Pay and Benefits	I would recommend KHS to a Friend or Relative		

RESULTS: At a **92.4% Overall Satisfaction** rating, Kern Health Systems ranks among the top employers in the US in Employee Satisfaction. This can only be achieved by the intentional efforts of leadership to value their staff, provide meaningful work, and provide an environment of inclusion and belonging. **Most notable is that all constructs were above our 80% desired benchmark, and 14 of the 16 constructs increased from 2021.**

Employee Satisfaction Trends

Overall Enthusiasm to come to work everyday

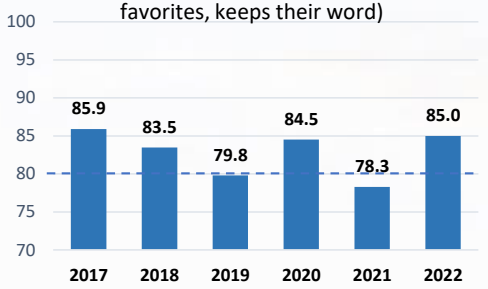


My Departments Leadership

(confidence, planning, doesn't play favorites, leads by example)

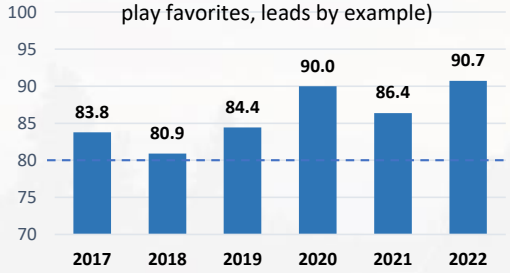
Executive Team

(confidence, planning, doesn't play favorites, keeps their word)



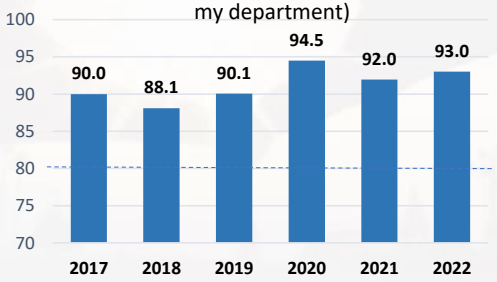
My Corporate Culture

(confidence, planning, direction, doesn't play favorites, leads by example)



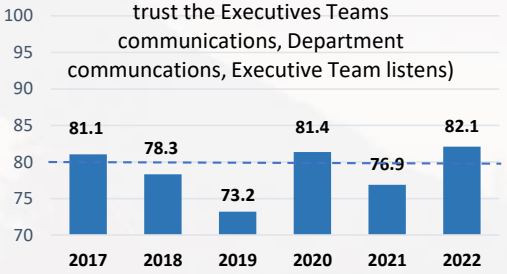
Pride

(proud to work at KHS, proud to wok in my department)



Corporate Communication

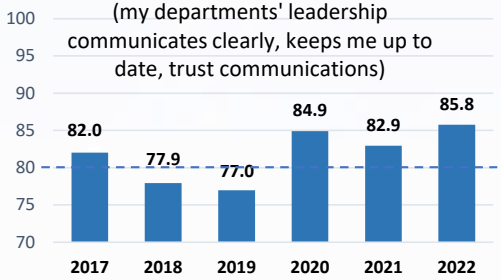
(KHS communications frequent enough, trust the Executives Teams communications, Department communcations, Executive Team listens)



Employee Satisfaction Trends

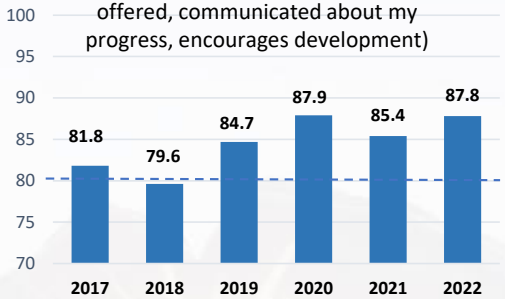
Department Communications

(my departments' leadership communicates clearly, keeps me up to date, trust communications)



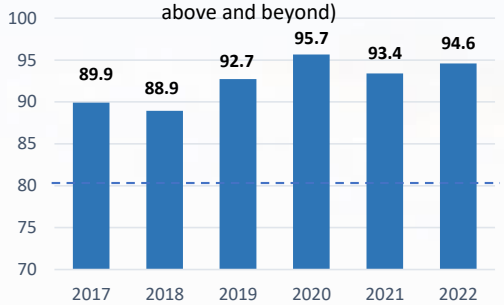
Career Development

(opportunities to learn and grow, OJT offered, communicated about my progress, encourages development)



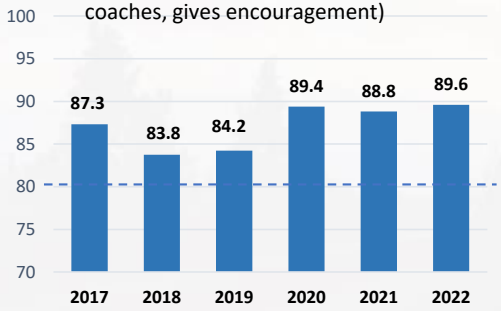
Your Role at KHS

(understand my role, willingness to go above and beyond)



Immediate Supervisor

(fair, handles issues satisfactorily, coaches, gives encouragement)

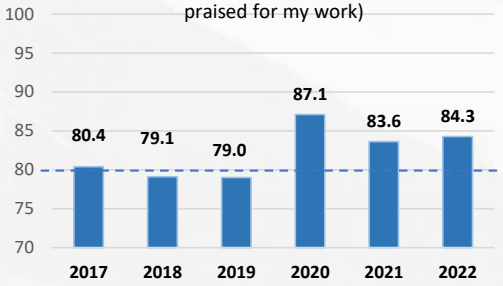


Diversity & Inclusion

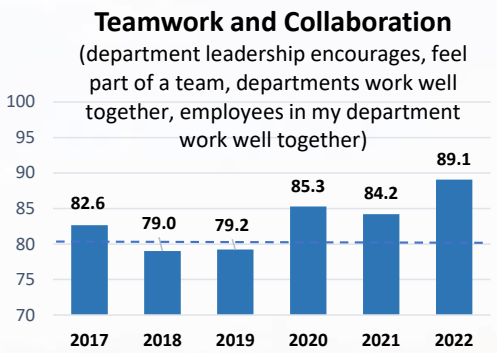
(all employees are treated fairly, comfort level with employees of diverse backgrounds, leadership ensures diversity)

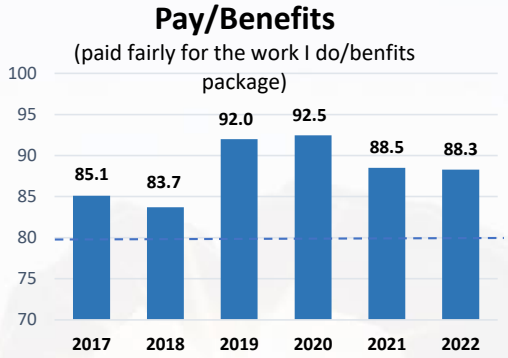
Recognition and Rewards

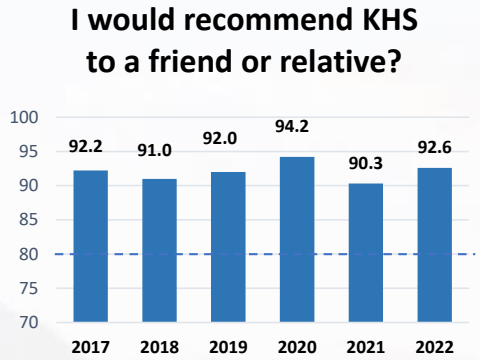
(I am valued, KHS recognizes work well done, praised for my work)



Employee Satisfaction Trends







Summary of the 2022 Survey

At a **92.4% Overall Satisfaction** and an **84.6% Overall Engagement** KHS continues to far exceed the national average. All satisfaction scores increased and one area was close to neutral.

Strengths

- KHS remains strong in **Diversity and Inclusion**.
- Employees have a complete understanding of **Their Role** and how it contributes to the mission of KHS and how it benefits our community.
- Employees feel a strong sense of **Pride** in working at KHS.
- Surveying our employees annually has given them an opportunity to have a voice in the company.
- Employees feel a strong connection with their **Immediate Supervisor**.

Opportunities

- Continue developing new and innovative ways to communicate to the company as a whole.
- Directors to partner and collaborate with other leadership for Inter-department communication or cross-functional project opportunities.
- Recognition – Feedback to employees on performance and praise for job well done during one-on-ones, during team meetings and monthly employee of the month nominations.

Questions

For additional information, please contact:

Anita Martin
Chief Human Resources Officer
(661) 664-5000

Kern Health Systems
2022 Employee Satisfaction & Engagement Survey Results

Report Prepared
for
KHS Board of Directors
April 13, 2023

Anita Martin, Chief Human Resources Officer
anita.martin@khs-net.com

Contents

Executive Summary

On the heels of 2021, which was coined as the year of "*The Great Resignation*," many organizations continued to face challenges. In 2022, many organizations brought employees back to the workplace, while others developed telecommuting and hybrid work schedules or a combination of all three. The blended workforce has become prevalent across all regions and many industries. This allowed some flexibility for employees and garnered higher levels of employee satisfaction and engagement. Yet, 2022 was not without its challenges. The four major challenges employers faced were;

- Attracting and retaining top talent.
- Upskilling and reskilling employees.
- Building and preserving company culture (particularly in a remote or hybrid environment).
- Reducing internal compliance and data security risk.

With people quitting their jobs at record pace in 2021 to seek "gig" work, or to take a break from their current profession, 2022 became the year that focused on recruiting, retaining top talent and keeping employees engaged. As noted by Forbes and Josh Bersin, 2022 quickly became the year of "too many jobs, not enough people."[1]

In addition to what organizations were facing in 2022, employees faced a myriad of challenges including balancing the rising costs of goods and services, a significant reduction in childcare options and managing their overall wellness and mental health. In addition, they continued to reexamine their priorities in pursuit of higher wages, more autonomy and greater flexibility. The collision of these variables between organizations and their employees resulted in an even greater need to retain top talent and keep them fully engaged.

In 2023, organizations will continue to face significant challenges including a competitive talent landscape, an exhausted workforce, and pressure to control costs amid a looming economic downturn. How employers respond to these challenges could determine whether they remain or become an employer of choice. During times of change and uncertainty, it is more important than ever to let employees know that they are valued, their work has purpose, and their voice is being heard. When employees experience these attributes, they remain engaged and connected to their work. Highly engaged employees drive performance and retention and provide that discretionary effort needed to meet and even exceed an organizations goals and objectives. KHS is committed to maintaining an engaged workforce and providing our employees a voice in their workplace.

[1] Bersin, Josh. Josh Bersin.com. Welcome to 2022: Too Many Jobs, Not Enough People – JOSH BERSIN. *"Welcome to 2022: Too Many Jobs, Not Enough People.* February 26, 2022. Accessed March 30, 2023.

The Survey

- Divided into 2 areas: Employee Satisfaction and Employee Engagement.
    - Why measure both? What's the difference?
    - While the terms "employee engagement" and "employee satisfaction" may sound similar, they are actually quite different.
- Employee satisfaction is the state of a worker enjoying their job — but not necessarily being engaged with it. Imagine the employee who gets to show up to work early and leave late without contributing much or breaking a sweat.
- Employee engagement is something that occurs when workers are committed to helping their companies achieve all of their goals. Engaged employees are motivated to show up to work every day and do everything within their power to help their companies succeed.[2]

[3]

[2] https://www.tinypulse.com/blog/employee-engagement-employee-satisfaction-difference

[3] https://www.decision-wise.com/employee-engagement-survey-download/

Employee Satisfaction:

- Similar items are grouped together, and their scores are averaged to produce sixteen construct measures. These constructs capture the concepts most utilized by leadership and drive organizational performance and engagement.

Overall Satisfaction	Enthusiasm to come to work daily	Executive Team	Department Leadership	Corporate Culture	Pride
Corporate Communications	Department Communications	Career Development	Your Role at KHS	Rewards and Recognition	Teamwork and Collaboration
Immediate Supervisor	Diversity	Pay and Benefits	I would recommend KHS to a Friend or Relative		

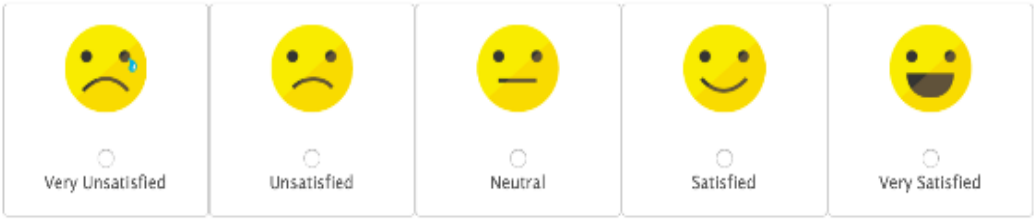
- Each construct consists of two (2) to eight (8) questions and are grouped together to get an average score for each construct.

Employee Engagement: The Gallup Q12 Questions

1) I know what is expected of me at work.
2) I have the materials and equipment I need to do my work right.
3) At work, I have the opportunity to do what I do best every day.
4) In the last seven days, I have received recognition or praise for doing good work.
5) My supervisor, or someone at work, seems to care about me as a person.
6) There is someone at work who encourages my development.
7) At work my opinions seem to count.
8) The mission or purpose of my company makes me feel my job is important.
9) My associates or fellow employees are committed to doing quality work.
10) I have a best friend at work.
11) In the last six months, someone at work has talked to me about my progress.
12) This last year, I have had opportunities to learn and grow.

Scoring

- Responses are scored on a 5-point scale from Very Unsatisfied to Very Satisfied. The scale is as follows;



1 **2** **3** **4** **5**

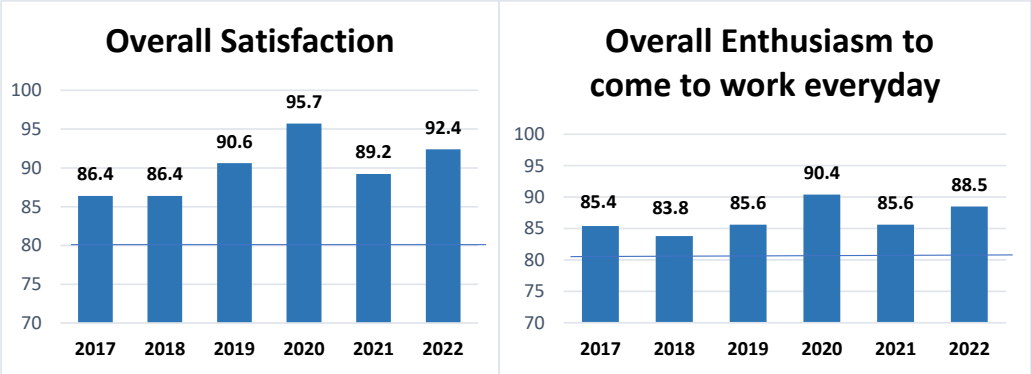
Response Rate

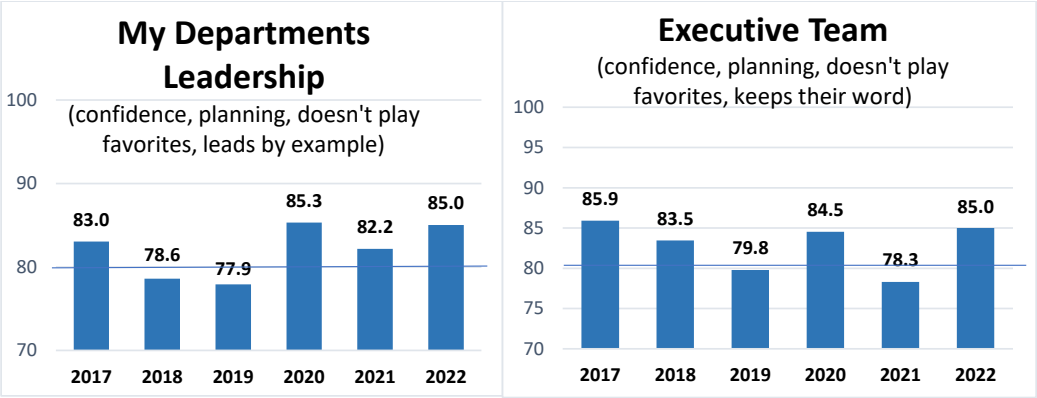
82.9%

The response rate to the survey is the first indication of the level of employee engagement in the organization. Of 491 active employees, 407 employees responded for a response rate of 82.9%. As a general rule, rates higher than 50% suggest soundness, while rates lower than 30% may indicate problems. At 82.9%, the response rate is considered high. High rates mean that employees have an investment in the organization and are willing to contribute towards making improvements within the workplace. With this level of engagement, employees have high expectations from leadership to act on the survey results.

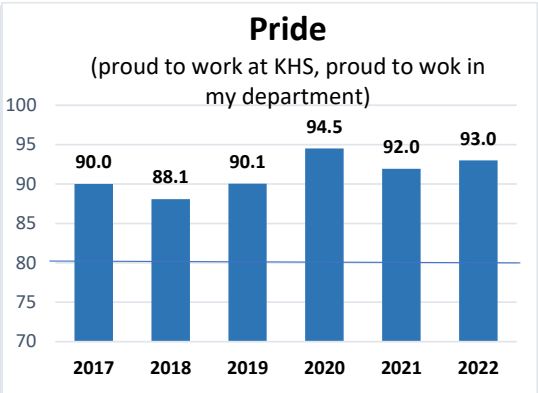
Employee Satisfaction Results 2017 – 2022

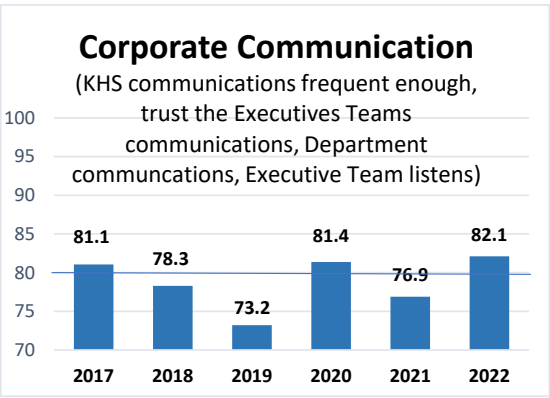
(Each number below represents the percentage of a "satisfied or very satisfied" response and an 80% desired benchmark).

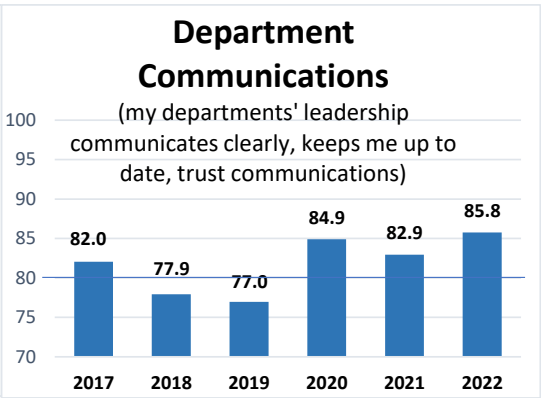


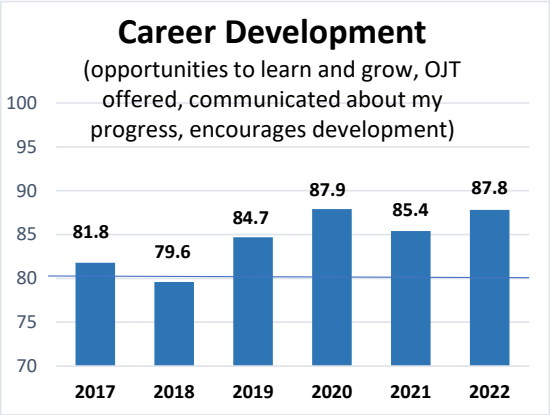


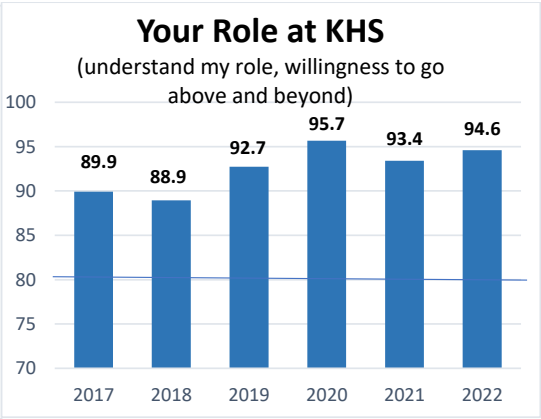

My Corporate Culture
(confidence, planning, direction, doesn't play favorites, leads by example)
100
95
90
85
80
75
70
83.8
80.9
84.4
90.0
86.4
90.7
2017
2018
2019
2020
2021
2022

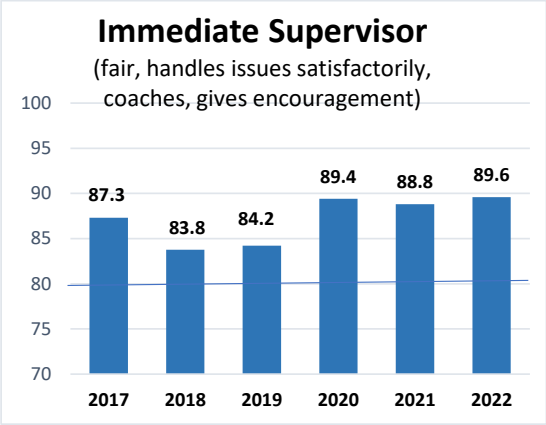

Pride
(proud to work at KHS, proud to wok in my department)
100
95
90
85
80
75
70
90.0
88.1
90.1
94.5
92.0
93.0
2017
2018
2019
2020
2021
2022

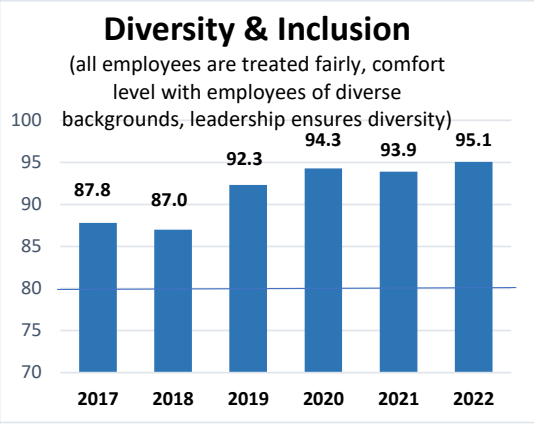

Corporate Communication
(KHS communications frequent enough, trust the Executives Teams communications, Department communcations, Executive Team listens)
100
95
90
85
80
75
70
81.1
78.3
73.2
81.4
76.9
82.1
2017
2018
2019
2020
2021
2022

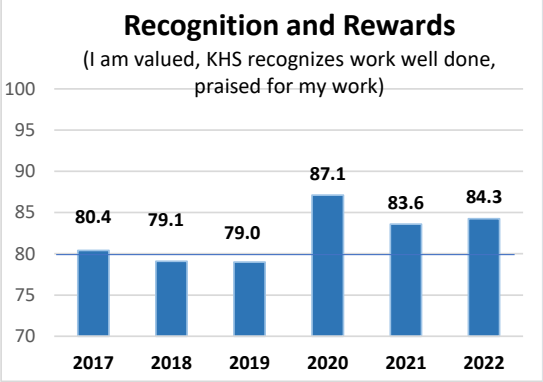

Department Communications
(my departments' leadership communicates clearly, keeps me up to date, trust communications)
100
95
90
85
80
75
70
82.0
77.9
77.0
84.9
82.9
85.8
2017
2018
2019
2020
2021
2022

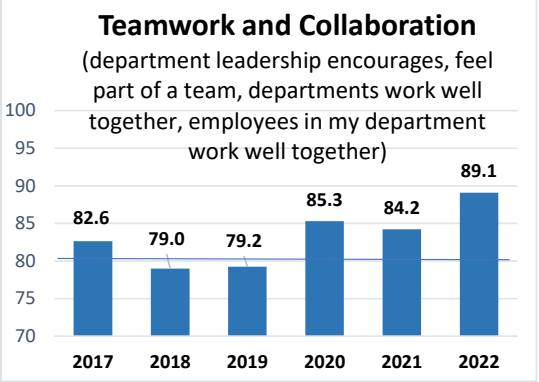

Career Development
(opportunities to learn and grow, OJT offered, communicated about my progress, encourages development)
100
95
90
85
80
75
70
81.8
79.6
84.7
87.9
85.4
87.8
2017
2018
2019
2020
2021
2022

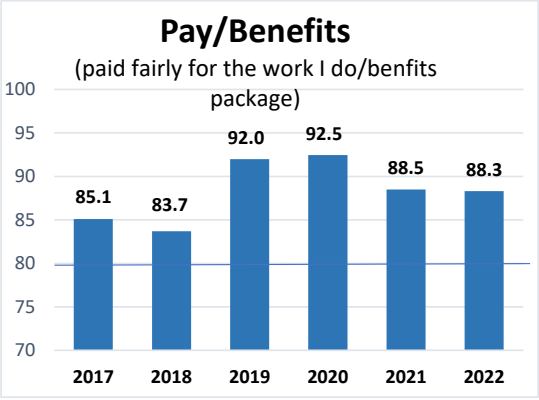

Your Role at KHS
(understand my role, willingness to go above and beyond)
100
95
90
85
80
75
70
89.9
88.9
92.7
95.7
93.4
94.6
2017
2018
2019
2020
2021
2022

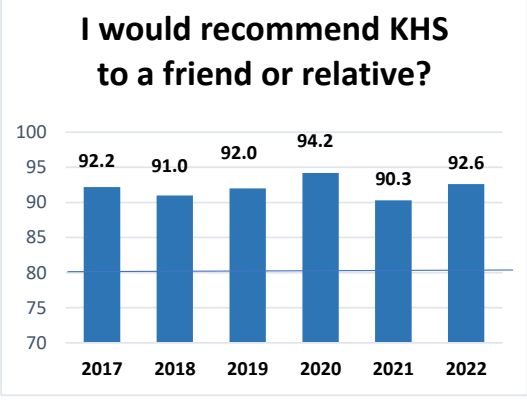

Immediate Supervisor
(fair, handles issues satisfactorily, coaches, gives encouragement)
100
95
90
85
80
75
70
87.3
83.8
84.2
89.4
88.8
89.6
2017
2018
2019
2020
2021
2022


Diversity & Inclusion
(all employees are treated fairly, comfort level with employees of diverse backgrounds, leadership ensures diversity)
100
95
90
85
80
75
70
87.8
87.0
92.3
94.3
93.9
95.1
2017
2018
2019
2020
2021
2022

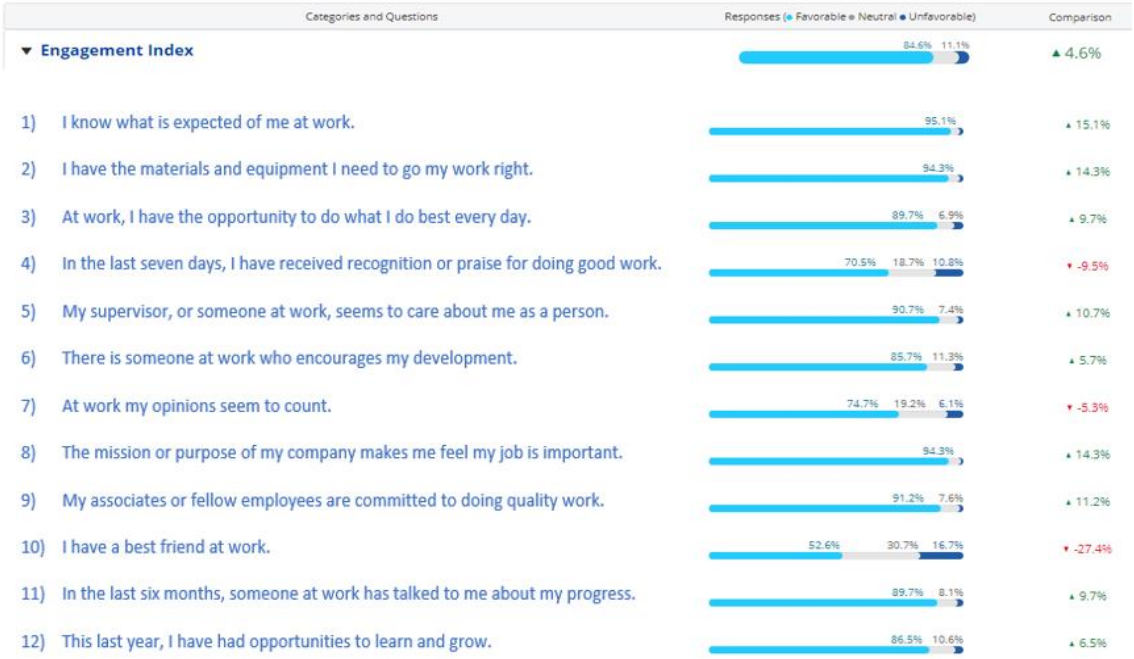

Recognition and Rewards
(I am valued, KHS recognizes work well done, praised for my work)
100
95
90
85
80
75
70
80.4
79.1
79.0
87.1
83.6
84.3
2017
2018
2019
2020
2021
2022


Teamwork and Collaboration
(department leadership encourages, feel part of a team, departments work well together, employees in my department work well together)
100
95
90
85
80
75
70
82.6
79.0
79.2
85.3
84.2
89.1
2017
2018
2019
2020
2021
2022

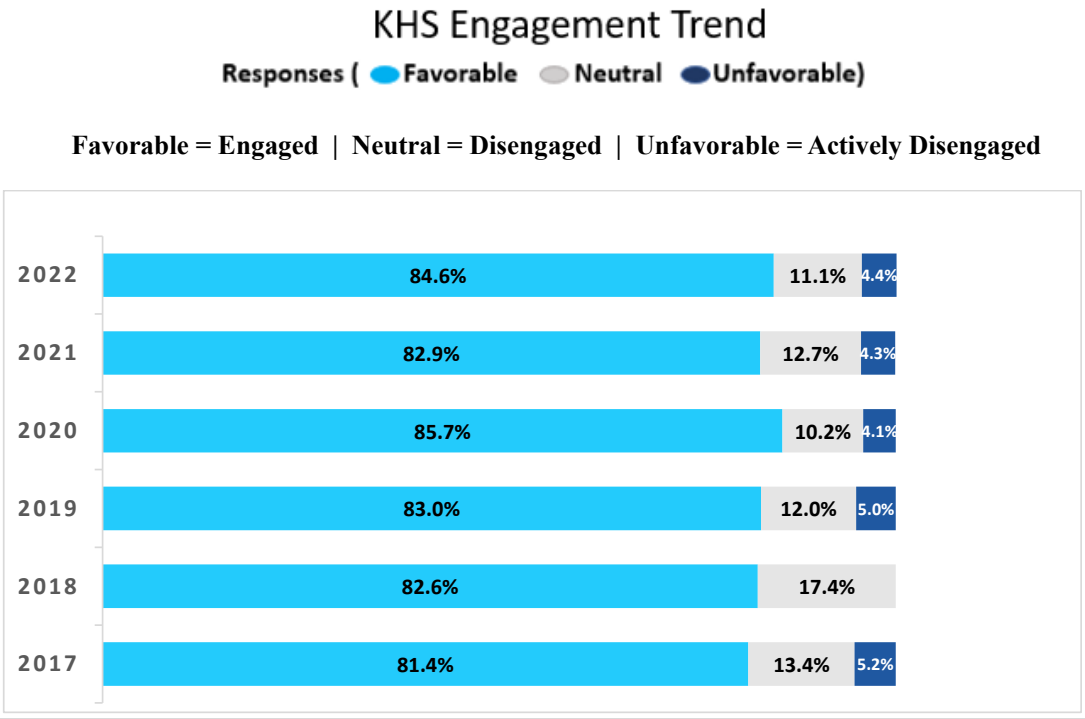

Pay/Benefits
(paid fairly for the work I do/benfits package)
100
95
90
85
80
75
70
85.1
83.7
92.0
92.5
88.5
88.3
2017
2018
2019
2020
2021
2022


I would recommend KHS to a friend or relative?
100
95
90
85
80
75
70
92.2
91.0
92.0
94.2
90.3
92.6
2017
2018
2019
2020
2021
2022

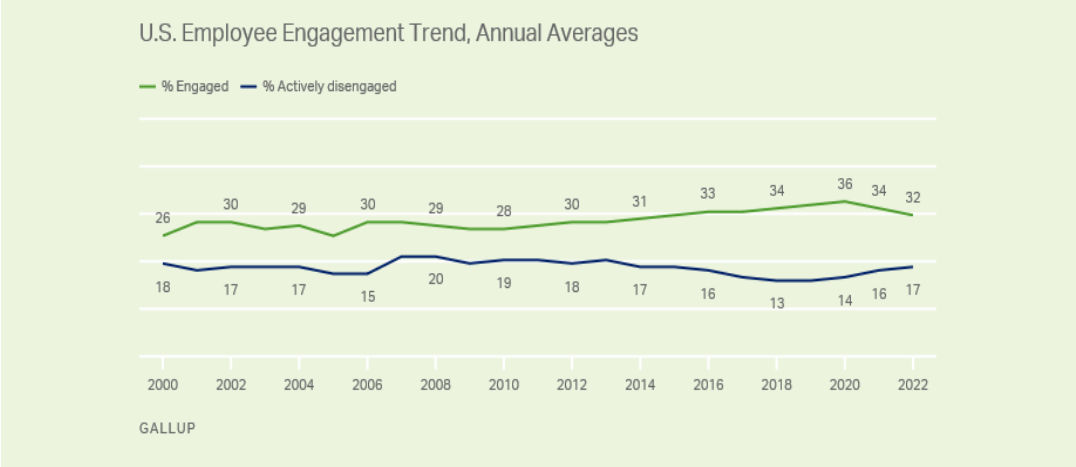
Employee Engagement Results 2022 – Gallup Q12



Employee Engagement 2017 – 2022



- **Engaged** – Employees are highly involved in and enthusiastic about their work and workplace. These employees personalize the company's goals and objectives and always work above and beyond their job requirements for the betterment of the organization.
- **Disengaged** – Employees are just putting in their time, but no passion or energy in their work. These employees consider their job a paycheck, nothing more.
- **Actively Disengaged** – Employees are unhappy, resentful, and spread negativity within the organization. These employees are looking for a job while on the job.



"After trending up in recent years, employee engagement in the U.S. saw its first annual decline in a decade -- dropping from 36% engaged employees in 2020 to 34% in 2021.

This pattern has continued into early 2022, as 32% of full- and part-time employees working for organizations are now engaged, while 17% are actively disengaged, an increase of one percentage point from last year.

The ratio of engaged to actively disengaged workers in the U.S. is 1.9 to 1, down from 2.1 to 1 in 2021 and 2.6 to 1 in 2020. The annual record high is a ratio of 2.7 to 1 in 2019.

Healthcare workers had the greatest engagement decline (nine points) from early 2021 to early 2022. Managers saw a seven-point decline from early to late 2021 -- but have since rebounded by three points in early 2022."[4]

[4] Harter, Jim. GALLUP. "*US Employee Engagement Slump Continues*". U.S. Employee Engagement Slump Continues (gallup.com). April 25, 2022. Accessed January 17, 2023.

Summary of the 2022 Survey

At a **92.4% Overall Satisfaction** rating, Kern Health Systems ranks among the top employers in the US in Employee Satisfaction. This can only be achieved by the intentional efforts of leadership to value their staff, provide meaningful work, and provide an environment of inclusion and belonging. Most notable is that all constructs were above our 80% desired benchmark, and 14 of the 16 constructs increased from 2021.

At an **84.6% Overall Engagement** – KHS has very high employee engagement against a national average of 32%. This is due to the employee-centric culture we have developed over the past 10 years. We believe that investing in our employees and ensuring they have meaningful work has created an employer of choice recognition throughout Kern County.

Strengths

- KHS remains strong in **Diversity and Inclusion**.
- Employees have a complete understanding of **Their Role** and how it contributes to the mission of KHS and how it benefits our community.
- Employees feel a strong sense of **Pride** in working at KHS.
- Surveying our employees annually has given them an opportunity to have a voice in the company.
- Employees feel a strong connection with their **Immediate Supervisor**.

Opportunities

- Developing new innovative ways to communicate to the company as a whole.
- Directors to partner and collaborate with other leadership for Inter-department communication or cross-functional project opportunities.
- Recognition – Feedback to employees on performance and praise for job well done during one-on-ones, during team meetings and monthly employee of the month nominations.

Next Steps

- Report 2022 Employee Satisfaction and Engagement Survey department results to Directors and task them with an Action Plan for areas with a score below 80%. (Complete)
- Present Action Plans in March to the Chief Executive Officer. (Complete)
- Report results of the 2021/22 Department Surveys and Department Action Plan to each department and improvements based on their Action Plans completed. (Complete)
- Schedule quarterly meetings to review progress of 2022/23 Action Plans.
- All Departments to continue quarterly team building activities.
- Continue using “All Employee” communication streams, such as our video newsletter and CEO Town Halls.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Amisha Pannu, Senior Director of Provider Network

Date: April 13, 2023

Re: Provider Satisfaction Survey

Background

Kern Health Systems (KHS) performs an annual Provider Satisfaction Survey to evaluate the level of engagement and satisfaction with our network of providers. KHS engaged a third-party vendor who provided 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 and Urgent Care Facilities, and Ancillary Providers. The survey was conducted over three waves during Q2 2022 and measured the Plan's Calendar Year (CY) 2021 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 85.2%. The Medicaid Line of Business satisfaction rate for like plans surveyed was an overall 62.1% satisfaction. KHS scored much higher than our local competitors.

Included is a presentation that summarizes the CY 2021 Provider Satisfaction Survey results and outlines efforts to continue to rate favorably by our Provider Network.

Requested Action

Receive and File.

2022 Provider Satisfaction Survey Results

Calendar Year 2021

Board of Directors

April 13, 2023

Background and Timeline

- KHS conducts an annual provider satisfaction survey
- The 2022 survey measured the CY 2021 KHS performance with network providers
- SPH Analytics (independent survey company) 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 2022

Survey Panel

Surveys were sent to the following provider types:

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

- 219 Total Surveys received
  - *CY 2020:* 239 surveys received
  - Provider offices incentivized for survey completion
- Confidence Level
  - Survey sample at 95% confidence level.

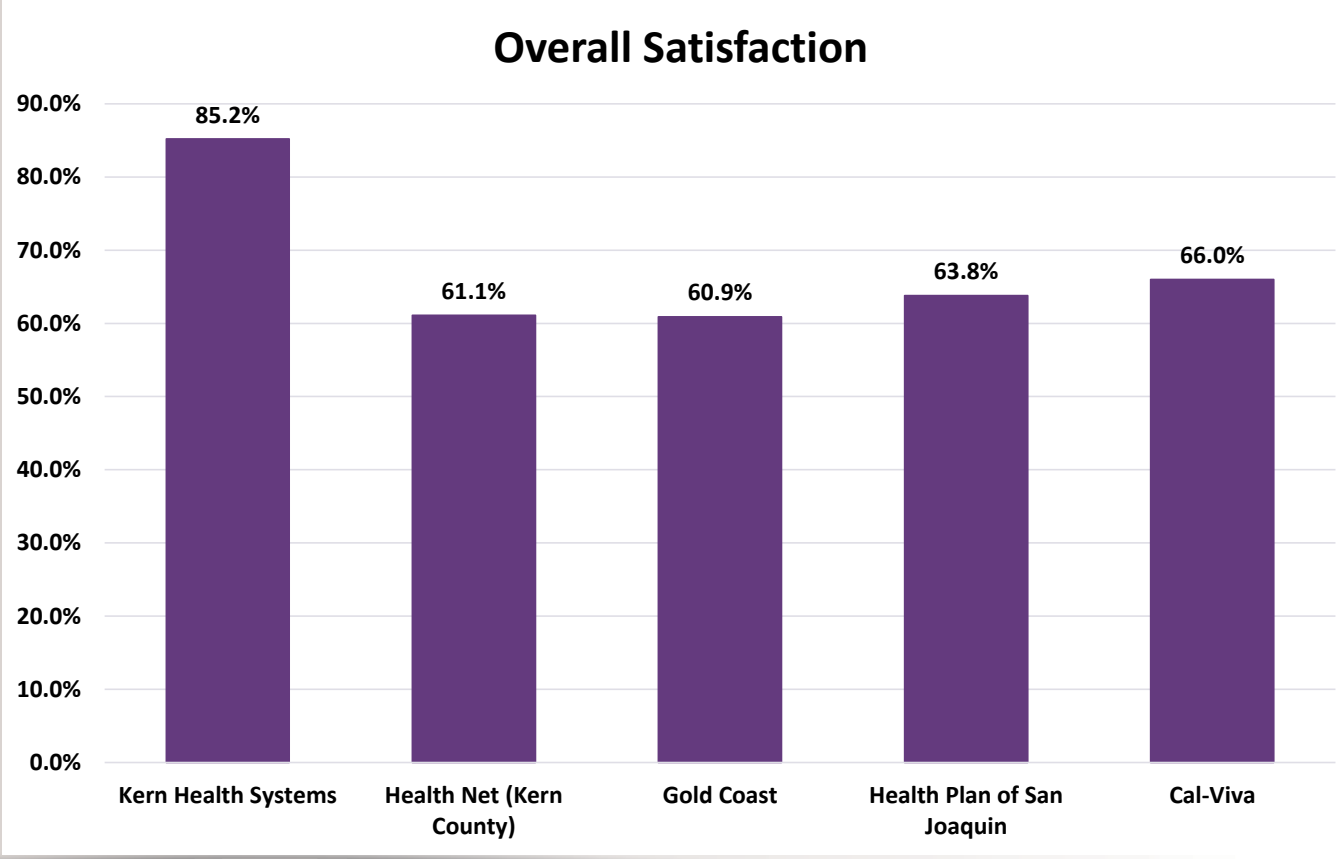
Report Highlights

Composites/ Attributes	KHS CY 2018 Summary Rate	KHS CY 2019 Summary Rate	KHS CY 2020 Summary Rate	KHS CY 2021 Summary Rate
Overall Satisfaction	86.5%	88.3%	84.7%	85.2%
Compared to Other Plans	59.8%	64.3%	55.7%	62.1%
Compensation	51.3%	58.1%	52.0%	53.5%
UM & Quality	54.0%	54.1%	50.7%	51.5%
Network/COC	50.7%	52.7%	47.7%	55.7%
Health Plan Call Center	60.0%	55.4%	61.1%	50.6%
Provider Relations	64.5%	70.5%	61.7%	70.8%
Recommend to Other MDs	93.0%	96.1%	94.8%	95.3%

Report Highlights

Composites/ Attributes	KHS 2021 Summary Rate	2021 National Medicaid Summary Scores		Percentile Ranking (At or Above 75th)
Overall Satisfaction	85.2%	70.3%	**Favorable**	**94th**
Other Local Plans	62.1%	40.1%	**Favorable**	**95th**
Compensation	53.5%	36.8%	**Favorable**	**93rd**
UM & Quality	51.5%	36.5%	**Favorable**	**92nd**
Network/COC	55.7%	33.5%	**Favorable**	**100th**
Health Plan Call Center	50.6%	40.3%	**Favorable**	**88th**
Provider Relations	70.8%	39.6%	**Favorable**	**100th**
Would Recommend	95.3%	86.4%	**Favorable**	**94th**

Health Plan Comparison



Next Steps

- Reviewed survey results/provider feedback with Department leadership
- Finalize Language Assistance Program Assessment Report based on results and submit to Department of Managed Health Care (DMHC)
  - Provider Network Management Department will work with Cultural & Linguistics to draft an action plan to address any interpreter access issues identified.
- Continue in-person provider visits which resumed in second half of 2022
- Explore additional communication avenues with providers
  - Continue Provider Newsletter, started in second half of 2022
  - Provider Focus Groups/Forums
- Continue to work with third part vendor (SPH Analytics) to gauge provider satisfaction. CY 2022 survey will kick-off Q2 2023

Questions

For additional information, please contact:

Amisha Pannu
Senior Director of Provider Network Management
(661) 664-5000

2022 Provider Satisfaction Survey

Calendar Year 2021

Survey Results

Report Prepared for

KHS Board of Directors

April 13, 2023

Amisha Pannu, Senior Director of Provider Network
amisha.pannu@khs-net.com

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 2022 Provider Satisfaction Survey asked providers to answer survey questions based on their experiences with KHS during Calendar Year 2021. We engaged an independent survey company, SPH Analytics, to conduct the survey on behalf of the Plan. SPH 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 SPH 2021 Medicaid Book of Business is made up of 86 plans with a total of 16,398 respondents. The SPH 2021 Aggregate Book of Business is made up of 131 plans with a total of 24,310 respondents. This is sixth annual Provider Satisfaction Survey that SPH Analytics has completed for the Plan.

The 2022 Provider Satisfaction Survey was conducted across three waves, in April, May, and June of 2022. Two waves of mailing outreach are conducted, following 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.

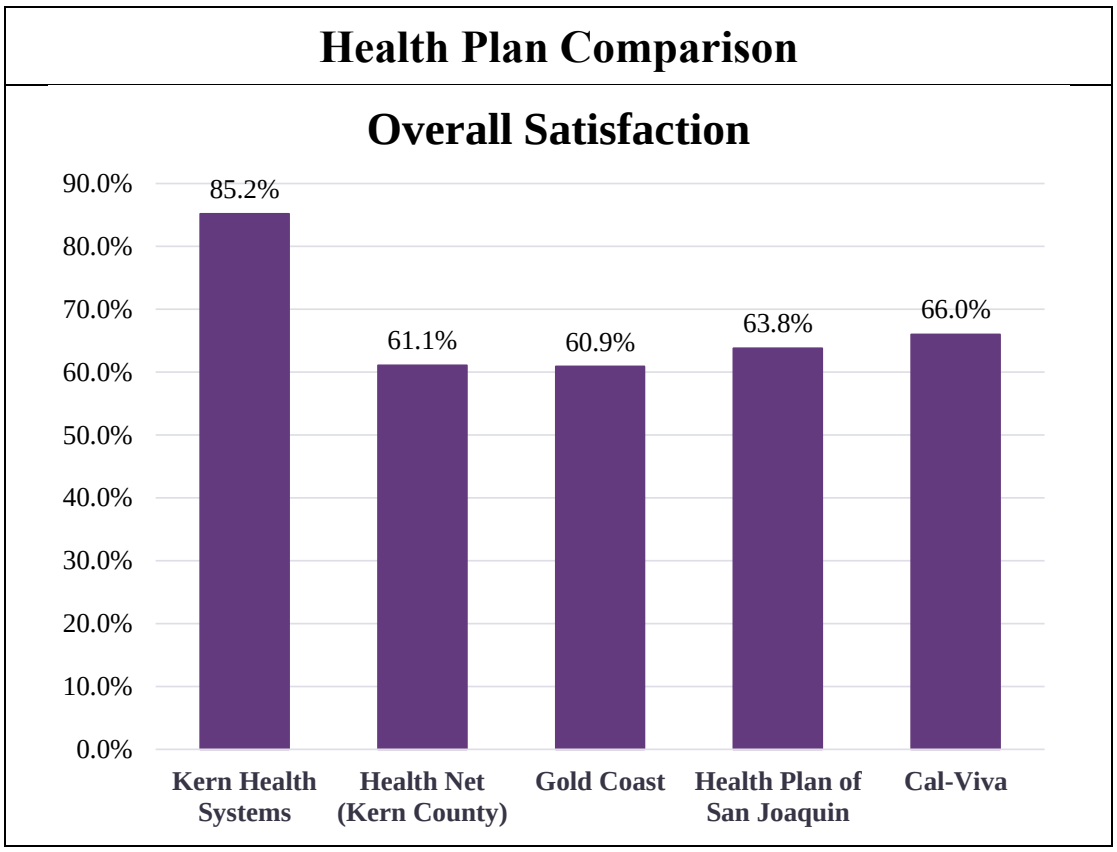
For 2022, 219 total surveys were received, down from 239 surveys received the prior year. KHS utilizes incentives for provider offices to try and promote survey participation.

RESULTS

Composite Scores: CY 2018 - CY2021				
Composites/ Attributes	**KHS CY 2018 Summary Rate**	**KHS CY 2019 Summary Rate**	**KHS CY 2020 Summary Rate**	**KHS CY 2021 Summary Rate**
Overall Satisfaction	86.5%	88.3%	84.7%	**85.2%**
Compared to Other Plans	59.8%	64.3%	55.7%	**62.1%**
Compensation	51.3%	58.1%	52.0%	**53.5%**
UM & Quality	54.0%	54.1%	50.7%	**51.5%**
Network/COC	50.7%	52.7%	47.7%	**55.7%**
Health Plan Call Center	60.0%	55.4%	61.1%	**50.6%**
Provider Relations	64.5%	70.5%	61.7%	**70.8%**
Recommend to Other MDs	93.0%	96.1%	94.8%	**95.3%**

Composite Scores: KHS vs SPH 2021 Medicaid Book of Business				
Composites/ Attributes	**KHS 2021 Summary Rate**	**2021 National Medicaid Summary Scores**		**Percentile Ranking (At or Above 75th)**
Overall Satisfaction	**85.2%**	70.3%	**Favorable**	**94th**
Other Local Plans	**62.1%**	40.1%	**Favorable**	**95th**
Compensation	**53.5%**	36.8%	**Favorable**	**93rd**
UM & Quality	**51.5%**	36.5%	**Favorable**	**92nd**
Network/COC	**55.7%**	33.5%	**Favorable**	**100th**
Health Plan Call Center	**50.6%**	40.3%	**Favorable**	**88th**
Provider Relations	**70.8%**	39.6%	**Favorable**	**100th**
Would Recommend	**95.3%**	86.4%	**Favorable**	**94th**

In the tables above, summary rate represents the most favorable response percentages. KHS experienced increases amongst seven (7) of the eight (8) scoring composites when compared to the prior years Provider Satisfaction Survey. KHS scored within the 75th percentile or higher in all scoring composites/attributes, with both Network/Coordination of Care and Provider Relations in the 100th percentile when compared against SPH's 2021 Medicaid Book of Business.



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

TRENDS

In comparing the 2022 Provider Satisfaction Survey results, SPH analytics identified measures that had the greatest improvement and decline.

Trending Up Measures that increased significantly compared to prior year:

- Quality of written provider communications, policy bulletins, manuals

Trending Down Measures that decreased significantly compared to prior year:

- Ease of reaching health plan call center staff over phone
- Over satisfaction with health plan's call center service

STRENGTHS/OPPORTUNITIES

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

Strengths

- Timeliness of claims processing
- Resolution of claim payment problems or disputes
- Accuracy of claims processing
- Provider Representatives ability to answer questions and resolved problems
- Quality of provider orientation process

Opportunities

- Coordination of appointments with an interpreter

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 2023.

As noted above, one of the measures included as part of the LAP Assessment, coordination of appointments with an interpreter, was identified as an opportunity of improvement for the Plan, with 36.8% summary rate for favorable responses. Upon finalization of the LAP Assessment analysis, the report will be shared with the KHS' Cultural & Linguistic Department, and together with the Provider Network Management Department, will draft an action plan to address any issues identified.

NEXT STEPS

The Provider Network Management Department met with Department leadership, including Member Services, Claims, and Health Services to review survey results and provider feedback.
In 2023, the Plan aims to continue the in-person Provider Relations Representative provider office visits which resumed in the second half of 2022. KHS is exploring additional communication avenues with our network of contract providers, including our Provider Newsletter and Provider Focus Groups/Forums. KHS will continue to utilize SPH Analytics, with the 2023 Provider Satisfaction Survey, CY 2022 kicking off April 2022.

KERN HEALTH SYSTEMS

TO: **KHS Board of Directors**

FROM: **Alan Avery, Chief Operating Officer**

DATE: **April 13, 2023**

RE: **2022 Member Satisfaction Survey**

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 seven years, KHS has engaged SPH Analytics to conduct our Member Satisfaction Survey. SPH Analytics is a CMS and NCQA approved Medicaid, Medicare, and Commercial Health Plan survey vendor with a sizeable clientele in California and throughout the United States. SPH Analytics utilizes scores from several benchmarks to provide comparative and trending data for the results from member responses to the fifty-nine questions provided in the survey. They provided two sets of benchmarks for us to consider-(1) National NCQA Accredited Adult Medicaid Plans and (2) Regional Health & Human Services Region 9 health plans consisting of California, Hawaii, Arizona, and Nevada. Given we are not NCQA accredited at this time, we utilize Region 9 health plans as our benchmark, which is heavily weighted by California Health Plans.

The 2022 Member Satisfaction Survey results show that overall, 72.3% of our members are satisfied with KHS compared to the regional benchmark of 59.2%. As we look to the future, we will endeavor to continue to encourage the use of the Member Portal and the self-service tools available there, by listening to the voice of our members through direct feedback from members and the expansion of the KHS member engagement strategies. The survey does not account for any lingering effects of the COVID-19 pandemic on patient satisfaction. Access to primary and specialty care may have been impacted by some provider offices reduced hours, short staffing or members continued reluctance to seek care.

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

2022 Member Satisfaction Survey

Board of Directors Meeting

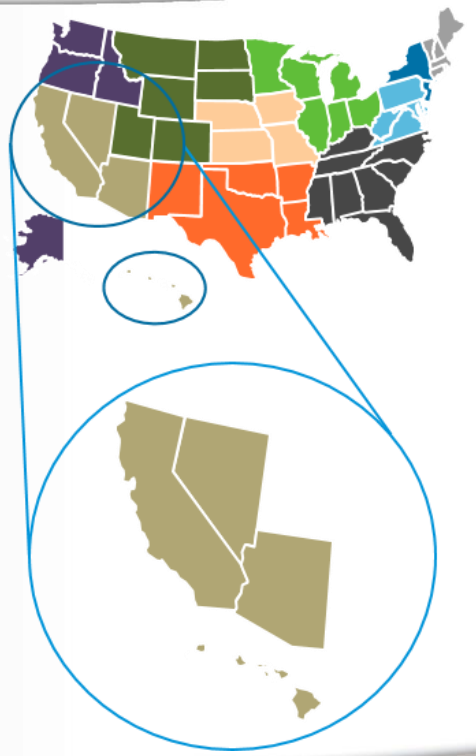
April 13, 2023

Methodology

- A sampling of 5,000 KFHC eligible member households was selected and 4998 were eligible.
  - There were a total of 492 completed responses.
    - 338 completed responses by mail.
    - 154 completed responses on the internet.
- Results were measured in comparison with other plan survey data for the Region
- The study is used to identify areas of needed improvement
- Strategies are developed and implemented to improve member experience and satisfaction

Region 9: San Francisco

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



KERN HEALTH SYSTEMS

Regional Performance

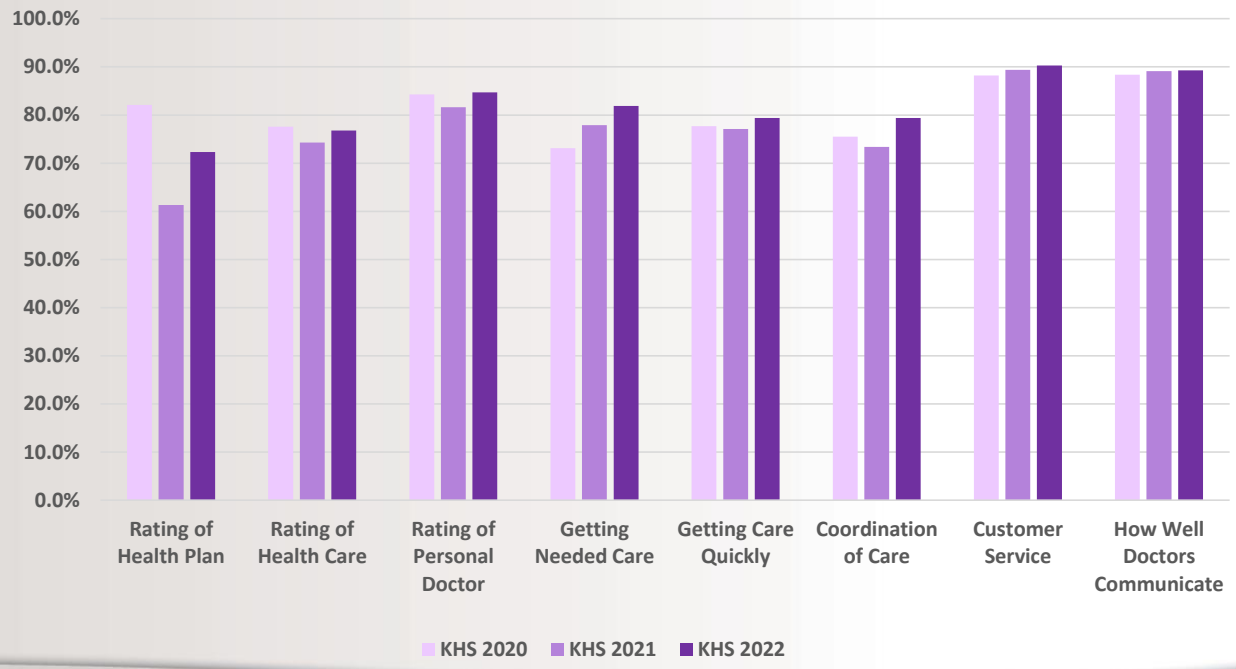
- KHS scored significantly higher than the regional rate for *Rating of Health Plan* as well as exceeding the regional rates of other measurement areas. *Coordination of Care* results show needed improvement.

Regional Results			
	KHS Summary Rate	2022 SPH BoB Region	Performance Indicator
Rating of Health Plan	72.3%	59.2%	↑
Rating of Health Care	61.7%	53.0%	↑
Rating of Personal Doctor	66.8%	64.6%	↑
Getting Needed Care	81.9%	76.8%	↑
Getting Care Quickly	79.4%	73.6%	↑
Coordination of Care	78.5%	79.9%	↓
Customer Service	90.3%	86.9%	↑
How Well Doctors Communicate	89.3%	89.2%	↑

KERN HEALTH SYSTEMS

Trending Performance

- 2022 marks the third year KHS has used the CAHPS survey tool to measure member experience and satisfaction.
- As such, results provide year over year trends that show improvement or decline. Though there is decline in 2021, 2022 provides that KHS' strategies and efforts show a slight or better upward trend.



KERN HEALTH SYSTEMS

2021 Performance Improvement Review

- In 2021 the results of the study provided opportunities for improvement.
- Listed are the strategies and subsequent efforts adopted by KHS to improve member experience and satisfaction. The 2022 results are evidence that the strategies KHS implemented assisted in improving the summary rate scores.

Recommended Strategy	Results
Support members and collaborate with providers to enhance access to care through innovative and proactive approaches.	• KHS provided grant funds for a Street Medicine program to provide health service delivery to the homeless • Improved outreach strategies to assist members due for a health action to schedule provider appointments
Provide resources to support and drive improvement in physician-patient communication and patient-centered interviewing.	• KHS improved member data delivery to providers via the KHS Provider Portal which included adding if the member had an alternative format for written materials. • Increased provider bulletin delivery to ensure providers receive important information, educational materials, and helpful resources that supported this strategy
Encourage patients to bring a list of all medications to all appointments.	• Educational articles published in the member newsletter
Support patients in navigating health care and remove obstacles.	• Live outreach calls conducted to advise members of needed wellness exams and assist with scheduling appointments
Seek opportunities to improve processes and procedures.	• Improve call service IVR selection for providers for more efficient call routing

KERN HEALTH SYSTEMS

2022 Performance Improvement Strategy

KHS will implement the following improvement strategies in 2023 based on the 2022 MSS responses.

- Evaluate and implement institutionalizing telehealth and street medicine to alleviate access to care challenges.
- Discover opportunities for improved member and provider communication through technology using multiple modalities.
- Educate and engage members to encourage member action for health status improvement.
- Educate and engage providers to encourage improvement for how well doctors communicate with members.

KERN HEALTH SYSTEMS

For more information:

Alan Avery
Chief Operating Officer
(661) 664-5000

2022 Member Satisfaction Survey Results

Report Prepared for

KHS Board of Directors

April 13, 2023

Meeting

Alan Avery, Chief Operations Officer
Alan.avery@khs-net.com

BACKGROUND

The Kern Family Health Care (KFHC) Member Satisfaction Survey (MSS) is conducted annually by Kern Health Systems' (KHS) Member Services Department to measure member satisfaction. KHS selected SPH Analytics (SPH), a National Committee for Quality Assurance (NCQA) certified HEDIS® Survey Vendor to conduct the 2022 MSS utilizing the MY 2021 CAHPS® 5.1 Medicaid Adult Survey. NCQA requires health plans to submit CAHPS survey results in compliance with HEDIS® accreditation requirements.

OBJECTIVE

The overall objective of the CAHPS® study is to capture accurate and complete information about consumer reported experiences with health care. KHS uses the results of the survey to measure how well member expectations and goals are being met, which areas of service have the greatest effect on members' overall satisfaction, and to identify areas of opportunity for improvement to assist KHS in increasing the quality of care provided to members.

METHODOLOGY AND RESPONDENT DEMOGRAPHICS

Qualified respondents included members who were 18 years and older as of December 31 of the measurement year and were continuously enrolled for at least five of the previous six months of the measurement year.

This was the first year the MSS was offered through an internet protocol which began November 14, 2022. The MSS was also mailed on November 16, 2022. The sample included 5000 members of which 2 were found ineligible. A total of 4998 eligible respondents were sampled of which 492 were completed.

2022 RESPONSE RATE CALCULATION			
$\frac{\text{492 (Completed)}}{\text{5000 (Sample) - 2 (Ineligible)}}$	=	$\frac{\text{492}}{\text{4998}}$	= **9.8%**

KHS takes into consideration the demographics of those who responded to evaluate its performance from a health equity perspective. Member demographics of respondents are as follows:

Gender		Ethnicity		Age		Race	
Male	30.0%	**Hispanic/Latino**	74.7%	**18-34**	30.7%	**White**	53.8%
Female	70.0%	**Not Hispanic/Latino**	25.3%	**35-44**	15.8%	**Black or African American**	6.3%
				45-54	17.7%	**Asian**	5.6%
				55+	35.8%	**Hawaiian/Pacific Islander**	0.7%
						American Indian/Alaskan	3.2%
						Other	34.8%

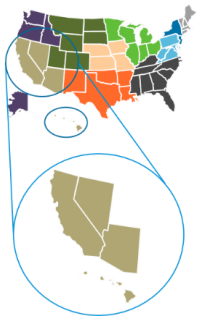
REGIONAL PERFORMANCE

KHS focused on the regional result analysis provided by SPH through their 2022 SPH Analytics MAS Book of Business (BoB) Region. SPH's analysis from a regional perspective aligns with the U.S. Department of Human Services regions. SPH compared sample data from the Medicaid (Medi-Cal for California) plans that contracted with SPH to administer the CAHPS survey and from data that was submitted to the NCQA.

KHS, as a Kern County Medi-Cal Managed Care Plan falls within Region 9:

Region 9: San Francisco

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



KHS' summary rate score results show that KHS' performance scored higher than the regional rate for most of the survey questions per the below table. Improvement needed is identified in the measurement pertaining to Coordination of Care.

Regional Results			
	KHS Summary Rate	2022 SPH BoB Region	Performance Indicator
Rating of Health Plan	72.3%	59.2%	↑
Rating of Health Care	61.7%	53.0%	↑
Rating of Personal Doctor	66.8%	64.6%	↑
Getting Needed Care	81.9%	76.8%	↑
Getting Care Quickly	79.4%	73.6%	↑
Coordination of Care	78.5%	79.9%	↓
Customer Service	90.3%	86.9%	↑
How Well Doctors Communicate	89.3%	89.2%	↑

TRENDING PERFORMANCE

This is the third year KHS has used the CAHPS survey tool to measure member experience and satisfaction. KHS reviewed the performance trending results. Though 2021 shows a dip in many measured areas as indicated in the chart below, KHS shows marked improvement in 2022.

Trending Results			
	2020	2021	2022
Rating of Health Plan	82.1%	61.3%	72.3%
Rating of Health Care	77.6%	74.3%	76.8%
Rating of Personal Doctor	84.3%	81.6%	84.7%
Getting Needed Care	77.7%	77.1%	79.4%
Getting Care Quickly	75.5%	73.4%	79.4%
Coordination of Care	88.2%	89.4%	90.3%
Customer Service	88.4%	89.1%	89.3%
How Well Doctors Communicate	82.1%	61.3%	72.3%

2021 PERFORMANCE IMPROVEMENT

The results of this annual study are evaluated to assist with member experience and satisfaction improvement strategies. SPH's final report provided a library of strategies to assist their clients with achieving these goals and objectives. In 2021 the results of the study provided opportunities for improvement. The following table provides the list of the strategies and subsequent efforts adopted by KHS to improve member experience and satisfaction. The 2022 results are evidence that the strategies KHS implemented assisted in improving the summary rate scores.

Recommended Strategy	Results
Support members and collaborate with providers to enhance access to care through innovative and proactive approaches.	• KHS provided grant funds for a Street Medicine program to provide health service delivery to the homeless • Improved outreach strategies to assist members due for a health action to schedule provider appointments
Provide resources to support and drive improvement in physician-patient communication and patient-centered interviewing.	• KHS improved member data delivery to providers via the KHS Provider Portal which included adding if the member had an alternative format for written materials. • Increased provider bulletin delivery to ensure providers receive important information, educational materials, and helpful resources that supported this strategy
Encourage patients to bring a list of all medications to all appointments.	• Educational articles published in the member newsletter
Support patients in navigating health care and remove obstacles.	• Live outreach calls conducted to advise members of needed wellness exams and assist with scheduling appointments
Seek opportunities to improve processes and procedures.	• Improve call service IVR selection for providers for more efficient call routing

2022 RESULTS – PERFROMANCE IMPROVEMENT STRATEGY

Evaluation of the results for the 2022 study and review of the SPH recommendations for improvement assisted KHS to identify the following strategies.

- Evaluate and implement institutionalizing telehealth and street medicine to alleviate access to care challenges.
- Discover opportunities for improved member and provider communication through technology using multiple modalities.
- Educate and engage members to encourage member action for health status improvement.
- Educate and engage providers to encourage improvement for how well doctors communicate with members.

In addition to implementing strategies for areas identified for needed improvement, KHS will continue to monitor performance in areas where there was marked improvement based on the results in order to continue improving member's experience and satisfaction.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Emily Duran, CEO

Date: April 13, 2023

Re: KHS Strategic Plan – 1st Quarter Update

Background

At the February 2023 KHS Board of Directors meeting, the 2023-2025 Corporate Strategic Plan was approved. At the close of each quarter Management will provide updates the Board and highlight key accomplishments in each strategic area. Overall, KHS is on track with items that were due to be completed during the first quarter and we are off to a great start. The KHS Strategic Plan has been incorporated into our operational updates with regular reports to all staff. It is important to keep all departments updated and energized about our ambitious plan to improve the lives of our members.

Included is a summary report which includes the strategic goals with a breakdown of specific strategies and accomplishments to date.

Requested Action

Receive and File.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2023

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	• Developed MCAS analysis and intervention strategy. • Began implementation of programs and interventions including Pay-For-Performance program updates, breast cancer screening programs, and mobile clinic services. • Enhancing MCAS reporting, dashboards, and oversight/monitoring tools. • Onboarded MCAS Outreach Specialist Team to connect with members with gaps in care. • Implementing meaningful data exchange with providers, including appointment information, EMR, and admission/discharge/transfer data.
Strategy 2	Meet National Committee for Quality Assurance (NCQA) standards and work toward accreditation.
Accomplishments	• Procurement completed for NCQA consulting services related to gap analysis and readiness. NCQA gap analysis and readiness assessment has been initiated. • NCQA training conducted on health plan and health equity accreditation. Additional training will occur as needed through the course of the accreditation process.
Strategy 3	Further maturity of the organization's Health Equity programs under the direction of the Chief Health Equity Officer.
Accomplishments	• Chief Health Equity Officer hired, and KHS Health Equity Office launched. Policies and procedures in progress. • Health Equity Office structure completed and approved. Job descriptions created and posted. Interviews conducted and offers accepted. • First draft of Quality Improvement and Health Equity Transformation Plan (QIHETP) developed; currently being reviewed by internal stakeholders.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2023

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	• Quarterly Network Provider Report, including appointment availability and network adequacy assessment. • Completion of Annual Network Certification Geographic Accessibility Analysis.
Strategy 2	Strengthen and expand the KHS provider network through innovative and effective recruitment and retention programs.
Accomplishments	• Created scholarship programs for RNs and Social Workers to support non-physician workforce. • Bakersfield College – Four scholarships of $2,000 each for nursing program. • CSUB – Four scholarships of $3,000 each to nursing students and two scholarships of $2,000 each for Social Work students. • Expanding contracts with additional Long Term Care facilities to support the new benefit.
Strategy 3	Identify business needs and gaps in current workforce to inform target areas and approaches.
Accomplishments	• Conducted departmental review of current and future workforce internal needs.
Strategy 4	Meet the growing operational demands of the organization by creating recruitment and retention programs for internal staffing and leadership needs.
Accomplishments	• Held first onsite career fair which resulted in over 300 attendees and 1,200 applications. • Initiated internal process to update the KHS Succession Plan.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2023

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	• Expansion of ECM providers to additional OMNI (Mall View) location • Expansion of three new Community Support services: Medically Tailored Meals, Sobering Centers and Caregiver Respite. A total of six (6) new Community Based Organizations joined the network. • Launched pilot project on implementation of Health Risk Assessments (HRAs) via iPads in clinical settings
Strategy 2	Strengthen Existing and Establish New Community Partnerships to Support CalAIM.
Accomplishments	• CalAIM Kern Collaborative meetings held monthly in collaboration with HC2 Strategies and Health Net leadership promoting local engagement efforts with regional partners through this forum. • Released a provider bulletin requesting letters of interest for funding to expand CS and ECM services in specified geographical areas based on identified populations. • Ongoing assistance and progress-monitoring of providers implementing CalAIM Incentive Program funding.
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	• Collaboration with DHCS on the early implementation preparations for LTC Phase II and ECM Populations of Focus expansion.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2023

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	• Began development of Medicare Business Strategy, Market Assessment, Compliance Readiness Plan, and 3-year Roadmap.
Strategy 2	Analysis of the appropriate market factors to maximize the competitiveness of the product.
Accomplishments	• Market and Competitor analysis is underway.
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	• Corporate Project is underway. Conducting resource planning, assessing technical inventory, and analyzing provider network.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2023

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	• Initiation and Execution of the Behavioral Health Corporate Project, under the direction of the Behavioral Health Director. • Ongoing development of relevant policies and procedures. • Development and approval of BH job descriptions, and job requisitions. • Discussing revised Scope of Work with preferred BH providers.
Strategy 2	Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS).
Accomplishments	• Ongoing meetings with Kern Behavioral Health and Recovery Services (KBHRS) to set up process for sending and receiving referrals/screenings for BH Services. Discussions on problem solving barriers to data sharing, creating systems that will improve collaboration between entities. • Meetings with KBHRS Substance Use Disorder (SUD) Administrator on Coordination of Care for members in SUD treatment.
Strategy 3	Communication and coordination with County Behavioral Health regarding DHCS requirements.
Accomplishments	• Participating in several recurring meetings related to quality oversight and process improvements. • Working to setup bi-directional data exchange for referrals and other relevant member information.
Strategy 4	Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment services.
Accomplishments	• Analyzing provider data to determine usage of MAT medications. • Added MAT services in the BH Scope of Work, collaborating with providers. • Working to receive Admission, Discharge, and Transfer (ADT) data from local hospitals.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2023

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	• Conducting restructuring of Member Engagement department, including promotion of internal candidate to Member Engagement Manager. • Drafting additional job descriptions and updating policies and procedures. • Collaboration with internal MCAS team to analyze member gaps in care and develop programs for remediation.
Strategy 2:	Work with internal staff and external partners to develop strategies that ensure continuity of coverage for our members.
Accomplishments	• Working with County Department of Human Services (DHS) to bi-directionally share member demographic and re-enrollment information to assist in redetermination efforts. • Onboarded County DHS staff to internal workspaces and established communication and workflow processes related to redeterminations. • Developed comprehensive Communication Plan to begin outreach to members up for renewal.
Strategy 3:	Leverage convenient technology to enhance the effectiveness of engagement and suit members' needs.
Accomplishments	• Reviewing additional capabilities to enhance member rewards delivery. • Operationalized MCAS Gaps in Care outreach process using Outreach Specialists.

KERN HEALTH SYSTEMS

Strategic Plan Status Report: Q1 2023

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 1	Conduct exploratory analysis of the necessary major components needed for the creation of a KHS non-profit foundation.
Accomplishments	• Conducting research on a potential KHS foundation, e.g., financials, goals, timelines. • Investigated non-profit status options. • Interviewed Inland Empire Health Plan (IEHP) to discuss their process in developing a Foundation. • Received legal referrals to further evaluate the process.

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: April 13, 2023

Re: 2023 Budget Change Request

Background

Due to receiving updated information after the Board of Directors ("Board") approved the 2023 Budget, Management is seeking approval to adjust the following 2023 Budget items:

1) MCO Tax (Net Position Budget Neutral)
2) Hospital Directed Payments (Net Position Budget Neutral)
3) Proposition 56 Value Based Supplemental Payment Program (Net Position Budget Neutral)

Discussion

MCO Tax

In previous years, California taxed Managed Care Organizations ("MCOs") and used the proceeds to leverage federal funds to support the Medi-Cal program. The MCO Tax freed up approximately $1.5 billion in General Fund revenues each year to go to Medi-Cal. These freed-up funds support an array of public services and systems that are funded through the State budget. Apparently, due to new federal rules, California's current MCO tax no longer complies with federal guidelines and needs to be revised. Management believes that a new MCO Tax will be created that will adhere to federal rules while also generating substantial General Fund savings. However, until such time a new MCO Tax is approved by California State Legislators, Management is recommending the removal of the MCO Tax Revenue and Expense from the 2023 Budget.

Fiscal Impact

There will not be an increase or decrease in the net position to the 2023 Budget as the removal of $145 million of MCO Tax Revenue and $145 million of MCO Tax expense is budget neutral.

(Please see Footnote A in Attachment 1)

Hospital Directed Payments

At the time of developing the 2023 Budget for Hospital Directed Payments ("HDP") Management was utilizing the most current HDP rates known to KHS. After finalizing the 2023 Budget, KHS received CY 2023 rates from DHCS on February 17, 2023.

Fiscal Impact

There will not be an increase or decrease in the net position to the 2023 Budget for Hospital Directed Payments as the additional $21.8 million of revenue and the $21.8 million of expense is budget neutral.

(Please see Footnote B in Attachment 1)

Proposition 56 Value Based Supplemental Payment Program

The Proposition 56 Value Based Supplemental Payment Program directed Medi-Cal Managed Care Plans (MCPs), like KHS, to make value based enhanced payments to eligible network providers for meeting specific measures and benchmarks. These enhanced payments were in addition to existing contracted payments eligible network providers receive from KHS.

This particular Proposition 56 program ended in 2022 and should not have been included in the 2023 Budget.

Fiscal Impact

There will not be an increase or decrease in the net position to the 2023 Budget for Proposition 56 Value Based Payment Program as the removal of $11.7 million of revenue and $11.7 million of expense is budget neutral.

(Please see Footnote C in Attachment 1)

Requested Action

Approve 2023 Budget Changes.

KERN HEALTH SYSTEMS
P & L BY MAJOR CATEGORY OF SERVICE
2023 BUDGET REVISIONS

	2023 BUDGET AS ORIGINALLY APPROVED $	2023 BUDGET AS ORIGINALLY APPROVED PMPM	2023 BUDGET REVISED $	2023 BUDGET REVISED PMPM	2023 BUDGET (REDUCTIONS)/INCREASE $	2023 BUDGET (REDUCTIONS)/INCREASE PMPM
REVENUE						
Capitation (excludes Prop 56 & GEMT)	942,680,028	226.66	942,680,028	226.66	-	-
LTC Dual/Non Dual Capitation	93,705,838	22.53	93,705,838	22.53	-	-
Maternity Kick Supplemental Payment	36,227,616	8.71	36,227,616	8.71	-	-
Enhanced Care Management	25,475,578	6.13	25,475,578	6.13	-	-
Major Organ Transplant	6,615,222	1.59	6,615,222	1.59	-	-
CalAIM Incentive Program	30,606,291	7.36	30,606,291	7.36	-	-
Proposition 56 Supplemental Payments	79,782,687	19.18	68,093,297	19.18	(11,689,390) (C)	(2.81)
Ground Emergency Medical Transportation (GEMT) Supplemental Payments	6,392,315	1.54	6,392,315	1.54	-	-
Total MCAL Revenue	1,221,485,574	293.70	1,209,796,184	290.89	(11,689,390)	(2.81)
Add-Ons (Directed Provider Payments)	228,984,127	52.92	250,749,761	57.95	21,765,634 (B)	5.03
MCO Tax Revenue	144,952,825	33.50	-	-	(144,952,825) (A)	(33.50)
Interest	5,158,950	1.24	5,158,950	1.24	-	-
Reinsurance	914,969	0.22	914,969	0.22	-	-
TOTAL REVENUE	**1,601,496,445**	**385.07**	**1,466,619,864**	**352.64**	**(134,876,581)**	**(32.43)**
MEDICAL						
Inpatient Hospital	281,876,533	67.78	281,876,533	67.78	-	-
Outpatient Facility	122,276,102	29.40	122,276,102	29.40	-	-
Emergency Room Facility	68,934,910	16.58	68,934,910	16.58	-	-
Long-Term Care Facility - Long-Term	93,705,838	22.53	93,705,838	22.53	-	-
Primary Physician Services	53,023,513	12.75	53,023,513	12.75	-	-
Urgent Care	30,571,682	7.35	30,571,682	7.35	-	-
Physician Specialty	173,754,546	41.78	173,754,546	41.78	-	-
Behavioral Health Treatment and Mental Health	22,620,105	5.44	22,620,105	5.44	-	-
Vision	4,252,839	1.02	4,252,839	1.02	-	-
Other Medical Professional	22,607,969	5.44	22,607,969	5.44	-	-
Enhanced Care Management	24,201,799	5.82	24,201,799	5.82	-	-
Major Organ Transplant	6,284,461	1.51	6,284,461	1.51	-	-
DME	12,742,556	3.06	12,742,556	3.06	-	-
Home Health and CBAS	12,024,455	2.89	12,024,455	2.89	-	-
Other- Ambulance and Non-Emergent Transportation	19,687,593	4.73	19,687,593	4.73	-	-
Other - LTC (Short-Term), SNF, Hospice	22,009,483	5.29	22,009,483	5.29	-	-
Pay for Performance Quality Incentive	6,238,425	1.50	6,238,425	1.50	-	-
CalAIM Incentive Program	29,075,976	6.99	29,075,976	6.99	-	-
Provider Incentive Payments - Prop 56 & GEMT	81,866,252	19.68	70,176,862	19.68	(11,689,390) (C)	(2.81)
Add Ons Directed Provider Payments	228,984,127	52.92	250,749,761	57.95	21,765,635 (B)	5.03
Reinsurance Premium	914,969	0.22	914,969	0.22	-	-
UM/QA Costs (including Utilization & Quality Review)	52,759,517	12.69	52,759,517	12.69	-	-
Total Medical Costs	**1,370,413,650**	**329.51**	**1,380,489,894**	**331.93**	**10,076,245**	**2.42**
GROSS PROFIT/(LOSS)	**231,082,795**	**55.56**	**86,129,970**	**20.71**	**(144,952,825)**	**(34.85)**
ADMINISTRATIVE	**84,390,686**	**20.29**	**84,390,686**	**20.29**	-	-
NET PROFIT/(LOSS) BEFORE MCO TAX	**146,692,109**	**35.27**	**1,739,284**	**0.42**	**(144,952,825)**	**(34.85)**
MCO TAX EXPENSE	**144,952,825**	**34.85**	-	-	**(144,952,825)** (A)	**(34.85)**
NET PROFIT/(LOSS) AFTER MCO TAX	**1,739,284**	**0.42**	**1,739,284**	**0.42**	-	-
D-SNP EXPENSES	**7,503,760**		**7,503,760**		-	
NET PROFIT/(LOSS) AFTER GRANT EXPENSE	**(5,764,476)**		**(5,764,476)**		-	

(A) MCO Tax Changes
(B) Hospital Directed Payment Budget Changes
(C) Proposition 56 Value Based Supplemental Payment Program

Attachment 1

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: April 13, 2023

Re: December 2022 Financial Results

The December results reflect a $24,629,028 Net Increase in Net Position which is a $24,796,523 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $21.3 million favorable variance primarily due to:

   A) $4.4 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $7.1 million unfavorable variance primarily due to **timing differences** from reversing out previously recorded revenue under the Cal Aim Incentive Payment Program ("IPP"). Management believed that these funds would be earned in Calendar Year 2022 and now expects the revenue to be earned in Calendar Year 2023. Amounts are offset against expenses included in 2C (1) below.

   C) $1.0 million favorable variance primarily due to recording additional revenue earned under the Cal Aim Housing and Homelessness Incentive Program ("HHIP").

   D) $9.6 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2022 from DHCS in March 2023 offset against amounts included in 2D below.

   E) $12.4 million favorable variance in Rate Adjustments-Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2021 from DHCS in February 2023 offset against amounts included in 2E below.

2) Total Medical Costs reflect a $5.7 million favorable variance primarily due to:

   A) $1.3 million favorable variance in Physician Services primarily due to lower-than-expected utilization of Primary Care and Referral Specialty Services over the last several months.

   B) $8.4 million favorable variance in Inpatient primarily from favorable utilization from the June 30, 2022 Milliman Actuary Review liability estimate.

C) $9.9 million favorable variance in Other Medical primarily due to **timing differences** from:

1) $8.2 million related to reversing out previously recorded estimated expenses relating to CalAim IPP that management believed would be incurred in Calendar Year 2022 and that are now expected to be incurred in Calendar Year 2023. Amounts are offset against revenue included in 1B above.

2) $1.7 million related to reversing out previously recorded estimated expenses relating to CalAim HHIP that management believed would be incurred in Calendar Year 2022 and that are now expected to be incurred in Calendar Year 2023.

D) $9.6 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2022 from DHCS in March 2023 offset against amounts included in 1D above.

E) $12.4 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2021 from DHCS in February 2023 offset against amounts included in 1E above.

F) $1.1 million favorable variance in Non-Claims Expense Adjustment primarily due to lower than expected Ground Emergency Medical Transportation ("GEMT") utilization from the prior year.

G) $6.7 million favorable variance in IBNR, Incentive, Paid Claims Adjustment primarily relating to:

1) Removal of $3.7 million of unused COVID-19 Back to Care financial incentives that were offered to providers to encourage and promote members "back to care" after the decline in preventive and specialty care that occurred during the Covid-19 pandemic.

2) Reduction of the remaining 2021 P4P liability of $2.7 million due to lower-than-expected payouts.

3) Total Administrative Expenses reflect a $2.7 million unfavorable variance primarily due to:

A) $1.3 million unfavorable variance in Compensation primarily due to the Inflation Stipend Payment approved by the Compensation Committee in lieu of a 2023 Cost of Living Adjustment.

B) $.6 million unfavorable variance in Other Administrative Expenses primarily due to the accrual of regulatory fines for 2021 and expected regulatory fines for 2022.

C) $.5 million unfavorable variance in Administrative Expense Adjustment relating to the CalPERS Net Pension True-up Adjustment for the period July 1, 2021 to June 30, 2022 required under GASB 68 ($.2 million); and an increase in the Allowance for Claims Processing Expense which is a statutory requirement ($.3 million).

The December Medical Loss Ratio is 59.8% which is favorable to the 92.9% budgeted amount. The December Administrative Expense Ratio is 10.1% which is unfavorable to the 6.8% budgeted amount. Excluding the one-time items mentioned in items 1B and 3A-C above, the Administrative Expense Ratio for December was 6.6%.

The results for the 12 months ended December 31, 2022 reflects a Net Increase in Net Position of $71,279,986. This is a $74,833,342 favorable variance to the budget and includes approximately $22.2 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 85.6% which is favorable to the 92.9% budgeted amount. The year-to-date Administrative Expense Ratio is 6.7% which is favorable to the 7.0% budgeted amount.

Kern Health Systems
Financial Packet
December 2022

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF DECEMBER 31, 2022

ASSETS	DECEMBER 2022	NOVEMBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 99,137,387	$ 179,619,246	$ (80,481,859)
Short-Term Investments	317,979,109	210,720,910	107,258,199
Premiums Receivable - Net	102,277,912	109,732,438	(7,454,526)
Premiums Receivable - Hospital Direct Payments	436,815,600	396,795,571	40,020,029
Interest Receivable	389,179	168,011	221,168
Provider Advance Payment - Current Portion	844,067	2,361,487	(1,517,420)
Other Receivables	1,803,091	2,071,184	(268,093)
Prepaid Expenses & Other Current Assets	3,217,027	2,723,407	493,620
Total Current Assets	$ 962,463,372	$ 904,192,254	$ 58,271,118
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,241,823	1,259,875	(18,052)
Computer Hardware and Software - Net	23,159,335	20,493,849	2,665,486
Building and Building Improvements - Net	33,715,199	33,791,308	(76,109)
Capital Projects in Progress	2,241,699	4,168,950	(1,927,251)
Total Capital Assets	$ 64,448,762	$ 63,804,688	$ 644,074
LONG TERM ASSETS:			
Provider Advance Payment	263,964	-	263,964
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,588,890	1,604,652	(15,762)
Total Long Term Assets	$ 2,152,854	$ 1,904,652	$ 248,202
DEFERRED OUTFLOWS OF RESOURCES	$ 8,154,860	$ 4,731,067	$ 3,423,793
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 1,037,219,848	$ 974,632,661	$ 62,587,187
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 4,139,353	$ 4,033,090	106,263
Accrued Other Operating Expenses	4,353,705	2,223,938	2,129,767
Accrued Taxes and Licenses	32,495,339	21,611,880	10,883,459
Claims Payable (Reported)	18,643,958	19,495,865	(851,907)
IBNR - Inpatient Claims	51,058,132	56,225,683	(5,167,551)
IBNR - Physician Claims	17,600,496	19,440,798	(1,840,302)
IBNR - Accrued Other Medical	27,425,468	26,682,535	742,933
Risk Pool and Withholds Payable	3,505,791	5,714,494	(2,208,703)
Statutory Allowance for Claims Processing Expense	2,831,842	2,509,938	321,904
Other Liabilities	109,327,418	119,115,609	(9,788,191)
Accrued Hospital Directed Payments	436,633,258	396,613,229	40,020,029
Total Current Liabilities	$ 708,014,760	$ 673,667,059	$ 34,347,701
NONCURRENT LIABILITIES:			
Net Pension Liability	10,218,206	1,500,000	8,718,206
TOTAL NONCURRENT LIABILITIES	$ 10,218,206	$ 1,500,000	$ 8,718,206
DEFERRED INFLOWS OF RESOURCES	$ 230,571	$ 5,338,319	$ (5,107,748)
NET POSITION:			
Net Position - Beg. of Year	247,476,325	247,476,325	-
Increase (Decrease) in Net Position - Current Year	71,279,986	46,650,958	24,629,028
Total Net Position	$ 318,756,311	$ 294,127,283	$ 24,629,028
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 1,037,219,848	$ 974,632,661	$ 62,587,187

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED DECEMBER 31, 2022

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
212,779	211,000	1,779	Family Members	2,459,855	2,446,200	13,655
96,065	85,630	10,435	Expansion Members	1,076,986	990,960	86,026
17,501	16,630	871	SPD Members	201,877	192,960	8,917
10,169	7,740	2,429	Other Members	114,149	92,880	21,269
14,635	13,000	1,635	Kaiser Members	165,042	156,000	9,042
351,149	334,000	17,149	Total Members - MCAL	4,017,909	3,879,000	138,909
			REVENUES			
34,345,215	37,039,924	(2,694,709)	Title XIX - Medicaid - Family and Other	446,292,516	432,168,373	14,124,143
30,862,645	29,821,559	1,041,086	Title XIX - Medicaid - Expansion Members	368,065,120	345,165,460	22,899,660
15,500,822	15,582,898	(82,076)	Title XIX - Medicaid - SPD Members	183,770,921	180,810,348	2,960,573
10,883,460	11,048,894	(165,434)	Premium - MCO Tax	124,665,083	124,665,083	-
27,573,903	17,923,941	9,649,962	Premium - Hospital Directed Payments	229,310,845	208,314,785	20,996,060
714,738	86,149	628,589	Investment Earnings And Other Income	1,588,464	1,000,000	588,464
152,481	57,780	94,701	Reinsurance Recoveries	152,481	670,140	(517,659)
12,446,127	-	12,446,127	Rate Adjustments - Hospital Directed Payments	34,995,749	-	34,995,749
333,950	-	333,950	Rate/Income Adjustments	29,864	-	29,864
132,813,341	111,561,146	21,252,195	TOTAL REVENUES	1,388,871,043	1,292,794,188	96,076,855
			EXPENSES			
			Medical Costs:			
16,678,607	17,974,242	1,295,635	Physician Services	221,023,011	208,398,110	(12,624,901)
6,175,363	5,998,074	(177,289)	Other Professional Services	62,529,225	70,432,157	7,902,932
5,082,054	5,848,762	766,708	Emergency Room	57,618,727	67,820,138	10,201,411
12,591,938	21,014,598	8,422,660	Inpatient	242,222,642	243,605,904	1,383,262
59,818	57,780	(2,038)	Reinsurance Expense	595,993	670,140	74,147
9,093,742	8,933,535	(160,207)	Outpatient Hospital	107,494,563	103,561,502	(3,933,061)
6,543,097	16,447,919	9,904,822	Other Medical	184,499,703	191,227,492	6,727,789
504,771	481,500	(23,271)	Pay for Performance Quality Incentive	5,772,260	5,584,500	(187,760)
27,573,903	17,923,941	(9,649,962)	Hospital Directed Payments	229,310,845	208,314,785	(20,996,060)
12,446,126	-	(12,446,126)	Hospital Directed Payment Adjustment	35,328,905	-	(35,328,905)
(1,071,264)	-	1,071,264	Non-Claims Expense Adjustment	(1,944,184)	-	1,944,184
(6,704,318)	-	6,704,318	IBNR, Incentive, Paid Claims Adjustment	(23,722,941)	-	23,722,941
88,973,837	94,680,351	5,706,514	Total Medical Costs	1,120,728,749	1,099,614,728	(21,114,021)
43,839,504	16,880,795	26,958,709	GROSS MARGIN	268,142,294	193,179,460	74,962,834
			Administrative:			
4,707,264	3,369,438	(1,337,826)	Compensation	39,393,605	40,508,261	1,114,656
1,262,419	1,108,544	(153,875)	Purchased Services	11,911,295	13,302,530	1,391,235
220,189	212,108	(8,081)	Supplies	1,363,089	2,545,291	1,182,202
627,772	526,572	(101,200)	Depreciation	7,065,025	6,318,863	(746,162)
966,290	366,066	(600,224)	Other Administrative Expenses	4,498,063	4,392,788	(105,275)
508,526	-	(508,526)	Administrative Expense Adjustment	3,212,805	-	(3,212,805)
8,292,460	5,582,728	(2,709,732)	Total Administrative Expenses	67,443,882	67,067,733	(376,149)
97,266,297	100,263,079	2,996,782	TOTAL EXPENSES	1,188,172,631	1,166,682,461	(21,490,170)
35,547,044	11,298,067	24,248,977	OPERATING INCOME (LOSS) BEFORE TAX	200,698,412	126,111,727	74,586,685
10,883,459	11,048,894	165,435	MCO TAX	124,658,814	124,665,083	6,269
24,663,585	249,173	24,414,412	OPERATING INCOME (LOSS) NET OF TAX	76,039,598	1,446,644	74,592,954
			NONOPERATING REVENUE (EXPENSE)			
-	-	-	Gain on Sale of Assets	-	-	-
-	(333,334)	333,334	Provider Grants/CalAIM Initiative Grant	(4,091,430)	(4,000,000)	(91,430)
(34,557)	(83,334)	48,777	Health Home	(668,182)	(1,000,000)	331,818
(34,557)	(416,668)	382,111	TOTAL NONOPERATING REVENUE (EXPENSE)	(4,759,612)	(5,000,000)	240,388
24,629,028	(167,495)	24,796,523	NET INCREASE (DECREASE) IN NET POSITION	71,279,986	(3,553,356)	74,833,342
59.8%	92.9%	33.2%	MEDICAL LOSS RATIO	85.6%	92.9%	7.2%
10.1%	6.8%	-3.4%	ADMINISTRATIVE EXPENSE RATIO	6.7%	7.0%	0.2%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED DECEMBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
212,779	211,000	1,779	Family Members	2,459,855	2,446,200	13,655
96,065	85,630	10,435	Expansion Members	1,076,986	990,960	86,026
17,501	16,630	871	SPD Members	201,877	192,960	8,917
10,169	7,740	2,429	Other Members	114,149	92,880	21,269
14,635	13,000	1,635	Kaiser Members	165,042	156,000	9,042
351,149	334,000	17,149	Total Members - MCAL	4,017,909	3,879,000	138,909
			REVENUES			
154.05	169.33	(15.28)	Title XIX - Medicaid - Family and Other	173.38	170.21	3.18
321.27	348.26	(26.99)	Title XIX - Medicaid - Expansion Members	341.75	348.31	(6.56)
885.71	937.04	(51.32)	Title XIX - Medicaid - SPD Members	910.31	937.04	(26.72)
32.34	34.42	(2.08)	Premium - MCO Tax	32.36	33.49	(1.13)
81.94	55.84	26.10	Premium - Hospital Directed Payments	59.52	55.95	3.56
2.12	0.27	1.86	Investment Earnings And Other Income	0.41	0.27	0.14
0.45	0.18	0.27	Reinsurance Recoveries	0.04	0.18	(0.14)
36.99	0.00	36.99	Rate Adjustments - Hospital Directed Payments	9.08	0.00	9.08
0.99	0.00	0.99	Rate/Income Adjustments	0.01	0.00	0.01
394.67	347.54	47.13	TOTAL REVENUES	360.48	347.25	13.23
			EXPENSES			
			Medical Costs:			
49.56	55.99	6.43	Physician Services	57.37	55.98	(1.39)
18.35	18.69	0.33	Other Professional Services	16.23	18.92	2.69
15.10	18.22	3.12	Emergency Room	14.95	18.22	3.26
37.42	65.47	28.05	Inpatient	62.87	65.43	2.56
0.18	0.18	0.00	Reinsurance Expense	0.15	0.18	0.03
27.02	27.83	0.81	Outpatient Hospital	27.90	27.82	(0.08)
19.44	51.24	31.80	Other Medical	47.89	51.36	3.48
1.50	1.50	0.00	Pay for Performance Quality Incentive	1.50	1.50	0.00
81.94	55.84	(26.10)	Hospital Directed Payments	59.52	55.95	(3.56)
36.99	0.00	(36.99)	Hospital Directed Payment Adjustment	9.17	0.00	(9.17)
(3.18)	0.00	3.18	Non-Claims Expense Adjustment	(0.50)	0.00	0.50
(19.92)	0.00	19.92	IBNR, Incentive, Paid Claims Adjustment	(6.16)	0.00	6.16
264.40	294.95	30.56	Total Medical Costs	290.88	295.36	4.48
130.28	52.59	77.69	GROSS MARGIN	69.60	51.89	17.71
			Administrative:			
13.99	10.50	(3.49)	Compensation	10.22	10.88	0.66
3.75	3.45	(0.30)	Purchased Services	3.09	3.57	0.48
0.65	0.66	0.01	Supplies	0.35	0.68	0.33
1.87	1.64	(0.23)	Depreciation	1.83	1.70	(0.14)
2.87	1.14	(1.73)	Other Administrative Expenses	1.17	1.18	0.01
1.51	0.00	(1.51)	Administrative Expense Adjustment	0.83	0.00	(0.83)
24.64	17.39	(7.25)	Total Administrative Expenses	17.50	18.01	0.51
289.04	312.35	23.31	TOTAL EXPENSES	308.39	313.37	4.98
105.63	35.20	70.44	OPERATING INCOME (LOSS) BEFORE TAX	52.09	33.87	18.22
32.34	34.42	2.08	MCO TAX	32.35	33.49	1.13
73.29	0.78	72.52	OPERATING INCOME (LOSS) NET OF TAX	19.74	0.39	19.35
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
0.00	(1.04)	1.04	Reserve Fund Projects/Community Grants	(1.06)	(1.07)	0.01
(0.10)	(0.26)	0.16	Health Home	(0.17)	(0.27)	0.10
(0.10)	(1.30)	1.20	TOTAL NONOPERATING REVENUE (EXPENSE)	(1.24)	(1.34)	0.11
73.19	(0.52)	73.71	NET INCREASE (DECREASE) IN NET POSITION	18.50	(0.95)	19.45
59.8%	92.9%	33.2%	MEDICAL LOSS RATIO	85.6%	92.9%	7.2%
10.1%	6.8%	-3.4%	ADMINISTRATIVE EXPENSE RATIO	6.7%	7.0%	0.2%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH DECEMBER 31, 2022	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
ENROLLMENT							
Members - MCAL	298,205	309,342	310,281	312,490	314,691	315,663	319,333
REVENUES							
Title XIX - Medicaid - Family and Other	36,899,197	37,009,614	37,126,546	36,539,594	36,762,722	35,766,911	37,731,384
Title XIX - Medicaid - Expansion Members	30,241,720	29,968,453	29,945,915	29,350,530	29,812,384	29,600,713	30,533,210
Title XIX - Medicaid - SPD Members	16,506,513	14,953,594	14,858,906	14,791,754	14,924,745	14,887,158	15,402,431
Premium - MCO Tax	10,273,393	9,899,314	9,894,054	9,893,826	9,894,054	9,872,493	9,910,584
Premium - Hospital Directed Payments	16,836,470	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276	18,280,365
Investment Earnings And Other Income	(694,967)	329,573	86,457	(1,241,065)	(326,288)	357,517	(633,952)
Reinsurance Recoveries	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	(3,586)	230,177	24,013	26,907,309	3,898	(23,892)	5,129
Rate/Income Adjustments	5,625	957,475	977,794	493,268	59,935	(4,649,731)	(364,397)
TOTAL REVENUES	110,064,365	110,955,070	110,568,181	134,684,350	109,037,367	103,739,445	110,864,754
EXPENSES							
Medical Costs:							
Physician Services	17,972,930	17,538,030	19,319,317	19,919,152	18,291,501	17,895,843	18,921,901
Other Professional Services	4,344,076	5,041,033	4,902,710	5,254,779	5,361,545	4,835,075	5,112,961
Emergency Room	4,391,622	5,209,937	5,098,972	5,150,400	5,098,584	4,139,529	3,167,228
Inpatient	17,137,562	20,610,105	20,031,970	20,232,342	20,364,608	21,395,635	19,551,774
Reinsurance Expense	86,147	53,660	53,896	57,686	56,409	56,248	57,216
Outpatient Hospital	6,083,159	8,214,215	8,223,126	8,686,122	8,458,833	8,281,163	9,196,013
Other Medical	11,502,354	17,263,621	17,534,988	15,788,879	16,341,907	16,301,024	15,522,071
Pharmacy	10,620,178	-	-	-	-	-	-
Pay for Performance Quality Incentive	1,420,000	464,013	465,422	465,421	472,037	473,494	478,060
Hospital Directed Payments	16,836,470	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276	18,280,365
Hospital Directed Payment Adjustment	(3,586)	230,177	24,013	26,678,156	3,898	(3,419)	5,129
Non-Claims Expense Adjustment	(44,256)	43,538	4,118	572,469	62,025	(1,371,999)	29,799
IBNR, Incentive, Paid Claims Adjustment	(1,022,824)	627	(1,010,781)	(3,987,493)	(2,812,496)	(3,724,314)	(4,072,490)
Total Medical Costs	89,323,832	92,275,826	92,302,247	116,767,047	89,604,768	86,206,555	86,250,027
GROSS MARGIN	20,740,533	18,679,244	18,265,934	17,917,303	19,432,599	17,532,890	24,614,727
Administrative:							
Compensation	2,592,690	3,116,842	2,847,002	3,108,703	3,075,151	3,259,102	2,980,813
Purchased Services	1,355,474	846,917	877,498	1,098,614	783,960	927,532	850,526
Supplies	164,659	191,908	(8,268)	103,207	41,533	145,499	66,970
Depreciation	746,072	571,126	571,126	571,126	570,835	575,899	626,073
Other Administrative Expenses	605,706	389,918	259,997	346,089	252,930	300,845	329,335
Administrative Expense Adjustment	(194,326)	(1,904)	(44,283)	31,776	164,256	(2,834)	811,890
Total Administrative Expenses	5,270,275	5,114,807	4,503,072	5,259,515	4,888,665	5,206,043	5,665,607
TOTAL EXPENSES	94,594,107	97,390,633	96,805,319	122,026,562	94,493,433	91,412,598	91,915,634
OPERATING INCOME (LOSS) BEFORE TAX	15,470,258	13,564,437	13,762,862	12,657,788	14,543,934	12,326,847	18,949,120
MCO TAX	9,895,157	9,894,054	9,894,054	9,893,826	9,894,054	9,888,018	9,894,051
OPERATING INCOME (LOSS) NET OF TAX	5,575,101	3,670,383	3,868,808	2,763,962	4,649,880	2,438,829	9,055,069
TOTAL NONOPERATING REVENUE (EXPENSE)	(175,210)	(400,389)	(986,700)	(1,001,012)	(1,110,153)	744,870	(1,996,822)
NET INCREASE (DECREASE) IN NET POSITION	5,399,891	3,269,994	2,882,108	1,762,950	3,539,727	3,183,699	7,058,247
MEDICAL LOSS RATIO	87.4%	89.4%	89.9%	90.2%	88.3%	89.9%	82.2%
ADMINISTRATIVE EXPENSE RATIO	6.4%	6.1%	5.4%	6.6%	6.0%	6.9%	6.9%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH DECEMBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	DECEMBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	323,572	324,961	325,920	329,121	331,947	336,514	4,152,040
REVENUES							
Title XIX - Medicaid - Family and Other	37,514,641	37,941,354	37,957,277	37,949,223	39,648,035	34,345,215	483,191,713
Title XIX - Medicaid - Expansion Members	30,993,375	31,238,545	31,275,148	31,549,369	32,934,833	30,862,645	398,306,840
Title XIX - Medicaid - SPD Members	15,833,803	15,065,828	15,760,220	15,913,345	15,878,315	15,500,822	200,277,434
Premium - MCO Tax	10,883,460	10,883,459	10,883,460	10,883,459	10,883,460	10,883,460	134,938,476
Premium - Hospital Directed Payments	18,674,627	18,595,974	18,857,014	18,961,885	19,322,384	27,573,903	246,147,315
Investment Earnings And Other Income	1,002,315	(121,473)	353,347	179,268	888,027	714,738	893,497
Reinsurance Recoveries	-	-	-	-	-	152,481	152,481
Rate Adjustments - Hospital Directed Payments	9,235	(4,343)	(4,606,563)	9,926	(5,267)	12,446,127	34,992,163
Rate/Income Adjustments	350,036	245,168	203,911	124,448	1,298,007	333,950	35,489
TOTAL REVENUES	115,261,492	113,844,512	110,683,814	115,570,923	120,847,794	132,813,341	1,498,935,408
EXPENSES							
Medical Costs:							
Physician Services	18,984,281	18,198,409	18,622,853	18,169,774	18,483,343	16,678,607	238,995,941
Other Professional Services	5,137,341	5,208,793	5,024,917	5,041,998	5,432,710	6,175,363	66,873,301
Emergency Room	4,764,039	4,661,044	4,773,821	4,790,820	5,682,299	5,082,054	62,010,349
Inpatient	22,935,749	20,834,103	22,797,560	22,462,437	18,414,421	12,591,938	259,360,204
Reinsurance Expense	(33,668)	(25,136)	142,533	58,493	58,838	59,818	682,140
Outpatient Hospital	10,013,268	9,928,749	9,352,210	9,319,855	8,727,267	9,093,742	113,577,722
Other Medical	15,416,935	15,241,576	15,744,662	16,418,094	16,382,849	6,543,097	196,002,057
Pharmacy	-	-	-	-	-	-	10,620,178
Pay for Performance Quality Incentive	485,358	485,358	490,964	493,681	493,681	504,771	7,192,260
Hospital Directed Payments	18,674,627	18,595,974	18,857,014	18,961,885	19,322,384	27,573,903	246,147,315
Hospital Directed Payment Adjustment	9,235	(4,343)	(4,064,727)	9,926	(5,266)	12,446,126	35,325,319
Non-Claims Expense Adjustment	17,040	5,019	9,821	(248,768)	4,018	(1,071,264)	(1,988,440)
IBNR, Incentive, Paid Claims Adjustment	(238,100)	487,881	(789,121)	(435,695)	(436,641)	(6,704,318)	(24,745,765)
Total Medical Costs	96,166,105	93,617,427	90,962,507	95,042,500	92,559,903	88,973,837	1,210,052,581
GROSS MARGIN	19,095,387	20,227,085	19,721,307	20,528,423	28,287,891	43,839,504	288,882,827
Administrative:							
Compensation	3,307,910	3,148,970	3,213,222	3,387,496	3,241,130	4,707,264	41,986,295
Purchased Services	1,078,360	1,144,312	997,356	1,009,393	1,034,408	1,262,419	13,266,769
Supplies	74,368	117,566	85,530	66,157	258,430	220,189	1,527,748
Depreciation	576,074	583,814	583,673	584,905	622,602	627,772	7,811,097
Other Administrative Expenses	414,331	315,625	298,240	304,229	320,234	966,290	5,103,769
Administrative Expense Adjustment	425,467	300,000	420,793	299,429	299,689	508,526	3,018,479
Total Administrative Expenses	5,876,510	5,610,287	5,598,814	5,651,609	5,776,493	8,292,460	72,714,157
TOTAL EXPENSES	102,042,615	99,227,714	96,561,321	100,694,109	98,336,396	97,266,297	1,282,766,738
OPERATING INCOME (LOSS) BEFORE TAX	13,218,877	14,616,798	14,122,493	14,876,814	22,511,398	35,547,044	216,168,670
MCO TAX	10,883,459	10,883,460	10,883,459	10,883,460	10,883,460	10,883,459	134,553,971
OPERATING INCOME (LOSS) NET OF TAX	2,335,418	3,733,338	3,239,034	3,993,354	11,627,938	24,663,585	81,614,699
TOTAL NONOPERATING REVENUE (EXPENSE)	(3,380)	57,925	(27,966)	(5,428)	4,000	(34,557)	(4,934,822)
NET INCREASE (DECREASE) IN NET POSITION	2,332,038	3,791,263	3,211,068	3,987,926	11,631,938	24,629,028	76,679,877
MEDICAL LOSS RATIO	90.4%	88.9%	89.0%	88.7%	80.8%	59.8%	85.8%
ADMINISTRATIVE EXPENSE RATIO	6.9%	6.6%	6.5%	6.6%	6.4%	10.1%	6.7%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH DECEMBER 31, 2022	DECEMBER 2021	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
ENROLLMENT							
Members - MCAL	298,205	309,342	310,281	312,490	314,691	315,663	319,333
REVENUES							
Title XIX - Medicaid - Family and Other	181.56	177.17	177.17	173.28	173.44	168.25	176.65
Title XIX - Medicaid - Expansion Members	382.19	357.24	355.03	344.90	345.21	341.10	343.27
Title XIX - Medicaid - SPD Members	1,042.14	903.21	907.36	895.60	912.10	913.04	917.14
Premium - MCO Tax	34.45	32.00	31.89	31.66	31.44	31.28	31.04
Premium - Hospital Directed Payments	56.46	56.92	56.90	57.44	56.90	56.80	57.25
Investment Earnings And Other Income	(2.33)	1.07	0.28	(3.97)	(1.04)	1.13	(1.99)
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	(0.01)	0.74	0.08	86.11	0.01	(0.08)	0.02
Rate/Income Adjustments	0.02	3.10	3.15	1.58	0.19	(14.73)	(1.14)
TOTAL REVENUES	369.09	358.68	356.35	431.00	346.49	328.64	347.18
EXPENSES							
Medical Costs:							
Physician Services	60.27	56.69	62.26	63.74	58.13	56.69	59.25
Other Professional Services	14.57	16.30	15.80	16.82	17.04	15.32	16.01
Emergency Room	14.73	16.84	16.43	16.48	16.20	13.11	9.92
Inpatient	57.47	66.63	64.56	64.75	64.71	67.78	61.23
Reinsurance Expense	0.29	0.17	0.17	0.18	0.18	0.18	0.18
Outpatient Hospital	20.40	26.55	26.50	27.80	26.88	26.23	28.80
Other Medical	38.57	55.81	56.51	50.53	51.93	51.64	48.61
Pharmacy	35.61	0.00	0.00	0.00	0.00	0.00	0.00
Pay for Performance Quality Incentive	4.76	1.50	1.50	1.49	1.50	1.50	1.50
Hospital Directed Payments	56.46	56.92	56.90	57.44	56.90	56.80	57.25
Hospital Directed Payment Adjustment	(0.01)	0.74	0.08	85.37	0.01	(0.01)	0.02
Non-Claims Expense Adjustment	(0.15)	0.14	0.01	1.83	0.20	(4.35)	0.09
IBNR, Incentive, Paid Claims Adjustment	(3.43)	0.00	(3.26)	(12.76)	(8.94)	(11.80)	(12.75)
Total Medical Costs	299.54	298.30	297.48	373.67	284.74	273.10	270.09
GROSS MARGIN	69.55	60.38	58.87	57.34	61.75	55.54	77.08
Administrative:							
Compensation	8.69	10.08	9.18	9.95	9.77	10.32	9.33
Purchased Services	4.55	2.74	2.83	3.52	2.49	2.94	2.66
Supplies	0.55	0.62	(0.03)	0.33	0.13	0.46	0.21
Depreciation	2.50	1.85	1.84	1.83	1.81	1.82	1.96
Other Administrative Expenses	2.03	1.26	0.84	1.11	0.80	0.95	1.03
Administrative Expense Adjustment	(0.65)	(0.01)	(0.14)	0.10	0.52	(0.01)	2.54
Total Administrative Expenses	17.67	16.53	14.51	16.83	15.53	16.49	17.74
TOTAL EXPENSES	317.21	314.83	311.99	390.50	300.27	289.59	287.84
OPERATING INCOME (LOSS) BEFORE TAX	51.88	43.85	44.36	40.51	46.22	39.05	59.34
MCO TAX	33.18	31.98	31.89	31.66	31.44	31.32	30.98
OPERATING INCOME (LOSS) NET OF TAX	18.70	11.87	12.47	8.84	14.78	7.73	28.36
TOTAL NONOPERATING REVENUE (EXPENSE)	(0.59)	(1.29)	(3.18)	(3.20)	(3.53)	2.36	(6.25)
NET INCREASE (DECREASE) IN NET POSITION	18.11	10.57	9.29	5.64	11.25	10.09	22.10
MEDICAL LOSS RATIO	87.4%	89.4%	89.9%	90.2%	88.3%	89.9%	82.2%
ADMINISTRATIVE EXPENSE RATIO	6.4%	6.1%	5.4%	6.6%	6.0%	6.9%	6.9%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH DECEMBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	DECEMBER 2022	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	323,572	324,961	325,920	329,121	331,947	336,514	4,152,040
REVENUES							
Title XIX - Medicaid - Family and Other	173.99	175.92	175.56	174.37	180.89	156.69	175.22
Title XIX - Medicaid - Expansion Members	340.07	338.95	338.39	334.55	344.93	323.22	349.77
Title XIX - Medicaid - SPD Members	941.54	880.12	911.57	926.33	919.20	897.35	926.36
Premium - MCO Tax	33.64	33.49	33.39	33.07	32.79	32.34	32.50
Premium - Hospital Directed Payments	57.71	57.23	57.86	57.61	58.21	81.94	59.28
Investment Earnings And Other Income	3.10	(0.37)	1.08	0.54	2.68	2.12	0.22
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.45	0.04
Rate Adjustments - Hospital Directed Payments	0.03	(0.01)	(14.13)	0.03	(0.02)	36.99	8.43
Rate/Income Adjustments	1.08	0.75	0.63	0.38	3.91	0.99	0.01
TOTAL REVENUES	356.22	350.33	339.60	351.15	364.06	394.67	361.01
EXPENSES							
Medical Costs:							
Physician Services	58.67	56.00	57.14	55.21	55.68	49.56	57.56
Other Professional Services	15.88	16.03	15.42	15.32	16.37	18.35	16.11
Emergency Room	14.72	14.34	14.65	14.56	17.12	15.10	14.93
Inpatient	70.88	64.11	69.95	68.25	55.47	37.42	62.47
Reinsurance Expense	(0.10)	(0.08)	0.44	0.18	0.18	0.18	0.16
Outpatient Hospital	30.95	30.55	28.69	28.32	26.29	27.02	27.35
Other Medical	47.65	46.90	48.31	49.88	49.35	19.44	47.21
Pharmacy	0.00	0.00	0.00	0.00	0.00	0.00	2.56
Pay for Performance Quality Incentive	1.50	1.49	1.51	1.50	1.49	1.50	1.73
Hospital Directed Payments	57.71	57.23	57.86	57.61	58.21	81.94	59.28
Hospital Directed Payment Adjustment	0.03	(0.01)	(12.47)	0.03	(0.02)	36.99	8.51
Non-Claims Expense Adjustment	0.05	0.02	0.03	(0.76)	0.01	(3.18)	(0.48)
IBNR, Incentive, Paid Claims Adjustment	(0.74)	1.50	(2.42)	(1.32)	(1.32)	(19.92)	(5.96)
Total Medical Costs	297.20	288.09	279.09	288.78	278.84	264.40	291.44
GROSS MARGIN	59.01	62.24	60.51	62.37	85.22	130.28	69.58
Administrative:							
Compensation	10.22	9.69	9.86	10.29	9.76	13.99	10.11
Purchased Services	3.33	3.52	3.06	3.07	3.12	3.75	3.20
Supplies	0.23	0.36	0.26	0.20	0.78	0.65	0.37
Depreciation	1.78	1.80	1.79	1.78	1.88	1.87	1.88
Other Administrative Expenses	1.28	0.97	0.92	0.92	0.96	2.87	1.23
Administrative Expense Adjustment	1.31	0.92	1.29	0.91	0.90	1.51	0.73
Total Administrative Expenses	18.16	17.26	17.18	17.17	17.40	24.64	17.51
TOTAL EXPENSES	315.36	305.35	296.27	305.95	296.24	289.04	308.95
OPERATING INCOME (LOSS) BEFORE TAX	40.85	44.98	43.33	45.20	67.82	105.63	52.06
MCO TAX	33.64	33.49	33.39	33.07	32.79	32.34	32.41
OPERATING INCOME (LOSS) NET OF TAX	7.22	11.49	9.94	12.13	35.03	73.29	19.66
TOTAL NONOPERATING REVENUE (EXPENSE)	(0.01)	0.18	(0.09)	(0.02)	0.01	(0.10)	(1.19)
NET INCREASE (DECREASE) IN NET POSITION	7.21	11.67	9.85	12.12	35.04	73.19	18.47
MEDICAL LOSS RATIO	90.4%	88.9%	89.0%	88.7%	80.8%	59.8%	85.8%
ADMINISTRATIVE EXPENSE RATIO	6.9%	6.6%	6.5%	6.6%	6.4%	10.1%	6.7%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
28,759,683	27,742,460	1,017,223	Premium - Medi-Cal	332,179,922	323,065,799	9,114,123
3,007,164	2,764,572	242,592	Premium - Maternity Kick	35,013,500	33,174,867	1,838,633
561,764	481,327	80,437	Premium - Enhanced Care Management	6,385,633	5,646,630	739,003
148,149	135,216	12,933	Premium - Major Organ Transplant	1,695,193	1,579,824	115,369
(3,942,735)	511,325	(4,454,060)	Premium - Cal AIM	4,806,610	5,935,333	(1,128,723)
994,052	789,615	204,437	Premium - BHT Kick	9,489,105	9,165,661	323,444
3,627,095	4,184,219	(557,124)	Premium - Provider Enhancement	45,718,769	48,584,425	(2,865,656)
218,469	211,288	7,181	Premium - Ground Emergency Medical Transportation	2,528,627	2,457,114	71,513
145,440	107,480	37,960	Premium - Behavorial Health Integration Program	2,997,251	1,247,599	1,749,652
-	-	-	Premium - Vaccine Incentive	1,405,896	-	1,405,896
179,373	-	179,373	Premium - Student Behavioral Health Incentive	723,053	-	723,053
646,227	-	646,227	Premium - Housing and Homelessness Incentive	1,945,137	-	1,945,137
534	112,420	(111,886)	Other	1,403,820	1,311,118	92,702
34,345,215	37,039,924	(2,694,709)	Total Title XIX - Medicaid - Family & Other	446,292,516	432,168,372	14,124,144
			Title XIX - Medicaid - Expansion Members			
28,598,269	25,963,969	2,634,300	Premium - Medi-Cal	321,915,685	300,428,562	21,487,123
472,424	234,964	237,460	Premium - Maternity Kick	5,069,482	2,819,568	2,249,914
1,025,905	870,522	155,383	Premium - Enhanced Care Management	11,527,078	10,069,795	1,457,283
244,063	217,419	26,644	Premium - Major Organ Transplant	2,748,828	2,515,002	233,826
(1,692,492)	476,942	(2,169,434)	Premium - Cal AIM	1,954,384	5,519,451	(3,565,067)
-	-	-	Premium - BHT Kick	12,659	-	12,659
1,560,890	1,710,475	(149,585)	Premium - Provider Enhancement	19,138,036	19,794,610	(656,574)
240,130	216,558	23,572	Premium - Ground Emergency Medical Transportation	2,705,996	2,506,137	199,859
64,104	100,253	(36,149)	Premium - Behavorial Health Integration Program	1,227,859	1,160,182	67,677
-	-	-	Premium - Vaccine Incentive	266,803	-	266,803
77,539	-	77,539	Premium - Student Behavioral Health Incentive	304,387	-	304,387
270,529	-	270,529	Premium - Housing and Homelessness Incentive	804,586	-	804,586
1,284	30,456	(29,172)	Other	389,337	352,152	37,185
30,862,645	29,821,559	1,041,086	Total Title XIX - Medicaid - Expansion Members	368,065,120	345,165,460	22,899,660
			Title XIX - Medicaid - SPD Members			
13,742,139	13,216,693	525,447	Premium - Medi-Cal	159,902,400	153,354,959	6,547,442
503,755	475,452	28,303	Premium - Enhanced Care Management	5,856,057	5,516,730	339,327
156,557	151,167	5,390	Premium - Major Organ Transplant	1,821,687	1,754,010	67,677
(311,529)	242,816	(554,345)	Premium - Cal AIM	375,112	2,817,427	(2,442,315)
734,966	803,085	(68,119)	Premium - BHT Kick	7,961,180	9,318,292	(1,357,112)
445,592	493,975	(48,383)	Premium - Provider Enhancement	5,567,216	5,731,653	(164,437)
153,631	148,672	4,959	Premium - Ground Emergency Medical Transportation	1,787,634	1,725,060	62,574
11,240	51,040	(39,800)	Premium - Behavorial Health Integration Program	234,954	592,219	(357,265)
-	-	-	Premium - Vaccine Incentive	56,559	-	56,559
13,956	-	13,956	Premium - Student Behavioral Health Incentive	56,034	-	56,034
50,515	-	50,515	Premium - Housing and Homelessness Incentive	152,088	-	152,088
15,500,822	15,582,898	(82,076)	Total Title XIX - Medicaid - SPD Members	183,770,921	180,810,348	2,960,573

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED DECEMBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
3,340,550	4,131,178	790,628	Primary Care Physician Services	44,537,801	47,913,134	3,375,333
11,427,771	12,139,131	711,360	Referral Specialty Services	152,001,271	140,725,214	(11,276,057)
1,900,986	1,694,633	(206,353)	Urgent Care & After Hours Advise	24,374,439	19,650,262	(4,724,177)
9,300	9,300	-	Hospital Admitting Team	109,500	109,500	-
16,678,607	17,974,242	1,295,635	TOTAL PHYSICIAN SERVICES	221,023,011	208,398,110	(12,624,901)
			OTHER PROFESSIONAL SERVICES			
332,322	337,331	5,009	Vision Service Capitation	3,813,776	3,912,401	98,625
2,799,619	2,154,063	(645,556)	Medical Departments - UM Allocation *	23,515,151	25,848,750	2,333,599
1,555,420	1,592,700	37,280	Behavior Health Treatment	16,371,942	18,483,954	2,112,012
162,467	159,952	(2,515)	Mental Health Services	1,876,783	1,855,001	(21,782)
1,325,535	1,754,028	428,493	Other Professional Services	16,951,573	20,332,051	3,380,478
6,175,363	5,998,074	(177,289)	TOTAL OTHER PROFESSIONAL SERVICES	62,529,225	70,432,157	7,902,932
5,082,054	5,848,762	766,708	EMERGENCY ROOM	57,618,727	67,820,138	10,201,411
12,591,938	21,014,598	8,422,660	INPATIENT HOSPITAL	242,222,642	243,605,904	1,383,262
59,818	57,780	(2,038)	REINSURANCE EXPENSE PREMIUM	595,993	670,140	74,147
9,093,742	8,933,535	(160,207)	OUTPATIENT HOSPITAL SERVICES	107,494,563	103,561,502	(3,933,061)
			OTHER MEDICAL			
1,546,895	1,681,398	134,503	Ambulance and NEMT	16,608,318	19,499,514	2,891,196
999,703	724,766	(274,937)	Home Health Services & CBAS	10,682,786	8,405,842	(2,276,944)
1,207,878	1,106,708	(101,170)	Utilization and Quality Review Expenses	9,973,063	13,280,496	3,307,433
415,812	1,514,887	1,099,075	Long Term/SNF/Hospice	18,395,118	17,565,966	(829,152)
5,356,659	6,099,683	743,024	Provider Enhancement Expense - Prop. 56	66,902,643	70,739,567	3,836,924
629,834	547,693	(82,141)	Provider Enhancement Expense - GEMT	5,704,108	6,353,903	649,795
23,625	-	(23,625)	Vaccine Incentive Program Expense	3,204,529	-	(3,204,529)
220,783	258,772	37,989	Behaviorial Health Integration Program	4,460,064	3,000,000	(1,460,064)
2,606,669	1,827,301	(779,368)	Enhanced Care Management	22,726,446	21,233,150	(1,493,296)
521,331	504,687	(16,644)	Major Organ Transplant	5,952,423	5,848,837	(103,586)
(8,466,492)	1,231,083	9,697,575	Cal AIM Incentive Programs	8,023,046	14,272,213	6,249,167
1,480,400	950,941	(529,459)	DME/Rebates	11,867,159	11,028,004	(839,155)
6,543,097	16,447,919	9,904,822	TOTAL OTHER MEDICAL	184,499,703	191,227,492	6,727,789
504,771	481,500	(23,271)	PAY FOR PERFORMANCE QUALITY INCENTIVE	5,772,260	5,584,500	(187,760)
27,573,903	17,923,941	(9,649,962)	HOSPITAL DIRECTED PAYMENTS	229,310,845	208,314,785	(20,996,060)
12,446,126	-	(12,446,126)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	35,328,905	-	(35,328,905)
(1,071,264)	-	1,071,264	NON-CLAIMS EXPENSE ADJUSTMENT	(1,944,184)	-	1,944,184
(6,704,318)	-	6,704,318	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(23,722,941)	-	23,722,941
88,973,837	94,680,351	5,706,514	Total Medical Costs	1,120,728,749	1,099,614,728	(21,114,021)

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED DECEMBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
9.93	12.87	2.94	Primary Care Physician Services	11.56	12.87	1.31
33.96	37.82	3.86	Referral Specialty Services	39.45	37.80	(1.65)
5.65	5.28	(0.37)	Urgent Care & After Hours Advise	6.33	5.28	(1.05)
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
49.56	55.99	6.43	TOTAL PHYSICIAN SERVICES	57.37	55.98	(1.39)
			OTHER PROFESSIONAL SERVICES			
0.99	1.05	0.06	Vision Service Capitation	0.99	1.05	0.06
8.32	6.71	(1.61)	Medical Departments - UM Allocation *	6.10	6.94	0.84
4.62	4.96	0.34	Behavior Health Treatment	4.25	4.96	0.72
0.48	0.50	0.02	Mental Health Services	0.49	0.50	0.01
3.94	5.46	1.53	Other Professional Services	4.40	5.46	1.06
18.35	18.69	0.33	TOTAL OTHER PROFESSIONAL SERVICES	16.23	18.92	2.69
15.10	18.22	3.12	EMERGENCY ROOM	14.95	18.22	3.26
37.42	65.47	28.05	INPATIENT HOSPITAL	62.87	65.43	2.56
0.18	0.18	0.00	REINSURANCE EXPENSE PREMIUM	0.15	0.18	0.03
27.02	27.83	0.81	OUTPATIENT HOSPITAL SERVICES	27.90	27.82	(0.08)
			OTHER MEDICAL			
4.60	5.24	0.64	Ambulance and NEMT	4.31	5.24	0.93
2.97	2.26	(0.71)	Home Health Services & CBAS	2.77	2.26	(0.51)
3.59	3.45	(0.14)	Utilization and Quality Review Expenses	2.59	3.57	0.98
1.24	4.72	3.48	Long Term/SNF/Hospice	4.77	4.72	(0.06)
15.92	19.00	3.08	Provider Enhancement Expense - Prop. 56	17.36	19.00	1.64
1.87	1.71	(0.17)	Provider Enhancement Expense - GEMT	1.48	1.71	0.23
0.07	0.00	(0.07)	Vaccine Incentive Program Expense	0.83	0.00	(0.83)
0.66	0.81	0.15	Behaviorial Health Integration Program	1.16	0.81	(0.35)
7.75	5.69	(2.05)	Enhanced Care Management	5.90	5.70	(0.20)
1.55	1.57	0.02	Major Organ Transplant	1.54	1.57	0.03
(25.16)	3.84	28.99	Cal AIM Incentive Programs	2.08	3.83	1.75
4.40	2.96	(1.44)	DME	3.08	2.96	(0.12)
19.44	51.24	31.80	TOTAL OTHER MEDICAL	47.89	51.36	3.48
1.50	1.50	0.00	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	0.00
81.94	55.84	(26.10)	HOSPITAL DIRECTED PAYMENTS	59.52	55.95	(3.56)
36.99	0.00	(36.99)	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	9.17	0.00	(9.17)
(3.18)	0.00	3.18	NON-CLAIMS EXPENSE ADJUSTMENT	(0.50)	0.00	0.50
(19.92)	0.00	19.92	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(6.16)	0.00	6.16
264.40	294.95	30.56	Total Medical Costs	290.88	295.36	4.48

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH DECEMBER 31, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	3,472,901	3,950,940	3,869,340	4,216,012	3,710,885	3,643,312
Referral Specialty Services	11,390,029	12,825,148	13,133,782	12,603,720	12,666,671	14,157,633
Urgent Care & After Hours Advise	2,665,800	2,534,829	2,906,730	1,462,769	1,508,987	1,111,956
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300	9,000
TOTAL PHYSICIAN SERVICES	17,538,030	19,319,317	19,919,152	18,291,501	17,895,843	18,921,901
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	298,113	299,421	320,479	313,381	312,490	317,864
Medical Departments - UM Allocation *	1,874,290	1,814,144	1,930,871	1,799,307	1,920,750	1,835,227
Behavior Health Treatment	1,143,733	984,520	1,425,684	1,406,426	1,172,372	1,493,794
Mental Health Services	385,915	151,598	138,742	134,047	69,233	98,672
Other Professional Services	1,338,982	1,653,027	1,439,003	1,708,384	1,360,230	1,367,404
TOTAL OTHER PROFESSIONAL SERVICES	5,041,033	4,902,710	5,254,779	5,361,545	4,835,075	5,112,961
EMERGENCY ROOM	5,209,937	5,098,972	5,150,400	5,098,584	4,139,529	3,167,228
INPATIENT HOSPITAL	20,610,105	20,031,970	20,232,342	20,364,608	21,395,635	19,551,774
REINSURANCE EXPENSE PREMIUM	53,660	53,896	57,686	56,409	56,248	57,216
OUTPATIENT HOSPITAL SERVICES	8,214,215	8,223,126	8,686,122	8,458,833	8,281,163	9,196,013
OTHER MEDICAL						
Ambulance and NEMT	1,321,069	1,293,500	1,339,544	1,466,846	1,405,832	825,707
Home Health Services & CBAS	733,519	813,833	841,676	781,545	1,039,980	1,056,675
Utilization and Quality Review Expenses	767,373	755,405	504,541	724,744	1,037,565	642,907
Long Term/SNF/Hospice	1,585,601	1,669,982	1,938,253	1,975,528	1,770,701	1,113,446
Provider Enhancement Expense - Prop. 56	5,806,204	5,819,707	5,888,710	5,878,051	5,871,736	6,032,156
Provider Enhancement Expense - GEMT	463,070	463,069	300,851	354,994	480,313	494,051
Vaccine Incentive Program Expense	1,143,595	1,628,354	173,216	136,387	739	85,682
Behaviorial Health Integration Program	824,339	824,339	824,339	225,048	216,518	220,783
Enhanced Care Management	2,023,406	1,561,486	1,821,649	1,818,393	1,820,636	1,866,858
Major Organ Transplant	472,866	473,613	496,178	480,362	480,654	492,226
Cal AIM Incentive Programs	1,241,196	1,257,731	1,089,466	1,285,346	1,268,891	1,807,413
DME	881,383	973,969	570,456	1,214,663	907,459	884,167
TOTAL OTHER MEDICAL	17,263,621	17,534,988	15,788,879	16,341,907	16,301,024	15,522,071
PAY FOR PERFORMANCE QUALITY INCENTIVE	464,013	465,422	465,421	472,037	473,494	478,060
HOSPITAL DIRECTED PAYMENTS	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276	18,280,365
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	230,177	24,013	26,678,156	3,898	(3,419)	5,129
NON-CLAIMS EXPENSE ADJUSTMENT	43,538	4,118	572,469	62,025	(1,371,999)	29,799
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	627	(1,010,781)	(3,987,493)	(2,812,496)	(3,724,314)	(4,072,490)
Total Medical Costs	92,275,826	92,302,247	116,767,047	89,604,769	86,206,555	86,250,027

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH DECEMBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	DECEMBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES							
Primary Care Physician Services	3,951,533	3,298,914	3,859,118	3,539,808	3,684,488	3,340,550	44,537,801
Referral Specialty Services	12,653,874	12,435,011	13,253,634	12,805,568	12,648,430	11,427,771	152,001,271
Urgent Care & After Hours Advise	2,369,574	2,455,184	1,501,101	1,815,098	2,141,425	1,900,986	24,374,439
Hospital Admitting Team	9,300	9,300	9,000	9,300	9,000	9,300	109,500
TOTAL PHYSICIAN SERVICES	18,984,281	18,198,409	18,622,853	18,169,774	18,483,343	16,678,607	221,023,011
OTHER PROFESSIONAL SERVICES							
Vision Service Capitation	315,663	323,003	327,811	326,350	326,879	332,322	3,813,776
Medical Departments - UM Allocation *	1,913,288	1,861,229	1,890,140	1,939,399	1,936,887	2,799,619	23,515,151
Behavior Health Treatment	1,392,248	1,798,262	1,282,862	1,345,602	1,371,019	1,555,420	16,371,942
Mental Health Services	112,742	68,357	180,406	152,793	221,811	162,467	1,876,783
Other Professional Services	1,403,400	1,157,942	1,343,698	1,277,854	1,576,114	1,325,535	16,951,573
TOTAL OTHER PROFESSIONAL SERVICES	5,137,341	5,208,793	5,024,917	5,041,998	5,432,710	6,175,363	62,529,225
EMERGENCY ROOM	4,764,039	4,661,044	4,773,821	4,790,820	5,682,299	5,082,054	57,618,727
INPATIENT HOSPITAL	22,935,749	20,834,103	22,797,560	22,462,437	18,414,421	12,591,938	242,222,642
REINSURANCE EXPENSE PREMIUM	(33,668)	(25,136)	142,533	58,493	58,838	59,818	595,993
OUTPATIENT HOSPITAL SERVICES	10,013,268	9,928,749	9,352,210	9,319,855	8,727,267	9,093,742	107,494,563
OTHER MEDICAL							
Ambulance and NEMT	1,358,335	1,416,945	1,597,466	1,521,656	1,514,523	1,546,895	16,608,318
Home Health Services & CBAS	1,083,945	780,644	739,073	777,227	1,034,966	999,703	10,682,786
Utilization and Quality Review Expenses	696,258	672,539	1,076,096	1,003,496	884,261	1,207,878	9,973,063
Long Term/SNF/Hospice	1,750,512	1,694,897	1,573,989	1,516,247	1,390,150	415,812	18,395,118
Provider Enhancement Expense - Prop. 56	5,197,617	5,212,169	5,228,484	5,256,673	5,354,477	5,356,659	66,902,643
Provider Enhancement Expense - GEMT	503,001	546,014	520,821	492,730	455,360	629,834	5,704,108
Vaccine Incentive Program Expense	2,148	1,922	825	(3,500)	11,536	23,625	3,204,529
Behaviorial Health Integration Program	220,782	220,783	220,783	220,784	220,783	220,783	4,460,064
Enhanced Care Management	1,907,842	1,905,031	1,936,841	1,945,941	1,511,694	2,606,669	22,726,446
Major Organ Transplant	504,463	485,910	510,244	512,675	521,901	521,331	5,952,423
Cal AIM Incentive Programs	1,195,617	1,328,191	1,352,580	2,135,655	2,527,452	(8,466,492)	8,023,046
DME	996,415	976,531	987,460	1,038,510	955,746	1,480,400	11,867,159
TOTAL OTHER MEDICAL	15,416,935	15,241,576	15,744,662	16,418,094	16,382,849	6,543,097	184,499,703
PAY FOR PERFORMANCE QUALITY INCENTIVE	485,358	485,358	490,964	493,681	493,681	504,771	5,772,260
HOSPITAL DIRECTED PAYMENTS	18,674,627	18,595,974	18,857,014	18,961,885	19,322,384	27,573,903	229,310,845
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	9,235	(4,343)	(4,064,727)	9,926	(5,266)	12,446,126	35,328,905
NON-CLAIMS EXPENSE ADJUSTMENT	17,040	5,019	9,821	(248,768)	4,018	(1,071,264)	(1,944,184)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(238,100)	487,881	(789,121)	(435,695)	(436,641)	(6,704,318)	(23,722,941)
Total Medical Costs	96,166,105	93,617,427	90,962,508	95,042,500	92,559,903	88,973,837	1,120,728,749

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH DECEMBER 31, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
PHYSICIAN SERVICES						
Primary Care Physician Services	11.23	12.73	12.38	13.40	11.76	11.41
Referral Specialty Services	36.82	41.33	42.03	40.05	40.13	44.34
Urgent Care & After Hours Advise	8.62	8.17	9.30	4.65	4.78	3.48
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	56.69	62.26	63.74	58.13	56.69	59.25
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	0.96	0.96	1.03	1.00	0.99	1.00
Medical Departments - UM Allocation *	6.06	5.85	6.18	5.72	6.08	5.75
Behavior Health Treatment	3.70	3.17	4.56	4.47	3.71	4.68
Mental Health Services	1.25	0.49	0.44	0.43	0.22	0.31
Other Professional Services	4.33	5.33	4.60	5.43	4.31	4.28
TOTAL OTHER PROFESSIONAL SERVICES	16.30	15.80	16.82	17.04	15.32	16.01
EMERGENCY ROOM	16.84	16.43	16.48	16.20	13.11	9.92
INPATIENT HOSPITAL	66.63	64.56	64.75	64.71	67.78	61.23
REINSURANCE EXPENSE PREMIUM	0.17	0.17	0.18	0.18	0.18	0.18
OUTPATIENT HOSPITAL SERVICES	26.55	26.50	27.80	26.88	26.23	28.80
OTHER MEDICAL						
Ambulance and NEMT	4.27	4.17	4.29	4.66	4.45	2.59
Home Health Services & CBAS	2.37	2.62	2.69	2.48	3.29	3.31
Utilization and Quality Review Expenses	2.48	2.43	1.61	2.30	3.29	2.01
Long Term/SNF/Hospice	5.13	5.38	6.20	6.28	5.61	3.49
Provider Enhancement Expense - Prop. 56	18.77	18.76	18.84	18.68	18.60	18.89
Provider Enhancement Expense - GEMT	1.50	1.49	0.96	1.13	1.52	1.55
Vaccine Incentive Program Expense	3.70	5.25	0.55	0.43	0.00	0.27
Behaviorial Health Integration Program	2.66	2.66	2.64	0.72	0.69	0.69
Enhanced Care Management	6.54	5.03	5.83	5.78	5.77	5.85
Major Organ Transplant	1.53	1.53	1.59	1.53	1.52	1.54
Cal AIM Incentive Programs	4.01	4.05	3.49	4.08	4.02	5.66
DME	2.85	3.14	1.83	3.86	2.87	2.77
TOTAL OTHER MEDICAL	55.81	56.51	50.53	51.93	51.64	48.61
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	1.49	1.50	1.50	1.50
HOSPITAL DIRECTED PAYMENTS	56.92	56.90	57.44	56.90	56.80	57.25
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.74	0.08	85.37	0.01	(0.01)	0.02
NON-CLAIMS EXPENSE ADJUSTMENT	0.14	0.01	1.83	0.20	(4.35)	0.09
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.00	(3.26)	(12.76)	(8.94)	(11.80)	(12.75)
Total Medical Costs	298.30	297.48	373.67	284.74	273.10	270.09

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH DECEMBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	DECEMBER 2022	YEAR TO DATE 2022
PHYSICIAN SERVICES							
Primary Care Physician Services	12.21	10.15	11.84	10.76	11.10	11.20	11.56
Referral Specialty Services	39.11	38.27	40.67	38.91	38.10	38.32	39.44
Urgent Care & After Hours Advise	7.32	7.56	4.61	5.51	6.45	6.37	6.32
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	58.67	56.00	57.14	55.21	55.68	55.93	57.35
OTHER PROFESSIONAL SERVICES							
Vision Service Capitation	0.98	0.99	1.01	0.99	0.98	1.11	0.99
Medical Departments - UM Allocation *	5.91	5.73	5.80	5.89	5.83	9.39	6.10
Behavior Health Treatment	4.30	5.53	3.94	4.09	4.13	5.22	4.25
Mental Health Services	0.35	0.21	0.55	0.46	0.67	0.54	0.49
Other Professional Services	4.34	3.56	4.12	3.88	4.75	4.45	4.40
TOTAL OTHER PROFESSIONAL SERVICES	15.88	16.03	15.42	15.32	16.37	20.71	16.23
EMERGENCY ROOM	14.72	14.34	14.65	14.56	17.12	17.04	14.95
INPATIENT HOSPITAL	70.88	64.11	69.95	68.25	55.47	42.23	62.85
REINSURANCE EXPENSE PREMIUM	(0.10)	(0.08)	0.44	0.18	0.18	0.20	0.15
OUTPATIENT HOSPITAL SERVICES	30.95	30.55	28.69	28.32	26.29	30.49	27.89
OTHER MEDICAL							
Ambulance and NEMT	4.20	4.36	4.90	4.62	4.56	5.19	4.31
Home Health Services & CBAS	3.35	2.40	2.27	2.36	3.12	3.35	2.77
Utilization and Quality Review Expenses	2.15	2.07	3.30	3.05	2.66	4.05	2.59
Long Term/SNF/Hospice	5.41	5.22	4.83	4.61	4.19	1.39	4.77
Provider Enhancement Expense - Prop. 56	16.06	16.04	16.04	15.97	16.13	17.96	17.36
Provider Enhancement Expense - GEMT	1.55	1.68	1.60	1.50	1.37	2.11	1.48
Vaccine Incentive Program Expense	0.01	0.01	0.00	(0.01)	0.03	0.08	0.83
Behaviorial Health Integration Program	0.68	0.68	0.68	0.67	0.67	0.74	1.16
Enhanced Care Management	5.90	5.86	5.94	5.91	4.55	8.74	5.90
Major Organ Transplant	1.56	1.50	1.57	1.56	1.57	1.75	1.54
Cal AIM Incentive Programs	3.70	4.09	4.15	6.49	7.61	(28.39)	2.08
DME	3.08	3.01	3.03	3.16	2.88	4.96	3.08
TOTAL OTHER MEDICAL	47.65	46.90	48.31	49.88	49.35	21.94	47.87
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.49	1.51	1.50	1.49	1.69	1.50
HOSPITAL DIRECTED PAYMENTS	57.71	57.23	57.86	57.61	58.21	92.47	59.50
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	0.03	(0.01)	(12.47)	0.03	(0.02)	41.74	9.17
NON-CLAIMS EXPENSE ADJUSTMENT	0.05	0.02	0.03	(0.76)	0.01	(3.59)	(0.50)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(0.74)	1.50	(2.42)	(1.32)	(1.32)	(22.48)	(6.16)
Total Medical Costs	297.20	288.09	279.09	288.78	278.84	298.36	290.81

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED DECEMBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
1,141,181	459,798	(681,383)	110 - Executive	6,087,092	5,592,574	(494,518)
292,103	234,469	(57,634)	210 - Accounting	2,587,854	2,813,628	225,774
468,818	359,967	(108,851)	220 - Management Information Systems	4,485,248	4,319,603	(165,645)
52,111	54,298	2,187	221 - Business Intelligence	434,757	651,576	216,819
414,710	383,664	(31,046)	222 - Enterprise Development	3,585,622	4,603,968	1,018,346
625,197	533,193	(92,004)	225 - Infrastructure	6,028,984	6,398,316	369,332
863,755	615,321	(248,434)	230 - Claims	7,140,227	7,383,852	243,625
194,196	187,947	(6,249)	240 - Project Management	1,970,072	2,255,364	285,292
229,140	180,989	(48,151)	310 - Health Services - Utilization Management	1,931,130	2,171,868	240,738
518	14,039	13,521	311 - Health Services - Quality Improvement	1,918	168,468	166,550
142	513	371	312 - Health Services - Education	1,402	6,156	4,754
51,623	50,828	(795)	313- Pharmacy	445,265	609,936	164,671
4,365	2,308	(2,057)	314 - Enhanced Care Management	113,914	27,696	(86,218)
86,184	74,558	(11,626)	316 -Population Health Management	741,013	894,696	153,683
9	333	324	317 - Community Based Services	492	3,996	3,504
7	-	(7)	318 - Housing & Homeless Incentive Program	13	-	(13)
442,112	359,942	(82,170)	320 - Provider Network Management	3,849,640	4,319,304	469,664
1,276,805	871,663	(405,142)	330 - Member Services	8,946,025	10,459,956	1,513,931
910,011	721,857	(188,154)	340 - Corporate Services	9,514,100	8,662,284	(851,816)
191,794	97,177	(94,617)	360 - Audit & Investigative Services	1,119,841	1,166,124	46,283
115,881	92,450	(23,431)	410 - Advertising Media	753,003	1,109,400	356,397
78,989	76,696	(2,293)	420 - Sales/Marketing/Public Relations	832,783	920,352	87,569
344,283	303,042	(41,241)	510 - Human Resourses	3,660,682	3,636,504	(24,178)
508,526	(92,324)	(600,850)	Administrative Expense Adjustment	3,212,805	(1,107,888)	(4,320,693)
8,292,460	5,582,728	(2,709,732)	Total Administrative Expenses	67,443,882	67,067,733	(376,149)

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED DECEMBER 31, 2022	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022
110 - Executive	424,308	403,286	429,743	446,418	470,648	353,073
210 - Accounting	233,241	178,928	252,864	163,976	225,728	222,884
220 - Management Information Systems (MIS)	335,777	238,917	337,588	352,426	352,473	336,194
221 - Business Intelligence	13,042	65,687	31,834	45,508	45,708	16,186
222 - Enterprise Development	307,654	250,898	286,566	265,813	303,353	291,350
225 - Infrastructure	473,799	427,685	536,529	343,776	562,405	524,493
230 - Claims	582,040	548,583	591,767	559,648	590,588	529,776
240 - Project Management	171,917	152,433	174,210	123,662	152,467	105,055
310 - Health Services - Utilization Management	139,536	126,622	128,165	132,502	154,797	166,719
311 - Health Services - Quality Improvement	277	15,545	(90)	186	(15,257)	178
312 - Health Services - Education	-	180	2,174	310	89	222
313- Pharmacy	39,824	36,716	38,879	36,385	35,680	34,727
314 - Enhanced Care Management	3,281	241	19	12,005	22,519	12,559
316 -Population Health Management	65,121	62,696	63,150	64,161	66,172	55,430
317 - Community Based Services	-	24	22	17	5	36
318 - Housing & Homeless Incentive Program	-	-	-	-	9,346	(9,346)
320 - Provider Network Management	327,923	326,761	325,559	269,804	308,858	305,807
330 - Member Services	754,477	623,424	700,611	644,994	694,732	635,012
340 - Corporate Services	786,930	685,514	778,083	735,005	751,597	842,924
360 - Audit & Investigative Services	69,757	69,895	71,016	82,269	83,957	69,158
410 - Advertising Media	11,825	27,353	55,984	38,254	34,202	52,260
420 - Sales/Marketing/Public Relations	66,531	51,460	70,326	65,913	62,815	72,927
510 - Human Resourses	309,451	254,507	352,740	341,377	295,995	236,093
Total Department Expenses	5,116,711	4,547,355	5,227,739	4,724,409	5,208,877	4,853,717
ADMINISTRATIVE EXPENSE ADJUSTMENT	(1,904)	(44,283)	31,776	164,256	(2,834)	811,890
Total Administrative Expenses	5,114,807	4,503,072	5,259,515	4,888,665	5,206,043	5,665,607

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED DECEMBER 31, 2022	JULY 2022	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	DECEMBER 2022	YEAR TO DATE 2022
110 - Executive	504,491	507,150	480,177	415,725	510,892	1,141,181	6,087,092
210 - Accounting	202,574	217,615	205,332	194,777	197,832	292,103	2,587,854
220 - Management Information Systems (MIS)	449,253	372,062	379,477	401,399	460,864	468,818	4,485,248
221 - Business Intelligence	42,730	15,934	35,696	42,115	28,206	52,111	434,757
222 - Enterprise Development	256,153	306,526	262,856	324,056	315,687	414,710	3,585,622
225 - Infrastructure	450,547	601,972	415,178	490,604	576,799	625,197	6,028,984
230 - Claims	654,284	578,899	474,159	598,883	567,845	863,755	7,140,227
240 - Project Management	152,605	157,820	252,716	169,021	163,970	194,196	1,970,072
310 - Health Services - Utilization Management	167,284	163,063	169,157	185,718	168,427	229,140	1,931,130
311 - Health Services - Quality Improvement	1,002	823	317	(1,702)	121	518	1,918
312 - Health Services - Education	895	37	(2,865)	130	88	142	1,402
313- Pharmacy	33,787	23,774	43,043	35,057	35,770	51,623	445,265
314 - Enhanced Care Management	16,919	22,248	18,382	452	924	4,365	113,914
316 -Population Health Management	54,747	51,020	55,570	57,087	59,675	86,184	741,013
317 - Community Based Services	7	157	25	156	34	9	492
318 - Housing & Homeless Incentive Program	42	(42)	-	6	-	7	13
320 - Provider Network Management	307,080	299,800	313,213	324,920	297,803	442,112	3,849,640
330 - Member Services	682,669	677,858	715,313	789,492	750,638	1,276,805	8,946,025
340 - Corporate Services	814,888	815,575	836,837	741,929	814,807	910,011	9,514,100
360 - Audit & Investigative Services	91,281	88,356	86,380	117,460	98,518	191,794	1,119,841
410 - Advertising Media	169,122	54,424	23,027	43,549	127,122	115,881	753,003
420 - Sales/Marketing/Public Relations	58,511	60,358	75,839	137,183	31,931	78,989	832,783
510 - Human Resourses	340,172	294,858	338,192	284,163	268,851	344,283	3,660,682
Total Department Expenses	5,451,043	5,310,287	5,178,021	5,352,180	5,476,804	7,783,934	64,231,077
ADMINISTRATIVE EXPENSE ADJUSTMENT	425,467	300,000	420,793	299,429	299,689	508,526	3,212,805
Total Administrative Expenses	5,876,510	5,610,287	5,598,814	5,651,609	5,776,493	8,292,460	67,443,882

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF DECEMBER 31, 2022

ASSETS	DECEMBER 2022	NOVEMBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,124,665	$ 1,145,891	(21,226)
Interest Receivable	5,960	2,400	3,560
TOTAL CURRENT ASSETS	$ 1,130,625	$ 1,148,291	$ (17,666)
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,136,102	1,136,102	-
Increase (Decrease) in Net Position - Current Year	(5,477)	12,189	(17,666)
Total Net Position	$ 1,130,625	$ 1,148,291	$ (17,666)
TOTAL LIABILITIES AND NET POSITION	$ 1,130,625	$ 1,148,291	$ (17,666)

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED DECEMBER 31, 2022

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
3,560	-	3,560	Interest	12,847	-	12,847
(21,226)	-	(21,226)	Other Investment Income	(18,324)	-	(18,324)
(17,666)	-	(17,666)	TOTAL REVENUES	(5,477)	-	(5,477)
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
(17,666)	-	(17,666)	GROSS MARGIN	(5,477)	-	(5,477)
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
(17,666)	-	(17,666)	OPERATING INCOME (LOSS)	(5,477)	-	(5,477)
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
(17,666)	-	(17,666)	NET INCREASE (DECREASE) IN NET POSITION	(5,477)	-	(5,477)
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
0%	0%	0%	ADMINISTRATIVE EXPENSE RATIO	0%	0%	0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2022 MEMBER MONTHS	JAN'22	FEB'22	MAR'22	APR'22	MAY'22	JUN'22	JULY'22	AUG'22	SEPT'22	OCT'22	NOV'22	DEC'22
ADULT AND FAMILY													
ADULT	**756,826**	60,708	60,882	61,379	61,726	61,739	62,276	63,581	64,006	64,336	65,252	65,208	65,733
CHILD	**1,703,029**	139,223	139,605	140,344	141,029	141,356	141,902	142,505	142,059	142,208	142,524	143,228	147,046
SUB-TOTAL ADULT & FAMILY	**2,459,855**	**199,931**	**200,487**	**201,723**	**202,755**	**203,095**	**204,178**	**206,086**	**206,065**	**206,544**	**207,776**	**208,436**	**212,779**
OTHER MEMBERS													
PARTIAL DUALS - FAMILY	**9,850**	824	801	811	796	815	837	842	814	844	828	838	800
PARTIAL DUALS - CHILD	**0**	0	0	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	**74**	4	13	6	5	5	5	6	6	6	6	6	6
FULL DUALS (SPD)													
SPD FULL DUALS	**104,225**	8,138	8,257	8,336	8,411	8,662	8,572	8,684	8,794	8,813	9,027	9,168	9,363
SUBTOTAL OTHER MEMBERS	**114,149**	**8,966**	**9,071**	**9,153**	**9,212**	**9,482**	**9,414**	**9,532**	**9,614**	**9,663**	**9,861**	**10,012**	**10,169**
TOTAL FAMILY & OTHER	**2,574,004**	**208,897**	**209,558**	**210,876**	**211,967**	**212,577**	**213,592**	**215,618**	**215,679**	**216,207**	**217,637**	**218,448**	**222,948**
SPD													
SPD (AGED AND DISABLED)	**201,877**	16,556	16,376	16,516	16,363	16,305	16,794	16,817	17,118	17,289	17,179	17,063	17,501
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	**1,059,952**	82,803	83,199	83,828	85,037	85,412	87,526	89,680	90,672	90,902	92,658	93,776	94,459
ACA Expansion Duals	**17,034**	1,086	1,148	1,270	1,324	1,369	1,421	1,457	1,492	1,522	1,647	1,692	1,606
SUB-TOTAL MED-CAL EXPANSION	**1,076,986**	**83,889**	**84,347**	**85,098**	**86,361**	**86,781**	**88,947**	**91,137**	**92,164**	**92,424**	**94,305**	**95,468**	**96,065**
TOTAL KAISER	**165,042**	**12,787**	**13,032**	**13,253**	**13,407**	**13,552**	**13,722**	**13,842**	**13,972**	**14,126**	**14,281**	**14,433**	**14,635**
TOTAL MEDI-CAL MEMBERS	**4,017,909**	**322,129**	**323,313**	**325,743**	**328,098**	**329,215**	**333,055**	**337,414**	**338,933**	**340,046**	**343,402**	**345,412**	**351,149**

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Robert Landis, CFO

Date: April 13, 2023

Re: January 2023 Financial Results

The January results reflect a $7,637,615 Net Increase in Net Position which is a $10,253,840 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $5.7 million unfavorable variance primarily due to:

   A) $6.4 million favorable variance primarily due to higher-than-expected budgeted membership.

   B) $2.4 million unfavorable variance primarily due to **timing differences** on waiting for DHCS approval over the next several months to record revenue under the CalAim Incentive Payment Program, Student Behavioral Health Incentive Program and the Housing and Homelessness Incentive Program offset against expense amounts included in 2B below.

   C) $11.4 million unfavorable variance in Premium-MCO Tax due to the elimination of the MCO Tax for Calendar Year 2023. This amount is offset against MCO Tax Expense included in 3 below.

   D) $2.5 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2023 from DHCS in February 2023 offset against amounts included in 2C below.

2) Total Medical Costs reflect a $2.9 million favorable variance primarily due to:

   A) $1.2 million favorable variance in Other Professional Services primarily due to the timing of hiring 2023 Budgeted Utilization Management Employees during the first quarter of 2023.

   B) $2.9 million favorable variance primarily in Other Medical primarily due to **timing differences** on waiting for providers to submit invoices to record expenses under the CalAim Incentive Payment Program, Student Behavioral Health Incentive Program and the Housing and Homelessness Incentive Program offset against revenue amounts included in 1B above.

C) $2.5 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2023 from DHCS in February 2023 offset against amounts included in 1D above.

3) $11.4 million favorable variance in MCO Tax due to the elimination of the MCO Tax for Calendar Year 2023. This amount is offset against Premium-MCO Tax included in 1C above.

The January Medical Loss Ratio is 85.2% which is favorable to the 94.3% budgeted amount. The January Administrative Expense Ratio is 6.5% which is favorable to the 7.9% budgeted amount.

Kern Health Systems
Financial Packet
January 2023

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF NET POSITION
AS OF JANUARY 31, 2023

ASSETS	JANUARY 2023	DECEMBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 146,636,659	$ 99,137,387	$ 47,499,272
Short-Term Investments	258,356,298	317,979,109	(59,622,811)
Premiums Receivable - Net	91,980,380	102,277,912	(10,297,532)
Premiums Receivable - Hospital Direct Payments	457,340,977	436,815,600	20,525,377
Interest Receivable	129,012	389,179	(260,167)
Provider Advance Payment	1,076,436	844,067	232,369
Other Receivables	1,965,813	1,803,091	162,722
Prepaid Expenses & Other Current Assets	3,781,227	3,217,027	564,200
Total Current Assets	$ 961,266,802	$ 962,463,372	$ (1,196,570)
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,221,770	1,241,823	(20,053)
Computer Hardware and Software - Net	22,633,344	23,159,335	(525,991)
Building and Building Improvements - Net	33,639,091	33,715,199	(76,108)
Capital Projects in Progress	2,251,492	2,241,699	9,793
Total Capital Assets	$ 63,836,403	$ 64,448,762	$ (612,359)
LONG TERM ASSETS:			
Provider Advance Payment	-	263,964	(263,964)
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,588,890	1,588,890	-
Total Long Term Assets	$ 1,888,890	$ 2,152,854	$ (263,964)
DEFERRED OUTFLOWS OF RESOURCES	$ 8,154,860	$ 8,154,860	$ -
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 1,035,146,955	$ 1,037,219,848	$ (2,072,893)
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 4,663,421	$ 4,139,353	524,068
Accrued Other Operating Expenses	4,107,630	4,353,705	(246,075)
Accrued Taxes and Licenses	-	32,495,339	(32,495,339)
Claims Payable (Reported)	16,907,221	18,643,958	(1,736,737)
IBNR - Inpatient Claims	49,331,713	51,058,132	(1,726,419)
IBNR - Physician Claims	19,599,991	17,600,496	1,999,495
IBNR - Accrued Other Medical	29,184,581	27,425,468	1,759,113
Risk Pool and Withholds Payable	4,004,381	3,505,791	498,590
Statutory Allowance for Claims Processing Expense	2,831,842	2,831,842	-
Other Liabilities	110,214,837	109,327,418	887,419
Accrued Hospital Directed Payments	457,158,635	436,633,258	20,525,377
Total Current Liabilities	$ 698,004,252	$ 708,014,760	$ (10,010,508)
NONCURRENT LIABILITIES:			
Net Pension Liability	10,518,206	10,218,206	300,000
TOTAL NONCURRENT LIABILITIES	$ 10,518,206	$ 10,218,206	$ 300,000
DEFERRED INFLOWS OF RESOURCES	$ 230,571	$ 230,571	$ -
NET POSITION:			
Net Position - Beg. of Year	318,756,311	247,476,325	71,279,986
Increase (Decrease) in Net Position - Current Year	7,637,615	71,279,986	(63,642,371)
Total Net Position	$ 326,393,926	$ 318,756,311	$ 7,637,615
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 1,035,146,955	$ 1,037,219,848	$ (2,072,893)

KERN HEALTH SYSTEMS
MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2023

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
208,290	209,000	(710)	Family Members	208,290	209,000	(710)
96,149	92,500	3,649	Expansion Members	96,149	92,500	3,649
17,442	17,000	442	SPD Members	17,442	17,000	442
27	-	27	LTC Members	27	-	27
10,506	8,700	1,806	Other Members	10,506	8,700	1,806
14,759	14,000	759	Kaiser Members	14,759	14,000	759
347,173	341,200	5,973	Total Members - MCAL	347,173	341,200	5,973
			REVENUES			
38,355,206	38,588,794	(233,588)	Title XIX - Medicaid - Family and Other	38,355,206	38,588,794	(233,588)
35,864,920	33,143,366	2,721,554	Title XIX - Medicaid - Expansion Members	35,864,920	33,143,366	2,721,554
18,119,057	16,794,927	1,324,130	Title XIX - Medicaid - SPD Members	18,119,057	16,794,927	1,324,130
201,227	-	201,227	Title XIX - Medicaid - LTC Members	201,227	-	201,227
-	11,430,201	(11,430,201)	Premium - MCO Tax	-	11,430,201	(11,430,201)
21,209,673	18,730,665	2,479,008	Premium - Hospital Directed Payments	21,209,673	18,730,665	2,479,008
1,400,146	398,193	1,001,953	Investment Earnings And Other Income	1,400,146	398,193	1,001,953
-	72,088	(72,088)	Reinsurance Recoveries	-	72,088	(72,088)
(684,297)	-	(684,297)	Rate Adjustments - Hospital Directed Payments	(684,297)	-	(684,297)
(968,410)	-	(968,410)	Rate/Income Adjustments	(968,410)	-	(968,410)
113,497,522	119,158,234	(5,660,712)	TOTAL REVENUES	113,497,522	119,158,234	(5,660,712)
			EXPENSES			
			Medical Costs:			
20,302,072	20,420,080	118,008	Physician Services	20,302,072	20,420,080	118,008
5,493,905	6,719,129	1,225,224	Other Professional Services	5,493,905	6,719,129	1,225,224
5,195,994	5,462,936	266,942	Emergency Room	5,195,994	5,462,936	266,942
22,641,712	22,541,723	(99,989)	Inpatient	22,641,712	22,541,723	(99,989)
90,859	72,088	(18,771)	Reinsurance Expense	90,859	72,088	(18,771)
9,616,781	9,792,000	175,219	Outpatient Hospital	9,616,781	9,792,000	175,219
15,528,820	18,462,505	2,933,685	Other Medical	15,528,820	18,462,505	2,933,685
498,590	491,512	(7,078)	Pay for Performance Quality Incentive	498,590	491,512	(7,078)
21,209,673	18,730,665	(2,479,008)	Hospital Directed Payments	21,209,673	18,730,665	(2,479,008)
(684,297)	-	684,297	Hospital Directed Payment Adjustment	(684,297)	-	684,297
(128,832)	-	128,832	Non-Claims Expense Adjustment	(128,832)	-	128,832
9,076	-	(9,076)	IBNR, Incentive, Paid Claims Adjustment	9,076	-	(9,076)
99,774,353	102,692,638	2,918,285	Total Medical Costs	99,774,353	102,692,638	2,918,285
13,723,169	16,465,596	(2,742,427)	GROSS MARGIN	13,723,169	16,465,596	(2,742,427)
			Administrative:			
3,547,045	4,009,841	462,796	Compensation	3,547,045	4,009,841	462,796
939,926	1,690,082	750,156	Purchased Services	939,926	1,690,082	750,156
87,606	227,316	139,710	Supplies	87,606	227,316	139,710
680,616	649,950	(30,666)	Depreciation	680,616	649,950	(30,666)
660,263	449,119	(211,144)	Other Administrative Expenses	660,263	449,119	(211,144)
109,675	-	(109,675)	Administrative Expense Adjustment	109,675	-	(109,675)
6,025,131	7,026,307	1,001,176	Total Administrative Expenses	6,025,131	7,026,307	1,001,176
105,799,484	109,718,945	3,919,461	TOTAL EXPENSES	105,799,484	109,718,945	3,919,461
7,698,038	9,439,290	(1,741,252)	OPERATING INCOME (LOSS) BEFORE TAX	7,698,038	9,439,290	(1,741,252)
-	11,430,201	11,430,201	MCO TAX	-	11,430,201	11,430,201
7,698,038	(1,990,911)	9,688,949	OPERATING INCOME (LOSS) NET OF TAX	7,698,038	(1,990,911)	9,688,949
			NONOPERATING REVENUE (EXPENSE)			
34,557	-	34,557	Provider Grants/CalAIM/Home Heath	34,557	-	34,557
(94,980)	(625,313)	530,333	D-SNP Expenses	(94,980)	(625,313)	530,333
(60,423)	(625,313)	564,890	TOTAL NONOPERATING REVENUE (EXPENSE)	(60,423)	(625,313)	564,890
7,637,615	(2,616,225)	10,253,840	NET INCREASE (DECREASE) IN NET POSITION	7,637,615	(2,616,225)	10,253,840
85.2%	94.3%	9.1%	MEDICAL LOSS RATIO	85.2%	94.3%	9.1%
6.5%	7.9%	1.4%	ADMINISTRATIVE EXPENSE RATIO	6.5%	7.9%	1.4%

KERN HEALTH SYSTEMS
MEDI-CAL
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION - PMPM
FOR THE MONTH ENDED JANUARY 31, 2023

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
208,290	209,000	(710)	Family Members	208,290	209,000	(710)
96,149	92,500	3,649	Expansion Members	96,149	92,500	3,649
17,442	17,000	442	SPD Members	17,442	17,000	442
27	-	27	LTC Members	27	-	27
10,506	8,700	1,806	Other Members	10,506	8,700	1,806
14,759	14,000	759	Kaiser Members	14,759	14,000	759
347,173	341,200	5,973	Total Members - MCAL	347,173	341,200	5,973
			REVENUES			
175.30	177.26	(1.96)	Title XIX - Medicaid - Family and Other	175.30	177.26	(1.96)
373.01	358.31	14.71	Title XIX - Medicaid - Expansion Members	373.01	358.31	14.71
1,038.82	987.94	50.88	Title XIX - Medicaid - SPD Members	1,038.82	987.94	50.88
0.00	0.00	0.00	Title XIX - Medicaid - LTC Members	0.00	0.00	0.00
0.00	34.93	(34.93)	Premium - MCO Tax	0.00	34.93	(34.93)
63.80	57.25	6.56	Premium - Hospital Directed Payments	63.80	57.25	6.56
4.21	1.22	3.00	Investment Earnings And Other Income	4.21	1.22	3.00
0.00	0.22	(0.22)	Reinsurance Recoveries	0.00	0.22	(0.22)
(2.06)	0.00	(2.06)	Rate Adjustments - Hospital Directed Payments	(2.06)	0.00	(2.06)
(2.91)	0.00	(2.91)	Rate/Income Adjustments	(2.91)	0.00	(2.91)
341.43	364.18	(22.74)	TOTAL REVENUES	341.43	364.18	(22.74)
			EXPENSES			
			Medical Costs:			
61.07	62.41	1.33	Physician Services	61.07	62.41	1.33
16.53	20.54	4.01	Other Professional Services	16.53	20.54	4.01
15.63	16.70	1.06	Emergency Room	15.63	16.70	1.06
68.11	68.89	0.78	Inpatient	68.11	68.89	0.78
0.27	0.22	(0.05)	Reinsurance Expense	0.27	0.22	(0.05)
28.93	29.93	1.00	Outpatient Hospital	28.93	29.93	1.00
46.72	56.43	9.71	Other Medical	46.72	56.43	9.71
1.50	1.50	0.00	Pay for Performance Quality Incentive	1.50	1.50	0.00
63.80	57.25	(6.56)	Hospital Directed Payments	63.80	57.25	(6.56)
(2.06)	0.00	2.06	Hospital Directed Payment Adjustment	(2.06)	0.00	2.06
(0.39)	0.00	0.39	Non-Claims Expense Adjustment	(0.39)	0.00	0.39
0.03	0.00	(0.03)	IBNR, Incentive, Paid Claims Adjustment	0.03	0.00	(0.03)
300.15	313.85	13.70	Total Medical Costs	300.15	313.85	13.70
41.28	50.32	(9.04)	GROSS MARGIN	41.28	50.32	(9.04)
			Administrative:			
10.67	12.26	1.58	Compensation	10.67	12.26	1.58
2.83	5.17	2.34	Purchased Services	2.83	5.17	2.34
0.26	0.69	0.43	Supplies	0.26	0.69	0.43
2.05	1.99	(0.06)	Depreciation	2.05	1.99	(0.06)
1.99	1.37	(0.61)	Other Administrative Expenses	1.99	1.37	(0.61)
0.33	0.00	(0.33)	Administrative Expense Adjustment	0.33	0.00	(0.33)
18.13	21.47	3.35	Total Administrative Expenses	18.13	21.47	3.35
318.28	335.33	17.05	TOTAL EXPENSES	318.28	335.33	17.05
23.16	28.85	(5.69)	OPERATING INCOME (LOSS) BEFORE TAX	23.16	28.85	(5.69)
0.00	34.93	34.93	MCO TAX	0.00	34.93	34.93
23.16	(6.08)	29.24	OPERATING INCOME (LOSS) NET OF TAX	23.16	(6.08)	29.24
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
0.10	0.00	0.10	Reserve Fund Projects/Community Grants	0.10	0.00	0.10
(0.29)	(1.91)	1.63	Health Home	(0.29)	(1.91)	1.63
(0.18)	(1.91)	1.73	TOTAL NONOPERATING REVENUE (EXPENSE)	(0.18)	(1.91)	1.73
22.98	(8.00)	30.97	NET INCREASE (DECREASE) IN NET POSITION	22.98	(8.00)	30.97
85.2%	94.3%	9.1%	MEDICAL LOSS RATIO	85.2%	94.3%	9.1%
6.5%	7.9%	1.4%	ADMINISTRATIVE EXPENSE RATIO	6.5%	7.9%	1.4%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH JANUARY 31, 2023	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022	JULY 2022
ENROLLMENT							
Members - MCAL	309,342	310,281	312,490	314,691	315,663	319,333	323,572
REVENUES							
Title XIX - Medicaid - Family and Other	37,009,614	37,126,546	36,539,594	36,762,722	35,766,911	37,731,384	37,514,641
Title XIX - Medicaid - Expansion Members	29,968,453	29,945,915	29,350,530	29,812,384	29,600,713	30,533,210	30,993,375
Title XIX - Medicaid - SPD Members	14,953,594	14,858,906	14,791,754	14,924,745	14,887,158	15,402,431	15,833,803
Title XIX - Medicaid - LTC Members	-	-	-	-	-	-	-
Premium - MCO Tax	9,899,314	9,894,054	9,893,826	9,894,054	9,872,493	9,910,584	10,883,460
Premium - Hospital Directed Payments	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276	18,280,365	18,674,627
Investment Earnings And Other Income	329,573	86,457	(1,241,065)	(326,288)	357,517	(633,952)	1,002,315
Reinsurance Recoveries	-	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	230,177	24,013	26,907,309	3,898	(23,892)	5,129	9,235
Rate/Income Adjustments	957,475	977,794	493,268	59,935	(4,649,731)	(364,397)	350,036
TOTAL REVENUES	110,955,070	110,568,181	134,684,350	109,037,367	103,739,445	110,864,754	115,261,492
EXPENSES							
Medical Costs:							
Physician Services	17,538,030	19,319,317	19,919,152	18,291,501	17,895,843	18,921,901	18,984,281
Other Professional Services	5,041,033	4,902,710	5,254,779	5,361,545	4,835,075	5,112,961	5,137,341
Emergency Room	5,209,937	5,098,972	5,150,400	5,098,584	4,139,529	3,167,228	4,764,039
Inpatient	20,610,105	20,031,970	20,232,342	20,364,608	21,395,635	19,551,774	22,935,749
Reinsurance Expense	53,660	53,896	57,686	56,409	56,248	57,216	(33,668)
Outpatient Hospital	8,214,215	8,223,126	8,686,122	8,458,833	8,281,163	9,196,013	10,013,268
Other Medical	17,263,621	17,534,988	15,788,879	16,341,907	16,301,024	15,522,071	15,416,935
Pharmacy	-	-	-	-	-	-	-
Pay for Performance Quality Incentive	464,013	465,422	465,421	472,037	473,494	478,060	485,358
Hospital Directed Payments	17,606,870	17,654,496	17,949,134	17,905,917	17,928,276	18,280,365	18,674,627
Hospital Directed Payment Adjustment	230,177	24,013	26,678,156	3,898	(3,419)	5,129	9,235
Non-Claims Expense Adjustment	43,538	4,118	572,469	62,025	(1,371,999)	29,799	17,040
IBNR, Incentive, Paid Claims Adjustment	627	(1,010,781)	(3,987,493)	(2,812,496)	(3,724,314)	(4,072,490)	(238,100)
Total Medical Costs	92,275,826	92,302,247	116,767,047	89,604,768	86,206,555	86,250,027	96,166,105
GROSS MARGIN	18,679,244	18,265,934	17,917,303	19,432,599	17,532,890	24,614,727	19,095,387
Administrative:							
Compensation	3,116,842	2,847,002	3,108,703	3,075,151	3,259,102	2,980,813	3,307,910
Purchased Services	846,917	877,498	1,098,614	783,960	927,532	850,526	1,078,360
Supplies	191,908	(8,268)	103,207	41,533	145,499	66,970	74,368
Depreciation	571,126	571,126	571,126	570,835	575,899	626,073	576,074
Other Administrative Expenses	389,918	259,997	346,089	252,930	300,845	329,335	414,331
Administrative Expense Adjustment	(1,904)	(44,283)	31,776	164,256	(2,834)	811,890	425,467
Total Administrative Expenses	5,114,807	4,503,072	5,259,515	4,888,665	5,206,043	5,665,607	5,876,510
TOTAL EXPENSES	97,390,633	96,805,319	122,026,562	94,493,433	91,412,598	91,915,634	102,042,615
OPERATING INCOME (LOSS) BEFORE TAX	13,564,437	13,762,862	12,657,788	14,543,934	12,326,847	18,949,120	13,218,877
MCO TAX	9,894,054	9,894,054	9,893,826	9,894,054	9,888,018	9,894,051	10,883,459
OPERATING INCOME (LOSS) NET OF TAX	3,670,383	3,868,808	2,763,962	4,649,880	2,438,829	9,055,069	2,335,418
TOTAL NONOPERATING REVENUE (EXPENSE)	(400,389)	(986,700)	(1,001,012)	(1,110,153)	744,870	(1,996,822)	(3,380)
NET INCREASE (DECREASE) IN NET POSITION	3,269,994	2,882,108	1,762,950	3,539,727	3,183,699	7,058,247	2,332,038
MEDICAL LOSS RATIO	89.4%	89.9%	90.2%	88.3%	89.9%	82.2%	90.4%
ADMINISTRATIVE EXPENSE RATIO	6.1%	5.4%	6.6%	6.0%	6.9%	6.9%	6.9%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH JANUARY 31, 2023	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	DECEMBER 2022	JANUARY 2023	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	324,961	325,920	329,121	331,947	336,514	332,414	4,484,454
REVENUES							
Title XIX - Medicaid - Family and Other	37,941,354	37,957,277	37,949,223	39,648,035	34,345,215	38,355,206	521,546,919
Title XIX - Medicaid - Expansion Members	31,238,545	31,275,148	31,549,369	32,934,833	30,862,645	35,864,920	434,171,760
Title XIX - Medicaid - SPD Members	15,065,828	15,760,220	15,913,345	15,878,315	15,500,822	18,119,057	218,396,491
Title XIX - Medicaid - LTC Members	-	-	-	-	-	201,227	201,227
Premium - MCO Tax	10,883,459	10,883,460	10,883,459	10,883,460	10,883,460	-	134,938,476
Premium - Hospital Directed Payments	18,595,974	18,857,014	18,961,885	19,322,384	27,573,903	21,209,673	267,356,988
Investment Earnings And Other Income	(121,473)	353,347	179,268	888,027	714,738	1,400,146	2,293,643
Reinsurance Recoveries	-	-	-	-	152,481	-	152,481
Rate Adjustments - Hospital Directed Payments	(4,343)	(4,606,563)	9,926	(5,267)	12,446,127	(684,297)	34,307,866
Rate/Income Adjustments	245,168	203,911	124,448	1,298,007	333,950	(968,410)	(932,921)
TOTAL REVENUES	113,844,512	110,683,814	115,570,923	120,847,794	132,813,341	113,497,522	1,612,432,930
EXPENSES							
Medical Costs:							
Physician Services	18,198,409	18,622,853	18,169,774	18,483,343	16,678,607	20,302,072	259,298,013
Other Professional Services	5,208,793	5,024,917	5,041,998	5,432,710	6,175,363	5,493,905	72,367,206
Emergency Room	4,661,044	4,773,821	4,790,820	5,682,299	5,082,054	5,195,994	67,206,343
Inpatient	20,834,103	22,797,560	22,462,437	18,414,421	12,591,938	22,641,712	282,001,916
Reinsurance Expense	(25,136)	142,533	58,493	58,838	59,818	90,859	772,999
Outpatient Hospital	9,928,749	9,352,210	9,319,855	8,727,267	9,093,742	9,616,781	123,194,503
Other Medical	15,241,576	15,744,662	16,418,094	16,382,849	6,543,097	15,528,820	211,530,877
Pharmacy	-	-	-	-	-	-	10,620,178
Pay for Performance Quality Incentive	485,358	490,964	493,681	493,681	504,771	498,590	7,690,850
Hospital Directed Payments	18,595,974	18,857,014	18,961,885	19,322,384	27,573,903	21,209,673	267,356,988
Hospital Directed Payment Adjustment	(4,343)	(4,064,727)	9,926	(5,266)	12,446,126	(684,297)	34,641,022
Non-Claims Expense Adjustment	5,019	9,821	(248,768)	4,018	(1,071,264)	(128,832)	(2,117,272)
IBNR, Incentive, Paid Claims Adjustment	487,881	(789,121)	(435,695)	(436,641)	(6,704,318)	9,076	(24,736,689)
Total Medical Costs	93,617,427	90,962,507	95,042,500	92,559,903	88,973,837	99,774,353	1,309,826,934
GROSS MARGIN	20,227,085	19,721,307	20,528,423	28,287,891	43,839,504	13,723,169	302,605,996
Administrative:							
Compensation	3,148,970	3,213,222	3,387,496	3,241,130	4,707,264	3,547,045	45,533,340
Purchased Services	1,144,312	997,356	1,009,393	1,034,408	1,262,419	939,926	14,206,695
Supplies	117,566	85,530	66,157	258,430	220,189	87,606	1,615,354
Depreciation	583,814	583,673	584,905	622,602	627,772	680,616	8,491,713
Other Administrative Expenses	315,625	298,240	304,229	320,234	966,290	660,263	5,764,032
Administrative Expense Adjustment	300,000	420,793	299,429	299,689	508,526	109,675	3,128,154
Total Administrative Expenses	5,610,287	5,598,814	5,651,609	5,776,493	8,292,460	6,025,131	78,739,288
TOTAL EXPENSES	99,227,714	96,561,321	100,694,109	98,336,396	97,266,297	105,799,484	1,388,566,222
OPERATING INCOME (LOSS) BEFORE TAX	14,616,798	14,122,493	14,876,814	22,511,398	35,547,044	7,698,038	223,866,708
MCO TAX	10,883,460	10,883,459	10,883,460	10,883,460	10,883,459	-	134,553,971
OPERATING INCOME (LOSS) NET OF TAX	3,733,338	3,239,034	3,993,354	11,627,938	24,663,585	7,698,038	89,312,737
TOTAL NONOPERATING REVENUE (EXPENSE)	57,925	(27,966)	(5,428)	4,000	(34,557)	(60,423)	(4,995,245)
NET INCREASE (DECREASE) IN NET POSITION	3,791,263	3,211,068	3,987,926	11,631,938	24,629,028	7,637,615	84,317,492
MEDICAL LOSS RATIO	88.9%	89.0%	88.7%	80.8%	59.8%	85.2%	85.7%
ADMINISTRATIVE EXPENSE RATIO	6.6%	6.5%	6.6%	6.4%	10.1%	6.5%	6.7%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH JANUARY 31, 2023	JANUARY 2022	FEBRUARY 2022	MARCH 2022	APRIL 2022	MAY 2022	JUNE 2022	JULY 2022
ENROLLMENT							
Members - MCAL	309,342	310,281	312,490	314,691	315,663	319,333	323,572
REVENUES							
Title XIX - Medicaid - Family and Other	177.17	177.17	173.28	173.44	168.25	176.65	173.99
Title XIX - Medicaid - Expansion Members	357.24	355.03	344.90	345.21	341.10	343.27	340.07
Title XIX - Medicaid - SPD Members	903.21	907.36	895.60	912.10	913.04	917.14	941.54
Title XIX - Medicaid - LTC Members	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Premium - MCO Tax	32.00	31.89	31.66	31.44	31.28	31.04	33.64
Premium - Hospital Directed Payments	56.92	56.90	57.44	56.90	56.80	57.25	57.71
Investment Earnings And Other Income	1.07	0.28	(3.97)	(1.04)	1.13	(1.99)	3.10
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	0.74	0.08	86.11	0.01	(0.08)	0.02	0.03
Rate/Income Adjustments	3.10	3.15	1.58	0.19	(14.73)	(1.14)	1.08
TOTAL REVENUES	358.68	356.35	431.00	346.49	328.64	347.18	356.22
EXPENSES							
Medical Costs:							
Physician Services	56.69	62.26	63.74	58.13	56.69	59.25	58.67
Other Professional Services	16.30	15.80	16.82	17.04	15.32	16.01	15.88
Emergency Room	16.84	16.43	16.48	16.20	13.11	9.92	14.72
Inpatient	66.63	64.56	64.75	64.71	67.78	61.23	70.88
Reinsurance Expense	0.17	0.17	0.18	0.18	0.18	0.18	(0.10)
Outpatient Hospital	26.55	26.50	27.80	26.88	26.23	28.80	30.95
Other Medical	55.81	56.51	50.53	51.93	51.64	48.61	47.65
Pharmacy	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Pay for Performance Quality Incentive	1.50	1.50	1.49	1.50	1.50	1.50	1.50
Hospital Directed Payments	56.92	56.90	57.44	56.90	56.80	57.25	57.71
Hospital Directed Payment Adjustment	0.74	0.08	85.37	0.01	(0.01)	0.02	0.03
Non-Claims Expense Adjustment	0.14	0.01	1.83	0.20	(4.35)	0.09	0.05
IBNR, Incentive, Paid Claims Adjustment	0.00	(3.26)	(12.76)	(8.94)	(11.80)	(12.75)	(0.74)
Total Medical Costs	298.30	297.48	373.67	284.74	273.10	270.09	297.20
GROSS MARGIN	60.38	58.87	57.34	61.75	55.54	77.08	59.01
Administrative:							
Compensation	10.08	9.18	9.95	9.77	10.32	9.33	10.22
Purchased Services	2.74	2.83	3.52	2.49	2.94	2.66	3.33
Supplies	0.62	(0.03)	0.33	0.13	0.46	0.21	0.23
Depreciation	1.85	1.84	1.83	1.81	1.82	1.96	1.78
Other Administrative Expenses	1.26	0.84	1.11	0.80	0.95	1.03	1.28
Administrative Expense Adjustment	(0.01)	(0.14)	0.10	0.52	(0.01)	2.54	1.31
Total Administrative Expenses	16.53	14.51	16.83	15.53	16.49	17.74	18.16
TOTAL EXPENSES	314.83	311.99	390.50	300.27	289.59	287.84	315.36
OPERATING INCOME (LOSS) BEFORE TAX	43.85	44.36	40.51	46.22	39.05	59.34	40.85
MCO TAX	31.98	31.89	31.66	31.44	31.32	30.98	33.64
OPERATING INCOME (LOSS) NET OF TAX	11.87	12.47	8.84	14.78	7.73	28.36	7.22
TOTAL NONOPERATING REVENUE (EXPENSE)	(1.29)	(3.18)	(3.20)	(3.53)	2.36	(6.25)	(0.01)
NET INCREASE (DECREASE) IN NET POSITION	10.57	9.29	5.64	11.25	10.09	22.10	7.21
MEDICAL LOSS RATIO	89.4%	89.9%	90.2%	88.3%	89.9%	82.2%	90.4%
ADMINISTRATIVE EXPENSE RATIO	6.1%	5.4%	6.6%	6.0%	6.9%	6.9%	6.9%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH JANUARY 31, 2023	AUGUST 2022	SEPTEMBER 2022	OCTOBER 2022	NOVEMBER 2022	DECEMBER 2022	JANUARY 2023	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	324,961	325,920	329,121	331,947	336,514	332,414	4,186,249
REVENUES							
Title XIX - Medicaid - Family and Other	175.92	175.56	174.37	180.89	156.69	175.30	173.53
Title XIX - Medicaid - Expansion Members	338.95	338.39	334.55	344.93	323.22	373.01	344.32
Title XIX - Medicaid - SPD Members	880.12	911.57	926.33	919.20	897.35	1,038.82	920.53
Title XIX - Medicaid - LTC Members	0.00	0.00	0.00	0.00	0.00	0.00	0.93
Premium - MCO Tax	33.49	33.39	33.07	32.79	32.34	0.00	29.78
Premium - Hospital Directed Payments	57.23	57.86	57.61	58.21	81.94	63.80	59.84
Investment Earnings And Other Income	(0.37)	1.08	0.54	2.68	2.12	4.21	0.71
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.45	0.00	0.04
Rate Adjustments - Hospital Directed Payments	(0.01)	(14.13)	0.03	(0.02)	36.99	(2.06)	8.20
Rate/Income Adjustments	0.75	0.63	0.38	3.91	0.99	(2.91)	(0.22)
TOTAL REVENUES	350.33	339.60	351.15	364.06	394.67	341.43	358.88
EXPENSES							
Medical Costs:							
Physician Services	56.00	57.14	55.21	55.68	49.56	61.07	57.65
Other Professional Services	16.03	15.42	15.32	16.37	18.35	16.53	16.25
Emergency Room	14.34	14.65	14.56	17.12	15.10	15.63	15.01
Inpatient	64.11	69.95	68.25	55.47	37.42	68.11	63.27
Reinsurance Expense	(0.08)	0.44	0.18	0.18	0.18	0.27	0.16
Outpatient Hospital	30.55	28.69	28.32	26.29	27.02	28.93	27.98
Other Medical	46.90	48.31	49.88	49.35	19.44	46.72	47.78
Pharmacy	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Pay for Performance Quality Incentive	1.49	1.51	1.50	1.49	1.50	1.50	1.50
Hospital Directed Payments	57.23	57.86	57.61	58.21	81.94	63.80	59.84
Hospital Directed Payment Adjustment	(0.01)	(12.47)	0.03	(0.02)	36.99	(2.06)	8.28
Non-Claims Expense Adjustment	0.02	0.03	(0.76)	0.01	(3.18)	(0.39)	(0.50)
IBNR, Incentive, Paid Claims Adjustment	1.50	(2.42)	(1.32)	(1.32)	(19.92)	0.03	(5.66)
Total Medical Costs	288.09	279.09	288.78	278.84	268.04	300.15	291.55
GROSS MARGIN	62.24	60.51	62.37	85.22	126.64	41.28	67.33
Administrative:							
Compensation	9.69	9.86	10.29	9.76	13.99	10.67	10.26
Purchased Services	3.52	3.06	3.07	3.12	3.75	2.83	3.07
Supplies	0.36	0.26	0.20	0.78	0.65	0.26	0.35
Depreciation	1.80	1.79	1.78	1.88	1.87	2.05	1.85
Other Administrative Expenses	0.97	0.92	0.92	0.96	2.87	1.99	1.23
Administrative Expense Adjustment	0.92	1.29	0.91	0.90	1.51	0.33	0.79
Total Administrative Expenses	17.26	17.18	17.17	17.40	24.64	18.13	17.55
TOTAL EXPENSES	305.35	296.27	305.95	296.24	292.68	318.28	309.10
OPERATING INCOME (LOSS) BEFORE TAX	44.98	43.33	45.20	67.82	102.00	23.16	49.78
MCO TAX	33.49	33.39	33.07	32.79	32.34	0.00	29.78
OPERATING INCOME (LOSS) NET OF TAX	11.49	9.94	12.13	35.03	69.65	23.16	20.00
TOTAL NONOPERATING REVENUE (EXPENSE)	0.18	(0.09)	(0.02)	0.01	(0.10)	(0.18)	(1.15)
NET INCREASE (DECREASE) IN NET POSITION	11.67	9.85	12.12	35.04	69.55	22.98	18.85
MEDICAL LOSS RATIO	88.9%	89.0%	88.7%	80.8%	61.3%	85.2%	85.6%
ADMINISTRATIVE EXPENSE RATIO	6.6%	6.5%	6.6%	6.4%	10.1%	6.5%	6.7%

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2023

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
30,888,919	29,622,758	1,266,161	Premium - Medi-Cal	30,888,919	29,622,758	1,266,161
2,910,453	2,782,482	127,971	Premium - Maternity Kick	2,910,453	2,782,482	127,971
545,350	510,205	35,145	Premium - Enhanced Care Management	545,350	510,205	35,145
192,262	141,622	50,640	Premium - Major Organ Transplant	192,262	141,622	50,640
-	435,209	(435,209)	Premium - Cal AIM	-	435,209	(435,209)
3,541,632	4,198,354	(656,722)	Premium - Provider Enhancement	3,541,632	4,198,354	(656,722)
162,846	182,920	(20,074)	Premium - Ground Emergency Medical Transportation	162,846	182,920	(20,074)
-	245,400	(245,400)	Premium - Student Behavioral Health Incentive	-	245,400	(245,400)
-	352,514	(352,514)	Premium - Housing and Homelessness Incentive	-	352,514	(352,514)
113,744	117,330	(3,586)	Other	113,744	117,330	(3,586)
38,355,206	38,588,794	(233,588)	Total Title XIX - Medicaid - Family & Other	38,355,206	38,588,794	(233,588)
			Title XIX - Medicaid - Expansion Members			
32,190,066	28,771,050	3,419,017	Premium - Medi-Cal	32,190,066	28,771,050	3,419,017
609,164	236,486	372,678	Premium - Maternity Kick	609,164	236,486	372,678
790,209	936,390	(146,181)	Premium - Enhanced Care Management	790,209	936,390	(146,181)
325,628	233,870	91,758	Premium - Major Organ Transplant	325,628	233,870	91,758
-	405,655	(405,655)	Premium - Cal AIM	-	405,655	(405,655)
1,680,268	1,847,705	(167,437)	Premium - Provider Enhancement	1,680,268	1,847,705	(167,437)
234,340	202,131	32,209	Premium - Ground Emergency Medical Transportation	234,340	202,131	32,209
-	195,905	(195,905)	Premium - Student Behavioral Health Incentive	-	195,905	(195,905)
-	281,415	(281,415)	Premium - Housing and Homelessness Incentive	-	281,415	(281,415)
35,245	32,760	2,485	Other	35,245	32,760	2,485
35,864,920	33,143,366	2,721,554	Total Title XIX - Medicaid - Expansion Members	35,864,920	33,143,366	2,721,554
			Title XIX - Medicaid - SPD Members			
16,856,627	14,990,405	1,866,222	Premium - Medi-Cal	16,856,627	14,990,405	1,866,222
399,252	486,030	(86,778)	Premium - Enhanced Care Management	399,252	486,030	(86,778)
232,938	154,530	78,408	Premium - Major Organ Transplant	232,938	154,530	78,408
-	229,926	(229,926)	Premium - Cal AIM	-	229,926	(229,926)
494,818	505,909	(11,091)	Premium - Provider Enhancement	494,818	505,909	(11,091)
135,422	136,170	(748)	Premium - Ground Emergency Medical Transportation	135,422	136,170	(748)
-	119,827	(119,827)	Premium - Student Behavioral Health Incentive	-	119,827	(119,827)
-	172,130	(172,130)	Premium - Housing and Homelessness Incentive	-	172,130	(172,130)
18,119,057	16,794,927	1,324,130	Total Title XIX - Medicaid - SPD Members	18,119,057	16,794,927	1,324,130
			Title XIX - Medicaid - LTC Members			
199,854	-	199,854	Premium - Medi-Cal	199,854	-	199,854
602	-	602	Premium - Enhanced Care Management	602	-	602
722	-	722	Premium - Major Organ Transplant	722	-	722
-	-	-	Premium - Cal AIM	-	-	-
11	-	11	Premium - Provider Enhancement	11	-	11
38	-	38	Premium - Ground Emergency Medical Transportation	38	-	38
-	-	-	Premium - Student Behavioral Health Incentive	-	-	-
-	-	-	Premium - Housing and Homelessness Incentive	-	-	-
201,227	-	201,227	Total Title XIX - Medicaid - LTC Members	201,227	-	201,227

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2023

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
4,153,283	4,175,030	21,747	Primary Care Physician Services	4,153,283	4,175,030	21,747
14,090,583	13,838,172	(252,411)	Referral Specialty Services	14,090,583	13,838,172	(252,411)
2,048,906	2,397,578	348,672	Urgent Care & After Hours Advise	2,048,906	2,397,578	348,672
9,300	9,300	-	Hospital Admitting Team	9,300	9,300	-
20,302,072	20,420,080	118,008	TOTAL PHYSICIAN SERVICES	20,302,072	20,420,080	118,008
			OTHER PROFESSIONAL SERVICES			
332,837	335,069	2,232	Vision Service Capitation	332,837	335,069	2,232
2,029,340	2,804,617	775,277	Medical Departments - UM Allocation *	2,029,340	2,804,617	775,277
1,234,423	1,363,474	129,051	Behavior Health Treatment	1,234,423	1,363,474	129,051
378,598	411,436	32,838	Mental Health Services	378,598	411,436	32,838
1,518,707	1,804,534	285,827	Other Professional Services	1,518,707	1,804,534	285,827
5,493,905	6,719,129	1,225,224	TOTAL OTHER PROFESSIONAL SERVICES	5,493,905	6,719,129	1,225,224
5,195,994	5,462,936	266,942	EMERGENCY ROOM	5,195,994	5,462,936	266,942
22,641,712	22,541,723	(99,989)	INPATIENT HOSPITAL	22,641,712	22,541,723	(99,989)
90,859	72,088	(18,771)	REINSURANCE EXPENSE PREMIUM	90,859	72,088	(18,771)
9,616,781	9,792,000	175,219	OUTPATIENT HOSPITAL SERVICES	9,616,781	9,792,000	175,219
			OTHER MEDICAL			
1,792,123	1,559,348	(232,775)	Ambulance and NEMT	1,792,123	1,559,348	(232,775)
970,272	956,791	(13,481)	Home Health Services & CBAS	970,272	956,791	(13,481)
776,558	1,592,010	815,452	Utilization and Quality Review Expenses	776,558	1,592,010	815,452
2,732,047	2,217,606	(514,441)	Long Term/SNF/Hospice	2,732,047	2,217,606	(514,441)
5,430,893	5,972,440	541,547	Provider Enhancement Expense - Prop. 56	5,430,893	5,972,440	541,547
496,477	495,159	(1,318)	Provider Enhancement Expense - GEMT	496,477	495,159	(1,318)
1,428,973	1,835,994	407,021	Enhanced Care Management	1,428,973	1,835,994	407,021
751,183	503,521	(247,662)	Major Organ Transplant	751,183	503,521	(247,662)
30,326	2,316,082	2,285,756	Cal AIM Incentive Programs	30,326	2,316,082	2,285,756
1,119,968	1,013,555	(106,413)	DME/Rebates	1,119,968	1,013,555	(106,413)
15,528,820	18,462,505	2,933,685	TOTAL OTHER MEDICAL	15,528,820	18,462,505	2,933,685
498,590	491,512	(7,078)	PAY FOR PERFORMANCE QUALITY INCENTIVE	498,590	491,512	(7,078)
21,209,673	18,730,665	(2,479,008)	HOSPITAL DIRECTED PAYMENTS	21,209,673	18,730,665	(2,479,008)
(684,297)	-	684,297	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(684,297)	-	684,297
(128,832)	-	128,832	NON-CLAIMS EXPENSE ADJUSTMENT	(128,832)	-	128,832
9,076	-	(9,076)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	9,076	-	(9,076)
99,774,353	102,692,638	2,918,285	Total Medical Costs	99,774,353	102,692,638	2,918,285

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA - PMPM
FOR THE MONTH ENDED JANUARY 31, 2023

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
12.49	12.76	0.27	Primary Care Physician Services	12.49	12.76	0.27
42.39	42.29	(0.10)	Referral Specialty Services	42.39	42.29	(0.10)
6.16	7.33	1.16	Urgent Care & After Hours Advise	6.16	7.33	1.16
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
61.07	62.41	1.33	TOTAL PHYSICIAN SERVICES	61.07	62.41	1.33
			OTHER PROFESSIONAL SERVICES			
1.00	1.02	0.02	Vision Service Capitation	1.00	1.02	0.02
6.10	8.57	2.47	Medical Departments - UM Allocation *	6.10	8.57	2.47
3.71	4.17	0.45	Behavior Health Treatment	3.71	4.17	0.45
1.14	1.26	0.12	Mental Health Services	1.14	1.26	0.12
4.57	5.52	0.95	Other Professional Services	4.57	5.52	0.95
16.53	20.54	4.01	TOTAL OTHER PROFESSIONAL SERVICES	16.53	20.54	4.01
15.63	16.70	1.06	EMERGENCY ROOM	15.63	16.70	1.06
68.11	68.89	0.78	INPATIENT HOSPITAL	68.11	68.89	0.78
0.27	0.22	(0.05)	REINSURANCE EXPENSE PREMIUM	0.27	0.22	(0.05)
28.93	29.93	1.00	OUTPATIENT HOSPITAL SERVICES	28.93	29.93	1.00
			OTHER MEDICAL			
5.39	4.77	(0.63)	Ambulance and NEMT	5.39	4.77	(0.63)
2.92	2.92	0.01	Home Health Services & CBAS	2.92	2.92	0.01
2.34	4.87	2.53	Utilization and Quality Review Expenses	2.34	4.87	2.53
8.22	6.78	(1.44)	Long Term/SNF/Hospice	8.22	6.78	(1.44)
16.34	18.25	1.92	Provider Enhancement Expense - Prop. 56	16.34	18.25	1.92
1.49	1.51	0.02	Provider Enhancement Expense - GEMT	1.49	1.51	0.02
4.30	5.61	1.31	Enhanced Care Management	4.30	5.61	1.31
2.26	1.54	(0.72)	Major Organ Transplant	2.26	1.54	(0.72)
0.09	7.08	6.99	Cal AIM Incentive Programs	0.09	7.08	6.99
3.37	3.10	(0.27)	DME	3.37	3.10	(0.27)
46.72	56.43	9.71	TOTAL OTHER MEDICAL	46.72	56.43	9.71
1.50	1.50	0.00	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	0.00
63.80	57.25	(6.56)	HOSPITAL DIRECTED PAYMENTS	63.80	57.25	(6.56)
(2.06)	0.00	2.06	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(2.06)	0.00	2.06
(0.39)	0.00	0.39	NON-CLAIMS EXPENSE ADJUSTMENT	(0.39)	0.00	0.39
0.03	0.00	(0.03)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.03	0.00	(0.03)
300.15	313.85	13.70	Total Medical Costs	300.15	313.85	13.70

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH THROUGH JANUARY 31, 2023	JANUARY 2023	YEAR TO DATE 2023
PHYSICIAN SERVICES		
Primary Care Physician Services	4,153,283	4,153,283
Referral Specialty Services	14,090,583	14,090,583
Urgent Care & After Hours Advise	2,048,906	2,048,906
Hospital Admitting Team	9,300	9,300
TOTAL PHYSICIAN SERVICES	20,302,072	20,302,072
OTHER PROFESSIONAL SERVICES		
Vision Service Capitation	332,837	332,837
Medical Departments - UM Allocation *	2,029,340	2,029,340
Behavior Health Treatment	1,234,423	1,234,423
Mental Health Services	378,598	378,598
Other Professional Services	1,518,707	1,518,707
TOTAL OTHER PROFESSIONAL SERVICES	5,493,905	5,493,905
EMERGENCY ROOM	5,195,994	5,195,994
INPATIENT HOSPITAL	22,641,712	22,641,712
REINSURANCE EXPENSE PREMIUM	90,859	90,859
OUTPATIENT HOSPITAL SERVICES	9,616,781	9,616,781
OTHER MEDICAL		
Ambulance and NEMT	1,792,123	1,792,123
Home Health Services & CBAS	970,272	970,272
Utilization and Quality Review Expenses	776,558	776,558
Long Term/SNF/Hospice	2,732,047	2,732,047
Provider Enhancement Expense - Prop. 56	5,430,893	5,430,893
Provider Enhancement Expense - GEMT	496,477	496,477
Enhanced Care Management	1,428,973	1,428,973
Major Organ Transplant	751,183	751,183
Cal AIM Incentive Programs	30,326	30,326
DME	1,119,968	1,119,968
TOTAL OTHER MEDICAL	15,528,820	15,528,820
PAY FOR PERFORMANCE QUALITY INCENTIVE	498,590	498,590
HOSPITAL DIRECTED PAYMENTS	21,209,673	21,209,673
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(684,297)	(684,297)
NON-CLAIMS EXPENSE ADJUSTMENT	(128,832)	(128,832)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	9,076	9,076
Total Medical Costs	99,774,353	99,774,353

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM THROUGH JANUARY 31, 2023	JANUARY 2023	YEAR TO DATE 2023
PHYSICIAN SERVICES		
Primary Care Physician Services	12.49	12.49
Referral Specialty Services	42.39	42.39
Urgent Care & After Hours Advise	6.16	6.16
Hospital Admitting Team	0.03	0.03
TOTAL PHYSICIAN SERVICES	61.07	61.07
OTHER PROFESSIONAL SERVICES		
Vision Service Capitation	1.00	1.00
Medical Departments - UM Allocation *	6.10	6.10
Behavior Health Treatment	3.71	3.71
Mental Health Services	1.14	1.14
Other Professional Services	4.57	4.57
TOTAL OTHER PROFESSIONAL SERVICES	16.53	16.53
EMERGENCY ROOM	15.63	15.63
INPATIENT HOSPITAL	68.11	68.11
REINSURANCE EXPENSE PREMIUM	0.27	0.27
OUTPATIENT HOSPITAL SERVICES	28.93	28.93
OTHER MEDICAL		
Ambulance and NEMT	5.39	5.39
Home Health Services & CBAS	2.92	2.92
Utilization and Quality Review Expenses	2.34	2.34
Long Term/SNF/Hospice	8.22	8.22
Provider Enhancement Expense - Prop. 56	16.34	16.34
Provider Enhancement Expense - GEMT	1.49	1.49
Enhanced Care Management	4.30	4.30
Major Organ Transplant	2.26	2.26
Cal AIM Incentive Programs	0.09	0.09
DME	3.37	3.37
TOTAL OTHER MEDICAL	46.72	46.72
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50
HOSPITAL DIRECTED PAYMENTS	63.80	63.80
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(2.06)	(2.06)
NON-CLAIMS EXPENSE ADJUSTMENT	(0.39)	(0.39)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.03	0.03
Total Medical Costs	300.15	300.15

KERN HEALTH SYSTEMS

MEDI-CAL

SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT

FOR THE MONTH ENDED JANUARY 31, 2023

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
687,266	503,783	(183,483)	110 - Executive	687,266	503,783	(183,483)
228,231	269,724	41,493	210 - Accounting	228,231	269,724	41,493
365,046	388,289	23,243	220 - Management Information Systems	365,046	388,289	23,243
63,805	26,641	(37,164)	221 - Business Intelligence	63,805	26,641	(37,164)
353,608	421,256	67,648	222 - Enterprise Development	353,608	421,256	67,648
104,241	201,164	96,923	223 - Enterprise Configuration	104,241	201,164	96,923
412,631	675,879	263,248	225 - Infrastructure	412,631	675,879	263,248
620,932	690,413	69,481	230 - Claims	620,932	690,413	69,481
140,118	272,020	131,902	240 - Project Management	140,118	272,020	131,902
194,388	145,307	(49,081)	310 - Health Services - Utilization Management	194,388	145,307	(49,081)
89	51,625	51,536	311 - Health Services - Quality Improvement	89	51,625	51,536
88	143	55	312 - Health Services - Education	88	143	55
39,747	70,663	30,916	313- Pharmacy	39,747	70,663	30,916
475	3,292	2,817	314 - Enhanced Care Management	475	3,292	2,817
62,921	78,415	15,494	316 -Population Health Management	62,921	78,415	15,494
165	1,218	1,053	317 - Community Based Services	165	1,218	1,053
-	31,941	31,941	318 - Housing & Homeless Incentive Program	-	31,941	31,941
-	134,370	134,370	319 - CAL AIM Incentive Payment Program (IPP)	-	134,370	134,370
-	947	947	601 - Behavioral Health	-	947	947
-	4,315	4,315	602 - Quality & Health Equity	-	4,315	4,315
317,123	345,411	28,288	320 - Provider Network Management	317,123	345,411	28,288
802,035	1,205,474	403,439	330 - Member Services	802,035	1,205,474	403,439
892,136	871,256	(20,880)	340 - Corporate Services	892,136	871,256	(20,880)
138,360	145,475	7,115	360 - Audit & Investigative Services	138,360	145,475	7,115
68,972	56,416	(12,556)	410 - Member Engagement	68,972	56,416	(12,556)
60,714	210,572	149,858	420 - Sales/Marketing/Public Relations	60,714	210,572	149,858
362,364	361,965	(399)	510 - Human Resourses	362,364	361,965	(399)
109,675	(141,667)	(251,342)	Administrative Expense Adjustment	109,675	(141,667)	(251,342)
6,025,131	7,026,307	1,001,176	Total Administrative Expenses	6,025,131	7,026,307	1,001,176

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED JANUARY 31, 2023	JANUARY 2023	YEAR TO DATE 2023
110 - Executive	687,266	687,266
210 - Accounting	228,231	228,231
220 - Management Information Systems (MIS)	365,046	365,046
221 - Business Intelligence	63,805	63,805
222 - Enterprise Development	353,608	353,608
223 - Enterprise Configuration	104,241	104,241
225 - Infrastructure	412,631	412,631
230 - Claims	620,932	620,932
240 - Project Management	140,118	140,118
310 - Health Services - Utilization Management	194,388	194,388
311 - Health Services - Quality Improvement	89	89
312 - Health Services - Education	88	88
313- Pharmacy	39,747	39,747
314 - Enhanced Care Management	475	475
316 -Population Health Management	62,921	62,921
317 - Community Based Services	165	165
318 - Housing & Homeless Incentive Program	-	-
319 - CAL AIM Incentive Payment Program (IPP)	-	-
601 - Behavioral Health	-	-
602 - Quality & Health Equity	-	-
320 - Provider Network Management	317,123	317,123
330 - Member Services	802,035	802,035
340 - Corporate Services	892,136	892,136
360 - Audit & Investigative Services	138,360	138,360
410 - Member Engagement	68,972	68,972
420 - Sales/Marketing/Public Relations	60,714	60,714
510 - Human Resourses	362,364	362,364
Total Department Expenses	5,915,456	5,915,456
ADMINISTRATIVE EXPENSE ADJUSTMENT	109,675	109,675
Total Administrative Expenses	6,025,131	6,025,131

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
BALANCE SHEET STATEMENT
AS OF JANUARY 31, 2023

ASSETS	JANUARY 2023	DECEMBER 2022	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,130,625	$ 1,124,665	5,960
Interest Receivable	2,000	5,960	(3,960)
TOTAL CURRENT ASSETS	$ 1,132,625	$ 1,130,625	$ 2,000
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,130,625	1,136,102	(5,477)
Increase (Decrease) in Net Position - Current Year	2,000	(5,477)	7,477
Total Net Position	$ 1,132,625	$ 1,130,625	$ 2,000
TOTAL LIABILITIES AND NET POSITION	$ 1,132,625	$ 1,130,625	$ 2,000

KERN HEALTH SYSTEMS
GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2023

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
2,000	-	2,000	Interest	2,000	-	2,000
	-	-	Other Investment Income	-	-	-
2,000	-	2,000	TOTAL REVENUES	2,000	-	2,000
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
2,000	-	2,000	GROSS MARGIN	2,000	-	2,000
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
2,000	-	2,000	OPERATING INCOME (LOSS)	2,000	-	2,000
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
2,000	-	2,000	NET INCREASE (DECREASE) IN NET POSITION	2,000	-	2,000
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
0%	0%	0%	ADMINISTRATIVE EXPENSE RATIO	0%	0%	0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2023 MEMBER MONTHS	JAN'23
ADULT AND FAMILY		
ADULT	**58,409**	58,409
CHILD	**149,881**	149,881
SUB-TOTAL ADULT & FAMILY	**208,290**	**208,290**
OTHER MEMBERS		
PARTIAL DUALS - FAMILY	**851**	851
PARTIAL DUALS - CHILD	**0**	0
PARTIAL DUALS - BCCTP	**6**	6
FULL DUALS (SPD)		
SPD FULL DUALS	**9,649**	9,649
SUBTOTAL OTHER MEMBERS	**10,506**	**10,506**
TOTAL FAMILY & OTHER	**218,796**	**218,796**
SPD		
SPD (AGED AND DISABLED)	**17,442**	17,442
MEDI-CAL EXPANSION		
ACA Expansion Adult-Citizen	**94,512**	94,512
ACA Expansion Duals	**1,637**	1,637
SUB-TOTAL MED-CAL EXPANSION	**96,149**	**96,149**
LONG TERM CARE (LTC)		
LTC	**27**	27
LTC DUALS	**0**	0
TOTAL LTC	**27**	**27**
TOTAL KAISER	**14,759**	**14,759**
TOTAL MEDI-CAL MEMBERS	**347,173**	**347,173**

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T1408	DELL MARKETING L.P.	723,103.94	2,081,848.00	AZURE OVERAGES, MICROSOFT TRUE UP & ANNUAL MICROSOFT LICENSES ASSURANCE	MIS INFRASTRUCTURE
T1045	KAISER FOUNDATION HEALTH - HMO	541,149.98	6,197,314.21	DEC. 2022 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T1845	DEPARTMENT OF MANAGED HEALTH CARE ****	444,762.06	927,541.26	2022-2023 MCAL ANNUAL ASSESSMENT -1ST INSTALLMENT PAYMENT	ADMINISTRATION
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	270,000.00	637,303.70	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI
T5503	SECURE-CENTRIC INC ****	191,889.68	219,589.28	RUBRIK CLOUD DATA MANAGEMENT SOFTWARE SUPPORT	MIS INFRASTRUCTURE
T4350	COMPUTER ENTERPRISE	190,878.30	3,990,188.90	NOV. 2022 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T4982	NGC US, LLC	159,000.00	3,000,007.92	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T5479	TRANSFORMING LOCAL COMMUNITIES, INC	112,014.77	339,607.23	OCT. & NOV. 2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4237	FLUIDEDGE CONSULTING, INC.	88,760.00	680,442.10	NOV. 2022 CONSULTING SERVICES	VARIOUS
T4733	UNITED STAFFING ASSOCIATES	82,832.81	711,173.73	NOV. & DEC. 2022 TEMP HELP - (11) MS	VARIOUS
T1180	LANGUAGE LINE	78,618.22	802,144.12	NOV. 2022 INTERPRETATION SERVICES	MEMBER SERVICES
T2918	STINSON'S ****	59,486.53	168,857.51	AUG., OCT. & NOV 2022 OFFICE SUPPLIES	VARIOUS

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T2562	CACTUS SOFTWARE LLC ****	53,069.77	53,069.77	CREDENTIALING SOFTWARE RENEWAL	MIS INFRASTRUCTURE
T1272	COFFEY COMMUNICATIONS INC. ****	51,157.43	134,113.16	WINTER EDITION MEMBER NEWSLETTER	HEALTH EDUCATION
T5337	CAZADOR CONSULTING GROUP INC	50,004.33	441,044.78	NOV. 2022 TEMPORARY HELP - (2) IT: (10) MS (1): UM	VARIOUS
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	45,513.84	1,367,465.81	OCT. & NOV. 2022 PROFESSIONAL SERVICES & NOV. 2022 EDI CLAIM PROCESSING	VARIOUS
T5562	JDM SOLUTIONS INC.	44,700.00	84,600.00	NOV. 2022 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	42,265.53	485,923.03	DEC. 2022 EMPLOYEE HEALTH BENEFITS	VARIOUS
T5396	NYMI INC ****	41,125.00	92,645.00	SOFTWARE LICENSE RENEWAL	MIS INFRASTRUCTURE
T5421	PREMIER ACCESS INSURANCE COMPANY	40,251.41	464,589.76	DEC. 2022 EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T2584	UNITED STATES POSTAL SVC. - HASLER	40,000.00	360,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
WT/ACH	USPS	40,000.00	150,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	35,887.50	518,130.00	NOV. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5546	BITWISE TECHNOLOGY CONSULTING, LLC	31,736.14	145,403.77	NOV. 2022 OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T2167	PG&E	31,261.88	391,657.38	NOV. 2022 USAGE / UTILITIES	CORPORATE SERVICES
T4460	PAYSPAN, INC ****	29,784.58	243,610.25	NOV. 2022 ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T5574	CARMAX AUTO SUPERSTORES, INC ****	29,764.35	61,716.70	2022 EQUINOX COMPANY VEHICLE	CORPORATE SERVICES
T4708	HEALTH MANAGEMENT ASSOCIATES, INC ****	29,581.68	115,227.93	SEPT., OCT., & NOV. 2022 PROFESSIONAL SERVICES	ADMINISTRATION
T5568	MICHELLE OXFORD ****	28,000.00	51,100.00	NOV. 2022 CONSULTING SERVICES	ADMINISTRATION
T2458	HEALTHCARE FINANCIAL, INC	27,500.00	326,788.44	OCT. 2022 PROFESSIONAL SERVICES	ADMINISTRATION
T5447	PROSPHIRE, LLC ****	27,360.00	254,980.00	OCT. 2022 PROFESSIONAL SERVICES	CAPITAL PROJECT
T3011	OFFICE ALLY, INC	26,540.62	257,577.36	NOV. 2022 EDI CLAIM PROCESSING	CLAIMS
T5509	NGUYEN CAO LUU-TRONG	25,050.00	170,550.00	NOV. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC.	24,873.00	115,191.00	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T1861	CERIDIAN HCM, INC.	23,580.49	270,069.60	NOV. & DEC. 2022 MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4452	WELLS FARGO	23,377.50	284,867.54	DEC - ACH MISC CREDIT CARD PURCHASES	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	20,914.57	316,735.53	NOV. 2022 EDI CLAIM PROCESSING	CLAIMS
		3,805,795.91			
	TOTAL VENDORS OVER $20,000	3,805,795.91			
	TOTAL VENDORS UNDER $20,000	402,287.90			
	TOTAL VENDOR EXPENSES- DECEMBER	**$ 4,208,083.81**			

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	6,197,314.21	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE INC.	3,990,188.90	PROFESSIONAL SERVICES / CONSULTING SERVICES	VARIOUS
T4391	OMNI FAMILY HEALTH	3,009,560.61	HEALTH HOMES GRANT	COMMUNITY GRANTS
T4982	NGC US, LLC	3,000,007.92	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
T1071	CLINICA SIERRA VISTA	2,760,963.65	2022 HEALTH HOMES GRANT & PROVIDER CARE QUALITY GRANT PROGRAM	COMMUNITY GRANTS
T1408	DELL MARKETING L.P.	2,081,848.00	HARDWARE & COMPUTER EQUIPMENT & LICENSE FEES	MIS INFRASTRUCTURE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	1,367,465.81	PROFESSIONAL SERVICES & ANNUAL LICENSING	VARIOUS
T2704	MCG HEALTH LLC	1,214,288.28	HEALTH CARE MANAGEMENT & SOFTWARE LICENSE 8/5/2022 -08/04/2023	UTILIZATION MANAGEMENT
T2686	ALLIANT INSURANCE SERVICES INC.	1,122,033.92	2022 -2023 INSURANCE PREMIUMS	ADMINISTRATION
T1845	DEPARTMENT OF MANAGED HEALTH CARE	927,541.26	2022-2023 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T5111	ENTISYS 360	850,833.77	ACROPOLIS ANNUAL LICENSE 2022	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1180	LANGUAGE LINE SERVICES INC.	802,144.12	INTERPRETATION SERVICES	MEMBER SERVICES
T4733	UNITED STAFFING ASSOCIATES	711,173.73	TEMPORARY HELP	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC.	680,442.10	CONSULTING SERVICES/UPDATE TO STANDARD BUSINESS REPORTING-CALAIM EXPANSION	VARIOUS
T4483	INFUSION AND CLINICAL SERVICES, INC	671,067.96	HEALTH HOMES GRANT	COMMUNITY GRANT
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	637,303.70	PREFUND HEALTH EDUCATION MEMBER INCENTIVES	UTILIZATION MANAGEMENT-QI
T3130	OPTUMINSIGHT, INC	581,767.00	ANNUAL LICENSED SOFTWARE EASYGROUP & INCREMENTAL LICENSE	MIS INFRASTRUCTURE
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	518,130.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2488	THE LINCOLN NATIONAL LIFE INSURANCE	485,923.03	VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T5421	PREMIER ACCESS INSURANCE COMPANY	464,589.76	EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T5337	CAZADOR CONSULTING GROUP INC	441,044.78	TEMPORARY HELP	VARIOUS
T4737	TEKSYSTEMS, INC.	438,587.35	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5022	SVAM INTERNATIONAL INC	427,702.50	PROFESSIONAL SERVICES	IT BUSINESS INTELLIGENCE
T4699	ZEOMEGA, INC.	403,202.65	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT
T2167	PG&E	391,657.38	USAGE / UTILITIES	CORPORATE SERVICES
T4165	SHI INTERNATIONAL CO.	372,709.91	NETWORK SWITCHES WITH SUPPORT	MIS INFRASTRUCTURE
T2584	UNITED STATES POSTAL SVC. - HASLER	360,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5466	ZIPARI, INC	343,008.00	2022 JIVA MEMBER PORTAL	MIS INFRASTRUCTURE
T5479	TRANSFORMING LOCAL COMMUNITIES, INC	339,607.23	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T2458	HEALTHCARE FINANCIAL, INC	326,788.44	PROFESSIONAL SERVICES	ADMINISTRATION
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	316,735.53	EDI CLAIM PROCESSING (EMDEON)	CLAIMS
T4193	STRIA LLC	285,379.86	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T4657	DAPONDE SIMPSON ROWE PC	285,280.22	LEGAL FEES	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4452	WELLS FARGO	284,867.54	ACH- MISC CREDIT CARD PURCHASES	VARIOUS
T3449	CDW GOVERNMENT	280,310.84	HEADSETS, CABLES & ADOBE LICENSES	MIS INFRASTRUCTURE
T1861	CERIDIAN HCM, INC.	270,069.60	MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T3011	OFFICE ALLY, INC	257,577.36	EDI CLAIM PROCESSING	CLAIMS
T5447	PROSPHIRE, LLC	254,980.00	CONSULTING - CLINICAL ADMINISTRATOR STAFF AUGMENTATION	UTILIZATION MANAGEMENT
T4460	PAYSPAN, INC	243,610.25	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T2726	DST PHARMACY SOLUTIONS, INC.	237,601.79	PHARMACY CLAIMS	PHARMACY
T5005	CRAYON SOFTWARE EXPERTS LLC	233,512.45	ANNUAL SOFTWARE LICENSE AND ESD AZURE OVERAGE	MIS INFRASTRUCTURE
T5155	A-C ELECTRIC COMPANY	229,186.50	CARPOOL SOLAR PROJECT DEPOSIT	CAPITAL
T4695	EDIFECS, INC.	227,371.33	ANNUAL TSM MAINTENANCE	MIS INFRASTRUCTURE
T5503	SECURE-CENTRIC INC	219,589.28	POLARIS LICENSE, SUPPORT & CLOUD VAULT BACKUP SUPPORT	CAPITAL PROJECT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5319	CITIUSTECH INC.	219,162.00	FAST+ ANNUAL MAINTENANCE & SUPPORT	MIS INFRASTRUCTURE
T4353	TWE SOLUTIONS, INC	219,139.32	INTERNAL AUDIT SOFTWARE	MIS INFRASTRUCTURE
T5145	CCS ENGINEERING FRESNO INC.	201,296.41	JANITORIAL & ADDITIONAL DAY PORTER	CORPORATE SERVICES
T5435	TEGRIA SERVICES GROUP - US, INC.	170,750.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5509	NGUYEN CAO LUU-TRONG	170,550.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2918	STINSONS	168,857.51	2022 OFFICE SUPPLIES	VARIOUS
T2469	DST HEALTH SOLUTIONS, LLC.	156,427.30	ANNUAL ACG LICENSE & SUPPORT	BUSINESS INTELLEGENCE
T5333	CENTRAL CALIFORNIA ASTHMA COLLABORATIVE	154,812.20	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5322	MANINDER KHALSA	154,030.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4707	SHAFTER PEDIATRICS	150,000.00	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
WT/ACH	USPS	150,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5546	BITWISE TECHNOLOGY CONSULTING, LLC	145,403.77	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T1005	COLONIAL LIFE & ACCIDENT	141,846.21	LIFE INSURANCE PREMIUM	VARIOUS
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	138,936.44	2022 ANNUAL DUE ASSESSMENT	VARIOUS
T1183	MILLIMAN USA	136,171.75	CY2020/2021 TNE & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION
T1272	COFFEY COMMUNICATIONS INC.	134,113.16	MEMBER NEWSLETTER/WEBSITE IMPLEMENTATION	HEALTH EDUCATION/MEDIA & ADVERTISING
T1128	HALL LETTER SHOP	133,601.77	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS	VARIOUS
T5292	ALL'S WELL HEALTH CARE SERVICES	128,292.54	TEMPORARY HELP	VARIOUS
T4582	HEALTHX, INC.	124,728.00	MAINTENANCE AND SUPPORT FEES - PROVIDER AND MEMBER PORTAL	MIS INFRASTRUCTURE
T5275	CREATIVE FINANCIAL STAFFING, LLC.	123,966.32	RECRUITMENT FEES	HUMAN RESOURCES
T4708	HEALTH MANAGEMENT ASSOCIATES, INC.	115,227.93	CONSULTING SERVICES	ADMINISTRATION
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC.	115,191.00	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4059	KERN VALLEY HEALTHCARE DISTRICT	113,434.63	2022 PROVIDER QUALITY CARE GRANT	COMMUNITY GRANTS
T5486	ALLIED GENERAL CONTRACTORS, INC	111,425.76	BUILDING IMPROVEMENTS	CORPORATE SERVICES
T5360	SYNERGY PHARMACY SOLUTIONS INC.	108,900.00	2021 KOMOTO ASTHMA PROGRAM	POPULATION HEALTH MANAGEMENT
T5300	CENTRAL VALLEY OCCUPATION MEDICAL GROUP, INC	105,960.00	COVID-19 TESTING	HUMAN RESOURCES
T2961	SOLUTION BENCH, LLC	104,061.95	2022/2023 ANNUAL M-FILES & SCANFINITY LICENSES SUPPORT	MIS INFRASTRUCTURE
T4038	POLYCLINIC MEDICAL CENTER, INC	102,089.73	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T3001	MERCER	101,000.00	PROFESSIONAL SERVICES	HUMAN RESOURCES
T4484	JACOBSON SOLUTIONS	99,313.81	TEMPORARY HELP	UTILIZATION MANAGEMENT-UM
T4503	VISION SERVICE PLAN	99,135.99	EMPLOYEE HEALTH BENEFITS	VARIOUS
T2933	SIERRA PRINTERS, INC	98,754.35	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T1022	UNUM LIFE INSURANCE CO.	97,208.26	EMPLOYEE PREMIUM	PAYROLL DEDUCTION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5121	TPX COMMUNICATIONS	95,716.80	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T4688	VANGUARD MEDICAL CORPORATION	95,000.00	2021-2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T1001	KERN MEDICAL CENTER	93,375.00	(21) POP UP COVID 19 CLINICS	PROVIDER NETWORK MANAGEMENT
T5396	NYMI INC	92,645.00	WEARABLES/ SOFTWARE/MAINTENANCE FOR TRACING DEVICES	CORPORATE SERVICES
T4686	CENTRIC HEALTH	86,939.92	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	86,750.68	ONSITE SECURITY	CORPORATE SERVICES
T5562	JDM SOLUTIONS INC.	84,600.00	2022 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T4792	KP LLC	83,712.56	PROVIDER DIRECTORIES & FORMULARY (SUPPORT/MAINT.)	PHARMACY/PROVIDER RELATIONS
T5529	FINDHELP	83,000.00	COMMUNITY SUPPORT REFERRAL SYSTEM IMPLEMENTATION	CAPITAL PROJECT
T4963	LINKEDIN CORPORATION	81,729.00	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T5329	RELAY NETWORK, LLC	80,000.04	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2413	TREK IMAGING INC	77,410.32	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T4217	CONTEXT 4 HEALTHCARE, INC	75,142.83	AMA ROYALTY FEE & CPT RENEWAL	MIS INFRASTRUCTURE
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	73,600.00	2022 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	70,414.30	EDI CLAIM PROCESSING	CLAIMS
T4052	RAHUL SHARMA	70,000.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4585	DELANO UNION SCHOOL DISTRICT	70,000.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T5185	HOUSING AUTHORITY COUNTY OF KERN	67,600.00	2021 HOUSING AUTHORITY GRANT	POPULATION HEALTH MANAGEMENT
T2509	USPS	67,555.35	FUND MAILING PERMIT #88	CORPORATE SERVICES
T5109	RAND EMPLOYMENT SOLUTIONS	64,164.97	TEMPORARY HELP	VARIOUS
T3986	JACQUELYN S. JANS	62,992.25	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING
T5574	CARMAX AUTO SUPERSTORES, INC	61,716.70	COMPANY VEHICLES (2)	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5377	TELEHEALTHDOCS MEDICAL GROUP	59,047.43	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5376	KCHCC	58,200.00	COVID-19 VACCINE CAMPAIGN GRANT	HEALTH EDUCATION
T5313	HEALTH LITERACY INNOVATIONS, LLC	57,630.00	LITERACY ADVISOR ANNUAL SOFTWARE LICENSE	MIS INFRASTRUCTURE
T2969	AMERICAN BUSINESS MACHINES INC	57,332.29	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T4785	COMMGAP	56,863.75	INTERPRETATION SERVICES	HEALTH EDUCATION
T5132	TIME WARNER CABLE LLC	55,025.27	INTERNET SERVICES	MIS INFRASTRUCTURE
T1195	KOMOTO PHARMACY, INC	54,500.00	COVID-19 POP UP CLINIC	PROVIDER NETWORK MANAGEMENT
T4182	THE LAMAR COMPANIES	53,679.00	OUTDOOR ADVERTISEMENT - BILLBOARDS	ADVERTISING
T2446	AT&T MOBILITY	53,348.70	CELLULAR PHONE/INTERNET USAGE	MIS INFRASTRUCTURE
T2562	CACTUS SOFTWARE LLC ****	53,069.77	CREDENTIALING ENTERPRISE RENEWAL	MIS INFRASTRUCTURE
T5387	NAVIA BENEFITS SOLUTIONS, INC.	52,724.21	FSA EMPLOYEE PREMIUM & SECTION 125 ADMINISTRATION	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5420	PAYPRO ADMINISTRATORS	52,016.12	FSA EMPLOYEE BENEFIT	VARIOUS
T5568	MICHELLE OXFORD	51,100.00	CONSULTING SERVICES	EXECUTIVE
T5215	RICHARD GARCIA	50,850.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4934	APPLE INC.	50,202.17	EQUIPMENT - CELL PHONES	VARIOUS
T5426	UNIVERSAL HEALTHCARE SERVICES, INC	50,000.00	PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5367	ADVENTIST HEALTH DELANO	49,697.20	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T4607	AGILITY RECOVERY SOLUTIONS INC.	49,609.70	PROFESSIONAL SERVICES	ADMINISTRATION
T2441	LAURA J. BREZINSKI	52,450.00	MARKETING MATERIALS	MARKETING
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	49,500.00	2021 AUDIT FEES	FINANCE
T5487	MR2 SOLUTIONS, INC	49,400.00	2022/2023 VIRTUAL CHIEF INFORMATION SECURITY OFFICER	MIS INFRASTRUCTURE
T4563	SPH ANALYTICS	46,784.40	2021/2022 PROVIDER SATISFACTION SURVEYS	MEMBER SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5018	FIRESTONE GRILL - BAKERSFIELD	46,599.64	EMPLOYEE SERVICE AWARDS 2022	MARKETING
T5408	MARY HARRIS	44,820.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5340	GARTNER INC	42,391.67	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	MIS ADMINISTRATION
T2941	KERN PRINT SERVICES INC.	42,234.09	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T5455	HC2 STRATEGIES, INC	41,345.00	CALAIM ROUNDTABLE SUPPORT	COMMUNITY SUPPORT SERVICES
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT	40,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T5389	ADAKC	38,953.97	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5107	CITRIX SYSTEMS, INC.	38,250.00	ANNUAL SERVICE RENEWAL	MIS INFRASTRUCTURE
T5286	BROOKLYNNS BOX INC.	37,750.00	PROVIDER GRANT PROGRAM 2021-2022	COMMUNITY GRANT
T5467	MOSS ADAMS LLP	36,997.00	2022 CLAIMS AUDIT TOOL ANNUAL SUPPORT	CLAIMS
T3515	DOUG HAYWARD	36,565.85	CONSULTING SERVICES	ADMINISTRATION
T5398	GOLDEN EMPIRE GLEANERS	36,549.44	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4605	KERNVILLE UNION SCHOOL DISTRICT	36,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	35,953.34	COMMUNITY SPONSORSHIP	ADMINISTRATION
T4502	MORGAN CONSULTING RESOURCES, INC.	35,840.00	RECRUITMENT FEES - DIRECTOR OF POPULATION HEALTH MANAGEMENT	HUMAN RESOURCES
T4331	COTIVITI, INC	34,831.97	CALIFORNIA MEDI-CAL MEDICAID MEASURES	QUALITY IMPROVEMENT
T1152	MICHAEL K. BROWN LANDSCAPE & MAINTENANCE CO. INC.	33,892.86	2022 BUILDING MAINTENANCE	CORPORATE SERVICE
T5520	BG HEALTHCARE CONSULTING, INC	33,825.00	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T3092	LINKS FOR LIFE, INC.	33,100.00	COMMUNITY RESOURCES GRANT PROGRAM	COMMUNITY GRANT
T4514	A.J. KLEIN, INC. T.DENATALE, B. GOLDNER	32,376.82	LEGAL FEES	ADMINISTRATION
T5401	KERN MEDICAL SUPPLY, LLC	32,303.30	2021/2022 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5321	TYK TECHNOLOGIES LTD	32,250.00	TYK LICENSE RENEWAL 22/23	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5490	WORKSITE LABS, INC	31,620.00	EMPLOYEE ON-SITE COVID TESTING	HUMAN RESOURCES
T4417	KAISER FOUNDATION HEALTH PLAN - OR	30,197.04	2021-2022 EMPLOYEE HEALTH BENEFITS PREMIUM	VARIOUS
T5325	WADE A MCNAIR	30,000.00	LEADERSHIP ACADEMY TRAINING	HUMAN RESOURCES
T1097	NCQA	29,247.00	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	HEALTH SERVICES - QI
T4944	CENTRAL VALLEY FARMWORKER FOUNDATION	28,600.50	COVID EDUCATION OUTREACH SPECIALIST	PROVIDER NETWORK MANAGEMENT
T4496	VOX NETWORK SOLUTIONS, INC	28,310.97	TELSTRAT LICENSES & ANNUAL HOSTING	MIS INFRASTRUCTURE
T3084	KERN COUNTY - COUNTY COUNSEL ****	27,937.90	LEGAL FEES	ADMINISTRATION
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	27,530.00	ADVERTISEMENT - MEDIA	MARKETING
T5494	LDP ASSOCIATES, INC	27,300.00	2022/2023 DISASTER RECOVERY & PC COOLING MAINT.	VARIOUS
T1694	KERN COUNTY FAIR	27,104.00	TICKETS, PARKING AND HAND WASHING STATIONS SPONSORSHIP	MARKETING
T5201	JAC SERVICES, INC	27,103.50	AC MAINTENANCE & SERVICE	CORPORATE SERVICES

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	26,946.07	EMPLOYEE PREMIUM	ADMINISTRATION
T4228	THE SSI GROUP, LLC	26,602.80	EDI CLAIM PROCESSING	CLAIMS
T4424	GUROCK SOFTWARE GmbH	26,565.00	TESTRAIL RENEWAL	MIS INFRASTRUCTURE
T4993	LEGALSHIELD	26,554.10	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION
T4466	SMOOTH MOVE USA	26,419.48	OFF SITE STORAGE	CORPORATE SERVICES
T1347	ADVANCED DATA STORAGE	25,877.79	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T5488	SALUSKY LAW GROUP	25,417.00	LEGAL FEES	ADMINISTRATION
T4663	DEVELOPMENT DIMENSIONS INTERNATIONAL, INC	25,000.00	2021-2023 LEADERSHIP LICENSE	HUMAN RESOURCES
T5578	KIMBERLY A MARTIN ****	24,447.50	NOV. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4920	OTIS ELEVATOR COMPANY	23,622.30	ELEVATION INSPECTION AND MAINTENANCE	CORPORATE SERVICES
T5366	CONCUR TECHNOLOGIES, INC	23,569.25	2021 - 2022 SAP PROFESSIONAL SERVICES	FINANCE

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4731	LOGMEIN USA, INC.	23,137.81	INTERNET SERVICES	MIS INFRASTRUCTURE
T5480	PRESS GANEY ASSOCIATES LLC	22,500.00	PROVIDER AND MEMBER SATISFACTION SURVEYS	VARIOUS
T5395	LIVONGO HEALTH INC ****	22,350.00	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4611	LAMONT SCHOOL DISTRICT	22,000.00	2022-2024 SCHOOL WELLNESS GRANT	HEALTH EDUCATION
T5159	AT&T CORP ****	21,661.15	INTERNET SERVICES	MIS INFRASTRUCTURE
T4216	NEXSTAR BROADCASTING INC	20,650.00	ADVERTISEMENT - MEDIA	MARKETING
T5161	INTEGRATED HEALTHCARE ASSOCIATION	20,142.92	CONSULTING SERVICES	PROVIDER NETWORK MANAGEMENT
		48,497,096.89		
	TOTAL VENDORS OVER $20,000	48,497,096.89		
	TOTAL VENDORS UNDER $20,000	1,760,855.97		
	TOTAL VENDOR EXPENSES-YTD	**50,257,952.86**		

Note:
****New vendors over $20,000 for the month of December

KERN·HEALTH SYSTEMS

January AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T4699	ZEOMEGA, INC	766,615.22	ANNUAL LICENSE RENEWAL & OCT. NOV. 2022 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T1045	KAISER FOUNDATION HEALTH - HMO	576,009.86	JAN. 2023 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T5155	A-C ELECTRIC COMPANY	568,931.25	CARPOOL SOLAR PROJECT	CAPITAL
T4350	COMPUTER ENTERPRISE	291,179.06	NOV. & DEC .2022 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T1071	CLINICA SIERRA VISTA	269,045.65	OCT. 2022 GRANT PROGRAM	COMMUNITY GRANTS
T4165	SHI INTERNATIONAL CO.	234,170.07	WORKFORCE LICENSING & MAINTENANCE RENEWAL	MIS INFRASTRUCTURE
T2469	DST HEALTH SOLUTIONS, LLC.	167,100.00	ANNUAL ACG LICENSE & SUPPORT RENEWAL	MIS INFRASTRUCTURE
T4737	TEKSYSTEMS, INC.	125,040.00	OCT. & NOV. 2022 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T2458	HEALTHCARE FINANCIAL, INC	123,624.79	OCT. & NOV. 2022 PROFESSIONAL SERVICES	ADMINISTRATION
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	77,000.00	2023 MEMBER DUES	ADMINISTRATION
T4963	LINKEDIN CORPORATION	65,388.50	LINKEDIN LEARNING ANNUAL RENEWAL	HUMAN RESOURCES
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	58,987.50	DEC. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5432	CATALYST SOLUTIONS, LLC	57,456.00	OCT. NOV & DEC. 2022 PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE

KERN·HEALTH SYSTEMS

January AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T5436	THE BEACON STUDIOS, LLC	56,502.00	ADVERTISING -TV COMMERCIAL	MEDIA & ADVERTISING
T4237	FLUIDEDGE CONSULTING, INC.	53,080.00	DEC. 2022 CONSULTING SERVICES	VARIOUS
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	47,377.00	2023 ANNUAL DUES	ADMINISTRATION
T1408	DELL MARKETING L.P.	43,702.83	MONITORS AND WORKSTATIONS	MIS INFRASTRUCTURE
T5421	PREMIER ACCESS INSURANCE COMPANY	41,399.10	JAN. 2023 EMPLOYEE DENTAL BENEFITS PREMIUM	VARIOUS
T5509	NGUYEN CAO LUU-TRONG	37,012.50	DEC. 2022 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5574	CARMAX AUTO SUPERSTORES, INC	30,451.85	VEHICLE FOR ENHANCED CARE MANAGEMENT VISITS	CORPORATE SERVICES
T5568	MICHELLE OXFORD	29,400.00	NOV. 2022 CONSULTING SERVICES	ADMINISTRATION
T5429	JANE MACADAM	29,118.77	2022 HYBRID COMMUTING	COMPLIANCE
T4554	THE KEN BLANCHARD COMPANIES	28,845.93	LEADERSHIP TRAINING COURSES	HUMAN RESOURCES
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC	28,833.47	DEC. 2022 PROFESSIONAL SERVICES & DEC. 2022 EDI CLAIM PROCESSING	VARIOUS
T4452	WELLS FARGO	27,813.25	ACH- MISC CREDIT CARD PURCHASES	VARIOUS

KERN·HEALTH SYSTEMS

January AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T3011	OFFICE ALLY, INC	27,370.46	DEC. 2022 EDI CLAIM PROCESSING	CLAIMS
T4733	UNITED STAFFING ASSOCIATES	26,120.65	DEC. 2022 TEMPORARY HELP - (11) MS	VARIOUS
T4460	PAYSPAN, INC	24,778.63	NOV. 2022 ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T1861	CERIDIAN HCM, INC.	24,620.70	DEC. 2022 & JAN. 2023 MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T5337	CAZADOR CONSULTING GROUP INC	24,196.45	DEC. 2022 TEMPORARY HELP - (1) ACCTG: (2) IT: (10) MS: (1) QI : (1) UM	VARIOUS
T5520	BG HEALTHCARE CONSULTING, INC	23,100.00	DEC. 2022 CONSULTING SERVICES	POPULATION HEALTH MANAGEMENT
T5022	SVAM INTERNATIONAL INC	21,924.00	NOV. 2022 PROFESSIONAL SERVICES	MIS ADMINISTRATION
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC.	21,000.00	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T2578	AMERICAN HEART ASSOCIATION - KERN COUNTY	20,000.00	YR 1 OF 3 COMMITMENT SPONSORSHIP	MEDIA & ADVERTISING
T4982	NGC US, LLC	20,000.00	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS
		4,067,195.49		
	TOTAL VENDORS OVER $20,000	4,067,195.52		
	TOTAL VENDORS UNDER $20,000	518,770.50		
	TOTAL VENDOR EXPENSES- JANUARY	**$ 4,585,966.02**		

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							
FluidEdge	$50,000.00	Yes	PNM	Emily Duran	Interim Program Manager for ECM and PNM dept. (Katie Sykes)	1/3/2022	3/31/2022
CEI	$93,555.00	Yes	PM	LaVonne Banks	Project Manager/Scrum Master professional resources (Mark Stepko)	1/3/2022	4/30/2022
HD Dynamics	$53,760.00	Yes	PNM	Emily Duran	Support and consulting hours for CRM for HHP	1/3/2022	12/31/2022
Symplr	$35,700.00	Yes	IT	Richard Pruitt	Annual support for Cactus SaaS & DEA licenses	1/6/2022	1/5/2023
Mercer	$95,000.00	Yes	HR	Anita Martin	Compensation study for 75 KHS jobs	1/20/2022	12/31/2022
KP	$35,000.00	Yes	HE	Isabel Silva	Prenatal, postpartum, and COVID guides insert mailing	1/2/2022	12/31/2022
Lamar	$37,336.00	Yes	MRK	Louie Iturriria	5 Billboard Advertisement	1/24/2022	1/23/2023
Jacquelyn Jans	$63,000.00	Yes	MRK	Louie Iturriria	Marketing and corporate image consultant	1/2/2022	12/31/2022
Poppyrock	$99,600.00	Yes	MRK	Louie Iturriria	Graphic design for KHS/KFHC members and provider	1/2/2022	12/31/2023
February							
Gartner	$42,391.67	Yes	IT	Richard Pruitt	Individual Access Advisor license	2/1/2022	1/31/2023
MKB Landscaping	$30,800.00	Yes	CS	Alonso Hurtado	Weekly landscaping services	2/10/2022	2/9/2023
Dell	$56,799.22	Yes	IT	Richard Pruitt	Dell laptops (18), Docking Stations (18), and monitors (36)	2/9/2022	2/8/2026
Coffey Communications	$70,000.00	Yes	HE	Isabel Silva	Provider Directory Print agreement	2/15/2022	2/14/2023
ZeOmega	$57,818.70	Yes	IT	Richard Pruitt	Member portal implementation	2/9/2022	12/31/2022
March							
Wade McNair	$30,000.00	Yes	HR	Anita Martin	Leadership Academy Training for new and experienced leaders	3/1/2022	6/17/2022
Ceridian	$34,170.00	Yes	HR	Anita Martin	Additional 201 bulk of hours for project driven work and configurations	3/10/2022	3/9/2023
HC2	$54,756.00	Yes	PNM	Emily Duran	Needs assessment for CalAIM initiatives	3/10/2022	3/9/2023
April							
TWE Solutions	$91,450.00	Yes	IT	Richard Pruitt	licenses	4/29/2022	4/29/2023
Citrix	$38,250.00	Yes	IT	Richard Pruitt	403 Citrix ADC Premium Edition and Desktop licenses	4/2/2022	4/1/2023
SSI Group, LLC	$56,000.00	Yes	Claims	Robin Dow-Morales	EDI claims and electronic transactions	4/4/2022	4/3/2024
FluidEdge	$67,200.00	Yes	PNM	Emily Duran	Interim Program Manager, Katie Sykes	4/2/2022	6/30/2022
Dell	$53,328.33	Yes	IT	Richard Pruitt	25 Dell 5420 Laptops and 25 Docking stations	4/21/2022	4/20/2026
Cognizant	$54,000.00	Yes	IT	Richard Pruitt	Claims Integrity Implementation for Zelis	4/21/2022	3/20/2025
Coffey Communications	$89,360.00	Yes	MRK	Louie Iturriria	KHS Digital platform agreement	4/1/2022	3/31/2023
May							
Dell	$98,096.46	Yes	IT	Richard Pruitt	Dell 5520 Latitude, Qnty 49	5/18/2022	5/17/2026
Cognizant	$99,999.00	Yes	IT	Richard Pruitt	Nutanix Xi Leap Cloud annual renewal	5/27/2022	5/26/2023
MR2	$44,400.00	Yes	IT	Richard Pruitt	vCISO (Virtual Chief Information Security) Services	5/26/2022	5/25/2023

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
June							
Milliman	$99,900.00	Yes	ACCT	Veronica Barker	D-SNP (Base, Level and Gap Analysis)	6/1/2022	5/31/2023
HMA	$99,000.00	Yes	ACCT	Veronica Barker	Actuarial Services (RDT, SDR's & Rate Analysis)	6/1/2022	5/31/2023
LDPq	$40,365.00	Yes	CS	Alonso Hurtado	floor)	6/4/2022	6/3/2025
Presidio	$50,550.00	Yes	IT	Richard Pruitt	Exchange Online Migration	6/14/2022	6/13/2023
Presidio	$57,174.00	Yes	IT	Richard Pruitt	SSRS Dashboard Discovery & Power BI implementation	6/14/2022	6/13/2023
TWE Solutions	$99,946.40	Yes	IT	Richard Pruitt	24x7 Managed Security services	6/14/2022	6/13/2023
Context4 Healthcare	$75,142.83	Yes	IT	Richard Pruitt	ICD-10 and CPT codes through AMA co-termed w/HCPCS codes	6/27/2022	6/27/2023
LDP	$41,535.00	Yes	CS	Alonso Hurtado	Support & maint. for 3 APC cooling units	6/4/2022	6/3/2025
JLL/Technologies	$38,752.00	Yes	CS	Alonso Hurtado	Cubicle resource scheduling app	6/28/2022	6/27/2023
July							
Spectrum	$61,164.00	Yes	IT	Richard Pruitt	1Gbps of Internet access	7/17/2022	7/16/2025
AT&T	$63,576.00	Yes	IT	Richard Pruitt	1Gbps of Internet access for KHS building	7/13/2022	7/12/2025
Rest and Reassure, LLC	$72,000.00	Yes	IT	Richard Pruitt	Consulting services for Cal-Aim & PHM dept requirements	7/15/2022	12/31/2022
Solution Bench	$76,461.95	Yes	IT	Richard Pruitt	M-files subscription base licenses & 2 add-on modules	7/23/2022	7/22/2022
CDW-G	$41,811.41	Yes	IT	Richard Pruitt	Juniper switches support & maint.	7/1/2022	6/30/2023
FluidEdge	$67,200.00	Yes	PNM	Amisha Pannu	PNM consultant, Katie Sykes	7/1/2022	9/30/2022
BG Healthcare Consulting	$30,000.00	Yes	PHM	Deborah Murr	Consulting services to audit KHS policies	7/13/2022	12/31/2022
August							
Octopai	$64,800.00	Yes	IT	Richard Pruitt	Data Lineage System	8/10/2022	8/9/2023
Cotiviti	$80,750.00	Yes	PHM	Deborah Murr	HRA outreach of SPD members	8/1/2022	7/31/2023
Dell	$98,099.72	Yes	IT	Richard Pruitt	(49) 5520 laptops	8/30/2022	8/29/2026
September							
CCS	$193,740.00	Yes	CS	Alonso Hurtado	Janitorial Services for KHS building	9/6/2022	9/5/2023
Spectrum	$84,480.00	Yes	IT	Richard Pruitt	Cloud Connect to Azure	9/24/2022	9/23/2024
The Periscope Group	$98,880.00	Yes	UM	Deb Murr	In-home assessment visits to members	9/5/2022	9/4/2023
JMD Solutions	$144,000.00	Yes	IT	Richard Pruitt	Kern Medical Data Extration and Transformation	9/26/2022	1/31/2023
TriZetto	$95,000.00	Yes	CL	Robin Dow-Morales	Electronic claims processing	9/6/2022	9/5/2025
October							
HMA	$99,150.00	Yes	COMP	Jane MacAdam	Dept	10/5/2022	5/30/2023
Catalyst Solutions	$90,720.00	Yes	IT	Richard Pruitt	D-SNP Advisor/ Program Manager	10/11/2022	12/31/2022
FluidEdge	$96,200.00	Yes	COMP	Jane MacAdam	Consulting services	10/4/2022	12/31/2022
Dell	$99,856.63	Yes	IT	Richard Pruitt	Additional (47) Dell Latitude 5530 Laptops	10/27/2022	10/26/2026
Optum	$61,177.00	Yes	IT	Richard Pruitt	Payment system	10/1/2022	4/30/2024

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
Secure-Centric	$191,889.68	Yes	IT	Richard Pruitt	Rubrik brick	10/20/2022	10/19/2023
Coffey Communications	$111,674.00	Yes	HE	Isabel Silva	Printing services Addendum	10/26/2022	2/14/2023
November							
FluidEdge	$62,400.00	Yes	PM	LaVonne Banks	NCQA Program Manager	11/1/2022	12/31/2022
December							
CDW-G	$67,420.75	Yes	HE	Richard Pruitt	Fortinet-Fortigate renewal and support co-termed	12/31/2022	12/31/2023
SHI	$122,471.74	Yes	IT	Richard Pruitt	(86) TelStrat Hosting licenses	12/1/2022	1/31/2026
Dell	$161,579.74	Yes	IT	Richard Pruitt	(76) Dell 5530 laptops	12/7/2022	12/6/2026
January							
Jacquelyn S. Jans	$135,840.00	Yes	MRK	Louie Iturriria	Marketing & Corporate Image Consulting	1/2/2023	12/31/2024
HD Dynamics	$50,000.00	Yes	PNM	Amisha Pannu	Consulting services for Microsoft Dynamics CRM	1/2/2023	12/31/2023
Rest and Reassure, LLC	$144,000.00	Yes	PHM	Deb Murr	Consulting services for Cal-Aim & PHM dept requirements	1/2/2023	12/31/2023
BG Healthcare	$189,000.00	Yes	PHM	Deb Murr	Consulting services	1/2/2023	12/23/2022
SHI	$51,094.74	Yes	IT	Richard Pruitt	VMWare renewal	1/1/2023	12/31/2023
Catalyst	$199,999.00	Yes	Exec	Michell Oxford	D-SNP and related Medicare health plan resource	1/30/2023	6/2/2023
Jennifer Clancy	$49,500.00	Yes	BH	Deb Murr	Behavioral Health Department Development	1/30/2023	5/30/2023
Lamar	$69,115.56	Yes	MRK	Louie Iturriria	(6) Billboards Advertising	1/23/2023	6/30/2024
Cotiviti	$175,000.00	Yes	QI	Jane Daughenbaugh	Medical record retrieval services	1/27/2023	5/31/2023

2022 TECHNOLOGY CONSULTING RESOURCES																	
ITEM	PROJECT	CAP/EXP	BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	YTD TOTAL	REMAINING BALANCE
#	Project Name																
1	*Community Based Organization Referral System*	*CAP*	$370,080	$15,440	$30,360	$20,160	$20,160	$0	$0	$0	$0	$0	$7,920			$94,040	$276,040
2	*Medical Management/Fraud, Waste, and Abuse Programs*	*CAP*	$500,000	$21,120	$35,798	$25,066	$17,472	$0	$0	$0	$0	$0				$99,456	$400,544
3	*Claims Workflow Conversion (QNXT)*	*CAP*	$472,800		$8,826	$51,501	$57,335	$40,726	$37,318	$45,317	$38,701	$18,094	$7,120	$0	$0	$304,938	$167,862
4	*Data Linage System*	*CAP*	$184,800	$17,472	$0	$19,320	$0	$0	$37,789	$0	$0	$0	$0	$15,840	$18,480	$108,901	$75,899
5	*Analytic Software (Power BI) Migration*	*CAP*	$124,800						$36,691	$17,472	$0	$0				$54,163	$70,637
6	*Communication Software Replacement*	*CAP*	$121,800					$17,600	$0	$23,920	$0	$0	$0	$0		$41,520	$80,280
8	*Staff Augmentation*	*EXP*	$7,393,315	$410,586	$359,294	$356,945	$344,059	$373,337	$342,030	$312,222	$427,515	$436,176	$513,823	$494,462	$594,583	$4,965,032	$2,428,283
	Totals:	**Totals**	**$9,167,595**	**$464,618**	**$434,278**	**$472,992**	**$439,026**	**$431,663**	**$453,828**	**$398,931**	**$466,216**	**$454,270**	**$528,863**	**$510,302**	**$613,063**	**$5,668,050**	**$3,499,545**

Updated 3/8/23

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
April 13, 2023

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 03/01/2023				
Advanced Dermatology and Cosmetic Care, A Medical Corp	DME	4100 Empire Dr Ste 120 Bakersfield CA 93309		4/1/2023
Avina Health Inc.	Clinical Pharmacy Services	2110 Truxtun Ave Ste 400 Bakersfield CA 93301	Non-Dispensing Pharmacy / Clinical Services Only	4/1/2023
Biological Laboratory Inc. dba: BioLab	Laboratory	2828 H Street Ste. E Bakersfield CA 93301		4/1/2023
Kern Podiatry-Foot and Ankle Clinic Inc dba: Dr. Nieto - Foot and Ankle Clinic	Podiatry	3535 San Dimas Street Bakersfield CA 93301	Existing Provider: Ruben Nieto DPM	4/1/2023
Kern Valleyidence Opco LLC dba: San Joaquin Nursing & Rehabilitation Center	SNF	3601 San Dimas Street Bakersfield CA 93301		**Retro-Eff 03/01/2023**
RY Williams MD Medical Corporation	General Surgery/Surg Onc.	2603 H Street Bakersfield CA 93301	Existing Provider: Rachel Williams MD	4/1/2023
Shivom Corporation dba: Ming Plaza Pharmacy	Pharmacy	2726-A Ming Avenue Bakersfield CA 93304		4/1/2023
PAC 04/05/2023				
Chaparral Medical Group, Inc.	Street Medicine	6501 Truxtun Avenue Bakersfield CA 93309	Existing Provider: Rishi Patel DO	**Retro-Eff 04/01/2023**
F&T 900 Inc dba: E Ride	Transportation	5300 California Ave Ste. 400A Bakersfield CA 93309		5/1/2023
Gina Gordon-Lopez dba: Social Stamina Behavior Consult Services Inc	ABA	1520 Brundage Lane Bakersfield CA	Existing Provider: Gina Gordon-Lopez	5/1/2023
Hassan Chahine MD Inc	IM/Hospitalist	Kindred Hospital 14148 Francisquito Ave Baldwin Park 845 N Lark Ellen Avenue West Covina		5/1/2023
HumanGood NorCal dba: Rosewood Health Facility	SNF	1401 New Stine Road Bakersfield CA		**Retro-Eff 04/01/2023**

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
April 13, 2023

Legal Name DBA	Specialty	Address	Comments	Term Effective Date
A-1 Oxygen, Inc.	DME/Oxygen	2015 Westwind Dr Ste. 9 Bakersfield CA	Site Closed	3/14/2023
Healing Care Hospice, Inc.	Hospice	2323 16th Street Ste. 306 Bakersfield CA	Business Dissolved	3/13/2023
Raj Gopal, MD	Cardiology	2828 H Street Ste. E Bakersfield CA	Business Dissolved	3/17/2023
Valley Medical Transportation, Inc.	Transportation	222 S Tipton Street Visalia CA	Business Dissolved	3/11/2023

KERN HEALTH SYSTEMS

TO: **KHS Board of Directors**

FROM: **Alan Avery, COO**

DATE: **April 13, 2023**

RE: **1st Quarter 2023 Operations Report**

Kern Health System's (KHS) Operational Departments started off the 2023 New Year in great fashion, continuing to meet and in many cases, exceed regulatory and health plan performance goals during the 1st Quarter. Operational efficiency and productivity continue to look great as we manage the increased claims submission, increased membership, and preparing to assist our members to renew their Medi-Cal coverage during the next twelve months beginning in April. Not only are we truly back to normal following the COVID-19 pandemic, but we are also about to enter an all-hands-on deck approach to ensure we retain all eligible KHS members.

Claims

We continue to break records in the number of incoming provider claims received every month with the 1st Quarter of 2023 reporting an increase of 136,000 claims submitted in comparison to the 1st Quarter of 2022. This increase can be attributed to the significant new increase in KHS membership, lack of member terminations due to the hold of the redetermination process, and members once again seeking healthcare services. There are no concerns with the increased number of claim receipts as 99% of those claims continue to be submitted electronically with only 1% of the claims received via paper. These paper claims are forwarded to a local partner (Stria) who scans the paper claims and converts them into an electronic file format allowing them to load electronically into the KHS claims workflow. Once loaded into the claims workflow, the QNXT core system processes them automatically. The auto adjudication on the claims increased slightly from 86% to 87%, meaning claims were received and processed without any manual intervention.

In 2022, the Claims Department implemented the Claims Provider Call Center where providers could contact the Claims Department directly with questions and concerns. Previously, providers would call the Member Services Department who would take a message and the Claims staff would return the call. Provider calls are now routed directly to the Claims staff who have on-line access to the claims processing and payment details. The staff managing these calls are seasoned Claims Processors III who can resolve most calls immediately or with minimal investigation. During the 1st Quarter of 2023 the Claims Provider Call Center received 8,981 calls, compared to 8,841 calls in the 4th Quarter of 2022 and 7,705 calls in the 3rd Quarter of 2022.

Member Services

Member and Provider call volume in the Member Services Department increased during the 1st Quarter of 2023 to 70,459 compared to the previous quarter with a volume of 68,025 calls. The top five reasons members call Member Services remain the same: (1) New Member questions, (2) Changing PCP, (3) Making demographic changes, (4) ID Card replacement and (5) Checking referral status. There was a total of 111,401 outbound calls made during the 1st Quarter of 2023. In comparison to 4th Quarter, there were an additional 47,621 calls made during the 1st Quarter of 2023, resulting in a 50% increase. This increase can be attributed to the significant new member growth in the 1st Quarter, as well as addressing gaps in care issues as members call on other non-related questions and concerns. When a gap in care is identified by the member services representatives, they help the member call their provider to set up an appropriate appointment to close the gap.

With the reopening of the building last July, members are once again wanting to meet face to face with member services representatives to address their questions. On-site member visits in the 1st Quarter increased by 60%, with 867 visitors to the building to address their questions and pick up new I.D. cards. We continue to successfully manage incoming phone activity by encouraging members to obtain their own personal account on the KHS Member Portal powered by the Zipari/HealthX member portal. Currently 60,112 members have online accounts which allows them to perform on their own all the top five reasons they would normally call Member Services

Provider Relations

On a quarterly basis, the Provider Network Management Department monitors network growth, capacity, and accessibility.

The Primary Care Provider (PCP) network increased by 10 providers while the specialty provider network decreased by one provider during the 1st Quarter. Our complete contracted provider network consisted of 3,407 providers at the close of the 1st Quarter.

The Provider Network Management Department monitors network capacity/adequacy via a Full-Time Equivalency (FTE) provider to member ratio, based on regulatory requirements. For PCPs, the regulatory standard is one FTE PCP for every 2,000 members; as of the 1st Quarter of 2023, the Plan maintains a network of one FTE PCP for every 1,828 members, meeting the requirement. The Plan is also required to maintain a network of one FTE physician for every 1,200 members; as of the 1st Quarter of 2023, the Plan maintains a network of one FTE Physician for every 395 members, meeting the requirement. Even as our membership continues to grow, the Plan's network continues to meet all regulatory capacity/adequacy requirements. The Plan's Provider Network Management Department maintains ongoing recruitment and contracting efforts to promote network growth and ensure access to care for Plan members.

The last key provider network indicator that we continually monitor, and report is PCP and Specialty care appointment availability. Non-urgent PCP appointments must be available within 10 days. We reported 3.5 days during the 1st Quarter of 2023. Non-urgent appointments with a specialist must be available within 15 days. Our specialist appointment are currently 10.6 days.

Human Resources

During the 1st Quarter of 2023, the Human Resources Department continued to support the increased recruiting efforts of the Health Plan, including scheduling 160 interviews, onboarding 43 new hires and recruiting for 27 open positions. In addition, they launched an Employee Book Club, introduced a Yoga course, and started quarterly retirement seminars. The department also conducted 30 instructor lead courses totaling over 84 classroom hours with 360 employees participating. Lastly, the department organized the first KHS sponsored onsite career fair. Over 300 attendees attended the event and generated significant increase in job interests. During the first quarter 1,200 applications were received for open positions compared to 699 applications for the last three quarters combined (March-December) of 2022.

Staffing increased to 518 employees in the 1st Quarter with employee turnover at a modest 4.80%. We had 4 employees who left KHS voluntarily for other positions and 2 employees who retired.

Grievance Report

The grievance report for the 1st Quarter of 2023was cutoff on March 24th and no estimations for the remaining week was made given the diversity and volume of the incoming grievances. It appears total grievances (formal and exempt) will continue to follow similar trends of 2022 activity with formal grievances continuing to be the driver to that trend while exempt grievance are on a general decline. Even though there has been a sizeable decrease in exempt cases, it may have been caused by a significant increase in Potential Inappropriate Care and Quality of Services grievances.

The Department of Health Care Services (DHCS) requires health plans to forward copies of all member discrimination grievances within 10 days to the DHCS Office of Civil Rights when members allege discrimination based on any characteristic protected by federal or state nondiscrimination laws. Characteristics protected by federal or state nondiscrimination laws include sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental ability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, or health status. The plan received 49 grievances classified as discrimination during the 1st Quarter compared to 46 received during the previous quarter. All discrimination grievances were reported timely to DHCS Office of Civil Rights.

Part two of the Grievance Report is the disposition of the formal grievances. All formal grievances are now sent to the Quality Department for clinical review to identify Potential Inappropriate Care issues. Following their review of the 1306 grievances received, 539 of the decisions were upheld, 185 required further review, 384 were overturned and ruled in favor of the member, and 198 cases are still under review. The Quality Department has not identified any trends that need to be addressed. The primary reason for overturning the original decision of the grievance occurs when we receive additional supporting documentation from the member or the provider.

Lastly, to fully understand the dynamics and relativity of the grievance volume, the plan calculates the number of grievances received in relation to the number of medical visits and the enrollment. During the 1st Quarter, there was over a million medical encounters provided to our 360,000 members many of whom are new to managed care. KHS received 1.24 grievances per 1,000 members, below the average of the other Local Health Plan averages between 1.00 – 3.99 per month.

1st Quarter 2023 Operational Report

Alan Avery
Chief Operating Officer
April 13, 2023

1st Quarter 2023 Claims Department Indicators

Activity	Goal	1st Quarter 2023	Status	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter 2022
Claims Received		**1,049,582***		958,308	982,337	954,234	913,452
Electronic	95%	**99%**		99%	99%	98%	98%
Paper	5%	**1%**		1%	1%	2%	2%
Claims Processed Within 30 days	90%	**95%**		99%	99%	99%	99%
Claims Processed within 45 days	95%	**99%**		99%	99%	99%	99%
Claims Processed within 90 days	99%	**100%**		100%	100%	100%	99%
Claims Inventory-Under 30 days	96%	**99%**		99%	99%	99%	99%
31-45 days	<3%	**<1%**		<1%	<1%	1%	<1%
Over 45 days	<1%	**<1%**		<1%	<1%	<1%	<1%
Auto Adjudication	85%	**87%**		86%	85%	87%	88%
Audited Claims with Errors	<3%	**2%**		<2%	2%	2%	1%
Claims Disputes	<5%	**<1%**		<1%	1%	1%	1%
Provider Calls (New Category)				8841	7705		

*3/17/2023 reporting cutoff. Estimated 10 additional days of claims

KERN HEALTH SYSTEMS

1st Quarter 2023 Member Service Indicators

Activity	Goal	1st Quarter 2023	Status	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter 2022
Incoming Calls		**68,925***		56,216	66,020	66,410	70,459
Abandonment Rate	<5%	**4%**		1%	1.00%	1.00%	3.39%
Avg. Answer Speed	<2:00	**:53**		:16	:09	:05	:23
Average Talk Time	<8:00	**8:50**		8:14	7:34	7:22	7:10
Top Reasons for Member Calls	Trend	**1. New Member** **2. PCP Change** **3. Demographic Changes** **4. ID Card** **5. Referrals**		1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demo 4. Referrals 5. ID Card
Outbound Calls	Trend	**111,401***		72350	85,326	77,818	89,784
# of Walk Ins	Trend	**867**		540	204	0	0
Member Portal Accounts-Q/Total	4%	**2977** **60112** **(16.37%)**		2778 57145 (16.41%)	4058 54,361 (15.93%)	3163 50,303 (15.09%)	3640 47,937 (14.70%)

*3/24 Reporting Cutoff. Estimated 5 additional days of incoming & outbound calls

KERN HEALTH SYSTEMS

1st Quarter 2023 Provider Network Indicators

Activity	Goal	1st Quarter 2023	Status	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter 2022
Provider Counts							
# of PCP		438		428	434	441	441
% Growth		2.34%		(1.38%)	(1.81%)	0%	3.76%
# of Specialist		504		505	495	448	442
% Growth		[.20%]		2.02%	10.49%	1.34%	[.45%]
FTE PCP Ratio	1:2000	1:1828		1:1755	1:1759	1:1938	1:1893
FTE Physician Ratio	1:1200	1:395		1:393	1:507	1:704	1:685
PCP	< 10 days	3.5 days		2.8 days	4.3days	6.5days	4.1 days
Specialty	< 15 days	10.6 days		6.9 days	12.2 days	9.5 days	11.4 days

KERN HEALTH SYSTEMS

1st Quarter 2023 Human Resources Indicators

Activity	Budget	1st Quarter 2023	Status	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter 2022
Staffing Count	592	**518**		486	480	478	459
Employee Turnover	12%	**4.80%**		8.53%	8.97%	8.8%	6.32%
Turnover Reasons	Voluntary (4) Involuntary Retired (2)	**66.6%** **0%** **33.3%**		68% 15% 17%	61% 16% 23%	65% 10% 25%	85.7% 0% 14.3%

KERN HEALTH SYSTEMS

1st Quarter 2023 Grievance Report

Category	Q1 2023*	Status	Issue	Q4	Q3	Q2	Q1 2022
Access to Care	107		Appointment Availability	108	132	117	169
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	312		Questioning denial of service	335	346	259	138
Other Issues	48		Miscellaneous	38	30	20	41
Potential Inappropriate Care	627		Questioning services provided. All cases forwarded to Quality Dept.	670	514	415	479
Quality of Service	163		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	156	86	120	125
Discrimination (New Category)	49		Alleging discrimination based on the protected characteristics	46	73	34	15
Total Formal Grievances	1306			1353	1181	965	967
Exempt	1564		Exempt Grievances-	1816	2328	2087	1404
Total Grievances (Formal & Exempt)	2870			3169	3509	3052	2371

***3/24 Reporting Cutoff. No estimations.**

KHS Grievances per 1,000 members – 1.24/month.
LHPC Average 1.0 – 3.99/month

KERN HEALTH SYSTEMS

Additional Insights-Formal Grievance Detail

Issue	2023 1st Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	**64**	**31**	**0**	**14**	**19**
Coverage Dispute	**0**	**0**	**0**	**0**	**0**
Specialist Access	**43**	**15**	**0**	**16**	**12**
Medical Necessity	**312**	**100**	**0**	**132**	**80**
Other Issues	**48**	**31**	**0**	**3**	**14**
Potential Inappropriate Care	**627**	**252**	**185**	**190**	**0**
Quality of Service	**163**	**80**	**0**	**29**	**54**
Discrimination	**49**	**30**	**0**	**0**	**19**
Total	**1306**	**539**	**185**	**384**	**198**

KERN HEALTH SYSTEMS

Questions

For additional information, please contact:

Alan Avery
Chief Operating Officer
(661) 664-5005

KERN HEALTH SYSTEMS

To: **KHS Board of Directors**

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

Date: **April 13, 2023**

Re: **Health Services Trend Report**

KHS Population Health Management

AS part of the California Advancing and Innovating Medi-Cal (CalAIM), DHCS is moving Medi-Cal toward a population health approach that prioritizes prevention and whole-person care.

This approach to care offers Medi-Cal members coordinated and equitable access to services that address their physical, behavioral, developmental, dental, and long-term care needs throughout their lives, from birth to a dignified end of life. To meet this CalAIM requirement, in January 2023 KHS implemented a Population Health Management (PHM) Program.

KHS has developed a comprehensive Population Health Management (PHM) Model of Care (MOC) that identifies and addresses members unique health and psychosocial needs at all points along the continuum of care. The MOC helps ensure KHS targets the right population and implements appropriate assessments and interventions to improve the quality of care while also driving down costs. KHS utilizes a risk stratification, a simple yet effective method that sorts patients into distinct groups of similar complexity and care needs. For individual Members, KHS aims to increase the self-awareness, improve self-management skills, and assist the Member in setting and achieving goals for healthy lifestyle behavior change.

KHS has identified the following high risk populations and implemented programs:

- 596 members with the diagnosis of COPD in addition to 6 other chronic conditions and a high risk of admission in 6 months. KHS out reached to these members and was able to enroll 434 of them into a COPD program.
- Members at risk of complex transitions. We identified 4874 members at risk of complex transitions as they were admitted to the hospital. We were able to enroll 534 of them into the TOC program. The transitional of care clinics ensure that our members who have complex needs move seamless through the care continuum from acute to back home with disruption of their care. Those who do not have a home, we provide support, so they stay at the least restrictive environment that meets their care needs. Our goal is to expand.
- ER Navigation program is a program at one of our hospital ER where KHS has a team including a physician to coordinate and arrange follow up care for our members who go to ER but might be admitted just because they need follow up care which if not provided will negatively affect their health.

So far, we are seeing significant reductions in utilization of ER, UC and acute hospital services by the cohorts of members enrolled in these programs.

Program	Enrolled	ER utilization Reduction/1000	UC utilization Reduction/1000	Acute admissions Reduction/1000
COPD	**434**	**86**	**23**	**23**
Transitions of Care	**535**	**149**	**28**	**120**
ER Navigation	**481**	**125**	**5**	**26**

We are currently working on an obesity, Diabetes, Maternal Mental Health, and an End Stage Renal Disease program.

Medical Cost and Utilization Trend Analyses: (Attachment A)

Physician Services: *(*PCPs, Specialist, Hospitalist and Ancillary Services):

The utilization of physician services by all Aide codes in for the first two months of 2023 has remained stable for all Aide codes even though the SPDs are above projections. This is a welcomed finding which signals that our members were going to their doctors to get the routine care they need.

The SPD population is made up of mainly members with multiple chronic conditions and we see this in the number of visits per 1000/member.

The top 3 diagnosis driving utilization of professional services are Chronic kidney /end staged kidney disease, Hypertension, and diabetes. These diagnoses require frequent routine doctor visit to keep them under control. These 3 diagnoses are the focus of our population health programs. Our goals to ensure that these diseases are control, reduce complications, identify social and behavioral factors that influence their development. This will help develop holistic interventions to manage these members in collaboration with other community organizations and their primary care provider.

In-Patient Utilization

The overall PMPM for inpatient utilization for all aid codes remained stable and close to projection for January and February 2023.

For all Aide codes combined, the top 4 reasons for inpatient stay related to pregnancy and delivery. We have on the average 400 deliveries every month.

Most of the inpatient stays are at Kern Medical with BMH a close second. KHS Population health programs are focusing on care coordination and safe transitions of our members through the continuum of care. This focus will ensure that there is continuity of care at all levels of the system and reduction of readmissions to the acute hospital.

Emergency Room (ER)

The number of ER visits remained at or below projections for all of 2023. Most of our members continue to use Bakersfield Memorial Hospital for ER services. The most frequent diagnoses associated with an ED visit in all combine Aide codes in February 2023 was upper respiratory infections followed by chest pain and urinary tract infections.

Obstetrics Services

The primary C/Section (18%) in February, 2023 is below the State averages. Most of the deliveries are occurring at Bakersfield memorial hospital and Kern Medical Hospital

MCAS Tracking Update

The purpose of this report is to show, in "real time", how KHS is performing year-to-date in the MCAS measurement categories. For the most part, the data for this report is based on information from medical service claims. The report compares the current month performance against the plan performance the same moth in the previous year and against the Minimum Performance Level (MPL) set by the State.

Each measurement count requires a patient encounter specific to service(s), that when performed, will indicate the measurement was met for that patient. All KHS members identified as having the medical condition associated with the measurement represent the denominator. When members receive service(s), it is recorded as "compliant" becoming part of the numerator. The level of achievement is shown as the percentage (%) of members receiving the required (service(s). The minimum target performance percentage (MPL) is established by DHCS each year and the previous year's MPL is used here to determine how well our MCAS program performs against this standard.

The state has increased the number of measures that we are held to the MPL from 15 in 2022 to 18 in 2023.

Interventions to improve our performance in MCAS:

- Develop a Quality Improvement & MCAS 101 e-learning education program for designated member and provider-facing KHS departments and provider groups.
- Develop a provider guide & coding card with descriptions of MCAS measures for current measure year & MCAS codes for compliance and tips for improving measure performance.

- Realigned Physician Pay for Performance (P4P). Incentivized physicians to go over and beyond to close gaps in care. Providers were educated of all changes to program and the strategic focus for 2023, modification to the P4P to tie performance to minimal performance level (MPL) compliance and changed the frequency of payment from quarterly to monthly.
- Obtaining EMR access and cross walking data to reflect real-time compliance.
- Receiving appointment data exchange from providers in order to review gaps in care closure opportunities.
- Ongoing Baby Steps program. Monthly education guides are sent to members regarding prenatal and postpartum care - including what to expect during pregnancy and after. Additionally, there are resources to help track appointments for moms and babies.
- 1st Quarter 2023, Member Engagement Reward Program Campaigns, included:
    - Text message to encourage members to schedule their preventative health services and inform them of incentive rewards.
    - Mailers sent out to 85K households encouraging members to schedule preventative health care services.
    - Provider Bulletin update on Well Child Visits.
    - Robocalls to members who were unable to be reached by text or live calls.
- Social Media Posts educating and encouraging members to schedule preventative health care screenings (Cervical Cancer, A1C testing, Prenatal visits).
- Operationalizing the outreach program. Partnering with all members facing departments to ensure all outreach efforts support each other and develop a robust process to ensure there is no duplication of efforts.
    - Conducted an in-service meeting with Outreach team. The objectives of the in-service were the following:
        - Provide an overview of MCAS measures.
        - Inform of KHS historical MCAS performance
        - Inform of the critical role they play in outreaching to the members.
    - The Strike team will continue to meet with the outreach team regularly to get feedback from them on opportunities to improve the process.
    - By stratifying the data by ages, the outreach team prioritize calling members aging out of measures (WCV, CIS-10, IMA-2, LSC.W30) within the next 45 days to schedule preventative health care services.

- Updating member incentives to incentivize members for completing A1C testing.
- Collaborating with *Early Head Start/ Head Start* program to focus on early childhood immunizations and lead screening.
- Engaging with California Farmworker Foundation to focus on preventative health care screenings.
- Initiate partnership with mobile unit providers to host mobile clinics in different geographical areas for preventative health services.
- Pilot point of service gift cards for closing gap in care.
- Partnered with local Telehealth organization to outreach, schedule, and complete follow up visits for members who have been to ER for substance use disorders and/or BH issues.
- 3/29 – Kickoff of Monthly KHS Provider Partnership Webinar
    - Purpose - to provide a platform for KHS and Providers to collaborate in order to discuss best practices, barriers, opportunities for improvements and to provide regulatory & organizational updates.
    - Over 50 plus provider groups attended.

Summary of 18 Measures held to MPL for MY2023:

- 2 new measures for 2023
- 1 measure meeting MPL
- 9 measures compliance rate increase from last year this time
- 6 measures compliance rate slightly below from last year this time

Kern Health Systems

KHS Medical Management Performance Dashboard (Critical Performance Measurements)

KERN HEALTH SYSTEMS

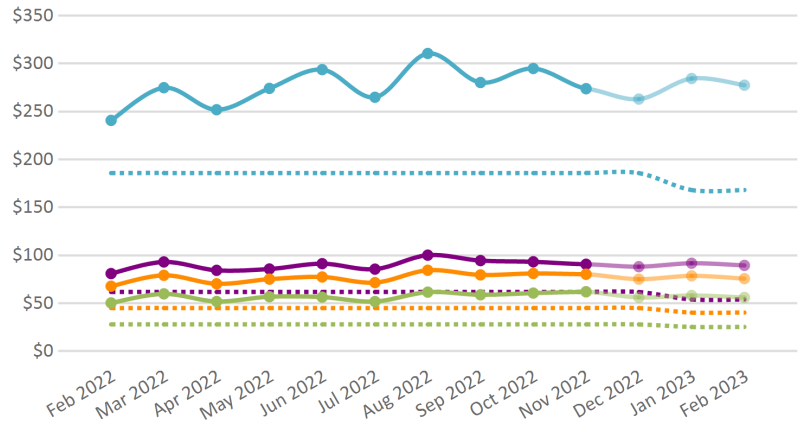
Governed Reporting System

Physician Services

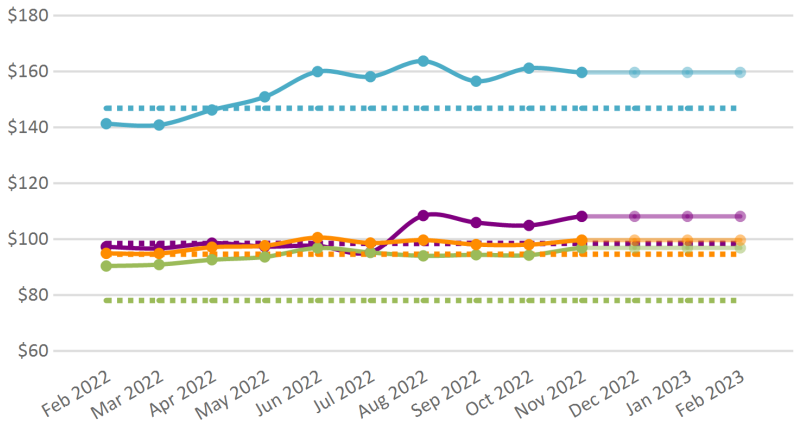
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

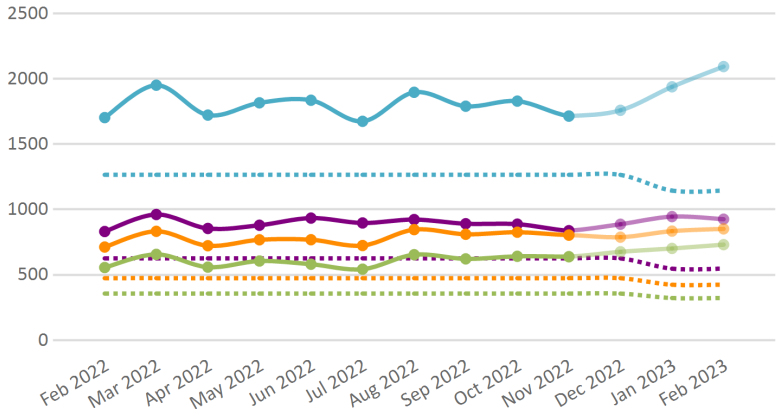
Professional Services Incurred by Aid Group PMPM



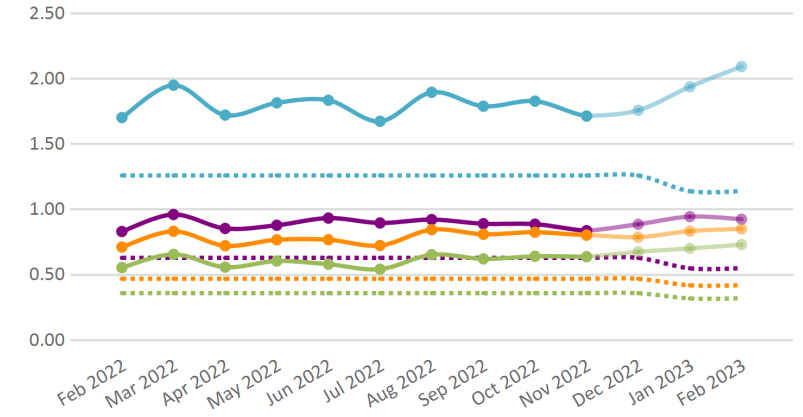
Cost per Professional Service Visit by Aid Group



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



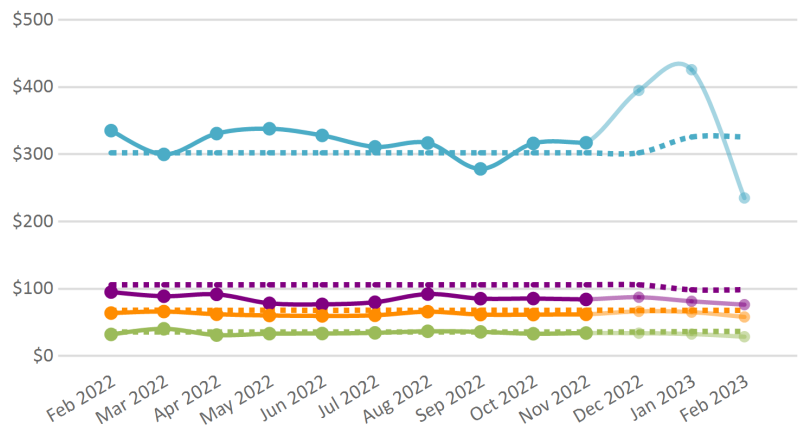
Professional Service Visits per Member per Month by Aid Group



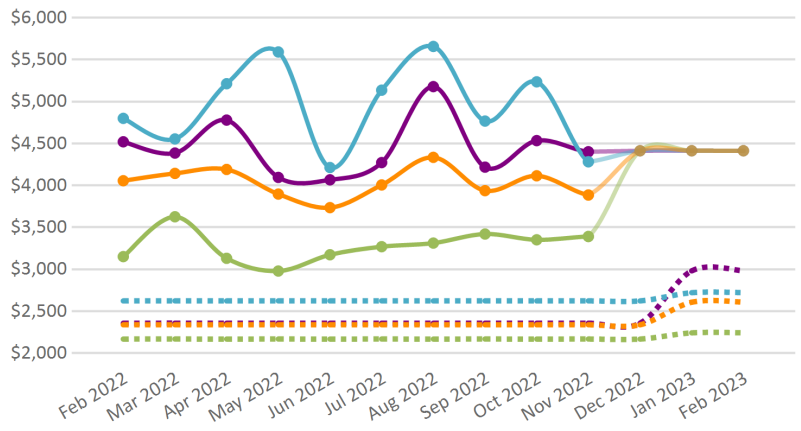
Inpatient

(Includes: Inpatient Hospital Claims)

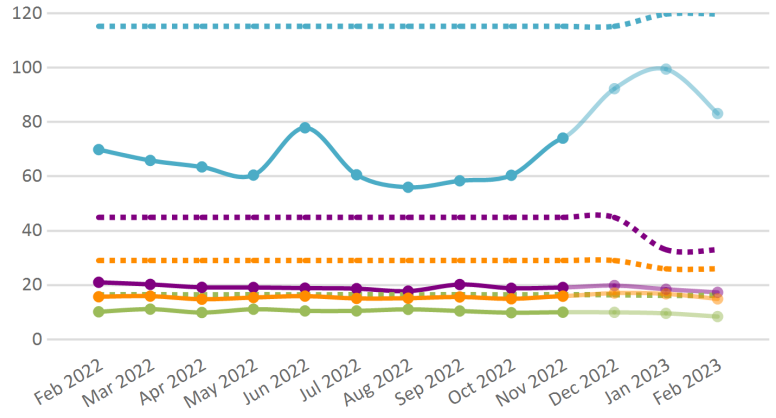
Inpatient Services Incurred by Aid Group PMPM



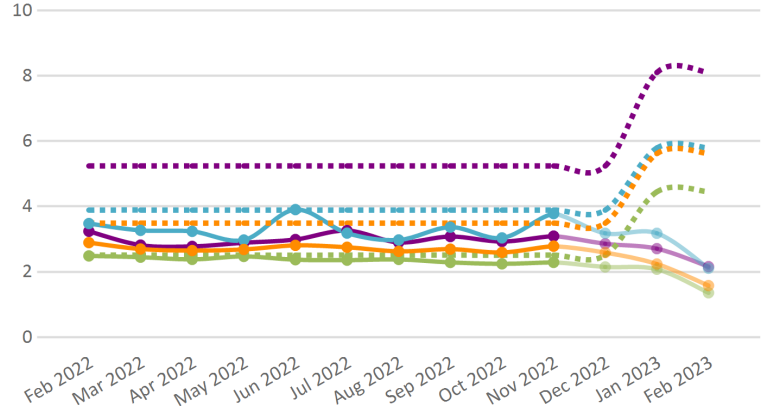
Cost Per Bed Day by Aid Group



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



Average Length of Stay in Days by Aid Group

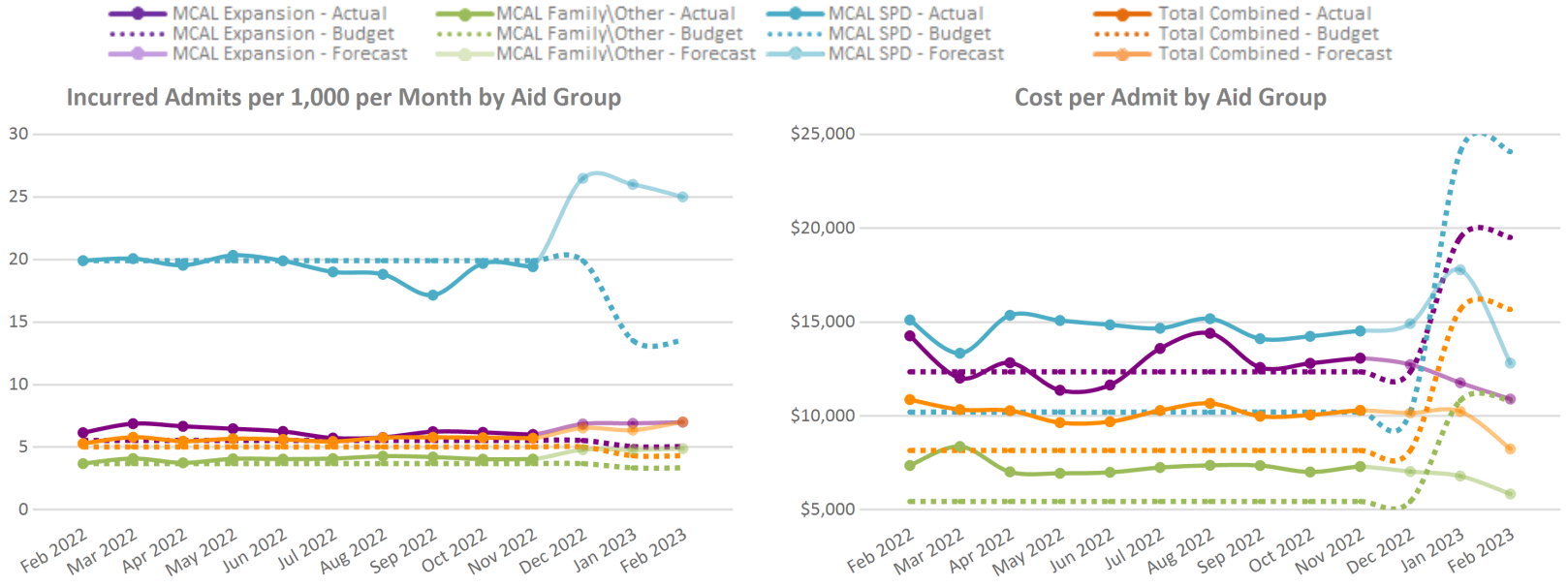


KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient

(Includes: Inpatient Hospital Claims)



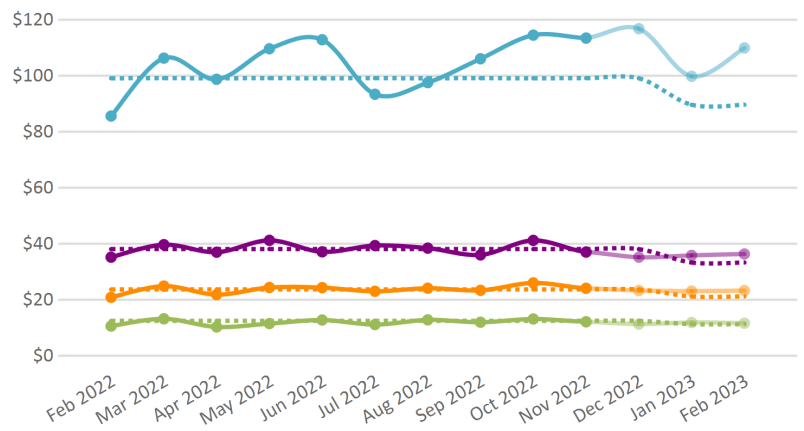
KERN HEALTH SYSTEMS

Governed Reporting System

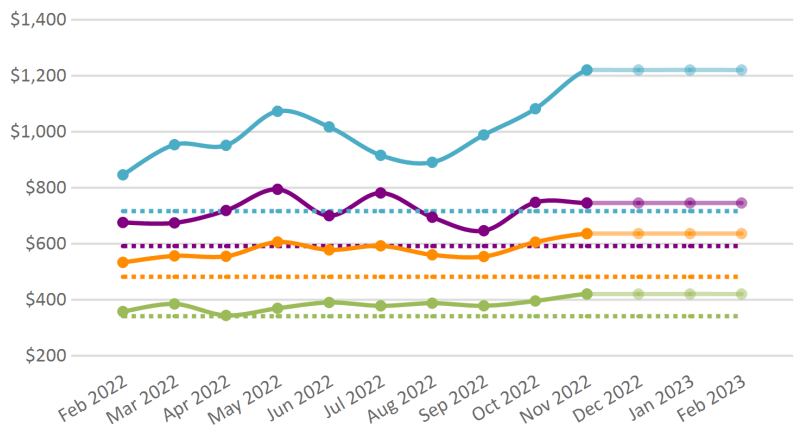
Outpatient Hospital

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

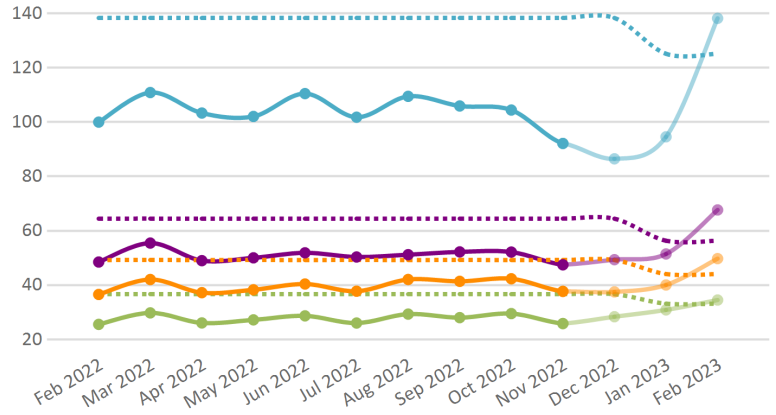
Outpatient Services Incurred by Aid Group PMPM



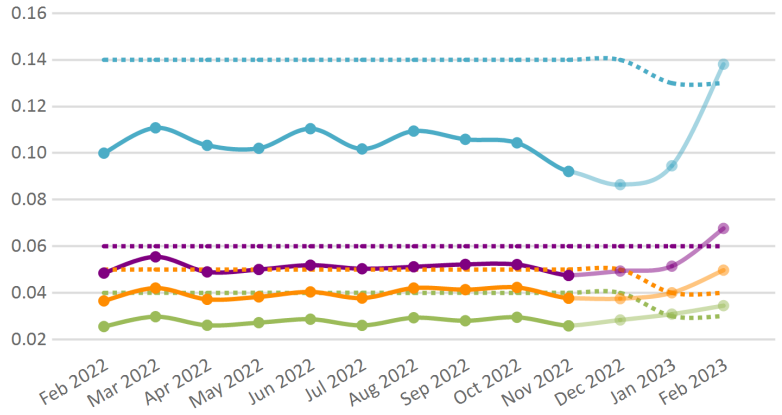
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



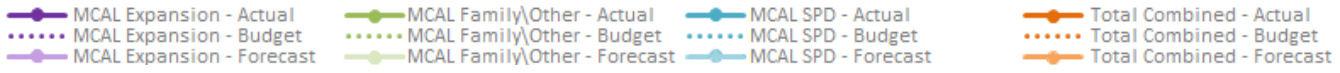
Outpatient Visits per Member per Month by Aid Group



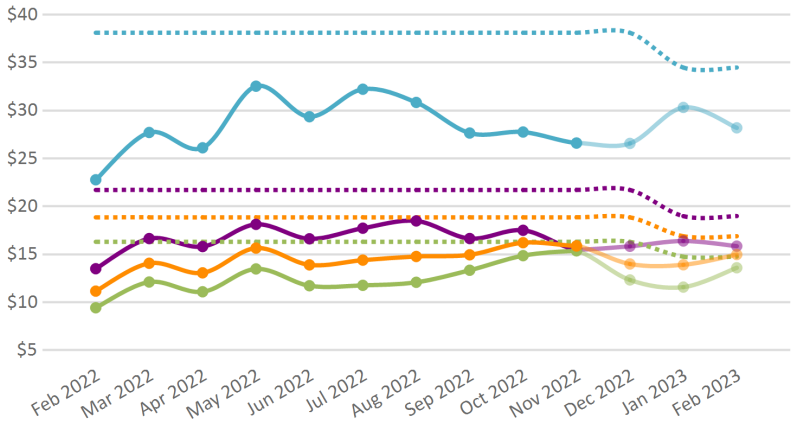
KERN HEALTH SYSTEMS

Governed Reporting System

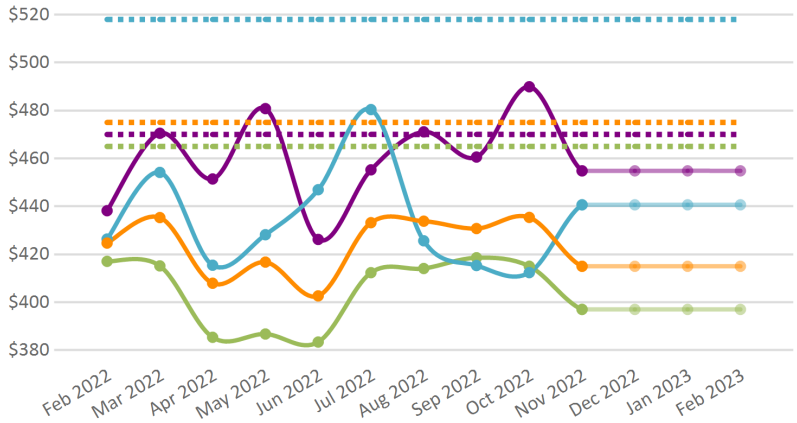
Emergency Room



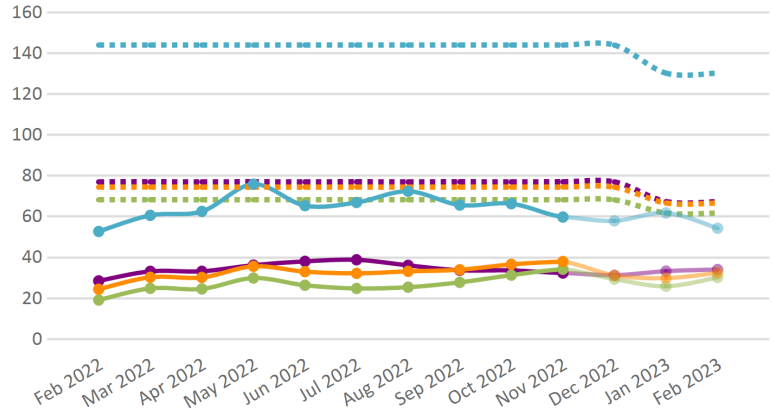
ER Services Incurred by Aid Group PMPM



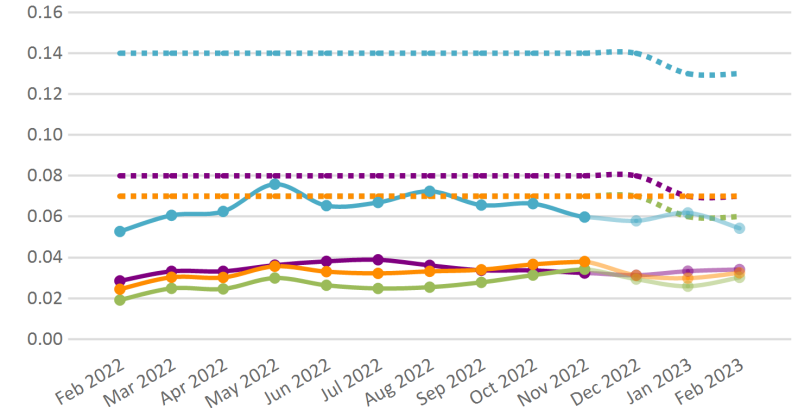
Cost Per ER Visit by Aid Group



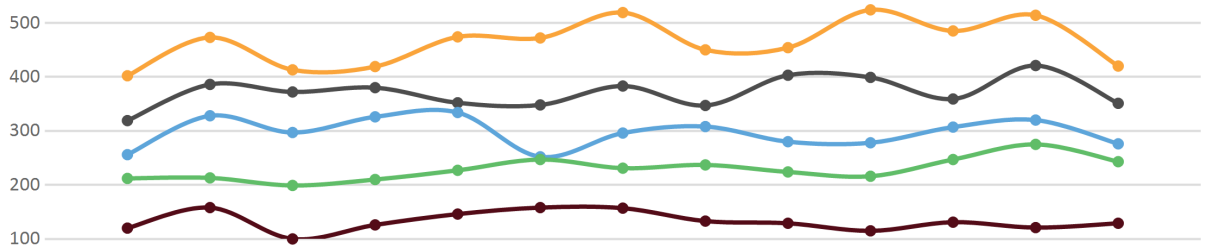
ER Visits per 1,000 per Month by Aid Group



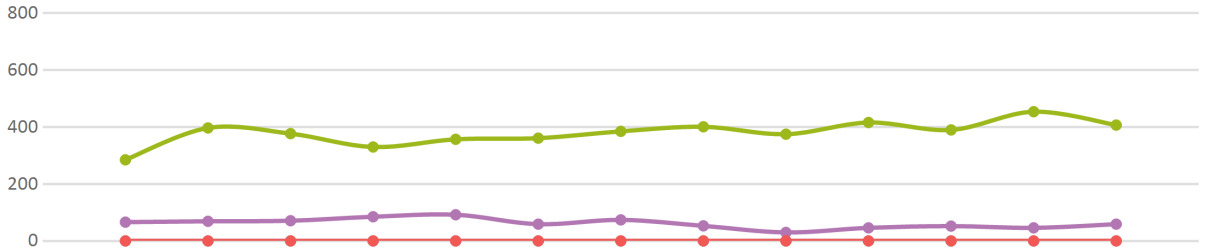
ER Visits per Member per Month by Aid Group



Inpatient Admits by Hospital



	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
KERN MEDICAL	402	473	413	419	474	472	519	450	454	524	485	514	420
BAKERSFIELD MEMORIAL	319	386	372	380	352	348	383	347	403	399	359	421	351
ADVENTIST HEALTH	256	328	297	326	334	252	296	308	280	278	307	320	276
MERCY HOSPITAL	212	213	199	210	227	247	231	237	224	216	247	275	243
GOOD SAMARITAN HOSPITAL	120	158	100	126	146	158	157	133	129	115	131	121	129

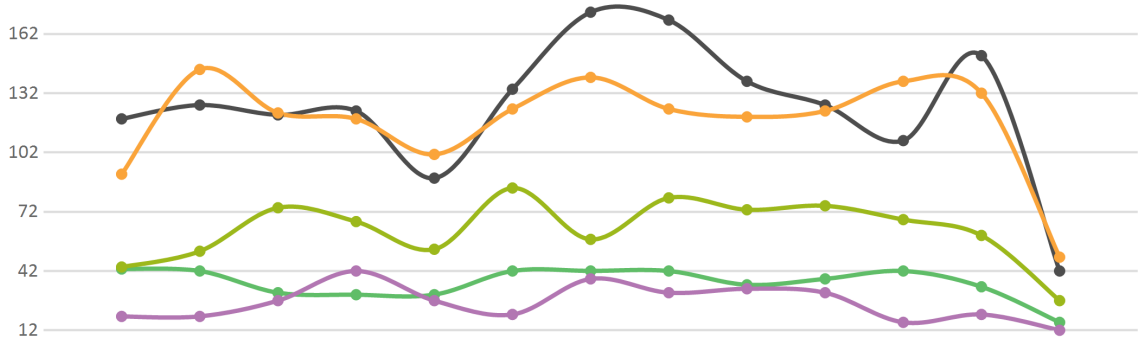


	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
DELANO REGIONAL HOSPITAL	66	69	71	85	92	59	74	53	30	46	52	46	59
OUT OF AREA	285	397	377	330	357	361	385	401	375	416	390	454	407
BAKERSFIELD HEART HOSP	38	37	22	37	42	34	44	31	34	34	37	33	47

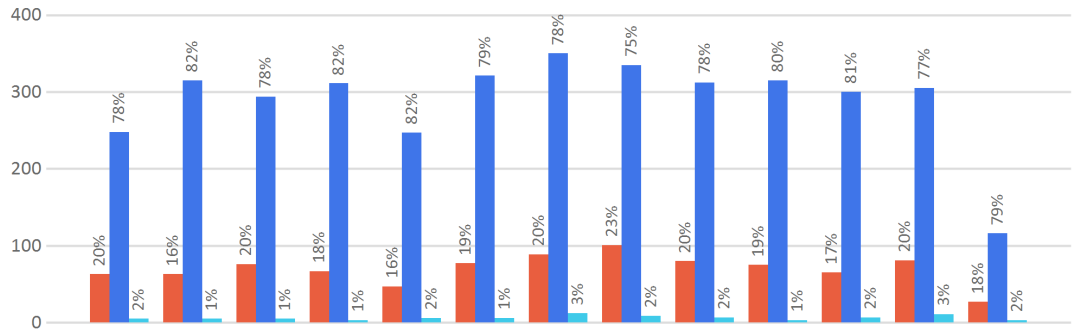
KERN HEALTH SYSTEMS

Governed Reporting System

Obstetrics Metrics

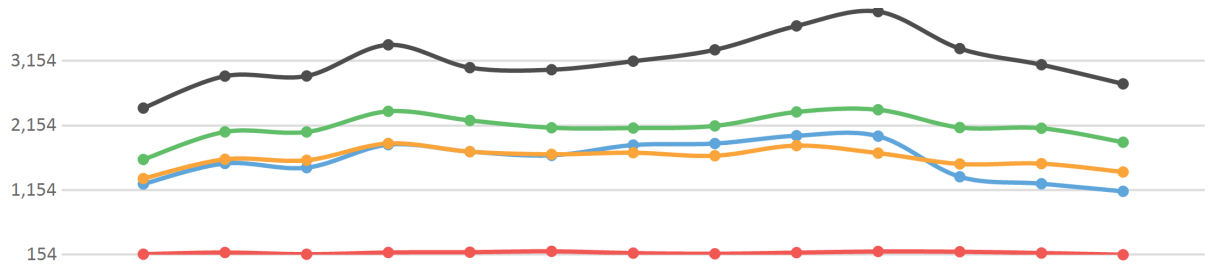


	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
BAKERSFIELD MEMORIAL	119	126	121	123	89	134	173	169	138	126	108	151	42
KERN MEDICAL	91	144	122	119	101	124	140	124	120	123	138	132	49
OTHER	44	52	74	67	53	84	58	79	73	75	68	60	27
MERCY HOSPITAL	43	42	31	30	30	42	42	42	35	38	42	34	16
DELANO REGIONAL HOSPITAL	19	19	27	42	27	20	38	31	33	31	16	20	12

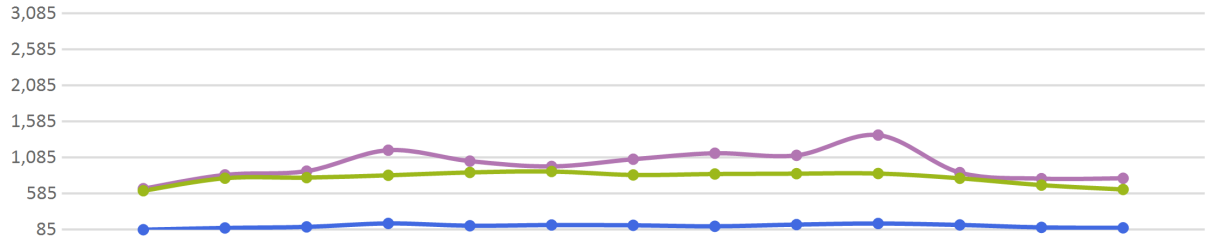


	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
VAGINAL DELIVERY	248	315	294	311	247	321	350	335	312	315	300	305	116
C-SECTION DELIVERY	63	63	76	67	47	77	89	101	80	75	65	81	27
PREVIOUS C-SECTION DELIVERY	5	5	5	3	6	6	12	9	7	3	7	11	3

Emergency Visits by Hospital



	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
BAKERSFIELD MEMORIAL	2,424	2,919	2,921	3,403	3,050	3,018	3,150	3,326	3,696	3,918	3,345	3,095	2,799
MERCY HOSPITAL	1,628	2,056	2,054	2,374	2,233	2,119	2,115	2,148	2,364	2,398	2,123	2,112	1,895
KERN MEDICAL	1,333	1,631	1,616	1,876	1,749	1,708	1,733	1,686	1,843	1,727	1,559	1,564	1,434
ADVENTIST HEALTH	1,249	1,567	1,502	1,857	1,749	1,692	1,852	1,875	1,996	1,989	1,361	1,253	1,135
BAKERSFIELD HEART HOSP	162	188	161	188	193	206	178	168	186	204	200	180	154



	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
DELANO REGIONAL HOSPITAL	654	845	897	1,187	1,036	962	1,062	1,145	1,116	1,397	877	793	798
OUT OF AREA	625	799	807	839	879	892	844	857	862	864	798	703	643
KERN VALLEY HEALTHCARE	85	109	124	172	140	150	146	132	156	171	151	117	111

MCAS MY2023 Performance Trending Metrics through April 2023

AMR	BCS	CBP	CCS	CDEV
67.16 %	44.95 %	24.84 %	45.47 %	9.06 %
MPL: 64.78% Over MPL by 2.38% AMR is not held to MPL. Previous YTD: 69.20%	MPL: 50.95% Under MPL by 6.00% Previous YTD: 45.07%	MPL: 59.85% Under MPL by 35.01% Previous YTD: 14.35%	MPL: 57.64% Under MPL by 12.17% Previous YTD: 41.90%	MPL: 35.60% Under MPL by 26.54% Previous YTD: 5.50%

CHL Adults and Peds	CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	HBD HBA1C >9%
34.11 %	14.49 %	10.68 %	10.18 %	83.45 %
MPL: 55.32% Under MPL by 21.21% Previous YTD: 34.62%	MPL: 34.79% Under MPL by 20.30% Previous YTD: 15.22%	MPL: 21.24% Under MPL by 10.56% Previous YTD: 8.83%	MPL: 54.51% Under MPL by 44.33% Previous YTD: 12.76%	MPL: 39.90% Under MPL by 43.55% Inverted Measure Previous YTD: 81.34%

IMA	LSC	PPC Post	PPC Pre	TFLCH
22.44 %	48.92 %	57.36 %	26.42 %	11.21 %
MPL: 35.04% Under MPL by 12.60% Previous YTD: 24.23%	MPL: 63.99% Under MPL by 15.07% Previous YTD: 40.89%	MPL: 77.37% Under MPL by 20.01% Previous YTD: 59.68%	MPL: 85.40% Under MPL by 58.98% Previous YTD: 29.77%	MPL: 50.00% Under MPL by 38.79% Previous YTD: 9.03%

KERN HEALTH SYSTEMS

Governed Reporting System

MCAS MY2023 Performance Trending Metrics through April 2023

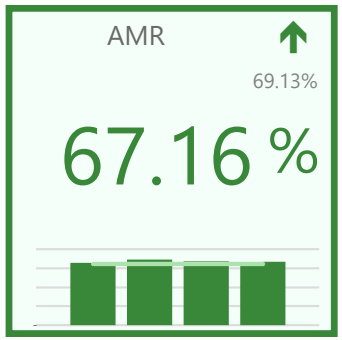
W30 0 - 15 Months	W30 15 - 30 Months	WCV
29.97 %	51.11 %	8.54 %
MPL: 55.72% Under MPL by 25.75% Previous YTD: 34.57%	MPL: 65.83% Under MPL by 14.72% Previous YTD: 48.74%	MPL: 48.93% Under MPL by 40.39% Previous YTD: 10.62%

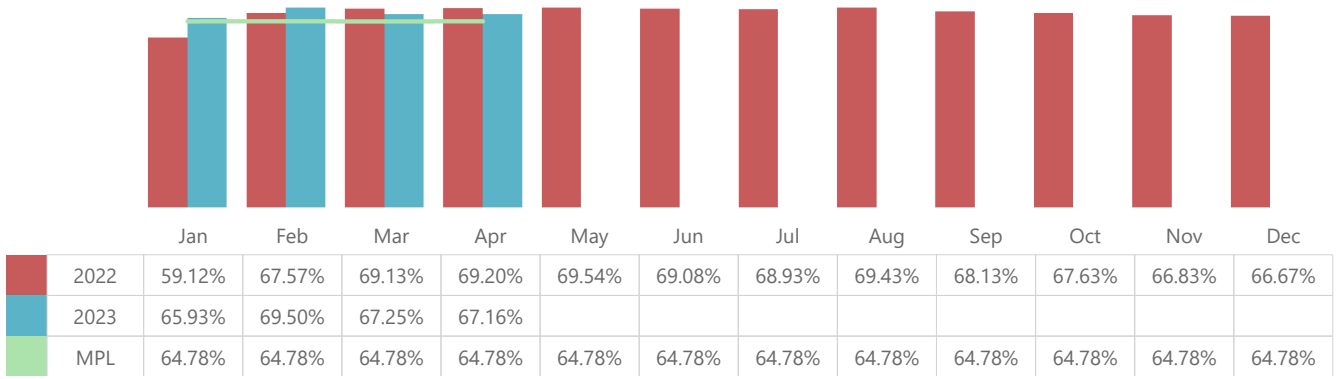
Measure rates do not include medical record reviews nor chart reviews

MCAS MY2023 Performance Trending Metrics through April 2023

Asthma Medication Ratio

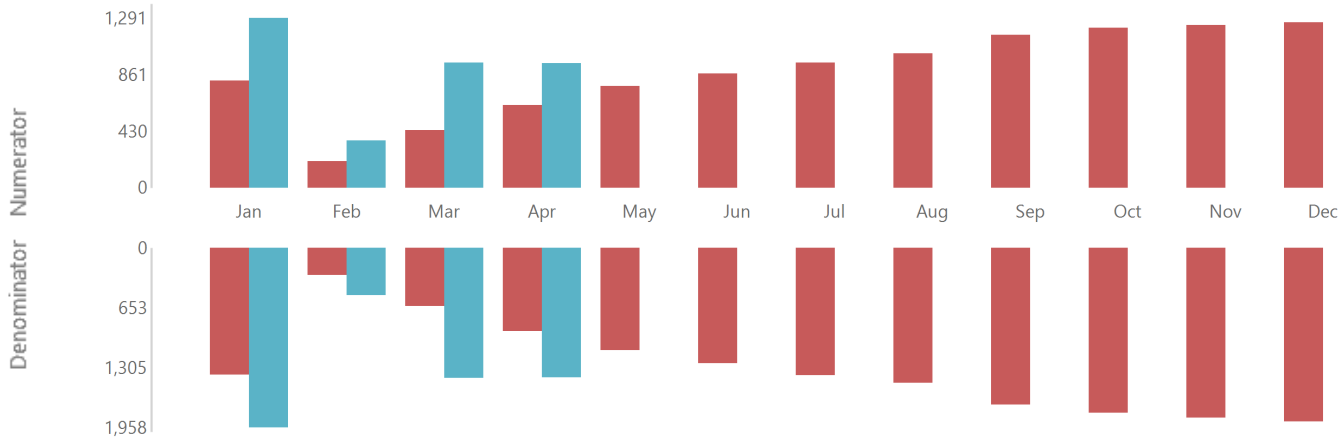
The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
This measure is not held to MPL.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	59.12%	67.57%	69.13%	69.20%	69.54%	69.08%	68.93%	69.43%	68.13%	67.63%	66.83%	66.67%
2023	65.93%	69.50%	67.25%	67.16%								
MPL	64.78%	64.78%	64.78%	64.78%	64.78%	64.78%	64.78%	64.78%	64.78%	64.78%	64.78%	64.78%

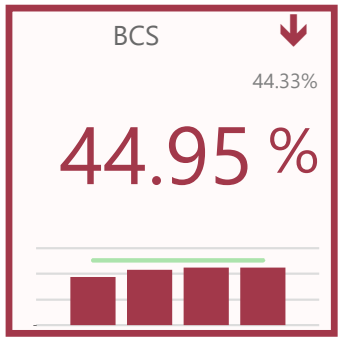
949
1,413

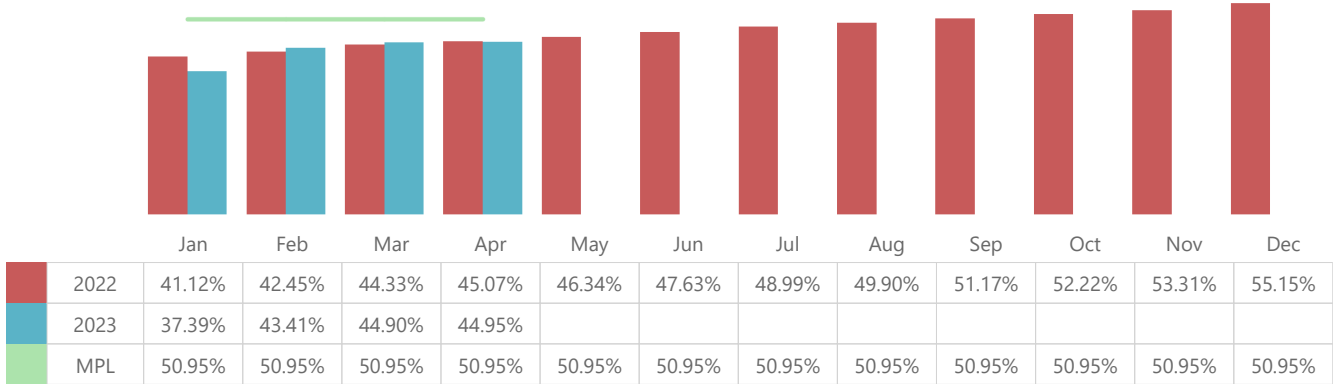


MCAS MY2023 Performance Trending Metrics through April 2023

Breast Cancer Screening

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. Measurement period: January 1–December 31.

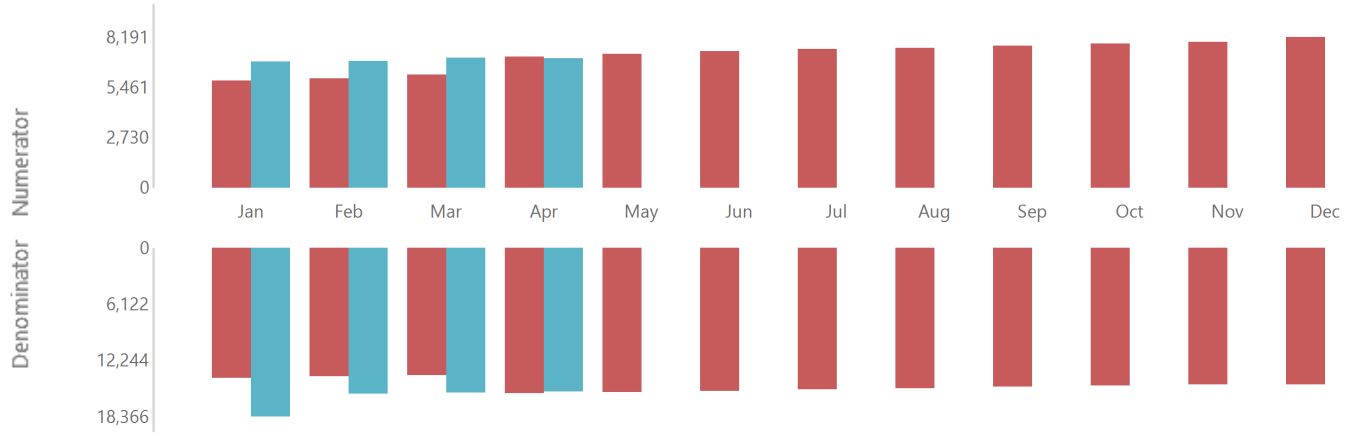




		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	41.12%	42.45%	44.33%	45.07%	46.34%	47.63%	48.99%	49.90%	51.17%	52.22%	53.31%	55.15%
	2023	37.39%	43.41%	44.90%	44.95%								
	MPL	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%	50.95%

7,031

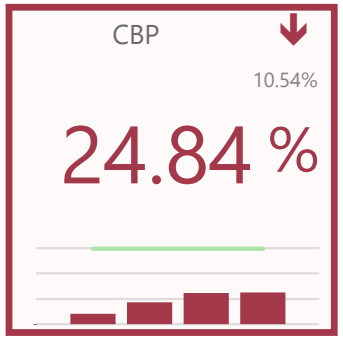
15,642

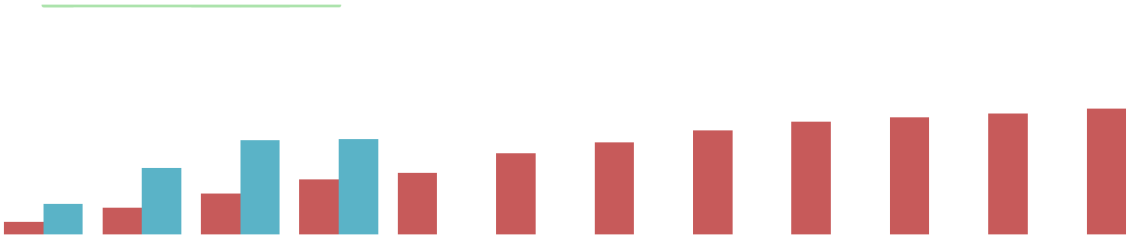


MCAS MY2023 Performance Trending Metrics through April 2023

Controlling High Blood Pressure

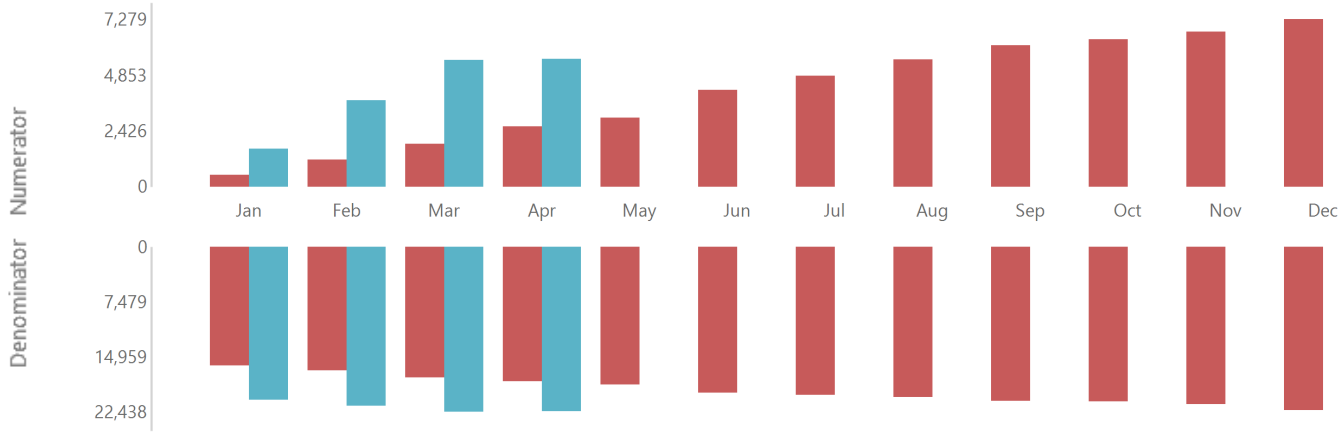
The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	3.20%	6.97%	10.54%	14.35%	16.00%	21.14%	23.98%	27.11%	29.32%	30.54%	31.48%	32.81%
	2023	7.88%	17.34%	24.56%	24.84%								
	MPL	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%	59.85%

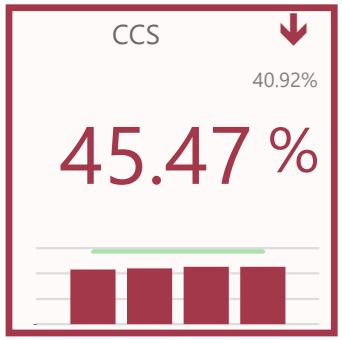
5,555
22,365

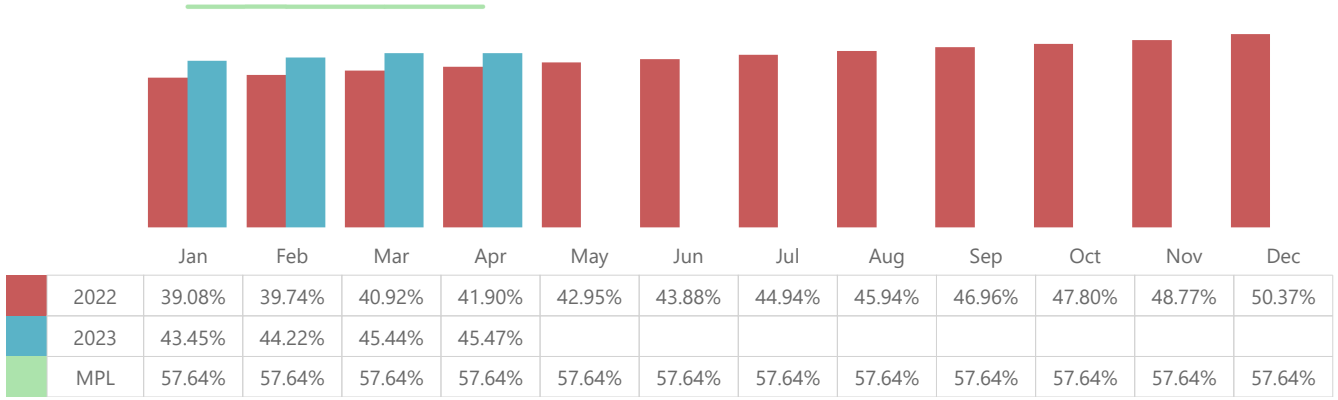


MCAS MY2023 Performance Trending Metrics through April 2023

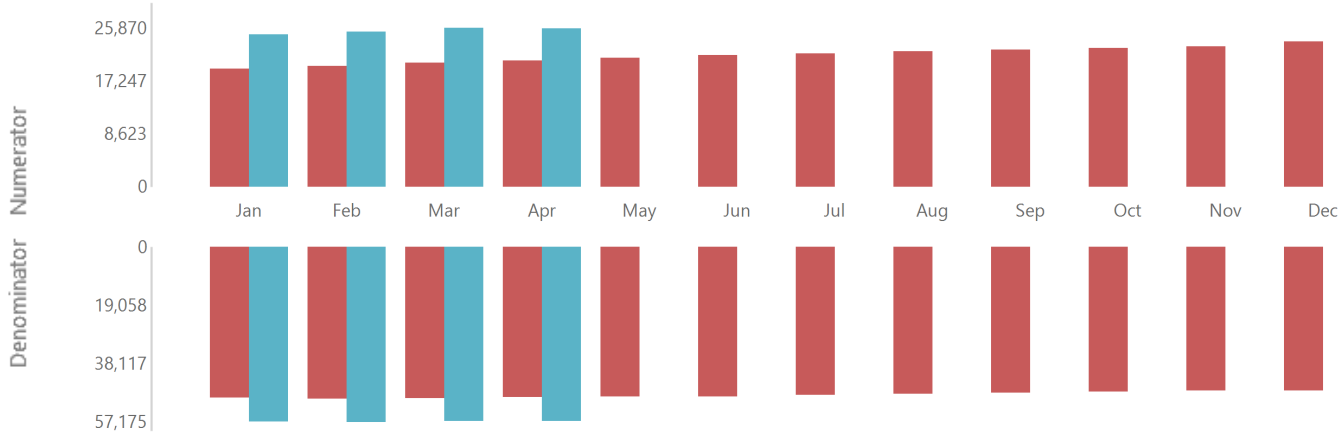
Cervical Cancer Screening

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





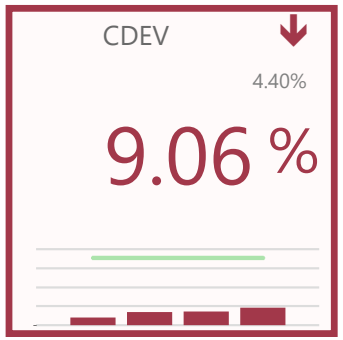
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	39.08%	39.74%	40.92%	41.90%	42.95%	43.88%	44.94%	45.94%	46.96%	47.80%	48.77%	50.37%
	2023	43.45%	44.22%	45.44%	45.47%								
	MPL	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%	57.64%

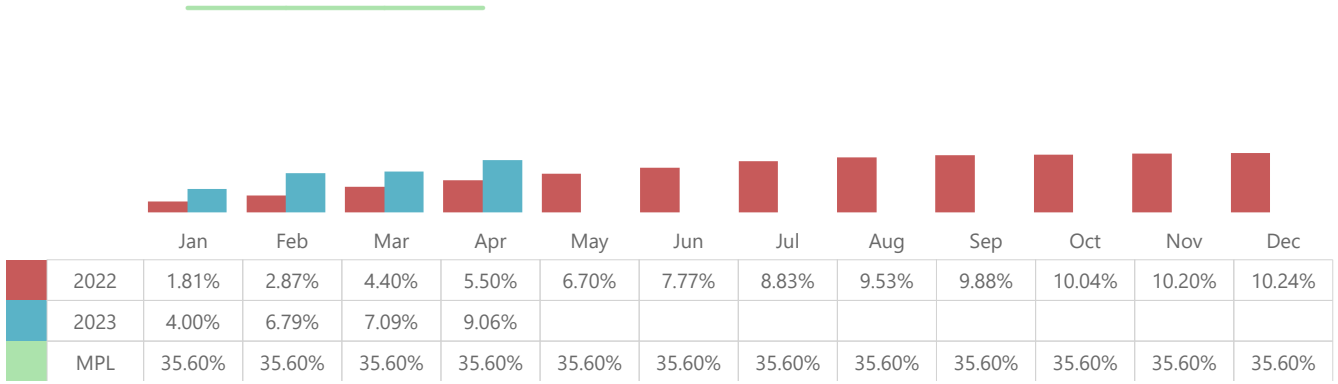


MCAS MY2023 Performance Trending Metrics through April 2023

Developmental Screening in the First 3 Years of Life

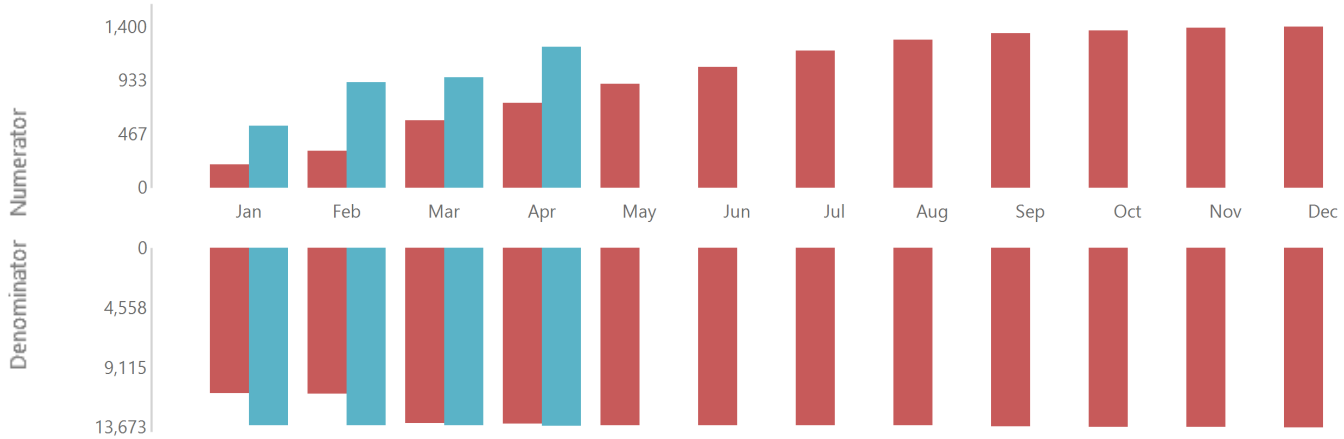
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	1.81%	2.87%	4.40%	5.50%	6.70%	7.77%	8.83%	9.53%	9.88%	10.04%	10.20%	10.24%
2023	4.00%	6.79%	7.09%	9.06%								
MPL	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%

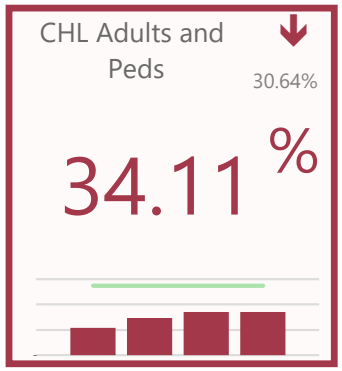
1,227
13,546

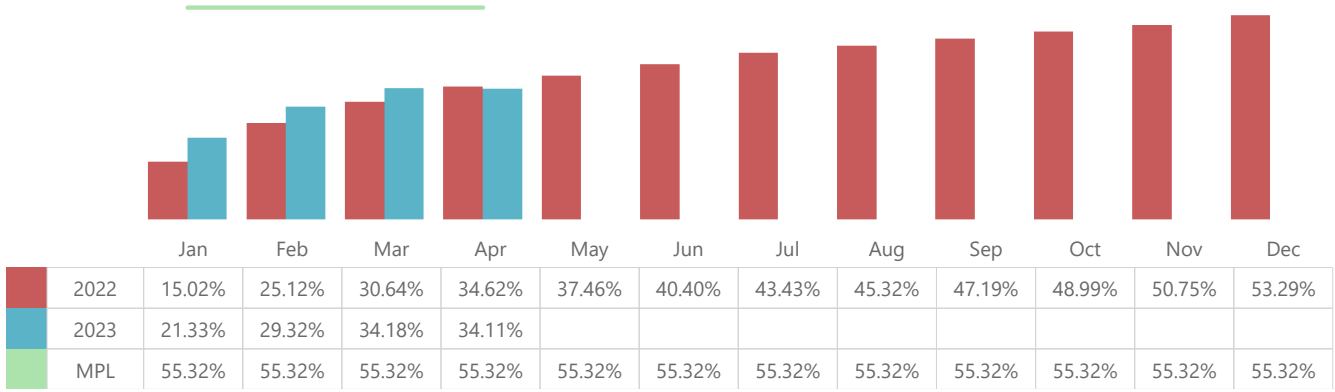


MCAS MY2023 Performance Trending Metrics through April 2023

Chlamydia Screening in Women

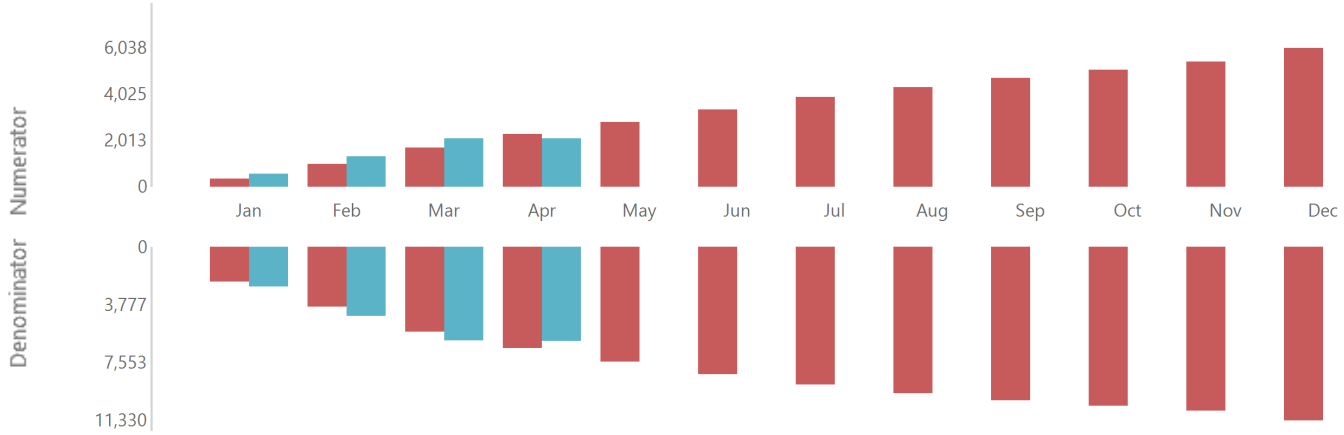
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.





2022	15.02%	25.12%	30.64%	34.62%	37.46%	40.40%	43.43%	45.32%	47.19%	48.99%	50.75%	53.29%
2023	21.33%	29.32%	34.18%	34.11%								
MPL	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%	55.32%

2,097
6,148



MCAS MY2023 Performance Trending Metrics through April 2023

Childhood Immunization Status

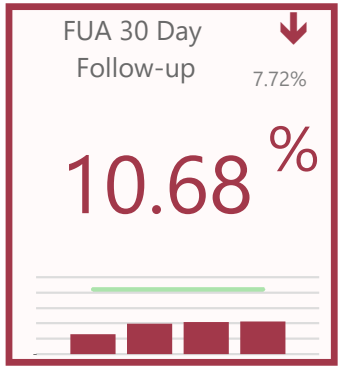
The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis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

955
6,592

MCAS MY2023 Performance Trending Metrics through April 2023

Follow-Up After Emergency Department Visit for Substance Use

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30 days of the ED visit.

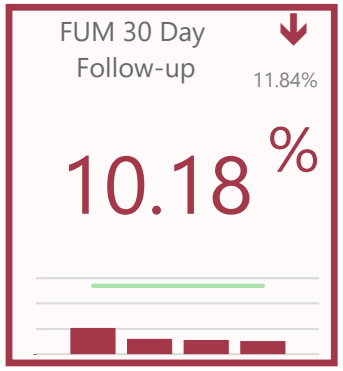


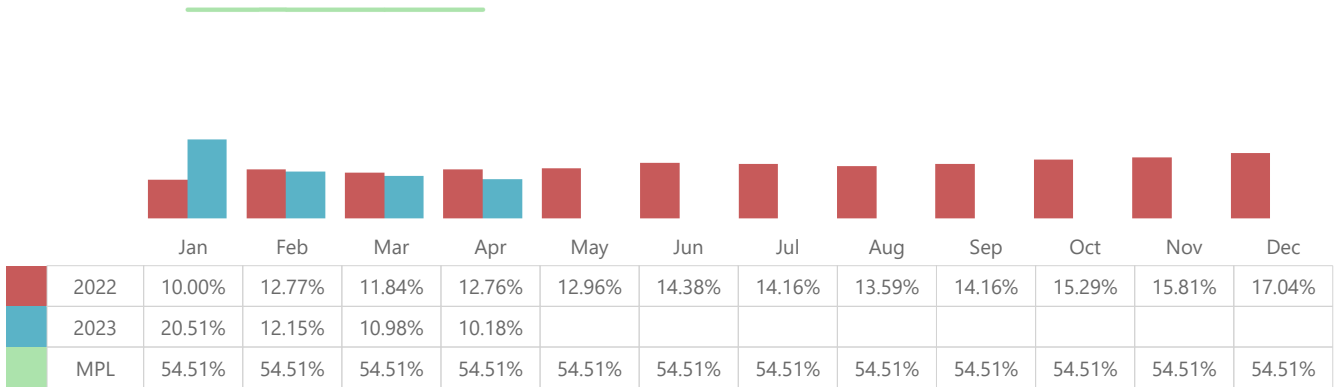
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	3.08%	5.65%	7.72%	8.83%	9.45%	9.40%	10.57%	11.26%	11.10%	10.95%	11.09%	10.65%
	2023	6.41%	9.90%	10.49%	10.68%								
	MPL	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%	21.24%

MCAS MY2023 Performance Trending Metrics through April 2023

Follow-Up After Emergency Department Visit for Mental Illness

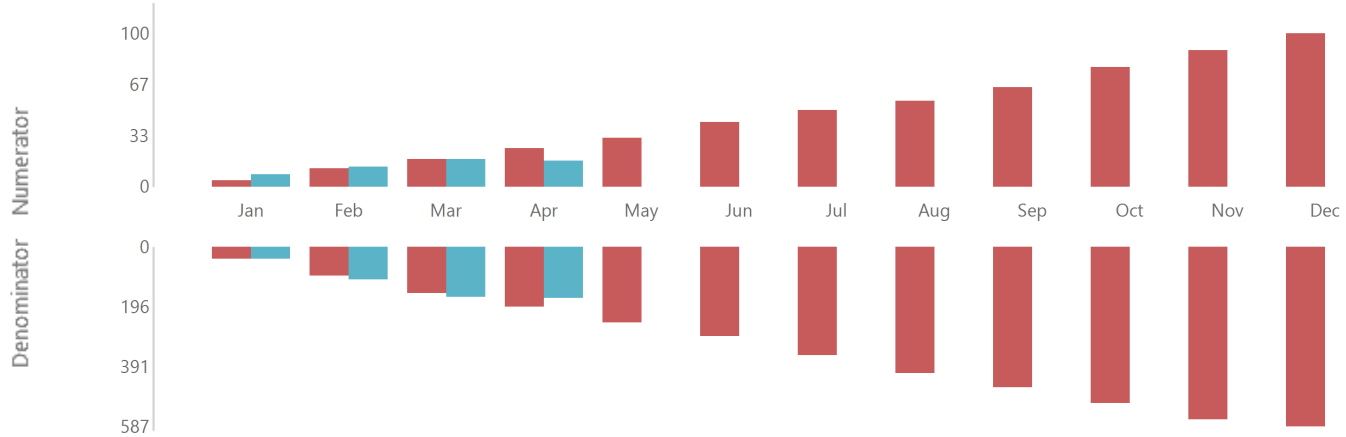
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	10.00%	12.77%	11.84%	12.76%	12.96%	14.38%	14.16%	13.59%	14.16%	15.29%	15.81%	17.04%
2023	20.51%	12.15%	10.98%	10.18%								
MPL	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%	54.51%

17
167

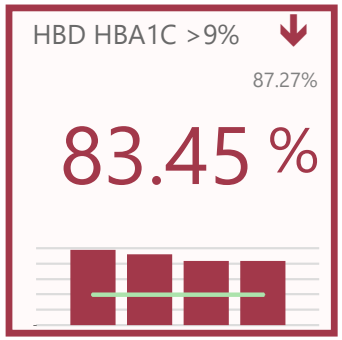


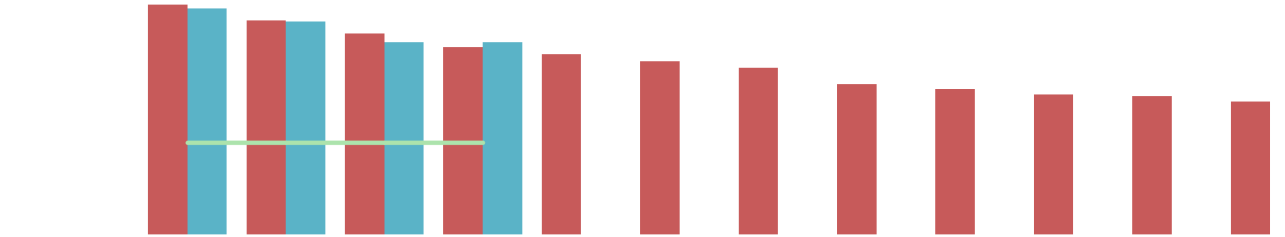
MCAS MY2023 Performance Trending Metrics through April 2023

Hemoglobin A1c Testing & Control for Patients With Diabetes

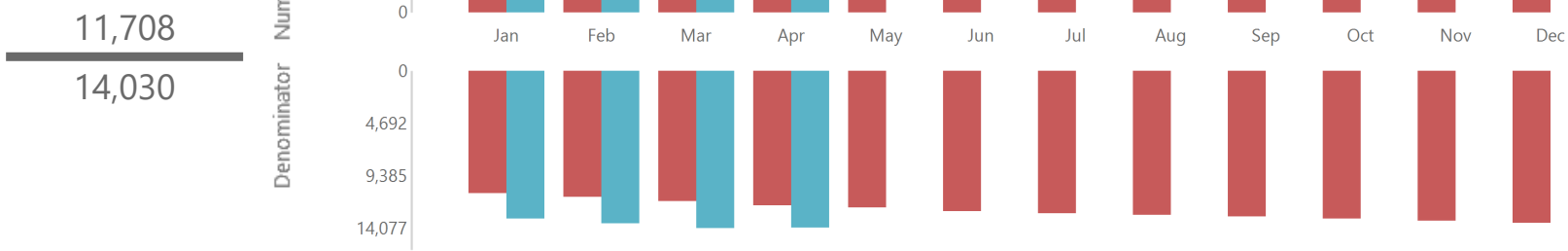
The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:
- HbA1c Control (<8.0%).
- HbA1c Poor Control (>9.0%).

Inverted Measure - a lower rate is desired for this measure.





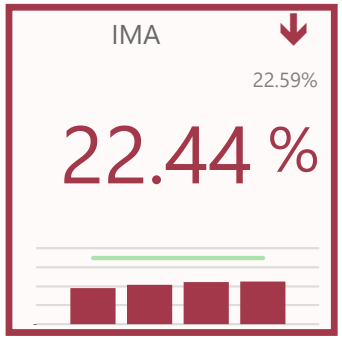
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	99.84%	92.98%	87.27%	81.34%	78.42%	75.14%	72.33%	65.22%	63.14%	60.86%	59.96%	57.62%
2023	98.29%	92.49%	83.46%	83.45%								
MPL	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%	39.90%

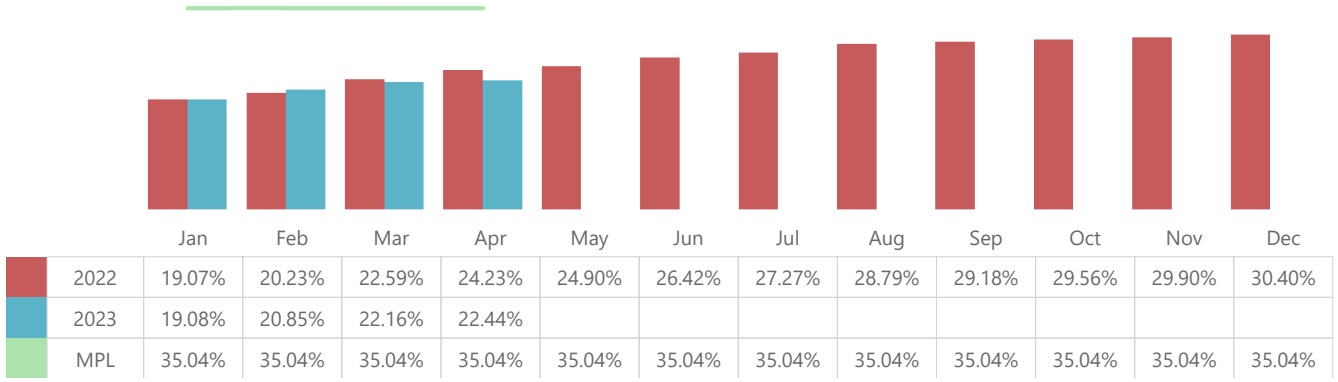


MCAS MY2023 Performance Trending Metrics through April 2023

Immunizations for Adolescents

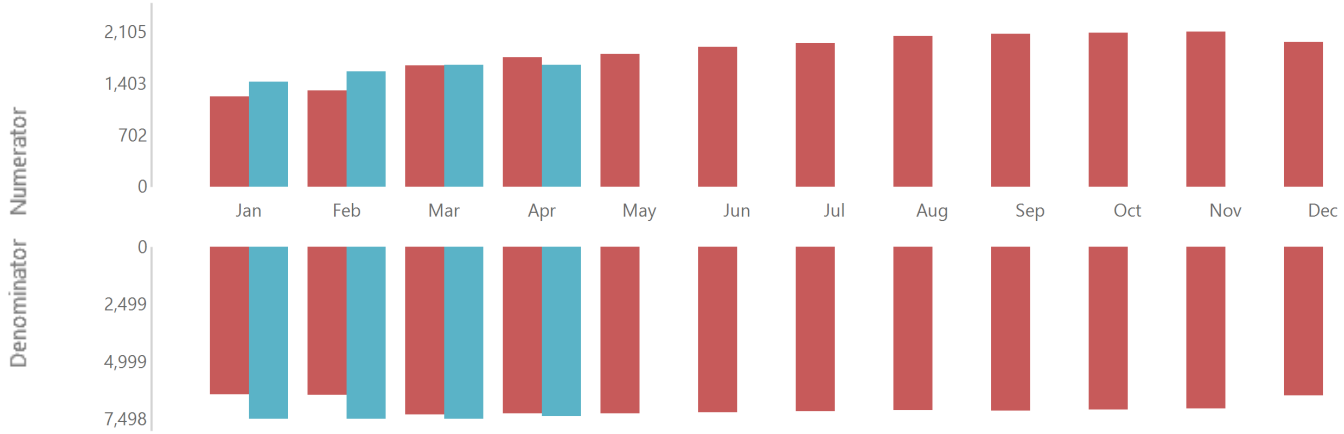
The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and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





2022	19.07%	20.23%	22.59%	24.23%	24.90%	26.42%	27.27%	28.79%	29.18%	29.56%	29.90%	30.40%
2023	19.08%	20.85%	22.16%	22.44%								
MPL	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%	35.04%

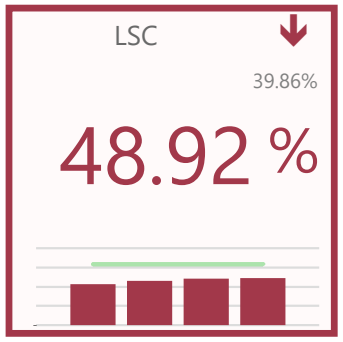
1,654
7,370

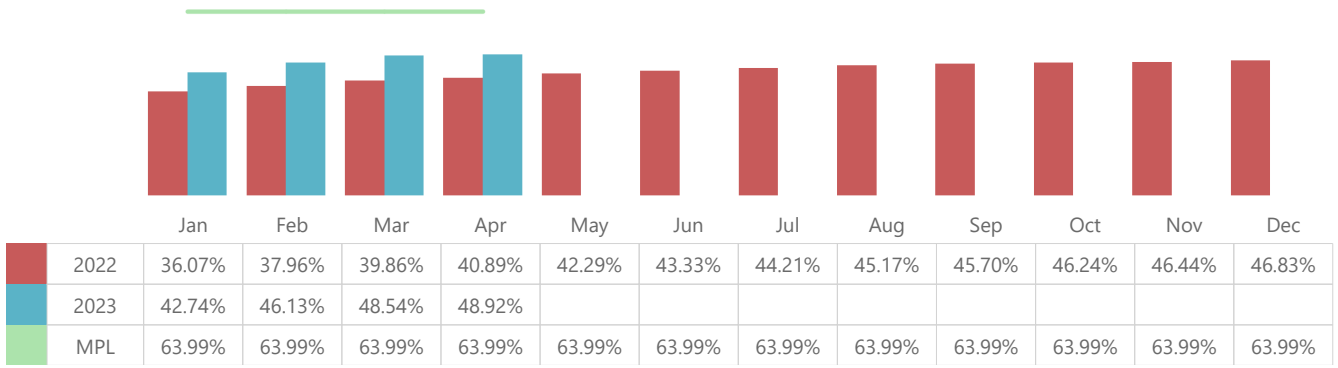


MCAS MY2023 Performance Trending Metrics through April 2023

Lead Screening in Children

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

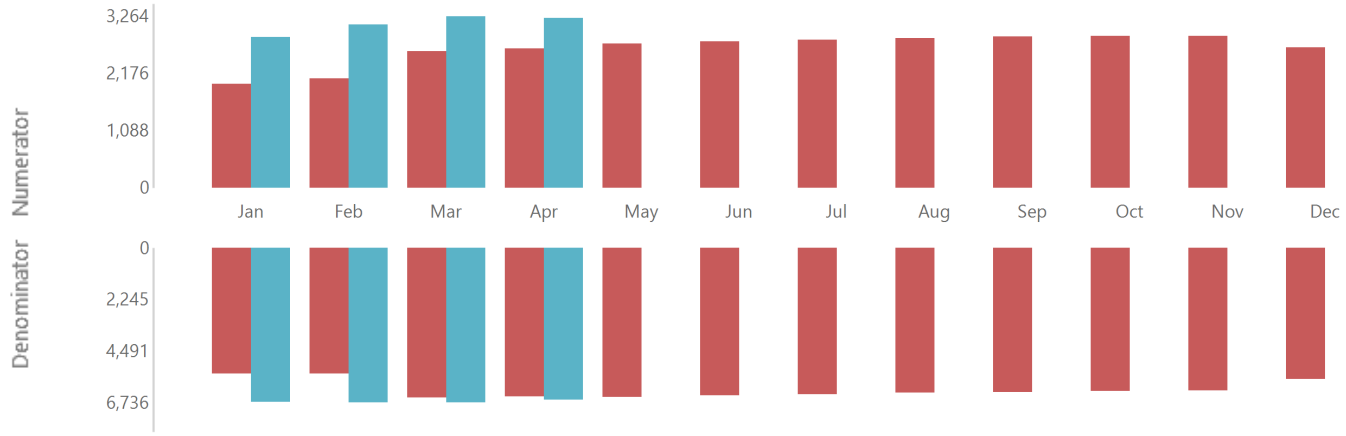




	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	36.07%	37.96%	39.86%	40.89%	42.29%	43.33%	44.21%	45.17%	45.70%	46.24%	46.44%	46.83%
2023	42.74%	46.13%	48.54%	48.92%								
MPL	63.99%	63.99%	63.99%	63.99%	63.99%	63.99%	63.99%	63.99%	63.99%	63.99%	63.99%	63.99%

3,234

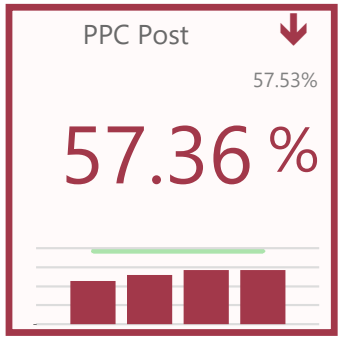
6,611

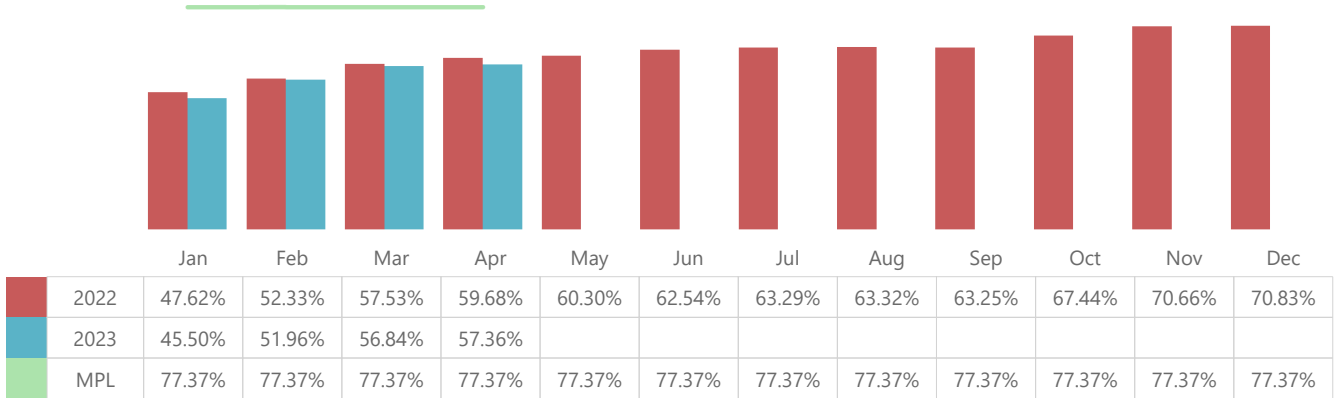


MCAS MY2023 Performance Trending Metrics through April 2023

Prenatal and Postpartum Care

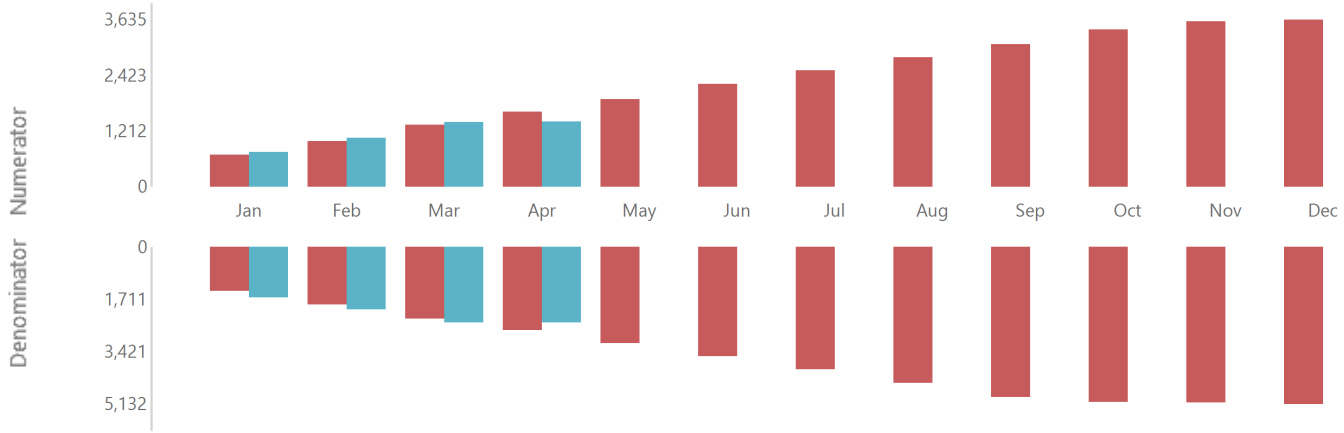
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	47.62%	52.33%	57.53%	59.68%	60.30%	62.54%	63.29%	63.32%	63.25%	67.44%	70.66%	70.83%
	2023	45.50%	51.96%	56.84%	57.36%								
	MPL	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%	77.37%

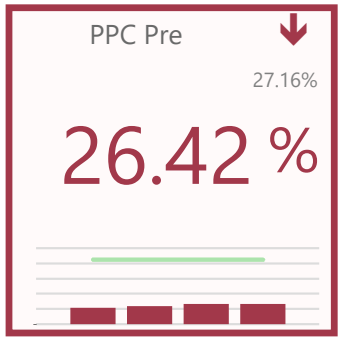
1,422
2,479

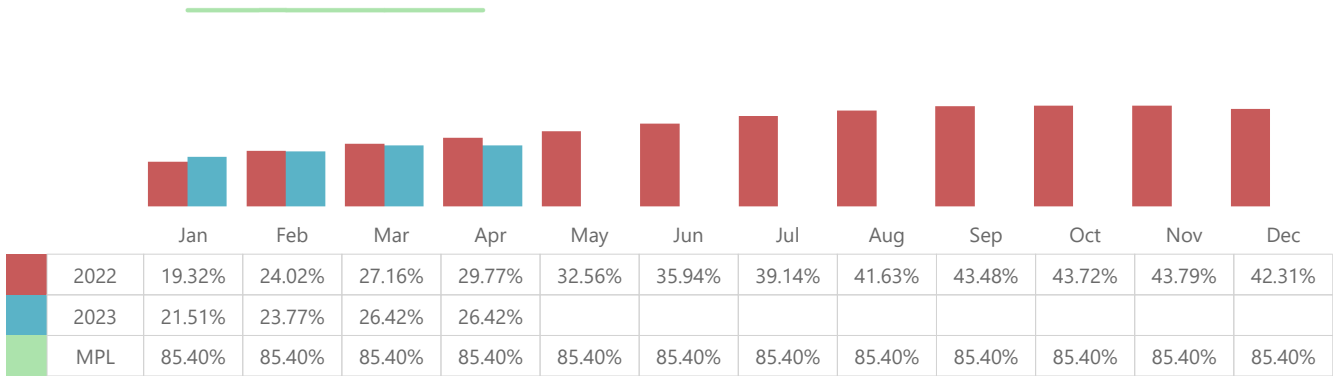


MCAS MY2023 Performance Trending Metrics through April 2023

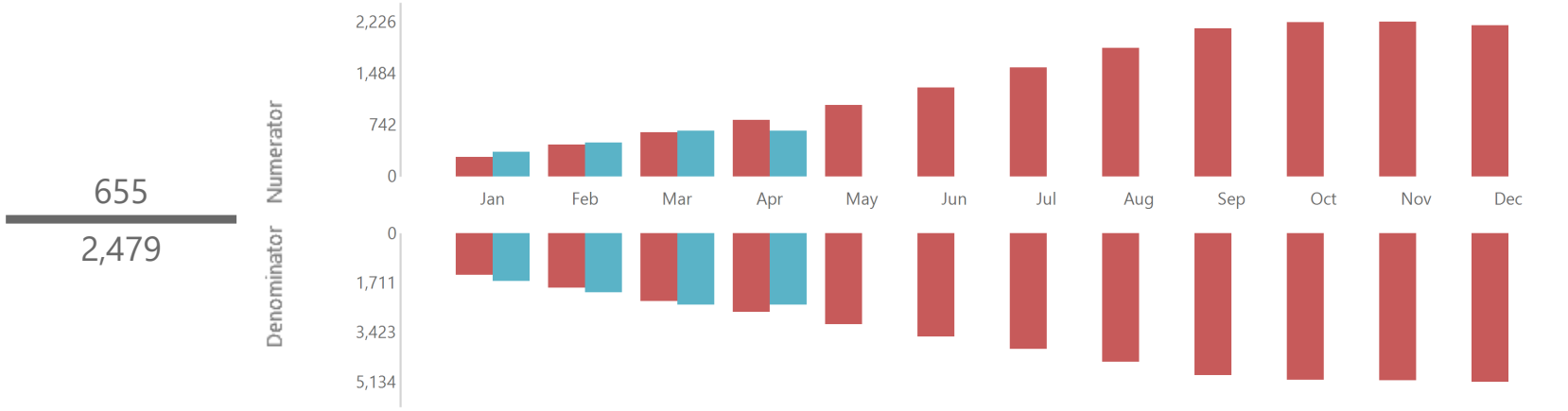
Prenatal and Postpartum Care

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





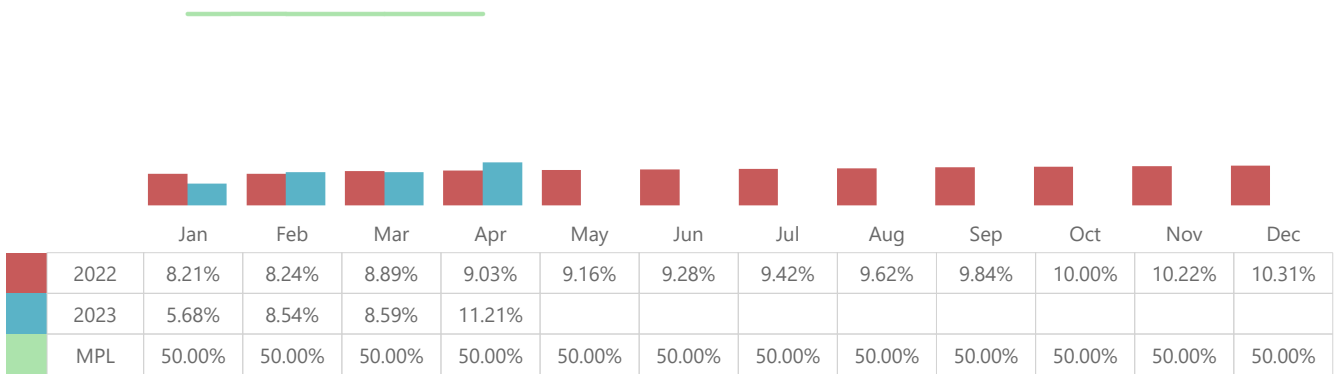
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2022	19.32%	24.02%	27.16%	29.77%	32.56%	35.94%	39.14%	41.63%	43.48%	43.72%	43.79%	42.31%
	2023	21.51%	23.77%	26.42%	26.42%								
	MPL	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%



MCAS MY2023 Performance Trending Metrics through April 2023

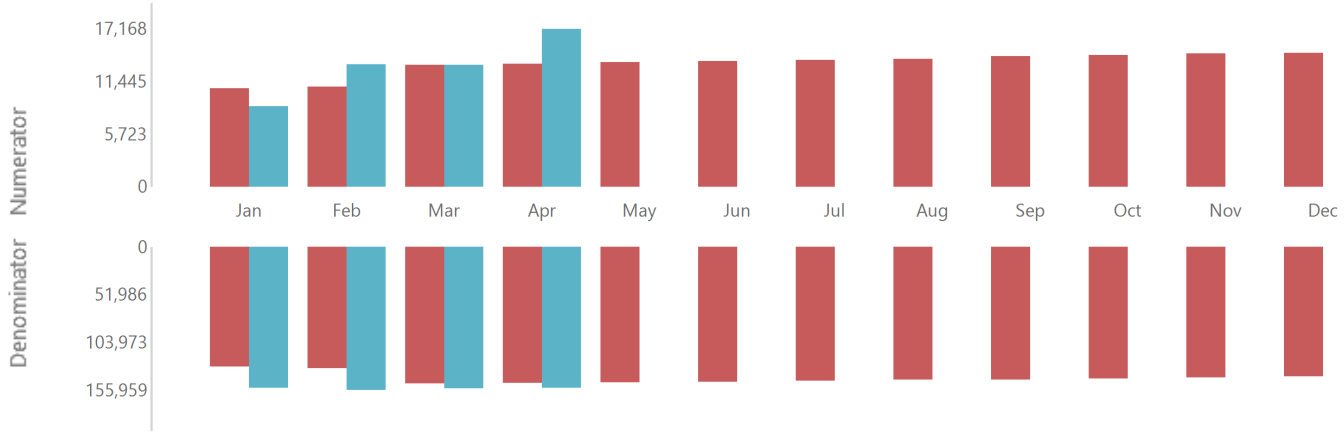
Prevention: Topical Fluoride for Children

Percentage of children aged 1–21 years who received at least 2 topical fluoride applications as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	8.21%	8.24%	8.89%	9.03%	9.16%	9.28%	9.42%	9.62%	9.84%	10.00%	10.22%	10.31%
2023	5.68%	8.54%	8.59%	11.21%								
MPL	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%

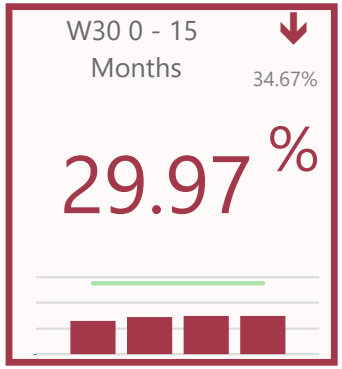
17,168
153,198

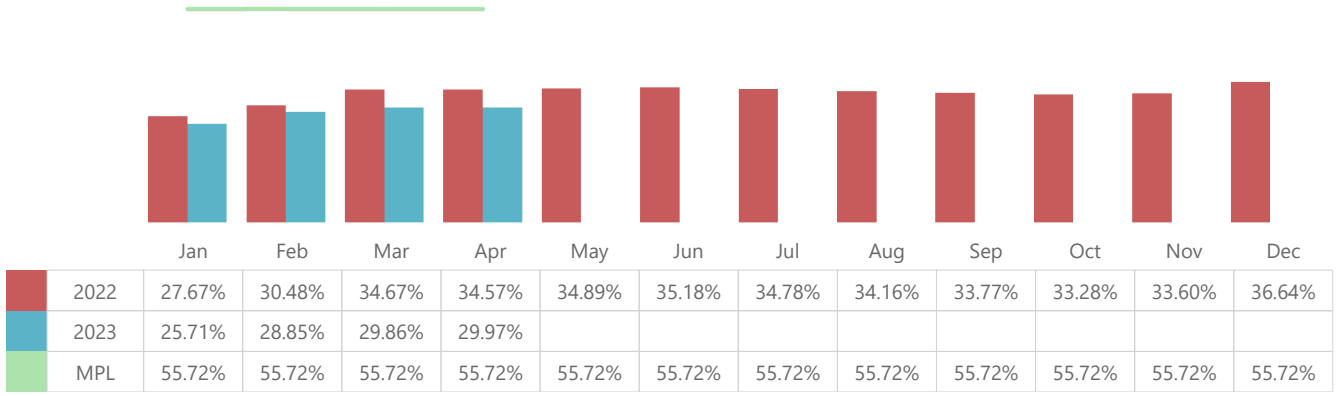


MCAS MY2023 Performance Trending Metrics through April 2023

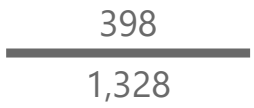
Well-Child Visits in the First 30 Months of Life

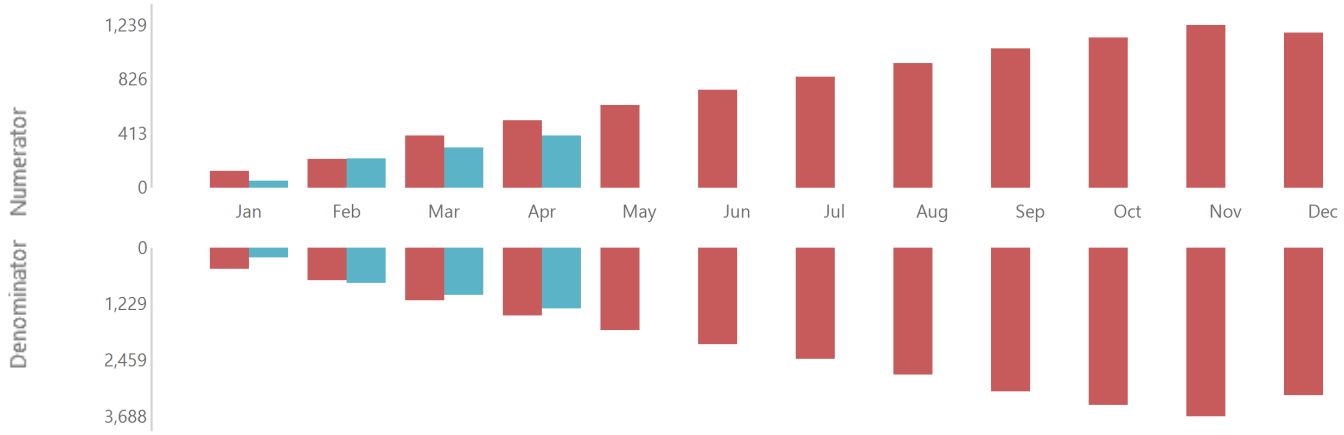
The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	27.67%	30.48%	34.67%	34.57%	34.89%	35.18%	34.78%	34.16%	33.77%	33.28%	33.60%	36.64%
2023	25.71%	28.85%	29.86%	29.97%								
MPL	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%	55.72%

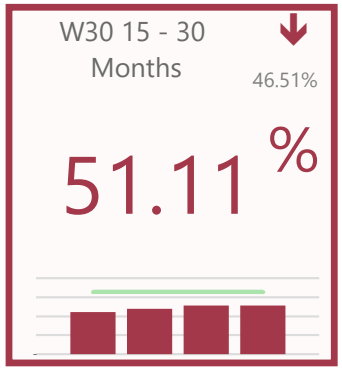


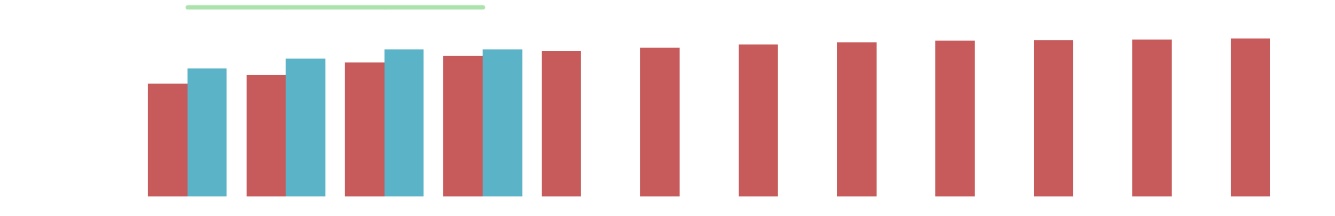


MCAS MY2023 Performance Trending Metrics through April 2023

Well-Child Visits in the First 30 Months of Life

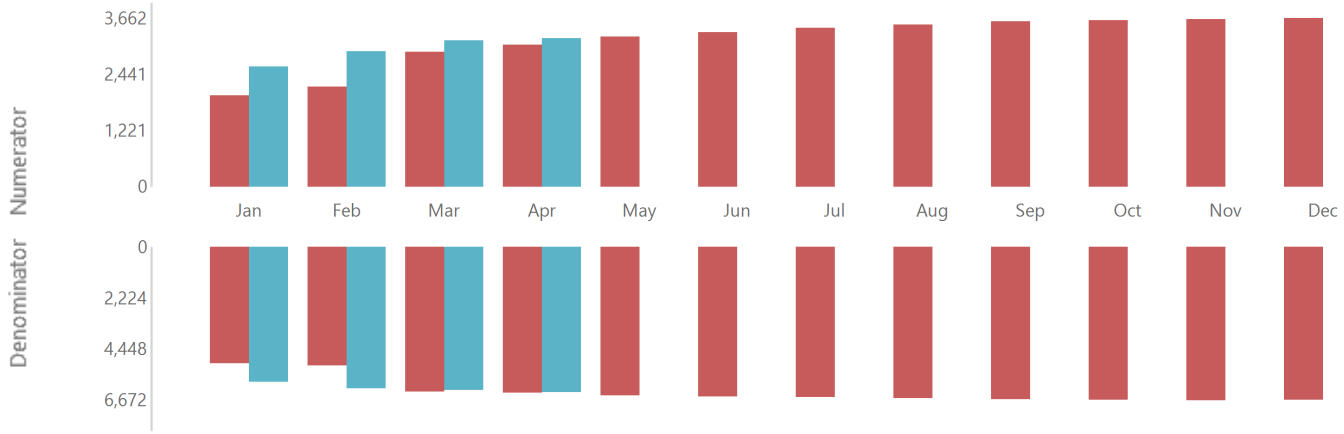
The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.





2022	39.17%	42.17%	46.51%	48.74%	50.47%	51.61%	52.79%	53.48%	54.07%	54.39%	54.54%	54.94%
2023	44.55%	47.80%	51.05%	51.11%								
MPL	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%	65.83%

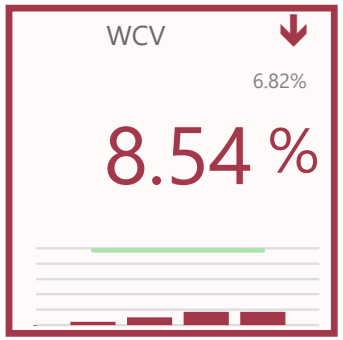
3,234
6,328

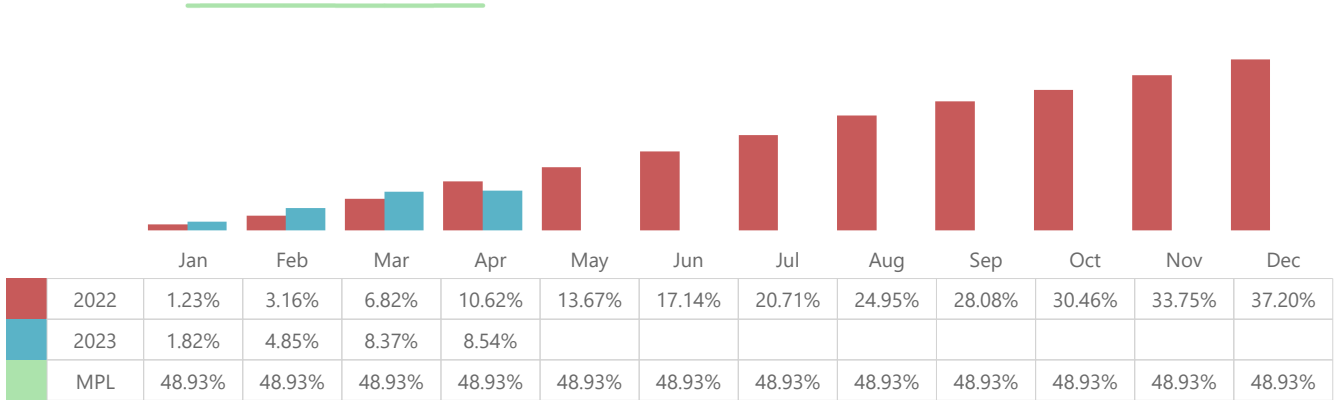


MCAS MY2023 Performance Trending Metrics through April 2023

Child and Adolescent Well-Care Visits

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

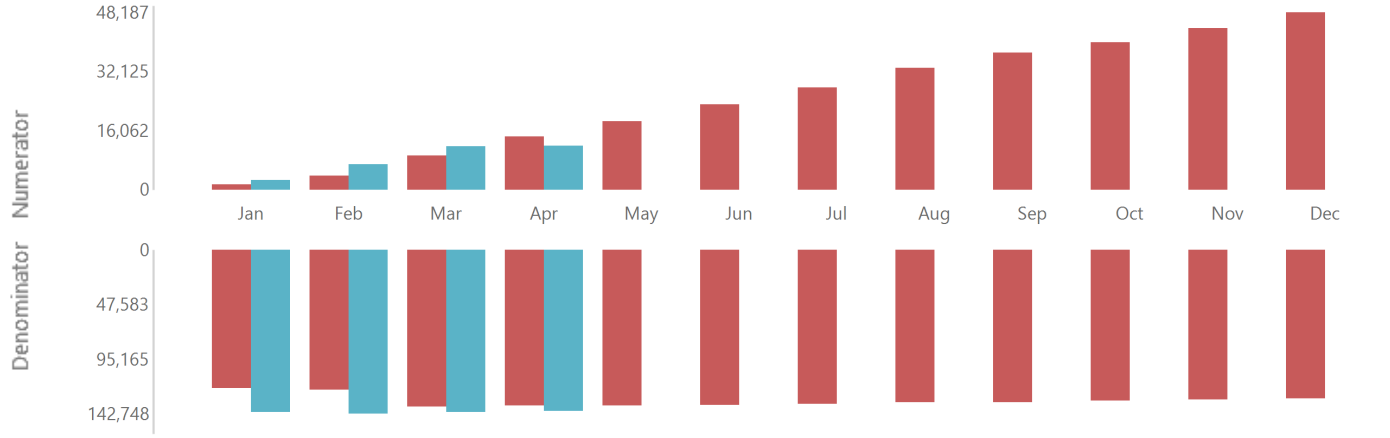




	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	1.23%	3.16%	6.82%	10.62%	13.67%	17.14%	20.71%	24.95%	28.08%	30.46%	33.75%	37.20%
2023	1.82%	4.85%	8.37%	8.54%								
MPL	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%	48.93%

11,982

140,265



KERN HEALTH SYSTEMS

Chief Executive Officer's Report

Board of Directors Meeting

Emily Duran

April 13, 2023

COMPLIANCE AND REGULATORY ACTIVITIES

The April 2023 Compliance and Regulatory Affairs Report highlights current Kern Health Systems (KHS) oversight activities with details included under ***Attachment A: Compliance and Regulatory Affairs***.

KHS STRATEGIC PLAN UPDATE

On October 13, 2022, the KHS Board of Directors engaged in a strategic planning session which identified the key priority areas for the organization. The strategic plan will provide a roadmap for 2023-2025. Included under ***Attachment B: Strategic Plan Q1 Status Report*** is a breakdown of the corporate goals strategies and accomplishments after the close of the 1st Quarter of 2023.

STATE PROGRAM DEVELOPMENT

KHS is preparing for the implementation of several Department of Health Care Services (DHCS) programs coming later in 2023 and 2024:

Long Term Care (LTC), Phase 2: Effective 1/1/24, DHCS will implement the next phase of the Long-Term Care carve-in by requiring members receiving care in Intermediate Care and Subacute Facilities to enroll in a Managed Care Plan (MCP) to receive their LTC benefits. This transition was originally scheduled for July 2023 but was delayed by DHCS to allow more time to prepare for the transition. MCPs recently received a draft All Plan Letter from DHCS which outlines the proposed requirements. Plans also received estimated member counts of those transitioning, for Kern the estimate is 267 members. There is an internal project team preparing for the implementation of these new services/populations.

Medi-Cal Expansion to Undocumented Adults: The State budget expanded full-scope Medi-Cal services to individuals who are 26 through 49 years of age without satisfactory immigration status. DHCS intends to implement this expansion on 1/1/24. To-date, plans have seen the draft member notices which DHCS will be sending to these members beginning in November. KHS also received estimated member transition counts, and for Kern County the initial estimate was 5,350 members. More details are expected to be received from DHCS as the transition approaches, included refined member counts.

Enhanced Care Management (ECM)*:* KHS staff are preparing for upcoming new populations which will be included under ECM. Effective 7/1/23, MCPs will expand ECM to the Child and Youth populations. Effective 1/1/24, MCPs will expand ECM to certain individuals transitioning from incarceration, and to certain pregnant and postpartum individuals. In preparation for the Child and Youth Population of Focus, Plans had to submit an updated Model of Care to DHCS in February. The internal ECM team is working to identify and contract with providers capable of providing services to this population. In addition, staff are working on identifying eligible members in preparation for the go-live date. DHCS is convening stakeholder meetings related to implementation planning.

2024 Health Plan Transitions: In late 2022, DHCS announced the results of their Statewide re-procurement of the Commercial Health Plans who serve Medi-Cal. This included the announcement that Health Net would be replaced by Anthem Blue Cross as the commercial option in Kern County beginning in 2024. Additionally, DHCS will be extending Kaiser a direct contract in Counties where they operate, including Kern County. DHCS has acknowledged these transitions will result in a large shift in membership throughout the State. DHCS has committed to provide Plans with more information on the transition process and subsequent requirements, beginning in Q2 2023.

LEGISLATIVE SUMMARY UPDATE

State Legislation: The deadline for bill introductions was February 17th. Policy committees continued to meet up to the Spring recess, which was April 1st through the 10th. Post-recess hearings resumed at full pace leading up to the first policy committee deadlines which are at the end of April. To-date, staff are tracking 70 bills of relevance. The bill tracking document is included as ***Attachment C: Bill Tracker***. Staff are highly engaged with our Associations in prioritizing, reviewing, and advocating on relevant bills.

State Budget: Legislative budget subcommittee hearings have commenced, and some budget bill language has been introduced. The next major milestone in the budget process will be the release of the Governor's May Revision. As previously noted, the January budget proposal forecast a budget shortfall of $22.5 billion. More recent financial projections show the revenue shortfall is growing, potentially by billions more. It remains to be seen how the Governor's administration and the Legislature will ultimately reconcile the deficit. Staff remain engaged as conversations occur, and in anticipation of the May Revise release.

One of the provisions included in the January draft budget is a proposal to expand Community Supports to include up to 6 months of transitional rent payments for certain individuals. Potentially eligible individuals would include those experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system and who are at risk of inpatient hospitalization or emergency department visits. This service would be optional for Plans to implement, and would be effective by July 2024, subject to federal approvals.

STUDENT YOUTH BEHAVIORAL HEALTH INITIATIVE (SBHIP)

Background: The State Budget for 2021-2022 included $13.2 million over three years in incentive funding to build infrastructure, partnerships, and capacity for school behavioral health services in Kern County. In collaboration, KHS and HealthNet convened several stakeholders in Kern County including local education and behavioral health agencies, to collectively identify specific school districts, student populations, and interventions to build infrastructure and support behavioral services on or near campuses. KHS and HealthNet engaged a consultant to complete a county wide needs assessment to collect both qualitative and quantitative data to identify the existing gaps and opportunities within the county education system. Eight school districts in total originally agreed to participate including Arvin

Union, Bakersfield City, Edison Elementary, Kern High, Lost Hills Union Elementary, Kernville Union, McFarland Union, Kern County Superintendent of Schools Special Education and Alternative Education Program.

Update: All eight of the district's needs assessments, each detailing the school districts' identified gaps and proposed project plans were aligned with the four interventions selected across the school districts for implementation including Behavioral Health and Wellness Programs, Substance Use Disorder Programs, Family and Parent Support Services, and fostering stronger partnerships between the schools, managed care plans and county behavioral health to increase student's behavioral health access to these vital Medi-Cal services.

KHS submitted the project plans and identified milestones to DHCS on December 29, 2022. KHS received approval of Kern County's needs assessment on March 8, 2023, thereby releasing the remaining needs assessment 50% funding allocations totaling $541,737.00. Followed shortly thereafter, on March 14, 2023, KHS received approval for the project plans and milestones, releasing the initial 50% funding allocations totaling $4,830,669.00, to begin infrastructure builds based on the selected targeted interventions.

KHS can qualify for the remaining 50% of funding allocations over the next two years based on bi-quarterly monitoring reports detailing deliverables progress towards meeting predefined goals and metrics outlined in the proposed project plans submitted by KHS to DHCS. Upon sunset of the incentive funds in December 2024, KHS will have ensured operational and financial transparency of these combined efforts and culminating with the successful launch of the student behavioral health support program within Kern County's schools.

INCENTIVE PAYMENT PROGRAM (IPP)

Background: The CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of Enhanced Care Management (ECM) and Community Supports (CS) by incentivizing managed care plans (MCPs), in accordance with 42 CFR Section 438.6(b), to drive MCP delivery system investment in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports. In January, KHS submitted a gap assessment report to DHCS identifying the gaps in services for ECM and Community Supports in Kern County. Based on the gap assessment report, KHS has been approved for $14.2 million dollars in incentive funds to expansion our ECM and CS programs. We are also supporting some of the current ECM and CS programs with delivery system infrastructure upgrades. All projects have milestones that the provider must meet to earn the incentive funds. The IPP program time frame is January 1, 2022 to December 31, 2023.

Update: Incentive Payment funding continues to support delivery system infrastructure and improve the quality of care for our members throughout Kern County. In Q1 2023, one new Enhanced Care Management (ECM) location went live in East Bakersfield – OMNI Mall View Rd. Three additional

ECM sites are scheduled to go live in Q3 and Q4 of this year. In addition, in Q1 several community support services were implemented and are available for our members. Those services include Short Term Hospitalization- Good Samaritan Hospital, Respite Services -SD Consulting and Recuperative Care services- Corbow. These services will provide members the additional clinical support post discharge, with a special focus on individuals who do not any support to assist with their medical needs. Another focus population of focus are the unsheltered members. These services will alleviate the hospitals who are challenged with safely discharging our members.

As previously reported, KHS received approval for a second year of incentive funds intended to expand our network of ECM providers and community support services. A Provider Bulletin for year two of IPP projects was send to all providers and Community Based Organizations asking for letters of interest in these programs and we have received numerous inquiries. The IPP funds for Program Year 2 will be allocated based on identified geographical needs of KHS members. The goal is to finalize IPP projects by mid-April 2023.

HOUSING AND HOMELESSNESS INCENTIVE PROGRAM (HHIP)

Background: As a part of the State's overarching home and community-based services (HCBS) spending plan, the California Department of Health Care Services (DHCS) launched the Housing and Homelessness Incentive Program (HHIP) from January 1, 2022, to December 31, 2023. HHIP aims to prevent and reduce homelessness and housing instability & insecurity by addressing social determinants of health while improving health outcomes and accessibility to whole-person care for those who are a part of the Medi-Cal population and simultaneously experiencing or at risk of being homeless. HHIP is a voluntary incentive program that will allow Medi-Cal Managed Care Plans (MCPs) to earn incentive funds by collaborating with providers and community-based organizations to build capacity & infrastructure to streamline a continuity of housing and homelessness services. All projects have milestones approved by DHCS, and the provider must meet to earn the incentive funds.

KHS has partnered with agencies to advance health equity and housing accessibility to those who are at risk of or are experiencing homelessness. Kern Health Systems has awarded 13 network providers and community-based organizations in support of 19 housing and homelessness service delivery projects. These 19 projects range from Street Medicine, Mental & Behavioral Health Support Services, Prevention & Diversion, Non-Congregate Shelters & Expanding Emergency Shelters for Youth, Adults and Families, and includes Non-Congregate Permanent Housing for Youth, Adults and Families. The population of focus for HHIP includes those who are from marginalized communities such as at-risk youth; aging and older adults; veterans and their families who do not qualify for veteran's health care services; people with disabilities; and individuals who identify as LGBTQ+ community members.

Update: By March 31, 2023, our permanent supportive housing, shelter expansion, and transitional housing projects will have onboarded and hired staff to provide housing services. In addition, our street medicine and street outreach programs will also onboard their practitioners and outreach staff who project to engage with at least 245 (two-hundred-forty-five) persons experiencing homelessness by the

end of Q1 2023. Through HHIP funds, 1 (one) medical mobile unit and 6 (six) additional vehicles will be purchased specifically to reach persons experiencing homelessness in rural and urban areas of Kern County. In addition, 5 (five) housing units for homeless adults with high-service needs and mental health conditions will be completed in Delano; 2 (two) homes providing permanent supportive housing for women and their minor children experiencing homelessness will also be purchased; 60 bed days of emergency shelter will be provided to persons experiencing homelessness in East and West Kern; and families at risk of homelessness will have received rental and utility assistance. These projects demonstrate a commitment to address inequities and disparities in homeless populations in Kern County. Moreover, these projects aim to achieve equitable provision wrap-around services for those who are disproportionately impacted by homelessness, are at risk of homelessness, and/or are experiencing housing instability. Kern Health Systems has received 2 of 4 full payments from DHCS for our 2022 submissions (the Local Health Plan & Investment Plan) indicating our success in meeting DHCS metrics and scoring well to receive full payment. The next two reports that are tied to fund drawdowns from DHCS are HHIP performance reports: Report 1 due in March 2023 and Report 2 due in January 2024.

KHS APRIL 2023 ENROLLMENT:

Medi-Cal Enrollment

As of April 1, 2023, Medi-Cal enrollment is 237,935, which represents an increase of 0.7% from March enrollment.

Seniors and Persons with Disabilities (SPDs)

As of April 1, 2023, SPD enrollment is 18,079, which represents an increase of 0.5% from March enrollment.

Expanded Eligible Enrollment

As of April 1, 2023, Expansion enrollment is 98,841, which represents an increase of 1.7% from March enrollment.

Kaiser Permanente (KP)

As of April 1, 2023, Kaiser enrollment is 15,574, which represents an increase of 1.7% from March enrollment.

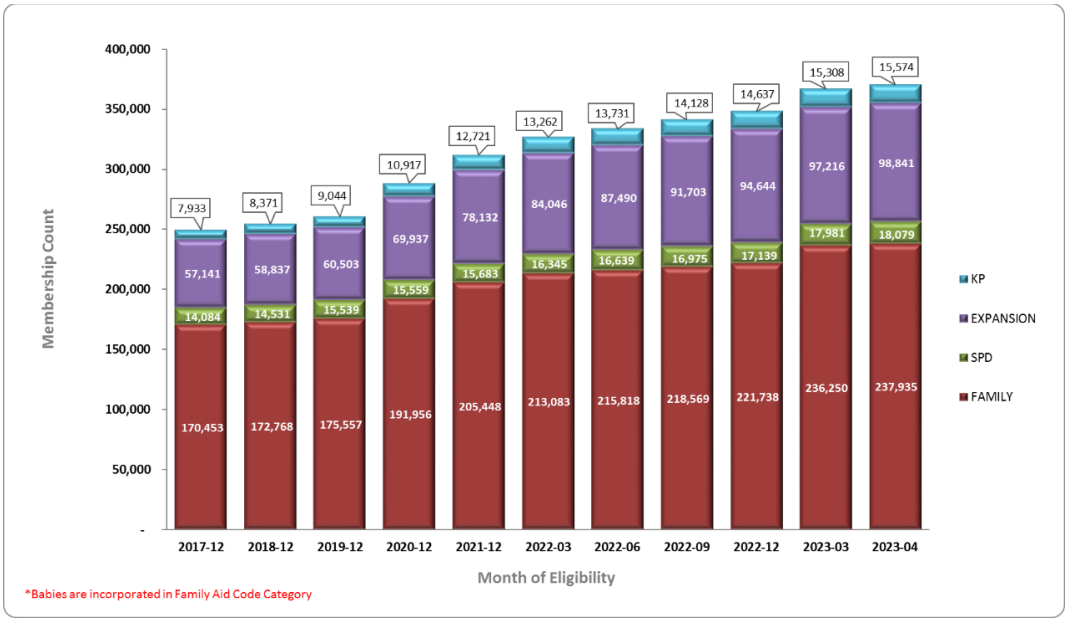
Total KHS Medi-Cal Managed Care Enrollment

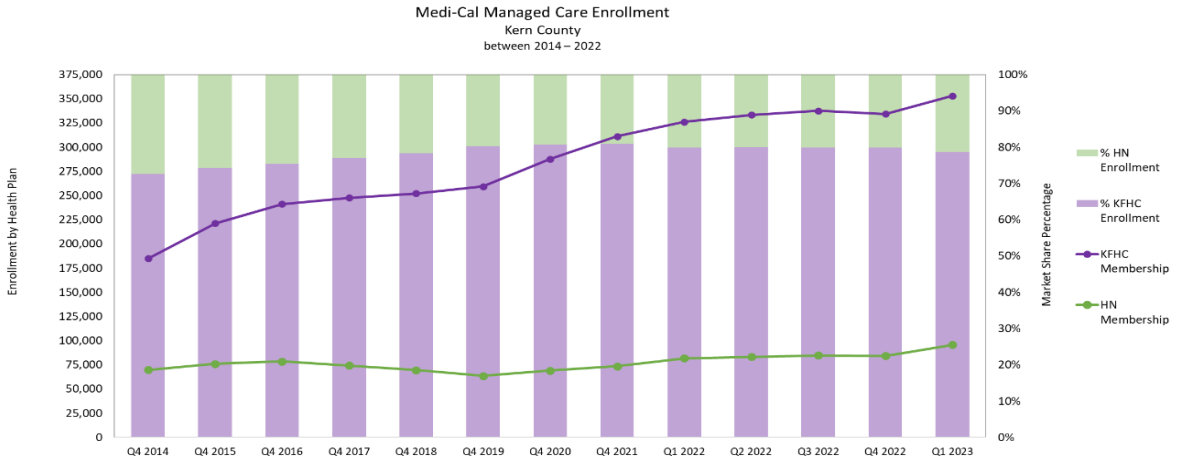
As of April 1, 2023, total Medi-Cal enrollment is 370,429, which represents an increase of 1.0 % from March enrollment.

Membership as of Month of Eligibility	FAMILY	SPD	EXPANSION	KP	BABIES	Member Total
2017-12	170,006	14,084	57,141	7,933	447	249,611
2018-12	172,290	14,531	58,837	8,371	478	254,507
2019-12	175,128	15,539	60,503	9,044	429	260,643
2020-12	191,549	15,559	69,937	10,917	407	288,369
2021-12	204,999	15,683	78,132	12,721	449	311,984
2022-03	212,658	16,345	84,046	13,262	425	326,736
2022-06	215,353	16,639	87,490	13,731	465	333,678
2022-09	218,037	16,975	91,703	14,128	532	341,375
2022-12	221,240	17,139	94,644	14,637	498	348,158
2023-03	235,844	17,981	97,216	15,308	406	366,755
2023-04	237,529	18,079	98,841	15,574	406	370,429

Enrollment Update: During the public health emergency (PHE), the Department of Health Care Services froze Medi-Cal redeterminations. Thus, the Kern County Department of Human Services suspended their "automated discontinuance process" for Medi-Cal Redeterminations. The automated discontinuance process was in place locally prior to the PHE when Medi-Cal beneficiaries did not complete the Annual Eligibility Redetermination process. During the PHE, Kern DHS worked new Medi-Cal applications, reenrollments, successful renewals, additions, etc. (anything with a positive outcome). The Consolidated Appropriations Act of 2023 passed by Congress decoupled redeterminations from the public health emergency declaration. The unwinding of Medi-Cal continuous enrollment provision began April 1, 2023 for Medi-Cal eligibles who are due to renew their Medi-Cal eligibility in June 2023. Thus, beginning in July 2023, the "automated discontinuance process" for Medi-Cal Redeterminations will resume.

Market Share – 4 of every 5 Medi-Cal managed care enrollees are KFHC members (as per Medi-Cal Managed Care Enrollment Kern County chart).





KHS DHS MEDI-CAL RENEWAL PARTNERSHIP

Background: During the public health emergency (PHE), the Department of Health Care Services froze Medi-Cal redeterminations. Thus, the Kern County Department of Human Services suspended their "automated discontinuance process" for Medi-Cal Redeterminations. The automated discontinuance process was in place locally prior to the PHE when Medi-Cal beneficiaries did not complete the Annual Eligibility Redetermination process. During the PHE, Kern DHS worked new Medi-Cal applications, reenrollments, successful renewals, additions, etc. (anything with a positive outcome). The Consolidated Appropriations Act of 2023 passed by Congress decoupled redeterminations from the public health emergency declaration. The unwinding of Medi-Cal continuous enrollment provision began April 1 for Medi-Cal eligibles who are due to renew their Medi-Cal eligibility in June 2023. During the unwinding of Medi-Cal continuous enrollment, the State, County, KHS and other stakeholders are working together to ensure continuity of coverage since the complete Medi-Cal redetermination process resumed. Since more than half of Medi-Cal enrollees complete their annual renewal through the manual mailing process, it is important Kern DHS has updated contact information of Medi-Cal enrollees. As such, Kern DHS is educating local residents about the importance of sharing updated contact information such as mailing addresses, phone numbers, email addresses, etc. KHS also supports this effort by educating our health plan members about this through printed materials, website, social media, text messages, and robocalls. KHS also shares demographic updates via a data exchange with Kern DHS.

Update: As the unwinding of Medi-Cal continuous enrollment provision began, Kern DHS out stationed two full time Human Services Technicians (HST) staff on-site at KHS on February 27, 2023. KHS funds these positions to assist Kern DHS process updates from KHS and complete the renewal process for Kern Family Health Care members. The number of HSTs can increase if needed based on workload (agreement covers up to 5 per year). Beginning in April 2023 and monthly thereafter, Kern DHS will notify KHS which members must complete the manual mailing renewal process and provide timelines and due dates. KHS will communicate the importance of completing this process to members using text messages, robocalls, mail, and phone calls. KHS will share the information with staff, contracted providers, and local enrollment entities. KHS will continue to work with local Medi-Cal enrollment

entities to support the correct completion of the renewal applications which Kern DHS will review and use to determine eligibility.

COMMUNITY EVENTS

KHS will share sponsorship in the following events in April and May:

Organization Name	Event Name	Donated Amount
Bakersfield ARC	"A night for Bakersfield ARC"	$2,500
Bakersfield Rotary East	"2023 Vino Amore"	$1,000
California Coverage & Health Initiatives (CCHI)	"15th Annual Champions for Coverage"	$1,000
Kern Community Foundation	"Women's and Girls' Fund Annual Luncheon"	$1,000
California Living Museum and Camp KEEP	"KEEP CALM Jamboree"	$5,000
Garden Pathways	34th Street Neighborhood community cleanup efforts for the "Great American Cleanup"	$400
Bakersfield North Rotary	"Dinner at the Derby"	$10,000
American Cancer Society	"Relay for Life" events in Delano and Bakersfield and "Bark for Life" in Tehachapi	$5,000
Kern Economic Development Corporation	"2023 Kern County Economic Summit"	$2,500
Sikh Women's Association	"6th Annual 5K Walk for Hope"	$5,000
CASA of Kern County	"2023 Derby Party"	$1,200
Leukemia & Lymphoma Society	"2023 Man & Woman of the Year"	$2,500
No Sister Left Behind	"5K Walk and Health Fair"	$1,000
City of Wasco	"2023 Bike Rodeo"	$1,000
Shafter Library and Learning Center	"Día del Niño"	$1,000
Bakersfield Museum of Art	"Artmix"	$1,000
Morning Star Fresh Food Ministry	"Morning Star Banquet"	$3,500
California Immunization Coalition	"Annual Immunization Summit"	$5,000
JJ's Legacy	"JJ's Gala"	$1,500
Lamont Family Resource Center	5K Color Run	$5,000
Alzheimer's Disease Association of Kern County	"2023 Senior Prom"	$2,500
Children First Campaign	"2023 East Bakersfield Festival"	$5,000
First 5 Kern	"ACEs – Building Community Resilience Conference"	$2,500

KHS will also participate in the following events in April and May:

- United Way of Kern County Tacos and Taxes Resource Fair – Saturday, April 15th from 10:00am – 4:00pm at East Bakersfield High School
- Grimmway Farms "Health & Benefits Fair" – Sunday, April 16th from 12:00 – 5:00pm at the Kern County Fairgrounds
- Homeless Outreach Committee Resource Fair – Thursday, April 20th from 9:00am – 12:00pm at Rio Mirada
- 2023 Kern Family Health Care Community Wellness Event – Saturday, April 29th from 10:00am – 2:00pm at KHS Building
- Cesar Chavez Foundation "Día del Trabajador" Health Fair – Sunday, April 30th from 1:00 – 5:00pm at 40 Acres in Delano
- Annual Mental Health Awareness Fair – Thursday, May 4th from 5:00 – 7:00pm at Kelly F Blanton Student Education Center
- Homeless Outreach Committee Resource Fair – Thursday, May 18th from 9:00am – 12:00pm at The Blanco

Employee Video Newsletter: KHS' Video Employee Newsletter can be seen by clicking the following link: https://vimeo.com/814410157

KHS Media Clips: We compiled local media coverage that KHS received in February and March. Please see ***Attachment D: KHS Media Clips***. Click on the title or "Read More" to view the complete article.

KHS ORGANIZATIONAL HIGHLIGHTS

Employee Career Fair: On January 4, 2023 KHS held its first onsite career event. Our executives and department leadership represented our various departments at this event. The goal was to showcase our amazing workplace, our great culture and our many career opportunities.

The event highlighted in local print, news and radio, social media, and with our community business partners. The response was phenomenal. We had over 300 attendees at the event and all of our department representatives were fully engaged with those who attended. The results surpassed our expectations and received positive feedback from every department. Following the event in the first quarter we have received over 1,300 employment applications. For comparison purposes, in the timeframe of March through December 2022, we received 699 applicants. Over 160 interviews were

scheduled, and 43 job offers were accepted in this first quarter. Our first career event was a huge success, and we are looking forward to the next planned event on Tuesday, June 13, 2023.

Pay for Performance (P4P) Provider Meeting: KHS hosted our annual Pay for Performance (P4P) Dinner on January 26th, to introduce KHS goals for 2023 and the quality measures covered under the P4P program. KHS incentivizes contracted Primary Care Providers through a Pay for Performance program by identifying quality criteria focused on Healthcare Effectiveness Data and Information Set (HEDIS), Managed Care Accountability Set (MCAS), and health plan defined measures. With approximately 200 attendees, there was representation from Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and independent provider practices. The event focused on providing valuable information on ways to increase quality outcomes for Kern Family Health Care members. KHS staff representing all departments were present, to promote organizational engagement with our provider community.

2023 Summer Externship Summary: KHS will be offering summertime externship opportunities. Summer externs will go through the standard KHS hiring process (i.e. a background check, drug screening, orientation) and will be provided the opportunity to participate in job related trainings. All externs will work onsite with an assigned supervisor/workplace mentor. The target candidates will be high school junior/seniors, college, and university students. The intent is to expose the various career opportunities KHS has to offer to our local workforce. Areas of focus will be in technology, health education, claims processing, accounting, customer service, clinical programs, and health care administration. Externs will work no more than 28 hours per week. This will be a paid externship program.

KERN HEALTH SYSTEMS

Compliance and Regulatory Affairs

Board of Directors Meeting

Jane MacAdam
Director of Compliance & Regulatory Affairs
April 13, 2023

CEO Board Report - Attachment A

All Plan Letters and Regulatory Guidance released since the February 2023 Kern Health Systems Board of Directors' meeting:

The Department of Health Care Services (DHCS) released two revised attachments for All Plan Letters (APL) , one revised APL and four new APLs during this time period.

- APL 17-020 - American Indian Health Programs (Issued 12/15/2017 and Attachment # 1 Revised 3/2/2023)

  This APL's Attachment #1 was updated and includes information on the list of American Indian Health Program Providers.

- APL 21-008 - Tribal Federally Qualified Health Center Providers (Issued 5/12/2021 and Attachment #2 Revised 3/2/2023)

  This APL's Attachment #2 was updated and includes information on the list of Tribal Federally Qualified Health Center Providers.

Continued…

- APL 23-003 - California Advancing and Innovating Medi-Cal Incentive Payment Program (Issued 3/8/2023)

  The APL provides Plans with guidance on the Incentive Payment Program implemented by the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

- APL 23-004 - Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Issued 3/14/2023)

  The APL provides requirements to Plans on the Skilled Nursing Facility Long Term Care benefit standardization provisions of the California Advancing and Innovating Medi-Cal initiative, including the mandatory transition of beneficiaries to managed care.

- APL 23- 005 - Requirements for Coverage of Early and Periodic Screening, Diagnostic, & Treatment (EPSDT) Under 21 (Issued 3/16/2023)

  The APL clarifies the responsibilities of the Plan to provide EPSDT services to eligible Members under the age of 21. This policy applies to all Members under the age of 21 who are enrolled in the Plan. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provisions of Medi-Cal services, including EPSDT.

Continued…

- APL 22-029 - Dyadic Services and Family Therapy Benefit (Issued 12/27/2022 and revised 3/20/2023)

  The APL provides the Plan with guidance on coverage requirements for the provision of the new Dyadic Services and family therapy benefit effective January 1, 2023.

- APL 23-006 - Delegation and Subcontractor Network Certification (Issued 3/28/2023)

  The APL provides the Plan with guidance on the requirements for delegation and monitoring of Subcontractors. This APL also details the Subcontractor Network Certification process wherein the Plan must provide assurances that each Subcontractor's and Downstream Subcontractor's Provider Network meets state and federal Network adequacy and access requirements.

Continued…

The Department of Managed Health Care (DMHC) released five All Plan Letters (APL) during this time period.

- APL 23-005 - Network Service Area Confirmation Process (Issued 2/13/2023)

  The APL requires specified health plans to participate in a Network Service Area Confirmation Process to establish compliance with Rule 1300.67.2.2 and Section 1367.03, pursuant to the exemption from the Administrative Procedures Act set forth in Section 1367.03(f)(3).

- APL 23-006- Independent Medical Review Application Complaint Form (Issued 2/24/2023)

  The APL informs all Plans that the Department has revised the Independent Medical Review Application/Complaint Form (DMHC 20-224)

- APL 23-007 - Provider Directory Annual Filing Requirements (Issued 3/23/2023)

  The APL reminds Plans of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department of Managed Health Care.

Continued…

- APL 23-008 - Health Plan Requirements to Timely Pay Claims (Issued 3/24/2023)

  This APL highlights and remind plans of timely payment and utilization management obligations with respect to hospitals.

- APL 23-009 - Health Plan Coverage of Preventive Services (Issued 3/30/2023)

  This APL reminds Plans of their obligation to cover preventive services as required by the Knox-Keene Health Care Service Plan Act.

2024 Operational Contract Readiness

Deliverable due dates and status:

- 92% of materials submitted to date are in approved status
- Significant volume of deliverables due in April/May; KHS is on track for submissions

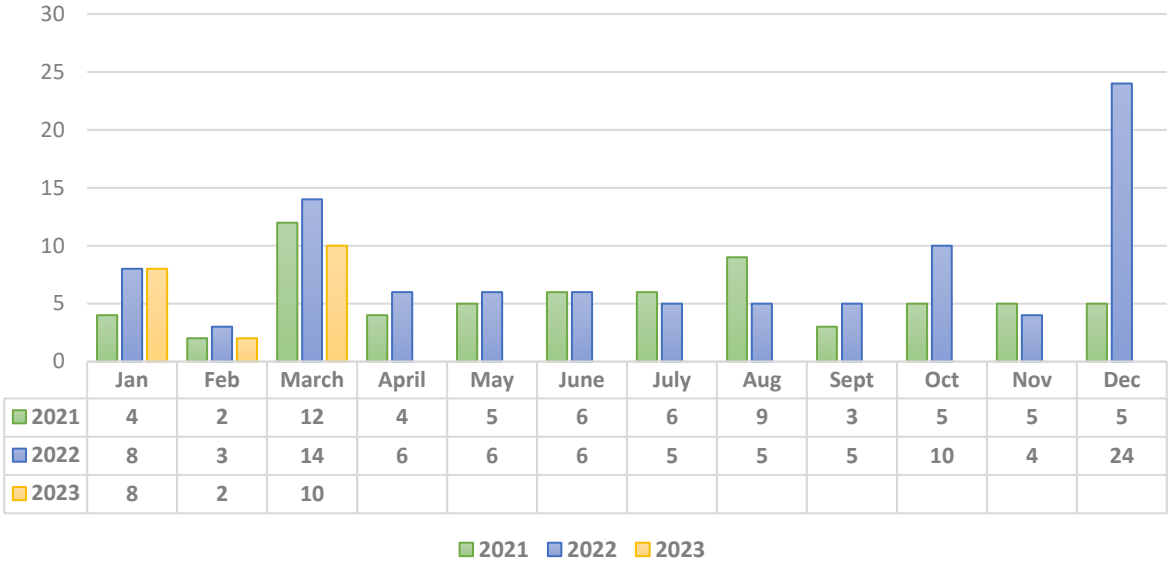
2024 Contract - Operational Readiness					
DHCS Deliverable Due Date	# of Deliverables Due	Current Status			
		Approved	Under Review at DHCS	Additional Information Requested by DHCS	On Hold *
8/12/2022	20	20	0	0	0
9/12/2022	27	27	0	0	0
10/3/2022	14	14	0	0	0
12/19/2022	37	34	0	2	1
1/9/2023	23	19	0	4	0
3/1/2023	3	2	1	0	0
3/30/2023	2	0	2	0	0
4/24/2023	31				
5/22/2023	34				
6/5/2023	1				
6/14/2023	2				
7/10/2023	2				
7/14/2023	6				
8/4/2023	15				
8/18/2023	5				
TBD	16				
Total	**238**	**116**	**3**	**6**	**1**

2024 Operational Readiness Additional Information Requests		
Requests for Additional Information (AIR)	# of Deliverables	Percentage
No AIR	84	66.67%
One AIR	35	27.78%
Two AIR	6	4.76%
Three AIR	1	0.79%
Total	**126**	**100%**

* On Hold = DHCS is not proceeding with reviewing this deliverable based on feedback received and/or additional forthcoming guidance

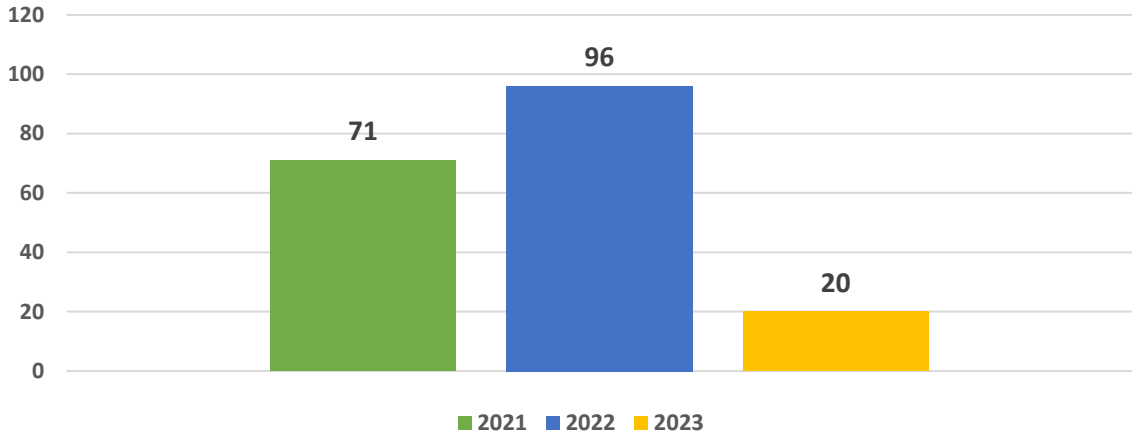
KERN HEALTH SYSTEMS

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



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2021	4	2	12	4	5	6	6	9	3	5	5	5
2022	8	3	14	6	6	6	5	5	5	10	4	24
2023	8	2	10									

Comparison of All Plan Letters and Guidance Letters Received by the Plan for Years 2021, 2022, & 2023



Number of Regulatory Reports & Filings
Submissions to Government Agencies
February 2023 and March 2023

Regulatory Agency	February 2023		March 2023	
	Ad Hoc	Standard	Ad Hoc	Standard
DHCS	25	31	30	32
DMHC	0	9	0	9

Regulatory Audits

Department of Managed Health Care (DMHC)

2020 DMHC Non-Routine Survey:

- 08/15/2022 – DHCS issued preliminary audit report for the 2020 Non-Routine Survey, with two findings:

  1. The Plan failed to demonstrate its *Varicose Veins Treatment Modalities* criteria are consistent with sound clinical principles and processes

  2. The Plan failed to evaluate all criteria used to determine whether to authorize health care services at least annually.

- 09/28/2022 – KHS submitted response to preliminary report, corrective actions taken, and supporting documentation.

  Corrective Actions:

  - Retired internal criteria 12/02/2020
  - Use only Medi-Cal and other evidence-based criteria to review
    - 106 requests confirmed to have used Medi-Cal or other evidence-based criteria
  - No longer use internally developed criteria
  - PAC reviews/approved changes to medical necessity criteria used at least annually

- 03/01/2023 - KHS Received Final Audit Report accepting KHS Corrective Actions as having corrected the deficiencies, with no additional follow-up needed.

Department of Managed Health Care (DMHC)

DMHC Routine Medical Survey – January 2023:

- DMHC conducted interviews for the Routine Medical Survey in January of 2023
- The Survey Period is 09/1/2020 through 08/31/2022 and included the following general survey areas:
  - Quality Assurance
  - Utilization Management
  - Grievance & Appeals
  - Access & Availability
  - Language Assistance
  - Access to Emergency Services & Payments
  - Prescription Drug Coverage
  - Continuity of Care
- For the audit, KHS submitted numerous documents:
  - over 1,850 documents for the pre-audit deliverables
  - over 750 detailed verification study requests (samples of grievances, call inquires, potential quality issues, etc.)
  - An additional 1,025 documents submitted due to follow-up requests received since the interviews

Department of Managed Health Care (DMHC)

DMHC Routine Medical Survey – January 2023 (continued):

- KHS is awaiting Preliminary Audit Report
  - Preliminary Report should be provided within 90 days after DMHC completion of review
  - KHS will have 45 days to submit response to preliminary report and Corrective Action Plan (CAP)
  - DMHC reviews response & CAP and provides final report
  - KHS has ten (10) days to request information be appended to final report
  - Final Report posted to website/public within 180 days from completion of survey
    - If deficiencies outstanding as of Final Report, DMHC will conduct a Follow Up Survey and issue Follow Up report within 18 months
    - Uncorrected or repeat deficiencies may be reported to the Office of Enforcement

Department of Health Care Services (DHCS)

2021 Medical Audit – September 2021

The DHCS conducted a Routine Medical Survey of Kern Health Systems from September 13, 2021 through September 24, 2021. The survey period was from August 1, 2019 through July 31, 2021.

- DHCS continued to review the KHS Corrective Action Plan submitted 03/11/2022 and additional supporting documentation was provided throughout the past year.
- Compliance continues to monitor the elements of the Corrective Action.
- It is unclear how the open Corrective Action Plan from the prior audit period will impact the results of the 2022 Medical Audit conducted in November.
- 03/23/2023 – KHS received the final closure letter for our 2021 DHCS Medical Survey Corrective Action Plan, accepted as submitted with all deficiencies showing as accepted with no further action needed.

Note: DHCS may still take additional actions as deemed appropriate regarding the deficiencies

Department of Health Care Services (DHCS)

2022 DHCS Routine Medical Survey – November 2022:

- DHCS still in the process of completing the routine medical survey for 2022
- The survey period is 11/01/2021 – 10/31/2022
- The interview portion of the Audit began the week of 11/28/2022 and continued through 12/09/2022
- For the audit, KHS submitted numerous documents:
  - Pre-Audit deliverables included over 1,000 documents submissions
  - Samples (verification studies) involved providing detailed screen prints, letters, case documentation, etc. for over 350 sample cases (Care Management, Potential Quality Issues, Grievances, Prior Authorizations, Claims, etc.)
  - KHS has also responded to over 250 follow up requests for additional information, including an 1000 additional documents in extremely short turn-around timeframes (often 24 hours)
- DHCS has scheduled an Exit Conference for 04/11/2023 during which they will review the preliminary report:
  - KHS should receive preliminary report 04/07/2023
  - KHS has 15 days from receipt to provide response and any additional documentation for consideration
  - DHCS will then issue final audit report.

Compliance Department
Fraud, Waste, & Abuse Activity
February 2023 and March 2023

KERN HEALTH SYSTEMS

The Compliance Department maintains communications with State and Federal agencies and cooperates with their related investigations and requests for information.

State Medi-Cal Program Integrity Unit, US Department of Justice, and the Kern County Deputy Attorney's Office Requests for Information for the months of February 2023 and March 2023

Providers:

The Plan received Three (3) request for information from the State Medi-Cal Program Integrity Unit - related to potential provider fraud, waste, or abuse during this time period.

Members:

The Plan received zero (0) requests for information from the State Medi-Cal Program Integrity Unit related to Plan Members during this time period.

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

Fraud, Waste & Abuse
Allegations Reported to the Plan
February 2023 and March 2023

The Plan investigates and reports information and evidence of alleged fraud, waste, & abuse cases to appropriate state and federal officials.

Information compiled during an investigation is forwarded to the appropriate state and federal agencies as required.

Members:

During months of February 2023 and March 2023, the Compliance Department received thirteen (13) allegations of fraud, waste, or abuse involving Plan Members.

Providers:

During months of February 2023 and March 2023, the Compliance Department received fourteen (14) allegations of Provider fraud.

The Plan continues to investigate the allegations and required reporting to DHCS has been submitted timely in all cases.

Compliance Department
HIPAA Breach Activity
February 2023 and March 2023

KERN HEALTH SYSTEMS

Summary of Potential Protected Health Information ("PHI") Disclosures for the months of February 2023 and March 2023 :

The Plan is dedicated to ensuring the privacy and security of the PHI and personally identifiable information ("PII") that may be created, received, maintained, transmitted, used or disclosed in relation to the Plan's members. The Plan strictly complies with the standards and requirements of Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH").

In February and March 2023, the Compliance Department received and reviewed forty-four (44) potential HIPAA incidents. Forty of the cases were closed by the Plan as non-breaches. One incident was closed as a non-breach by the DHCS and the DHCS is currently reviewing three cases submitted by the Plan.

2023 Corporate Goals Tracking

Corporate Goal:

Goal 1: Behavioral Health Program - Over the last several years, managed care plans have experienced a number of behavioral health focused services that transitioned under their scope of services. In 2018, the managed care plans assumed responsibility of Autistic Behavioral Therapy (ABA) and non-specialty mental health service delivery. Most recently, the plans are to collaborate with the specialty mental health provider to incorporate a "No Wrong Door" structure which requires close engagement between providers in coordinating behavioral and mental health care for the member, regardless of initial screening or service entry point. KHS currently lacks the personnel to oversee the services specific to behavioral health, and with an increased focus in care integrations, the need to develop a department is essential.

Deliverables	Start Date	Due Date	% Complete	Q1 Status
Develop and incorporate a Behavioral Health department into the KHS organizational structure. Create/update policies, procedures and operationalize the department in the 1st – 2nd Quarter, 2023.	1/1/2023	6/30/2023	30%	Initiation and Execution of the Behavioral Health Corporate Project. Ongoing development of relevant policies and procedures. Development and approval of BH job descriptions, and job requisitions.
Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS) and communicate with MHPs regarding DHCS requirements. Create a formal collaborative structure with Kern Behavioral Health and Recovery Services and other entities that provide behavioral and mental health services during the 2nd Quarter, 2023.	1/1/2023	6/30/2023	30%	Development of Scope of Work document for the new contracts for BH Providers. Meetings with BH providers to discuss BH Scope of Work. Ongoing meetings with Kern Behavioral Health and Recovery Services (KBHRS) to set up process for sending and receiving referrals/screenings for BH Services. Discussions on problem solving barriers to data sharing, creating systems that will improve collaboration between entities. Meetings with KBHRS Substance Use Disorder (SUD) Administrator on Coordination of Care for members in SUD treatment.
Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment services. Coordinate with participating Primary Care Providers, Inpatient Hospitals, Emergency Rooms, or other contracted medical settings for Medications for Addiction Treatment (MAT – aka Medication Assisted Treatment) starting in the 3rd Quarter, 2023.	7/1/2023	12/31/2023	0%	N/A
Evaluate the availability of emergency stabilization services. Coordinate with participating Primary Care Providers and Kern Behavioral Health and Recovery Services regarding access to care for substance use disorder (SUD) services in the 4th Quarter, 2023.	10/1/2023	12/31/2023	0%	N/A

Corporate Goal:

Goal 2: Quality and Health Equity Program - DHCS has published the 2022 Comprehensive Quality Strategy (CQS) that focuses on guiding principles of eliminating health disparities from inherent delivery system bias, using community-based partnerships; data driven improvements that address the whole person; and transparency, accountability and member involvement. These principles and strategies are meant to improve the clinical outcomes of our membership. There are also three specific focus areas that include children's preventative care, maternity care and birth equity, and behavioral health integration.

Deliverables	Start Date	Due Date	% Complete	Q1 Status
Identify organizational structure for the role of a Health Equity Officer, as required in the DHCS CQS. This position will be responsible for carrying out the CQS strategies in collaboration with the Quality Improvement and Population Health Management departments. Project to launch 1st Quarter, 2023.	1/1/2023	3/31/2023	100%	Chief Health Equity Officer hired and KHS Health Equity Office launched. Policies and procedures in progress. Health Equity Office structure completed and approved. Job descriptions created and posted. Interviews conducted and offers accepted. First draft of Quality Improvement and Health Equity Transformation Plan (QIHETP) developed; currently being reviewed by internal stakeholders.
Identify and assess members risks guiding the development of care management programs and focused strategies in the 2nd Quarter, 2023.	1/1/2023	6/30/2023	40%	Internal updates to Risk Stratification and Segmentation processes are ongoing. Re-structured Care Management (CM) Team to ensure all members received appropriate CM services. Hired LVNs and Community Health Workers to provide Care Management to moderate and low level risk members.
Create strategies to engage members as "owners of their own care". Member Engagement Program - Develop a robust member and community engagement program in the 2nd and 3rd Quarter, 2023	4/1/2023	9/30/2023	0%	N/A
Develop communication strategies that will focus on keeping families and communities healthy via prevention during the 3rd Quarter, 2023.	7/1/2023	9/30/2023	0%	N/A
Create early interventions for rising risk and patient centered chronic disease management by the end of the 3rd Quarter, 2023.	4/1/2023	9/30/2023	0%	N/A
Expand on programs that focus on whole person care for high-risk populations, addressing drivers of health by the end of the 4th Quarter, 2023.	4/1/2023	12/31/2023	0%	N/A

Corporate Goal:

Goal 3: Health Information Data Exchange & Security - Kern Health Systems is accountable to the Health Insurance Portability and Accountability Act of 1995 (HIPAA) Security Rule which leverages the National Institute Standards and Technology (NIST) for Information Security (InfoSec) practices. Additionally, the plan is obligated through contracts with the State of California to ensure that the health plan maintains data and systems following these standards. As KHS continues to expand on the health information data exchanges with numerous provider groups that potentially do not have technology safeguards in place, it also raises KHS security concerns. As a result, KHS continuously scrutinizes and updates its information and cyber security protocols and practices to ensure that the best strategies and tools are being used based to provide a secure and protected environment. Over the next year, KHS will establish 24-hour monitoring of its Information Security systems to ensure that there is immediate action to avoid potential threats. After the installation of this new system, KHS will perform its annual 3rd party audit of the Information Security procedures and controls and provide an Executive presentation to key stakeholders.

Deliverables	Start Date	Due Date	% Complete	Q1 Status
Procure, install, and configure new logging and monitoring system in the 1st Quarter, 2023	1/1/2023	3/31/2023	100%	Logging and monitoring system has been procured and installed. Currently monitoring 3rd party events.
Perform annual 3rd party audit following the NIST security framework to independently evaluate Kern Health Systems starting the 2nd Quarter, 2023	4/1/2023	6/30/2023	0%	N/A
Analyze audit and perform risk management and remediation on any findings to close gaps by end of 3rd Quarter, 2023	7/1/2023	9/30/2023	0%	N/A
Provide an Executive presentation to key stakeholders on the status of the Corporate Information Security strategies and audit by end of 4th Quarter, 2023.	10/1/2023	12/31/2023	0%	N/A

Corporate Goal:

Goal 4: Dual Eligible Special Needs Population (DSNP) and Medicare - Promoting integrated care by incorporating mandatory Medi-Cal Managed care enrollment for individuals who are dual eligible for (Medi-Cal and Medicare) is part of the CalAIM initiative to improve health. Although this is optional for managed care plans, it is strongly recommended by DHCS. The goal is to promote integration and align enrollment of the DSNP population, increase coordination of care, and better health outcomes. KHS would be eligible to offer a Medicare Advantage product in 2025-2026 contingent on preparation, fiscal and operational feasibility, and both DHCS and CMS approvals. In order to evaluate our role and readiness for this new line of business, the process and preparation is being initiated.

Goal 4a: National Committee for Quality Assurance (NCQA) Health Plan and Health Equity Accreditation - One component of DHCS' CalAIM initiative will require Health Plans to receive accreditation from the National Committee for Quality Assurance (NCQA) by 2026. This accreditation consists of a rigorous framework of policies and procedures designed to improve quality and quality measurement. Plans are evaluated across a number of departments and functions including Quality Improvement, Population Health Management, Provider Network Management, Utilization Management, and Member Services. Becoming NCQA accredited will require a multi-year approach to preparation. In 2023 KHS will assess current policy and procedure against the NCQA requirements to build out a remediation plan.

Deliverables	Start Date	Due Date	% Complete	Q1 Status
KHS will embark in a detailed Medicare Advantage Fiscal and Operational Feasibility study and gap analysis. This will require the procurement of consulting services that have the expertise in Medicare implementation for Medi-Cal focused plans. This process will start in the 1st Quarter of 2023 with final reporting by 4th Quarter, 2023.	1/1/2023	12/31/2023	25%	Initial Milliman Gap Analysis completed by end of 2022. Internal Medicare leadership onboarded and Corporate Project is executing. Developed internal assessment of capabilities. Medicare market and competitor analysis is in progress.

NCQA Gap Analysis will be initiated and will encompass all KHS departments. Education and training will be provided to all stakeholders on NCQA standards and accreditation processes. The Gap Analysis will assess the current plan position against NCQA standards starting in the 1st Quarter, 2023.	12/1/2022	2/28/2023	100%	Procurement completed for NCQA consulting services related to gap analysis and readiness. NCQA gap analysis and readiness assessment has been initiated. NCQA training conducted on health plan and health equity accreditation. Additional training will occur as needed through the course of the accreditation process.
Conduct NCQA readiness and gap assessment across all Health Plan functions and relevant NCQA standards starting in the 3rd – 4th Quarter, 2023.	1/1/2023	7/31/2023	45%	Internal documents gathering and staff interviews are in progress.
Develop a deliverable document with gaps and recommendations for remediation with reference to NCQA standard requirements. Develop timeline for readiness and application process will start in the 3rd – 4th Quarter, 2023.	6/1/2023	12/31/2023	0%	N/A

Corporate Goal:

Goal 5 – DHCS Incentive Programs - Starting in 2021, DHCS introduced Incentive Programs to promote health plan, provider, and community service organizations collaborative participation to carry out the development of several areas of the CalAIM initiatives. These incentive programs are not a requirement and participation is voluntary, however these funds are available to assist in building program and service delivery models, including infrastructure.

Deliverables	Start Date	Due Date	% Complete	Q1 Status
Goal 5a - Incentive Payment Program (IPP)				
KHS will host CalAIM Roundtables in partnership with key stakeholders, and/or continue promoting local engagement efforts with regional partners through diverse forums starting in 1st Quarter, 2023.	1/1/2023	12/31/2023	25%	CalAIM Kern Collaborative meetings held monthly in collaboration with HC2 Strategies and Health Net leadership promoting local engagement efforts with regional partners through this forum. Kern CalAIM Collaborative Steering Committee meeting also meeting monthly to offset planning and priority initiatives introduced at larger CalAIM Kern Collaborative meeting.
Establish quarterly performance monitoring capabilities ensuring milestones are met by KHS Provider Network and CBOs in order to award Provider proposals with earned dollars for Program Year 2023.	1/1/2023	12/31/2023	25%	Providers are submitting monthly progress reports with updates on milestones. Monthly meetings with providers to offer support to ensure milestones are met and address any challenges.
				The KHS Grants team aligns Provider Milestones with each priority area and will incorporate

Track high-priority budgeted solutions implemented, respective to each Priority Area strategy, as they are outlined in the Program Year 2 Incentive Payment Measure Set prior to an initial submission scheduled by DHCS by end of 3rd Quarter, 2023.	1/1/2023	9/30/2023	30%	with such priority area and will incorporate emerging CalAIM initiatives and quality measures as they are introduced for Submissions 3-5. Milestones will be updated ahead of each round of funding. On a monthly basis, internal teams meet to review operations with each Provider Site/CBO to include promotion of such high-priority items. KHS successfully submitted for reporting period 2B on 3/15/2023 and is working to develop an IPP performance monitoring tool specific to measuring baseline results from 2B versus target results and % change for future Submission periods 3-5. As DHCS releases updates and additional guidance for reporting periods, internal staff are engaged in reviewing and implementing any changes.
Goal 5b - Housing and Homelessness Incentive Program (HHIP)				
Implement the “Local Homelessness Plan (LHP)” determining what is necessary to meet structural and capacity requirements to fulfill HHIP objectives by 1st Quarter, 2023.	1/1/2023	3/31/2023	100%	Contracts for HHIP were finalized and executed in December 2022. Progression towards fulfilling HHIP objectives is discussed via meetings, committees, and working groups. HHIP projects are implemented and on track to meet milestones outlined in respective contracts addressing the needs in the County as outlined in the LHP.
Complete and submit to DHCS the “MCP Submission 1” outlining implementation approach to address gaps and needs by February 2023.	1/1/2023	3/10/2023	100%	Staff collected the necessary information for reporting and submitted by DHCS' updated due date of 3/10.
Create performance monitoring capability to measure the Local Homelessness Plan (LHP) success as defined as demonstrated performance against measure targets linked to achievement of HHIP milestones by 2nd Quarter, 2023.	3/1/2023	6/30/2023	50%	Progress reports collected monthly from HHIP contracted providers.
Complete and submit to DHCS the “MCP Submission 2” outlining implementation approach to address gaps and needs by December 2023.	10/1/2023	12/31/2023	0%	N/A
Goal 5c - Student Behavioral Health Improvement Program (SBHIP)				

Implement the “Project Plan (Milestone One)” determining what is necessary to fulfill SBHIP initiatives including each targeted intervention & the County Needs Assessment for Program Year 2, starting the 1st Quarter, 2023.	1/1/2023	12/31/2023	25%	Stakeholder and subgroup meetings are being held to discuss targeted interventions and monitor progress. Funding distribution logic established. Met with each district to discuss potential funding to be received for development of budgets. Needs assessment and Project Plans approved by DHCS. Draft of SBHIP funding contract with Kern County Superintendent of Schools for review.
Complete and submit to DHCS an initial Bi-Quarterly Report by end of 2nd Quarter, 2023.	5/15/2023	6/30/2023	0%	N/A
Complete and submit to DHCS a second Bi-Quarterly Report by end of 4th Quarter, 2023.	11/15/2023	12/31/2023	0%	N/A

Corporate Goal:

Goal 6 - Institutionalizing Telehealth Coverage Revisions as New (Permanent) Medi-Cal Benefit* - Telehealth Services has shown to be an effective method for maintaining the physician / patient relationship during the pandemic. DHCS modified its benefits to expand telehealth as an alternative to office visits during the stay-at-home order. DHCS intends to make permanent and expand several telehealth provisions that were allowed during the Public Health Emergency, effective in 2023.

Deliverables	Start Date	Due Date	% Complete	Q1 Status
Determine the impact to the participating provider network by 1st Quarter, 2023.Determine the impact to KHS, its policy, procedures, protocols, tracking and reporting by 1st Quarter, 2023	1/1/2023	TBD	25%	DHCS released draft All-Plan Letter (APL) language related to the extension and continuance of telehealth flexibilities allowed during the PHE. DHCS is reviewing feedback on the draft APL and preparing for final release to Plans.
Inform participating providers telehealth will become a permanent benefit effective 2023 under Medi-Cal by 4th Quarter, 2022	TBD	TBD	0%	N/A
Convey logistical information about the benefit and procedures providers will need to follow when using telehealth services and receiving payment for telehealth services by 1st Quarter, 2023	TBD	TBD	0%	N/A
Inform members that telehealth will be added to their Medi-Cal benefits explaining what it is, why it is beneficial and how this service will be provided and used for the member’s benefit by 1st Quarter, 2023	TBD	TBD	0%	N/A
Post implementation, audit each activity to ensure installation and performance meets KHS and government agencies expectations (ongoing over 2023)	TBD	TBD	0%	N/A

Subject to DHCS finalization of policy and release of guidance (APL)

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

Title	Description	Status
AB 47 (Horvath)	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB47	CAHP Opposed 03/20/23 - In committee: Set, first hearing. Hearing canceled at the request of author.
AB 55 (Rodriguez)	This bill would set the Medi-Cal fee-for-service reimbursement rate for emergency medical transports at $350 per transport. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB55	01/26/23 - Referred to Com. on HEALTH.
AB 85 (Weber)	This bill would require a health care service plan contract on or after January 1, 2024, to include coverage for screenings for social determinants of health, as defined. The bill would require a health care service plan or health insurer to provide primary care providers with adequate access to community health workers in counties where the health care service plan or health insurer has enrollees or insureds, as specified. The bill would make social determinants of health screenings a covered benefit for Medi-Cal beneficiaries and would require the State Department of Health Care Services to provide reimbursement for those screenings. This bill would require HCAI to convene a working group, with specified membership, to create a standardized model and procedures for connecting patients with community resources, to assess the need for a centralized list of accredited community providers, and to determine gaps in research and data to inform policies on system changes to address social determinants of health. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB85	CAHP Opposed 01/26/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 236 (Holden)	This bill would require a plan or insurer to annually audit and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on January 1, 2024, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before January 1, 2027. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2024, unless specified criteria applies. If an enrollee, by telephone call or electronic means, requests information on whether or not a provider is contracted as an in-network provider to provide covered benefits, the health care service plan shall respond in writing or electronic format no later than one business day after receiving the request. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB236	CAHP Opposed 03/21/23 - Re-referred to Com. on APPR.
AB 254 (Bauer-Kahan)	The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA makes a business that offers software or hardware to consumers that is designed to maintain medical information in order to make the information available to an individual or a provider of health care at the request of the individual or a provider of health care for purposes of allowing the individual to manage the individual's information or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. This bill would revise the definition of "medical information" to include reproductive or sexual health application information, which the bill would define to mean information related to a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service. The bill would make a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA.	03/15/23 - From committee: Do pass and re-refer to Com. on P. & C.P.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

	https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB254	
AB 317 (Weber)	This bill would require a health care service plan that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB317	03/22/23 - From committee: Do pass and re-refer to Com. on APPR.
AB 352 (Bauer-Kahan)	This bill would require specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to sensitive services, as specified. The bill would additionally prohibit a provider of health care, health care service plan, contractor, or employer from cooperating with any inquiry or investigation by, or from 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 or that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of this state, unless the request for medical information is authorized in accordance with specified existing provisions of law. The bill would define “sensitive services” for these purposes to mean all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB352	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 365 (Aguiar-Curry)	This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1, 2024, to review and update, as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB365	03/22/23 - From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar.
AB 425 (Alvarez)	This bill, the Pharmacogenomics Advancing Total Health for All Act (PATH for All Act), subject to an appropriation, would add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing, by a laboratory with specified licensing, accreditation, and certification, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications. The bill would cover the benefit under Medi-Cal if a medication, as defined, is being considered for use, or is already being administered, and is approved for use, in treating a Medi-Cal beneficiary's condition and is known to have a gene-drug or drug-drug-gene interaction that has been demonstrated to be clinically actionable, as specified, if the test is ordered by an enrolled Medi-Cal clinician or pharmacist. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB425	03/15/23 - In committee: Hearing postponed by committee.
AB 459 (Haney)	This bill would require the California Health and Human Services Agency, by July 1, 2026, to establish the California Behavioral Health Outcomes and Accountability Review (CBH-OAR), consisting of performance indicators, county self-assessments, and county and health plan improvement plans. The bill would require the agency to establish a risk corridor structure, as specified, that applies to all health payers who provide behavioral health services in California. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB459	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.
AB 492 (Pellerin)	This bill would, on or before July 1, 2024, require the department to make grants, incentive payments, or other financial support available to Medi-Cal managed care plans to develop and implement reproductive and behavioral health integration pilot programs in partnership with identified qualified providers, in order to improve access to behavioral health services. The bill would define "qualified provider" as a Medi-Cal provider that is enrolled in the Family PACT Program and that provides abortion-	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

	and contraception-related services. For funding eligibility, a Medi-Cal managed care plan shall identify the qualified providers and the services that will be provided through the pilot program, as specified. The bill would, on or before July 1, 2024, require the department to make grants or other financial support available to qualified providers for reproductive and behavioral health integration pilot programs for the integration of behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB492	
AB 557 (Hart)	This bill would extend the Brown Act abbreviated teleconferencing provisions when a declared state of emergency is in effect, or in other situations related to public health, as specified, indefinitely. The bill would also extend the period for a legislative body to make the above-described findings related to a continuing state of emergency and social distancing to not later than 45 days after the first teleconferenced meeting, and every 45 days thereafter, in order to continue to meet under the abbreviated teleconferencing procedures. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB557	02/17/23 - Referred to Com. on L. GOV.
AB 564 (Villapudua)	This bill would require the department to allow applicants or providers to submit electronic signatures for all enrollment forms, including, but not limited to, claims and remit forms, in the Medi-Cal program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB564	02/17/23 - Referred to Com. on HEALTH.
AB 576 (Weber)	Would require the Department of Health Care Services to fully reimburse providers for the provision of medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research, and the discretion of the provider. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB576	02/17/23 - Referred to Com. on HEALTH.
AB 586 (Calderon)	This bill would add climate change remediation to the list of community supports. For purposes of these provisions, the bill would define “climate change remediation” as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather or other climate events, including air conditioners, heaters, air filters, or generators, among other specified devices for certain purposes.	02/17/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

	https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB586	
AB 608 (Schiavo)	This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered. The bill would require the department to seek any necessary federal approvals to cover preventive services that are recommended by a physician or other licensed practitioner and that are rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site, as specified. The bill would also require the department to seek any necessary federal approvals to allow a nonlicensed perinatal health worker rendering those preventive services to be supervised by (1) an enrolled Medi-Cal provider that is a clinic, hospital, community-based organization (CBO), or licensed practitioner, or (2) a CBO that is not an enrolled Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB608	02/17/23 - Referred to Com. on HEALTH.
AB 614 (Wood)	This bill would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the MediCal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB614	02/17/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 620 (Connolly)	Existing law requires a health care service plan that provides coverage for hospital, medical, or surgical expenses to provide coverage for the testing and treatment of phenylketonuria, including coverage for the formulas and special food products that are part of a prescribed diet, as specified. This bill would require a health care service plan contract that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after January 1, 2024, to provide coverage for the testing and treatment of other digestive and inherited metabolic disorders. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB620	CAHP Opposed 02/17/23 - Referred to Com. on HEALTH.
AB 665 (Carrillo)	This bill would remove the requirement that, in order to consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, the minor must present a danger of serious physical or mental harm to themselves or to others, or be the alleged victim of incest or child abuse. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB665	02/23/23 - Referred to Com. on JUD.
AB 677 (Addis)	Spot bill related to the Confidentiality of Medical Information Act. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB677	02/14/23 - From printer. May be heard in committee March 16.
AB 719 (Boerner-Horvath)	This bill would require the department to require managed care plans to contract with public transit operators for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public transit operator. The bill would require the rates reimbursed by the managed care plan to the public transit operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB719	CAHP Opposed 02/23/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 815 (Wood)	This bill would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons and other health care providers in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025. This bill would require a health care service plan or health insurer, or its delegated entity, to accept a valid credential from a board-certified entity without imposing additional criteria requirements and to pay a fee to a board-certified entity based on the number of contracted providers credentialed through the board-certified entity. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB815	03/14/23 - Re-referred to Com. on HEALTH.
AB 845 (Alvarez)	This bill would establish within the State Department of Health Care Services an Older Adult Behavioral Health Services Administrator to oversee behavioral health services for older adults. The bill would prescribe the functions of the administrator and their responsibilities, including developing outcome and related indicators for older adults for the purpose of assessing the status of behavioral health services for older adults, monitoring the quality of programs for those adults, and guiding decision making on how to improve those services. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB845	02/23/23 - Referred to Coms. on AGING & L.T.C. and HEALTH.
AB 847 (Rivas)	This bill would extend eligibility for pediatric palliative care services and concurrent treatment for an underlying illness for those individuals who have been determined eligible for those services prior to 21 years of age, after 21 years of age. The bill would require a managed care plan to be liable for payment of these services received in a county different from the individual's county of residence if they are not available in that county. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB847	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.
AB 904 (Calderon)	This bill would require a health care service plan or health insurer, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. The bill would authorize the departments to jointly convene a workgroup to examine the implementation of these programs.	03/30/23 - Re-referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

	https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB904	
AB 907 (Lowenthal)	Would require a health care service plan on or after January 1, 2024, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by a provider. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB907	CAHP Opposed 03/20/23 - Re-referred to Com. on HEALTH.
AB 931 (Irwin)	This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB931	CAHP Opposed 02/23/23 - Referred to Com. on HEALTH.
AB 1036 (Bryan)	This bill would require a physician, upon an individual's arrival to an emergency department of a hospital, to certify in the treatment record whether an emergency medical condition existed, or was reasonably believed to have existed, and required emergency medical transportation services, as specified. This bill would, if a physician has certified that emergency medical transportation services according to these provisions, require a health care service plan, disability insurance policy, and Medi-Cal managed care plan, to provide coverage for emergency medical transport, consistent with an individual's plan or policy. The bill would specify that the indication by a physician pursuant to these provisions is limited to an assessment of the medical necessity of the emergency medical transport services, and does not apply or otherwise impact provisions regarding coverage for care provided following completion of the emergency medical transport. The bill would specify for Medi-Cal benefits, these provisions do not apply to various specified provisions relating to nonemergency transport services or any other law or regulation related to reimbursement or authorization requirements for services provided for emergency services and care. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1036	CAHP Opposed 03/02/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 1085 (Maienschein)	This bill would require the department to seek any necessary federal approvals for a Medi-Cal benefit to cover housing support services by 7/1/24. Under the bill, subject to receipt of those federal approvals, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness, as specified. Under the bill, the services would include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, as defined. If the evaluation finds that the state has insufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, the bill would require the department to provide recommendations for building capacity and a timeline for implementation consistent with the analysis findings. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1085	03/23/23 - From committee: Amend, and do pass as amended and re-refer to Com. on APPR.
AB 1091 (Wood)	This bill, the Health Care Consolidation and Contracting Fairness Act of 2023, would prohibit a contract issued, amended, or renewed on or after January 1, 2024, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's or health facility's entrance into a contract that contains specified terms. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1091	03/02/23 - Referred to Coms. on HEALTH and JUD.
AB 1120 (Gabriel)	This bill would require a school district, county office of education, state special school, or charter school that serves pupils in grades 6 to 12, inclusive, to, in consultation with school and community stakeholders, school-employed mental health professionals, and behavioral health experts, and before an unspecified school year, adopt a policy on universal mental health screening of pupils for youth behavioral disorders, as defined, in grades 6 to 12, inclusive, as provided. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1120	03/09/23 - Re-referred to Com. on ED.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 1122 (Bains)	This bill would authorize an applicant or provider to submit any primary authoritative source documentation as proof of required information, and would require the Director of Health Care Services to reasonably accept alternative formats and sources of that documentation so long as it is verified as authentic and comes from a primary source. This bill would authorize the applicant or provider to submit its application for enrollment up to 30 days before having an established place of business and have its application considered by the department. Under this bill, if the department fails to provide notice of a remediation period for discrepancies or areas of noncompliance that are reasonably remediable within a 30-day period, a denial of the application would not be effective and the provider would be authorized to give notice to the department that the deficiencies have been remedied within this period of time. The bill would require the department to consider the newly submitted information and proceed with consideration of the enrollment. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1122	03/13/23 - Re-referred to Com. on HEALTH.
AB 1202 (Lackey)	This bill would, no later than January 1, 2025, require each Medi-Cal managed care plan to conduct, and report to the department the results of, an analysis to identify the number and, as appropriate, the geographic distribution of Medi-Cal providers needed to ensure the Medi-Cal managed care plan's compliance with time or distance and appointment time standards for pediatric primary care, across all service areas of the plan. The bill would, no later than January 1, 2026, require the department to prepare and submit a report to the Legislature that includes certain information, including a summary of the results reported by Medi-Cal managed care plans, specific steps for Medi-Cal managed care plan accountability, evidence of progress and compliance, and level of accuracy of provider directories. The bill would, no later than July 1, 2024, require the department to submit a report to the Legislature, and to make it publicly available, with certain information for the 2019, 2020, 2021, and 2022 calendar years, including (1) the number of children 0 to 5 years of age, inclusive, and the number of children 6 to 18 years of age, inclusive, who are Medi-Cal beneficiaries receiving any of specified early childhood preventive or developmental services, and (2) the number of pregnant persons, and the number of postpartum persons, who are Medi-Cal beneficiaries receiving any of specified services.	03/30/23 - Re-referred to Com. on APPR.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

	https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1202	
AB 1230 (Valencia)	This bill would require the department, commencing no later than January 1, 2025, to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), as defined, to provide care to dual eligible beneficiaries. The bill would require that a HIDE-SNP or FIDE-SNP contract authorize a beneficiary to select from a number of available options and to maintain their established or selected health care providers. The bill would also require a contracting plan to perform all applicable required care coordination and data-sharing functions, and to provide documentation demonstrating the care integration that dual eligible beneficiaries receive through a HIDE-SNP or FIDE-SNP contract. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1230	03/02/23 - Referred to Com. on HEALTH.
AB 1241 (Weber)	Existing law requires providers furnishing service through video synchronous interaction or audio-only synchronous interaction, by a date set by the department, no sooner than January 1, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified. This bill would instead require, under the above-described circumstance, a provider to maintain the ability to either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care. The bill would specify that the referral and facilitation arrangement would not require a provider to schedule an appointment with a different provider on behalf of a patient. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1241	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.
AB 1288 (Reyes)	Would prohibit a health insurer from subjecting a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder that is prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder to prior authorization. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1288	CAHP Opposed 03/02/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 1300 (Flora)	Spot bill related to the Knox-Keene quality care requirements. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1300	02/17/23 - From printer. May be heard in committee March 19.
AB 1316 (Irwin)	This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment. The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the beneficiary. The bill would require coverage, including by a Medi-Cal managed care plan, for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of duration, or whether the beneficiary is voluntary, or involuntarily detained for evaluation and treatment, including emergency room professional services. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1316	03/02/23 - Referred to Coms. on HEALTH and JUD.
AB 1331 (Wood)	Would establish the Data Exchange Framework governing board and require the board to approve any modifications to that data sharing agreement and its policies and procedures. The bill would require the governing board to consist of 5 members, appointed as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1331	03/02/23 - Referred to Com. on HEALTH.
AB 1338 (Petrie-Norris)	This bill would add fitness, physical activity, recreational sports, and mental wellness memberships to the above-described list of community supports. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1338	03/02/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 1451 (Jackson)	This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of a behavioral health crisis that is identified during an appointment at a contracted facility where an enrollee or insured is receiving treatment from a contracted provider for a medical condition, as specified. The bill would authorize treatment for the behavioral health crisis to be provided at the contracted facility, if the facility has the appropriate staff to provide that care. The bill would require the treatment to be provided without preauthorization, and would authorize the provider or facility to use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee or insured. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1451	CAHP Opposed 03/09/23 - Referred to Com. on HEALTH.
AB 1470 (Quirk-Silva)	The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to develop standard forms, including intake and assessment forms, relating to medical necessity criteria, mandatory screening and transition of care tools, and documentation requirements pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions. The bill would authorize the department to develop and maintain a list of department-approved nonstandard forms. The bill would require the department to conduct, on or before July 1, 2025, regional trainings for personnel and provider networks of applicable entities, including county mental health plans, Medi-Cal managed care plans, and entities within the fee-for-service delivery system, on proper completion of the standard forms. The bill would require each applicable entity to distribute the training material and standard forms to its provider networks, and to commence, no later than July 1, 2025, exclusively using the standard forms, unless it uses department-approved nonstandard forms. The bill would require providers of applicable entities to use those forms, as specified. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202320240AB1470	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 1481 (Boerner Horvath)	This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). The bill would make a presumptively eligible pregnant person eligible for coverage of all medical care, services, prescriptions, and supplies available under the Medi-Cal program, except for inpatient services and institutional long-term care. The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified. The bill would allow a pregnant individual under 26 years of age who can consent to services without parental approval to receive presumptive eligibility by a qualified hospital. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1481	03/20/23 - Re-referred to Com. on HEALTH.
AB 1502 (Schiavo)	This bill would prohibit a health care service plan or health insurer from discriminating on the basis of race, color, national origin, sex, age, or disability through the use of clinical algorithms in its decision making. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1502	03/09/23 - Referred to Coms. on HEALTH and JUD.
AB 1608 (Joe Patterson)	Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1608	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 1644 (Bonta)	This bill would make medically supportive food and nutrition intervention plans, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the department. The bill would require medically supportive food and nutrition intervention plans be covered when determined to be medically necessary by a health care provider or health care plan. In order to qualify for coverage under the Medi-Cal program, the bill would require medically supportive food and nutrition intervention plans include at least 3 of 6 specified medically supportive food and nutrition interventions. The bill would only provide coverage for nutrition support interventions when combined with the minimum 3 interventions. The bill would require health care providers or health care plans to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention plan and include culturally appropriate foods whenever possible. The bill would establish the Medically Supportive Food and Nutrition Benefit Committee to assist the department in developing final guidance related to eligible populations, the duration and dosage of medically supportive food and nutrition intervention plans, the rate setting process, determination of permitted providers, and continuing education for health care providers and health care plans, as specified. The bill would require the committee to include certain stakeholders knowledgeable in medically supportive food and nutrition interventions and stakeholders from Medi-Cal consumer advocacy organizations. The bill would require the committee to meet at least quarterly and would require the department to issue final guidance on or before July 1, 2026. The bill would also include findings and declarations of the Legislature relating to the need for medically supportive food and nutrition intervention coverage under the Medi-Cal program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1644	03/23/23 - From committee chair, with author's amendments: Amend, and re-refer to Com. on HEALTH.
AB 1690 (Kalra)	Spot bill stating the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1690	02/18/23 - From printer. May be heard in committee March 20.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

AB 1698 (Wood)	Spot bill related to Medi-Cal rates. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1698	02/18/23 - From printer. May be heard in committee March 20.
SB 70 (Wiener)	This bill would prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, regardless of whether or not the drug, dose, or dosage form is on the plan's or insurer's formulary. The bill would prohibit a health care service plan contract from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB70	CAHP Opposed 03/08/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
SB 257 (Portantino)	Beginning on January 1, 2025, this bill would require health plans and insurers to provide coverage without imposing cost sharing for, among other things, screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer, except as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB257	CAHP Opposed 03/16/23 - Set for hearing March 29.
SB 282 (Eggman)	This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB282	03/22/23 - Re-referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

SB 299 (Eggman)	This bill would remove loss of contact with a beneficiary, as evidenced by the return of mail, as a circumstance requiring prompt redetermination and would delete requirement for a county to send a notice of action terminating eligibility if the prepopulated form is returned and the purpose for the redetermination is loss of contact with the beneficiary. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB299	03/23/23 - From committee: Do pass as amended and re-refer to Com. on APPR.
SB 311 (Eggman)	This bill would require the department to submit a state plan amendment no later than January 1, 2024, to enter into a Medicare Part A buy-in agreement with the federal Centers for Medicare and Medicaid Services. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB311	LHPC Support 03/23/23 - From committee: Do pass and re-refer to Com. on APPR with recommendation: To consent calendar.
SB 324 (Limon)	This bill would add laparoscopic surgery for endometriosis as a covered benefit under Medi-Cal without prior authorization or other utilization review. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB324	CAHP Opposed 03/09/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
SB 339 (Weiner)	Existing law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. This bill would instead authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. This bill would require a health care service plan and health insurer to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist, including costs for the pharmacist's services and related testing ordered by the pharmacist, and reimburse pharmacist services at 100% of the fee schedule for physician services. The bill would include preexposure prophylaxis furnished by a pharmacist as pharmacist services on the Medi-Cal schedule of benefits.	CAHP Opposed 03/14/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E. D.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

	https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB339	
SB 340 (Eggman)	This bill, for purposes of Medi-Cal reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB340	03/16/23 - Set for hearing March 29.
SB 424 (Durazo)	This bill would statutorily expand the list of CCS-eligible medical conditions to include those conditions that are specified in existing CCS-related regulations. The bill would, commencing no later than January 1, 2026, and every 5 years thereafter, require the department to consult with, at a minimum, CCS medical directors and experts from the department's CCS technical advisory committees, to consider the addition of other medical conditions to the list, by regulation. Existing law establishes a Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in a Medi-Cal managed care plan served by a county organized health system or Regional Health Authority, or, commencing no sooner than January 1, 2024, an alternate health care service plan, in certain listed counties. This bill would specify that only those listed counties are authorized for the Whole Child Model program. https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202320240SB424	03/29/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

SB 427 (Portantino)	This bill would prohibit a health care service plan from subjecting antiretroviral drugs, devices, or products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of AIDS/HIV to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request. The bill would prohibit a health care service plan contract from imposing any cost-sharing or utilization review requirements for antiretroviral drugs, devices, or products that are either approved by the FDA or recommended by the CDC for the prevention of AIDS/HIV. The bill would require a grandfathered health care service plan contract or health insurance policy to provide coverage for those drugs, devices, or products, and would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, devices, or products, including by supplying participating providers directly with a drug, device, or product, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB427	CAHP Opposed 03/21/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
SB 496 (Limon)	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2024, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions if the test is supported by medical and scientific evidence, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB496	CAHP Opposed 02/22/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

SB 502 (Allen)	This bill would require the department, subject to an appropriation, to file all necessary state plan amendments to exercise the option made available under CHIP provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB502	02/22/23 - Referred to Com. on HEALTH.
SB 525 (Durazo)	This bill would require a health care worker minimum wage of $25 per hour for hours worked in covered health care employment, as defined, subject to adjustment, as prescribed. This bill would require, for covered health care employment where the employee is paid on a salary basis, that the employee earn a monthly salary equivalent to no less than 2 times the health care worker minimum wage for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB525	03/21/23 - Set for hearing April 12.
SB 535 (Nguyen)	Spot bill related to Knox-Keene Act provisions of continuity of care and access. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB535	02/22/23 - Referred to Com. on RLS.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

SB 537 (Becker)	This bill would authorize certain legislative bodies to use alternate teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. The bill would also require a legislative body to provide a record of attendance on its internet website within 7 days after a teleconference meeting, as specified. The bill would define "legislative body" for this purpose to mean a board, commission, or advisory body of a multijurisdictional cross county agency, the membership of which board, commission, or advisory body is appointed and which board, commission, or advisory body is otherwise subject to the act. The bill would also define "multijurisdictional" to mean a legislative body that includes representatives from more than one county, city, city and county, special district, or a joint powers entity. With respect to the alternative teleconferencing provisions operative until January 1, 2026, the bill would expand the circumstances of "just cause" to apply to the situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB537	03/22/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
SB 598 (Skinner)	Would, on or after January 1, 2025, prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB598	CAHP Opposed 03/22/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
SB 694 (Eggman)	This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program for the treatment of high blood pressure. The bill would state the intent of the Legislature that those covered devices and services be consistent in scope with devices and services that are recognized under	03/01/23 - Referred to Com. on HEALTH.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

	specified existing billing codes or their successors. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB694	
SB 770 (Weiner)	This bill would direct the Secretary of the California Health and Human Services Agency to pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The bill would further require the secretary to establish a Waiver Development Workgroup comprised of members appointed by the Governor, Speaker of the Assembly, and President Pro Tempore of the Senate, as specified. The bill would require the workgroup to include stakeholders representing various specified interests, including consumers, patients, health care professionals, labor unions, government agencies, and philanthropic organizations. The bill would also require the secretary to submit a complete set of recommendations regarding the elements to be included in a formal waiver application, as specified, by no later than June 1, 2024. The bill would include legislative findings related to the findings of the commission and declare the intent of the Legislature in implementing a unified health care financing system in California. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB770	03/20/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

SB 805 (Portantino)	This bill would expand the criteria for a qualified autism service professional to include a behavioral health professional and a registered, certified, or licensed health care associate or assistant, as specified. The bill would expand the criteria for a qualified autism service paraprofessional to include a behavioral health paraprofessional, as specified. This bill would require the department to adopt emergency regulations to address the use of behavioral health professionals and behavioral health paraprofessionals in group practice provider behavioral intervention services. The bill would require the department to establish rates and the educational or experiential qualifications and professional supervision requirements necessary for these positions to provide behavioral intervention services, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB805	03/22/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
SB 819 (Eggman)	Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB819	03/20/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.

KERN HEALTH SYSTEMS

ATTACHMENT C: BILL TRACKER

SB 870 (Caballero)	This bill would extend the MCO provider tax to an unspecified date and would make conforming changes to the timeline of related provisions by incorporating other unspecified dates. The bill would reorganize the taxing tiers of the MCO provider tax, in a manner consistent with the modified tax structure under the previous waiver, but with unspecified tax rate amounts. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB819	03/20/23 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.

KERN HEALTH SYSTEMS

MEDIA Clips

This news compilation is intended for KHS purposes only. KERN COUNTY

Kern Family Health Care creates two CSUB scholarship funds
By CSUB

California State University, Bakersfield and Kern Family Health Care (KFHC) are coming together to help meet the workforce needs in Kern County. KFHC which provides Medi-Cal coverage to Kern County residents has established two new scholarship funds at CSUB, one for nursing majors and the other for students pursuing their Master in Social Work (MSW). The company hopes to help students obtain their degrees and get into the local health care industry.

Read More

Community Sponsorships Help Students Proceed
By Bakersfield College

Kern Health Systems created a new scholarship which will award $8,000 each year to nursing students.

Read More

CSUB honors four Alumni Hall of Fame inductees
By The Bakersfield Californian

For any proof that Friday was a special night at Cal State Bakersfield, there was no need to look further than Emily Duran's twin daughters, Charlotte and Rebecca.

Read More

CSUB hosts alumni Hall of Fame event Friday
By KGET

The alumni Hall of Fame event returns for its 17th year to honor four local inductees for their contributions to the community.

Read More

Local Newscasts

KGET Channel 17 - NBC
Monday – Friday
5 am, 6 am, 12 pm, 5 pm - 6:30 pm, 11 pm
Sat. & Sun.
5 pm, 6 pm, 11 pm

KERO Channel 23 – ABC
Monday – Friday
4:30 am, 11 am, 5 pm, 6 pm, 7 pm, 11 pm
Sat. & Sun.
6 am, 8 am, 6 pm, 11 pm

KBAK Channel 29 – CBS
Monday – Friday
4:30 am, 12 pm, 5 pm, 6 pm, 7 pm, 11 pm
Sat. & Sun.
5 pm, 6 pm , 11 pm

KBFX Channel 58 – Fox
Monday – Friday
7 am, 12:30 pm, 10 pm

Sat. & Sun.
6 pm, 10 pm

KERN HEALTH SYSTEMS

MEDIA Clips

This news compilation is intended for KHS purposes only. KERN COUNTY

Addressing the stark healthcare disparities for Black mothers and infants
By KERO 23

According to the CDC, Black women are three times more likely to die from a pregnancy-related cause than white women. The Black Infant Maternal Health Initiative, which collects data from the CDC and other health monitoring organizations, reports that in Kern County, Black infants are also 1.5 times more likely to die than infants of other races. Director of Health Education with Kern Family Health Care Isabel Silva says there is still no reasoning for the disparity.

Read More

Black Trailblazers: Celebrating the legacy of leadership
By KERO 23

Community leader Traco Matthews and T Johnson say the best way to honor the legacy of Black leaders of the past is to pass it on to the Black leaders of the future. One of the most significant things about Black History Month is highlighting Black leaders from the past who took part in marches, movements, and fought for the rights that are enjoyed today.

Read More

Kern Medical opens new imaging center
By The Bakersfield Californian

The hospital received $2.5 million in state grant funding to purchase the machines. “When we talk about the underserved population, and those individuals that have barriers to care, it really is difficult for us to understand,” said Emily Duran, CEO of Kern Health Systems. “It’s important to have imaging centers and facilities like we have here.”

Read More

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Martha Tasinga, MD, CMO, PAC Chair

Date: April 13, 2023

Re: KHS REVISED POLICY AND PROCEDURE – 4.01-P Credentialing Program

---

Background

Modification to Kern Health Systems (KHS) policies pertaining to Credentialing Program were approved by the Physician Advisory Committee on 4/5/2023.

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

Policy Description Modification –

- Section 7.0 – ADDITIONAL INFORMATION
  - Subsection 7.8 (New) New section added to outline credentialing assessment and requirements for Community Healthcare Workers (CHW Providers)
  - Subsection 7.9 (New) New section added to outline credentialing assessment and requirements for Doula Birth Providers
  - Subsection 7.10 (New) New section added to outline credentialing assessment and requirements for Dyadic Care Service Providers and Non-Specialty Mental Health Service Providers (Associate Clinical Social Workers, Associate Marriage/Family Therapy, Associate Professional Counselors, and Psychology Assistants.)
- Attachment D – NON-LICENSED OTHER PROVIDER TYPES SPECIFIC CREDENTIALING CRITERIA
  - Added Attachment D to outline the specific credentialing assessment, requirements and criteria for these on-licensed provider types.
  - References: CHW APL 22-016, or any superseding APL; Doula Services APL 22-031 or any superseding APL; and DHCS NSMHS Provider Manual and/or DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit.

These changes were made to bring policy changes required by new All Plan letters 22-016 (CHW), 22-031 (Doula Services) and 22-029 (Dyadic Care) outlining the credentialing assessment requirements for these non-licensed provider types.

Requested Action

Approve policy revisions to the 4.01-P Credentialing Program

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Credentialing Program				POLICY #: 4.01-P	
DEPARTMENT: Provider Network Management					
Effective Date:	Review/Revised Date:	DMHC		PAC	
01/1997	04/2023	DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Senior Director of Provider Network

POLICY:
Kern Health Systems ("KHS") members are entitled to quality health care. It is the policy of KHS that every reasonable effort is made to verify health care providers with whom KHS contracts meet the basic standards of training, certification, and performance. Credentialing and recredentialing requirements are applicable to all licensed practitioners, non-physician practitioners, ancillary and facility providers contracted with KHS (collectively referred to herein as "provider(s)"). A contracted provider must be credentialed with KHS in order to treat KHS members.

PROCEDURES:
Credentialing is defined as the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership. It is the process by which health care providers are evaluated and approved for provider status as contractors and subcontractors in the KHS network. The credentialing program has been developed in accordance with state and federal requirements, accreditation guidelines and comply with the

Department of Managed Health Care ("DMHC") and the Department of Health Care Services ("DHCS") requirements, including DHCS All Plan Letter ("APL") 22-013 and subsequent updates to this APL, if any. KHS meets all DMHC and DHCS requirements, and has established credentialing criteria, including the verification sources used, based on state, federal and current accreditation guidelines from the National Committee for Quality Assurance ("NCQA") credentialing standards.

SCOPE OF PROVIDERS COVERED BY CREDENTIALING

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

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

PROVIDERS WHO DO NOT NEED TO BE CREDENTIALED

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

- Hospitalist practicing exclusively in an inpatient setting
- Radiologist practicing in an outpatient setting
- Anesthesiologist in an ambulatory care setting or practicing in an office setting specific to pain management.

NON-DISCRIMINATORY CREDENTIALING FOR PROVIDERS

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

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

1.0 APPLICATION

Application for provider status is made by submitting a completed application together with the applicable and required supporting documents to the Provider Network Management Department. Application forms are available through the Provider Network Management Department and are available electronically on the KHS Provider Portal.

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

No application shall be acted upon unless it is complete, signed and dated, which includes completion of the application form, attestation questionnaire, release of information and submission of all supporting documents, including any additional information requested by the PAC. If the provider is notified that the application (or supporting documents) is incomplete or illegible, the provider must provide the missing information for the credentialing process to continue within 10-calendar days. The provider is responsible for providing the information to satisfy the process or request by the PAC. It is the provider's burden to provide all information requested and to resolve any difficulties in verifying or obtaining the documentation required to satisfy the credentialing requirements. If the provider fails to provide this information, the credentialing application will be deemed incomplete and will result in an administrative denial or withdrawal of application from the KHS network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.
Applications are evaluated according to the credentialing criteria and verification sources set forth in Attachments A & B. An application that does not satisfy these criteria, as determined by the PAC or Board of Directors, may be denied. The PAC may deny provider status if the information submitted is insufficient to resolve reasonable doubts as to the provider's qualifications. KHS reserves the right to exercise discretion when applying any criteria and to exclude providers who do not meet the criteria. KHS Board of Directors, after considering PAC recommendation, may waive any requirement for network participation established by these policies and procedures for good cause if it is determined that such waiver is necessary to meet the needs of KHS and the community it serves. The refusal to waive any requirement shall not entitle the provider to a hearing or any other rights of review.

1.1 Required Attestation

The application includes an attestation which includes, but is not limited to the

following statements by the applicant:

A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation, and reasons for the same;
B. History of loss of license and/or felony conviction(s), including plea of *nolo contendere*;
C. History of loss or limitation of privileges and/or disciplinary activity;
D. Lack of present illegal drug use;
E. A current and signed attestation by the applicant of the accuracy and completeness of the application.

2.0 APPLICATION REVIEW/COMMITTEE AND BOARD REVIEW

2.1 Application Review

The PAC shall serve as the Credentials Committee and shall be responsible for the review of all applications.

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

A. The appropriate license and/or board certification or registration to practice in California.
B. Evidence of graduation or completion of any required education
C. Proof of completion of any relevant medical residency and/or specialty training.
D. Work history
E. Hospital and clinic privileges in good standing
F. History of suspension or curtailment of hospital and clinic privileges
G. Current Drug Enforcement Administration identification number.
H. National Provider Identifier number
I. Current malpractice or professional insurance in an adequate amount, as required for the particular provider type
J. History of liability claims against the provider
K. Provider information, if any, entered in the National Practitioner Data Bank, when applicable
L. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network
M. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the relevant DHCS All Plan Letter and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy.

2.2 Discrepancies in Credentialing Information

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

within 10-calendar days of the notification.

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

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

2.4 Provider Rights

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

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

2.5 Confidentiality

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

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

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

2.6 Credentialing File Review

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

All providers participating in the KHS network must be approved by the PAC. The CMO has the authority to determine whether or not credentialing or recredentialing files are "clean" and meet established criteria. A file must meet the following criteria to be considered a "clean file":

A. No malpractice cases that resulted in settlement or judgment paid on behalf of the provider within the previous 5-years for initial applicants or since the last credentialing/recredentialing review date;
B. No 805/805.1 reports, State Licensing accusations, limitations or sanctions on licensure;
C. No adverse events from other regulatory, state or federal agencies, i.e., OIG, NPDB, Medicare Opt Out, Medi-Cal Suspended or Ineligible list, System for Award Management, etc.
D. Current and signed attestation confirming correctness and completeness of application
E. For those offices requiring an office site visit, overall score of 90% or higher;
F. For recredentialing, no more than seven (7) member complaints, no internal quality of care case reviews, no utilization management or compliance issues or trends in the prior 3-years.
G. The CMO will have the discretion to refer any member complaint or quality of care concern for a comprehensive review by the PAC regardless of the severity score.
H. Those files determined by the CMO not meeting the above criteria or at his/her sole discretion, will require comprehensive review by the PAC.

2.7 Comprehensive Reviews

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

The CMO or his/her designee reviews the applications and prepares his/her approval or recommendations to the PAC, as follows:

A. The recommendation is reviewed by the PAC which prepares its approval or recommendation, such as modification or denial, which is submitted to the Board of Directors.
B. If the PAC recommends the denial of the application based on:
    a. A perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; and/or
    b. A perceived issue with conduct or professional competence which affects or could affect adversely the health or welfare of a patient or patients

Then the application shall be referred to Peer Review and/or the Board for consideration and recommendation. The Peer Review and/or Board has the

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

2.8 Provisional Approval

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

If provisional approvals are granted by the Board of Directors, the applicant shall be presented to the PAC at its next meeting for approval.

2.9 Locum Tenens

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

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

If there are malpractice actions pending and/or closed against a Locum Tenens provider, KHS may at its sole discretion allow for the provider to serve as a Locum Tenens depending on the nature of the malpractice actions. In any of the described

situations, the Locum Tenens provider must receive written approval from KHS prior to rendering services to KHS members, if payment is to be made.

If the Locum Tenens status is approved by KHS, the Locum Tenens provider will be compensated for services at the same rate as the KHS contracted provider. However, KHS is not responsible for the compensation arrangement between the provider on leave and the Locum Tenens provider. The use of the same Locum Tenens provider will be limited to 90 consecutive days. KHS reserves the right to approve a Locum Tenens status extension due to extenuating circumstances.

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

2.10 PAC Decision Regarding Credentialing

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

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

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

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

2.11 Effective Date

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

2.12 Notification of Decisions Regarding Initial Applicants

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

3.0 PROVIDER RESPONSIBILITY TO REPORT CHANGES

Once approved, each provider shall remain in compliance with the credentialing criteria and report to the CMO all of the following:

A. The commencement or resolution of any civil action against the provider for professional negligence
B. Any change in the provider's license or DEA status
C. The initiation of and reason for any investigation or the filing of any complaint against the provider by any government agency
D. Any adverse determination by any facility or entity with a credentialing or peer review process concerning provider's quality of care.
E. A change in any hospital or practice privilege granted to the practitioner by any facility or entity with a credentialing or peer review process
F. Any change in the provider's errors and omissions or professional negligence insurance coverage including changes affecting coverage of specific clinical procedures or privileges of the practitioner
G. Conviction of the provider or entry of a plea of *nolo contendere* to any felony;
H. Conviction of a provider or entry of a plea of *nolo contendere* to any misdeameanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services
I. Conviction of the provider of any crime or an entry of a plea of *nolo contendere* to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to practice medicine or deliver health care services
J. The filing of any charges against the provider alleging unlawful sale, use, or possession of any controlled substance.
K. Suspension from the federal Medicare or Medicaid programs for any reason;
L. Lost or surrendered a license, certificate, or approval to provide health care;
M. Any other adverse occurrence that relates to the provider's license or practice, including but not limited to revocation or suspension of a license by a federal, California, or another state's licensing, certification, or approval authority;
N. If the provider is a clinic, group, corporation or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization of any crimes set forth above.

4.0 RECREDENTIALING AND COMPLIANCE WITH LAWS

Each provider is recredentialed every 36-months. However, recredentialing may be made sooner when required by a change in relevant provider information or if the PAC makes such recommendation.[ii] The process includes a review of all applicable areas for credentialing.

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

A provider may be reviewed any time at the request of the QI/UM Committee, the PAC, the Chief Executive Officer, the CMO, or the Board of Directors. During recredentialing, KHS will consider information from other sources pertinent to the credentialing process, including

but not limited to, quality improvement activities, member grievances, and medical record reviews.

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

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

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

These credentialing policies shall be reviewed at least annually by the PAC which may recommend revisions or amendments to the Board of Directors.

5.0 HEARING RIGHTS

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

6.0 RELEASE

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

7.0 ADDITIONAL INFORMATION

7.1 Specialists Practicing Primary Care

Providers with sub-specialties recognized by the ABMS or one of its member boards may function in the role of a Primary Care Practitioner (PCP) if they meet the requirements to be a PCP (See Attachment A). However, KHS credentialed specialists functioning as a KHS credentialed PCP may not self-refer for specialty care. If the provider sees a member assigned to him/her for primary care, he/she may not bill as a specialist even if that member's condition is within the provider's sub-specialty. The provider may accept authorized sub-specialty referrals from providers outside of his/her group for those services provided as a sub-specialist.

7.2 Scope of Mid-Level Practitioners

KHS members either select or are randomly assigned to a contracted PCP. The PCP may choose to arrange with a mid-level practitioner to provide primary care to assigned members but must provide active supervision of the care delivered.

A current specialty practitioner may employ a mid-level practitioner and may permit this practitioner to participate in the care delivered to members in accordance with the Standardized Procedure Guidelines, Delegation of Services Agreement, and KHS Policy and Procedure *4.04-P Non-Physician Medical Practitioners*. Mid-level practitioners will be credentialed in the specific specialty in which they will be working. The credentialing will be dependent on the training and experience in the field in which the mid-level is requesting to be credentialed.[iii]

KHS will require either 6 months formal training in a program or one year of full time experience in the field which credentialing is requested.

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

7.3 Facility and Ancillary Providers

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

A. Provider must be physically located in and providing services in Kern County for one year prior to application;
B. must be in good standing with KHS;
C. must be able to submit claims electronically;
D. must be able to participate in the KHS electronic funds transfer (EFT) program;
E. laboratory providers must be able to submit lab results/data to KHS electronically;
F. Durable medical equipment (DME) providers must be able to service KFHC Members seven (7) days a week.
G. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the DHCS APL 19-004 and/or within the established process outlined in *KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy*.

7.4 Medical Transportation Providers (Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT)

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

All current and prospective NMT/NEMT providers must be screened, enrolled and approved through DHCS Medi-Cal Fee-For-Service in accordance with APL 22-013

Screening and Enrollment and KHS Policy and Procedure, 4.43-P Medi-Cal Enrollment Policy and 5.15-P Member Transportation Assistance to be considered for KHS Network.

7.5 Enhanced Care Management (ECM) and Community Supports (CS) Providers

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

7.6 HIV/AIDS Provider

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

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

1. Whether they wish to be designated an HIV/AIDS specialist
2. Whether they meet the defined criteria as per California H&S Code 1374.16

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

7.7 MENTAL HEALTH AND SUBSTANCE USE DISORDER PROVIDER CREDENTIALS

Effective January 1, 2023, Managed Care Plans that cover and who credential health care providers in mental health and substance use disorder services for its network, will assess and verify the qualifications of a health care provider within 60-calendar days after receiving a completed provider credentialing application.

Upon receipt of an application from a mental health or substance abuse provider, the KHS Credentialing Staff will notify the applicant within seven (7) business days of receiving the application to verify receipt and inform the applicant whether the application is complete. Applications returned as "incomplete" will be given 15-calendar days to return any incomplete or missing required information.

A mental health or substance abuse provider application is considered complete based on the requirements set forth in this Policy and Procedure, Sections 1.0 Application, Section 2.0 Application Review and Attachment B – Behavioral Health Practitioner Provider Specific Credentialing Criteria.

Pursuant to Section 2.8, Provisional Approval will be granted and approved for those applicants whose credentialing file meet clean file criteria and are absent of , but not limited to, any adverse actions, disciplinary licensing actions, including conduct or professional competency. Files with adverse actions or information will be reviewed at the next scheduled Physician Advisory Committee for determination. [Reference: AB 2581 (Salas, CH. 533, Stats. 2022)]

7.8 COMMUNITY HEALTH WORKER

CHW Providers must have a lived experience that aligns with and provides a connection between the CHW and the member or population being served. CHW Providers are not licensed providers, require a Supervising Provider, do not follow traditional credentialing requirements and do not have a corresponding state-level enrollment pathway.

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the CHW Provider meets the requirements outlined in the DHCS APL 22-016 Community Health Worker, including but not limited to having valid NPI Number, possess lived experience that aligns with and provides a connection between the CHW and the member or population being served; has obtained a minimum of six (6) hours of additional relevant training annually; has a Supervising Provider employed by the same organization overseeing the CHW with which is KHS Contracted. CHW Providers are required to demonstrate, and Supervising Provider must maintain evidence of, minimum qualifications through a Certificate Pathway or a Lived Experience Pathway consistent with APL 22-016, or any superseding APL. *Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy*.

Supervising Providers, with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS' Provider Enrollment Division. For the Supervising Providers that do not have a corresponding state-level enrollment pathway, they will not be required to enroll in the Medi-Cal program. Supervising Providers, without a state level enrollment pathway, must complete the appropriate provider application, Supervising Attestation and Acknowledgement form for submission to KHS Credentialing for review and approval. KHS will verify the supervising provider meets the qualification as a licensed provider, or other acceptable supervising provider designated within a hospital, outpatient clinic, local health jurisdiction (LHJ) or a community-based organization (CBO), employing or otherwise overseeing the CHW, with which Kern Health Systems (KHS) contracts.

— 7.9 DOULA PROVIDERS

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the doula provider meets the requirements outlined in the DHCS All Plan Letter (APL) 22-031 Doula Services, or any superseding APL. Doulas are not licensed providers, do not require supervision, do not follow traditional credentialing requirements and have a corresponding state-level pathway for enrolling in Medi-Cal. *Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy*.

7.10 DYADIC SERVICE CARE PROVIDERS / NON-SPECIALTY MENTAL HEALTH SERVICES PROVIDER MANUAL (NSMHS)

KHS Provider Network will include Psychiatric and Psychological Service providers as outlined in the DHCS NSMHS provider manual and/or who provide Dyadic Care Services by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Additionally, Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render these services under the supervision of credentialed practitioner, who is qualified to provide supervision and whose licensure is not currently suspended, limited/restricted or on probation.

Network Providers who are licensed independent practitioners will be subject to the credentialing and enrollment process outlined in Section 1.0 -6.0 of this policy and are required to enroll as Medi-Cal Providers, consistent with APL 22-013, or any superseding APL, if there is a state-level enrollment pathway for them to do so. For Associate or Assistant provider types, when there is no state-level enrollment pathway, the KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate these providers meets the requirements outlined in the DHCS NSMHS Provider Manual and/or DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

ATTACHMENTS:

Attachment A: Provider Specific Credentialing Criteria – Practitioners
Attachment B: Provider Specific Credentialing Criteria – BH-Practitioners
Attachment C: Org-Facilities, Ancillary Services, Pharmacies
Attachment D: Non-Licensed Other Provider Types

REFERENCE:

Revision 04-2023: Credentialing Policy Section 7.0 has been revised to add related credentialing requirements specific to Doula Service Providers, Dyadic Care Service Providers and Community Health Workers.
References include: APL 22-016 Community Health Workers; APL 22-031 Doula Services; DHCS APL 22-029 Dyadic Services, DHCS Provider Manual NSMHS & CA Board of Behavioral Sciences–

Revision 03-2023: Credentialing Policy Section 7.0 has been revised to add section related to compliance with Assembly Bill 2581 Health Care Coverage: Mental Health and Substance Use Disorders – Provider Credentials. **Revision 01-2023:** Credentialing Policy has gone through a comprehensive revision by KHS PNM Management and legal review with DSR Health Law to bring into current practice and compliance with all state, federal, DHCS APLs and NCQA credentialing standards. In addition, DSR Health Law performed a regulatory review making further updates and revisions to bring into compliance with DHCS Contract language, DHCS All Plan Letters related to credentialing and screening/enrollment processes, CalAIM and California Business and Professions Code where applicable. KHS PAC Approved 2/1/2023 and KHS BOD Approved 2/16/2023**. Revision 2015-06:** QAS Provider requirements per DHCS 14-026; and Behavioral Health Provider requirements. Revision **2014-12:** Item B. in Section 7.4 "cannot be physician owned, either directly or indirectly;" was deleted as requested by Compliance Director 10/01/2014. SBIRT training removed from *Policy 2.22-I Facility Site Review* and added to credentialing per COO. **Revision 2013-07**: New Attachment "N" Walk in Clinic Providers. Approved at the Physician Advisory Committee (PAC) Meeting on March 6, 2013. [1]**Revision 2012-10:** Language added to allow Mid-levels participate in a specialty settings and perform initial evaluations. The specialty physician must see the patient at lease every third visit. **Revision 2012-08**: Deleted requirement for non-physicians to pay $100 Credentialing process fee. R**evision 2012-01:** Revisions to attachments only. **Revision 2011-06:** Policy approved by management 11/15/10. However additional changes we provided by Director of Claims and Provider Relations regarding SPD members, Specialists and Emergency Room Physicians. Policy KHS Board approved 4/14/11. Revision to Attachments A and D regarding credentialing criteria. Board approved on 10/14/2010. Additional language added (01/2011) per Director of Claims and Provider Relations see Section 7.3 and 7.4 language from policies 4.4-P and 4.25-P respectively. **Revision 2010-05:** Physicians Advisory Committee added clarification of credentialing requirements in Attachment A #6. **Revision 2009-09: Revised by Provider Relation Director. Revision 2007-03:** Revised per DHS/DMHC Medical Review Audit (YE 10/31/06). **Revision 2005-11:** Revised per DHS Work Plan (07/10/05). **Revision 2005-04**: **Revision 2003-06**: Revised per DHS comment letter 03/04/03. **Revision 2002-08:** Routine review/revision. Revised per DHS Comment (10/30/01). Hospital Based Physicians section added per request of Medical Director. Radiology claims section added per request of Medical Director. *Policy #4.03 – Pharmacy Credentialing* deleted, and necessary information added to this policy. Pharmacy portion revised per DHS Comment (09/19/01). Revised per MMCD Policy Letter 02-03.

---

[i] DHS Contract Section 6.5.4.2
[ii] MMCD Policy Letter 02-03 § II

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Martha Tasinga, MD, CMO, PAC Chair

Date: April 13, 2023

Re: KHS NEW POLICY AND PROCEDURE – NEW-P HIV/AIDS Specialist Identification

---

Background

Newly added to Kern Health Systems (KHS) policies pertaining to HIV/AIDS Specialist Identification was approved by the Physician Advisory Committee on 4/5/2023.

PNM Credentialing has been in compliance with the survey requirements of this specific state regulatory requirement; however, it has not been outlined in policy format as to our process and procedure for conducting this annual survey and reporting requirements.

Policy Description –

- New Policy & Procedure
    - The purpose of this policy is to describe KHS' process of identifying and reconfirming appropriately qualified physicians within the provider network who meet the definition of an HIV/AIDS specialist.
    - Annually surveying KHS Credentialed ID Providers or other providers who meet the established criteria
    - Annually sending internal communication to UM/Referral Dept, CMO and UM Medical Director of the confirmed HIV/AIDS Providers who agreed and meet established criteria.)
- Attachment A – HIV/AIDS Specialist Survey Form used for Annual survey.

This new policy was developed as required by Assembly Bill 2168 Standing Referral for HIV/AIDS Patients and Title 28-CCR Section 1300.74.16 establishing the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA Health & Safety Code 1374.16.

Requested Action

Approve new policy and procedure for New-P HIV/AIDS Specialist Identification.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: HIV/AIDS Specialist Identification				POLICY #: NEW-P	
DEPARTMENT: Provider Network Management					
Effective Date: 4/1/2023	Review/Revised Date:	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Chief Executive Officer

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

POLICY:
For Kern Health Systems (KHS) network, the identification and reconfirmation of the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State Regulation is documented on an annual basis.

PURPOSE:
The purpose of this policy is to describe KHS' process of identifying and reconfirming appropriately qualified physicians within the provider network who meet the definition of an HIV/AIDS specialist.

DEFINITION:
HIV/AIDS Specialist: Is defined as a provider with demonstrated expertise in treating HIV/AIDS. The criteria that must be met, in order to be designated as an HIV/AIDS provider includes, but is not limited to, one of the following:

- Association with either of the following: HIV Medicine Association or the American Academy of HIV Medicine

- Board certified in Infectious Disease and has clinically managed 25 HIV patients in the past 12 months and completed 15 hours of Category 1 CME in HIV medicine, five hours of which were related to antiretroviral therapy
- Clinical management of at least 20 HIV-infected members within the last 24 months and completed board certification in Infectious Disease
- In the past 24 months, has clinically managed at least 20 HIV patients and in the past 12 months has completed 15 hours of Category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Examination administered by the American Academy of HIV Medicine.

PROCEDURES:

1.0 Annually, the Credentialing Staff personnel will survey the KHS credentialed Infectious Disease specialists or other physicians who meet the above criteria to determine the following:
   1. Whether or not they wish to be designated as an HIV/AIDS specialist
   2. Whether or not they meet one of the above criteria

2.0 The Credentialing Manager will send the results of the survey results, as a list of those specialists who meet the above criteria and who agreed to be designated as HIV/AIDS specialists, annually via email to the Utilization Management (UM) Department Manager, responsible for referrals, the Chief Medical Officer and UM Medical Director.

ATTACHMENT:

A – HIV/AIDS Specialist Survey Form

REFERENCES:

Legislation/Regulation:

AB 2168 – Standing Referral for HIV/AIDS Patients – Effective 1/1/01
The previous requirements for AB 1181 apply to standing referral for the chronically ill and now add human immune deficiency (HIV) and acquired immune deficiency syndrome (AIDS) to ensure HIV/AIDS patients are provided the same access to a specialist.

CA H&SC 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

TITLE 28CCR 1300.74.16 establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

KERN HEALTH SYSTEMS

Annual HIV/AIDS Specialist Survey Form

TO:	DATE:
PROVIDER NAME:	PROVIDER SPECIALTY:

CA Health & Safety Code 1374.16 requires establishment of a process for a standing referral to a specialist to refer members with a condition or disease that requires specialty medical care over a prolonged period of time or is life-threatening, degenerative or disabling to a specialist that has expertise in treating that condition or disease. Section 1300.74.16 of Title 28 established the required qualification of an HIV/AIDS Specialist to who a member is being treated for the condition or disease. **If you qualify** as an HIV Specialist pursuant to these regulations, please check the appropriate boxes. Please sign and date this form and return to Kern Health Systems **ATTN: credentialing@khs-net.com**

☐ **No**, I do not wish to be designated as an HIV/AIDs Specialist.

☐ **Yes**, I do wish to be designated as an HIV/AIDs Specialist based on the below criteria:

☐ Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; **or**

☐ Board certified, or has earned a Certificate of Added Qualification in the field of HIV medicine granted by a member board of the American Board of Medical Specialties; **or**

☐ Board certified in the field of Infectious Diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:

(a) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; **and**

(b) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **or**

☐ Meets the following qualifications:

(a) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; **and**

(b) Has completed any of the following:

(1) In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or in the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; **or**

(2) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required). If at any time I choose not to continue to maintain the said qualifications for an "HIV Specialist", I will notify Kern Health Systems Provider Relations Department immediately.

SIGNATURE:	DATE:

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

KERN HEALTH SYSTEMS

To: KHS Board of Directors

From: Martha Tasinga, MD, CMO, PAC Chair

Date: April 13, 2023

Re: KHS NEW POLICY AND PROCEDURE – NEW-P ONGOING MONITORING & SANCTION ACTIVITY REVIEW

Background

Newly added to Kern Health Systems (KHS) policies pertaining to Ongoing Monitoring & Sanction Activity Review was approved by the Physician Advisory Committee on 4/5/2023.

PNM Credentialing has been in compliance with the monitoring activities & requirements of this specific federal & state regulatory requirement; however, it has not been outlined in policy format as to our process and procedure for conducting monthly ongoing monitoring and sanction activity review.

Policy Description –

- New Policy & Procedure
    - The purpose of this policy is to describe KHS' process for reviewing the sanction reports published by state and federal programs, licensing agencies, CMS/Medicare, DHCS, and NPDB Continuous Query;
    - Reviewing the reports within 30-days of published report;
    - Describing actions, interventions when provider is identified; and
    - Documenting the verifications on monthly basis, quarterly if applicable or through subscription service

This new policy was developed as required by DHCS All Plan Letter 19-004/Exhibit A, Medicare Managed Care Manual Chapter 6, and NCQA Credentialing Standards CR.5 Ongoing Monitoring that requires verification of practitioners and organizational providers ensuring all credentialed & contracted providers are absent from being identified as ineligible or suspended, sanctioned, debarred, excluded, restricted or opted out of Federal and State Programs.

Requested Action

Approve new policy and procedure for Ongoing Monitoring & Sanction Activity Review.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Ongoing Monitoring & Sanction Activity Review				POLICY #: NEW-P	
DEPARTMENT: Provider Network Management					
Effective Date:	Review/Revised Date: 03.27.2023	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Chief Executive Officer

_____ Date _____

_____ Date _____

POLICY:
Kern Health Systems ("KHS") requires verification of practitioners and organizational providers ensuring all contracted providers are absent from being identified as ineligible or suspended, sanctioned, debarred, excluded, restricted or opted out of Federal and State Programs.

DEFINITIONS:

Adverse Event	Adverse Event may include, but are not limited to, an injury that occurs while a member is receiving healthcare services from a provider; criminal indictments or convictions; media alerts; notification from other health plans; 805 Reports filed with the Medical Board of California; NPDB clinical privilege actions; pattern or trend of quality of care cases filed against practitioner.
Complaint	A complaint is the same as a Grievance. When KHS is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.
DHCS	Department of Health Care Services (California)
Grievance	A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care of services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by KHS to make an authorization decision.
MBC	Medical Board of California
OIG	HHS Officer of Inspector General
RPD	DHCS Restricted Provider List
SAM	System for Award Management

PROCEDURES:
The following procedure will be followed in reviewing the sanction reports:

1. Primary source verification of Medicare and Medicaid sanction activity is obtained from:
   a. The Office of Inspector General (OIG)
   b. The System for Award Management (SAM) formerly the Excluded Parties List System (EPLS)
   c. DHCS Medi-Cal Provider Suspended and Ineligible List (S&I)
   d. DHCS Restricted Provider List (RPD)
   e. National Practitioner Data Bank (NPDB) Continuous Query upon receipt.
   f. Record of review is maintained in the Provider's KHS electronic credentials.
   g. Monthly review is conducted through the KHS Business Intelligence "sweep" report ran against all providers listed in the Symplr Credentialing database (Participating Providers) and providers in the QNXT database (Participating and Non-Participating)

2. Primary source verification of California state licensure including licensure status, public actions, and 805 reports, as applicable, is obtained from the appropriate California licensing board at the time of initial, recredentialing and upon license expiration/renewal.

3. Ongoing monitoring of providers in-between credentialing and recredentialing cycles is accomplished by reviewing the reports listed below relevant to the current provider types within the KHS Provider Network. The Credentialing Staff receives information when sanctions are filed against a provider and checks these providers against the KHS Network.

   The reports are reviewed within thirty (30) days of release (published/posting date if available), unless otherwise noted that there is no release date. If the reporting entity does not publish sanction information on a set schedule or published date, KHS Credentialing Staff will do one of the following:
   - Record the "date reviewed" on the document and indicate there is no release/published date.
   - Query the information at least every six (6) months if the reporting entity does not publish a sanctions report; or
   - KHS utilizes the sanction alert subscription service through the National Practitioner Data Banks Continuous Query for all credentialed licensed independent practitioners.

   A. Medical Board of California (www.mbca.gov) – KHS subscribes to e-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBC. *

   B. Osteopathic Medical Board of California (www.ombca.gov/consumers/enforce_actions.shtml) – KHS subscribes to e-mail notifications and reviews the website monthly for published enforcement and disciplinary action reports.*

   C. Medical Board of California Board of Podiatric Medicine (www.bpm.ca.gov/enforce/discpumm.shtml) KHS reviews the website monthly for published enforcement and disciplinary action reports for all doctors of Podiatric Medicine monthly.*

   D. Board of Psychology (www.psychboard.ca.gov) – KHS subscribes to e-mail notifications and reviews the website monthly for published enforcement and disciplinary action reports.*

   E. California Board of Registered Nursing – KHS utilizes the National Practitioner Data Bank (NPDB) Continuous Query process as a mechanism to receive disciplinary actions for Nurse Practitioners.*

   F. Additional Boards and Bureaus included in monthly monitoring: Acupuncture Board of California, Behavioral Health Science Board of California, Chiropractic Examiners Board of California,

California Board of Nautropathic Medicine, California Board of Optometry, Board of California Pharmacy, Physician Assistant Board of California, Board of California Psychology and Speech-Language Pathology and Audiology and Hearing Aid Dispenser Board of California.*

No provider with a suspended, revoked, or expired license will be allowed to see KHS members, qualify for Network membership or continued membership.

G. HHS Officer of Inspector General (www.oig.hhs.gov/fraudexclusions/exclusions_list.asp) – KHS subscribes to email notifications alerts when new sanction reports have been posted. OIG reports are downloaded from their website monthly for review.*

H. Medi-Cal Provider Suspended and Ineligible List (www.medi-cal.ca.gov) – KHS downloads the newest report from their website monthly for review. *

I. DHCS Restricted Provider List - KHS downloads the newest report from their website monthly for review.*

No excluded, ineligible, sanctioned, debarred or suspended providers qualify for Network membership or continued membership. **(Source: Medicare Managed Care Manual, Chapter 6 § 60.2; DHCS All Plan Letter APL 19-004)**

J. Medicare Opt-Out Physicians, Northern and Southern California (https:data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits) – KHS downloads the newest report from their website monthly for review.*

No prospective or current KHS Provider shall qualify for Network membership or continued membership if provider has opted-out of the CMS Medicare Program. ***(Source: Medicare Managed Care Manual: Chapter 6 § 60.2)***

K. Complaints, Grievances and Adverse Events (related to quality of care) – At a minimum, information on complaints, grievances or adverse events will be reviewed at least once every six (6) months pursuant to *Policy and Procedure #2.70-I Potential Quality of Care Issue (PQI), Section IV. PQI Review Process, Section K. Tracking and Trending*. Complaints, grievances and adverse events (quality of care related) are reviewed with the Chief Medical Officer, or designee, for appropriate action and follow-up which may include corrective action plans, education or counseling of the provider and when applicable, referral to the Physician Advisory Committee.

L. Performance Monitoring for Recredentialing – Additionally, recredentialing for all providers shall include performance monitoring data from quality improvement activities, utilization management, member services complaints/grievances and compliance activities. The Physician Advisory Committee monitors the performance and outcomes of practitioners. ***(Source: Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)***

4. All sanctions, disciplinary and adverse actions are reported immediately to the KHS Chief Medical Office and/or KHS Chief Executive Officer. The KHS Chief Medical Office and/or KHS Chief Executive Officer shall determine if immediate action is warranted. All sanctions and disciplinary actions will be reported to the next regularly scheduled Physician Advisory Committee meeting for appropriate action and follow-up which may include, but not limited to the course of action pursuant to Policy and Procedure 4.48-P Disciplinary Action such as corrective action plans, education or counseling of the provider when warranted.

5. If a Provider is identified on the Medicare Opt-Out listing or is actively excluded, ineligible, sanctioned, debarred or suspended on the OIG Report, Medi-Cal Suspended/Ineligible List or DHCS Restricted

Provider List, the provider will be inactivated from the KHS Provider Network and notified immediately of their ineligibility for new or continued network participation and membership.

6. Record of verifications shall include the published report date or website date of verification (if there is no new report or a new published date) and initials of KHS Credentialing Staff who completed the verification. This information is saved in the providers electronic credential file and recorded on the file processing checklist for initial and recredentialing. Monthly monitoring reports, conducted by KHS Credentialing Staff, are kept electronically by month of review and reported to the KHS Compliance Department's Fraud Waste and Abuse Committee.

REFERENCE:

National Committee of Quality Assurance Credentialing Standards CR.5 Ongoing Monitoring & Interventions 2023
Medicare Managed Care Manual, Chapter 6 § 60.3; Medicare Managed Care Manual: Chapter 6 § 60.2
DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract;
KHS Policy and Procedure #2.70-I Potential Quality of Care Issue (PQI)

24 A

SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, February 10, 2023

8:00 A.M.

COMMITTEE RECONVENED

Members: Martinez, Garcia, McGlew, Watson
ROLL CALL: ALL PRESENT

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

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

COMMITTEE ACTION SHOWN IN CAPS

1) Finance Committee Resolution to Allow Virtual Committee Meeting Participation Pursuant to Government Code Section 54953 (Fiscal Impact: None) - APPROVED
McGlew-Martinez: All Ayes

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

CA-4) Minutes for Kern Health Systems Finance Committee meeting on December 9, 2022- APPROVED
McGlew-Martinez: All Ayes

5) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2022 (Fiscal Impact: None) – IRA COHEN, UBS FINANCIAL SERVICES, INC., HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

6) Report on 2022 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

7) Request to change the previously approved 2023 reinsurance carrier from HM Life Insurance back to the current 2022 carrier IOA Re (2023 Fiscal Impact: $1,122,917; $914,969 Budgeted; $207,948 Not Budgeted) – KATHRYN BOWEN, ARTHUR J. GALLAGHER & CO., HEARD; APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

8) Report on 2022 Annual Travel Report (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

9) Report on 2022 Annual Report of Disposed Assets (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew: All Ayes

10) Review of Kern Health Systems Cyber Insurance Policy (Fiscal Impact: None) – CHRIS TOBIN, ALLIANT INSURANCE SERVICES, HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Garcia: All Ayes

11) Review of 2022 Budgeted Capital Projects scheduled to be completed in 2023 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

12) Report on Kern Health Systems Financial Statements for November 2022 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Watson: All Ayes

13) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2022 and IT Technology Consulting Resources for the period ended November 30, 2022 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-McGlew: All Ayes

ADJOURN TO FRIDAY, APRIL 7, 2023 AT 8:00 A.M.

24 B

SUMMARY

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, February 1, 2023

7:00 A.M.

COMMITTEE RECONVENED

Members: Aggarwal, Amin, Gevorgyan, Hair, Miller, Parmar, Patel, Gevorgyan, Lascano, Tasinga
ROLL CALL: 5 Present; 4 Absent – Aggarwal, Gevorgyan, Lascano, Tasinga

Meeting called to order at 7:07 A.M. by Dr. John P. Miller, M.D., Medical Director

NOTE: The vote is displayed in bold below each item. For example, Amin-Parmar denotes Member Amin made the motion and Member Parmar 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 (Gov. Code Sec. 54954.2[a])
NO ONE HEARD

ADJOURNED TO CLOSED SESSION @ 7:14 A.M.

CLOSED SESSION

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

Item No. 3 concerning Closed Session regarding peer review of PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING** (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE MEMBERS PRESENT; THE COMMITTEE APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING.

- COMPREHENSIVE REVIEWS WERE CONDUCTED FOR INITIAL APPLICATIONS LISTED BELOW WITH REVIEW OF ADDITIONAL ADVERSE INFORMATION AND/OR INFORMATION RELATED TO MALPRACTICE CASE(S) THAT RESULTED IN SETTLEMENT OR JUDGMENT MADE ON BEHALF OF THE PRACTITIONER:
- INITIAL #5 (TDC) - REVIEWED INFORMATION REGARDING SELF-DISCLOSED PERMIT LAPSE IN 2018-2019 WITH ISSUE RESOLVED AFTER ENTERING INTO CONSENT AGREEMENT WITH THE PHARMACY BOARD. RECOMMEND APPROVAL OF NETWORK PARTICIPATION.
- PRV002240 - REVIEWED INFORMATION REGARDING PASSED PROBATION IN 1991 AND COMPLETED IN 1994 AFTER SUCCESSFUL COMPLETION OF ALL TERMS AND CONDITIONS WITH NO FURTHER INCIDENCE. RECOMMEND APPROVAL OF NETWORK PARTICIPATION.
- PRV (A.R.) - REVIEWED INFORMATION REGARDING NPDB 2020 SETTLEMENT $29,999 ALLEGED FAILURE TO DIAGNOSE RESULTING IN DELAYED TREATMENT. MD EXPLANATION RECEIVED. THERE HAVE BEEN NO FURTHER CASE SETTLEMENTS. RECOMMEND APPROVAL OF NETWORK PARTICIPATION.
- PRV033328- REVIEWED INFORMATION REGARDING MED BOARD ACTION TAKEN IN 2011 WITH ADDITIONAL ACTION TAKEN BY SISTER MEDICAL BOARDS. PROVIDER SUCCESSFUL COMPLETED ALL PROBATIONARY REQUIREMENT INCLUDING PROFESSIONAL ASSISTANCE/DIVERSION PROGRAM WITH NO FURTHER INCIDENCE. RECOMMEND APPROVAL OF NETWORK PARTICIPATION.

- PRV083046- REVIEWED INFORMATION REGARDING NPDB 2017 SETTLEMENT $1MIL ALLEGED FAILURE TO DIAGNOSE RESULTING IN DELAYED TREATMENT. MD EXPLANATION RECEIVED. THERE HAVE BEEN NO FURTHER CASE SETTLEMENTS. RECOMMEND APPROVAL OF NETWORK PARTICIPATION.
- PRV007405- REVIEWED INFORMATION REGARDING NPDB 2017 SETTLEMENT $750,000 ALLEGED FAILURE TO DIAGNOSE RESULTING IN DELAYED TREATMENT. MD EXPLANATION RECEIVED. THERE HAVE BEEN NO FURTHER CASE SETTLEMENTS. RECOMMEND APPROVAL OF NETWORK PARTICIPATION.
  Item No. 3 concerning Closed Session regarding peer review of PROVIDERS RECOMMENDED FOR **RECREDENTIALING** (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE MEMBERS PRESENT; THE COMMITTEE APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING
- COMPREHENSIVE REVIEWS WERE CONDUCTED FOR RECREDENTIALING APPLICATIONS LISTED BELOW FOR REVIEW OF ADDITIONAL ADVERSE INFORMATION AND/OR INFORMATION RELATED TO MALPRACTICE CASE(S) THAT RESULTED IN SETTLEMENT OR JUDGMENT MADE ON BEHALF OF THE PRACTITIONER WITHIN THE PREVIOUS THREE YEARS:
- MEMBER GRIEVANCES: ALL PROVIDERS WITH SIGNIFICANT MEMBER & QUALITY GRIEVANCES WERE REVIEWED WITH NO QUALITY OF SERVICE OR CARE ISSUES REPORTED AS A RESULT OF THESE GRIEVANCES.
- PRV004219– REVIEWED INFORMATION REGARDING NPDB 2021 SETTLEMENT $29,999 ALLEGED NEGLIGENT TREATMENT OF CARDIAC EVENT; REFERRED FOR HIGHER LEVEL OF CARE AND PATIENT REFUSED. PA'S EXPLANATION RECEIVED. THERE HAVE BEEN NO FURTHER CASE SETTLEMENTS. RECOMMEND APPROVAL OF NETWORK PARTICIPATION.
- PRV000631 - MBC PROBATION COMPLETED 02/2021 WITH COMPLIANCE WITH ALL TERMS AND CONDITIONS. RECOMMEND CONTINUED RECREDENTIALING AND NETWORK PARTICIPATION.
- PRV048427 - MBC PROBATION ISSUED 02/2021 WITH VARIOUS TERMS AND CONDITIONS. PROVIDER IS MONITORED MONTHLY AND IS IN COMPLIANCE. RECOMMEND CONTINUED RECREDENTIALING AND NETWORK PARTICIPATION.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:20 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on December 7, 2022 – APPROVED
Amin-Patel: All Ayes

5) Review Policy 4.01-P Credentialing – YOLANDA HERRERA, KHS CREDENTIALING MANAGER, REVIEWED THE RED-LINED REVISIONS TO POLICY AND PROCEDURE 4.01-P CREDENTIALING. THIS POLICY HAS UNDERGONE SIGNIFICANT REVISION BY KHS PNM MANAGEMENT AS WELL AS THROUGH LEGAL REVIEW WITH DSR HEALTH LAW TO BRING INTO CURRENT PRACTICE AND COMPLIANCE WITH ALL STATE, FEDERAL, DHCS APLS AND NCQA CREDENTIALING STANDARDS. IN ADDITION, DSR HEALTH LAW PERFORMED A REGULATORY REVIEW MAKING FURTHER UPDATES AND REVISIONS TO BRING INTO COMPLIANCE WITH DHCS CONTRACT LANGUAGE, DHCS ALL PLAN LETTERS RELATED TO CREDENTIALING, CALAIM AND CALIFORNIA BUSINESS AND PROFESSIONS CODE WHERE APPLICABLE - APPROVED
Patel-Parmar: All Ayes

6) Review Policy 4.47-P Clinical Laboratory Improvements Amendments (CLIA) Certification Requirements – YOLANDA HERRERA, KHS CREDENTIALING MANAGER, REVIEWED THE RED-LINED REVISIONS TO POLICY AND PROCEDURE 4.47-P CLIA. SECTION 3.0 WAS REVISED TO DESCRIBE HOW CLIA CERTIFICATES ARE VERIFIED AT INITIAL, RECREDENTIALING AND UPON EXPIRATION INCLUDING REFERENCE TO THE WEBSITE USED FOR PRIMARY SOURCE VERIFICATION - APPROVED
Parmar-Patel: All Ayes

8) Review Policy 2.70-I Potential Quality of Care Issue (PQI) - APPROVED
Parmar-Patel: All Ayes

9) Review Policy 2.71-P Facility Site Review and Medical Record Review - APPROVED
Patel-Parmar: All Ayes

MEETING ADJOURNED AT 7:39 A.M. TO WEDNESDAY, MARCH 1, 2023 AT 7:00 A.M

24 C

SUMMARY

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, March 1, 2023

7:00 A.M.

COMMITTEE RECONVENED

Members: Aggarwal, Amin, Gevorgyan, Hair, Lascano, Parmar, Patel, Tasinga
ROLL CALL: 6 Present; 2 Absent – Amin, Hair

Meeting called to order at 7:09 A.M. by Dr. Tasinga, MD, CMO

NOTE: The vote is displayed in bold below each item. For example, Amin-Parmar denotes Member Amin made the motion and Member Parmar 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 (Gov. Code Sec. 54954.2[a])

PCP PATIENT FOLLOW-UPS ON LABORATORY TESTING:

MEMBERS PRESENTED CURRENT ISSUES ARISING FROM LACK ON INTEGRATED HEALTH OR ELECTRONIC MEDICAL RECORD WHEN A MEMBER IS SEEN OUTSIDE THE PCP OFFICE, AND MAY HAVE AN ABNORMAL LABORATORY TEST FINDING THAT HAS NOT BEEN ADDRESSED SINCE IT WAS CONDUCTED IN THE URGENT CARE OR EMERGENCY ROOM. SUGGESTIONS WERE ENTERTAINED SURROUNDING THE NEED FOR A CENTRALIZED INFORMATION PORTAL. JAKE HALL PRESENTED INFORMATION ON CURRENT ACTIVITIES TO BETTER ASSIST THE PHYSICIAN REGARDING THIS ISSUE. KHS I.T. DEPARTMENT IS CURRENTLY WORKING ON MEMBER HEALTH DATA ACCESSIBILITY TO THE PHYSICIANS IN THE COMING YEAR AS A CORPORATE PROJECT.

ADJOURNED TO CLOSED SESSION @ 7:27 A.M.

CLOSED SESSION

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

Item No. 3 concerning Closed Session regarding peer review of PROVIDERS RECOMMENDED FOR **INITIAL CREDENTIALING** (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE MEMBERS PRESENT; THE COMMITTEE APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING.

- THERE WERE NO COMPREHENSIVE REVIEWS FOR INITIAL APPLICANTS PRESENTED.

Item No. 3 concerning Closed Session regarding peer review of PROVIDERS RECOMMENDED FOR **RECREDENTIALING** (Welfare and Institutions Code Section 14087.38(o)) – HEARD; BY A UNANIMOUS VOTE OF THOSE MEMBERS PRESENT; THE COMMITTEE APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING

- COMPREHENSIVE REVIEWS WERE CONDUCTED FOR RECREDENTIALING APPLICATIONS LISTED BELOW FOR REVIEW OF ADDITIONAL ADVERSE INFORMATION AND/OR INFORMATION RELATED TO MALPRACTICE CASE(S) THAT RESULTED IN SETTLEMENT OR JUDGMENT MADE ON BEHALF OF THE PRACTITIONER WITHIN THE PREVIOUS 3 YEARS:

- MEMBER GRIEVANCES: ALL PROVIDERS WITH SIGNIFICANT MEMBER & QUALITY GRIEVANCES WERE REVIEWED WITH NO QUALITY OF SERVICE OR CARE ISSUES REPORTED AS A RESULT OF THESE GRIEVANCES.
- PRV029445 – REVIEWED INFORMATION REGARDING NPDB 2021 SETTLEMENT $900,000 ALLEGED WRONGFUL DEATH CLAIM ARISING FROM FAILURE TO TIMELY DIAGNOSE & TREAT CYTOMEGALOVIRUS (CMV) PATIENT EXPIRED AND PLAINTIFF ALLEGES SHOULD HAVE ADMINISTERED GANCICLOVIR AND TRANSFERRED PATIENT. PROVIDER EXPLANATION REVIEWED AND RECOMMEND APPROVAL OF CONTINUED NETWORK PARTICIPATION.
- PRV030673 - ALLEGED WRONGFUL DEATH AFTER CT SCAN COMPARED TO PREVIOUS FILMS THAT REVEALED MULTIPLE BILATERAL RENAL CYSTS WITH RECOMMENDATION TO FOLLOW UP. PLAINTIFF ALLEGED PHYSICIAN FAILED TO DIAGNOSE THE RENAL CELL CANCER RESULTING IN PATIENT'S DEATH ONE YEAR LATER. PROVIDER EXPLANATION REVIEWED AND RECOMMEND APPROVAL OF CONTINUED NETWORK PARTICIPATION.
- PRV000179 – MEMBER GRIEVANCES REVIEWED AND FOUND THE QUALITY OF SERVICE OR CARE ISSUES TO BE RESOLVED WITH NO FURTHER ISSUES REPORTED. RECOMMEND CONTINUED RECREDENTIALING AND NETWORK PARTICIPATION.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:46 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on February 1, 2023 – APPROVED
Patel-Parmar: All Ayes

MEETING ADJOURNED AT 7:59 A.M. TO WEDNESDAY, APRIL 5, 2023 @ 7:00 A.M