KERN HEALTH SYSTEMS

REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, February 19, 2026
at
8:00 A.M.

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

The public is invited.

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

AGENDA

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, February 19, 2026

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 SILENCE CELL PHONES AND OTHER ELECTRONIC DEVICES DURING THE MEETING.

BOARD TO RECONVENE

Directors: Watson, Thygerson, Singh, Elliott, Acharya, Alva, Bowers, Hoffmann, Johnson, Ma, Meave, Patel, Tamsi, Turnipseed
ROLL CALL:

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

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

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

DEPARTMENTAL MATTERS

CA-3) Minutes for Kern Health Systems Board of Directors regular meeting on December 18, 2025 (Fiscal Impact: None) –
APPROVE

4) Presentation by Healthcare Financial, Inc. on Assisting Kern Health Systems Members in Obtaining Supplemental Security Income and/or Medicare Coverage (Fiscal Impact: None) –
RECEIVE AND FILE

5) Report on Kern Health Systems 3-year Strategic Plan (2023-2025) (Fiscal Impact: None) –
RECEIVE AND FILE

6) Final Report of Kern Health Systems Grants and Strategic Initiatives (2023-2025) (Fiscal Impact: $659,002.17; Budgeted) –
APPROVE; AUTHORIZE KERN HEALTH SYSTEMS TO RETAIN UNEARNED FUNDS

CA-7) Report on Kern Health Systems Enterprise Risk Management Project Update (Fiscal Impact: None) –
RECEIVE AND FILE

CA-8) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2025 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-9) Report on 2025 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) –
RECEIVE AND FILE

CA-10) Report on 2025 Annual Travel Report (Fiscal Impact: None) –
RECEIVE AND FILE

CA-11) Report on 2025 Annual Report of Disposed Assets (Fiscal Impact: None) –
RECEIVE AND FILE

CA-12) Proposed Contract Extension with SAI360 increasing the Not-to-Exceed amount by $142,122 from $201,270 to $343,392 for the Platform including the Policy Manager and the Regulatory Compliance Manager for a two (2) year term from March 28, 2026 through March 27, 2028 (Fiscal Impact: $142,122 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-13) Proposed Contract Extension with Coffey Communications, Inc. increasing the Not-to-Exceed amount by $195,000 from $370,000 to $565,000, for the printing of Member Newsletters, for a one (1) year term from February 15, 2026 through February 14, 2027 (Fiscal Impact: $195,000; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-14) Proposed Contract Extension with Health Management Associates for Actuarial services for a one (1) year term from March 6, 2026 through March 5, 2027 (Fiscal Impact: $0; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-15) Proposed Increase in the Not-to-Exceed amount with DST Health Solutions, LLC, by $35,525 from $1,226,457 to $1,261,982, for the Johns Hopkins ACG Predictive Modeling tool, for the remaining term of the contract through December 31, 2026 (Fiscal Impact: $35,525; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-16) Proposed Increase in the Current Not-to-Exceed amount and Contract Extension with Anthony Dike, M.D., for Physician Review Services for Utilization Management, by $314,000 from $199,000 to $513,000, which includes $74,000 to increase the not-to-exceed under the current contract through April 17, 2026 and $240,000 for the contract extension through April 17, 2027 (Fiscal Impact: $314,000; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

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) Proposed revisions to policy and procedure – QP 23.05-P Credentialing Program, 23.09-P Urgent Care, and 23.14-P CLIA Requirements (Fiscal Impact: None) –
APPROVE

19) Report on Kern Health Systems financial statements for November 2025 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-20) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2025 and IT Technology Consulting Resources for the period ended November 30, 2025 (Fiscal Impact: None) –
RECEIVE AND FILE

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

CA-22) Kern Health Systems Chief Human Resources Officer report (Fiscal Impact: None) –
RECEIVE AND FILE

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

CA-24) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) –
RECEIVE AND FILE

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

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

CA-27) Miscellaneous Documents –
RECEIVE AND FILE

A) Minutes for Kern Health Systems Physician Advisory Committee meeting on December 3, 2025
B) Minutes for Kern Health Systems Utilization Management Committee meeting on December 4, 2025
C) Minutes for Kern Health Systems Community Advisory Committee meeting on December 9, 2025
D) Minutes for Kern Health Systems Finance Committee meeting on December 12, 2025
E) Minutes for Kern Health Systems Executive Quality Improvement Health Equity Committee Meeting on December 16, 2025

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

BOARD TO RECONVENE

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

ADJOURN TO APRIL 16, 2026 AT 8:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, December 18, 2025

8:00 A.M.

BOARD RECONVENED

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

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

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

BOARD ACTION SHOWN IN CAPS

NOTE: DIRECTOR PATEL ARRIVED AT 8:02 AM; AFTER THE ROLL CALL

PUBLIC PRESENTATIONS

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

   CASSANDRA CARLSON, BOARD CERTIFIED BEHAVIORAL ANALYST, AUTISM BEHAVIORAL SERVICES; SAMANTHA JIMENEZ, BEHAVIORAL SPECIALIST, AUTISM BEHAVIORAL SERVICES; LESLIE KIMBLE, CASE MANAGER; NATALIE ARRACHE, BOARD CERTIFIED BEHAVIORAL ANALYST & GROUP CLINICAL MANAGER, THE CENTER FOR AUTISM AND RELATED DISORDERS; CECILIA

GONZALEZ, ACCELERATION BEHAVIORAL THERAPIES; JESSICA BELL, MOTHER OF CHILD WITH AUTISM; IRMA SALDANA, MOTHER OF CHILD WITH AUTISM; ERIC LINDER, FORMER ASSEMBLYMEMBER AND GOVERNMENT RELATIONS, AUTISM BEHAVIORAL SERVICES, HEARD; CONCERNING FAMILIES REQUIRING AUTISM SERVICES AND THE CHALLENGES THEY ARE FACING WITH THE NEW AUTHORIZATION REQUIREMENTS

NOTE: DIRECTOR HOFFMANN ARRIVED AT 8:15 AM; DURING THE PUBLIC PRESENTATIONS

NOTE: DIRECTOR SINGH ARRIVED AT 8:20 AM; DURING THE PUBLIC PRESENTATIONS

NOTE: DIRECTOR BOWERS ARRIVED AT 8:23 AM; DURING THE PUBLIC PRESENTATIONS

NOTE: DIRECTOR TAMSI ARRIVED AT 8:24 AM, DURING THE PUBLIC PRESENTATIONS

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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DIRECTOR JOHNSON REPORTED HIS ABSTENSIONS FOR AGENDA ITEM NO. 24 WERE RECORDED VIA THE EMAIL HE TRANSMITTED PRIOR TO THE MEETING; CHAIRMAN WATSON RESPONDED NOTING AGENDA ITEM NO. 24 WAS TO BE REVIEWED IN CLOSED SESSION
10 Ayes; 4 Absent – Singh, Bowers, Hoffmann, Tamsi

DIRECTOR MEAVE SHARED CLINICIA SIERRA VISTA'S END OF THE YEAR REPORT AND STATED THAT IT WAS THE FIRST REPORT ISSUED IN 55 YEARS

DIRECTOR TURNIPSEED ANNOUNCED THAT HE ATTENDED THE BAKER TILLY 2025 EXECUTIVE HEALTHCARE CONFERENCE IN LAS VEGAS, NOV. 12-14 AND STATED THAT IT WAS A PRETTY SOLEMN AFFAIR; DIRECTOR TURNIPSEED ALSO ANNOUNCED THAT HE WANTS TO ADD STRESS TESTING ON THE FEBURARY AGENDA TO PREPARE FOR THE FUTURE

DIRECTOR ELLIOTT COMMENTED ON TODAY'S PUBLIC PRESENTATIONS AND THANKED THE VISITORS FOR BRINGING THIS TO OUR ATTENTION AND STATED THAT HE WOULD LIKE A FOLLOW UP ON THIS TO CLOSE THE LOOP AND FIGURE OUT WHERE THIS HAS FALLEN DOWN

DEPARTMENTAL MATTERS

CA-3) Minutes for Kern Health Systems Board of Directors regular meeting on October 23, 2025 (Fiscal Impact: None) – APPROVED
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

4) Presentation by Baker Tilly (formerly Moss Adams) on 2025 Audit Planning (Fiscal Impact: None) – DAMU STALIAN AND ASHLEY MERDA, BAKER TILLY; HEARD; APPROVED
Bowers-Acharya: 14 Ayes

CA-5) Report on Kern Health Systems investment portfolio for the third quarter ending September 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-6) Proposed reinsurance policy with Partner RE to mitigate costs incurred by Kern Health Systems for members with high medical costs from January 1, 2026 through December 31, 2026 (Fiscal Impact: $5,900,000 estimated; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

7) Proposed (Detailed) Kern Health Systems 2026-2028 Strategic Plan (Fiscal Impact: None) – DIRECTOR JOHNSON NOTED CONCERN REGARDING STRATEGIC PLAN SENT TO KERN HEALTH SYSTEMS BOARD OF DIRECTORS, REQUESTING TO MAKE PUBLIC ADDITIONAL STRATEGIC PLAN DOCUMENTATION, SUBJECT TO APPLICABLE REDACTIONS. DIRECTOR JOHNSON MADE A MOTION TO TABLE THE ITEM AND BRING BACK A REDACTED VERSION. A VOTE WAS TAKEN AND THIS MOTION FAILED. SUBSEQUENTLY, DIRECTOR ELLIOT MADE A MOTION TO APPROVE THE STRATEGIC PLAN AND POST THE FULL STRATEGIC PLAN ON THE KERN HEALTH SYSTEMS WEBSITE SUBJECT TO APPROPRIATE REDACTIONS. THIS MOTION PASSED. APPROVED
Elliott-Patel: 8 Ayes; 6 Nos; Thygerson, Acharya, Alva, Bowers Johnson, Turnipseed

8) Proposed Kern Health Systems 2026 Operating and Capital Budgets (Fiscal Impact: None) – APPROVED
Bowers-Alva: 14 Ayes

9) Proposed Budget Request for 2026 Project Consulting and Professional Services, from January 1, 2026 through December 31, 2026 (Fiscal Impact: $7,800,010 Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Bowers-Elliott: 14 Ayes

CA-10) Proposed Increase in the Not-to Exceed amount with Cognizant by $600,840 from $6,607,387 to $7,208,227 to adjust maintenance and support fees with Cognizant, reflecting corrected membership counts and ensuring accurate annual billing for the contract term from September 11, 2025, through September 10, 2029 (Fiscal Impact: $600,840 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-11) Proposed Increase in the Not-to Exceed amount with Crowe by $300,000 from $1,585,000 to $1,885,000 for additional Implementation Costs, the Crowe Government Accelerator Software and Expense Management and Crowe Contract Manager modules relating to the new Accounting Enterprise Resource Planning System from January 1, 2026, through November 30, 2030 (Fiscal Impact: $300,000 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-12) Proposed New Agreement with DELL, with a Not-to-Exceed amount of $2,000,000 for the replacement of core server infrastructure with Dell hardware, enabling flexible scaling of compute and storage resources, for a three (3) year term from January 1, 2026 through December 31, 2029 (Fiscal Impact: $2,000,000 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-13) Proposed New Agreement with Microsoft, with a Not-to-Exceed amount of $225,000 for Unified Support Services, which provide enterprise-wide access to Microsoft experts, proactive optimization, and rapid issue resolution to ensure reliability and maximize value across all Microsoft technologies, for a one (1) year term from January 1, 2026 through December 31, 2026 (Fiscal Impact: $225,000 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-14) Proposed Contract Extension with Zipari increasing the Not-to Exceed amount by $237,456 from $2,709,572 to $2,947,028 for the Member and Provider Portal for four (4) months from January 1, 2026, through April 30, 2026 (Fiscal Impact: $237,456 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-15) Proposed Contract Extension with CitiusTech increasing the Not-to Exceed amount by $37,500 from $853,880 to $891,380 for FHIR licensing, software and support for three (3) months from December 18, 2025, through March 31, 2026 (Fiscal Impact: $37,500 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

16) Report on Kern Health Systems financial statements for September 2025 and October 2025 (Fiscal Impact: None) – RECEIVED AND FILED
Patel-Tamsi: 13 Ayes – 1 Absent - Singh

NOTE: DIRECTOR SINGH LEFT THE DAIS AT 10:49 AM; DURING THE DISCUSSION OF ITEM 16 AND DID NOT RETURN

CA-17) Report on Tangible Net Equity and Liquidity Test as of September 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-18) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for September 2025 and October 2025 and IT Technology Consulting Resources for the period ended September 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-19) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

CA-20) Kern Health Systems Chief Compliance and Fraud Prevention Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

21) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Bowers-Patel: 13 Ayes – 1 Absent - Singh

22) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Acharya-Patel: 13 Ayes – 1 Absent – Singh

CA-23) Miscellaneous Documents – RECEIVED AND FILED
Ma-Alva: 9 Ayes; 5 Absent – Singh, Bowers, Hoffmann, Patel, Tamsi

A) Minutes for Kern Health Systems Physician Advisory Committee meeting on October 1, 2025
B) Minutes for Kern Health Systems Finance Committee meeting on October 17, 2025
C) Minutes for Kern Health Systems Fraud, Waste, and Abuse (FWA) Committee meeting on November 3, 2025
D) Minutes for Kern Health Systems Physician Advisory Committee meeting on November 5, 2025
E) Minutes for Kern Health Systems Health Equity Transformation Steering Committee meeting on November 18, 2025

F) Minutes for Kern Health Systems Governance and Compliance Committee meeting on November 20, 2025
G) Minutes for Kern Health Systems Drug Utilization Review Committee meeting on November 24, 2025

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 24 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **INITIAL CREDENTIALING FOR NOVEMBER 2025** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON HOLLOWAY, ROHANI, SIMONS; DIRECTOR ACHARYA ABSTAINED FROM VOTING ON CRAWFORD; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON CANO, PEREZ, CRAWFORD; DIRECTOR MEAVE ABSTAINED FROM VOTING ON CANO, PEREZ; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON HOLCOMB

Item No. 24 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **INITIAL CREDENTIALING FOR DECEMBER 2025** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON LUQUE, SRIVASTAVA, ALHASAN, CHOUDHURY, MALAVE, MERCHANT, WEISS, WILSON; DIRECTOR ACHARYA ABSTAINED FROM VOTING ON SRIVASTAVA, DOLLAR; DIRECTOR MEAVE ABSTAINED FROM VOTING ON AYODELE; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON GRANESE

Item No. 24 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **RECREDENTIALING FOR NOVEMBER 2025** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON AHMAD, CLARKE, DESAI, GARG, GUARNEROS, LEE, MADZIARSKI, PASCUAL, RAMZAN; DIRECTOR SINGH ABTAINED FROM VOTING ON DUGGAL; DIRECTOR ACHARYA ABSTAINED FROM VOTING ON ALVAREZ, GELVES, DUGGAL, PRIORITY URGENT CARE – PANAMA; DIRECTOR BOWERS ABSTAINED FROM VOTING ON DUGGAL; DIRECTOR HOFFMANN ABSTAINED

FROM VOTING ON AYALA-RODRIGUEZ, CHASE, PANSAWIRA, SANTOS; DIRECTOR MEAVE ABSTAINED FROM VOTING ON AYALA-RODRIGUEZ, CHASE, DIXON, PANSAWIRA, SANTOS; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON AQUINO, RIVERA

Item No. 24 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **RECREDENTIALING FOR DECEMBER 2025** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON KURAN, SUTTER, ZUVERZA; DIRECTOR ELLIOTT ABSTAINED FROM VOTING ON KERN VALLEY HEALTHCARE DISTRICT D/P SNF, GUTZMAN; DIRECTOR ACHARYA ABSTAINED FROM VOTING ON ALI; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON BELL, GILL, KERN BEHAVIORAL HEALTH & RECOVERY SERVICES, MARTINEZ DUENAS, MCDERMOTT, ORNELAZ; DIRECTOR MEAVE ABSTAINED FROM VOTING ON BELL, GILL, JOHNSON, MARTINEZ DUENAS, MCDERMOTT, ORNELAZ, STEWART; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON DURAN-PEREZ, STEWART, TAPIA

ADJOURN TO FEBRUARY 19, 2026 AT 8:00 A.M.

/s/ Sarabjeet Singh, Secretary
Kern Health Systems Board of Directors

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: Healthcare Financial, Inc. Presentation on Assisting Kern Health Systems Members in Obtaining Supplemental Security Income and/or Medicare Coverage

DATE: February 19, 2026

Background

Kern Health Systems (KHS) has been working with Healthcare Financial Inc. (HFI) since 2018. HFI assists Managed Care Organizations (MCOs) like KHS to identify members that potentially qualify for Supplemental Security Income (SSI) coverage and/or Medicare coverage.

Discussion

To potentially identify KHS members that might qualify for SSI, HFI receives KHS claims data that are run through their proprietary algorithms. When HFI and the KHS Case Management Team identifies a member who may have a disability, they contact the member and help them apply for SSI, all free of charge. This application process often ends with an initial denial whereby HFI then steps in to assist the member with the appeal process, again at no cost to the member.

Once the SSI application is approved, a member will receive the following:

- Monthly cash benefits averaging $800 per month that are not subject to federal income tax.
- Consistent income the member can allocate toward essential needs—housing, food, utilities, transportation.
- Upon approval, members often receive lump-sum retroactive payments that date back to when they sent their application to the Social Security Administration (SSA).

All of the above items lead to life-changing events for members and their families.

Over 1,100 KHS members have received approximately **$40 million** in SSI benefits since this program was launched in 2018.

HFI also assists KHS members in obtaining no-cost Medicare coverage. Members will enjoy no-cost Medicare coverage and access to an expanded network of healthcare providers along with the potential for Cash Benefits. Part A covers inpatient hospitalizations, Part B covers outpatient/dialysis providers, Part D covers pharmacy costs.

Representatives from HFI will be discussing the attached presentation and will be available to answer questions.

Requested Action

Receive and file.



Presented to

Kern Family Health Care™

HFI – KHS Partnership

February 19, 2026

HFI

HFI Overview

Our MCO Members

At HFI, our mission is to advocate for the most vulnerable members of our community. We assist patients in applying for essential programs such as Supplemental Security Income (SSI), Medicare, and a range of other programs that support their health and well-being.

By connecting patients to these critical resources, we address key social determinants of health, leading to improved health outcomes and a better overall quality of life.





HFI Enrollment Programs for KHS

HFI Social Security Disability (SSI) Program

Supplemental Security Income (SSI) is a Federal income supplement program.

It is designed to help aged, blind, and disabled people, who have little or no income; and

It provides cash to meet basic needs for food, clothing, and shelter.

HFI Medicare Program

HFI's Medicare Enrollment Program is specifically designed for Medicaid members who are Medicare-eligible.

Many Medicaid members who qualify for Medicare remain unenrolled

When Medicare becomes the primary payer, members, plans and states benefit - members gain enhanced, no cost coverage and enhanced benefits while the plans and states avoid inappropriate costs.

HFI's Social Security Disability Program (SSI)

HFI provides comprehensive SSI Disability support to KHS members—managing every step from application through enrollment. For vulnerable populations, SSI represents a critical pathway to economic security.



KHS Member Benefits

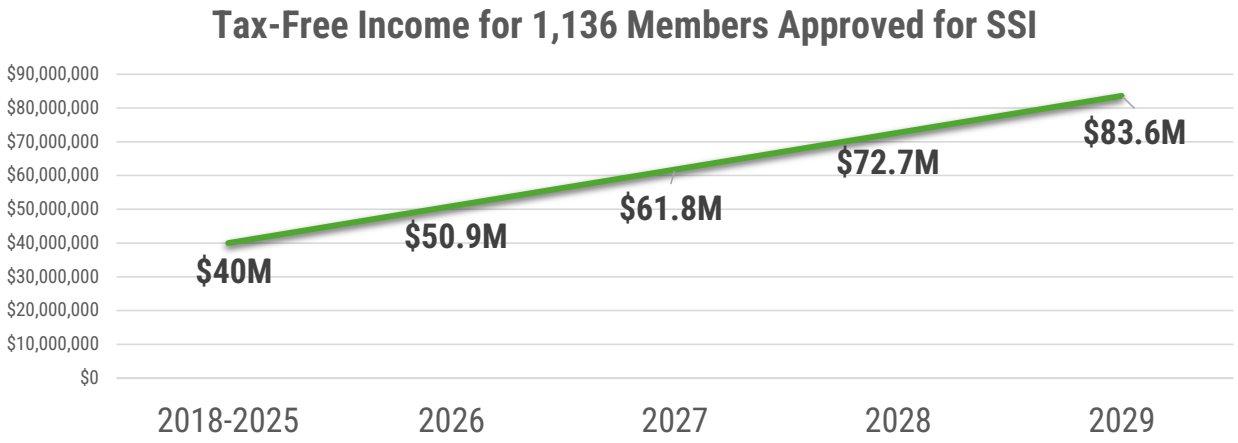
- More stable access to maintaining Medi-Cal coverage
- Consistent income they can allocate toward essential needs—housing, food, utilities, transportation (SDOH)
- SSI Average monthly benefit: $800 (tax free)
- Upon approval, members often receive lump-sum retroactive payments that date back to when their application was sent to SSA
- Life changing event for members and their families

SSI Income Supports Members' Social Determinants Of Health

Economic Stability	Physical Environment	Education	Food	Community	Healthcare
Income	Housing	Literacy	Hunger	Social Integration	Free Healthcare Coverage
Employment	Transportation	Higher Education	Food Insecurity	Community Engagement	Quality of Care

HFI/KHS SSI Estimated Member Income

2018 –2029



*SSI provides tax-free, monthly income to members: approximately $800+ per month.

Member Outcomes



Jaylee's Story

Jaylee (6) was diagnosed with Level 3 Autism and Sensory Processing Disorder. As a result, she has experienced developmental delays and receives various therapies through her school. In addition, Jaylee requires a special diet and struggles with social interactions and new environments.

HFI's Advocacy

Her KHS case manager Valerie, came across Jaylee and knew HFI could help. HFI contacted Jaylee's mother and assisted with an SSI application, which was submitted to SSA for review. HFI continued to work with Jaylee and SSA simultaneously as it moved through the various steps of the approval process.

SSI Comes into Play

After 12 months Jaylee's application was approved for SSI benefits. She was awarded a back payment of **$8,375.43** and a monthly payment of **$967**. This income will help give Jaylee's family the boost they need to help pay household expenses, nutritious food, and other items related to Social Determinants of Health.

Member Outcomes

Jiobani's Story

Jiobani (49) was diagnosed with stage 3 colon cancer, and heart disease. He experiences fatigue, lack of motivation, and has trouble walking.

HFI's Advocacy

His KHS case manager Cora, came across Jiobani and knew HFI could help. HFI contacted Jiobani and assisted with an SSDI application, which was submitted to SSA for review. HFI continued to work with Jiobani and SSA simultaneously as it moved through the various steps of the approval process.

SSDI Comes into Play

After 2 months Jiobani's application was approved for SSDI benefits. He was awarded a back payment of **$20,814** and a monthly payment of **$1,533**. This income will help Jiobani pay household expenses, purchase nutritious food, and other critical items related to Social Determinants of Health.



The contents of this presentation are strictly confidential and not to be shared without written permission from HFI.

HFI Medicare Programs

HFI Medicare Programs



HFI assists members to obtain Medicare Part A (inpatient) and/or Part B (outpatient/physician)

HFI Medicare programs are focused on members such as:

a. High cost, chronic diseases such as ESRD
b. Elderly

Provides members with:

a. No cost Medicare coverage
b. Access to national network of Providers
c. Stabilizes continuity of Care
d. Potentially eligible for cash benefits

Benefits of Creating Medicare Coverage



Medi-Cal members will enjoy no-cost Medicare coverage and access to an expanded network of healthcare providers along with the potential for SSA cash benefits. Ensures continuity of coverage if member loses coverage.



Providers will benefit from higher reimbursement rates for inpatient and outpatient services fostering less charity care.



The Medi-Cal Agency, facing budget reductions, shifting costs from Medi-Cal to Medicare can significantly reduce Medi-Cal expenditures.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Jeremy McGuire, Senior Director of Project Management and Government Relations

SUBJECT: Final 2023-2025 Strategic Plan status report

DATE: February 19, 2026

Background

With the conclusion of the 2023-2025 Strategic Plan, Management is providing a final summary of the initiatives completed and outcomes achieved. Throughout the lifecycle of the Strategic Plan, initiatives have been monitored for progress and reported to KHS Leadership and the Board of Directors, under the stewardship of their respective owners. KHS is proud of the significant strides made advancing the mission of the organization through these strategic initiatives. Major milestones include:

- Core quality metric improvements
- NCQA accreditation
- Healthcare workforce investments
- CalAIM initiative implementations
- Launch of Medicare Dual Special Needs Plan (D-SNP)
- Behavioral Health care expansion and integration
- Member engagement and retention efforts

A full overview of the accomplishments is included in the attached presentation.

Requested Action

Receive and file.

2023-2025 Strategic Plan Final Report



Agenda and Background

- With the conclusion of the 2023-2025 Strategic Plan, Management is providing a final summary of the initiatives completed and outcomes achieved.
- Throughout the lifecycle of the Strategic Plan, initiatives have been monitored for progress and reported to KHS Leadership and the Board of Directors, under the stewardship of their respective owners.
- Overall, KHS is proud of the significant strides made advancing the mission of the organization through these strategic initiatives.





1. Quality and Equity

Deliver exceptional quality outcomes and health equity for KHS members

- Increase overall quality with a drive toward achieving Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps.
- Meet National Committee for Quality Assurance (NCQA) standards and work toward accreditation.
- Further maturity of the organization’s Health Equity programs under the direction of the Chief Health Equity Officer.

Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps

- At the end of 2023, the MCAS Strike Team evolved into a dedicated Quality Performance Department. Quality Performance developed various initiatives in support of MCAS performance improvement. Notable initiatives from 2023-2025 include:
  - Partnerships established with more than 15 school districts and numerous CBOs to bridge gaps in care
  - Preventive care for pediatric and behavioral health prioritized with extended clinic hours
  - Lead screening machines purchased for multiple pediatric providers
  - Increased data exchange and EMR access
  - Dedicated outreach team for gap closure through mid-year 2025
  - Access increased in rural regions and school systems via mobile health care
  - Multiple mobile mammography events
  - Initiatives aimed at pregnant and newly postpartum mothers to support transition and encourage postpartum and well-care visits

- **Key Outcomes:**
  - For 2025 reporting, MPL was achieved for 12 MCAS measures and within 5% of MPL for 3 additional measures. This is a notable improvement compared to MPL achieved for 5 measures reported in 2023 and 8 measures reported in 2024.
  - Overall improvement in 15 of 18 measures for reporting year 2026 YTD compared to 2025 reporting.
  - Currently demonstrating improvement in most measures in the Children's Domain of Care for reporting year 2026 compared to 2025 reporting.

National Committee for Quality Assurance (NCQA)

- Detailed presentation was provided to the Board in August 2025. Below are some of the key achievements:
  - Completed 12,000+ project hours with 65 staff members across 34 departments.
  - Began with a comprehensive gap analysis with NCQA consultants and the development of a 3-year work plan for gap closure to prepare for NCQA Health Plan (HPA) and Health Equity (HEA) Accreditations.
  - Conducted regular mock file reviews with NCQA consultant for Utilization Management, Population Health Management, Quality Improvement, and Credentialing.
  - Developed 12 new operations and 102 analytical reports.
  - Updated 209 documented processes and materials.
  - Developed and implemented compliance software (SAI360) for on-going monitoring of standard compliance.
  - Developed 3-year re-accreditation workplan.

- **Key Outcomes:**
  - Health Plan Accreditation achieved 6/10/2025 with 99% score
  - Health Equity Accreditation achieved 8/5/2025 with 100% score



Health Equity Programs

- **Created Health Equity department, structures, policies, and processes. Integrated health equity into core operations using regional strategies and routine quality improvement processes.**
  - Expanded enterprise-wide data and qualitative insights, including SOGI data, member experience, and provider feedback, to guide action.
  - Equipped employees and providers with training and tools to deliver equitable, culturally responsive care.
  - Established structured listening and engagement mechanisms across Members, Providers, Employees, and Community to identify access barriers, service gaps, improve communication, and inform targeted interventions.
  - Administered DHCS' Equity Practice Transformation (EPT) program, investing over $8 million into 12 local provider practices to improve clinical operations and quality disparities.
  - Created Health Equity and Quality Performance Awards to recognize providers advancing health equity, quality performance, and member outcomes. Incentivizing quality innovation and best practices to accelerate outcomes.

- **Key Outcomes:**
  - Health Equity Department established in 2023 and reached **full NCQA HEA accreditation in under 2 years**
  - Established health equity as a sustained organizational capability, not a time-limited program

2. Workforce Development

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

- Identify Provider Network needs and gaps to inform target areas and approaches. Strengthen and expand the KHS provider network through innovative and effective recruitment and retention programs.
- Identify business needs and gaps in current workforce to inform target areas and approaches. Meet the growing operational demands of the organization by creating recruitment and retention programs for internal staffing and leadership needs.

Provider Network Recruitment and Retention

- Enhanced provider network analysis tools including the development of a **Provider Network Adequacy Committee** (NAC) and held quarterly meetings to review network adequacy and develop actions to address identified gaps.
- Developed and implemented the **Recruitment and Retention Grant program** centered on strengthening workforce stability and ensuring continuity of care for KHS members.
  - The initiative successfully added **68 new providers** to the network, including 18 MDs, 22 specialists, 9 mid level PCPs, 9 mid level specialists, 7 therapists, 1 BCBA, and 2 physical therapists. In addition, awardees were able to offer retention incentives to **76 existing providers**, helping maintain essential access to care for members.
- **Healthcare Workforce Expansion** initiative allocated funding to educational institutions and health care providers that work together to expand local nursing and physician professionals in Kern County.
  - Residency programs—Tehachapi rural residency launch, Delano clinic planning, Bakersfield Memorial's Internal Medicine Grad Medical Education program with Moorehouse, and Good Samaritan's Family & Psych residency progress.
  - Other education programs - Cerro Coso and Taft's upcoming ADN programs, and CSU Bakersfield launched its first doctoral-level nursing program in Fall 2025.
- Creation of new Medicare network to support 1/1/26 launch of D-SNP product.
- **Over this period the Primary Care Provider network increased from 433 to 579 providers, while the specialist network grew from 2,364 to 3,698 providers, strengthening member access to care.**

Internal Workforce Development

Employee Development

- Launched a formal Internal Mobility Program with a structured Professional Growth Pathway and supporting policy to provide transparent career advancement, consistent development expectations, and clearer skill-building opportunities for employees and leaders.
- Invested in strengthening our leadership pipeline by completing a vendor-led coaching program for Senior Director–level leaders, which concluded with a reflective review and clear next steps for continued development.

Succession Planning

- Building Succession Planning tracking to identify key roles to prepare leaders proactively.
- Launched pilot succession planning and talent review process for critical role.

Other initiatives

- Implemented a self-funded employee health plan, completing a comprehensive evaluation of options, securing Board approval and vendor agreements, and successfully launching the new plan on January 1, 2025.
- Completed a comprehensive compensation modernization effort, including adopting Mercer-recommended pay structures and equity adjustments from the market study, and implementing a revised, equity-focused Compensation Philosophy approved by executive leadership in January 2025.
- Conducted KHS Career Fair events and Internship programs.

• KHS was certified as a Great Place To Work and was recognized by Fortune as a Best Healthcare Workplace in 2025. We received a 92% overall rating on being a Great Place To Work from our employees.

3. CalAIM Initiatives

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

- Continued growth and maturity of existing CalAIM programs – Population Health Management (PHM), Enhanced Care Management (ECM), Community Supports (CSS), and Long-Term Care (LTC).
- Strengthen Existing and Establish New Community Partnerships to Support CalAIM.
- Ongoing collaboration between KHS staff and the Department of Health Care Services (DHCS) on the development and implementation of future CalAIM initiatives.

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) program delivered significant progress under the CalAIM initiative, achieving sustained program expansion, advancing major statewide priorities, and strengthening regional collaboration.

- Consistent year over year expansion, increasing from 28 program sites in 2023 to 47 by 2025. Enrollment more than doubled—from 7,000 to over 14,000 members.
- The program successfully introduced multiple new Populations of Focus, including six Children and Youth categories in 2023 and the Birth Equity populations for Adults and Youth in 2024.
- Throughout all three years, the CalAIM Kern Collaborative operated as a core regional engagement platform. Monthly meetings in 2023–2024 evolved into quarterly in person gatherings at Bakersfield College by 2025, increasing structure and visibility. Provider engagement deepened through the 2025 ECM/CSS provider fair and the inaugural Provider Appreciation Event.
- Planning and implementation of both the CDCR Justice Involved Initiative and the Kern County Justice Involved Initiative. Through extensive coordination with CDCR and a wide network of county partners—including Behavioral Health, Probation, Sheriff's Office, and Human Services.

- **Key Outcomes:**
  - Reduction in Emergency Department visits - since establishing a benchmark goal of a 5% quarterly reduction in ED use, the program has achieved a nearly 24% overall decrease—dropping from 663 ED visits per 1,000 members in Q3 2024 to 425 visits per 1,000 in Q4 2025.
  - KHS is consistently among the top Plans in the State in ECM enrollment percentage.

Community Support Services (CSS)

- By July 2024, Community Supports had fully implemented **all 14 pre-approved services**, marking a significant milestone in program expansion.
- Service utilization increased substantially, rising from **7,328 services delivered in 2023 to 13,814 in 2025**, nearly doubling over a two-year period.
- Expanded network of providers offering CSS **from 5 to 27 partners**, significantly increasing service capacity across Kern County and enabling delivery of 72 distinct Community Supports services.
- Implemented the **Closed Loop Referral Model** in 2025, enhancing care coordination by providing real-time referral status updates to both members and referring entities.
- **Reviewed and refined eligibility and authorization** criteria following the April 2025 CSS Policy Guide update, implementing a strengthened validation process with KHS Business Intelligence—using claims history, diagnostics, utilization patterns, and Johns Hopkins risk stratification—to ensure alignment with DHCS requirements, reinforce program integrity, and support appropriate utilization.
- Engaged in **statewide coordination** through DHCS Technical Assistance meetings, LHPC collaboration on best practices and sustainability, and participation in the Housing Advisory Committee.

- **Key Outcomes:**
  - Those who received Personal Care Services saw a **decrease in emergency room admissions** of 12.8%
  - Recuperative Care Services recipients saw a **decrease in Inpatient Hospital Services** of 57.8%
  - Short Term Post Hospitalization recipients had a **decrease in Inpatient Hospital Services** of 55.9%

Population Health Management (PHM)

Population Health Management (PHM) has focused on strengthening and fully implementing CalAIM programs.

- Expanded Transition of Care Services (TCS) and Long-Term Care (LTC) programs to ensure members receive timely, coordinated care without gaps. Dedicated teams, streamlined workflows, and strengthened oversight to improve consistency and accountability.
- Advanced disease management for high-risk members by developing special programs for individuals with kidney disease, heart failure, and complex care needs.
- Strengthened its population health infrastructure by identifying high-risk members and implementing standardized preventive and social determinants of health screenings, enabling earlier identification of needs and more timely connections to appropriate services.
- Enhanced data sharing, discharge planning, and follow-up care with hospitals and health systems.
- Partnered with skilled nursing facilities, SNFist providers, and intermediate and subacute care facilities to improve on-site medical care and care coordination for long-term care members.
- Participated in DHCS' Medi-Cal Connect program which provides additional data sources and risk insight to Health Plans.

- **Key Outcomes:**
  - Approximately 27,500 members have been outreached to regarding Transition of Care Services.
  - Case management staff administered over 26,000 psychosocial screenings to members enrolled in case management services.
  - KHS has taken over primary coverage for over 889 members residing in Long-Term Care facilities. 100% of LTC members receive routine SNFist visits.

4. Medicare Duals Special Needs Plan

Develop and implement a competitive Medicare D-SNP product in alignment with State and Federal requirements

- Development of the long-term D-SNP strategy and implementation roadmap.
- Analysis of the appropriate market factors to maximize the competitiveness of the product.
- Design and implementation of an efficient Medicare D-SNP offering with competitive advantages, leveraging KHS innovation and new business/new product development capabilities.

D-SNP Readiness and Implementation

Strategy and Roadmap – Multi-year effort to build long-term D-SNP strategy.

- Began with feasibility assessments, Milliman financial modeling, and early market and competitor analysis.
- Also included a formal three-year roadmap, buy vs build analysis, and multiple project charters.
- Additionally developed a structured delegation strategy, conducting a formal administrative services RFP and refining the Model of Care (MOC) and internal structure to support delegation oversight.

Market Analysis - KHS applied a structured market-intelligence approach to ensure the D-SNP product was competitively positioned.

- Conducted formal competitor analyses, including reviews of regional Medicare Advantage and D-SNP offerings, evaluations of benefit designs, and assessments of current Medi-Cal benefit opportunities.
- This allowed KHS to understand market dynamics, identify drivers of member value, and determine the strategic features required to differentiate its product.
- Developed robust marketing campaign and internal sales capabilities leading up to open enrollment.
- KHS is prepared to proactively adapt its product strategy to maintain market competitiveness. The organization will update its competitor analysis annually ahead of Medicare open enrollment, ensuring access to current intelligence on competing plans' benefit structures, member value propositions, and anticipated shifts in the Medi-Medi markets.

D-SNP Readiness and Implementation

Design and Implementation Efforts – Worked to build the internal operational, technical, and governance infrastructure required to support a delegated Medicare D-SNP product.

- Developed the CMS Model of Care, updated implementation plans, timelines, and capital budgets to support operational needs.
- Based on approved Model of Care, completed enterprise-wide resource planning and cross-functional coordination for claims, regulatory reporting, member materials, and other core operational processes.
- Executed major regulatory and operational milestones, including CMS bid and DHCS SMAC submissions, delegation contracts, and activation of key functions—appeals, call center, clinical oversight, data management, enrollment, and PBM outsourcing.
- Advanced toward the January 1, 2026 launch through full production testing, delegated partner integration, and clinical/technical troubleshooting, with continued 2026 work underway on reporting insights, STARS analytics, and operational maturity.

Key Outcomes:

- Achieved a **100% NCQA-aligned Model Of Care score** in early 2025
- Went live with D-SNP enrollment on 1/1/26 with over **750 enrolled members**
- Over **75% of Members** completed their Health Risk Assessment (HRA) prior to go-live
- From 2023-2025 project team members logged over **30,000 hours in support** of this product launch

5. Behavioral Health

Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions

- Development and maturity of an internal Behavioral Health (BH) Department.
- Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS).
- Communication and coordination with County Behavioral Health regarding DHCS requirements.
- Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment (MAT) services.

Behavioral Health

Development and maturity of an internal Behavioral Health (BH) Department

- Built a fully operational BH Department, including org structure, staffing, onboarding, policies, and program specifications.
- Implemented BH workflows in KHS' core system (JIVA) to track enrollment, monitor participation in BH programs, and support care coordination.
- Developed coordination workflows with Kern Behavioral Health & Recovery Services (BHRS).
- Strengthened Quality infrastructure through enhanced reporting, monitoring, and outcomes tracking.
- Launched BH audits (medical necessity, chart review, billing accuracy), BH Member Experience Survey, and provider training efforts.
- Created prototype dashboard and member stratification process to support Pop. Health Management.
- Advanced integration through NCQA initiatives and expanded provider-portal BH features.
- Finalized governance policies and enhanced clinical oversight and provider support workflows.

Behavioral Health

Evaluate and Ensure Adequate Mental Health Provider Network

- Addressed timeliness of access and referral aging through targeted network remediation efforts.
- Created processes to screen and evaluate prospective BH providers.
- Partnered with Provider Network Management (PNM) to support onboarding of new BH providers.
- Partnered with Credentialing to track and monitor provider growth on a quarterly basis, developed a credentialing application for associate-level staff, and processes to monitor and track non-credentialed ABA providers.

Provider Growth (2023–2025)

- Licensed Marriage and Family Therapists: 96 → 111
- Licensed Clinical Social Workers: 122 → 131
- Psychiatrists: 124 → 222
- Behavioral Technicians: 349 → 541
- Behavioral Analysts: 251 → 265

Behavioral Health

Coordination with County Behavioral Health

- Established the “No Wrong Door” approach in partnership with Kern BHRS.
- Implemented automated, bidirectional data exchange with Kern BHRS to support enrollment tracking and care coordination.
- Implemented Closed Loop Referral (CLR) processes to strengthen coordination and continuity of care.
- Executed and implemented Memoranda of Understanding (MOUs) with Kern BHRS for Behavioral Health Programs (BHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).
- Ongoing regular work to ensure policy alignment between agencies in support of the spirit of the MOU.

Evaluate & Develop Primary Care Provider Roles in SUD / MAT Services

- Laid foundation for Primary Care integration with Substance Use Disorder (SUD) / Medication Assisted Treatment (MAT) services, supporting future expansion.
- Designed MAT process flow and initiated credentialing review for Addiction Specialists.
- Developed oversight and reporting structure to support program performance monitoring.

Key Outcomes:

- 43% increase in members receiving Non-specialty Mental Health Services in 2025 compared to 2023.
- KHS Behavioral Health team received over 2,100 referrals in Q4 2025.
- Averaged over 5,400 inbound/outbound phone calls per month throughout 2025.

6. Member Engagement

Increase meaningful member engagement in their health care

- Identify and implement innovative and effective offerings designed to engage members more in their health care.
- Work with internal staff and external partners to develop strategies that ensure continuity of coverage for our members.
- Leverage convenient technology to enhance the effectiveness of engagement and suit members' needs.

Member Engagement

Innovative & effective offerings designed to engage members

- Completed a restructuring of the marketing and member engagement team including policy and procedure.
- Established a physical presence with Member Engagement Representatives (MER) placed in strategic offices in 10 outlying Kern County regions.
- Partnered with Quality Performance, Member Services, and Wellness & Prevention to conduct targeted outreach campaigns promoting mobile clinics, wellness exams, screenings, and health education.
- Collaborated with Health Equity, Cultural & Linguistics, and Member Services to support quarterly Regional Advisory Committee meetings across Kern County to gather insights on member and community needs.
- Updated protocols for member-facing staff to encourage member utilization of self-service tools on the member portal.

Leverage convenient technology to enhance the effectiveness of engagement

- Expanded and enhanced outreach channels to include Artificial Intelligence (AI) Interactive Voice Response (IVR) call outreach and text messages.
- Upgraded the Text Message Platform vendor to provide more direct message engagement and response.
- Enhanced the Member Rewards Program to provide a refillable Visa card to improve delivery time, oversight, and useability.
- Selection and implementation toward a new Member/Provider Portal with enhanced features.
- Utilized Gaps in Care reporting specific to the MER's region as a tool for visibility to focus efforts on needed care gaps.

Member Engagement

Develop strategies that ensure continuity of coverage for our members

- Developed annual tailored member communication strategies designed for maximum reach.
- Remarkable partnership with County Department of Human Services (DHS) to assist members in redetermination. Included sophisticated and detailed data exchanges, on-site DHS staff, access to enrollment systems, on-site document scanning, and regular communications between agencies.
- Multi-channel comprehensive outreach program including advertising (print, digital, radio), member mailings, and frequent phone outreach (call/text).
- Regular community engagement through local events, collaborative meetings, and direct member presentations in various venues.
- Coordination with providers and community partners to allow on-site Community Enrollment Navigators to assist members who attend appointments and enrollment events.
- Supported local Community Based Organizations regarding staffing and training.
- Updated internal and external processes and procedures for visibility into upcoming renewals.

• Key Outcomes

- Maintained an average member retention rate of 95%
- Texting campaigns averaged 67,000 messages per month with 13% click rate and 33% action rate.
- 75% increase in call volume output due to automated voice agent
- Direct enrollment assistance to an average of over 5,300 members per month
- Member Engagement Reps assisted around 225 members per month on average in outlying regions

7. KHS Foundation

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

- Conduct exploratory analysis of the necessary major components needed for the creation of a KHS non-profit foundation.
- Begin collaboration with law firm on the corporate formation documents and finalize the development phase of the foundation.
- Operational Activities, complete filing of 501(c)(3), and create funding source plan

KHS Foundation Development

- Explored partnerships with local law firms to begin the legal development phase.
- KHS connected with LeBeau Thelen to start filing the Articles of Incorporation.
- Finalized Articles of Incorporation, marking a key milestone and formally setting the foundation's legal framework.

- Legal drafted the foundation's bylaws to define governance, operational structure, and mission alignment.
- Established the Bylaws Committee. The committee convened to review the draft and provide input on revisions.
- Bylaws were finalized by the external law firm and are now awaiting final approval from the Foundation Committee.

- The final phase included appointing the initial Directors and holding the initial meeting to initiate operations.
- However, due to budget and policy uncertainties, foundation activity was paused for the remainder of 2025 – 2026.

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



KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Alan Avery, Chief Operations Officer

SUBJECT: 2023-2025 Grants and Strategic Initiatives

DATE: February 19, 2026

BACKGROUND

The 2023–2025 Kern Health Systems (KHS) Grants and Strategic Initiatives were approved by the Board on August 17, 2023. This memo outlines the conclusion of the initiative period and summarizes project impacts. The approved grants and initiatives were authorized for a two-year period: November 17, 2023, through November 17, 2025

I. Strategic Initiatives ($12,000,000)

There were two strategic initiatives, the Healthcare Workforce Expansion Program for $10,000,000 and Community-Based Organization (CBO) Program for $2,000,000.

The workforce expansion initiative was designed to expand the nursing and physician workforce through partnerships with contracted providers and local academic institutions. The focus areas for workforce expansion include workforce pipeline development, residency training expansion, and development of nursing degree programs. The Community-Based Organization (CBO) initiative was designed to support innovative social service delivery models aimed at reducing barriers to care and promoting wellness. The CBO initiative periodized closing gaps in care by focusing on non- clinical services.

II. Grant Programs ($8,000,000)

There were two grant programs, Provider Recruitment and Retention (R & R) Grant Program for $3,000,000 and Quality Grant Program for $5,000,000.

The R & R grant supported the expansion of access to Primary Care, Specialty Care, and Behavioral Health Services across Kern County. The goals of the R & R grant were to increase provider capacity, expand, appointment availability, strengthen rural access by recruiting and retaining physicians. The Quality Grant program developed innovative partnerships with network providers to elevate quality of care and improve health outcomes. The Quality grant invested in mobile clinics to close gaps in care in our rural communities.

The 2023–2025 Grants and Strategic Initiatives represent a significant investment in improving access, strengthening the healthcare workforce, and elevating quality of care for Kern County's most vulnerable populations. The partnerships and programs established during this period have advanced KHS's commitment to health equity and positioned the organization for continued progress. A comprehensive summary of the project impacts is included in the CEO report.

KHS appreciates the Board's leadership and support throughout this grant cycle.

REQUESTED ACTION

Approve; Authorize Kern Health Systems to Retain Unearned Funds totaling $659,002.17.

KERN HEALTH SYSTEMS

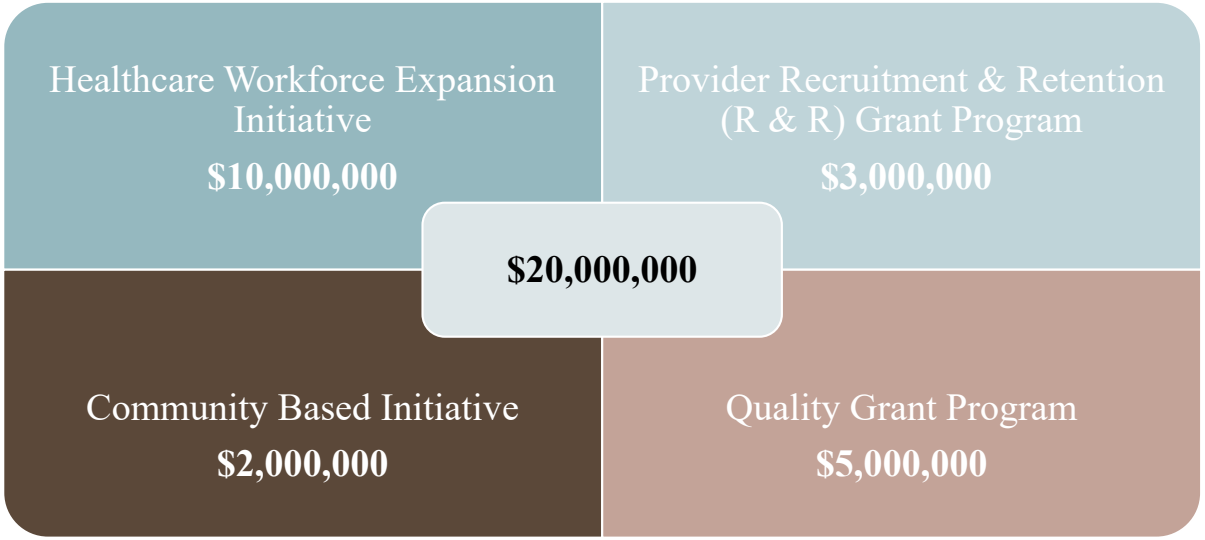
2023 – 2025 Grants and Strategic Initiatives

Alan Avery, COO

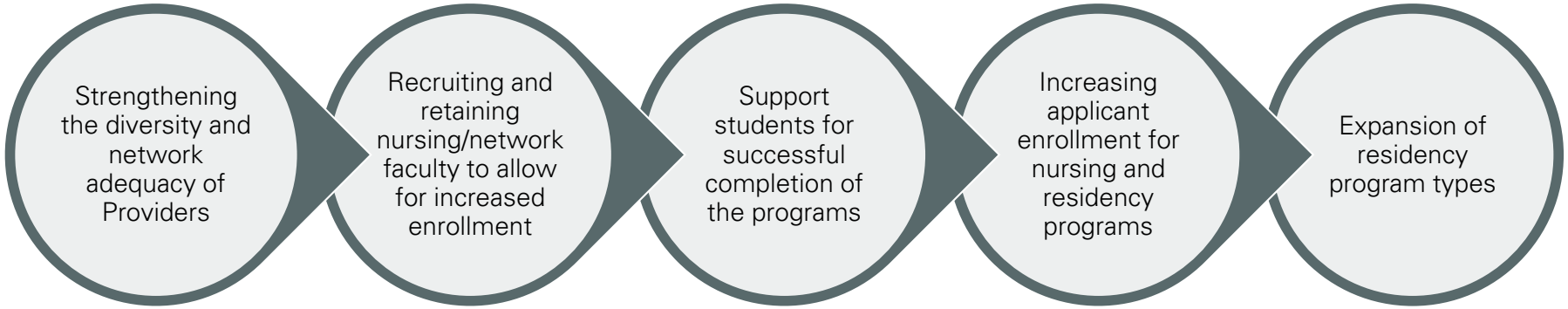
Background: Grants & Strategic Initiatives

The 2023–2025 Grants and Strategic Initiatives were approved by the Board of Directors on August 17, 2023, and authorized for a two-year period: November 17, 2023, through November 17, 2025

This presentation provides a high-level summary of the Grant and Strategic Initiative period. Addendum A attached, is a final detailed report for each project.



Healthcare Workforce Initiative Goals



Healthcare Workforce Initiative Impact

Residency Programs

- Feasibility study completed for a new Rural Family Medicine Residency with Adventist Health Tehachapi)
- **Internal Medicine Residency Program** launched at Bakersfield Memorial Hospital (10 residents in first cohort)
- Residency expansion at Clinica Sierra Vista: capacity increased from **24 → 36 residents**
- New residency & fellowship programs at Kern Medical (TY & General Surgery Residencies, Simulation Fellowship, Addiction Medicine Fellowship)
- Good Samaritan Hospital: Institutional Accreditation & Family Medicine Residency Accreditation achieved; **Psychiatry residency groundwork** completed.

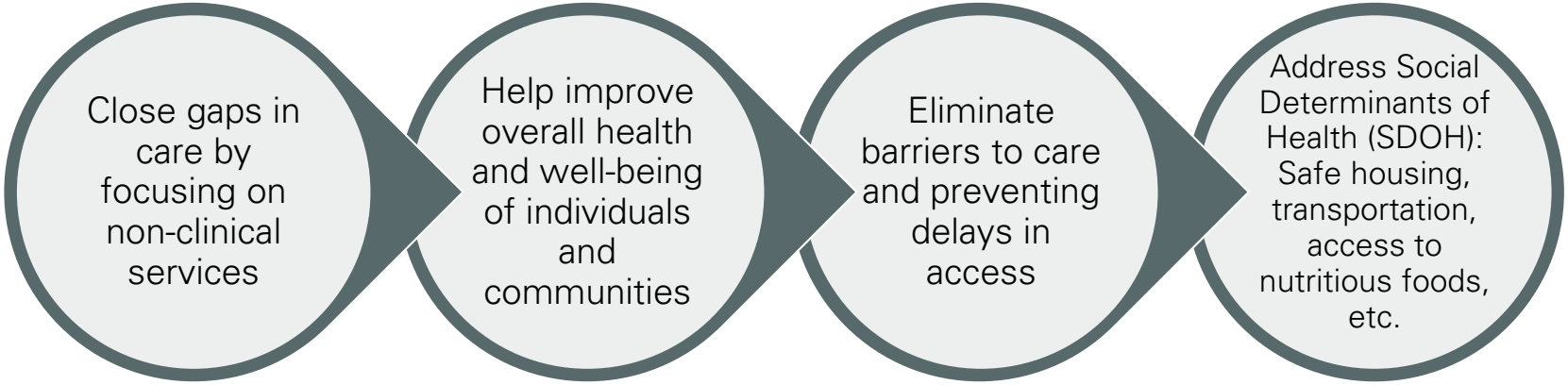
New Nursing & Graduate Programs

- **2 new ADN Programs** (Cerro Coso Community College; Taft College – BRN approval pending) First cohorts targeted: Cerro Coso: 10 students (Spring 2027)Taft College: 16–24 students (Fall 2026)
- **2 new Doctoral/Graduate Nursing Programs** at CSUB DNP-FNP and MSN-to-DNP
- 15 students in inaugural DNP cohort (Fall 2025)

Funding Breakdown

Organization Name	Amount Allocated	Amount Earned	Unearned Funds
Adventist Health Bakersfield	$100,000	$100,000	$ -
California State University, Bakersfield Foundation	$1,000,000	$1,000,000	$ -
Clinica Sierra Vista (CSV)	$2,000,000	$2,000,000	$ -
Dignity Health - Bakersfield Memorial Hospital	$1,000,000	$1,000,000	$ -
Good Samaritan Hospital	$1,000,000	$875,593.58	$124,406.42
Kern Community College District Cerro Coso Community College	$300,000	$283,843.81	$16,156.19
Kern Community College District Bakersfield College	$300,000	$ -	$300,000
Kern Medical (KM)	$4,000,000	$3,991,529.39	$8,470.61
West Kern Community College District Taft College	$300,000	$300,000	$ -
TOTALS	**$10,000,000**	**$9,550,966.78**	**$449,033.22**

Community Based Initiative Goals



Community Based Initiative Impact

Health & Wellness Outreach
- 6,500+ residents reached through fitness, nutrition, and health education campaigns
- 12,000+ community members reached through culturally rooted chronic disease & wellness programs
- 247 healing circle sessions delivered to support emotional well-being
- 2,421 incentives provided to support individuals in recovery

Access to Care & Medi-Cal Enrollment
- 3,000+ Medi-Cal referrals/renewal assists (Dolores Huerta Foundation)
- 90+ outreach events promoting Medi-Cal renewals & certifications

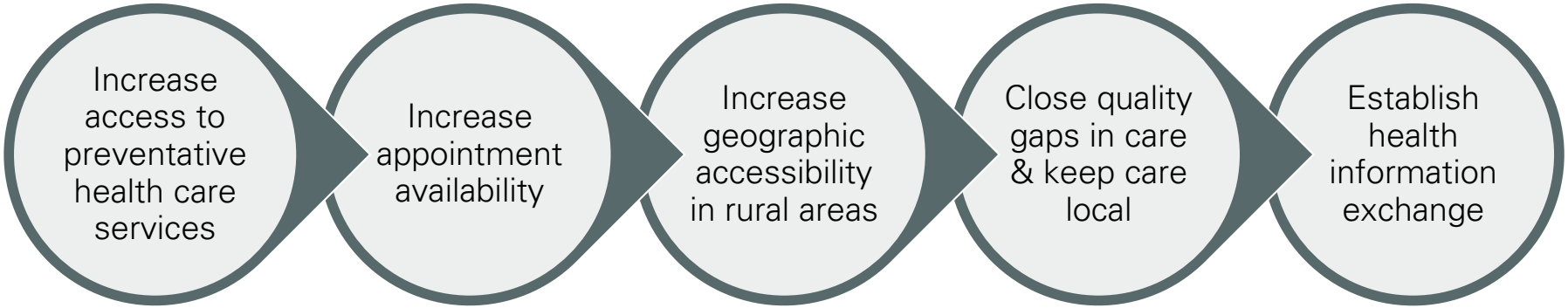
Support for Children & Families
- 10 wishes granted for children with critical illnesses
- 129 community partners, 80 providers, and 366 parents trained on early developmental monitoring (First 5 Kern)

Basic Needs & Social Supports
- Critical home repairs completed for families facing displacement (Habitat for Humanity)
- Food pantry operations sustained supporting East Kern families (Safe Haven Kids League)
- 15 Organ Transplant patients received financial support (JJ's Legacy)

Funding Breakdown

Organization Name	Amount Allocated	Amount Earned	Unearned Funds
Bakersfield Recovery Services	$50,000	$48,500	$1,500
Building Healthy Communities	$200,000	$200,000	$ -
California Farmworker Foundation	$200,000	$175,301	$24,699
Community Interventions	$200,000	$200,000	$ -
Dolores Huerta Foundation	$175,000	$175,000	$ -
First 5 Kern	$150,000	$150,000	$ -
Habitat for Humanity Golden Empire	$100,000	$100,000	$ -
Heather Berry Counseling, Inc.	$6,000	$6,000	$ -
JJ's Legacy	$22,500	$22,500	$ -
Kern County Cancer Foundation	$200,000	$200,000	$ -
Links for Life	$100,000	$100,000	$ -
Make A Wish Foundation	$25,000	$25,000	$ -
Safe Haven Kids League	$150,000	$150,000	$ -
The Mission of Kern	$20,000	$20,000	$ -
United Way of Kern County	$200,000	$200,000	$ -
Vision y Compromiso	$200,000	$200,000	$ -
*Undistributed Funds**	**$1,500**		**$1,500**
TOTALS	**$2,000,000**	**$1,972,301**	**$27,699**

Quality Grant Goals



Quality Grant Impact

KEY ACHIEVEMENTS

- Over **850+ mobile clinics** operated across multiple provider organizations, bringing care directly into communities.
- Significant increases in Lead Screening, Well Child Visits, immunizations, and annual physicals across funded providers.
- Over **12,000+ outreach calls** made to close care gaps and schedule members for needed services.
- Kern Medical, CSV, Omni, and PVMG collectively delivered thousands of visits, vaccinations, screenings, and school-based services.
- Coastal Kids increased Lead Screening rates from **66% → 80%.**
- San Michael Pediatrics scheduled 4,000 members; Universal completed **8,321 outreach calls.**
- Vanguard completed **4,011 clinical encounters in 2025**, improving wellness and cancer screening outcomes.

Funding Breakdown

Organization Name	Amount Allocated	Amount Earned	Unearned Funds
Coastal Kids	$150,000	$150,000	$ -
Clinica Sierra Vista	$1,136,625.74	$1,136,625.74	$ -
Kern Medical	$1,362,885.09	$1,362,885.09	$ -
Komoto Pharmacy	$104,100	$104,100	$ -
Omni	$1,500,489.17	$1,500,489.17	$ -
Polyclinic Medical Center Inc	$100,000	$100,000	$ -
Premier Valley Medical Group	$220,000	$220,000	$ -
San Michael Pediatrics	$100,000	$97,730.05	**$2,269.95**
Universal Healthcare Services Inc	$200,000	$200,000	$ -
Vanguard Medical Corporation	$125,900	$125,900	$ -
TOTALS	**$5,000,000**	**$4,997,730.05**	$2,269.95

Recruitment and Retention (R&R) Grant Goals

The Recruitment and Retention grant provided opportunities for our Providers to increase and improve access to:



R&R Impact

Recruitment Achievements

- 68 of 77 recruitment targets were met, achieving 88% despite challenges.
- Unmet milestones from Omni Family Health [5 Mid-Levels], Premier Valley Medical Group [2 Specialist MDs], and Singh Family Medical Group [2 PCP MDs]

Retention Successes

- All 76 retention commitments were fulfilled, demonstrating strong workforce stability.

	Total Numbers			
	Contract Obligation		Actual Numbers	
	Total Recruitment	Total Retention	Total Recruitment	Total Retention
MD -PCP	19	30	18	30
MD - Specialist	24	1	22	1
Mid-Level (PCP)	15	30	9	30
Mid-Level (Specialist)	9	2	9	2
Behavioral Health Therapist	7	13	7	13
BCBA	1	0	1	0
Physical Therapist	2	0	2	0
Totals	**77**	**76**	**68**	**76**

Funding Breakdown

Organization Name	Amount Allocated	Amount Earned	Unearned Funds
ACE Eyecare	$30,000	$30,000	
Adventist Health Delano	$30,000	$30,000	
Atul Aggarwal MD Cardiology Clinic	$30,000	$30,000	
Bakersfield American Indian Health	$20,000	$20,000	
Behavioral Momentum Services LLC	$10,000	$10,000	
Clinica Sierra Vista (CSV)	$681,975.44	$681,975.44	
Coastal Kids	$30,000	$30,000	
Kern Medical	$817,731.05	$817,731.05	
Kern Psychiatric Health and Wellness Center, Inc.	$10,000	$10,000	
Kern Valley Healthcare District MVHC	$40,000	$40,000	
KVHCD -Transportation	$95,000	$95,000	
Omni Family Healthcare	$900,293.50	$825,293.50	$75,000
Premier Valley Medical Group	$125,000	$65,000	$60,000
Rhema Therapy Inc	$20,000	$20,000	
Shafter Pediatrics	$20,000	$20,000	
Singh Family Medical Clinic	$35,000	$0	$35,000
Terrio Therapy Fitness Inc	$20,000	$20,000	
Universal Healthcare Services Inc	$35,000	$35,000	
Vanguard Medical Corporation	$20,000	$20,000	
VipMD	$20,000	$20,000	
*Undistributed Funds**	$10,000		$10,000
TOTALS	**$3,000,000**	**$2,820,000**	**$180,000**

Board Request

Authorize KHS to retain the unearned funds totaling $659,002.17.

KERN HEALTH SYSTEMS

Addendum A:

2023 - 2025 GRANTS AND INITIATIVES

Final Closeout Report

Prepared for KHS Board of Directors

February 19, 2026

Alan Avery, COO

HEALTHCARE WORKFORCE EXPANSION INITIATIVE

Background

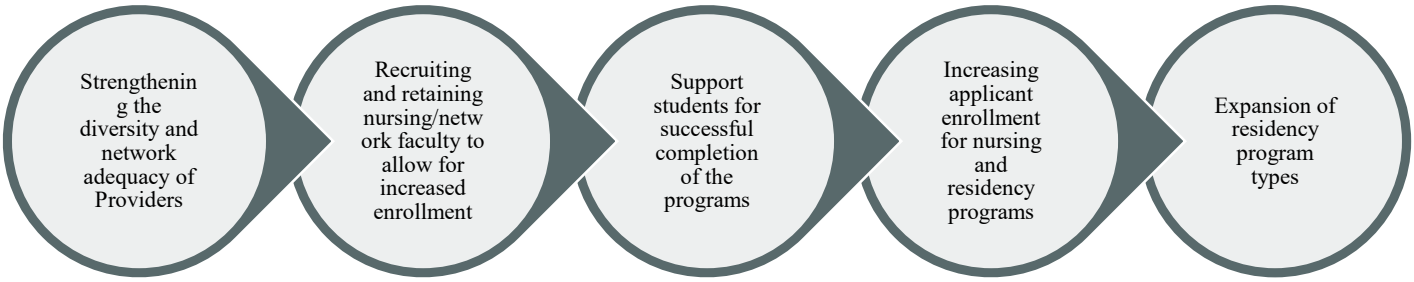
The Healthcare Workforce Expansion initiative allocated $10 million to educational institutions and health care providers that will work together to expand local nursing and physician professionals in Kern County.

Most of Kern County is federally designated as Health Professional Shortage and Medically Underserved Areas, which simply means that there is a severe provider shortage in our County. KHS recognizes that there are member waiting lists to see providers and specialists which results in a lack of access to health care, the current ratio of providers to members is not optimal when delivering an integrated health care delivery system.

The investment of this initiative is to grow our own local professional medical talent by cultivating the professional interests of students at a younger age and removing obstacles that give them a chance for higher education and ultimately post-graduate employment opportunities in Kern County. This Expansion initiative will also increase the number of primary care physician residents allowing for a larger, more robust, residency program in our community.

This section of the report summarizes the awardees projects and impacts for the healthcare expansion initiative.

Initiative Goals



Funding Breakdown

Organization Name	Amount Awarded	Amount Earned	Unearned Funds
Adventist Health Bakersfield	$100,000	$100,000	$ -
Kern Community College District Cerro Coso Community College	$300,000	$283,843.81	$16,156.19
West Kern Community College District Taft College	$300,000	$300,000	$ -
California State University, Bakersfield Foundation	$1,000,000	$1,000,000	$ -
Clinica Sierra Vista (CSV)	$2,000,000	$2,000,000	$ -
Dignity Health - Bakersfield Memorial Hospital	$1,000,000	$1,000,000	$ -
Good Samaritan Hospital	$1,000,000	$875,593.58	$124,406.42
Kern Medical (KM)	$4,000,000	$3,991,529.39	$8,470.61
Kern Community College District Bakersfield College	$300,000	$ -	$300,000
TOTALS	**$10,000,000**	**$9,550,966.78**	**$449,033.22**

Award Impact Summary

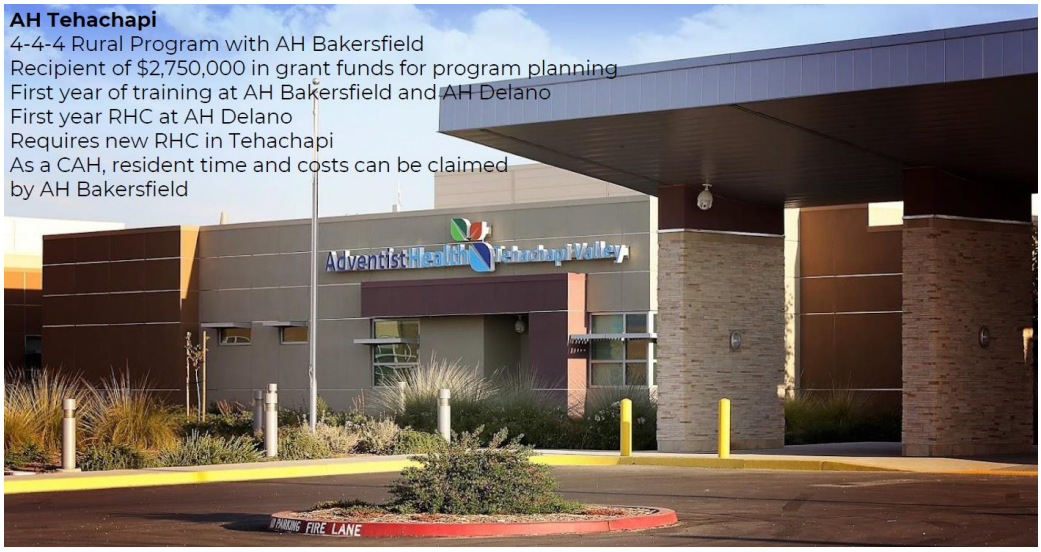
ADVENTIST HEALTH BAKERSFIELD

Funding Allocation: $100,000

Project Name: Family Practice Feasibility Study

Project Impact: This funding was utilized to conduct a feasibility study to determine the viability of a Rural Family Medicine residency program throughout Adventist Health's Central Valley rural health clinics. The feasibility study led to the launch of the rural residency program in Tehachapi, and work towards the Delano clinic. This growth of residency programs in Kern will help to address healthcare provider shortages





CERRO COSO COMMUNITY COLLEGE

Funding Allocation: $300,000

Project Name: Implementation of Associate Degree of Nursing (ADN) **Project Impact:** The funding assisted in establishing both the core administrative team and the high-fidelity clinical training facilities required to launch the new ADN program. The Board of Registered Nursing (BRN) approval is pending, but Cerro Coso anticipates launching the first cohort within approximately six months with an estimated start date of Spring 2027. **The program will be limited to 10 students in the first cohort**, in accordance with BRN requirements. During the grant period, the college focused on upskilling current nursing faculty, recruiting necessary staff and faculty, and completing the BRN self-study in collaboration with the BRN-provided educational consultant, all of which were critical steps toward establishing an approved ADN program.





TAFT COLLEGE

Funding Allocation: $300,000

Project Name: Associate Degree in Nursing (ADN) Program

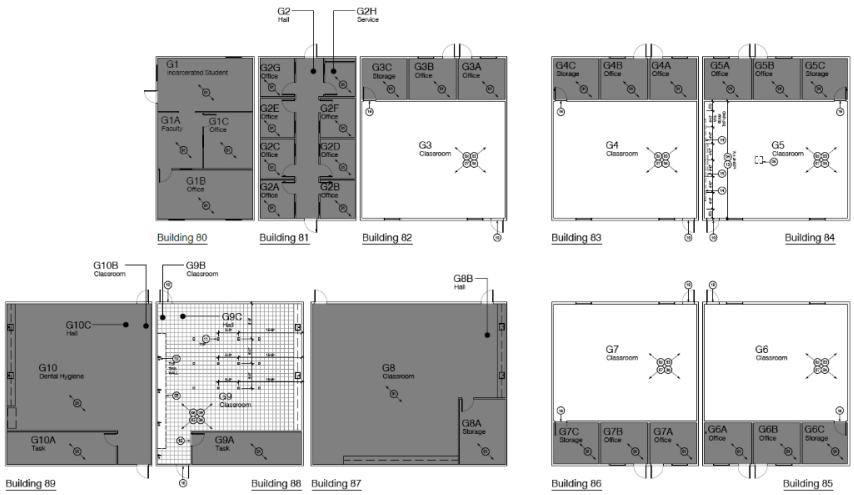
Project Impact: Register Program with California Board of Registered Nursing (BRN) and infrastructure funding for building improvements to increase space and slots for the program. Program approval is pending with BRN with an anticipated start date of Fall 2026 with a cohort of 16 – 24 students.





Infrastructure (Building Improvements)

In addition to the BRN application fee, the grant assisted with building the nursing lab.





CALIFORNIA STATE UNIVERSITY, BAKERSFIELD

Funding Allocation: $1,000,000

Project Name: CSUB Graduate Nursing Program Expansion

Project Impact: The grant funding assisted in launching two new graduate programs: Doctor of Nursing Practice–Family Nurse Practitioner (DNP-FNP) and Master of Science in Nursing to Doctor of Nursing Practice (MSN-DNP) Programs. In Fall 2025, CSUB welcomed its inaugural cohort of **15 Doctor of Nursing Practice students**, officially launching the university's first doctoral-level nursing program. The application period for the Fall 2026 cohort opened on October 1, 2025, and three information sessions have been scheduled to support recruitment and community engagement.







CLINICA SIERRA VISTA

Funding Allocation: $2,000,000

Project Name: Rio Bravo/Clinica Sierra Vista Primary Care Residency Expansion

Project Impact: To expand the healthcare workforce by increasing the primary care residency program capacity. The first phase of the project involves securing the necessary physical space to accommodate the residency capacity of 36, as required by ACGME.

Key Impact Area	Details
Infrastructure	Acquired West Niles parcel for future clinic and residency training site
Integrated Services	Medical, behavioral health, and dental care under one roof
Residency Expansion	Increase from 24 to 36 residents to address physician shortages
Specialty Expertise	Added HIV specialist and psychiatrist to faculty
Street Medicine	Enhanced rotations for care of individuals experiencing homelessness







BAKERSFIELD MEMORIAL HOSPITAL

Funding Allocation: $1,000,000

Project Name: BMH Graduate Medical Education Programs – Internal Medicine

Project Impact: Bakersfield Memorial Hospital developed a New Graduate Medical Education (GME) Program in 2025 in partnership with Morehouse under "More in Common Alliance" to recruit Internal Medicine residents who will practice in Kern County. **KHS funding supported the start-up expenses** including capital, faculty, administration, recruiting, accreditation, and related institutional costs, ensuring the successful ACGME accreditation.





The first class of 10 internal medicine residents celebrated their White Coat Ceremony with Bakersfield Memorial Hospital.

GOOD SAMARITAN HOSPITAL

Funding Allocation: $1,000,000

Project Name: Good Samaritan Healthcare Education Partnership

Project Impact: KHS funding supported operational milestones to expand on internal medicine and psychiatry residency programs in Kern County. Good Samaritan Hospital focused on renovations of the residency facilities, recruiting key faculty, and finalizing accreditation submissions to ACGME. Good Samaritan Hospital received **Institutional Accreditation, effective 1/13/2025,** the Family Residency accreditation was achieved effective 7/1/2025, and the Psych Residency application is in process. Only one milestone remains unmet, the submission of the resident interview list, which will be finalized in the next phase of the project. Overall, the grant enabled major foundational work essential for launching and sustaining the residency program.



KERN MEDICAL CENTER

Funding Allocation: $4,000,000

Project Name: Kern Medical Workforce Expansion Initiative

Project Impact: Through the healthcare workforce initiative funding, Kern Medical will continue expansion of our educational platform by focusing on medical student clerkship rotation development, fellowship program development, and research development

Key Impact Area	Details
Academic Partnerships	Doubled clerkship slots (32→64) with WesternU
Faculty Recruitment	3 educators in Addiction Med, Hem/Onc, Bariatric Surgery
Training Programs	Simulation Fellowship, Addiction Med Fellowship, TY & General Surgery Residencies
Research Excellence	2024 Resident Research Forum, publications for Open Forum Infectious Diseases (OFID)
Community Outreach	Free cervical cancer screenings at Mercado Latino



2025 Incoming Class of Residents and Fellows

A message from Kern Medical….

Kern Medical continues to strengthen its affiliation with the David Geffen School of Medicine at UCLA for its existing residencies and fellowships. Since 1982, the graduate medical education programs have been affiliated with UCLA, reflecting a long-standing commitment to academic excellence. Kern Medical is dedicated to building a more robust, meaningful, and integrated affiliation between our sponsored programs and those of UCLA as a way to attract both future faculty and residents. The Central Valley remains a medically underserved area in urgent need of additional primary care and specialty physicians.

COMMUNITY BASED

INITIATIVE

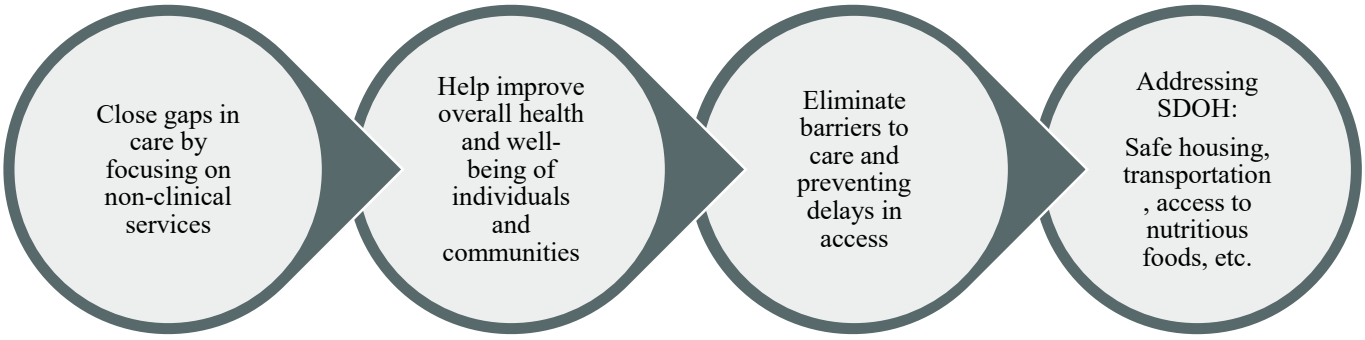
Background

The Community Based Initiative allocated $2 million to community-based organizations that will work together to create innovative social service delivery models that will focus on reducing barriers to care and focus on wellness and healthy living.

Prioritizing health and wellness education campaigns such as fitness programs, nutrition campaigns for children and adolescents, and access to social services to address key social determinants of health (SDOH) by promoting healthier lifestyles, reducing barriers to resources, and supporting overall well-being in underserved communities. Member navigation outreach and education to retain Medi-Cal coverage were prioritized by providing education on the renewal process and basic access to care on eligibility.

This section of the report summarizes the awardees projects and impacts for the community based initiative.

Initiative Goals



Funding Breakdown

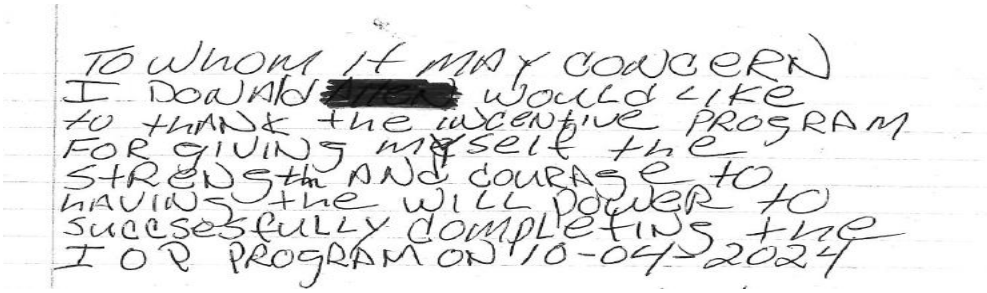
Organization Name	Amount Awarded	Amount Earned	Unearned Funds
Bakersfield Recovery Services	$50,000	$48,500	$1,500
Building Healthy Communities	$200,000	$200,000	$ -
California Farmworker Foundation	$200,000	$175,301	$24,699
Community Interventions	$200,000	$200,000	$ -
Dolores Huerta Foundation	$175,000	$175,000	$ -
First 5 Kern	$150,000	$150,000	$ -
Habitat for Humanity Golden Empire	$100,000	$100,000	$ -
Heather Berry Counseling, Inc.	$6,000	$6,000	$ -
JJ's Legacy	$22,500	$22,500	$ -
Kern County Cancer Foundation	$200,000	$200,000	$ -
Links for Life	$100,000	$100,000	$ -
Make A Wish Foundation	$25,000	$25,000	$ -
Safe Haven Kids League	$150,000	$150,000	$ -
The Mission of Kern	$20,000	$20,000	$ -
United Way of Kern County	$200,000	$200,000	$ -
Vision y Compromiso	$200,000	$200,000	$ -
*Undistributed Funds**	$1,500		$1,500
TOTALS	**$2,000,000**	**$1,972,301**	**$27,699**

BAKERSFIELD RECOVERY SERVICES (BRS)

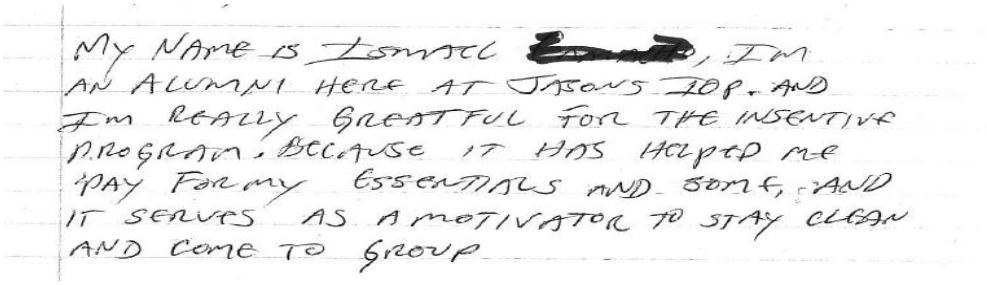
Funding Allocation: $50,000

Project Name: Pathway to Recovery

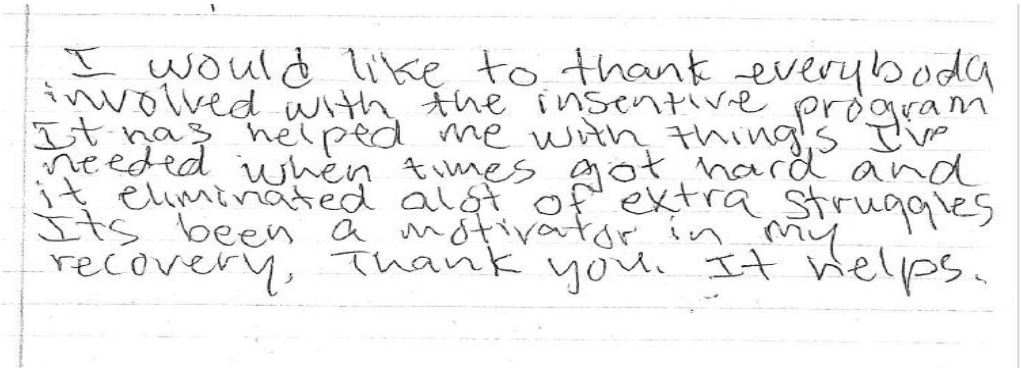
Project Impact: Provide Incentives to clients who test negative in their journey to recovery. The organization was able to handout **2,421 gift cards** to their clients to purchase essentials, treating themselves, or giving a gift to someone they cared about. The gift cards reinforced accountability by being tied to clean test results.



TO WHOM IT MAY CONCERN
I DONALD [redacted] WOULD LIKE
TO THANK THE INCENTIVE PROGRAM
FOR GIVING MYSELF THE
STRENGTH AND COURAGE TO
HAVING THE WILL POWER TO
SUCCESSFULLY COMPLETING THE
IOP PROGRAM ON 10-04-2024



MY NAME IS ISMAEL [redacted], IM
AN ALUMNI HERE AT JASONS IOP. AND
IM REALLY GREATFUL FOR THE INSENTIVE
PROGRAM. BECAUSE IT HAS HELPED ME
PAY FOR MY ESSENTIALS AND SOME, AND
IT SERVES AS A MOTIVATOR TO STAY CLEAN
AND COME TO GROUP



I would like to thank everybody
involved with the insentive program
It has helped me with things Ive
needed when times got hard and
it eliminated alot of extra struggles
Its been a motivator in my
recovery, Thank you. It helps.

BUILDING HEALTHY COMMUNITIES (BHC)

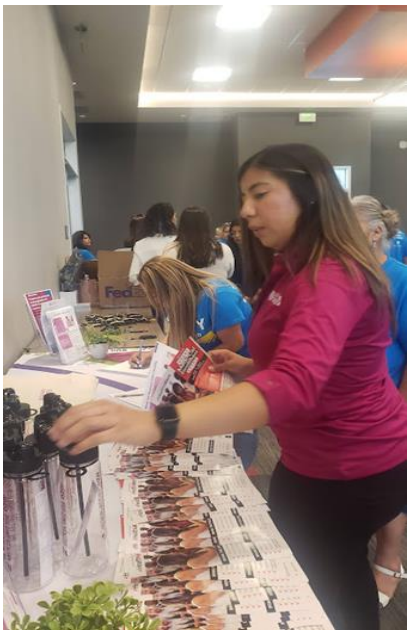
Funding Allocation: $200,000

Project Name: Health Equity for All

Project Impact: Conduct Medi-Cal enrollments and address social determinants of health by conducting outreach efforts of Kern County communities. BHC continues to conduct outreach events in the community to promote Medi-Cal enrollments and certifications. With more than 90 community events completed outreaching to over 6,500 people.









CALIFORNIA FARMWORKERS FOUNDATION (CFF)

Funding Allocation: $200,000

Project Name: Health and Wellness Mobile Health Clinics

Project Impact: This grant was designed to provide direct access to healthcare services for farmworkers, both in the fields and at their workplaces. Additionally, it supplied educational resources regarding healthcare options, empowering farmworkers and their families to secure the healthcare benefits they require.

Total Grant Summary

December 2023 - November 2025

Rural Mobile Chronic Illness Clinics & Educational Outreach

48
Total Site Visits
Farmworkers directly reached in the fields or at their worksites to ensure immediate access to medical services.

722
Patients Reached
The total count of farmworkers who were reached and provided care through our medical clinics.

5,120
Farmworkers Educated
Farmworkers reached and educated on Medi-Cal registration and enrollment.



Healthcare Services: Patients Treated

335 Blood Pressure

322 Glucose Checks

387 Flu Shots

317 BMI Screenings

16 Labs

1 Medical Referrals





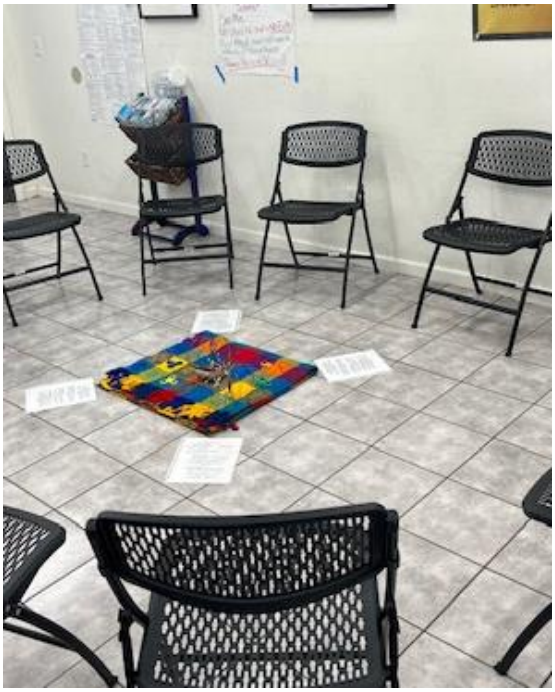


COMMUNITY INTERVENTIONS

Funding Allocation: $200,000

Project Name: Love In Action 2.0

Project Impact: The purpose of this grant initiative is to utilize approved funds to support the project goals of Love in Action 2.0. Community Interventions provides support group sessions three times per week to our community. **Throughout the grant cycle, the organization conducted 247 healing circle sessions and outreached to over 1,000 participants.**





DOLORES HUERTA FOUNDATION (DHF)

Funding Allocation: $175,000

Project Name: DHF Resource Center Initiative

Project Impact: The DHF Resource Center helped connect community members with Medi-Cal renewals. Application support, referring nearly **3,000 individuals since November 2023** through partnerships with Kern Family Health Care. At community events and college outreach, many residents learned about the new annual renewal requirement and requested additional materials to share with others. We also provided information on Project Food Box and helped students confirm their Medi-Cal provider. Overall, outreach increased awareness and supported continued access to vital Medi-Cal benefits.









Funding Allocation: $150,000

Project Name: Advancing Family-Engaged Development Monitoring in Kern County

Project Impact: The Kern Family Health Care grant allowed First 5 Kern to:

- Expand developmental screenings and introduce the Family-Engaged Developmental Monitoring (FEDM) model to pediatricians, community partners, and families.
- Findings from the 2024 Screening Gap Assessment guided training priorities for providers, partners, and parents.
- 129 community partners trained across 20 organizations.
- 80 Medi-Cal providers and staff trained (exceeding goal of 60).
- 366 parents/guardians trained (exceeding goal of 300), gaining tools like ASQ-3 and ASQ:SE-2 to monitor development at home.
- Parents reported increased confidence and clearer communication with medical providers.
- First 5 Kern will continue parent-focused developmental monitoring education beyond the grant period.



Funding Allocation: $100,000

Project Name: Critical Home Repair Program

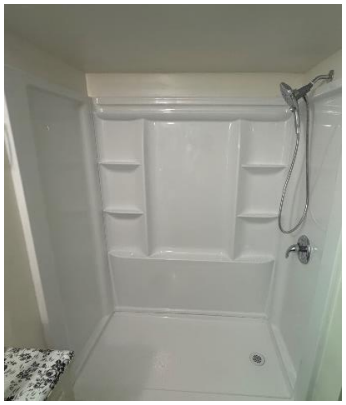
Project Impact: Grant funding supported payroll for staff to continue to perform critical home repairs for eligible members being impacted by housing displacement.

Art Sexton, a longtime member of the Habitat for Humanity Golden Empire Construction Team, brings over 30 years of construction experience to projects that improve the lives of local families. His work ranges from installing accessibility ramps to completing home modifications that enhance safety, comfort, and independence for community members in need. Art's expertise, attention to detail, and commitment to quality ensure every repair is completed with care and professionalism. His dedication helps keep homeowners safely housed and strengthens both the homes he works on and the community he serves.









HEATHER BERRY COUNSELING, INC.

Funding Allocation: $6,000

Project Name: Borel Fire Trauma and Grief Recovery Group

Project Impact: Provide space where participants can safely express and process their emotions related to the fire disaster and general loss. In the month of October, provider offered five support group sessions and in November three group sessions to support group focused trauma and grief recovery in Kernville.



JJ'S LEGACY

Funding Allocation: $22,500

Project Name: Organ Transplant Financial Assistance

Project Impact: Provided financial assistance to 15 low-income individuals who received an organ transplant.

Mr. Jose Manuel Sanchez Villareal is a 42-year-old single father of three children, one of whom is autistic. Mr. Sanchez began in-center hemodialysis treatment in 2016. He shared that it was a long and challenging health journey. He obtained a kidney transplant on September 24, 2023. He expressed relief that he no longer has to undergo dialysis treatment three times a week. Mr. Sanchez is optimistic about his future, including returning to work and raising his children. He was extremely grateful to have received a financial assistance grant, as he was currently on a fixed income and struggled to cover his daily expenses. Mr. Sanchez's story of determination and optimism was shared at our annual gala, where we honored his journey along with other recipients.



KERN COUNTY CANCER FOUNDATION



Funding Allocation: $200,000

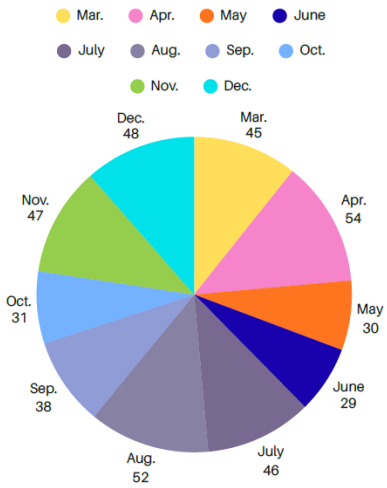
Project Name: Mobile Navigation Unit

Project Impact: The Mobile Navigation Unit grant has delivered measurable and meaningful impact across the community, particularly for the Medi-Cal population and patients facing financial, social, and health-related barriers. More than 30% of patients reached through the unit received mental health referrals; over 50% successfully applied for the Financial Assistance Program or utility assistance; and approximately 25% were newly approved for Medi-Cal. Additionally, 60% of patients received a food box, a gift card, or both, and many benefited from case management services and supplemental financial support through partner organizations. Beyond service delivery, the mobile unit created a safe, trusted, and welcoming environment, meeting patients where they are and reducing barriers related to transportation, technology, and comfort.

MOBILE UNIT PATIENT DATA

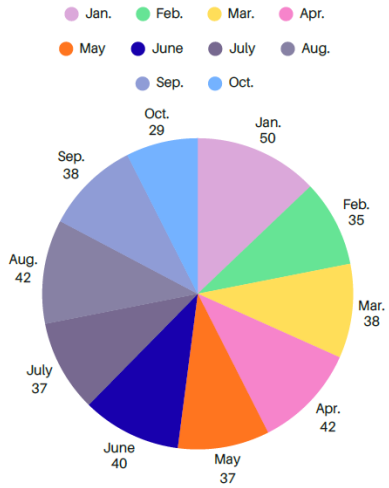
PATIENT DATA COLLECTED
MARCH-DECEMBER 2024
TOTAL PATIENTS: 420

New KCCF Patients retained since obtaining the mobile unit



PATIENT DATA COLLECTED
JANUARY- OCTOBER 2025
TOTAL PATIENTS: 388

New KCCF Patients retained since obtaining the mobile unit



LINKS FOR LIFE

Funding Allocation: $100,000

Project Name: Links for Life

Project Impact: The goal is to assist breast cancer survivors with nutrition education and grocery cards while in active cancer treatment.



The Grocery and Nutrition Program

Links for Life used KHS funds to provide up to four $100 grocery cards per breast cancer patient. To maximize the impact of this support, we offered monthly English- and Spanish-language virtual nutrition classes created by a registered dietician, focused on translating nutrition science into realistic food choices that align with participants' grocery card budgets.

IMPACT FACTS

SUPPORT FROM THE KERN HEALTH SYSTEM COMMUNITY GRANT ALLOWED LINKS FOR LIFE TO PROVIDE UP TO FOUR $100 GROCERY CARDS AND NUTRITION CLASSES TO HUNDREDS OF BREAST CANCER PATIENTS IN KERN COUNTY.

Grant period	November 2023 - November 2025
Funds awarded	$100,000

TOTAL LIVES TOUCHED* **933**

Deliverables	
Grocery cards delivered	451
Nutrition class attendees	371
KHS case manager training	March 2024

Nutrition Class demographics	
English	275
Spanish	96

Funds used	100%

*Based on an average household size of 2.5 persons. Source: Place Works, 2024, using data from the US Census Bureau's 2022 American Community Survey 1-Year Estimates. *Includes grant-funded staff.

MAKE A WISH FOUNDATION

Funding Allocation: $25,000

Project Name: Project Hope and Healing

Project Impact: 10 wishes were granted for children with critical illnesses in Kern County.

Juan's Story

Juan had gone to a routine oncology appointment in May 2024 and an MRI was performed. This MRI showed a new mass that was quite large and hadn't shown in scans earlier in the year, which triggered a new series of treatments and hospital stays. This new diagnosis has been extremely hard on Juan and his family. He suffers from depression and talks about his fear of dying. Juan is in a lot of pain and must spend time in a wheelchair as his ability to walk quickly declines. Juan's wish was to go to Superhero Island as he is a big fan of Captain America. Having a wish to focus on really helping Juan stay positive as he completed chemo and focused on his upcoming surgery. He was excited to go on a plane with his entire family and make memories that would last a lifetime.

Sequoia's Story

Sequoia was officially diagnosed with cystic fibrosis in September of 2023. Sequoia now must use her vest twice a day to break down the mucus in her lungs, along with breathing treatment. Sequoia also tends to get very bad headaches which affect her entire day. These are the times when the family feels very hopeless when they are unable to take the pain away from their little one. But they continue to push through. Sequoia asked for a Disney World Wish. She wanted to be close to the beach where she could get into warm water. She loves Disney. Her favorite character is Stitch. She liked the idea of visiting a theme park and enjoying the rides. This was her first time on a plane, and she looked forward to a wish like this!

SAFE HAVEN KIDS LEAGUE

Funding Allocation: $150,000

Project Name: Food Pantry

Project Impact: Funding supported volunteer staff that helped at the California City Food Pantry resource center. Staff fulfilled responsibilities including organizing and supporting all community events, operating the food pantry, managing after school program and tutoring, overseeing field trips, maintaining the resource center, and conducting community outreach across East Kern.









The Mission
AT KERN COUNTY
do you believe

Funding Allocation: $20,000

Project Name: Transportation for Better Health

Project Impact: The funds contributed to the goal to provide the best integrated health to those in the recovery program. The funding provided the resource to fuel 3 vans to transport residents to their needed appointments.

Success Story:

Joe had a good life, a thriving career and a close relationship with his family. Then his father died of a heart attack and it tore Joe's world apart. "I'd been a strong, successful person, but everything changed," he says. "I quit my job to be with Mom and we stayed in the house and reminisced, stuck in our grief. We started drinking and became alcoholics together."

For seven years, they lived off his mother's social security and went from living well in a three-bedroom home to living in poverty in a rented room, selling their belongings or recycling to get by.

One day, Joe's mother had to be hospitalized for pneumonia and placed on a breathing machine. "Her little heart couldn't handle it and stopped. She passed away the day I took her in," Joe says. "I was devastated and I couldn't stop drinking."

Then he learned about the Mission, and knew he needed help to get his life back on track. He entered our Addiction Recovery Program.

"Through life-skills classes and the staff gave me guidance and taught me accountability, humility and honesty."

"Love and the spirit of generosity are alive in the Mission."

Through grief classes, Joe also began to heal from the loss of his parents. "I read promises from the Lord that I didn't know before," he says.

Joe graduated from the program, is staying in our transitional housing and works as a case manager at Flood Ministries, helping people with housing vouchers maintain their homes and finances. "The Mission prepared me to help others," he says.

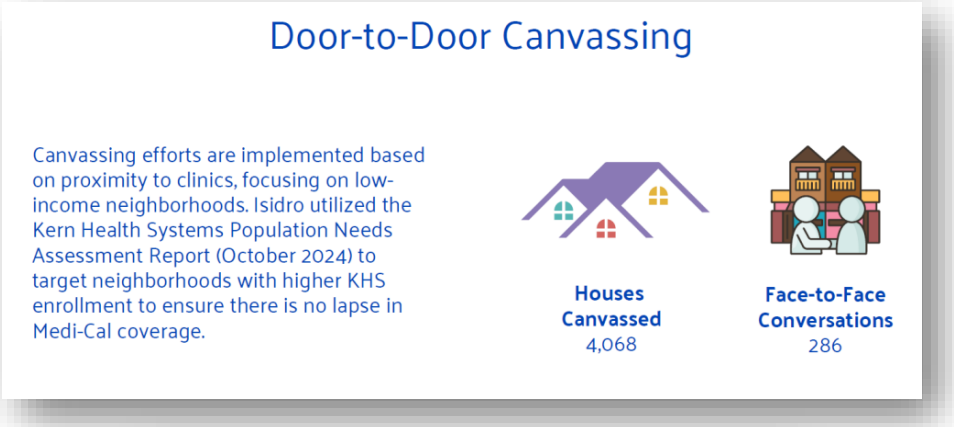
Because you gave from your heart to help Joe, his life has been changed by your partnership! "I was hopeless and spiritually bankrupt, but now I'm full of hope."

United Way of Kern County

Funding Allocation: $200,000

Project Name: Medi-Cal Enrollment Program

Project Impact: This program focused on increasing healthcare accessibility for underserved populations in Kern County by streamlining the enrollment process and providing essential outreach and training.





Visión y Compromiso

Funding Allocation: $200,000

Project Name: Me Veo Bien, Me Siento Bien (I look Good, I Feel Good)

Project Impact: Trauma-informed, culturally rooted health and chronic disease education program with 10 in-person sessions led by trained promotoras. Includes nutrition education, healthy recipe demos, bailo terapia (dance therapy), meditation, and grounding exercises. Weekly wellness goals supported by food diaries, activity logs, BP checks, and BMI readings

Program Reach

- **1,954** one-to-one outreach interactions
- **2,313** door-to-door engagements
- **12,086** community members reached through alternative media
- **105** MVBMSB classes delivered
- **3,706** additional contacts through phone banking



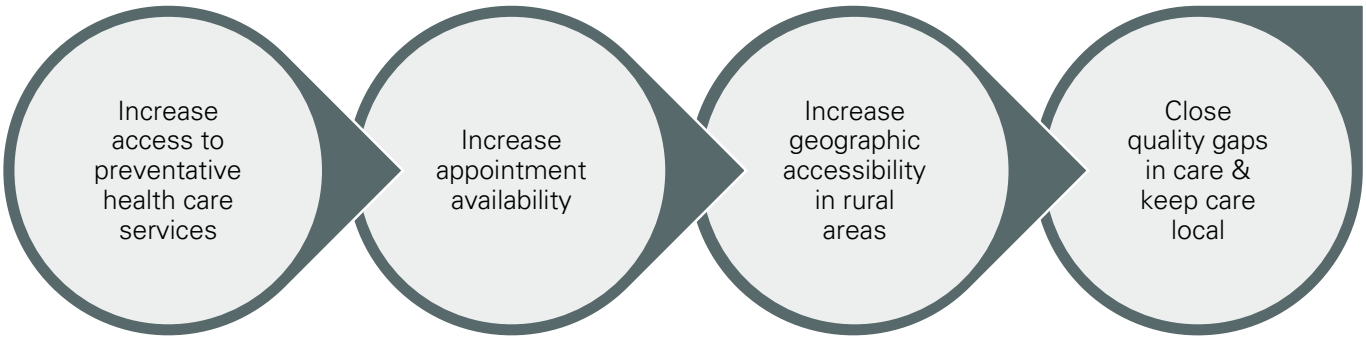
QUALITY GRANT

Background

Quality Grant allocated $5 million to providers to create and establish programs, infrastructure, and best practices that can be implemented immediately to increase performance. Establishing high performance practice habits and member engagement to support KHS' mission of increasing the health status of our members is always the driving force behind such efforts. The grant prioritized activities such as Mobile Clinics, Electronic Medical Record (EMR) & Data Exchange, Children Domains, and Cancer Prevention & Reproductive Health Domain.

This section of the report summarizes the awardees projects and impacts for the quality grant.

Initiative Goals



Funding Breakdown

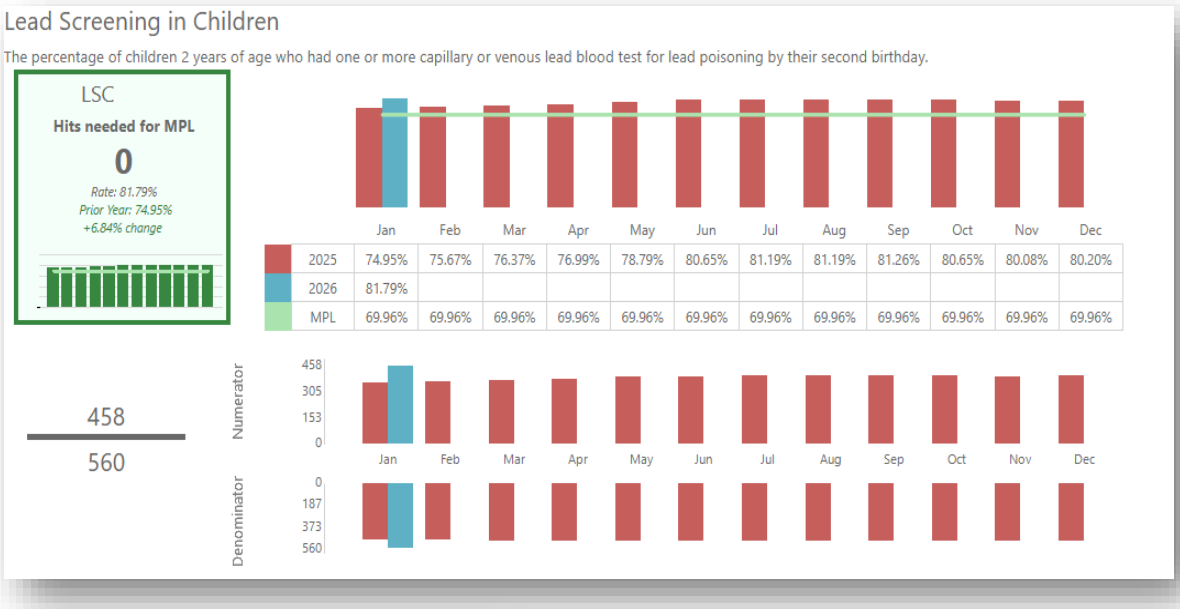
Organization Name	Amount Awarded	Amount Earned	Unearned Funds
Coastal Kids	$150,000	$150,000	$ -
Clinica Sierra Vista	$1,136,625.74	$1,136,625.74	$ -
Kern Medical	$1,362,885.09	$1,362,885.09	$ -
Komoto Pharmacy	$104,100	$104,100	$ -
Omni	$1,500,489.17	$1,500,489.17	$ -
Polyclinic Medical Center Inc	$100,000	$100,000	$ -
Premier Valley Medical Group	$220,000	$220,000	$ -
San Michael Pediatrics	$100,000	$97,730.05	$2,269.95
Universal Healthcare Services Inc	$200,000	$200,000	$ -
Vanguard Medical Corporation	$125,900	$125,900	$ -
TOTALS	**$5,000,000**	**$4,997,730.05**	**$2,269.95**

COASTAL KIDS

Funding Allocation: $150,000

Project Name: Improve MCAS Measures & Telemedicine Expansion

Project Impact: Improve Lead Screening measure by 10% and expand telemedicine services. Coastal Kids' performance for Lead Screening in Children (LSC) has increased from **66.25%** in January of 2024 to **80%** in December of 2025.







Office lab spaces where lead testing occurs

CLINICA SIERRA VISTA (CSV)

Funding Allocation: $1,136,625.74

Project Name: Expanding Pediatric Care Access Through Mobile School Based Clinics

Project Impact: CSV's mobile clinics were created to address persistent gaps in pediatric healthcare access, particularly in school settings where students' basic medical needs such as required immunizations and basic preventative services for school aged children can easily go unmet. Mobile units were hosted not only within Bakersfield, but also in surrounding communities such as McFarland, Kernville, Grow Academy, and Arvin. These efforts bring essential care directly to those who need it most, reducing barriers and improving health outcomes for all.

Contractual Obligation for number of Mobile Clinics: 94 | Total Mobile Clinics Completed: 267





KERN MEDICAL CENTER

Funding Allocation: $1,362,885.09

Project Name: Mobile Clinic Services

Project Impact: The Kern Medical Mobile Clinics aim to create a sustainable, long-term patient base by closing healthcare gaps in underserved and remote communities. Since the beginning of the grant period, Kern Medical has operated more than 200 mobile clinics, offering services such as school and sports physicals, immunizations and vaccinations, hearing and vision screenings, oral health assessments, and Medi-Cal enrollment support. The impact has been especially visible in local schools. In one district, chronic absenteeism dropped from 23.3% to 16.5% in just one year, resulting in hundreds more students being healthy and present in the classroom.

Services Provided: 2,342 visits, enrolling 1,676 new patients, administering more than 1,400 vaccinations, and completing 1,297 lab tests.





KOMOTO PHARMACY

Funding Allocation: $104,100

Project Name: Mobile Pediatric Vaccine Clinics

Project Impact: Increase the number of children and teens up-to-date on Advisory Committee on Immunization Practices (ACIP) recommended vaccines by hosting mobile clinics throughout Kern County. Since the kickoff of the program in April 2024, Komoto Pharmacy has administered over 559 doses of Vaccines for Children (VFC) to 245 patients throughout Delano, Bakersfield, Wasco, and Lamont.









OMNI FAMILY HEALTH

Funding Allocation: $1,500,489.17

Project Name: Increase Access to Healthcare via Mobile Units.

Project Impact: The goal of this project was to expand healthcare access across Kern County by deploying two mobile health units throughout Kern with over 90 mobile clinics. By bringing services directly into communities, Omni aimed to reducing barriers to care, improve health equity, and meet members where they are. This initiative focused on delivering convenient, community-based healthcare that supports early intervention, preventive services, and stronger connections between members and the care they need.





POLYCLINIC MEDICAL CENTER



Funding Allocation: $100,000

Project Name: Expansion of Weekend Hours

Project Impact: The goal for this project was for expansion of Saturday clinic hours, allowing the practice to staff weekend operations and delivering care to patients who are unable to visit during traditional weekday hours. This extension of access helped close gaps in care, created additional opportunities to reschedule missed appointments, and offered greater flexibility for families with demanding schedules. Additionally, weekend outreach efforts enabled staff to connect with more members, improve appointment adherence, and ensure patients received the medical services they needed in a timely manner.

PREMIER VALLEY MEDICAL GROUP (PVMG)

Funding Allocation: $220,000

Project Name: Mobile Clinic

Project Impact: The grant funding supported the purchase of a van for the mobile unit, along with essential medical equipment, a lead machine, and payroll costs for the mobile van driver. These investments strengthened the mobile clinic's capacity to deliver services efficiently and reliably across the communities it serves such as Lake Isabella, Ridgecrest, California City, and Mojave and serving over 500 members.

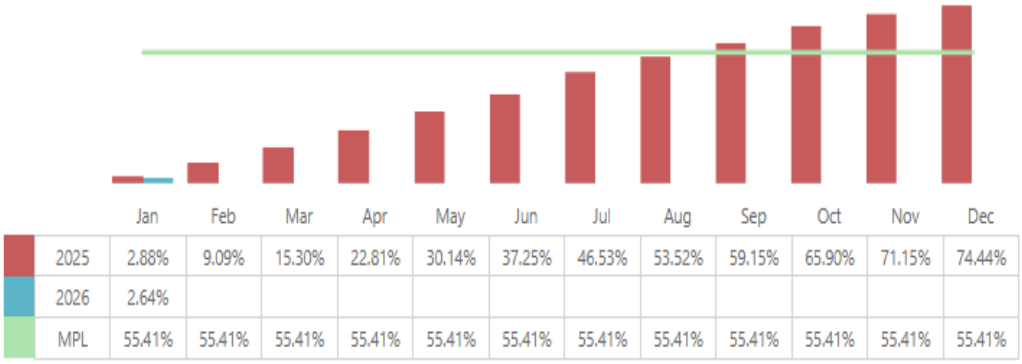


SAN MICHAEL PEDIATRICS

Funding Allocation: $100,000

Project Name: Increase Appointment Availability.

Project Impact: Improve HEDIS, quality, and workflow by hiring additional staff. On average, 300 calls were made to patients regarding their well child visits monthly. To date, almost 4,000 individuals have been scheduled.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	2.88%	9.09%	15.30%	22.81%	30.14%	37.25%	46.53%	53.52%	59.15%	65.90%	71.15%	74.44%
2026	2.64%											
MPL	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%

San Michael Pediatrics saw a significant increase from January 2025 with a **2.88%** to December of 2025 with a **74.44%.**

UNIVERSAL HEALTHCARE

Funding Allocation: $200,000

Project Name: Appointment Availability

Project Impact: Funding supported the monthly salaries and benefits of two staff members responsible for conducting outreach calls to increase appointment availability and improve access. During the grant period, the outreach team completed 8,321 outreach calls, which resulted in 1,165 patients being scheduled.



VANGUARD

Funding Allocation: $125,900

Project Name: Increase Wellness Child Visits and Reduce Cancer & Reproductive Health Gaps

Project Impact: To increase completion of Wellness Child Visits and improve preventive care outcomes. In addition, the grant supported the expansion of outreach capacity, enhancing care coordination, and providing resources that allowed the team to identify gaps more effectively and connect patients to timely, preventive services.

2025	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Total
Annual Physicals (Est)	128	164	165	156	181	157	152	130	160	140	**1533**
Female Annual	30	29	46	40	35	27	32	42	18	27	**326**
Annual Physical (New)	39	42	52	55	69	59	85	66	80	82	**629**
Initial Health Assessment	18	14	12	16	8	2	8	2	6	4	**90**
Sport & School Physical	5	1	1	3	7	2	3	3	2	11	**38**
Well Child Visit	85	137	172	175	162	137	169	140	109	109	**1395**
Grand Total	**305**	**387**	**448**	**445**	**462**	**384**	**449**	**383**	**378**	**370**	**4011**

RECRUITMENT AND RETENTION

(R&R) GRANT

Background

The Recruitment and Retention (R & R) Grant allocated $3,000,000 to address critical healthcare provider shortages and improve access to care across Kern County, with a particular focus on its rural and underserved communities. A comprehensive assessment of network needs identified several high-priority specialty shortages, including Allergy/Immunology, Cardiology, ENT/Otolaryngology, Oncology, Ophthalmology, Orthopedic Surgery, and Applied Behavior Analysis (ABA) services provided by Clinical Psychologists and Psychiatrists. These specialties are essential to meeting the complex healthcare needs of the population and reducing delays in diagnosis and treatment.

The R & R Grant emphasizes both recruitment and retention to promote workforce stability and continuity of care. By focusing not only on attracting new providers but also on retaining existing ones, the program helps ensure long-term network sustainability. This effort is supported through a collaborative approach, with Kern Health Systems partnering with multiple organizations to expand the provider network and strengthen the local healthcare workforce.

Initiative Goals

The Recruitment and Retention grant provided opportunities for our Providers to increase and improve access to:



Funding Breakdown

Organization Name	Amount Awarded	Amount Earned	Unearned Funds
ACE Eyecare	$30,000	$30,000	
Adventist Health Delano	$30,000	$30,000	
Atul Aggarwal MD Cardiology Clinic	$30,000	$30,000	
Bakersfield American Indian Health	$20,000	$20,000	
Behavioral Momentum Services LLC	$10,000	$10,000	
Clinica Sierra Vista (CSV)	$681,975.44	$681,975.44	
Coastal Kids	$30,000	$30,000	
Kern Medical	$817,731.05	$817,731.05	
Kern Psychiatric Health and Wellness Center, Inc.	$10,000	$10,000	
Kern Valley Healthcare District MVHC	$40,000	$40,000	
KVHCD -Transportation	$95,000	$95,000	
Omni Family Healthcare	$900,293.50	$825,293.50	$75,000
Premier Valley Medical Group	$125,000	$65,000	$60,000
Rhema Therapy Inc	$20,000	$20,000	
Shafter Pediatrics	$20,000	$20,000	
Singh Family Medical Clinic	$35,000	$0	$35,000
Terrio Therapy Fitness Inc	$20,000	$20,000	
Universal Healthcare Services Inc	$35,000	$35,000	
Vanguard Medical Corporation	$20,000	$20,000	
VipMD	$20,000	$20,000	
Undistributed Funds*	$10,000		$10,000
TOTALS	**$3,000,000**	**$2,820,000**	**$180,000**

Recruitment Achievements

- 68 of 77 recruitment targets were met, achieving 88% despite challenges.
- Unmet milestones from Omni Family Health [5 Mid-Levels], Premier Valley Medical Group [2 Specialist MDs], and Singh Family Medical Group [2 PCP MDs]

Retention Successes

- All 76 retention commitments were fulfilled, demonstrating strong workforce stability.

	Total Numbers			
	Contract Obligation		Actual Numbers	
	Total Recruitment	Total Retention	Total Recruitment	Total Retention
MD -PCP	19	30	18	30
MD - Specialist	24	1	22	1
Mid-Level (PCP)	15	30	9	30
Mid-Level (Specialist)	9	2	9	2
Behavioral Health Therapist	7	13	7	13
BCBA	1	0	1	0
Physical Therapist	2	0	2	0
Totals	**77**	**76**	**68**	**76**

R&R Impact

- The regulatory standard PCP to Member ratio is 1 FTE (Full-Time Equivalent) PCP for every 2,000 members.
- At the start of the R&R Grant Period in 2023, the Plan's PCP to member ratio was 1:1828, KHS is happy to report the new PCP to member ratio is **1 FTE PCP to every 1,312 members as of Q4 2025**. KHS anticipates that the Plan's membership should have better accessibility to their PCPs.

We extend our sincere gratitude to all of our provider & project partners across the Healthcare Workforce Initiative, Community-Based Initiative, Recruitment and Retention Grant, and Quality Grant for their dedication and partnership in advancing healthcare access and quality throughout Kern County. Through your commitment, these programs have driven meaningful improvements in workforce development, provider stability, care quality, and community-centered solutions, particularly for our rural and underserved populations. The collective impact of these grants is evident in expanded services, strengthened provider capacity, enhanced care coordination, and innovative community partnerships. Your efforts have made a lasting difference for our members and communities, and we deeply appreciate your continued collaboration in building a more accessible, high-quality, and equitable healthcare system.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Governance and Compliance Committee

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Enterprise Risk Assessment Project Update

DATE: February 19, 2026

BACKGROUND

On December 19, 2024, the Kern Health Systems Board of Directors approved Moss Adams/Baker Tilly to preform Enterprise Risk Management Services in collaboration with the Compliance department. Establishing an Enterprise Risk Management (ERM) program provides a framework to annually identify and evaluate emerging risks by combining existing risk management practices and process improvement opportunities to facilitate risk related interventions. KHS engaged Moss Adams/Baker Tilly in 2025 to assist KHS with assessing, analyzing current safeguards and monitoring used to define an Enterprise Risk Register as the organizational roadmap for risk mitigation and resolution.

DISCUSSION

Throughout the risk assessment project, KHS identified risks and assigned weightings for the likelihood and magnitude for each risk, to prioritize exposures in specific focus areas. This tool is essential in developing an audit and monitoring mitigation work plan and remediation strategies to reduce or ameliorate organizational risk that will continue throughout 2026.

Elements of the Risk Register include:

Risk Domain	Overall Risk Rating	Executive Risk Owner
Risk Definition	Identified Controls	Operational Risk Owner
Likelihood Rating	Control Reliance Rating	Management Risk Response
Magnitude Rating		Committee Oversight

Updates on the status of the Risk Management mitigation control activities and remediation progress will be provided over the next several months.

REQUESTED ACTION

Receive and file the Enterprise Risk Assessment Project update.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: Quarterly Review of Kern Health Systems Investment Portfolio

DATE: February 19, 2026

Background

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

- Preservation of principal
- Liquidity
- Yield

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

Short-Term Portfolio (Under 1 year)

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

Long-Term Portfolio (1-5 years)

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

Requested Action

Receive and File.

Kern Health Systems
Investment Portfolio
31-Dec-25

Short Term Portfolio (under 1 year)

Funds held in this time frame are typically utilized to pay providers, meet operating expenses, distribute pass-through monies, potential State premium recoupments and for amounts owed under various Risk Corridors.
Extra liquidity is maintained in the event the State is late with its monthly capitation payment.

Description			Dollar Amount	% of Portfolio	Maximum Allowed Per Policy	Approximate Current Yield	Liquidity	Principal Fluctuation
Wells Fargo - Cash and Sweep Accounts		(1)	$ 7,900,000	1.64%	100%	2.25%	1 Day	None
Money Market Accounts	(A)	(1)	$ 100,800,000	20.90%	40%	3.60%	1 Day	None
Local Agency Investment Fund (LAIF)	(B)	(2)	$ 50,200,000	10.41%	50%	4.03%	2 Days	None
US T-Bills & Federal Agencies at Wells Fargo		(1)	$ 199,700,000	41.41%	100%	3.56%	1 Day	Subject to Interest Rate Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)	(1)	$ 1,000,000	0.21%		4.31%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 359,600,000	74.56%		3.61%		

Long Term Port Folio (1 - 5 years)

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

UBS Managed Portfolio	(D)		$ 80,100,000	16.61%		3.88%	3 Days	Subject to Interest Rate and Credit Fluctuations
KHS Managed Portfolio at Wells Fargo	(C)		$ 42,600,000	8.83%		4.16%	3 Days	Subject to Interest Rate and Credit Fluctuations
Sub-Total			$ 122,700,000	25.44%		3.98%		
Total Portfolio			$ 482,300,000	100.00%		3.70%		

Yield Curve	Treasuries	Yield Curve AA Corporate Bonds	A Corporate Bonds	CD's
1 year	3.48%	3.65%	3.78%	3.50%
2 year	3.48%	3.63%	3.80%	3.70%
3 year	3.54%	3.72%	3.90%	3.70%
5 year	3.73%	4.00%	4.18%	3.85%

(A) Money market fund comprised of US Treasury and Repurchase Agreement Obligations.
(B) LAIF is part of a $162.6 Billion Pooled Money Investment Account managed by the State Treasurer of CA.
Majority of portfolio is comprised of Treasuries, CD's, Time Deposits and Commercial Paper.
(C) High quality diversified portfolio comprising Federal Agency Securities and Corporate Bonds
(D) High quality diversified portfolio comprising certificate of deposits, corporate bonds and notes, municipal securities and US Treasury Securities.
Includes investments maturing in less than 1 year that will be re-invested for over 1 year at maturity.

(1) Funds are utilized to pay providers, meet operating expenses, fund capital projects, distribute pass-through monies, potential State premium recoupments, MCO Tax advances, and for amounts owed under various Risk Corridors. Extra liquidity is maintained in the event the State is late with its monthly capitation payment.
(2) Funds are primarily utilized to fund various Grant Programs and the CalPERS Liability

Branch office
9201 Camino Media
Suite 230
Bakersfield, CA 93311

Financial Advisor
THE COHEN GROUP
6616633200

UBS Client Review

As of December 31, 2025

Report Prepared for: Kern Health Systems

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

What's inside

Portfolio Review. 2
Asset Allocation by Account. 5
Asset Allocation Review. 6
Bond Summary. 7
Bond Holdings. 8
Additional Information About Your Portfolio. 16
Important Information About This Report. 17

KHS Board of Directors Meeting, February 19, 2026

UBS

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

Portfolio Review

as of December 31, 2025

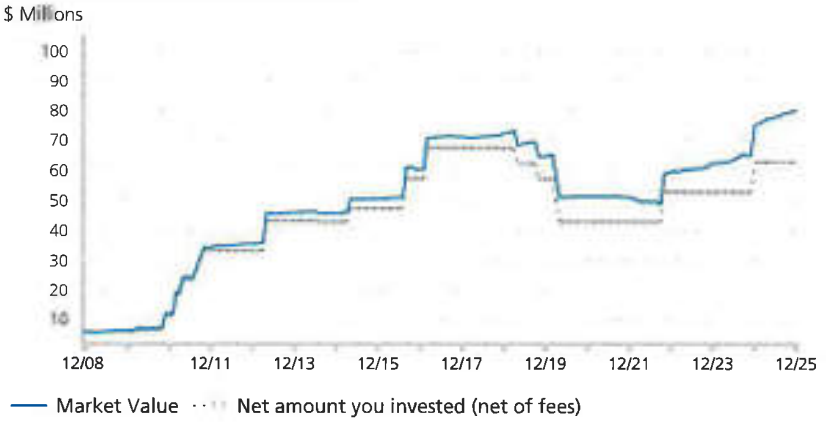
Asset Allocation Review

		Value on 12/31/2025 ($)	% of Portfolio
A	**Cash**	**231,909.82**	**0.29**
	Cash	231,909.82	0.29
	US	231,909.82	0.29
B	**Fixed Income**	**79,861,393.04**	**99.71**
	US	79,861,393.04	99.71
	Corporate IG Credit	79,861,393.04	99.71
C	**Equity**	**0.00**	**0.00**
D	**Commodities**	**0.00**	**0.00**
E	**Non-Traditional**	**0.00**	**0.00**
F	**Other**	**0.00**	**0.00**
Total Portfolio		**$80,093,302.86**	**100%**



Balanced mutual funds and Insurance & Annuity products are allocated in the 'Other' category

Sources of Portfolio Value



Portfolio Value and Investment Results

	Performance returns (annualized > 1 year)			
	For period of 12/31/2024 to 03/31/2025	For period of 03/31/2025 to 06/30/2025	For period of 06/30/2025 to 09/30/2025	For period of 09/30/2025 to 12/31/2025
Opening value	**75,185,423.80**	**76,625,024.22**	**78,006,238.75**	**79,165,399.33**
Net deposits/withdrawals	-30,167.59	-30,804.38	-31,668.65	-32,148.25
Div./interest income	696,186.36	579,304.42	958,957.11	762,857.18
Change in accr. interest	47,384.40	184,582.74	-108,573.38	40,688.50
Change in value	726,197.25	648,131.75	340,445.50	156,506.10
Closing value	**76,625,024.22**	**78,006,238.75**	**79,165,399.33**	**80,093,302.86**
Net Time-weighted ROR	1.91	1.80	1.49	1.17

Net deposits and withdrawals include program and account fees.

Summary of Gains and Losses

	Short term ($)	Long term ($)	Total ($)
2024 Realized gains and losses	**25,376.54**	**133,272.58**	**158,649.12**
Taxable	25,376.54	133,272.58	158,649.12
Tax-Deferred	0.00	0.00	0.00
2025 Year to date	**81,300.00**	**583,359.60**	**664,659.60**
Taxable	81,300.00	583,359.60	664,659.60
Tax-Deferred	0.00	0.00	0.00

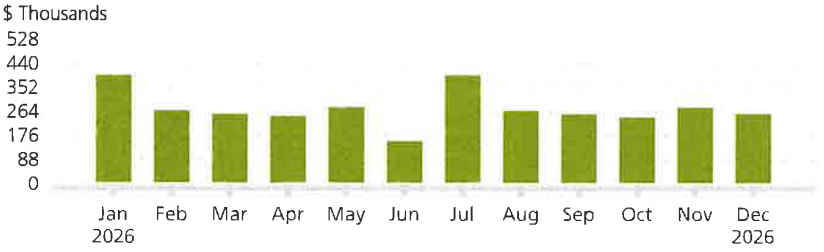
Prior to 2024, Interest income for short-term obligations that were held to maturity or redeemed is displayed as realized gain; however, it will be reported as interest income on your annual 1099 and PR480.6 tax forms.

Past performance does not guarantee future results and current performance may be lower/higher than past data presented.
Accrued interest, if any, has been included in the total market value.

Portfolio Review

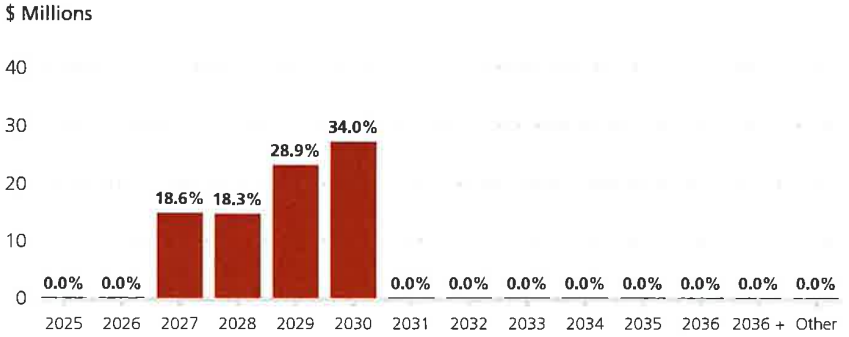
as of December 31, 2025 *(continued)*

Expected Cash Flow



Total taxable income: $3,363,726.38
Total expected cash flow: $3,363,726.38
Cash flows displayed account for known events such as maturities and mandatory puts.

Bond Maturity Schedule



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

Equity Sector Analysis

Compared to S&P 500 index

	Value on 12/31/2025 ($)	Actual (%)	Model (%)	Gap (%)
Communication Services	0.00	0.00	10.98	-10.98
Consumer Discretionary	0.00	0.00	10.87	-10.87
Consumer Staples	0.00	0.00	5.64	-5.64
Energy	0.00	0.00	3.04	-3.04
Financials	0.00	0.00	12.18	-12.18
Health Care	0.00	0.00	9.58	-9.58
Industrials	0.00	0.00	8.38	-8.38
Information Technology	0.00	0.00	33.15	-33.15
Materials	0.00	0.00	1.85	-1.85
Real Estate	0.00	0.00	1.82	-1.82
Utilities	0.00	0.00	2.19	-2.19
Total classified equity	**$0.00**			
Unclassified Securities	0.00			

Past performance does not guarantee future results and current performance may be lower/higher than past data presented.
Accrued interest, if any, has been included in the total market value.

UBS

Portfolio Review

as of December 31, 2025 *(continued)*

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

Summary of Performance by Account

		Performance start date	Value on 12/31/2025 ($)	% of portfolio		Performance returns (annualized > 1 year) For period of 12/31/2024 to 03/31/2025	For period of 03/31/2025 to 06/30/2025	For period of 06/30/2025 to 09/30/2025	For period of 09/30/2025 to 12/31/2025
EX XX120	BOND PORTFOLIO•PMP•Ira Cohen / Jason Cohen Fixed Income Risk profile: Conservative Return objective: Current Income	Dec 08, 2008	80,093,302.86	100.00%	Net time-weighted	1.91%	1.80%	1.49%	1.17%
Total Portfolio		**Dec 08, 2008**	**$80,093,302.86**	**100%**	**Net time-weighted**	**1.91%**	**1.80%**	**1.49%**	**1.17%**

Benchmarks - Annualized time-weighted returns	For period of 12/31/2024 to 03/31/2025	For period of 03/31/2025 to 06/30/2025	For period of 06/30/2025 to 09/30/2025	For period of 09/30/2025 to 12/31/2025
Blended Index	1.62%	1.37%	1.30%	1.19%
US Treasury Bill - 3 Mos	1.04%	1.07%	1.10%	1.01%
BBG US Agg (1-3 Y)	1.63%	1.27%	1.20%	1.18%
S&P 500	-4.27%	10.94%	8.12%	2.66%

Past performance does not guarantee future results and current performance may be lower/higher than past data presented.
Blended Index:06/30/2023 - Current: 45% BBG US Corp 1-3Y Incp76; 55% BBG US Agg Gvt & CR 1-3 Y+
+Additional benchmark information can be found on the benchmark composition page.

Asset Allocation by Account

as of December 31, 2025

		Equities ($/%)			Fixed Income ($/%)						
	Cash ($/%)	U.S.	Global	International	U.S.	Global	International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	Total
	231,909.82	**0.00**	**0.00**	**0.00**	**79,861,393.04**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$80,093,302.86**
Total Portfolio	**0.29**	**0.00**	**0.00**	**0.00**	**99.71**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**
	231,909.82	0.00	0.00	0.00	79,861,393.04	0.00	0.00	0.00	0.00	0.00	$80,093,302.86
	0.29	0.00	0.00	0.00	99.71	0.00	0.00	0.00	0.00	0.00	100.00%

EX XX120 • BOND PORTFOLIO • BSA PMP

Risk profile: Conservative
Return objective: Current Income

		Equities ($/%)			Fixed Income ($/%)						
	Cash ($/%)	U.S.	Global	International	U.S.	Global	International	Non-Traditional ($/%)	Commodities ($/%)	Other ($/%)	Total
	231,909.82	**0.00**	**0.00**	**0.00**	**79,861,393.04**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**$80,093,302.86**
Total Portfolio	**0.29**	**0.00**	**0.00**	**0.00**	**99.71**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**100%**

Balanced mutual funds and Insurance & Annuity products are allocated in the 'Other' category

Accrued interest, if any, has been included in the total market value.

Report created on: January 28, 2026

KHS Board of Directors Meeting, February 19, 2026

UBS

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

Asset Allocation Review

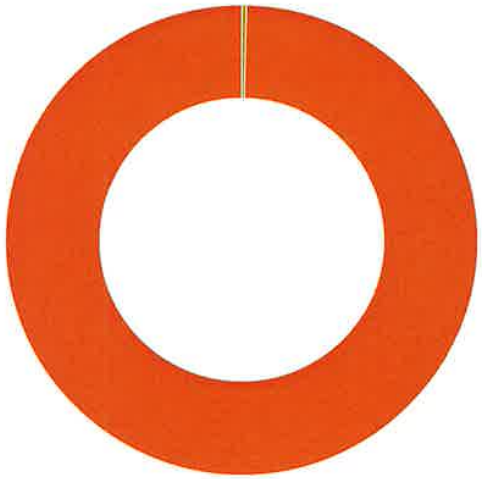
as of December 31, 2025

Summary of Asset Allocation

	Market value ($)	% of Portfolio
Cash	**231,909.82**	**0.29**
Cash	**231,909.82**	**0.29**
US	231,909.82	0.29
Fixed Income	**79,861,393.04**	**99.71**
US	**79,861,393.04**	**99.71**
Corporate IG Credit	79,861,393.04	99.71
Equity	**0.00**	**0.00**
Commodities	**0.00**	**0.00**
Non-Traditional	**0.00**	**0.00**
Other	**0.00**	**0.00**
Total Portfolio	**$80,093,302.86**	**100%**

Balanced mutual funds and Insurance & Annuity products are allocated in the 'Other' category

Total Value: $80,093,302.86



Accrued interest, if any, has been included in the total market value.

Report created on: January 28, 2026

Bond Summary

as of December 31, 2025

Bond Overview

Total quantity	78,091,000
Total market value	$78,998,494.52
Total accrued interest	$862,898.52
Total market value plus accrued interest	$79,861,393.04
Total estimated annual bond interest	$3,359,382.50
Average coupon	4.31%
Average current yield	4.25%
Average yield to maturity	3.92%
Average yield to worst	3.88%
Average modified duration	2.70
Average effective maturity	3.20

Investment Type Allocation

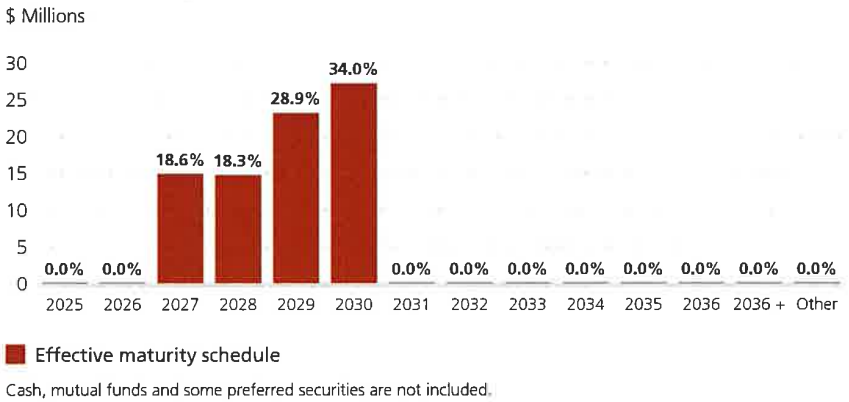
Investment type	Taxable ($)	Tax-exempt / deferred ($)	Total ($)	% of bond port.
U.S. corporates	79,861,393.04	0.00	79,861,393.04	100.00
Total	**$79,861,393.04**	**$0.00**	**$79,861,393.04**	**100%**

Credit Quality of Bond Holdings

Effective credit rating		Issues	Value on 12/31/2025 ($)	% of port.
A	Aaa/AAA/AAA	1	1,425,237.33	1.79
B	Aa/AA/AA	13	19,491,421.46	24.41
C	A/A/A	36	58,944,734.25	73.80
D	Baa/BBB/BBB	0	0.00	0.00
E	Non-investment grade	0	0.00	0.00
F	Certificate of deposit	0	0.00	0.00
G	Not rated	0	0.00	0.00
Total		**50**	**$79,861,393.04**	**100%**



Bond Maturity Schedule



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

Includes all fixed income securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.
Accrued interest, if any, has been included in the total market value.

UBS

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

Bond Holdings

as of December 31, 2025

Summary of Bond Holdings

Maturity Year	Issues	Quantity	Est. annual income ($)	Current yield (%)	Yield to maturity (%)	Yield to worst (%)	Modified duration	Adjusted cost basis ($)	Unrealized gain/loss ($)	Mkt. value ($)	% of bond portfolio maturing
2025	0	0			N/A	N/A	N/A				
2026	0	0			N/A	N/A	N/A				
2027	11	14,675,000	542,911.25	3.70%	3.67%	3.66%	1.50	14,396,281.95	294,609.30	14,831,821.39	18.60%
2028	9	14,441,000	591,507.50	4.07%	3.84%	3.78%	2.01	14,309,062.12	213,290.15	14,678,928.92	18.38%
2029	13	22,475,000	1,037,081.25	4.53%	4.00%	3.93%	2.74	22,338,446.45	560,274.55	23,164,916.35	28.99%
2030	17	26,500,000	1,187,882.50	4.42%	4.05%	4.03%	3.80	26,399,726.72	486,803.28	27,185,726.38	34.03%
2031	0	0			N/A	N/A	N/A				
2032	0	0			N/A	N/A	N/A				
2033	0	0			N/A	N/A	N/A				
2034	0	0			N/A	N/A	N/A				
2035	0	0			N/A	N/A	N/A				
2036	0	0			N/A	N/A	N/A				
2037	0	0			N/A	N/A	N/A				
2038	0	0			N/A	N/A	N/A				
2039	0	0			N/A	N/A	N/A				
2040	0	0			N/A	N/A	N/A				
2041	0	0			N/A	N/A	N/A				
2042	0	0			N/A	N/A	N/A				
2043	0	0			N/A	N/A	N/A				
2044	0	0			N/A	N/A	N/A				
2045	0	0			N/A	N/A	N/A				
2046	0	0			N/A	N/A	N/A				
2047	0	0			N/A	N/A	N/A				
2048	0	0			N/A	N/A	N/A				
2049	0	0			N/A	N/A	N/A				
2050	0	0			N/A	N/A	N/A				
2050 +	0	0			N/A	N/A	N/A				
Other	0	0			N/A	N/A	N/A				
Total	**50**	**78,091,000**	**$3,359,382.50**	**4.25%**	**3.92%**	**3.88%**	**2.70**	**$77,443,517.24**	**$1,554,977.28**	**$79,861,393.04**	

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.
Accrued interest, if any, has been included in the total market value.

Report created on: January 28, 2026

Bond Holdings

as of December 31, 2025 *(continued)*

Details of Bond Holdings

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Total Bond Portfolio		**78,091,000**	**4.31%**	**03/13/2029**	**N/A**	**$3,359,382.50** **4.25%**	**3.92%** **3.88%**	**2.70**	**$77,443,517.24** **$1,554,977.28**	**N/A**	**$78,998,494.52** **$862,898.52** **$79,861,393.04**	**100%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2027												
IBM CORP B/E 03.300% 012727 DTD012717 FC072717 CALL@MW+15BP	A3/A-/A- NR/NR/NR	1,100,000	3.30%	01/27/2027		36,300.00 3.32%	3.86% 3.86%	1.02	1,060,532.00 33,000.00	99.412	1,093,532.00 15,528.33	1.38%
COCA-COLA CO NTS B/E 03.375% 032527 DTD032520 FC092520 CALL@MW+40BP	A1/WD/A+ NR/NR/NR	1,675,000	3.38%	03/25/2027	01/25/2027 100.00	56,531.25 3.38%	3.61% 3.61%	1.18	1,644,582.00 25,577.25	99.711	1,670,159.25 15,075.00	2.11%
QUALCOMM INC NTS B/E 03.250% 052027 DTD052617 FC112017 CALL @MW+20BP	A2/NR/A NR/NR/NR	1,000,000	3.25%	05/20/2027	02/20/2027 100.00	32,500.00 3.27%	3.65% 3.65%	1.33	967,941.00 26,659.00	99.460	994,600.00 3,701.39	1.26%
ELI LILLY & CO NTS B/E 04.150% 081427 DTD081424 FC021425 CALL@MW+07BP	Aa3/NR/A+ NR/NR/NR	1,500,000	4.15%	08/14/2027	07/14/2027 100.00	62,250.00 4.12%	3.67% 3.64%	1.44	1,503,418.35 7,816.65	100.749	1,511,235.00 23,689.58	1.91%
META PLATFORMS INC NTS 03.500% 081527 DTD080922 FC021523 CALL@MW+15BP	Aa3/NR/AA- NR/NR/NR	1,500,000	3.50%	08/15/2027	07/15/2027 100.00	52,500.00 3.51%	3.62% 3.62%	1.54	1,446,825.00 50,340.00	99.811	1,497,165.00 19,833.33	1.90%
WALMART INC NTS B/E 03.950% 090927 DTD090922 FC030923 CALL@MW+10BP	Aa2/AA/AA NR/NR/NR	2,000,000	3.95%	09/09/2027	08/09/2027 100.00	79,000.00 3.93%	3.59% 3.58%	1.52	1,984,580.00 26,940.00	100.576	2,011,520.00 24,577.78	2.55%
CATERPILLAR FINL SERVICE 04.400% 101527 DTD081624 CALL@MW+10BP	A2/A+/A NR/NR/NR	1,200,000	4.40%	10/15/2027		52,800.00 4.35%	3.69% 3.69%	1.69	1,205,815.60 8,644.40	101.205	1,214,460.00 11,146.67	1.54%

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.
Accrued interest, if any, has been included in the total market value.

UBS

Bond Holdings

as of December 31, 2025 *(continued)*

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2027												
PEPSICO INC NTS B/E 03.000% 101527 DTD101017 FC041518 CALL@MW+15BP	A1/WD/A+ NR/NR/NR	2,100,000	3.00%	10/15/2027	07/15/2027 100.00	63,000.00 3.03%	3.57% 3.57%	1.71	2,046,975.00 32,550.00	99.025	2,079,525.00 13,300.00	2.63%
BANK OF AMER CORP 03.248% 102127 DTD102116 FC042117 CALL@MW+25BP	A1/AA-/A- NR/NR/NR	1,000,000	3.25%	10/21/2027	10/21/2026 100.00	32,480.00 3.28%	3.78% 3.78%	1.72	945,500.00 45,340.00	99.084	990,840.00 6,315.56	1.25%
THERMO FISHER SCIENTIFIC 04.800% 112127 DTD112122 CALL@MW+15BP	A2/A-/A- NR/NR/NR	1,100,000	4.80%	11/21/2027	10/21/2027 100.00	52,800.00 4.72%	3.81% 3.77%	1.70	1,096,733.00 22,792.00	101.775	1,119,525.00 5,866.67	1.42%
AMAZON.COM INC NTS B/E 04.550% 120127 DTD120122 FC060123 CALL@MW+10BP	A1/AA-/AA NR/NR/NR	500,000	4.55%	12/01/2027	11/01/2027 100.00	22,750.00 4.48%	3.64% 3.60%	1.73	493,380.00 14,950.00	101.666	508,330.00 1,895.83	0.64%
Total 2027		**14,675,000**	**3.70%**	**08/11/2027**		**$542,911.25 3.70%**	**3.67% 3.66%**	**1.50**	**$14,396,281.95 $294,609.30**		**$14,690,891.25 $140,930.14**	**18.60%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2028												
ECOLAB INC NTS B/E 05.250% 011528 DTD111722 CALL@MW+15BP	A3/A-/A- NR/NR/NR	1,000,000	5.25%	01/15/2028	12/15/2027 100.00	52,500.00 5.11%	3.86% 3.80%	1.84	1,005,652.08 21,347.92	102.700	1,027,000.00 24,208.33	1.30%
BRISTOL-MYERS SQUIBB CO 03.900% 022028 DTD022020 FC082020 CALL@MW+20BP	A2/WD/A NR/NR/NR	1,116,000	3.90%	02/20/2028	11/20/2027 100.00	43,524.00 3.89%	3.79% 3.78%	1.79	1,078,064.52 40,413.00	100.222	1,118,477.52 15,837.90	1.42%
SALESFORCE.COM INC NTS 03.700% 041128 DTD041118 FC101118 CALL@MW+15BP	A1/NR/A+ NR/NR/NR	2,000,000	3.70%	04/11/2028	01/11/2028 100.00	74,000.00 3.70%	3.70% 3.70%	2.14	1,959,650.00 40,390.00	100.002	2,000,040.00 16,444.44	2.53%

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.
Accrued interest, if any, has been included in the total market value.

Bond Holdings

as of December 31, 2025 *(continued)*

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2028												
GENERAL DYNAMICS CORP 03.750% 051528 DTD051118 FC111518 CALL@MW+15BP	A2/WD/A NR/NR/NR	2,000,000	3.75%	05/15/2028	02/15/2028 100.00	75,000.00 3.74%	3.66% 3.65%	1.99	1,950,170.00 53,750.00	100.196	2,003,920.00 9,583.33	2.54%
MERCK & CO INC NTS B/E 04.050% 051728 DTD051723 FC111723	Aa3/NR/A+ NR/NR/NR	1,975,000	4.05%	05/17/2028	04/17/2028 100.00	79,987.50 4.02%	3.71% 3.70%	2.15	1,977,460.07 12,451.18	100.755	1,989,911.25 9,776.25	2.52%
CME GROUP INC NTS B/E 03.750% 061528 DTD062118 FC121518 CALL@MW+15BP	Aa3/AA-/AA- NR/NR/NR	1,400,000	3.75%	06/15/2028	03/15/2028 100.00	52,500.00 3.75%	3.70% 3.70%	2.07	1,400,244.36 1,281.64	100.109	1,401,526.00 2,333.33	1.77%
JPMORGAN CHASE & CO NTS 4.851% 072528 DTD072522 FC012523 CALL@MW+30BP	A1/AA-/A NR/NR/NR	2,100,000	4.85%	07/25/2028	07/25/2027 100.00	101,871.00 4.79%	4.31% 3.99%	1.46	2,107,027.09 20,230.91	101.298	2,127,258.00 44,144.10	2.69%
UNION PAC CORP B/E 03.950% 091028 DTD060818 FC031019 CALL@MW+20BP	A3/A-/A- NR/NR/NR	2,250,000	3.95%	09/10/2028	06/10/2028 100.00	88,875.00 3.94%	3.85% 3.84%	2.30	2,230,830.00 24,637.50	100.243	2,255,467.50 27,403.13	2.86%
PROLOGIS NTS B/E 03.875% 091528 DTD062018 FC091518 CALL@MW+15BP	A2/WD/A NR/NR/NR	600,000	3.88%	09/15/2028	06/15/2028 100.00	23,250.00 3.88%	3.96% 3.96%	2.51	599,964.00 -1,212.00	99.792	598,752.00 6,845.83	0.76%
Total 2028		**14,441,000**	**4.10%**	**06/02/2028**		**$591,507.50 4.07%**	**3.84% 3.78%**	**2.01**	**$14,309,062.12 $213,290.15**		**$14,522,352.27 $156,576.65**	**18.38%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2029												
PROCTER & GAMBLE CO/THE 04.350% 012929 DTD012924 FC072924 CALL@MW+5BP	Aa3/NR/AA- NR/NR/NR	1,025,000	4.35%	01/29/2029		44,587.50 4.27%	3.68% 3.68%	2.81	1,022,627.50 22,175.50	101.932	1,044,803.00 18,825.83	1.32%
ELI LILLY & CO NTS B/E 04.500% 020929 DTD020924 FC080924 CALL@MW+10BP	Aa3/NR/A+ NR/NR/NR	1,500,000	4.50%	02/09/2029	01/09/2029 100.00	67,500.00 4.41%	3.83% 3.82%	2.74	1,492,560.00 36,495.00	101.937	1,529,055.00 26,625.00	1.94%

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.
Accrued interest, if any, has been included in the total market value.

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

Bond Holdings

as of December 31, 2025 *(continued)*

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2029												
LOCKHEED MARTIN CORP NTS 04.500% 021529 DTD012924 FC081524 CALL@MW+10BP	A2/A/A- NR/NR/NR	1,075,000	4.50%	02/15/2029	01/15/2029 100.00	48,375.00 4.43%	3.94% 3.93%	2.76	1,065,223.50 27,213.00	101.622	1,092,436.50 18,275.00	1.38%
WASTE MGMT INC NTS B/E 04.875% 021529 DTD080323 FC021524 CALL@MW+15BP	A3/A-/A- NR/NR/NR	2,325,000	4.88%	02/15/2029	01/15/2029 100.00	113,343.75 4.75%	3.97% 3.95%	2.74	2,327,834.38 58,406.12	102.634	2,386,240.50 42,818.75	3.02%
CISCO SYSTEMS INC NTS 04.850% 022629 DTD022624 FC082624 CALL@MW+10BP	A1/NR/AA- NR/NR/NR	1,950,000	4.85%	02/26/2029	01/26/2029 100.00	94,575.00 4.72%	3.93% 3.90%	2.78	1,967,553.24 35,252.76	102.708	2,002,806.00 32,838.54	2.54%
LAM RESEARCH CORP B/E 04.000% 031529 DTD030419 FC091519 CALL@MW+25BP	A2/NR/A- NR/NR/NR	1,500,000	4.00%	03/15/2029	12/15/2028 100.00	60,000.00 4.00%	3.97% 3.97%	2.75	1,457,025.00 44,085.00	100.074	1,501,110.00 17,666.67	1.90%
HOME DEPOT INC NTS B/E 04.900% 041529 DTD120423 FC041524	A2/A/A NR/NR/NR	2,000,000	4.90%	04/15/2029	03/15/2029 100.00	98,000.00 4.76%	3.93% 3.91%	2.91	2,001,875.28 57,384.72	102.963	2,059,260.00 20,688.89	2.61%
AMER EXPRESS CO NTS B/E 04.050% 050329 DTD050322 FC110322	A2/A/A- NR/NR/NR	2,000,000	4.05%	05/03/2029	03/03/2029 100.00	81,000.00 4.04%	3.94% 3.93%	2.91	1,946,340.00 60,600.00	100.347	2,006,940.00 13,050.00	2.54%
COMCAST CORP NTS B/E 05.100% 060129 DTD052224 FC120124 CALL@MW+10BP	A3/A-/A- NR/NR/NR	1,300,000	5.10%	06/01/2029	05/01/2029 100.00	66,300.00 4.94%	4.06% 4.04%	3.02	1,294,046.00 48,529.00	103.275	1,342,575.00 5,525.00	1.70%
APPLIED MATERIALS INC 04.800% 061529 DTD061124 FC121524 CALL@MW+10BP	A2/NR/A NR/NR/NR	2,300,000	4.80%	06/15/2029	05/15/2029 100.00	110,400.00 4.68%	3.99% 3.98%	3.07	2,308,001.55 51,338.45	102.580	2,359,340.00 4,906.67	2.99%
PEPSICO INC NTS B/E 04.500% 071729 DTD071724 FC011725 CALL@MW+10BP	A1/NR/A+ NR/NR/NR	2,000,000	4.50%	07/17/2029	06/17/2029 100.00	90,000.00 4.41%	3.88% 3.86%	3.17	1,994,280.00 46,640.00	102.046	2,040,920.00 41,000.00	2.58%

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Accrued interest, if any, has been included in the total market value.

Report created on: January 28, 2026

Bond Holdings

as of December 31, 2025 *(continued)*

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2029												
ELI LILLY & CO NTS B/E 04.200% 081429 DTD081424 FC021425 CALL@MW+10BP	Aa3/NR/A+ NR/NR/NR	1,500,000	4.20%	08/14/2029	07/14/2029 100.00	63,000.00 4.16%	3.89% 3.88%	3.19	1,471,080.00 44,595.00	101.045	1,515,675.00 23,975.00	1.92%
GOLDMAN SACHS GROUP INC 05.000% 123129 DTD123124 FC123125 MED TERM NTS	A2/A/BBB+ NR/NR/NR	2,000,000	5.00%	12/31/2029	12/31/2026 100.00	100,000.00 4.96%	4.75% 4.09%	0.96	1,990,000.00 27,560.00	100.878	2,017,560.00 0.00	2.55%
Total 2029		**22,475,000**	**4.62%**	**05/12/2029**		**$1,037,081.25 4.53%**	**4.00% 3.93%**	**2.74**	**$22,338,446.45 $560,274.55**		**$22,898,721.00 $266,195.35**	**28.99%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2030												
CATERPILLAR FINL SERVICE 04.800% 010830 DTD010825 FC070825 CALL@MW+10BP	A2/A+/A NR/NR/NR	2,000,000	4.80%	01/08/2030		96,000.00 4.64%	3.87% 3.87%	3.55	1,992,980.00 75,680.00	103.433	2,068,660.00 46,133.33	2.62%
CONOCOPHILLIPS CO NTS 04.700% 011530 DTD120524 FC071525 CALL@MW+10BP	A2/A/A- NR/NR/NR	1,000,000	4.70%	01/15/2030	12/15/2029 100.00	47,000.00 4.61%	4.17% 4.16%	3.57	993,920.00 25,610.00	101.953	1,019,530.00 21,672.22	1.29%
UNITEDHEALTH GROUP INC 04.800% 011530 DTD072524 FC011525 CALL@MW+10BP	A2/A/A+ NR/NR/NR	1,200,000	4.80%	01/15/2030	12/15/2029 100.00	57,600.00 4.68%	4.12% 4.11%	3.57	1,199,592.00 30,300.00	102.491	1,229,892.00 26,560.00	1.56%
WELLS FARGO & CO NTS B/E 05.198% 012330 DTD012324 FC072324 CALL@MW+20BP	A1/A+/BBB+ NR/NR/NR	1,500,000	5.20%	01/23/2030	01/23/2029 100.00	77,970.00 5.04%	4.37% 4.12%	2.75	1,498,260.00 47,640.00	103.060	1,545,900.00 34,220.17	1.96%
TRUIST FINANCIAL CORP 05.435% 012430 DTD012424 FC072424 MED TERM NTS	Baa1/A-/A- NR/NR/NR	2,500,000	5.44%	01/24/2030	01/24/2029 100.00	135,875.00 5.25%	N/A N/A	N/A	2,517,415.71 72,559.29	103.599	2,589,975.00 0.00	3.28%

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities.
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Report created on: January 28, 2026

UBS

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

Bond Holdings

as of December 31, 2025 *(continued)*

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2030												
ABBVIE INC NTS B/E 04.875% 031530 DTD022625 FC091525 CALL@MW+10BP	A3/NR/A- NR/NR/NR	2,500,000	4.88%	03/15/2030	02/15/2030 100.00	121,875.00 4.73%	4.06% 4.05%	3.65	2,499,625.00 78,350.00	103.119	2,577,975.00 35,885.42	3.26%
ECOLAB INC B/E 04.800% 032430 DTD032420 CALL@MW+50BP	A3/A-/A- NR/NR/NR	1,000,000	4.80%	03/24/2030	12/24/2029 100.00	48,000.00 4.68%	4.12% 4.08%	3.59	994,510.00 31,720.00	102.623	1,026,230.00 12,933.33	1.30%
TJX COS INC B/E 03.875% 041530 DTD040120 FC101520 CALL@MW+50BP	A2/NR/A NR/NR/NR	1,400,000	3.88%	04/15/2030	01/15/2030 100.00	54,250.00 3.89%	3.96% 3.96%	3.88	1,392,588.00 2,960.00	99.682	1,395,548.00 11,452.78	1.77%
WALMART INC NTS B/E 04.000% 041530 DTD041823 CALL@MW+10BP	Aa2/AA/AA NR/NR/NR	1,250,000	4.00%	04/15/2030	02/15/2030 100.00	50,000.00 3.96%	3.76% 3.75%	3.71	1,244,200.00 17,537.50	100.939	1,261,737.50 10,555.56	1.60%
APPLE INC NTS B/E 04.200% 051230 DTD051225 FC111225 CALL@MW+5BP	Aaa/NR/AA+ NR/NR/NR	1,400,000	4.20%	05/12/2030	04/12/2030 100.00	58,800.00 4.15%	3.89% 3.88%	3.85	1,391,012.00 26,222.00	101.231	1,417,234.00 8,003.33	1.79%
ALPHABET INC NTS B/E 04.000% 051530 DTD050125 FC111525 CALL@MW+5BP	Aa2/NR/AA+ NR/NR/NR	2,000,000	4.00%	05/15/2030	04/15/2030 100.00	80,000.00 3.99%	3.93% 3.93%	3.87	1,993,020.00 12,820.00	100.292	2,005,840.00 10,222.22	2.54%
NUCOR CORP NTS B/E 04.650% 060130 DTD030525 FC120125 CALL@MW+15BP	A3/A-/A- NR/NR/NR	1,500,000	4.65%	06/01/2030	05/01/2030 100.00	69,750.00 4.55%	4.11% 4.10%	3.87	1,507,905.60 24,689.40	102.173	1,532,595.00 5,812.50	1.94%
BERKSHIRE HATHAWAY 03.700% 071530 DTD011521 FC071521 CALL@MW+45BP	A3/NR/A- NR/NR/NR	1,750,000	3.70%	07/15/2030	04/15/2030 100.00	64,750.00 3.76%	4.09% 4.09%	4.06	1,693,912.50 28,017.50	98.396	1,721,930.00 29,856.94	2.18%
HOME DEPOT INC NTS B/E 03.950% 091530 DTD091525 FC031526 CALL@MW+10BP	A2/A/A NR/NR/NR	1,100,000	3.95%	09/15/2030	08/15/2030 100.00	43,450.00 3.96%	3.99% 3.99%	4.20	1,096,359.00 1,507.00	99.806	1,097,866.00 12,793.61	1.39%

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Report created on: January 28, 2026

Bond Holdings

as of December 31, 2025 *(continued)*

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Maturing 2030												
BROADCOM INC NTS B/E 04.200% 101530 DTD092925 FC041526 CALL@MW+10BP	A3/BBB+/A- NR/NR/NR	1,750,000	4.20%	10/15/2030	09/15/2030 100.00	73,500.00 4.20%	4.19% 4.19%	4.26	1,745,817.50 4,812.50	100.036	1,750,630.00 18,783.33	2.22%
AMPHENOL CORP NTS B/E 04.125% 111530 DTD111025 FC051526 CALL@MW+10BP	A3/NR/A- NR/NR/NR	1,650,000	4.13%	11/15/2030	10/15/2030 100.00	68,062.50 4.14%	4.22% 4.22%	4.34	1,636,107.00 6,880.50	99.575	1,642,987.50 9,642.19	2.08%
AMAZON COM INC NTS B/E 04.100% 112030 DTD112025 FC052026 CALL@MW+10BP	A1/AA-/AA NR/NR/NR	1,000,000	4.10%	11/20/2030	10/20/2030 100.00	41,000.00 4.09%	4.05% 4.05%	4.28	1,002,502.41 -502.41	100.200	1,002,000.00 4,669.44	1.27%
Total 2030		**26,500,000**	**4.49%**	**05/06/2030**		**$1,187,882.50 4.42%**	**4.05% 4.03%**	**3.80**	**$26,399,726.72 $486,803.28**		**$26,886,530.00 $299,196.38**	**34.03%**

	Effective rating/ Underlying rating (Mdy/Fitch/S&P)	Quantity	Coupon	Effective maturity	Call date/ Call price ($)	Est. annual income ($)/ Curr. yield (%)	YTM (%)/ YTW (%)	Modified duration	Adjusted cost basis ($)/ Unreal. g/l ($)	Market price ($)	Mkt. value ($)/ Accr. interest ($)	% of bond port.
Total Bond Portfolio		**78,091,000**	**4.31%**	**03/13/2029**	**N/A**	**$3,359,382.50 4.25%**	**3.92% 3.88%**	**2.70**	**$77,443,517.24 $1,554,977.28**	**N/A**	**$78,998,494.52 $862,898.52 $79,861,393.04**	**100%**

Includes all fixed-rate securities in the selected portfolio. Average yields and durations exclude Structured Product, Pass-Through, Perpetual Preferred, and Foreign securities. Accrued interest, if any, has been included in the total market value.

Additional Information About Your Portfolio

as of December 31, 2025

Benchmark Composition

Account EX XX120

Blended Index

Start - 05/15/2017: 50% BBG US Gvt 1-3 Y; 50% BBG USAgg GvtCr 1-5Y

05/15/2017 - 05/31/2018: 100% BBG Agg Bond

05/31/2018 - 11/04/2019: 100% BBG Agg Bond

11/04/2019 - 06/30/2023: 45% BBG US Corp 1-3Y Incp76; 55% BBG US Agg Gvt & CR 1-3 Y

06/30/2023 - Current: 45% BBG US Corp 1-3Y Incp76; 55% BBG US Agg Gvt & CR 1-3 Y

Disclosures Applicable to Accounts at UBS Financial Services Inc.

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

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

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

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

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

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

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

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

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

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

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

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

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

Benchmark/Major Indices: The past performance of an index is not a guarantee of future results. Any benchmark is shown for informational purposes only and relates to historical performance of market indices and not the performance of actual investments. Although most portfolios use indices as benchmarks, portfolios are actively managed and generally are not restricted to investing only in securities in the index. As a result, your

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Disclosures Applicable to Accounts at UBS Financial Services Inc. *(continued)*

portfolio holdings and performance may vary substantially from the index. Each index reflects an unmanaged universe of securities without any deduction for advisory fees or other expenses that would reduce actual returns, as well as the reinvestment of all income and dividends. An actual investment in the securities included in the index would require an investor to incur transaction costs, which would lower the performance results. Indices are not actively managed and investors cannot invest directly in the indices. Market index data maybe subject to review and revision. The benchmark index is selected from among the indices for which UBSFS has licensing agreements with the index provider. UBSFS does not have licensing agreements for all available indices. The benchmarks may vary from those used by the Money Manager or those listed in the prospectus. Further, there is no guarantee that an investor's account will meet or exceed the stated benchmark. Index performance information has been obtained from third parties deemed to be reliable. We have not independently verified this information, nor do we make any representations or warranties to the accuracy or completeness of this information.

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

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

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

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

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

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

Net Deposits/Withdrawals (external): When shown on a report, this information represents the net value of all cash and securities contributions and withdrawals, program fees (including wrap fees) and other fees added to or subtracted from your accounts from the first day to the last day of the period, excluding assets transferred to or from other UBS accounts after 12/31/2010. When fees are shown separately, net deposits / withdrawals does not include program fees (including wrap fees). When investment return is displayed net deposits / withdrawals does not include program fees (including wrap fees). For security contributions and withdrawals, securities are calculated using the end of day UBS FS price on the day securities are delivered in or out of the accounts. Wrap fees will be included in this calculation except when paid via an invoice or through a separate accounts billing arrangement. When shown on Client summary and/or Portfolio review report, program fees (including wrap fees) may not be included in net deposits/withdrawals. PACE Program fees paid from sources other than your PACE account are treated as a contribution. A PACE Program Fee rebate that is not reinvested is treated as a withdrawal.

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

Deposits (external): When shown on a report, this information represents the net value of all cash and securities contributions added to your accounts from the first day to the last day of the period, excluding assets transferred from other UBS accounts after 12/31/2010. On Client Summary Report and/or Portfolio Review Report, this may exclude the Opening balance. For security contributions, securities are calculated using the end of day UBS FS price on the day securities are delivered in or out of the accounts.

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

Withdrawals (external): When shown on a report, this information represents the net value of all cash and securities withdrawals subtracted from your accounts from the first day to the last day of the period, excluding assets transferred to other UBS accounts after 12/31/2010. On Client summary and/or portfolio review report Withdrawals may not include program fees (including wrap fees). For security withdrawals, securities are calculated using the end of day UBS FS price on the day securities are delivered in or out of the accounts.

Net Transfers (Internal): When shown on a report, this information represents the net value of all cash and securities transferred between your UBS accounts from the first day to the last day of the period.

Transfers In (Internal): When shown on a report, this information represents the net value of all cash and securities transferred to your UBS accounts from the first day to the last day of the period.

Transfers Out (Internal): When shown on a report, this information represents the net value of all cash and securities transferred from your UBS accounts from the first day to the last day of the period.

Dividends/Interest: Dividend and interest earned, when shown on a report, does not include income on securities that have been lent out & does not reflect your account's tax status or reporting requirements. Use only official tax reporting documents (i.e. 1099) for tax reporting purposes. The classification of private

Disclosures Applicable to Accounts at UBS Financial Services Inc. *(continued)*

investment distributions can only be determined by referring to the official year-end tax-reporting document provided by the issuer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Disclosures Applicable to Accounts at UBS Financial Services Inc. *(continued)*

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

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

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

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

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

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

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

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

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

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

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

Estimated Annual Income: The Estimated Annual Income is for informational purposes only and is calculated by the annualized per share dividends/interest paid, multiplied by the quantity of the shares held in the selected account(s). For Expected Cash Flow and Portfolio Holdings reports prior to June 23, 2023, savings products & sweep funds do not display such calculations and instead, values are displayed as N/A. For all other reports, Estimated Annual Income for savings products & sweep funds is not calculated or factored into aggregate calculations and will be displayed as 0.

Current Yield: Current Yield is estimated for informational purposes only and may not reflect changes in price. It's calculated by dividing the total estimated annual income by the current market value displayed. Current yield calculations display the current yield of the investment solely as of the date of this report. For Portfolio Holdings report generated prior to June 23, 2023, savings products & sweep funds do not include such information and instead, values are displayed as N/A. For all other reports, Current Yield for savings products & sweep funds is not calculated or factored into aggregate calculations and will be displayed as 0.

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

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

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

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

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

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

Disclosures Applicable to Accounts at UBS Financial Services Inc. *(continued)*

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

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

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

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

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

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

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

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

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

Gain/Loss: The gain/loss information may include calculations based upon non-UBS FS cost basis information. The firm does not independently verify or guarantee the accuracy or validity of any information provided by sources other than UBS FS. In addition, for Schedule K-1 reported investments, such as alternative investment funds, please refer to your annual K-1 and 1099 tax forms. If this report contains positions with unavailable cost basis, the gain/(loss) for these positions are excluded in the calculation for the Gain/(Loss). As a result these figures may not be accurate and are provided for informational purposes only. Clients should not rely on this information in making purchase or sell decisions, for tax purposes or otherwise. Rely only on year-end tax forms when preparing your tax return. See your monthly statement for additional information.

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

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

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

Account name(s) displayed in this report and labels used for groupings of accounts can be customizable "nicknames" chosen by you to assist you with your recordkeeping or may have been included by your financial

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Disclosures Applicable to Accounts at UBS Financial Services Inc. *(continued)*

advisor for reference purposes only. The names used have no legal effect, are not intended to reflect any strategy, product, recommendation, investment objective or risk profile associated with your accounts or any group of accounts, and are not a promise or guarantee that wealth, or any financial results, can or will be achieved. All investments involve the risk of loss, including the risk of loss of the entire investment.

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

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

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

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

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

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

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

Important information about brokerage and advisory services. As a firm providing wealth management services to clients, UBS Financial Services Inc. offers investment advisory services in its capacity as an SEC-registered investment adviser and brokerage services in its capacity as an SEC-registered broker-dealer. Investment advisory services and brokerage services are separate and distinct, differ in material ways and are governed by different laws and separate arrangements. It is important that clients understand the ways in which we conduct business, that they carefully read the agreements and disclosures that we provide to them about the products or services we offer. For more information, please review client relationship summary provided at **ubs.com/relationshipsummary**.

UBS Financial Services account protection
The Firm is a member of the Securities Investor Protection Corporation (SIPC), which protects securities customers of its members up to $500,000 (including $250,000 for claims for cash). Explanatory brochure available upon request or at www.sipc.org. The SIPC asset protection limits apply to all accounts that you hold in a particular capacity.

The Firm, together with certain affiliates, has also purchased supplemental insurance. The maximum amount payable to all eligible clients, collectively under this protection is $500 million as of December 10, 2019. Subject to the policy conditions and limitations, cash at the Firm is further protected for up to $1.9 million in the aggregate for all your accounts held in a particular capacity. A full copy of the policy wording is available upon request.

Neither the SIPC protection nor the supplemental protection apply to:

- Certain financial assets controlled by (and included in your account value) but held away from UBS Financial Services. For example certain (i) insurance products, including variable annuities, and (ii) shares of mutual funds registered in the name of the account holder on the books of the issuer or transfer agent);
- Investment contracts or investment interests (e.g., limited partnerships and private placements) that are not registered under the Securities Act of 1933;
- Commodities contracts (e.g., foreign exchange and precious metal contracts), including futures contracts and commodity option contracts;
- Securities on loan to UBS Financial Services; and
- Deposit accounts (except certificates of deposit) at UBS Bank USA, UBS AG U.S. branches and banks in the FDIC Insured Deposit Program.

The SIPC protection and the supplemental protection do not apply to these assets even if they otherwise appear on your statements. The SIPC protection and the supplemental protection do not protect against changes in the market value of your investments (whether as a result of market movement, issuer bankruptcy or otherwise).

UBS

Kern Health Systems

Account Number: EBXXX20

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

Filtered by: Entry Date 10/01/2025-12/31/2025, Call/Redemption,Sold

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
12/04/2025	12/04/2025	CALL REDEMPTION	BRISTOL-MYERS SQUIBB CO 03.900% 022028 DTD022020	691VG7	-884,000.000	REDEMPTION	886,537.08
12/04/2025	12/05/2025	SOLD	BANK OF AMER CORP 03.248% 102127 DTD102116 Trade#:34051 Blot:97	6686A3	-1,000,000.000	$98.995	993,919.78
12/01/2025	12/02/2025	SOLD	AMAZON.COM INC NTS B/E 03.300% 041327 DTD041322 Trade#:10935 Blot:97	702U21	-1,000,000.000	$99.387	998,361.67
11/18/2025	11/19/2025	SOLD	WALT DISNEY COMPANY/THE 03.375% 111526 DTD111519 Trade#:16356 Blot:97	691JH6	-1,350,000.000	$99.504	1,343,810.25
11/18/2025	11/19/2025	SOLD	ARCHER-DANIELS-MIDL& CO 02.500% 081126 DTD081116 Trade#:16355 Blot:97	667LW6	-1,500,000.000	$98.941	1,494,323.33

Filtered by: Entry Date 10/01/2025-12/31/2025, Bought

Entry Date	Settle Date	Activity	Description	Security#	Quantity	Price/Detail	Amount
12/05/2025	12/08/2025	BOUGHT	TJX COS INC B/E 03.875% 041530 DTD040120 Trade#:60334 Blot:97	875JV5	900,000.000	$99.197	-897,907.38
12/04/2025	12/05/2025	BOUGHT	HOME DEPOT INC NTS B/E 03.950% 091530 DTD091525 Trade#:34084 Blot:97	7122A3	1,100,000.000	$99.669	-1,106,014.56
12/01/2025	12/02/2025	BOUGHT	AMAZON COM INC NTS B/E 04.100% 112030 DTD112025 Trade#:11281 Blot:97	6169D0	1,000,000.000	$100.254	-1,003,906.67
11/18/2025	11/19/2025	BOUGHT	AMPHENOL CORP NTS B/E 04.125% 111530 DTD111025 Trade#:24199 Blot:97	634CP9	1,650,000.000	$99.158	-1,637,808.56
11/18/2025	11/19/2025	BOUGHT	BROADCOM INC NTS B/E 04.200% 101530 DTD092925 Trade#:21149 Blot:97	764QY4	1,750,000.000	$99.761	-1,756,025.83

Disclosure:

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

Important information about UBS brokerage and advisory services. As a firm providing wealth management services to clients, UBS Financial Services Inc. offers investment advisory services in its capacity as an SEC-registered investment adviser and brokerage services in its capacity as an SEC-registered broker-dealer. Investment advisory services and brokerage services are separate and distinct, differ in material ways and are governed by different laws and separate arrangements. It is important that you understand the ways in which we conduct business and that you carefully read the agreements and disclosures that we provide about the products or services we offer. For more information, please review client relationship summary provided at ubs.com/relationshipsummary.

The information is based upon the market value of your account(s) as of the close of business on 12/31/2025 and is subject to daily market fluctuation and in some cases may be rounded for convenience."

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

You have discussed the receipt of this individually customized report with your Financial Advisor and understand that it is being provided for information purposes only. If you would like to revoke such consent, and no longer receive this report, please notify your Financial Advisor and/or Branch Manager.

KHS Board of Directors Meeting, February 19, 2026

WELLS FARGO
Wells Fargo Bank, N.A.
550 S Tryon St.
Charlotte, NC 28202

Wells Fargo Bank, N.A.
333 S GRAND AVE
LOS ANGELES CA 90071

JONATHAN CHUANG
1-213-253-6202

Wells Fargo Bank, N.A.
Account Statement

Statement Period
12/01/2025 - 12/31/2025

KERN HEALTH SYSTEMS
2900 BUCK OWENS BOULEVARD

Account Number
[redacted]

Account Value Summary *USD*

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

	Amount Last Statement Period	Amount This Statement Period	% Portfolio
Cash	$ 0.00	**$ 0.00**	0%
Money Market Mutual Funds	119,833,781.24	**100,754,823.49**	29%
Bonds	79,669,729.89	**243,311,933.68**	71%
Stocks	0.00	**0.00**	0%
Total Account Value	**$ 199,503,511.13**	**$ 344,066,757.17**	**100%**

Value Change Since Last Statement Period	**$ 144,563,246.04**
Percent Increase Since Last Statement Period	**72%**
Value Last Year-End	**$ 519,073,102.39**
Percent Decrease Since Last Year-End	**34%**

Income Summary *USD*

	This Period	Year-To-Date
Interest	$ 287,607.25	$ 6,647,636.19
Dividends/Capital Gains	0.00	0.00
Money Market Mutual Funds Dividends	346,548.77	5,528,737.44
Other	0.00	0.00
Income Total	**$ 634,156.02**	**$ 12,176,373.63**

Interest Charged *USD*

Description	This Period
Debit Interest For December 2025	0.00
Total Interest Charged	**$ 0.00**

Money Market Mutual Funds Summary *USD*

Description	Amount
Opening Balance	**$ 119,833,781.24**
Deposits and Other Additions	443,216,732.25
Distributions and Other Subtractions	(462,642,095.77)
Dividends Reinvested	346,405.77
Change in Value	0.00
Closing Balance	**$ 100,754,823.49**

Important Information

This statement is provided to customers of Wells Fargo Bank, N.A. (the "Bank"). Statements are provided monthly for accounts with transactions and/or security positions.

Pricing: Security and other asset prices shown on the statement are obtained from independent vendors or internal pricing models. While we believe the prices are reliable, we cannot guarantee their accuracy. The prices indicated herein are as of the stated valuation date, which may not be the date of this statement, and are subject to change without notice. For exchange-listed securities, the price provided is the closing price of the relevant security at month end. For unlisted securities, it is the "bid" price of the relevant security at month end. The prices of instruments that trade infrequently are estimated using similar securities for which prices are available. Prices on the statement may not necessarily be obtained when the asset is sold.

Cash Balances: Cash held at the Bank is not covered by SIPC, but is instead eligible for FDIC insurance of up to $250,000 per depositor, per institution, in accordance with FDIC rules.

Mutual Funds: An investment in the fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. The fund's sponsor has no legal obligation to provide financial support to the fund, and you should not expect that the sponsor will provide financial support to the fund at any time.You have the right, in the course of normal business operations, to withdraw balances in the Bank Deposit Sweep or redeem shares of the money market mutual fund used in the sweep, subject to any open commitments in any of your accounts and have the proceeds returned to your accounts or remitted to you. Note, however, that as required by federal banking regulations, the banks in the Bank Deposit Sweep reserve the right to require seven days prior notice before permitting a transfer out of the Bank Deposit Sweep. In addition, the money market mutual funds in the sweep reserve the right to require one or more day's prior notice before permitting withdrawals. The Bank makes certain money market mutual funds available through the Bank Deposit Sweep and has entered into agreements with the mutual fund companies with respect to the available funds. Mutual funds are sold by prospectus only. Please read the prospectus for further information including sales charges,deferred sales charges, withdrawal charges and management or other fees.

Institutional Prime Funds: You could lose money by investing in the fund. Because the share price of the fund will fluctuate, when you sell your shares they may be worth more or less than what you originally paid for them. During times of market stress, the fund may impose a discretionary liquidity fee upon sale of your shares, if the fund's board determines the fee is in the fund's best interest. The Prime fund will impose a mandatory liquidity fee when you redeem fund shares, if daily net redemptions exceed 5% of the net assets and no exception applies.

Muni Substitute Interest: With respect to transactions involving your purchase of a municipal security having interest that is exempt from federal and/or state income taxes, if you do not receive good delivery of such securities on settlement date (i.e., all requirements for transferring title from the seller to the buyer have occurred), the interest that you accrue from the settlement date of the transaction until you receive good delivery may be considered by the Internal Revenue Service ("IRS") to be taxable ("substitute") interest. If you sell such securities before receiving good delivery, the IRS may consider all of the interest that you accrue to be taxable. You should consult with your tax advisor regarding the tax implication of any such fail to receive scenario.

Muni MSRB Disclosure: WFS is registered with the U.S. Securities and Exchange Commission ("SEC") and the Municipal Securities Rulemaking Board ("MSRB"). The website for the SEC is www.sec.gov and the website for the MSRB is www.msrb.org. There is a brochure available on the MSRB website that describes the protections provided by MSRB rules and how to file a complaint with the appropriate regulatory authority.

Non-deposit investment products offered or sold by the Bank, including investments in mutual funds available through the Bank, are not federally insured or guaranteed by or obligations of the U.S. government, the Federal Deposit Insurance Corporation ("FDIC"), the Federal Reserve System or any other government agency; are not bank deposits; are not obligations of, or endorsed or guaranteed in any way by any bank or the Bank; and are subject to risk, including the possible loss of principal, that may cause the value of the investment and the investment return to fluctuate. When the investment is sold, the amount may be higher or lower than the amount originally invested.

Customer Complaints and Reporting Discrepancies: All inquiries, statement reporting inaccuracies or discrepancies, or complaints regarding your account or the activity therein should be directed to:

Customer Service
550 S Tryon St
Floor:06, MAC: D1086-063
Charlotte,NC 28202-4200
1-800-645-3751, option 5,
WFSCustomerService@Wellsfargo.com.

To further protect their rights, customers should also reconfirm in writing to the above address any oral communications with the Bank relating to inaccuracies or discrepancies.

The Bank's financial statements are available upon request.

KHS Board of Directors Meeting, February 19, 2026

KERN HEALTH SYSTEMS
Account Number: [redacted]

Statement Ending: December 31, 2025

Portfolio Holdings

Security positions held with Wells Fargo Bank N.A.

Security ID	Description	Maturity Date	Coupon	Current Par / Original Par	Market Price*	Market Value	Original Par Pledged**	Callable
Bonds *USD*								
912797SE8	UNITED STATES TREASURY BILL	01/06/26	0.000%	50,000,000.000	99.9621	49,981,064.50		
912797SF5	UNITED STATES TREASURY BILL	01/13/26	0.000%	50,000,000.000	99.8934	49,946,695.00		
912797SG3	UNITED STATES TREASURY BILL	01/20/26	0.000%	50,000,000.000	99.8230	49,911,506.50		
912797SH1	UNITED STATES TREASURY BILL	01/27/26	0.000%	50,000,000.000	99.7546	49,877,280.00		
771196BS0	ROCHE HOLDINGS INC	03/05/26	0.991%	1,000,000.000	99.4971	994,971.34		Y
3130B7NJ9	FEDERAL HOME LOAN BANK	09/03/27	4.150%	5,970,000.000	99.9997	5,969,981.37		Y
09711CAJ3	BOFA FINANCE LLC	11/26/27	4.150%	3,000,000.000	100.4129	3,012,386.31		Y
3133ETE86	FEDERAL FARM CREDIT BANK	01/14/28	3.970%	5,000,000.000	99.9984	4,999,919.45		Y
95004HAC2	WELLS FARGO BANK NA	05/16/28	4.620%	3,000,000.000	100.1658	3,004,974.84		Y
3130B7VC5	FEDERAL HOME LOAN BANK	09/25/28	4.000%	3,075,000.000	100.0226	3,075,693.72		Y
3134HBX22	FREDDIE MAC	09/27/28	4.000%	2,000,000.000	99.9934	1,999,868.02		Y
3134HB3M1	FREDDIE MAC	11/03/28	4.125%	5,000,000.000	100.0220	5,001,097.85		Y
3133ET2J5	FEDERAL FARM CREDIT BANK	11/28/28	3.970%	5,013,000.000	99.9944	5,012,720.48		Y
3134HBU82	FREDDIE MAC	12/26/28	4.050%	5,495,000.000	99.9894	5,494,417.15		Y
3133ERC58	FEDERAL FARM CREDIT BANK	11/20/29	4.600%	5,000,000.000	100.5871	5,029,357.15		Y
				243,553,000.000		243,311,933.68	0.00	

See important information regarding security pricing on Page 2.

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

Daily Account Activity

Your investment transactions during this statement period.

Transaction / Trade Date	Settlement / Effective Date	Activity	Security ID	Description	Par / Quantity	Price	Principal Amount	Income Amount	Debit / Credit Amount
Transaction Activity *USD*									
12/05/25	12/08/25	Security Receipt	3134HB3M1	FREDDIE MAC	3,000,000.00	100.0000000	(3,000,000.00)	(12,031.25)	(3,012,031.25)
12/09/25	12/10/25	Security Receipt	3134HB3M1	FREDDIE MAC	2,000,000.00	99.9850000	(1,999,700.00)	(8,479.17)	(2,008,179.17)
12/16/25	12/16/25	Security Receipt	313313QW1	FED FARM CRD DISCOUNT NT	50,000,000.00	99.9284440	(49,964,222.00)	0.00	(49,964,222.00)
12/16/25	12/16/25	Security Receipt	912797RY5	UNITED STATES TREASURY BILL	50,000,000.00	99.9300000	(49,965,000.00)	0.00	(49,965,000.00)
12/16/25	12/17/25	Security Receipt	3133ET2J5	FEDERAL FARM CREDIT BANK	5,013,000.00	99.9850000	(5,012,248.05)	(10,503.63)	(5,022,751.68)
12/22/25	12/23/25	Security Receipt	912797SE8	UNITED STATES TREASURY BILL	50,000,000.00	99.8638889	(49,931,944.45)	0.00	(49,931,944.45)
12/22/25	12/23/25	Security Receipt	912797SF5	UNITED STATES TREASURY BILL	50,000,000.00	99.7958333	(49,897,916.67)	0.00	(49,897,916.67)
12/22/25	12/23/25	Security Receipt	912797SG3	UNITED STATES TREASURY BILL	50,000,000.00	99.7262222	(49,863,111.11)	0.00	(49,863,111.11)

020130 1006808 0014 2C027 UN#4160424-00003965 74887-0010 27584 01/05/26 P

KERN HEALTH SYSTEMS
Account Number: [redacted]

Statement Ending: December 31, 2025

Daily Account Activity (Continued)

Your investment transactions during this statement period.

Transaction Activity *USD*

Transaction / Trade Date	Settlement / Effective Date	Activity	Security ID	Description	Par / Quantity	Price	Principal Amount	Income Amount	Debit / Credit Amount
12/22/25	12/23/25	Security Receipt	912797SH1	UNITED STATES TREASURY BILL	50,000,000.00	99.6597222	(49,829,861.11)	0.00	(49,829,861.11)

Income / Payment Activity *USD*

12/09/25	12/09/25	Matured	912797RW9	UNITED STATES TREASURY BILL			30,000,000.00		30,000,000.00
12/09/25	12/09/25	Matured	912797RW9	UNITED STATES TREASURY BILL	(30,000,000.00)				
12/16/25	12/16/25	Matured	3130B6RM0	FEDERAL HOME LOAN BANK			3,150,000.00		3,150,000.00
12/16/25	12/16/25	Matured	3130B6RM0	FEDERAL HOME LOAN BANK	(3,150,000.00)				
12/16/25	12/16/25	Interest	3130B6RM0	FEDERAL HOME LOAN BANK				70,875.00	70,875.00
12/23/25	12/23/25	Matured	313313QW1	FED FARM CRD DISCOUNT NT			50,000,000.00		50,000,000.00
12/23/25	12/23/25	Matured	313313QW1	FED FARM CRD DISCOUNT NT	(50,000,000.00)				
12/23/25	12/23/25	Matured	912797RY5	UNITED STATES TREASURY BILL			50,000,000.00		50,000,000.00
12/23/25	12/23/25	Matured	912797RY5	UNITED STATES TREASURY BILL	(50,000,000.00)				
12/26/25	12/26/25	Matured	3130B0N47	FEDERAL HOME LOAN BANK			5,000,000.00		5,000,000.00
12/26/25	12/26/25	Matured	3130B0N47	FEDERAL HOME LOAN BANK	(5,000,000.00)				
12/26/25	12/26/25	Interest	3130B0N47	FEDERAL HOME LOAN BANK				62,500.00	62,500.00
12/26/25	12/26/25	Matured	3130B7M84	FEDERAL HOME LOAN BANK			8,000,000.00		8,000,000.00
12/26/25	12/26/25	Matured	3130B7M84	FEDERAL HOME LOAN BANK	(8,000,000.00)				
12/26/25	12/26/25	Interest	3130B7M84	FEDERAL HOME LOAN BANK				107,250.00	107,250.00
12/26/25	12/26/25	Interest	3134HBU82	FREDDIE MAC				46,982.25	46,982.25

Cash Activity *USD*

Transaction / Trade Date	Settlement / Eff. Date	Activity	Description	Debit Amount / Disbursements	Credit Amount / Receipts
12/02/25	12/02/25	ACH/DDA Transaction	DESIGNATED DDA	24,000,000.00	
12/09/25	12/09/25	ACH/DDA Transaction	DESIGNATED DDA	42,000,000.00	
12/12/25	12/12/25	ACH/DDA Transaction	DESIGNATED DDA	3,300,000.00	
12/16/25	12/16/25	ACH/DDA Transaction	DESIGNATED DDA		300,000,000.00
12/22/25	12/22/25	ACH/DDA Transaction	DESIGNATED DDA	67,953.33	
12/22/25	12/22/25	ACH/DDA Transaction	DESIGNATED DDA	143.00	
12/23/25	12/23/25	ACH/DDA Transaction	DESIGNATED DDA	33,000,000.00	
12/29/25	12/29/25	ACH/DDA Transaction	DESIGNATED DDA	54,000,000.00	

Money Market Fund Activity

Morgan Stan TreasSvc 8314	**Dividend paid this period**	**7 day* simple yield**	**30 day* simple yield**
*As of December 31, 2025			
USD	353.69	3.580%	3.630%

KHS Board of Directors Meeting, February 19, 2026

KERN HEALTH SYSTEMS
Account Number: [redacted]

Statement Ending: December 31, 2025

Money Market Fund Activity (Continued)

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**67,742.64**		**67,742.64000**
12/01/25	Reinvest	210.69000			210.69	67,953.33000
12/22/25	Redemption	(67,953.33000)		(67,953.33)		0.00000
12/22/25	Dividend				143.00	0.00000
	Ending Balance		**1.0000**			**0.00000**

Goldman FS Tr Ob Ins 468
*As of December 31, 2025
USD

Dividend paid this period	7 day* simple yield	30 day* simple yield
239,591.04	3.580%	3.690%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**84,119,006.15**		**84,119,006.15000**
12/01/25	Reinvest	239,591.04000			239,591.04	84,358,597.19000
12/02/25	Redemption	(24,000,000.00000)		(24,000,000.00)		60,358,597.19000
12/08/25	Redemption	(3,012,031.25000)		(3,012,031.25)		57,346,565.94000
12/09/25	Purchase	30,000,000.00000		30,000,000.00		87,346,565.94000
12/09/25	Redemption	(42,000,000.00000)		(42,000,000.00)		45,346,565.94000
12/10/25	Redemption	(2,008,179.17000)		(2,008,179.17)		43,338,386.77000
12/12/25	Redemption	(3,300,000.00000)		(3,300,000.00)		40,038,386.77000
12/16/25	Purchase	300,000,000.00000		300,000,000.00		340,038,386.77000
12/16/25	Redemption	(96,708,347.00000)		(96,708,347.00)		243,330,039.77000
12/17/25	Redemption	(5,022,751.68000)		(5,022,751.68)		238,307,288.09000
12/23/25	Redemption	(199,522,833.34000)		(199,522,833.34)		38,784,454.75000
12/23/25	Purchase	100,000,000.00000		100,000,000.00		138,784,454.75000
12/23/25	Redemption	(33,000,000.00000)		(33,000,000.00)		105,784,454.75000
12/26/25	Purchase	13,216,732.25000		13,216,732.25		119,001,187.00000
12/29/25	Redemption	(54,000,000.00000)		(54,000,000.00)		65,001,187.00000
	Ending Balance		**1.0000**	**65,001,187.00**		**65,001,187.00000**

JPMorgan UST Plus Inst 3918
*As of December 31, 2025
USD

Dividend paid this period	7 day* simple yield	30 day* simple yield
106,604.04	3.630%	3.680%

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Beginning Balance		**1.0000**	**35,647,032.45**		**35,647,032.45000**
12/01/25	Reinvest	106,604.04000			106,604.04	35,753,636.49000

KERN HEALTH SYSTEMS
Account Number: [redacted]

Statement Ending: December 31, 2025

Money Market Fund Activity (Continued)

Transaction Date	Activity	Shares	Price	Market Value ($)	Dividend Amount	Share Balance
	Ending Balance		**1.0000**	**35,753,636.49**		**35,753,636.49000**

KHS Board of Directors Meeting, February 19, 2026

PMIA/LAIF Performance Report as of 01/21/26

Quarterly Performance Quarter Ended 12/31/25

LAIF Apportionment Rate[2]:	4.20
LAIF Earnings Ratio[2]:	0.00011512010685708
LAIF Administrative Cost[1]*:	0.27
LAIF Fair Value Factor[1]:	1.002181483
PMIA Daily[1]:	3.97
PMIA Quarter to Date[1]:	4.09
PMIA Average Life[1]:	244

PMIA Average Monthly Effective Yields[1]

December	**4.025**
November	4.096
October	4.150
September	4.212
August	4.251
July	4.258

Pooled Money Investment Account Monthly Portfolio Composition [1] 12/31/25 $162.6 billion

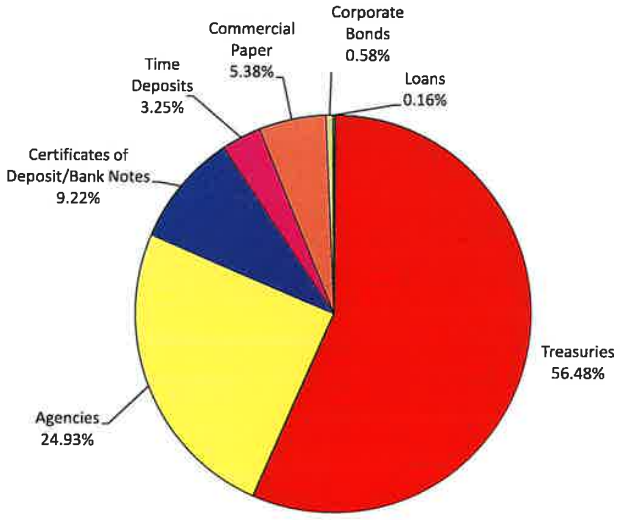


Chart does not include $910,000.00 in mortgages, which equates to 0.001%. Percentages may not total 100% due to rounding.

Daily rates are now available here. View PMIA Daily Rates

Notes: The apportionment rate includes interest earned on the CalPERS Supplemental Pension Payment pursuant to Government Code 20825 (c)(1) .

**The percentage of administrative cost equals the total administrative cost divided by the quarterly interest earnings. The law provides that administrative costs are not to exceed 5% of quarterly EARNINGS of the fund. However, if the 13-week Daily Treasury Bill Rate on the last day of the fiscal year is below 1%, then administrative costs shall not exceed 8% of quarterly EARNINGS of the fund for the subsequent fiscal year.*

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

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: 2025 Annual Review of Kern Health Systems Investment Policy

DATE: February 19, 2026

Background

The KHS Investment Portfolio follows the Board approved Investment Policy (Attachment 1). As part of their annual review, Senior Management **is not recommending any revisions to the Investment Policy at this time.** The Investment Policy stipulates the following order of investment objectives:

KHS utilizes three different investment organizations to invest the cash that is not needed for its immediate needs (Attachment 2). All investments follow the Board approved investment policy that stipulates the following order of investment objectives:

- Preservation of principal
- Liquidity
- Yield

UBS is a national brokerage firm with a Bakersfield office that administers the KHS Board approved investment policy in a segregated account. Investments are in high quality bonds with an average effective maturity of approximately 3 years. Actual performance returns have been compared to benchmark returns (Attachment 3).

The **Local Agency Investment Fund (LAIF)** is a public agency that allows smaller public agencies to pool their money and get the economies of scale that larger agencies with large portfolios receive. The California State Treasurer operates LAIF. Because it serves many agencies with short term liquidity needs, investments have an average maturity of approximately 8 months.

Wells Fargo is KHS' local bank. This is beneficial since surplus cash can be easily moved to and from the checking accounts. KHS invests directly with the Wells Fargo Securities Fixed Income division in high quality bonds and Money Market Funds.

Requested Action

Receive and file.

Attachment 1

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Investment Policy				POLICY #: 80.11-I	
DEPARTMENT: Finance					
Effective Date: 2010-10	Review/Revised Date: 02/15/2024	DMHC		PAC	
		DHCS		EQIHECOMMITTEE	
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Financial Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Controller

POLICY:

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

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

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

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

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

I. OBJECTIVES

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

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

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

II. PRUDENCE

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

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

III. ETHICS AND CONFLICTS OF INTEREST

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

IV. DELEGATION OF AUTHORITY

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

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

A. Financial Benchmarks

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

B. Safekeeping

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

C. Periodic Review of the Investment Policy

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

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

D. Chief Financial Officer's Procedures

The following procedures will be performed by the Chief Financial Officer:

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

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

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

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

E. Duties and Responsibilities of Finance Committee:

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

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

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

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

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

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

V. DEFINITIONS

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

VI. PERMITTED INVESTMENTS

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

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

Permitted investments shall include:

A. United States (U.S.) Treasuries

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

U.S. Government securities include:

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

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

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

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

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

Maximum term: Five Years

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

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

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

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

Maximum Term: Five years

C. State of California and Local Agency Obligations

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

Maximum Term: Five years

D. State and Local Agency Obligations Outside of California

Registered state warrants, treasury notes or bonds of any U.S. State and bonds, notes, warrants or other evidences of indebtedness of any local agency of the State, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's and A-1 by Standard & Poor's or equivalent or better for short-term obligations, or A by Moody's or A by Standard & Poor's or better for long-term debt. Public agency bonds issued for private purposes (industrial development bonds) are specifically excluded as allowable investments. Any single investment in a particular State is limited to 5% of portfolio at time of Purchase.

Maximum Term: Five years

Maximum of 20% of the portfolio

E. Bankers Acceptances

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

Eligible bankers' acceptances:

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

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

Maximum Term: 180 days

F. Commercial Paper

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

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

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

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

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

issuing corporation.

Maximum Term: 270 days

G. Negotiable Certificates of Deposit

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

Maximum Term: Five years

H. Repurchase Agreements

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

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

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

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

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

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

Maximum Term: One year

Reverse repurchase agreements are not allowed.

I. Corporate Debt Securities

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

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

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

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

Maximum Term: Five years

J. Money Market Funds

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

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

2. Such investment may not represent more than five percent (5%) of the money market fund's assets.

K. Mortgage or Asset-backed Securities

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

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

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

1. Are rated AAA (Code AA) by a nationally recognized rating service, and
2. Are issued by an issuer having an A or better rating by a nationally recognized rating service for its long-term debt.

Maximum Term: Five years

L. Variable and Floating Rate Securities

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

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

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

Maximum Term: Five Years

M. Local Agency Investment Fund (LAIF)

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

Maximum Term: Five Years

VII. POLICIES

A. Securities Lending

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

B. Leverage

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

C. Other Investments

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

D. Underlying Nature of Investments

Kern Health Systems and its Investment Manager shall not make investments in organizations which have a line of business that is visibly in conflict with the interests of public health (which shall be defined by the Kern Health Systems Board of Directors). Furthermore, Kern Health Systems shall not make investments in organizations with less than $100 billion of annual revenues in which it has a business relationship through contracting, purchasing, or other arrangements.

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

E. Investment Managers

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

F. Derivatives

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

G. Rating Category

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

H. Rating Downgrades

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

If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify the Chief Financial Officer or designee within two (2) business

days of the downgrade. A decision to retain a downgraded security shall be approved by the Chief Financial Officer or designee within five (5) business days of the downgrade.

I. Maximum Stated Term

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

J. Diversification Guidelines

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

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

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100%
B. Federal Agencies and U.S. Government Sponsored Enterprises	100%
C. State of California and Local Agency Obligations	100%
D. State and Local Agency Obligations Outside of California	20%
E. Bankers Acceptances	40%
F. Commercial Paper	25%
G. Negotiable Certificates of Deposit	30%
H. Repurchase Agreements	100%
I. Corporate Securities	40%
J. Money Market Funds	40%
K. Mortgage and Asset-backed Securities	20%
L. Variable and Floating Rate Securities	30%
M. Local Agency Investment Fund (LAIF)	50%

1. Issuer/Counterparty Diversification Guidelines – The percentages specified below shall be

adhered to on the basis of the entire portfolio:

a. Any one Federal Agency or Government Sponsored Enterprise 35%
b. Any one repurchase agreement counterparty name

If maturity/term is $\leq$ 7 days	50%
If maturity/term is > 7 days	25%

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

   a. Negotiable Certificates of Deposit with maturities greater than one year and less than five years shall not exceed the FDIC Insurance maximum amount at the time of purchase.
   b. Each Investment Advisor shall adhere to the diversification limits discussed in this section. If one Investment Advisor exceeds the aforementioned diversification limits, the Investment Advisor shall inform the Kern Health Systems Chief Financial Officer and second Investment Advisor (if any) by close of business on the day of the occurrence. Within the parameters authorized by the Government code, the Committee recognizes the practicalities of portfolio management, securities maturing, and changing status, and market volatility, and, as such, will consider breaches in:
      i. The context of the amount in relation to the total portfolio concentration.
      ii. Market and security specific conditions contributing to a breach in policy; and
      iii. The managers' actions to enforce the spirit of the policy and decisions made in the best interest of the portfolio.

REFERENCE:

Reference 2024-02: Updates made by the Chief Financial Officer. The policy was approved by the KHS Board of Directors on 2/15/2024. **Revision 2020-06:** Policy updated to reflect Board of Directors approved changes. **Revision 2015-04:** Item "M" Local Agency Investment Fund (LAIF) added to Section VII Permitted Investments as approved by KHS Board of Directors at April 2015 meeting. **Revision 2014-08:** Policy revised by Controller to allow for non-California municipal investments as approved by KHS Board of Directors. **Revision 2010-11:** Policy revised to conform to government code requirements. The Board of Directors approved current policy on October 14, 2010.

KERN HEALTH SYSTEMS
2025 INVESTMENT ANALYSIS

(Attachment 2)

	UBS	LAIF	Wells Fargo Securities
December 31, 2025 Balance	80,152,559	50,165,076	344,066,757
Average Monthly Balance	78,078,667	33,678,949	320,527,329
Total Dividend/Revenue (YTD)	4,985,144	1,373,264	17,458,132
Percentage	6.38%	4.08%	5.45%

Attachment 3

UBS

UBS Financial Services Inc.
9201 Camino Media, Suite 230
Bakersfield, CA 93311
Tel. 661-663-3200
Fax 855-877-7933

Ira S. Cohen
Senior Vice President – Wealth Management
Advisory & Brokerage Services
Senior Portfolio Manager
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The Kern Health Systems portfolio benchmarks are based on the indices that best match the portfolio. Although these benchmarks can change due to portfolio composition, these benchmarks align with the investment policy statement and current portfolio composition.

The benchmarks being used currently are a blended index, made up of the following:
55% Bloomberg U.S. Aggregate 1-3 Year Index and 45% Bloomberg US Corporate 1-3 Year Index

Specific make up of each index are:

Bloomberg U.S. Aggregate 1-3 Year Index - tracks investment grade, fixed-rate bonds, including treasuries, government-related, corporate and securitized issues. It only includes securities with a maturity between one and up to, but not including three years.
Bloomberg US Corporate 1-3 Year Index - measures the investment grade, fixed-rate, taxable corporate bond market with 1-3 year maturities.

UBS Financial Services Inc. is a subsidiary of UBS AG.

Summary of Performance by Account

		Performance start date	Value on 12/31/2025 ($)	% of portfolio		Performance returns (annualized > 1 year) 2025 12/31/2024 to 12/31/2025	For period of 12/31/2023 to 12/31/2025	For period of 12/31/2022 to 12/31/2025	For period of 12/31/2020 to 12/31/2025
EX XX120	BOND PORTFOLIO•PMP•Ira Cohen / Jason Cohen Fixed Income Risk profile: Conservative Return objective: Current Income	Dec 08, 2008	80,093,302.86	100.00%	Net time-weighted	6.53%	5.48%	5.29%	2.36%
Total Portfolio		**Dec 08, 2008**	**$80,093,302.86**	**100%**	**Net time-weighted**	**6.53%**	**5.48%**	**5.29%**	**2.36%**

Benchmarks - Annualized time-weighted returns	2025 12/31/2024 to 12/31/2025	For period of 12/31/2023 to 12/31/2025	For period of 12/31/2022 to 12/31/2025	For period of 12/31/2020 to 12/31/2025
Blended Index	5.59%	5.17%	5.11%	2.24%
US Treasury Bill - 3 Mos	4.29%	4.80%	4.91%	3.24%
BBG US Agg (1-3 Y)	5.39%	4.88%	4.80%	1.98%
S&P 500	17.88%	21.37%	22.98%	14.42%

Past performance does not guarantee future results and current performance may be lower/higher than past data presented.
Blended Index:06/30/2023 - Current: 45% BBG US Corp 1-3Y Incp76; 55% BBG US Agg Gvt & CR 1-3 Y+
+Additional benchmark information can be found on the benchmark composition page.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: 2025 Annual Travel Report

DATE: February 19, 2026

Background

Kern Health Systems Employee Travel and Expense Reimbursement Policy requires an annual travel report (attached) to be submitted to the KHS Board of Directors.

Discussion

KHS encourages employees to attend conferences and seminars to:

1. Obtain updated information on key issues about which they are concerned.
2. Interact with other health plans that may be experiencing similar issues and problems and solving those issues together.
3. Have issues addressed on a specific topic by recognized experts who are up to date with the latest developments in the field.
4. Evaluate the latest technologies that can potentially help make KHS more efficient.
5. Learn about facts and statistics that will help employees better understand the changing dynamics in the healthcare industry.

Examples of KHS travel include attending meetings with State regulators such as DHCS & DMHC, attending trade association conferences hosted by the Local Health Plans of California & the California Association of Health Plans, participating on vendor advisory boards and professional education and training seminars.

During 2025 $2,536 was spent on regulatory or trade association travel, $11,215 was spent on professional development, $86,159 was spent on conference attendance travel and $2,613 was spent on on-site staff meetings and vendor meetings. The total travel expenses incurred for 2025 were $102,523 which was approximately $178,000 under budget.

Requested Action

Receive and file for informational purposes only.

KERN·HEALTH SYSTEMS

2025 ANNUAL TRAVEL REPORT

	EMPLOYEE TITLE	CONFERENCE TITLE	REGULATORY OR TRADE ASSOCIATION (R), PROFESSIONAL DEVELOPMENT (P), CONFERENCES (C), OTHER (O)	IN County (IN), OUT of County (OUT), or OUT of State (OS)	LOCATION	START DATE	END DATE	TRAVEL & LODGING	MEALS	TOTAL AMOUNT SPENT
1	Chief Executive Officer	Local Health Plans of California Strategic Planning Retreat	C	OUT	San Francisco CA	1.22.25	1.24.25	451.69	184.00	635.69
2	Chief Information Officer	Central California Alliance for Health	R	OUT	Scotts Valley CA	2.06.25	2.07.25	435.49	107.50	542.99
3	Chief Information Officer	Gartner Leadership Forum	C	OS	Phoenix AZ	2.23.25	2.25.25	1,902.06	193.50	2,095.56
4	Chief Executive Officer	Association for Community Affiliated Plans Membership Council, Ops & Marketplace Meeting	C	OS	Seattle WA	3.11.25	3.13.25	1,019.61	230.00	1,249.61
5	Chief Operating Officer	Association for Community Affiliated Plans Membership Council, Ops & Marketplace Meeting	C	OS	Seattle WA	3.12.25	3.15.25	1,184.80	564.04	1,748.84
6	Chief Operating Officer	Local Health Plans of California COO Meeting	C	OUT	Rancho Cucamonga CA	3.20.25	3.21.25	471.81	129.00	600.81
7	Chief Financial Officer	CalOptima Health	C	OUT	Orange CA	3.30.25	3.31.25	197.40	107.50	304.90
8	Chief Executive Officer	CalOptima Health	C	OUT	Orange CA	3.30.25	3.31.25	373.00	172.00	545.00
9	Chief Information Officer	CalOptima Health -Local Health Plan of California Meeting	C	OUT	Orange CA	5.01.25	5.02.25	249.82	64.50	314.32
10	Chief Operating Officer	California Association of Health Plans Medi-Cal - Partnerships & Value Based Strategies for Sustainability	C	OUT	Burbank CA	7.08.25	7.08.25	30.29	21.50	51.79
11	Chief Operating Officer	California Association of Health Plans - 2025 Annual Conference	C	OUT	Palm Desert CA	9.28.25	10.01.25	1,352.23	193.50	1,545.73
12	Chief Executive Officer	Local Health Plans of California- Fall Board Meeting	C	OUT	Palm Desert CA	9.28.25	9.29.25	665.41	86.00	751.41
13	Chief Financial Officer	California Association of Health Plans - CFO Conference	C	OUT	Palm Desert CA	9.28.25	9.29.25	560.28	86.00	646.28
14	Chief Executive Officer	Association for Community Affiliated Plans - CEO Summit 2025	C	OS	Washington DC	10.06.25	10.10.25	2,907.22	276.00	3,183.22
							Executive Total	**11,801.11**	**2,415.04**	**14,216.15**

KERN·HEALTH SYSTEMS

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	EMPLOYEE TITLE	CONFERENCE TITLE	REGULATORY OR TRADE ASSOCIATION (R), PROFESSIONAL DEVELOPMENT (P), CONFERENCES (C), OTHER (O)	IN County (IN), OUT of County (OUT), or OUT of State (OS)	LOCATION	START DATE	END DATE	TRAVEL & LODGING	MEALS	TOTAL AMOUNT SPENT
15	Senior Director of Government Relations & Strategic Development	Local Health Plans of California - Strategic Planning Retreat	C	OUT	San Francisco CA	1.22.25	1.24.25	1,185.36	138.00	1,323.36
16	Senior Director of Government Relations & Strategic Development	Association for Community Affiliated Plans - Legislative Fly-In Policy Meeting	C	OS	Washington DC	2.10.25	2.13.25	1,650.36	299.00	1,949.36
17	Deputy Director of Government Relations & Strategic Development	Association for Community Affiliated Plans Legislative Fly-In Policy Meeting	C	OS	Washington DC	2.10.25	2.13.25	1,266.24	299.00	1,565.24
18	Senior Director of Government Relations & Strategic Development	Local Health Plans of California Legislative Day	C	OUT	Sacramento CA	2.25.25	2.26.25	827.96	129.00	956.96
19	Deputy Director of Government Relations & Strategic Development	Local Health Plans of California - Legislative Day	C	OUT	Sacramento CA	2.25.25	2.26.25	438.46	129.00	567.46
20	Senior Director of Government Relations & Strategic Development	California Association of Health Plans - State Program Committee Meeting	C	OUT	Burbank CA	3.25.25	3.25.25	158.00	43.00	201.00
21	Senior Director of Government Relations & Strategic Development	California Association of Health Plans - Medi-Cal Partnerships & Value Based Strategies for Sustainability	C	OUT	Burbank CA	7.08.25	7.08.25	80.00	10.75	90.75
22	Deputy Director of Government Relations & Strategic Development	California Association of Health Plans- Medi-Cal Partnerships & Value Based Strategies for Sustainability	C	OUT	Burbank CA	7.08.25	7.08.25	80.00	10.75	90.75
23	Deputy Director of Government Relations & Strategic Development	California Association of Health Plans - SPC Meeting	C	OUT	Sacramento CA	7.22.25	7.23.25	657.52	107.50	765.02
24	Senior Director of Government Relations & Strategic Development	California Association of Health Plans - 2025 Annual Conference	C	OUT	Palm Desert CA	9.28.25	10.01.25	1,377.43	172.00	1,549.43
25	Deputy Director of Government Relations & Strategic Development	California Association of Health Plans - 2025 Annual Conference	C	OUT	Palm Desert CA	9.28.25	10.01.25	1,377.43	172.00	1,549.43
26	Senior Director of Government Relations & Strategic Development	Association for Community Affiliated Plans - Legislative Fly-In Meeting	C	OS	Washington DC	11.03.25	11.06.25	1,789.79	299.00	2,088.79
27	Deputy Director of Government Relations & Strategic Development	Association for Community Affiliated Plans - Legislative Fly-In Meeting	C	OS	Washington DC	11.03.25	11.06.25	1,740.56	299.00	2,039.56
28	Senior Director of Government Relations & Strategic Development	Local Health Plans of California - Strategic Planning Retreat	C	OUT	Sacramento CA	12.01.25	12.02.25	822.36	86.00	908.36
							Government Relations & Strategic Development Total	**13,451.47**	**2,194.00**	**15,645.47**

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29	Senior System Administrator	Microsoft Community Conference	C	OS	Las Vegas NV	5.05.25	5.08.25	1,044.18	172.00	1,216.18
30	Network Administrator II	Cisco live Conference	P	OUT	San Diego CA	6.08.25	6.12.25	1,772.96	344.00	2,116.96
							MIS Total	**2,817.14**	**516.00**	**3,333.14**
31	Business Intelligence Developer IV	Microsoft Fabric Community Conference	C	OS	Las Vegas NV	3.30.25	4.02.25	1,397.47	172.00	1,569.47
32	Data Architect	Microsoft Fabric Community Conference	C	OS	Las Vegas NV	3.30.25	4.02.25	917.39	172.00	1,089.39
33	Business Intelligence Data Insights & Analytics Manager	National Committee for Quality Assurance - Health Innovation Summit	C	OUT	Chula Vista CA	10.12.25	10.15.25	670.85	193.50	864.35
34	Business Intelligence Supervisor	Johns Hopkins ACG System User Summit	C	OS	Phoenix AZ	10.26.25	10.28.25	1,391.58	236.50	1,628.08
							Business Intelligence Total	**4,377.29**	**774.00**	**5,151.29**
35	Database Administrator IV	Professinal Association for SQL Server - Data Community Summit 2025	C	OS	Seattle WA	11.18.25	11.22.25	1,299.73	345.00	1,644.73
							Enterprise Development Total	**1,299.73**	**345.00**	**1,644.73**
36	EC Configuration Analyst III	ZeOmega Connections 2025	C	OS	Dallas TX	4.28.25	4.30.25	1,847.43	240.00	2,087.43
37	Configuration Analyst IV	2025 Cognizant Health Sciences Conference	C	OS	San Antonio TX	5.18.25	5.21.25	2,266.83	185.00	2,451.83
38	Enterprise Configuration Supervisor	2025 Cognizant Health Sciences Conference	C	OS	San Antonio TX	5.18.25	5.21.25	1,611.92	185.00	1,796.92
39	Senior Director of Enterprise Process and Configuration	Local Health Plans of California - CIO Meeting	O	OUT	Scotts Valley CA	2.06.25	2.07.25	141.32	107.50	248.82
40	Senior Director of Enterprise Process and Configuration	ZeOmega Connections 2025	C	OS	Dallas TX	4.25.25	5.01.25	1,838.60	240.00	2,078.60
41	Senior Director of Enterprise Process and Configuration	Milliman Care Guidelines - Client Forum	C	OUT	San Diego CA	5.13.25	5.16.25	1,579.33	150.50	1,729.83
							Enterprise Configuration Total	**9,285.43**	**1,108.00**	**10,393.43**
42	Cyber Security Manager	Identity Event Microsoft Irvine Hub	P	OUT	Irvine CA	3.11.25	3.11.25	218.40	64.50	282.90
43	Cyber Security Manager	Cisco Tech Days	C	OUT	Clovis CA	10.23.25	10.23.25	162.40	-	162.40
							Cyber Security Total	**380.80**	**64.50**	**445.30**

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44	Director of Claims	Local Health Plans of California - Claims Director Quarterly Meeting	R	OUT	San Diego CA	5.08.25	5.10.25	753.69	129.00	882.69
45	Senior Director of Claims	Local Health Plans of California - Claims Director Quarterly Meeting	R	OUT	San Diego CA	5.08.25	5.10.25	183.44	129.00	312.44
46	Claims Administrative Manager	2025 Cognizant Health Sciences Conference	C	OS	San Antonio TX	5.17.25	5.21.25	2,883.97	203.50	3,087.47
47	Senior Director of Claims	Heath Industry Collaboration Effort - Annual Conference	C	OUT	Indian Wells CA	12.07.25	12.09.25	889.24	192.00	1,081.24
							Claims Total	**4,710.34**	**653.50**	**5,363.84**
48	Director of Utilization Management	Milliman Care Guidelines - Client Forum	C	OUT	San Diego CA	5.13.25	5.16.25	1,121.13	-	1,121.13
							Health Services - UM Total	**1,121.13**	**-**	**1,121.13**
49	NCQA Manager	Medi-Cal Managed Care Quality Improvement Plan Practices & Experiences Seminar	C	OUT	Sacramento CA	2.24.25	2.25.25	860.65	107.50	968.15
50	Medical Director QI	California Association of Health Plans - 2025 Annual Conference	C	OUT	Palm Desert CA	9.29.25	10.01.25	960.96	150.50	1,111.46
							Health Services - Quality Improvement Total	**1,821.61**	**258.00**	**2,079.61**
51	Health Education Specialist Bilingual I	University of San Francisco - Tobacco Treatment Specialist Training	P	OUT	San Francisco CA	2.10.25	2.13.25	1,380.53	345.00	1,725.53
52	Health Education Specialist Bilingual I	University of San Francisco - Tobacco Treatment Specialist Training	P	OUT	San Francisco CA	2.10.25	2.13.25	691.83	345.00	1,036.83
53	Member Health Educator Bilingual II	University of San Francisco - Tobacco Treatment Specialist Training	P	OUT	San Francisco CA	2.10.25	2.13.25	691.83	345.00	1,036.83
54	Cultural & Linguistics Specialist II Bilingual II Health Education	California Healthcare Interpreting Association 2025	C	OUT	Los Angeles CA	3.20.25	3.22.25	567.80	107.50	675.30
55	Cultural & Linguistics Specialist I Bilingual II Health Education	California Healthcare Interpreting Association 2025	C	OUT	Los Angeles CA	3.20.25	3.22.25	620.86	107.50	728.36
56	HE Manager of Community Health & Wellness	2025 California School Health Conference	C	OUT	Garden Grove CA	4.27.25	4.29.25	750.97	-	750.97
57	Senior Director of Wellness & Prevention	California Immunization Coalition Summit	C	OUT	Riverside CA	4.28.25	4.30.25	738.72	193.50	932.22
58	Senior Director of Wellness & Prevention	CalAIM Bridging Public Health & Managed Care	C	OUT	Sacramento CA	5.21.25	5.22.25	604.13	107.50	711.63
59	Health & Wellness Lifestyle Coach	Community Engagement Initiative Peer - Leading & Learning Network Meeting	C	OUT	San Diego CA	12.10.25	12.12.25	-	129.00	129.00
							Health Services - Health Ed Total	**6,046.67**	**1,680.00**	**7,726.67**

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60	Director of Population Health Management	Fellowship Classes	P	OUT	Newport CA	4.29.25	5.02.25	217.42	150.50	367.92
61	Director of Population Health Management	CalAIM Bridging Public Health & Managed Care	C	OUT	Sacramento CA	5.21.25	5.22.25	865.21	129.00	994.21
62	Director of Population Health Management	Fellowship Classes	P	OUT	Millbrae CA	9.23.25	9.26.25	416.59	193.50	610.09
63	Director of Population Health Management	Annual Palliative Care Summit	C	OUT	Costa Mesa CA	10.06.25	10.07.25	420.16	86.00	506.16
							Population Health Management Total	**1,919.38**	**559.00**	**2,478.38**
64	Director of Community & Social Services	Transitional Rent Workgroup	O	OUT	Sacramento CA	4.02.25	4.03.25	290.60	129.00	419.60
65	Director of Community & Social Services	Symposium on the Future of Behavioral Health & Housing	C	OUT	Sacramento CA	9.10.25	9.12.25	349.94	172.00	521.94
66	CSS Community and Social Services Manager	Clarity Connect 2025	C	OS	Las Vegas NV	11.17.25	11.20.25	755.27	172.00	927.27
							Community Support Services Total	**1,395.81**	**473.00**	**1,868.81**
67	Senior Director of Provider Network	Transitional Rent Workgroup	O	OUT	Sacramento CA	4.02.25	4.03.25	682.18	129.00	811.18
68	Grants & Special Programs Manager	California Association of Health Plans - Medi-Cal Partnerships & Value Based Strategies for Sustainability	C	OUT	Burbank CA	7.08.25	7.08.25	163.60	-	163.60
69	Senior Director of Provider Network	Symposium on the Future of Behavioral Health & Housing	C	OUT	Sacramento CA	9.10.25	9.12.25	846.94	172.00	1,018.94
70	Senior Director of Provider Network	Flex Pools TA All Academy Convening	C	OUT	Sacramento CA	11.04.25	11.05.25	581.25	129.00	710.25
							Provider Network Management Total	**2,273.97**	**430.00**	**2,703.97**
71	Homeless Services Manager	Clarity Connect 2025	C	OS	Las Vegas NV	11.17.25	11.20.25	861.56	193.50	1,055.06
							Homeless Management Information Systems Total	**861.56**	**193.50**	**1,055.06**
72	Director of Procurement & Facilities	ProcureCon Indirect West Conference 2025	C	OS	Las Vegas NV	3.02.25	3.05.25	1,288.11	258.00	1,546.11
							Corporate Services Total	**1,288.11**	**258.00**	**1,546.11**

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73	Compliance Manager Audits & Investigations - Compliance	Department of Justice - Managed Care Anti-Fraud Training	P	OUT	Los Angeles CA	2.04.25	2.04.25	45.25	43.00	88.25
74	Chief Compliance & Fraud Prevention Officer	Department of Justice - Annual Meeting	C	OUT	San Francisco CA	5.06.25	5.07.25	674.77	138.00	812.77
75	Chief Compliance & Fraud Prevention Officer	Gartner Enterprise Risk, Audit & Compliance Conference	C	OS	Grapevine TX	9.06.25	9.10.25	836.71	320.00	1,156.71
76	Director of Compliance & Regulatory Affairs	Annual National Health Care Anti-Fraud Association Training	C	OS	Nashville TN	11.18.25	11.21.25	583.89	-	583.89
							Compliance Total	**2,140.62**	**501.00**	**2,641.62**
77	Member Engagement Representative Lead Bilingual	Strengthening Managed Care Plans - Consumer Advisory Committee In-Person Meeting	C	OUT	Oakland CA	3.04.25	3.06.25	491.37	161.00	652.37
78	Member Engagement Manager	Strengthening Managed Care Plans - Consumer Advisory Committee In-Person Meeting	C	OUT	Oakland CA	3.04.25	3.06.25	491.37	161.00	652.37
							Member Engagement Total	**982.74**	**322.00**	**1,304.74**
79	Senior Marketing & Communications Specialist	Sprout Social for Social Media	P	OUT	Los Angeles CA	8.20.25	8.20.25	157.50	64.50	222.00
							Marketing Total	**157.50**	**64.50**	**222.00**
80	HR Program Manager	How to Communicate with Tact & Professionalism	P	OUT	San Jose CA	4.01.25	4.03.25	963.29	207.00	1,170.29
							Human Resources	**963.29**	**207.00**	**1,170.29**

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81	Director of Behavioral Health	California Association of Health Plans - Shaping the Future of Behavioral Health	C	OUT	Burbank CA	3.26.25	3.26.25	160.24	21.50	181.74
82	Director of Behavioral Health	Department of Health Care Services - Behavioral Health & Medi-Cal Managed Care Plan Summit	C	OUT	Sacramento CA	12.09.25	12.10.25	287.45	16.00	303.45
							Behavioral Health	**447.69**	**37.50**	**485.19**
83	Senior Health Equity Analyst	Strengthening Managed Care Plans - Consumer Advisory Committee In-Person Meeting	C	OUT	Oakland CA	3.04.25	3.06.25	591.37	161.00	752.37
84	Chief Health Equity Officer	Department of Health Care Services - CHEO On-Site Meeting	C	OUT	Sacramento CA	3.26.25	3.27.25	574.31	120.00	694.31
85	Chief Health Equity Officer	CHEO Meeting	C	OUT	Rancho Cucamonga CA	6.04.25	6.06.25	630.20	193.50	823.70
86	Chief Health Equity Officer	Racial Equity Commission Meeting	R	OUT	Salinas CA	6.25.25	6.26.25	660.00	138.00	798.00
87	Chief Health Equity Officer	California Association of Health Plans Seminar	C	OUT	Burbank CA	7.08.25	7.08.25	138.60	-	138.60
88	Chief Health Equity Officer	2025 Medi-Cal Managed Care Quality Conference	C	OUT	Sacramento CA	11.12.25	11.13.25	463.15	129.00	592.15
89	Health Equity Manager	National Committee for Quality Assurance - Health Innovation Summit	C	OUT	San Diego CA	10.12.25	10.15.25	1,786.60	172.00	1,958.60
							Quality and Health Equity Total	**4,844.23**	**913.50**	**5,757.73**
90	Senior Director of Delegation and Oversight	2025 Medicare, Medicaid, Duals & Commercial Markets Forum	C	OS	Baltimore MD	3.25.25	3.27.25	1,400.08	301.00	1,701.08
91	Director of Delegation & Oversight	2025 Medicare, Medicaid, Duals & Commercial Markets Forum	C	OS	Baltimore MD	3.25.25	3.27.25	1,279.88	301.00	1,580.88
92	Senior Director of Delegation and Oversight	The Rise Special Needs Plan Leadership Summit	C	OS	Boston MA	4.29.25	5.03.25	2,098.36	414.00	2,512.36
93	Director of Delegation & Oversight	The Rise Special Needs Plan Leadership Summit	C	OS	Boston MA	4.29.25	5.03.25	2,025.49	414.00	2,439.49
94	Director of Delegation & Oversight	California Association of Health Plans Medicare in CA Insights & Shifting Market Dynamics	C	OUT	Burbank CA	5.13.25	5.13.25	18.00	71.12	89.12
95	Director of Delegation & Oversight	Rise Risk Adjustment Forum 2025	C	OUT	Westlake Village CA	5.13.25	5.15.25	460.10	86.00	546.10
96	Senior Director of Delegation and Oversight	Local Health Plans of California - 3rd In Person Medicare D-SNP Collaborative Meeting	C	OUT	Sacramento CA	6.25.25	6.26.25	190.55	-	190.55
97	Director of Delegation & Oversight	Local Health Plans of California - 3rd In Person Medicare D-SNP Collaborative Meeting	C	OUT	Sacramento CA	6.25.25	6.26.25	190.55	-	190.55
							Medicare Total	**7,663.01**	**1,587.12**	**9,250.13**

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98	QP Senior Director of Contracting and Quality	Local Health Plans of California - Medi-Cal Managed Care Quality Improvement Seminar	C	OUT	Sacramento CA	2.26.25	2.27.25	1,272.39	107.50	1,379.89
99	QP MCAS/HEDIS Supervisor	Local Health Plan of California & Public Health Care System Collaboration Seminar	O	OUT	Burbank CA	5.29.25	5.29.25	37.37	21.50	58.87
100	QP Senior Director of Contracting and Quality	Department of Health Care Services - Medi-Cal Managed Care Quality Conference	C	OUT	Sacramento CA	11.12.25	11.13.25	1,098.17	129.00	1,227.17
							Quality Performance Total	**2,407.93**	**258.00**	**2,665.93**
101	Director of Development	Onsite Directors Meeting	O	IN	Bakersfield CA	7.29.25	7.29.25	216.30	37.00	253.30
102	Director of Development	Onsite Directors Meeting	O	IN	Bakersfield CA	9.03.25	9.03.25	216.30	37.00	253.30
103	Director of Development	Onsite Leadership Meeting	O	IN	Bakersfield CA	10.09.25	10.09.25	216.30	55.50	271.80
104	Senior Application Architect	Onsite Leadership Meeting	O	IN	Bakersfield CA	10.09.25	10.09.25	61.18	-	61.18
105	Director of Development	Onsite Leadership Meeting	O	IN	Bakersfield CA	11.05.25	11.05.25	216.30	18.50	234.80
106	QP Director of Quality Performance	The Growth Network Leadership Training	P	IN	Bakersfield CA	2.11.25	2.14.25	1,177.40	-	1,177.40
							Onsite Total	**2,103.78**	**148.00**	**2,251.78**

	Regulatory or Trade Associations	Professional Development	Conferences	Other - Vendor	Total	2025 Budget
Sub-Totals by Travel Type	**2,536.12**	**11,214.89**	**86,158.64**	**2,612.85**	**102,522.50**	**281,014.00**

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: 2025 Annual Report for Disposed Assets

DATE: February 19, 2026

Background

Kern Health Systems Asset and Surplus Property or Equipment Disposition Policy (Attachment 2) requires an annual report (Attachment 1) to be submitted to the KHS Finance Committee.

Discussion

KHS Department Managers are to identify property or equipment that is no longer being used in operations, indicate an item as non-repairable, obsolete, or surplus and are to submit a request for disposal of the item. It is the responsibility of the Corporate Services Department to dispose of equipment in a manner that maximizes returns while ensuring open and effective competition.

The principal methods for disposing of equipment no longer in use (in priority order) are:

1. Determine if the equipment can be used by another department at KHS.
2. Sale by competitive bid or direct negotiation.
3. Trade-in towards the purchase of a new, like item.
4. Donate surplus equipment within Kern County according to the following priority:
    a) Offer equipment to contracted providers to promote electronic business to business interactions.
    b) Offer to non-profit organizations and government agencies.
5. Sell or donate to KHS employees.
6. Items with a value of less than $50 which cannot be sold or donated will be recycled using an E-Waste vendor.

During 2025, a loss of $18,601 was recorded on the disposition of obsolete equipment.

Requested Actions

Receive and file for informational purposes only.

KERN·HEALTH SYSTEMS

Attachment 1

2025 Asset Dispositions

Date in Service	Category	Description	Book Value at Date of Disposal	Disposition Date	Reason for Disposal	Disposition Notes
12/31/2020	Equipment	25 - Latitude 5411 w/Thunderbolt Dock	943	6/30/2025	Obsolete	Disposed-Recycled
4/1/2021	Equipment	4 - Dell CTO 5420 BTX	796	12/31/2025	Obsolete	Disposed-Recycled
4/19/2018	Equipment	1 - DELL OPTIPLEX 7050 MT XCTO S# DG4CMN2	-	11/30/2025	Obsolete	Disposed-Recycled
10/10/2019	Equipment	1 - Optiplex 7070 NT XCTO S#2XLBBZ2	-	11/30/2025	Obsolete	Disposed-Recycled
10/5/2015	Equipment	1 - Optiplex 9020 Mini Tower S#BLOPW52	-	11/30/2025	Obsolete	Disposed-Recycled
4/15/2019	Equipment	1 - OPTIPLEX 7060 MINI TOWER XCTO S# 32SY2W2	-	11/30/2025	Obsolete	Disposed-Recycled
3/5/2015	Equipment	7 - Optiplex 3020 Small Form Factor CTO Serial#JRBS842	-	6/30/2025	Obsolete	Disposed-Recycled
1/1/2014	Equipment	3 - Office Desk w/Chair and Credenza	-	8/31/2025	Obsolete	Disposed-Recycled
10/16/2019	Equipment	5 - Latitude 5400 XCTO Base S#C51YZY2	-	11/30/2025	Obsolete	Disposed-Recycled
9/8/2018	Equipment	RUBERIK R6410S APPL 120TD PART#RBKR6410S01	-	11/30/2055	Obsolete	Disposed-Recycled
9/8/2018	Equipment	RUBERIK R6410S APPL 120TD PART#RBKR6410S01	-	11/30/2025	Obsolete	Disposed-Recycled
1/31/2019	Equipment	Nutanix Hardware NX-3360-G6-6138CM 4 Node	-	11/30/2025	Obsolete	Disposed-Recycled
12/31/2021	Equipment	4- PRESIDIO NETWORKED SOLUTIONS GROUP LLC	16,862 (A)	11/30/2025	Obsolete	Disposed-Recycled
12/1/2019	Equipment	HD-RMWS3-2MN-NA REMOTE Monitoring WS, NA, 2MN, P620 S#3D8KDV	-	11/30/2025	Obsolete	Disposed-Recycled
12/1/2019	Equipment	43 Iphones tag#3257-3299	-	11/30/2025	Obsolete	Disposed-Recycled
TOTAL LOSS RECOGNIZED ON DISPOSITION OF OFFICE FURNITURE & EQUIPMENT			**$ 18,601**			

Footnote:
(A) Obsolete due to IT hardware consolidation; older devices were replaced, unsupported, and had no remaining or resale value at disposal

Attachment 2

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Asset and Surplus Property or Equipment Disposition	**Policy #**	80.21-I
Policy Owner	Accounting	**Original Effective Date**	01/06/2012
Revision Effective Date	01/24/2024	**Approval Date**	
Line of Business	☒ Medi-Cal ☐ Medicare		

I. PURPOSE

To appropriately dispose of Kern Health Systems (KHS) owned tagged assets and surplus equipment that no longer has operational value.

II. POLICY

A. ASSET DISPOSITION AUTHORITY

Any Department Manager may identify KHS' property or equipment that is no longer being used in operations, whether that item is non-repairable, obsolete, or surplus, and may submit a request for disposal of that item. It is the responsibility of the Corporate Services department to dispose of surplus equipment in a manner that maximizes returns while ensuring open and effective competition. Surplus equipment and property may be disposed of via: interdepartmental transfer, sale by competitive bid or direct negotiation, trade-in on new property, donation, e-waste recycling, or scrap. Proceeds from the sale or recycling of equipment shall go into the KHS General Fund.

B. NOTIFICATION AND VERIFICATION

1. Notification to Accounting of intent to dispose of property
    a. When a Department Manager has determined an item is non-repairable, obsolete or surplus, they will notify the Accounting department to obtain the necessary specification details located on either the item's existing equipment card (in the case of a fixed asset) or purchasing documentation for non-capitalized items.
    b. Upon receipt of the information from the Accounting department, the Department Manager will complete the Intent to Dispose of Property (IDP) form and will submit the form to Corporate Services.
2. Verification of Non-Repairable, Obsolete or Surplus

    Corporate Services will make a reasonable effort to classify the item into one of the following categories: Non-Repairable, Obsolete or Surplus.

a. Non-Repairable Equipment: equipment that is broken beyond repair.
b. Obsolete Equipment: equipment that has no useful value to KHS, has little to no monetary value, but may have value to another organization.
c. Surplus Equipment: equipment in working order that is no longer being used by a department.

3. Notification to Accounting of sale, donation or recycling of property
When a fixed asset is sold, donated, or recycled, Corporate Services will notify Accounting by completing a Disposal of Fixed Asset (DFA) form. Corporate Services will attach the completed and executed IDP form to the DFA form. Accounting will review the DFA form and will record the disposition of the fixed asset on the equipment card.
4. The Controller will maintain the log of assets sold, transferred, traded, donated or scrapped.
5. On an annual basis, the Chief Financial Officer (CFO) will present a listing of disposed assets for review by the Finance Committee.
6. In the event a potential disposal item has a book or market value in excess of $5,000.00, then Board approval is required before disposition is authorized.

C. DISPOSITION METHODS

The principal methods for disposal of surplus equipment are:

1. Interdepartmental transfer: Prior to disposal, Corporate Services will make a reasonable effort to ensure the equipment cannot be used by another department. If the item can be used by another department, Corporate Services will deliver that item to the requesting department. In the case of a fixed asset, Corporate Services will indicate the new location on the IDP form and will forward the form to Accounting so that a change in location can be recorded on the equipment card. A copy of the IDP form will also be sent to the requesting Department Manager.

2. Sale by competitive bid or direct negotiation: If obsolete or surplus equipment is in working condition and has previously been determined to have a resale value greater than $100, Corporate Services will attempt to bundle like (or networked) items and sell the equipment via an online auction competitive bidding process or directly negotiated sale. It will be made clear to all prospective buyers that assets are sold as-is and at the buyer's risk. No warranty or after sale service will be offered. Delivery of the equipment will be at the buyer's expense.

3. Trade-in: If the surplus equipment has trade-in value toward the purchase of a new, like item, the item will be hauled away by the new equipment vendor. The trade-in value will be reflected on the invoice for the new equipment.

4. Donate or Sell:
   a. KHS will donate surplus equipment within Kern County according to the following priority list:
   b. KHS Provider Network Management will offer computer equipment to contracted providers to promote electronic business to
   c. business interactions.
   d. KHS will offer equipment to non-profit organizations and governmental agencies.

e. KHS will sell equipment to KHS employees.

5. Prior to the sale or donation of any computer equipment, KHS will ensure that the computers are scrubbed clean of all corporate information (all electronic files deleted and licensed software removed), and the operating system will be reloaded. Inventory and identification tags will be removed. KHS will donate computer equipment as is, with no guarantee toward the current or future working condition of the equipment. KHS will not provide technical assistance with set-up or operation of the equipment.

6. E-Waste: Electronic items that have monetary value less than $50.00, which cannot be sold or donated, will be recycled using an approved e-waste vendor selected by Corporate Services. Corporate Services will complete a DFA form and will submit to Accounting.

7. Scrap: If the surplus equipment is broken and is not e-waste, Corporate Services will make a reasonable effort to determine the cost of repairs, the extended life of the repairs, and compare the repaired value against the cost of a replacement item. If the cost to repair the item is greater than replacement or if the item cannot be repaired due to the non-availability of parts, the item will be marked as scrap. Scrap equipment will be physically disposed of following current city and county dump site requirements.

III. DEFINITIONS

TERMS	DEFINITIONS
Asset	Any tangible property owned by KHS, either with or without value, excluding real property.
Disposal/Disposition	The sale, replacement, transfer, scrap, discard, recycling or other means of disposing of assets.
E Waste	Electronic items to be recycled such as computers, monitors, phones.
Fixed Asset	Classification of an item determined at the time of purchase to meet the capitalization requirements established by policy 80.11, Budget Guidelines.
Item	Any piece of property or equipment.
Obsolete	Significant decline in the competitiveness, usefulness, or value of an item or property whether due to alternatives that perform better, are cheaper, or both; or due to changes in user preference or requirements. For the purposes of this policy, obsolete will mean little to no monetary value.
Salvage Value	The estimated residual value of a depreciable asset (fixed asset) at the end of its economic or useful life.
Surplus Equipment	Excess, obsolete, salvageable or non-salvageable assets which are sold, replaced through the budget process, transferred, scrapped, discarded or otherwise removed from service by any other means of disposal.

Useful Life	The number of years an asset is determined to last at the time of purchase, to which a matching depreciation period is assigned.

IV. ATTACHMENTS

Attachment A: Intent to Dispose of KHS Property
Attachment B: Disposal of Fixed Asset(s)

V. REFERENCES

Reference Type	Specific Reference
Other	N/A

VI. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revisions	01/24/2024	Revisions made by Accounting Manager to include Provider Network Management to Section 4.0, Donate or Sell. Updates also made to Attachments A & B were also made.	Maria Gonzalez
Effective	01/06/2012	Developed by KHS' Chief Financial Officer to appropriately dispose of KHS owned assets and surplus equipment that no longer have an operational value.	Robert Landis

VII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Board of Directors (BOD)		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Financial Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 80.21-I, Asset and Surplus Property or Equipment Disposition

Reason for revision: Revisions made by Accounting Manager to include Provider Network Management to Section 4.0, Donate or Sell. Updates also made to Attachments A & B were also made.

Director Approval		
Title	**Signature**	**Date Approved**
Veronica Barker Controller	Veronica Barker	1/26/2024
Andrea Hylton Director of Procurement and Facilities		1/26/2024

Date posted to public drive: _____

Date posted to website ("P" policies only) : _____

KERN HEALTH SYSTEMS

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

Intent to Dispose of Property, Plant & Equipment

Department:	
Contact Person:	**Phone:**

QTY	Serial number	Description	KHS Tag #

Status of Item: ☐ Non-Repairable ☐ Obsolete ☐ Surplus

Comments:

Verification of Item Status: _____

New Location of Surplus Equipment: _____

Provider Network Management_____

Cc: Accounting, Provider Network Management, Corporate Service, Department Manager

80.21-I, Attachment A, Intent to Dispose of Property Plant & Equipment

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd
Bakersfield, CA 93308
661-664-5000

Disposal of Fixed Asset

Department:	
Contact Person:	**Phone:**

QTY	Serial number	Description	KHS Tag #

Disposition Notes: (method and details of disposal: donate, trade-in, sell, E-waste, scrap)

CHAIN OF CUSTODY

MIS (computer equip only): _____ **Date:** _____ **Time:** _____

Relinquished: _____ **Date:** _____ **Time:** _____

Received: _____ **Date:** _____ **Time:** _____

cc: Accounting, Relinquishing Department and Corporate Services (Original stays with accounting)

80.21-I, Attach B, Disposal of Fixed Asset

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Contract Extension with SAI360 for the Policy Management Platform and the Regulatory Compliance Manager

DATE: February 19, 2026

Background

Kern Health Systems (KHS) currently relies on SAI360 to support several core compliance functions, including policy version control, document management, regulatory tracking, and internal notifications. Prior to implementing SAI360, these activities were managed manually using spreadsheets and email communications, creating challenges in accuracy, timeliness, and reporting.

With expanded lines of business, and heightened regulatory requirements, KHS required a modernized digital workflow solution to ensure consistent, auditable, and scalable compliance operations. KHS initially entered into a two-year contract with SAI360 in March 2024. Since implementation, SAI360 has served as the system of record for compliance policies and regulatory guidance and has also been expanded to support National Committee for Quality Assurance (NCQA) accreditation tracking and monitoring, and Data governance workflows integrated within the same platform.

Discussion

The SAI360 platform includes two modules under the current agreement: Policy Manager and Regulatory Compliance Manager. Additionally, KHS purchased the Whistleblower and Case Management module under a separate agreement to support digital reporting and tracking of fraud, privacy concerns, ethics issues, and other regulatory requirements. Both agreements include access to SAI360's support portal and technical resources for system implementation, configuration, and user training. The modular nature of SAI360 enables KHS to expand platform capabilities over time, ensuring adaptability to evolving compliance, program integrity, and regulatory needs.

Financial Impact

Cost to increase the existing not-to-exceed amount by $142,122 in budgeted expenses.

Requested Action

Approve; Authorize the CEO to sign and amend the existing contract, with legal approval, with SAI360 for the Platform including the Policy Manager and the Regulatory Compliance Manager for a two (2) year term increasing the not-to-exceed amount by $142,122 from $201,270 to $343,392 from March 28, 2026 through March 27, 2028.

Docusign Envelope ID: CD8F2AE5-85D0-481a-a502-E175A04FE002

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name:	Compliance	Department Head:	Deborah Murr
Vendor Name:	SAI360	Contact Name & Email Address:	Martha McLain, Martha.McLain@sai360.com

Description of Contract	
Type of Agreement: Continuation of agreement ☐ New agreement ☐ Amendment No. ☐ Memorandum of Understanding ("MOU")	Background: Kern Health Systems (KHS) currently relies on SAI360 to support several core compliance functions, including policy version control, document management, regulatory tracking, and internal notifications. Prior to implementing SAI360, these activities were managed manually using spreadsheets and email communications, creating challenges in accuracy, timeliness, and reporting. With expanded lines of business, and heightened regulatory requirements, KHS required a modernized digital workflow solution to ensure consistent, auditable, and scalable compliance operations. KHS initially entered into a two-year contract with SAI360 in March 2024. Since implementation, SAI360 has served as the system of record for compliance policies and regulatory guidance and has also been expanded to support National Committee for Quality Assurance (NCQA) accreditation tracking and monitoring, and Data governance workflows integrated within the same platform.
	Brief Explanation of Services to be Provided: The SAI360 platform includes two modules under the current agreement: Policy Manager and Regulatory Compliance Manager. Additionally, KHS purchased the Whistleblower and Case Management module under a separate agreement to support digital reporting and tracking of fraud, privacy concerns, ethics issues, and other regulatory requirements.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification (Please include information relevant to whether an RFI, RFQ, RFP, or vendor award was made and dates of same):

☒ Sole source – no competitive process can be performed. Brief reason for sole source: KHS holds an ongoing agreement with SAI360.

☐ Board of Directors Approval Required

☐ Regulatory Approval Required
☐ Retroactive Agreement

Exhibits Required:

☒ HIPAA Business Associate Agreement ("BAA")
☐ DMHC Administrative Services Requirements
☐ Vendor Data Transfer Checklist
☐ Insurance Exhibit
☐ Medi-Cal Requirements

Other Exhibits required:

Fiscal Impact		
KHS Governing Board previously approved this expense in KHS' FY 2026 Administrative Budget	☐ No	☒ Yes
Will this require additional funds?	☒ No	☐ Yes
Capital project	☒ No	☐ Yes

Project Type:

Budget Cost Center: 360 GL# 5407

Maximum Cost of Agreement not to exceed: $142,122 for two years (Y1: $63,344 | Y2: $67,778)

An additional $5,000 for year one and $6,000 for year two was included for the Whistleblower and Case Management Add-on

Note: Aggregate $343,392 with the existing MSA in place

Contract Terms and Conditions

Effective date: 3/28/26 Termination date: 3/27/28

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: CD8F2AE5-85D0-481a-8502-E175A04FE002

Approvals	
Contract Owner: Signed by: Deborah Murr F00A348898D04C7... Department Head or Contract Owner Date: 2/3/2026	**Approved as to Form:** Signed by: Ann StoryGarza E325942D8E45475... KHS Legal Counsel Date: 2/2/2026
Compliance DMHC/DHCS Review: DocuSigned by: Deborah Murr BD08CF3F87CF4C4... Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs Date: 2/2/2026	**Purchasing:** Signed by: Alonso Hurtado 75A924007C46480... Director of Procurement and Business Optimization Date: 2/2/2026
Reviewed as to Budget: DocuSigned by: Robert Landis 018DB2ACA6904FF... Chief Financial Officer or Controller Date: 2/2/2026	**IT Approval:** DocuSigned by: CB0457C562F24EE... Chief Information Officer or IT Director Date: 2/2/2026
Chief Executive Officer Date	
Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.	
KHS Board Chairman Date	

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Isabel Silva, Senior Director of Wellness and Prevention

SUBJECT: Contract Extension with Coffey Communications for Member Newsletters

DATE: February 19, 2026

Background

As part of its contractual obligations with the Department of Health Care Services (DHCS), Kern Health Systems (KHS) must maintain a comprehensive health education program that provides educational interventions related to the appropriate use of health care services, risk reduction, healthy lifestyle promotion, and self-care for managing health conditions. In addition, KHS is required to ensure that all written member communications are written at or below a sixth-grade reading level and are available in alternative formats, such as large print. One of the primary strategies leveraged by KHS, as well as by other Medi-Cal managed care plans, to support member education is the development and distribution of member newsletters.

To support this effort, KHS contracts with Coffey Communications. Coffey Communications also serves as a vendor for other Medi-Cal Managed Care Health Plans and the County of Kern. Coffey provides newsletter layout and design services, access to a national library of health education content, Spanish translation services, and coordination of printing and household mail fulfillment. Each member newsletter issue is produced in English, Spanish, and large-print formats and includes approximately fourteen (14) articles covering an array of topics. These topics include, but are not limited to, health education, access to services, member rights and responsibilities, instructions on accessing interpreting services or filing a grievance, changes in benefits, and available community resources.

Discussion

KHS produces three (3) member newsletter issues annually to meet DHCS health education and communication requirements. Coffey Communications supplies the necessary design, translation, and production services that allow KHS to maintain compliant, accessible, and timely member communications in both print and digital formats. To maintain compliance with DHCS obligations and ensure members continue receiving essential health education materials in accessible formats that support informed use of services and overall member engagement. KHS is requesting approval to extend its agreement with Coffey Communications for an additional one-year term.

Financial Impact

Cost to increase the existing not-to-exceed amount by $195,000 in budgeted expenses.

Requested Action

Approve; Authorize the CEO to sign and amend the existing contract, with legal approval, with Coffey Communications for the extension of our member newsletter for a term of one (1) year increasing the current not-to-exceed amount by $195,000, from $370,000 to $565,000, from February 15, 2026 through February 14, 2027.

Docusign Envelope ID: 514A6375-CB3D-41B3-8821-10B4B64DE207

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: HE Department Head: Isabel Silva

Vendor Name: Coffey Communications, Inc. Contact Name & Email Address: Ashley Doering adoering@coffeycomm.com

Description of Contract	
Type of Agreement: ☐ New agreement ☒ Amendment No. 2 ☐ Memorandum of Understanding ("MOU")	Background: Kern Health Systems (KHS) is required by the Department of Health Care Services (DHCS) to maintain a comprehensive health education program that supports appropriate care use, risk reduction, healthy lifestyles, and self-management. KHS must also ensure all written member materials meet a sixth-grade reading level and are available in alternative formats. To meet these requirements, KHS develops and distributes member newsletters as a primary education strategy. Coffey Communications provides layout, design, translation, and fulfillment services, using their national library of health education content. Each issue includes approximately fourteen articles covering health education, access to care, member rights, grievances, benefits updates, and community resources.
	Brief Explanation of Services to be Provided: Coffey Communications will provide KHS with three (3) member newsletter issues in both print and digital formats. Member newsletters contain health, member and benefit related articles to maintain compliance with DHCS obligations and KHS policy and procedures.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification (Please include information relevant to whether an RFI, RFQ, RFP, or vendor award was made and dates of same):

☒ Sole source – no competitive process can be performed. Brief reason for sole source:

☒ Board of Directors Approval Required

☐ Regulatory Approval Required

☐ Retroactive Agreement

Exhibits Required:

☐ HIPAA Business Associate Agreement ("BAA")
☐ DMHC Administrative Services Requirements
☐ Vendor Data Transfer Checklist
☐ Insurance Exhibit
☐ Medi-Cal Requirements

Other Exhibits required:

Fiscal Impact		
KHS Governing Board previously approved this expense in KHS' FY 2026 Administrative Budget	☐ No	☒ Yes
Will this require additional funds?	☒ No	☐ Yes
Capital project	☒ No	☐ Yes

Project Type:

Budget Cost Center: 312 GL# 5645

Maximum Cost of Agreement not to exceed: $195,000 for one year

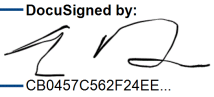
Note: This will increase the total NTE from $370k to $565k.

Contract Terms and Conditions

Effective date: 02/15/2026 Termination date: 02/14/2027

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 514A6375-CB3D-41B3-8821-10B4B64DE207

Approvals	
Contract Owner: DocuSigned by: Isabel Silva 7E3F59E57ADE40A... Department Head or Contract Owner Date: 2/3/2026	**Approved as to Form:** KHS Legal Counsel Date:
Compliance DMHC/DHCS Review: DocuSigned by: Deborah Murr BD08CF3F87CF4C4... Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs Date: 2/3/2026	**Purchasing:** Signed by: Alonso Hurtado 75A924007C46480... Director of Procurement and Business Optimization Date: 2/3/2026
Reviewed as to Budget: Chief Financial Officer or Controller Date:	**IT Approval:** DocuSigned by:  CB0457C562F24EE... Chief Information Officer or IT Director Date: 2/3/2026

Chief Executive Officer

Date

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

KHS Board Chairman

Date

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Veronica Barker, Controller

SUBJECT: Request to Extend the Contract with Health Management Associates for Actuarial Services

DATE: February 19, 2026

Background

Health Management Associates (HMA) is a nationally recognized healthcare consulting firm that provides actuarial support required for Kern Health Systems (KHS) regulatory submissions to the Department of Health Care Services (DHCS). The Board last approved the existing contract with HMA in February 2025. HMA has extensive experience working with Medi-Cal managed care plans across California and brings the expertise needed to help KHS meet state reporting requirements, ensuring accuracy and compliance of key financial and operational filings.

Discussion

HMA provides essential support for the preparation of the annual Rate Development Template (RDT), the primary data source DHCS uses to establish Medi-Cal capitation rates. The RDT is updated each year and often requires resubmission during DHCS' data refresh cycle, in addition to a written discussion guide that addresses state-identified focus areas. HMA ensures KHS' submission is complete, accurate, and reflective of the plans experience, which is critical to maintaining stable and actuarially sound capitation revenue. HMA also assists KHS throughout the year with Supplemental Data Requests (SDRs), which require detailed review of utilization, financial, and operational data. They analyze KHS' responses using internal data, past submissions, and industry benchmarks, and assess the impact of DHCS pricing workbooks tied to future rate cycles. Their guidance supports consistent, transparent reporting and informs financial and operational planning tied to upcoming rate periods.

Financial Impact

There is not a financial impact as this request is limited to extending just the contract term. There is not an increase to the previously Board approved not-to-exceed amount as expenditures remain within the existing approval authority.

Requested Action

Approve; Authorize the CEO to sign and amend the existing contract, with legal approval, with Health Management Associates for the extension of Actuarial Services for a term of one (1) year, from March 6, 2026 through March 5, 2027.

Docusign Envelope ID: 7684C0E4-F9ED-4F8C-9FED-D7164219ABED

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name:	ACCT	Department Head:	Veronica Barker
Vendor Name:	HMA	Contact Name & Email Address:	Kyle Edrington Kedrington@wakely.com

Description of Contract

Type of Agreement:

☐ New agreement

☒ Amendment No. 2

☐ Memorandum of Understanding ("MOU")

Background:

Health Management Associates (HMA) is a nationally recognized healthcare consulting firm that provides actuarial support required for Kern Health Systems (KHS) regulatory submissions to the Department of Health Care Services (DHCS). The Board last approved the existing contract with HMA in February 2025. HMA has extensive experience working with Medi-Cal managed care plans across California and brings the expertise needed to help KHS meet state reporting requirements, ensuring accuracy and compliance of key financial and operational filings.

Brief Explanation of Services to be Provided:

HMA will provide KHS with Actuarial Services. These services will consist of RDT and discussion guide, Rate Analysis, SDRs, and other actuarial analysis.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification (Please include information relevant to whether an RFI, RFQ, RFP, or vendor award was made and dates of same):

☒ Sole source – no competitive process can be performed. Brief reason for sole source:

KHS will continue with HMA to provide actuarial services due to their extensive knowledge and experience with our plan and other CA managed Care Plans. KHS leverages its use of actuarial services between two industry leaders.

☒ Board of Directors Approval Required

☐ Regulatory Approval Required

☐ Retroactive Agreement

Exhibits Required:

☐ HIPAA Business Associate Agreement ("BAA")
☐ DMHC Administrative Services Requirements
☐ Vendor Data Transfer Checklist
☐ Insurance Exhibit
☐ Medi-Cal Requirements

Other Exhibits required:

Fiscal Impact

KHS Governing Board previously approved this expense in KHS' FY 2026 Administrative Budget ☐ No ☒ Yes

Will this require additional funds? ☒ No ☐ Yes

Capital project ☒ No ☐ Yes

Project Type:

Budget Cost Center: 210 GL# 5470

Maximum Cost of Agreement not to exceed: $398,000 in total aggregate costs approved by the KHS Board in Feb 2025.

Note: Current NTE cost approved by Board in Feb 2025 is $398k. This agreement extends the agreement term and will not have any financial increase to the $398k NTE. Total contract spend against NTE is $173k with a remaining NTE balance of $225k.

Contract Terms and Conditions

Effective date: 03/06/2026 Termination date: 03/05/2027

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 7684C0E4-F9ED-4F8C-9FED-D7164219ABED

Approvals	
Contract Owner: DocuSigned by: Veronica Barker 1088C33433C1403... Department Head or Contract Owner Date: 2/3/2026	**Approved as to Form:** KHS Legal Counsel Date:
Compliance DMHC/DHCS Review: DocuSigned by: Deborah Murr BD08CF3F87CF4C4... Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs Date: 2/3/2026	**Purchasing:** Signed by: Alonso Hurtado 75A924007C46480... Director of Procurement and Business Optimization Date: 2/3/2026
Reviewed as to Budget: Chief Financial Officer or Controller Date:	**IT Approval:** DocuSigned by: CB0457C562F24EE... Chief Information Officer or IT Director Date: 2/3/2026

Chief Executive Officer

Date

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

KHS Board Chairman

Date

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Cesar Delgado, Chief Information Officer

SUBJECT: Request to Increase the Not-to-Exceed amount with DST Health Solutions, LLC for the John Hopkins ACG Predictive Modeling Tool

DATE: February 19, 2026

Background

Kern Health Systems (KHS) selected DST Health Solutions, LLC in 2017 to provide the Johns Hopkins ACG Predictive Modeling tool following a competitive procurement process. The tool supports KHS' population health, risk stratification, utilization forecasting, and care-management operations. It remains embedded across multiple internal systems and programs, including member stratification, provider dashboards, and population analytics. The contract was renewed in January 2024 for a three-year term through December 31, 2026, which included continued licensing for the core ACG model and the GeoHealth module.

Discussion

Under the current agreement, DST calculates annual licensing and support fees based on the number of Covered Lives reported by KHS at the start of each contract year. The growth of KHS in years one (1) and two (2) of the current 2024-2026 term exceeded the levels originally projected. This growth directly impacts the annual license fee because Covered Lives drive the ACG Module pricing structure. This membership-based adjustment is consistent with the pricing methodology established in the Agreement and is necessary to maintain access to the full ACG system and GeoHealth capabilities. The requested increase to the not-to-exceed amount ensures KHS remains compliant with the contract terms, avoids service interruption, and continues to utilize the predictive modeling functions that support risk-stratified care management and operational planning.

Financial Impact

Cost to increase the existing not-to-exceed amount by $35,525 in budgeted expenses.

Requested Action

Approve; Authorize the CEO to sign and amend the existing contract, with legal approval, with DST Health Solutions, LLC for the John Hopkins ACG Predictive Modeling Tool to increase the current not-to-exceed amount by $35,525 from $1,226,457 to $1,261,982 for the remaining term of the contract through December 31, 2026.

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: MIS

Department Head: Cesar Delgado

Vendor Name: DST Health Solutions, LLC

Contact Name & Email Address: Alison Schult
aschult@dsthealthsolutions.com

Description of Contract	
Type of Agreement: ☐ New agreement ☐ Amendment No. ☐ Memorandum of Understanding ("MOU") ☒ Other: Continuation of agreement	Background: Kern Health Systems (KHS) is dedicated to establishing a cost-effective, integrated managed healthcare system, emphasizing the importance of staying within budget guidelines set by state capitation rates. Since 2017, KHS has been leveraging a predictive modeling tool, which plays a critical role in risk stratification across its entire membership. This tool facilitates early identification and predictive analytics, enabling the implementation of targeted intervention programs and contributing to cost reductions in managing complex member cases. With the evolving landscape of regulatory expectations for health plans, including the need to improve clinical quality and address health disparities, KHS recognizes the growing importance of predictive analytics in healthcare. To sustain its commitment to high-quality care and cost efficiency, KHS is pursuing the continued use of its Predictive Modeling tool, enriched by the addition of the GeoHealth Module. Brief Explanation of Services to be Provided: DST currently provides KHS with licensing, software, and technical support for the John Hopkins ACG predictive modeler and GeoHealth Module for a three (3) year term. Based on increase of membership. KHS is needing to increase the currently approved NTE cost to cover the remaining term.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification (Please include information relevant to whether an RFI, RFQ, RFP, or vendor award was made and dates of same):

☒ Sole source – no competitive process can be performed. Brief reason for sole source:
KHS currently has an ongoing contract w/DST through 12/31/26.

☒ Board of Directors Approval Required
☐ Regulatory Approval Required
☐ Retroactive Agreement

Exhibits Required:

☐ HIPAA Business Associate Agreement ("BAA")
☐ DMHC Administrative Services Requirements
☐ Vendor Data Transfer Checklist
☐ Insurance Exhibit
☐ Medi-Cal Requirements

Other Exhibits required:

Fiscal Impact		
KHS Governing Board previously approved this expense in KHS' FY 2026 Administrative Budget	☐ No	☒ Yes
Will this require additional funds?	☒ No	☐ Yes
Capital project	☒ No	☐ Yes

Project Type:

Budget Cost Center: 221 GL# 5406

Maximum Cost of Agreement not to exceed: $636,575 for three-year term

Note:
In December 2023, KHS BOD approved a NTE of $601,050 for the current term of three years for a total aggregate of $1,226,457. Due to an increase in membership over the years, KHS needs to increase the current NTE by an additional $35,525 increasing the total aggregate to $1,261,982.

Contract Terms and Conditions

Effective date: 1/1/2024 Termination date: 12/31/2026

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 9E5E337B-EFBF-468D-986D-BA89ED91DCE7

Approvals	
Contract Owner: DocuSigned by: CB0457C562F24EE... Department Head or Contract Owner Date: 2/3/2026	**Approved as to Form:** Signed by: Ann StoryGarza E325942D8E45475... KHS Legal Counsel Date: 2/3/2026
Compliance DMHC/DHCS Review: DocuSigned by: Deborah Murr BD08CF3F87CF4C4... Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs Date: 2/3/2026	**Purchasing:** Signed by: Alonso Hurtado 75A924007C46480... Director of Procurement and Business Optimization Date: 2/3/2026
Reviewed as to Budget: DocuSigned by: Robert Landis 018DB2ACA6904FF... Chief Financial Officer or Controller Date: 2/3/2026	**IT Approval:** DocuSigned by: CB0457C562F24EE... Chief Information Officer or IT Director Date: 2/3/2026
_____ Chief Executive Officer _____ Date	
Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.	
_____ KHS Board Chairman _____ Date	

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Christine Pence, Senior Director of Health Services

SUBJECT: Request to Increase the Not-To-Exceed and Contract Extension with Anthony Dike, M.D. for Physician Review Services

DATE: February 19, 2026

Background

Kern Health Systems (KHS) relies on a Physician Reviewer to perform critical Utilization Management (UM) functions that require licensed clinical review and oversight. Under state, federal, and accreditation standards, certain authorization determinations, specifically those involving modification or denial based on medical necessity, that cannot be completed by UM nurses or referral specialists and must be reviewed by a physician. The Physician Reviewer provides this level of clinical review by applying KHS' approved criteria hierarchy, including Medi-Cal and MCG guidelines, to ensure authorization decisions are accurate, consistent, and compliant with regulatory requirements.

Discussion

KHS has an ongoing operational need for physician-level review to support timely referral processing while ensuring adherence to required turnaround time standards and maintaining the integrity of its medical necessity review workflows. To maintain continuity of services and clinical consistency within the UM program, KHS would like to continue with Anthony Dike, M.D. as a Physician Reviewer. Continuation of this agreement is necessary to ensure KHS maintains regulatory compliance, supports timely referral processing, and upholds quality standards within the UM department. KHS is requesting approval to increase the current not-to-exceed amount to cover projected expenses through the term of the current contract.

Financial Impact

Cost to increase the existing not-to-exceed amount by $314,000 in budgeted expenses.

Requested Action

Approve; Authorize the CEO to sign and amend the existing contract, with legal approval, with Anthony Dike, M.D. for Physician Review services to increase the not-to-exceed amount by $314,000 from $199,000 to $513,000, which includes $74,000 to increase the not-to-exceed under the current term through April 17, 2026 and $240,000 for the contract extension from April 18, 2026 through April 17, 2027.

Docusign Envelope ID: 24F7CF75-5E26-4579-BCCE-D821C0AD60AB

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name:	UM	Department Head:	Christine Pence
Vendor Name:	Anthony C. Dike, M.D.	Contact Name & Email Address:	Anthony C. Dike, M.D. acdike@hotmail.com

Description of Contract

Type of Agreement:

☐ New agreement

☒ Amendment No. 1

☐ Memorandum of Understanding ("MOU")

Background:

Kern Health Systems (KHS) relies on a Physician Reviewer to perform critical Utilization Management (UM) functions that require licensed clinical oversight. Under state, federal, and accreditation standards, certain authorization determinations, specifically those involving modification or denial based on medical necessity, that cannot be completed by UM nurses or referral specialists and must be reviewed by a physician. The Physician Reviewer provides this level of clinical review by applying KHS's approved criteria hierarchy, including MCG and nationally recognized guidelines, to ensure authorization decisions are accurate, consistent, and compliant with regulatory requirements. KHS has an ongoing operational need for physician-level review to support timely referral processing, meet required turnaround times, and uphold the integrity of its medical necessity review workflows in accordance with regulatory requirements.

Brief Explanation of Services to be Provided:

Anthony C. Dike, M.D., will provide physician review of authorization requests to support timely referral processing.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification (Please include information relevant to whether an RFI, RFQ, RFP, or vendor award was made and dates of same):

☒ Sole source – no competitive process can be performed. Brief reason for sole source:

☒ Board of Directors Approval Required
☒ Regulatory Approval Required
☐ Retroactive Agreement

Exhibits Required:

☐ HIPAA Business Associate Agreement ("BAA")
☐ DMHC Administrative Services Requirements
☐ Vendor Data Transfer Checklist
☐ Insurance Exhibit
☐ Medi-Cal Requirements

Other Exhibits required:

Fiscal Impact		
KHS Governing Board previously approved this expense in KHS' FY 2026 Administrative Budget	☐ No	☒ Yes
Will this require additional funds?	☒ No	☐ Yes
Capital project	☒ No	☐ Yes

Project Type:

Budget Cost Center: 310 GL# 5645

Maximum Cost of Agreement not to exceed: $240,000 for one year

Note:

Contract Terms and Conditions

Effective date: 04/18/2026 Termination date: 04/17/2027

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 24F7CF75-5E26-4579-BCCE-D821C0AD60AB

Approvals	
Contract Owner: Signed by: Christine Pence 2F9D6624757043F... Department Head or Contract Owner Date: 2/3/2026	**Approved as to Form:** KHS Legal Counsel Date:
Compliance DMHC/DHCS Review: DocuSigned by: Deborah Murr BD08CF3F87CF4C4... Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs Date: 2/3/2026	**Purchasing:** Signed by: Alonso Hurtado 75A924007C46480... Director of Procurement and Business Optimization Date: 2/3/2026
Reviewed as to Budget: Chief Financial Officer or Controller Date:	**IT Approval:** DocuSigned by: CB0457C562F24EE... Chief Information Officer or IT Director Date: 2/3/2026

_____
Chief Executive Officer

_____
Date

Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.

_____
KHS Board Chairman

_____
Date

KERN HEALTH SYSTEMS

AGREEMENT AT A GLANCE

Department Name: UM

Department Head: Christine Pence

Vendor Name: Anthony C. Dike, M.D.

Contact Name & Email Address: Anthony C. Dike, M.D. acdike@hotmail.com

Description of Contract	
Type of Agreement: ☐ New agreement ☒ Amendment No. 1 ☐ Memorandum of Understanding ("MOU")	Background: Kern Health Systems (KHS) relies on a Physician Reviewer to perform critical Utilization Management (UM) functions that require licensed clinical oversight. Under state, federal, and accreditation standards, certain authorization determinations, specifically those involving modification or denial based on medical necessity, that cannot be completed by UM nurses or referral specialists and must be reviewed by a physician. The Physician Reviewer provides this level of clinical review by applying KHS's approved criteria hierarchy, including MCG and nationally recognized guidelines, to ensure authorization decisions are accurate, consistent, and compliant with regulatory requirements. KHS has an ongoing operational need for physician-level review to support timely referral processing, meet required turnaround times, and uphold the integrity of its medical necessity review workflows in accordance with regulatory requirements.
	Brief Explanation of Services to be Provided: Anthony C. Dike, M.D., will provide physician review of authorization requests to support timely referral processing.

☐ Summary of Quotes and/or Bids attached. *Pursuant to KHS Policy #8.11-I, KHS will secure competitive quotes and bids to obtain the maximum value from the expenditures. Electronic (e-mail/fax) solicitation may be used for purchases of up to One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00) but must be documented on the RFQ form (Attachment A). Actual bid, sole or single source justification and/or cost price analysis documents are required for purchases over One Hundred Thousand Dollars or more if not budgeted ($100,000.00) and Two Hundred Thousand Dollars or more if budgeted ($200,000.00). Request for Proposal (RFP) shall be used to solicit bids for professional services over Two Hundred Thousand Dollars ($200,000). Lowest bid price not accepted must be fully explained and justified in writing. All bids will be treated as a not to exceed amount with "change orders" used to track any changes.)*

Brief vendor selection justification (Please include information relevant to whether an RFI, RFQ, RFP, or vendor award was made and dates of same):

☒ Sole source – no competitive process can be performed. Brief reason for sole source:

Docusign Envelope ID: 24F7CF75-5E26-4579-BCCE-D821C0AD60AB

☒ Board of Directors Approval Required
☒ Regulatory Approval Required
☐ Retroactive Agreement

Exhibits Required:

☐ HIPAA Business Associate Agreement ("BAA")
☐ DMHC Administrative Services Requirements
☐ Vendor Data Transfer Checklist
☐ Insurance Exhibit
☐ Medi-Cal Requirements

Other Exhibits required:

Fiscal Impact		
KHS Governing Board previously approved this expense in KHS' FY 2026 Administrative Budget	☐ No	☒ Yes
Will this require additional funds?	☒ No	☐ Yes
Capital project	☒ No	☐ Yes

Project Type:

Budget Cost Center: 310 GL# 5645

Maximum Cost of Agreement not to exceed: An additional $74,000 for the remainder of the term

Note: This cost is in addition to the approved NTE of $199k, for a new NTE of $273k for the current term.

Contract Terms and Conditions

Effective date: 04/18/2025 Termination date: 04/17/2026

Explain extension provisions, termination conditions and required notice:

Approvals	
Contract Owner: Signed by: Christine Pence 2F9D6624757043F... Department Head or Contract Owner Date: 2/3/2026	**Approved as to Form:** KHS Legal Counsel Date:
Compliance DMHC/DHCS Review: DocuSigned by: Deborah Murr BD08CF3F87CF4C4... Chief Compliance and Fraud Prevention Officer or Director of Compliance and Regulatory Affairs Date: 2/3/2026	**Purchasing:** Signed by: Alonso Hurtado 75A924007C46480... Director of Procurement and Business Optimization Date: 2/3/2026
Reviewed as to Budget: Chief Financial Officer or Controller Date:	**IT Approval:** DocuSigned by: CB0457C562F24EE... Chief Information Officer or IT Director Date: 2/3/2026
Chief Executive Officer Date	
Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.	
KHS Board Chairman Date	

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
February 19, 2026

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 02/04/2026 (12)				
Universal Healthcare IPA, Inc.	Hospitalist & TOC DSNP Only	2120 Truxtun Ave Bakersfield CA	**Medicare LOB Only**	**Retro-Eff 1/1/2026**
Cyti Health PC	Mental Health	400 California Ave B Ste 9 Bakersfield CA		**Retro-Eff 2/1/2026**
Antelope Hospice Corporation dba: Alden Hospice	Hospice	1061 W Avenue M14 D Palmdale CA		**3/1/2026**
Divine Birthing Services LLC	Doula	43824 20th Street West #1716 Lancaster CA		**3/1/2026**
Ekjyot S. Gill, MD	Ophthalmology	1739 W Ave J Lancaster CA		**3/1/2026**
Joint and Bone Institute of California	Orthopedic Surgery	432 Lexington St. Suite C Delano CA 5300 Lennox Avenue Ste. 104 Bakersfield CA	Existing Prov: K. Srivastava MD	**3/1/2026**
Leonard S. Kurian MD, A Medical Corporation	OB/GYN	1331 West Ave J Ste 102 Lancaster CA	Existing Prov: L. Kurian MD	**3/1/2026**
Mamababy Doula Services	Doula	2701 Bomark Ct Apt B Bakersfield CA		**3/1/2026**
Pacific Care Group LLC	Home Health	15300 Ventura Blvd Ste 305 Sherman Oaks CA		**3/1/2026**
Thrive Together ABA	ABA Services	4900 California 2nd Floor Bakersfield CA		**3/1/2026**
Veracyte Labs SD Corporation	Laboratory	6925 Lusk Blvd Ste 200 San Diego CA		**3/1/2026**
THC Orange County LLC TIN: 330629983	Acute Hospital	Kindred Hospital - Brea Kindred Hospital - San Gabriel Kindred Hospital - Santa Ana Kindred Hospital - San Francisco	**All Kindred Hospitals are under one contract but have various TINs and own NPI Numbers	**3/1/2026**
KND Development 54 LLC TIN: 260717650	Acute Hospital	Kindred Hospital - Riverside	**Kindred	**3/1/2026**
KND Development 55 LLC TIN: 260717700	Acute Hospital	Kindred Hospital - Rancho	**Kindred	**3/1/2026**
KND Real Estate 40 LLC TIN: 262166651	Acute Hospital	Kindred Hospital - Paramount	**Kindred	**3/1/2026**

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
February 19, 2026

Legal Name (6) DBA	Specialty	Address	Comments	Contract Effective Date
Dream Big Children's Center Inc	ABA Provider	4900 California Avenue Tower B 2nd Floor Bakersfield CA	No BCBA Providers	12/27/2025
Evan Dimmitt	Physical Med/Rehab	5001 Commerce Drive Bakersfield CA	Moved out of State	12/31/2025
Hans C. Yu, DO	OB/GYN	9508 Stockdale Hwy Ste. 110 Bakersfield CA	MBC License Suspension	1/2/2026
Tandem Diabetes Care, Inc.	DME	11705 Roselle Street San Diego CA	Site Closed	1/6/2026
Biological Laboratory, Inc.	Laboratory	2828 H Street Ste. E Bakersfield CA	Site Closed	1/19/2026
InspireMe Counseling and Wellness Center	Mental Health	1701 Westwind Drive Ste. 106 Bakersfield CA	Change of Ownership	1/31/2026

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Martha Tasinga, Chief Medical Officer

SUBJECT: Revised Policy and Procedure – QP 23.05-P Credentialing Program, 23.09-P Urgent Care, and 23.14-P CLIA Requirements

DATE: February 19, 2026

Background

02/24/2026 PAC reviewed and approved the red-lined revisions to Quality Performance Policy and Procedures:

- **23.05-P_Credentialing Program**
  - Annual review and revisions due to new and revised NCQA Standards that became effective 7/1/2025
  - Added and expanded Credentialing Definitions;
  - Restructured scope of providers credentialed to better identify scope during audits
  - Add areas of providers who do not require credentialing;
  - Added new NCQA requirements for CMO responsibilities; patient insurance coverage to be added to non-discriminatory; added CAQH application and required 120-day completion; added requirements for impairment, insurance and race; added verification sources new requirements and site reviews for primary care; documenting credentialing criteria and process per new NCQA requirements for files that meet and do not meet criteria; revised provisional credentialing per standards; removed language not currently being done by Credentialing Staff related to contracts; changed notifications from 60-days to 30-days new NCQA requirement; LocumTenens revised based on new NCQA requirements; added recredentialing extensions permitted by NCQA; Provider Termination and Reinstatement language per NCQA; Updated all P&P References to new numbers;
  - Additionally, the Credentialing Program Policy required complete restructure to flow according to process, standards and ease of navigation.
- **23.09-P_Urgent Care Center**
  - Renumbering changed from 4.31-P PNM to 23.09-P Quality Performance
  - Annual review and revisions: Adding definitions UC, ED and ACLS; updated policy numbers for P&Ps referenced in the policy that have changed.
- **23.14-P_CLIA Certificate Requirements**
  - Renumbering changed from 4.47-P PNM to 23.09-P Quality Performance
  - Annual review and minor revision adding CLIA Definition

Summary of revisions outlined below:

Policy Section	Policy Changes
P&P QP_23.05-P_Credentialing Program Revised	Annual Review with revisions including: o Annual review and revisions due to new and revised NCQA Standards that became effective 7/1/2025 o Added and expanded Credentialing Definitions; o Restructured scope of providers credentialed to better identify scope during audits o Add areas of providers who do not require credentialing; o Added Section C – new NCQA requirement for CMO responsibilities; Section D-added new NCQA for patient insurance coverage to be added to non-discriminatory; Section F added CAQH application and required 120-day completion; o Section F #1 Attestation added new NCQA requirements for impairment, insurance and race; o Section F #2 added verification sources new requirements and site reviews for primary care; o New Section F #3 documenting credentialing criteria and process per new NCQA requirements for files that meet and do not meet criteria; revised provisional credentialing per standards; o Section F #7, removed language not currently being done by Credentialing Staff related to contracts; o Section F #8 & #10 changed notifications from 60-days to 30-days new NCQA requirement; Section F #10 Locum Tenens revised based on new NCQA requirements; o Section H – added recredentialing extensions permitted by NCQA; o Section I New Provider Termination and Reinstatement language per NCQA; o Updated all P&P References to new numbers; o Additionally, the Credentialing Program Policy required complete restructure to flow according to process, standards and ease of navigation. o NCQA made significant updates in 2025 and mandatory requirements/language to be added to specific Credentialing Standards for: CR1-Credentialing Policies changes to Locum Tenen requirements, Factor 3-4 Decision making criteria and process, Factor 5 Managing Files that meet and do not meet criteria, Factor 7 Nondiscriminatory credentialing and recredentialing, Factor 9 Notification of decision changed from 60-days to 30-days, Factor 13 Appropriate documentation, CR3-Credentialing Verifications: Factor 1, licensure, Factor 4 Board certification time limits changed to 120-calendar days, Factor 5 Work History 180-day time limit, Factor 6 Malpractice history changed to 120-day time limit, Element C, Factor 6 Race Ethinicity and language • Revised Attachment A Credentialing Criteria for Practitioners and Behavioral Health Providers • Removed Attachment B for Facility / Organizational Providers due to new policy created specifically for HDO Credentialing.
P&P QP_23.09-P_Urgent Care Center Revised	Annual Review with revisions including: • Reformatted to KHS New Policy Template & Renumbered from 4.31-P to 23.09-P • Minor revisions adding definitions for UC, Emergency Dept & ACLS P&P referenced within this policy were also updated with

Policy Section	Policy Changes
	renumbering as appropriate.
P&P QP_23.14-P_CLIA Certification Requirements Revised	Annual Review with revisions including: • Reformatted to KHS New Policy Template and renumbered from 4.47-P to 23.09-P • Annual Review with minor edit adding CLIA Definition

Requested Action

- Approve revisions to policy and procedure: QP New Monitoring Provider Exclusions for Medicare
    - 23.05-P Credentialing Program with Attachments A-C - Revised
    - 23.09-P Urgent Care Center-Revised
    - 23.14-P CLIA Certification-Revised

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Credentialing Program	**Policy #**	23.05-P
Policy Owner	Contracting/Quality Performance	**Original Effective Date**	01/1997
Revision Effective Date	~~10/3/24~~ 2/1/2026	**Approval Date**	**2/4/2026**
Line of Business	☒ Medi-Cal ☒ Medicare ☒ Corporate		

I. PURPOSE

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)"). Providers must also meet the basic qualifications and be contracted and credentialed with KHS in prior to providing services to KHS members.

II. POLICY

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 and in accordance with 42 CFR section 438.214 and Part 2 of the Department of Health Care Services (DHCS) APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

III. DEFINITIONS

TERMS	DEFINITIONS
ABMS	American Board of Medical Specialties (ABMS): An NCQA-approved source for verification of board certification.
AMA Profile	American Medical Association (AMA) Physician Master File: An NCQA-approved source for verification of various MD credentials, including, but not limited to medical license, DEA certificate, education and training, board certification, sanction activity.
Application	A formal request for healthcare providers (doctors, clinics, etc.) to join an insurance network (like Medicaid, Medicare, or private insurers) by submitting detailed information for verification, ensuring they meet credentialing standards, licenses, and qualifications to get paid for services.
CAQH	Council for Affordable Quality Healthcare (CAQH): CAQH is a non-profit alliance of health plans and related associations working together to achieve the shared goal streamlining the business of healthcare. CAQH is an NCQA -certified and serves as a central repository for credentialing applications that provider organizations can access.
Credentialing	The process of determining a Provider or an entity's professional or technical competence may include registration, certification, licensure, and professional association membership in order to ensure that Network Providers are properly licensed and certified as required by state and federal law.
Facility or Organizational Provider	A provider who sees KHS members only as a result of the member being directed to a hospital, freestanding facility, or other inpatient setting. Examples of this type of provider are hospitalists, pathologists, radiologists, anesthesiologists, neonatologists, and emergency room physicians. The facility is responsible for credentialing these providers.
Freestanding Facilities	A health care facility that is physically, organizationally, and financially separate from a hospital and whose primary purpose is to provide immediate or short-term medical care on an outpatient basis. Examples of this type of facility include, but are not limited to, mammography centers, urgent care centers, surgical centers, and ambulatory behavioral health care facilities. KHS assesses these facilities as Organizational Providers.
Medi-Cal Fee-For-Service Enrollment	The official process where healthcare providers apply to and are approved by California's Department of Health Care Services (DHCS) to directly serve beneficiaries of Fee-for-Service (FFS) Medi-Cal, allowing them to bill DHCS for services rendered, distinct from enrolling with Managed Care Plans (MCPs).
Medi-Cal Suspended and Ineligible List	A public database maintained by California's Department of Health Care Services (DHCS) that identifies healthcare providers (individuals and entities) barred from participating in the Medi-Cal program due to fraud, abuse, felony convictions, license loss, or federal program exclusions, protecting beneficiaries and program integrity by preventing payments to these sanctioned providers.
Medicare Preclusion List	A list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
NCQA	National Committee for Quality Assurance: A private, nonprofit organization dedicated to improving healthcare quality by accrediting health plans, and other

	healthcare entities, developing performance measures like HEDIS and providing data-driven benchmarks to help consumers and purchasers make informed decisions, ultimately aiming for better care and outcomes.
NPDB	An information clearinghouse established by Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986), to collect and release certain information related to the professional competence and conduct of physicians, dentists, and other health care providers.
OIG	Office of Inspector General (OIG): In response to legislation preventing certain individuals and businesses from participating in federally funded health care programs (e.g., Medicare), the OIG developed a program to exclude these individuals and entities and maintain a list of all currently excluded parties.
Practitioner	Independent physician and/or non-physician medical professional such as Nurse Practitioners and Physician Assistants engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Provider	A healthcare provider is a person or entity that provides medical care or treatment and can include hospitals, clinics, labs, and medical supplies.
PSV	Primary Source Verification: Refers to contacting the entity, agency, or institution that issues a provider's credential for verification of the document's authenticity. Also refers to an entity, such as a state licensing agency with legal responsibility for originating a document and ensuring the accuracy of the document's information. For some credentials, the primary source does not need to be contacted directly if the verification is available through another NCQA approved source.
Restricted Provider Database (RPD)	Refers to databases maintained by the California Department of Health Care Services (DHCS) that identify providers excluded or restricted from the Medi-Cal program due to fraud, abuse, felony convictions, or license issues, primarily the **Suspended and Ineligible Provider List (S&I List).**
SAM	System for Award Management is the official U.S. government website that serves as a central database for entities (businesses, non-profits, etc.) wanting to do business with the federal government, allowing them to register, find opportunities, and manage information for contracts, grants, and other federal awards in one free, integrated system
Social Security Death Master File	A database maintained by the Social Security Administration (SSA) containing records of deceased individuals, including their name, Social Security Number (SSN), date of birth, and date of death, used by federal, state, and private entities to prevent fraud and ensure proper benefit payments.

IV. PROCEDURES

A. SCOPE OF PROVIDERS COVERED BY CREDENTIALING

The following types of practitioners/providers to be credentialed and recredentialed under these policies through Kern Health Systems (KHS) includes, but is not limited to:

- Medical Doctors (MDs & DOs),
- Dentist who provide services under medical benefit, (e.g. Oral Surgeons, DDS, DMD)
- Doctor of Podiatric Medicine (DPMs),
- Doctor of Chiropractic (DCs),

- Nurse Practitioners
- Other non-physician medical practitioners who may be within the scope of credentialing (e.g. Certified Nurse Midwife, Licensed Midwife, Physician Assistants, Registered Dieticians, Doula

Behavioral Healthcare Practitioners:

- Psychiatrists
- Addiction Medicine Specialists
- Doctoral or Master Level Psychologists (PhD, PsyD)
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Professional clinical counselors (LPCC,)
- Board Certified Behavioral Analyst (BCBA, BCBA-D)
- Other non-medical behavioral healthcare specialist Clinical Nurse Specialist, Psychiatric Nurse Practitioners, Certified Behavioral Analyst), licensed professional counselors and other behavioral healthcare specialist who may be within the scope of credentialing.

Additionally, KHS will credential and recredential:

1. All Network Providers who have a contracted independent relationship with KHS including those who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
2. All physician executives who serve in an administrative capacity for KHS.
3. 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.
4. All providers who provide telemedicine, telehealth, tele-remote consults interact with members.
5. All non-physician practitioners who may or may not have an independent relationship with KHS, including but not limited to: Doula's, Community Health Workers (CHW), Asthma Prevention Providers (APP), Associate MFT/CSW/Psychologist, Community Based Organizational providers pursuant to vetting requirements outlined in regulatory requirements such as DHCS All Plan Letters requiring review.
6. All health delivery organizational facilities, ancillary, pharmacies and who have a contract with KHS.

B. PROVIDERS WHO DO NOT NEED TO BE CREDENTIALED

Practitioners who do not need to be credential include:

1. Providers/Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or inpatient setting.
2. Practitioners who practice exclusively in free-standing facilities (e.g. Ambulatory Surgery Centers) and provide care for health plan members only because members are directed to the facility.
3. Practitioners who do not provide care for members (e.g. board-certified consultants who may provide a professional opinion to the treating practitioner/provider)
4. Rental network practitioners who provide out-of-area care only and members are not required

or given an incentive to see care from them.

C. CREDENTIALING DEPARTMENT STAFF / PARTICIPATION OF CHIEF MEDICAL OFFICER (MEDICAL DIRECTOR OR OTHER PHYSICIAN DESIGNEE)

Under the direction of the Senior Director of Contracting and Quality Performance, and the Credentialing Manager, Credentialing Department Staff is responsible for the development, effective coordination, and maintenance of the Credentialing Program. The Credentialing Manager oversees the work of the Credentialing Department Staff, who are responsible for the day-to-day activities of the department, including initial application processing, recredentialing, practitioner updates, ongoing monitoring and audit preparation.

The KHS Chief Medical Officer (or KHS Medical Director Designee) has overall responsibility, including chairing the PAC meetings, participating in the development and review of the credentialing program, credentialing process, credentialing policy and procedures, and is designated to review and approve practitioner and provider initial and recredentialing files and reports those actions to the Board of Directors.

D. 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 patient's insurance coverage (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.

Monitoring/reporting discrimination will be conducted semi-annually (February & August) by tracking and identifying discrimination in the credentialing and recredentialing processes to assure discriminatory practices do not occur. Any Executive Officer, provider, or employee who believes or becomes aware of any discriminatory act shall promptly report any violation in person or in writing to their supervisor or directly to the KHS Credentialing Manager. The Credentialing Manager reports semi-annually to the Physician Advisory Committee the number of complaints made alleging discrimination at credentialing or recredentialing. Additionally, a detailed summary of the credentialed and recredentialed practitioners age, gender and specialty type is presented semi-annually to the Physicians Advisory Committee (report excludes organization providers).

Pursuant to DMHC APL 23-025 - Senate Bill 487 (Atkins, Ch.261, Stats. 2023) Abortion: Provider Protections Codified under Health and Safety Code, Section 1375.61, prohibits discriminating, with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would

be lawful if provided in California.

E. 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 Provider Network Management (PNM), and 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 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. Read-Only access may be granted for Provider Relations Representatives as applicable to job requirements and duties.

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. Annually, PAC members will sign confidentiality statements.

F. APPLICATION

Application for provider status is made by submitting a completed application (CAQH or CPPA) together with the applicable and required supporting forms and documents. Application forms are available through the Provider Network Management Department, Quality Performance Contracting Department and are also available electronically on the KHS Provider Portal "Become a KHS Provider". To reduce administrative burdens and improve the exchange of information, KHS is a participating organization of the Council for Affordable Quality Healthcare (CAQH). If practitioners do not participate in the CAQH Provider Data Portal, KHS will accept the newest California Participating Provider Application (CPPA).

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 regulatory approved 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 KHS Physician Advisory Committee (PAC). If the provider is notified that the application (or supporting documents) is incomplete or illegible, the provider must provide the missing information for the credentialing process to continue within 10-calendar days. The provider is responsible for providing the information to satisfy the process or request by the PAC. It is the 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. **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. Absence of illegal drug use; lack of impairment due to chemical dependency/substance abuse.
   e. Current malpractice insurance coverage.
   f. Race, Ethnicity and Language (signed by the provider, especially if declining to disclose)
   g. A current and signed attestation by the applicant attesting to the correctness, accuracy and completeness of the application.
   h. Faxed, scanned, photocopied, digital, electronic (such as Adobe, DocuSign) signatures will be acceptable on the credentialing application. Signatures stamps and themed font signatures will not be accepted.

2. **Application Review/Verification Sources ~~COMMITTEE AND BOARD REVIEW~~**

   a. Application review & verification sources

   The PAC shall serve as the Credentials Committee and shall be responsible for the review of all applications. Primary Source verification activities must be conducted for practitioner/provider credentialing and recredentialing as established in this Policy and Procedure. An applicant's completed application and all other supporting documents and forms deemed pertinent shall be reviewed by PAC. KHS Credentialing Staff utilizes the following sources to verify credentials: (i) primary source; (ii) a contracted agent of the primary source (or its website); and/or (iii) an NCQA-accredited source listed for the credential (or its website).

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

   i. The appropriate license and/or board certification or registration to practice in California. (Verification Source: applicable state licensing or certifying agency via verbal, written or internet/electronic method.)

   ii. Evidence of graduation or completion of any required education (Verification Source: American Medical Association (AMA) Masterfile, American Osteopathic Association

(AOA) Official Osteopathic Master file, American Board of Medical Specialties (ABMS) Board Certification or directly from primary source Medical, Residency, Fellowship or Professional training Program.)

iii. Proof of completion of highest level of education relevant medical residency and/or specialty training. (Verification Source: AMA Masterfile, AOA Official Osteopathic Master file, ABMS Board Certification or directly from primary source Medical, Residency, Fellowship or Professional training Program.)

iv. Proof of completion of any relevant professional training (non-physicians) (Verification Source: National Student Clearinghouse or appropriate board/registry when the board or registry performs primary source verification of education.)

v. Work history (Verification Source: Documented on application or curriculum vitae/resume in month/year format)

vi. Hospital and clinic privileges in good standing or alternate admitting arrangements (Verification Source: Verbal, written or internet/electronic verification directly with the institution, hospital letter or directory.)

vii. National Practitioner Data Bank Query Report (Practitioners: Continuous Query)

viii. History of suspension or curtailment of hospital and clinic privileges (Verification Source: National Practitioner Data Bank (NPDB)

ix. Current Drug Enforcement Administration identification number. (Verification Source: Drug Enforcement Administration (DEA) Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile, DEA or Centers for Disease Control and Prevention (CDC) Certificate or photocopy of the certificate, or visual inspection of the original DEA or CDC Certificate including DEA waivers)

x. National Provider Identifier number (Verification Source: National Plan and Provider Enumeration System (NPPES) Registry)

xi. Current malpractice or professional insurance in an adequate amount, as required for the particular provider type. (Verification Source: Copy of certificate face-sheet, Federal Tort Letter, or if the provider's malpractice insurance coverage is current and provided in the application.)

xii. History of liability claims against the provider (Verification Source: NPDB with Continuous Query)

xiii. Provider information, if any, entered in the National Practitioner Data Bank, when applicable (Verification Source: NPDB with Continuous Query)

xiv. Practitioners who will serve as PCPs will meet the Facility Site and Medical Record Keeping Practice Standards as set forth in *Policy and Procedure 23.21-P Site Review*

and Medical Record Review Policy.

xv. History of sanctions, suspension, exclusion and termination 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 Managed Care Plan (MCP's) provider network. (Verification Source:

- NPDB with Continuous Query https://www.npdb.hrsa.gov
- Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) Database https://oig.hhs.gov/exclusions
- Centers for Medicare and Medicaid Services (CMS) Medicare Opt Out Affidavit https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits
- DHCS Medi-Cal Suspended/Ineligible List https://data.chhs.ca.gov/dataset/provider-suspended-and-ineligible-list-s-i-list/resource
- DHCS Restricted Provider List (RPD) https://cadhcs.sharepoint.com/sites/ai-rp (Downloaded by Credentialing Manager)
- CMS Preclusion List https://portal.cms.gov/myportal/efm (Downloaded by Credentialing Manager)
- System for Award Management (SAM) Database https://sam.gov/search

xvi. Query the Social Security Death Master File (SSDMF) Vendor/Staff Login: streamlineverify.com

xvii. Meets the requirements for Medi-Cal Fee for Service (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 23.13-P Medi-Cal Provider Enrollment Policy. (Verification Source: California Health and Human Services (CHHS) Portal for Enrolled Medi-Cal Fee for Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion)

3. Credentialing File Review/Decision-Making Criteria and Process

The credentialing criteria is reviewed and approved by the Chief Medical Officer, medical director or equally qualified designee and the PAC on an annual basis. The Quality Performance Credentialing Department and the Chief Medical Officer, (CMO) or his/her designee assist the PAC in investigating and evaluating applications. The CMO and Quality Performance Credentialing Lead and Credentialing Manager 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 prior to providing care to members. The CMO has the authority to determine and approve credentialing or recredentialing files meeting "clean file" established criteria. A file must meet the following

criteria to be considered a "clean file":

a. All practitioner/provider applicants are required to provide a current and valid license to practice in the State of California and certify that his/her license to practice has not been revoked or suspended by any State Licensing board.
b. Maintain valid DEA Certification and/or CDS Certificate or DEA Waiver or not required if not needed for practice.
c. Minimum professional liability insurance in amounts not less than one million dollars per claim and three million dollars in the aggregate.
d. Current Medical Staff or Allied Health Practitioner appointment with a participating hospital facility with privileges commensurate with the services to be performed as a contracted provider/practitioner, if applicable.
e. Provider has no history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner/provider within the previous 5-years for initial applicants and recredentialing applicants during the previous 3-years since the last review date.
f. No 805/805.1 reports of practitioner membership or privileges denied, revoked or terminated for medical cause or reason by any health care facility, nor any State Licensing accusations, limitations, or sanctions on licensure.
g. No actions reported to the NPDB
h. No adverse events or conviction of fraud or program abuse from other regulatory, state, or federal agencies, or other third party payer i.e., OIG, NPDB, Medicare Opt-Out, Medicare Preclusion List, Medi-Cal Suspended or Ineligible list, System for Award Management.
i. Possesses or maintains American Board certification or completion of a residency-training and/or fellowship program approved by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Associate (AOA) or other accrediting body acceptable to the PAC in his/her current specialty.
j. Never been convicted of a criminal felony. Never convicted of a criminal misdemeanor relating to the practice of his/her profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter that, in the opinion of the PAC, that would adversely affect the ability of the applicant to contract with PAC.
k. Current and signed attestation confirming correctness and completeness of application.
l. For those offices requiring an office site visit, overall score of 90% or higher.
m. For recredentialing, no unresolved quality of care member complaints, utilization management or compliance issues or trends in the prior 3-years that prevents recommendation for recredentialing. For Potential Quality Improvement (PQI), provider has a 1.0 or less ratio per 1,000 member interactions in a 3-year period.
n. 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.
o. Those files determined by the CMO not meeting the above criteria or at his/her sole discretion, will require comprehensive review by the PAC.

4. Comprehensive Reviews

Credentialing files considered not clean, when one or more "clean file" criteria (as listed above Section G.) are not meet and will require comprehensive review by PAC.

The CMO or his/her designee reviews the applications, provider's explanation and prepares his/her approval or recommendations to the PAC, as follows:

a. The CMO or designee's recommendation is reviewed by the PAC which prepares its approval or recommendation, such as modification or denial.

b. If the PAC recommends the denial of the application based on:

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

ii. 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 the Board of Directors for consideration and recommendation. The Board has the authority to request additional information, interview the applicant, or implement the Provider Hearing Policy and Procedure before a final determination is submitted to the Board for final action.

5. 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.

6. Provisional Approval ~~& Clean file Approval~~

~~In the circumstance where a provider file is ready for presentation to the PAC, however there is no PAC meeting scheduled, or was cancelled due to member scheduling conflicts, including but not limited to; lack of quorum to vote on matters, prior to the next Board of Directors meeting, the CMO may recommend the applicant(s) to the Board of Directors for provisional/clean file approval. In order to be considered for provisional approval, the applicant must~~:

Provisional Credentialing may be accepted under very limited circumstances. NCQA recognizes that occasionally it is in the interest of member access to make practitioners available prior to completion of the entire credentialing process. Additionally, in circumstances where a practitioner file is ready for presentation to the PAC, however there is no PAC scheduled, or cancelled due to scheduling conflicts, the CMO may grant provisional approval under the following:

- Practitioner submitted current, signed and dated credentialing application with signed attestation (CAQH Proview authorization or CPPA newest application)

- Meets the primary source criteria in the applicable exhibit (Attachments A& B) but not limited to primary sourced:
  - Current valid license to practice (CR3.A.1)
  - Written confirmation of the past 5-years malpractice claims and/or settlements from a malpractice carrier or the results of the NPDB-HIPDB query. (CR3.A.6)
  - A current completed and signed credentialing application and signed attestation. (CR3.C.1-6)
- Meet established clean file criteria within the required time limits per policy
- Is applying to the KHS network for the first time.
- Follows the same process for presenting provisional credentialing files to the PAC or CMO as it does for the regular process.
- Does not hold practitioners in provisional status for longer than 60-calendar days.
- Provisionally credentialed practitioners are not listed in the directory.
- Provisionally credentialed practitioners do not deliver care prior to the completion of provisional credentialing and receive an official approval letter.

- . ~~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 pending or current issues, requiring comprehensive review, reported by the Quality Improvement, Utilization Management, Member Services or Compliance Departments in the interval since the applicant was last credentialed.

If provisional approval is granted by the CMO, the applicant shall be presented to the PAC at its next meeting for ratification. The CMO approval date becomes the official approval date.

7. PAC Decision Regarding Credentialing

Decisions made by the PAC are considered to be the final decision-making body for practitioners applying for credentialing or recredentialing. 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 three years. 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.

8. 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.

9. Notification of Decisions Regarding Initial Applicants

KHS will notify, in writing, initial credentialing applicants of the decision within 30-days from the date of the PAC's credentialing decision. Initial applicants should refrain from rendering treatment, care, or services until they are in receipt of the official KHS letter with effective date.

10. Notification of Adverse Decisions Regarding Recredentialing

KHS will notify, in writing, recredentialing applicants of any adverse recredentialing decisions, including denial of recredentialing, within 30-days from the date of the PAC's credentialing decision.

11. Locum Tenens

KHS providers may utilize Locum Tenens if an existing contracted provider is unavailable to see KHS members.

- Provisional credentialing is required if the covering practitioner works less than sixty-(60)-calendar days.
- Full Credentialing is required if the practitioner works sixty (60)-calendar days or more.

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. 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.
c. 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 the provider to serve as a Locum Tenens depending on the

nature of the malpractice actions.

d. If the request is received after services are rendered, KHS will only retroactively pay for services rendered within the prior fourteen (14)-days of receipt of the request. Claims for services outside that timeframe will be denied.
e. In any of the situations described, the Locum Tenens provider must receive written approval from KHS prior to rendering services to KHS members, if payment is to be made.

12. 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 completion of a fellowship program, if applicable, 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 list provider specialties in member materials and practitioner directories that are consistent with the information obtained during the credentialing process including education/training verified through primary source, board certification specialties recognized according to ABMS/AOA, or as verified on other professional license certificate.

13. Appropriate Documentation information and activities in credentialing files

KHS maintains safeguards regarding the information used in the initial credentialing and recredentialing process against inappropriate modifications and updates in the credentialing files. KHS documents verification in the credentialing files using the following methods:

a. Credentialing documents are signed or initialed and dated by the credentialing staff who verified the information (electronic signature or initials with date/time stamp of the person who verified the information); and/or
b. A checklist included for each verification:
    i. The source used
    ii. The date of verification and/or
    iii. Checklist with a single signature and date for all verification that has a statement/attestation confirming the signatory verified all the information on that date signature or initials with date/time stamp of the person who verified the information.

14. 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:

a. Right to review credentials information: The provider may request 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 agencies, and/or board certification, but does not extend to review of information from peer reference recommendations, hospital privileges verifications or other information protected by law from disclosure including peer review protected information. Providers may submit their request for review to their Provider Relations Representative via written request, certified mail. The Credentialing Manager or Coordinator will coordinate a time and date for such access during regular business hours and in the presence of a credentialing staff personnel, KHS Chief Medical Officer or KHS Executive Officer within 72-hours of request. The provider is not permitted to remove, destroy, or photocopy documentation from the credentials file except what was originally provided by the provider upon application.

b. **Right to correct erroneous/inaccurate information:** The provider may correct erroneous or inaccurate information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application in the event that credentialing information obtained from primary sources varies substantially from that provided by a provider. The provider will have the opportunity to correct information in the application which is inconsistent with the information received via primary source verification process. The Credentialing Coordinator will notify the provider within fourteen (14) days via email, letter or fax of the discrepancy and will include the items found to be inconsistent. Such notice will not contain protected peer review information or copies of the NPDB Summary. The provider shall respond within 48-hours of the plan's notification or within 24-hours of provider's credentialing file review, in writing via email, letter or fax, regarding the inconsistent information on the application and return a formal response to the Credentialing Staff, PR Representative, or KHS Chief Medical Officer (CMO), within fourteen (14) days. The Credentialing Staff will reverify the primary source information until the discrepancy is resolved. If the discrepancy is not resolved within ninety (90) days or within 180-days from attestation date, whichever is sooner, the application will be deemed incomplete and will be considered administratively withdrawn and the file closed with no further action.
c. **Right to request/receive status update on application**: The provider may request review of information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. Providers may submit their request for review to their Provider Relations Representative via email, letter, or fax. The Credentialing Manager or Coordinator will review and provide the requested information in a timely and courteous manner no more than seven 7-business days of the request.

G. 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:

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

2. Any change in the provider's state license or DEA status

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

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

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

6. 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.

7. Conviction of the provider or entry of a plea of nolo contendere to any felony.

8. Conviction of a provider or entry of a plea of nolo contendere to any misdemeanor 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.

9. 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.

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

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

12. Lost or surrendered a license, certificate, or approval to provide health care.

13. 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.

14. 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.

H. RECREDENTIALING AND COMPLIANCE WITH LAWS

Each practitioner/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. The process includes a review signed and dated application with current attestation questions relevant to all applicable areas for credentialing.

Practitioner/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.

KHS may extend a practitioner's recredentialing cycle time-frame (beyond 36-months) if the practitioner is:

1. On an active military assignment
2. On medical leave (e.g. maternity leave)
3. On sabbatical
4. KHS documents the type of leave and will recredential the practitioner within 60-calendar days of the practitioner's return to practice.

A practitioner/provider may be reviewed any time at the request of the Executive Quality Improvement Health Equity Committee (EQIHEC), the PAC, the Chief Executive Officer, the Chief Medical Officer, or the KHS 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.

I. PRACTITIONER PROVIDER TERMINATIONS AND REINSTATEMENTS

KHS has an established process for practitioner terminations and reinstatements of practitioner's network participation and membership.

1. The practitioner/provider and Provider Agreement, if applicable, shall be automatically terminated on the effective date of any written decision of the licensing board of California (or similar licensing authority) setting forth the revocation or suspension, whether temporary or permanent, of physician/non-physician medical practitioner license to practice in the State of California.

2. The practitioner/provider and Provider Agreement, if applicable, shall be automatically terminated, effective immediately, upon written notice to the practitioner/provider or non-physician medical practitioner for failure to notify KHS of any of the circumstances described in Section 3- **Credentialing File Review/Decision-Making Criteria and Process** and/or Section F. Provider Responsibility to Report Changes.

3. If a practitioner has a break in network participation more than 30-calendar days, the practitioner must submit a new application for processing. If the break in service is less than 30-calendar days, credentialing will be conducted on elements that will not be in effect or that are no longer within the verification time limits.

4. KHS has the right to invoke suspension, reduction or terminate a practitioner's network participation and membership as set forth and described in Policy and Procedure XX – Provider Disciplinary Action.

J. HEARING RIGHTS

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

K. 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.

L. ADDITIONAL INFORMATION

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.

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.[ii]

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).

3. Facility and Ancillary Providers/ Assessment of Organizational 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 Kern Family Health Care (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, including established place of business and within the established process outlined in KHS Policy & Procedure 23.13-P Medi-Cal Provider Enrollment Policy.

KHS will conduct an initial and ongoing assessment of the providers with which it contracts. The assessment of the health care delivery provider will be conducted before it contracts with a provider, and for at least every 36-months thereafter, in accordance with KHS Policy & Procedure 23.16-I "Assessment of Organizational Providers.

i. Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Effective January 1, 2024, KHS will maintain an adequate Network consisting of ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes licensed and certified by the California Department of Public Health (CDPH). To meet KHS credentialing requirements, ICF-DD Homes must submit:

1) KHS Organizational/Ancillary/Facility Application –

2) An annual ICF/DD Attestation[1] under penalty of perjury that the following credentialing requirements are satisfied:
    a) Completion of the MCP's specific Provider Training within the last two (2) years
    b) Facility Site Audit from State Agency
    c) No Change in 5% Ownership Disclosure since the last submission to MCP
    d) Possess an active CDPH License and CMS Certification
    e) In good standing as a Regional Center Vendor

3) For the initial credentialing, ICF/DD Homes must submit the below items in addition to the annual ICF/DD Attestation:
4) W-9 Request for Taxpayer Identification Number and Certification
5) MCP Ancillary Facility Network Provider Application
6) Certificates of Insurance (Professional and General Liability)
7) City or County Business License (excludes ICF/DD-H and -N homes with six or less residents)
8) 5% Ownership Disclosure

ii. For the recredentialing, ICF/DD Homes must submit the below items every 2-years:
    1) KHS Organizational/Ancillary/Facility Application –
    2) An annual ICF/DD Attestation[2] under penalty of perjury that the following credentialing requirements are satisfied:
        a) Completion of the MCP's specific Provider Training within the last two (2) years
        b) Facility Site Audit from State Agency
        c) No Change in 5% Ownership Disclosure since the last submission to MCP
        d) Possess an active CDPH License and CMS Certification
        e) In good standing as a Regional Center Vendor

For changes in between credentialing cycles, the ICF/DD Home must report that change to KHS Credentialing including any required documentation within 90-days of when the change occurred.

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, KHS Policy & Procedure 23.13-P Medi-Cal Provider Enrollment Policy and 5.15-P Member Transportation Assistance to be considered for KHS Network.

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.

6. **Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (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:

   a. Whether they wish to be designated an HIV/AIDS specialist
   b. Whether they meet the defined criteria as per California Health and Safety (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. **Mental Health and Substance use Disorder Provider Credentials (CA AB2581)**

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)]

8. Community Health Worker (CHW)

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 National Provider Identifier (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.

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.

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

M. ATTACHMENTS

Attachment A:	Provider Specific Credentialing Criteria – Practitioners & BH Practitioners
Attachment B:	Provider Specific Credentialing Criteria – QAS Practitioners
Attachment C:	Non-Licensed Other Provider Types
Attachment D:	

N. REFERENCES

Reference Type	Specific Reference
DHCS Contract (Specify Section)	DHS Contract Section 6.5.4.2
Regulatory	MMCD Policy Letter 02-03 § II
Regulatory	NCQA Credentialing Standards 2025

O. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Retired	MM-DD-YYYY		
Revised	08/2024-3/2024	**Revision 08/2024:** Effective 8/2024, the policy was transferred to the QP Department, as a result the policy was renumbered to QP 23.05-P and Signatories were updated. **Revisions 03/2024:** Page 3 – Non-Discriminatory Credentialing added DMHC APL 23-025 Section 12 Abortion-Provider Protections language prohibiting discrimination against providers disciplined in other states that interfere with person's right to receive care that is lawful in this state. Approved by DMHC on 5/15/24.	Y. Herrera Cred Mgr
Revised	2023-2024	**Revisions 02/2024:** Page 3 - changed Non-Discriminatory Credentialing report dates to February & August. **Revisions 01-2024:** Section 7.3.1 added in accordance with DHCS APL 23-023 ICF/DD Credentialing Requirements. DHCS approved 3/22/2024 for APL 23-023. **Revisions 11-2023:** Section 2.1 Recommended by NCQA Consultants to add Primary Verification Approved Sources used by Credentialing to verify each item; Section 2.4 Provider Rights: Language restructured as recommended by NCQA Consultant to match Provider Rights Addendum; Section 2.8 revised to include CR1A-	Y. Herrera Cred Mgr

		Factors 3-5 for Managing files that meet clean-file criteria and approval by CMO; **Revisions 08-2023:** Credentialing Policy Section 2.9 – Added time-limited retroactive payment of 14-days on Locum Tenens request received after services are rendered as approved by Executive Roundtable on 07/25/23. **Revision 06-2023:** NCQA CR1A-6 added Nondiscriminatory monitoring; NCQA CR1A-11 - 2.3 added process to ensure information in member materials is consistent with information obtained in credentialing; NCQA CR1B-1-3 Practitioner Rights added language regarding all practitioners rights; Section 2.5 added PAC Members will annually sign confidentiality statements; NCQA CR1A-8 Section 2.13 added Notification of adverse recred decision; NCQA CR7 added language regarding assessment of organizational providers. **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. Approved by DMHC 11/2/2023 for DMHC APL 22-031. Approved by DHCS File and use 5/26/2023 and 8/2/2023 for DHCS APL 22-029. **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**.** DHCS File and Use disposition given on 6/2/2023	
Revised	2003-2015	**Revision 2015-06:** QAS Provider requirements per DHCS 14-026; and Behavioral Health Provider requirements. **Policy version 2015-06** was submitted and approved by DHCS for 2024 OR R.0025 on 9/3/2022. Policy Version was submitted and approved by DHCS for 2024 OR R.0045 on 2/6/2023. Policy version was submitted and approved by DHCS for 2024 OR R.0101 on 1/23/2023. **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	Y. Herrera Cred Mgr

		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. **Revision 2012-10:** Language added to allow Mid-levels participate in a specialty setting 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.	
REVISED	2/4/2026	Minor edits to Purpose and Policy; Added Credentialing Definitions, structured scope of providers credentialed to better identify during audits; add areas of providers who do not require credentialing, added Section C – new NCQA requirement for CMO responsibilities; Section D- added new NCQA for patient insurance coverage to be added to non-discriminatory; Section F added CAQH application and required 120-day completion; Section F #1 Attestation added new NCQA requirements for impairment, insurance and race; Section F #2 added verification sources new requirements and site reviews for primary care; New Section F #3 documenting credentialing criteria and process per new NCQA requirements for files that meet and do not meet criteria; revised provisional credentialing per standards; Section F #7, removed language not currently being done by Credentialing Staff related to	Y. Herrera Cred Mgr

		contracts; Section F #8 & #10 changed notifications from 60-days to 30-days new NCQA requirement; Section F #10 Locum Tenens revised based on new NCQA requirements; Section H – added recredentialing extensions permitted by NCQA; Section I New Provider Termination and Reinstatement language per NCQA; updated all P&P References and new numbers; additionally, the Credentialing Program Policy required complete restructure to flow according to process, standards and navigation. NCQA made significant updates in 2025 and mandatory requirements/language to be added to specific Credentialing Standards for: CR1-Credentialing Policies changes to Locum Tenen requirements, Factor 3-4 Decision making criteria and process, Factor 5 Managing Files that meet and do not meet criteria, Factor 7 Nondiscriminatory credentialing and recredentialing, Factor 9 Notification of decision changed from 60-days to 30-days, Factor 13 Appropriate documentation, CR3-Credentialing Verifications: Factor 1, licensure, Factor 4 Board certification time limits changed to 120-calendar days, Factor 5 Work History 180-day time limit, Factor 6 Malpractice history changed to 120-day time limit, Element C, Factor 6 Race Ethinicity and language.	

P. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Physician Advisory Committee (PAC)	2/4/2026	2/4/2026
Board of Directors (BOD)	2/19/2026	2/19/2026
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Human Resources Officer		
Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 23.05-P Credentialing Program

Last approved version: 10/3/2024

Reason for revision: Minor edits to Purpose and Policy; Added Credentialing Definitions, structured scope of providers credentialed to better identify during audits; add areas of providers who do not require credentialing, added Section C – new NCQA requirement for CMO responsibilities; Section D- added new NCQA for patient insurance coverage to be added to non-discriminatory; Section F added CAQH application and required 120-day completion; Section F #1 Attestation added new NCQA requirements for impairment, insurance and race; Section F #2 added verification sources new requirements and site reviews for primary care; New Section F #3 documenting credentialing criteria and process per new NCQA requirements for files that meet and do not meet criteria; revised provisional credentialing per standards; Section F #7, removed language not currently being done by Credentialing Staff related to contracts; Section F #8 & #10 changed notifications from 60-days to 30-days new NCQA requirement; Section F #10 Locum Tenens revised based on new NCQA requirements; Section H – added recredentialing extensions permitted by NCQA; Section I New Provider Termination and Reinstatement language per NCQA; updated all P&P References and new numbers; additionally, the Credentialing Program Policy required complete restructure to flow according to process, standards and navigation. NCQA made significant updates in 2025 and mandatory requirements/language to be added to specific Credentialing Standards for: CR1-Credentialing Policies changes to Locum Tenen requirements, Factor 3-4 Decision making criteria and process, Factor 5 Managing Files that meet and do not meet criteria, Factor 7 Nondiscriminatory credentialing and recredentialing, Factor 9 Notification of decision changed from 60-days to 30-days, Factor 13 Appropriate documentation, CR3-Credentialing Verifications: Factor 1, licensure, Factor 4 Board certification time limits changed to 120-calendar days, Factor 5 Work History 180-day time limit, Factor 6 Malpractice history changed to 120-day time limit, Element C, Factor 6 Race Ethinicity and language. Restructured Attachment A to be inclusive all providers within the scope of credentialing. Revised Attachment B to outline the Qualified Autism Provider Categories. Removed Attachment C Organizational/Facility Credentialing as this is now a separate and new Policy 23.16-I Assessment of Organizational Providers. Replaced Attachment D Other Non-Licensed Providers as Attachment C.

Director Approval		
Title	**Signature**	**Date Approved**

Jake Hall, Senior Director of Contracting and Quality Performance		

Date posted to public drive: _____

Date posted to website ("P" policies only) : _____

[i] DHS Contract Section 6.5.4.2

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Application Form Form/Document which includes elements required by this Policy, completed by an applicant who is requesting network participation with KHS. ***Verification Time Limit:*** 180 calendar days based on the date signed by the applicant. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner types approved by the KHS Physician Advisory Committee	**Requirement:** Application must be signed, dated, complete, accurate and current. The application includes an attestation which includes, but is not limited to the following statements by the applicant: A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with 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. Absence of illegal drug use; lack of impairment due to chemical dependency/substance abuse. E. Current malpractice insurance coverage. F. Race, Ethnicity and Language (signed by the provider, especially if declining to disclose) G. A current and signed attestation by the applicant attesting to the correctness, accuracy and completeness of the application. **Criteria**: 1) All attestations questions answered "no" and written explanation for affirmative "yes" answers; 2) All credentials verified must be consistent with attested application; and 3) Providers can clarify discrepancies in writing or verbally. **Source**: Application – Faxed, scanned, photocopied, digital, electronic (such as Adobe, DocuSign) signatures will be acceptable on the credentialing application. Signatures stamps and themed font signatures will not be accepted. **Exceptions**: 1) Incomplete applications will be returned to the applicant with a request for the missing items and will be considered incomplete and withdrawn if no response. 2) Applications exceeding 180-days will require provider to update the information, sign and date with statement attesting the application is current, complete and accurate.	✔ Initial Credentialing ✔ Recredentialing
NPI Number ***Verification Time Limit:*** **Prior to the credentialing decision** ***Practitioner Type:*** ☒ All practitioner types / Type 1 Individual NPI	**Requirement:** A current valid NPI number. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: **1.** NPPES Registry **Exceptions**: Atypical Providers who may not require NPI Number, example Qualified Autism Service Professionals or Paraprofessionals, and Community Healthcare Workers.	✔ Initial Credentialing ✔ Recredentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ All provider types / Type 2 Organizational NPI		
California State License State Sanctions, restrictions on licensure or limitations on scope of practice ***Verification Time Limit:*** 120 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner types with professional certificate (BCBA, RD)	**Requirement:** Current and valid California Licensure. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: applicable state licensing or certifying agency (or its website). **Criteria**: All practitioner/provider applicants are required to provide a current and valid license to practice in the State of California and certify that his/her license to practice has not been revoked or suspended by any State Licensing board. **Exceptions**: PAC will review on case by case basis: 1) Providers must provide explanations in writing for any previous, current or pending state sanction, restriction on license or limitations to scope of practice.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ NPDB Continuous Query
Drug Enforcement Agency (DEA) ***Verification Time Limit:*** **Prior to the credentialing decision** ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with DEA Certificate and/or furnishing licensure	**Requirement:** Current and valid Drug Enforcement Agency (DEA) registration number as applicable. - DEA cannot be linked to another facility or institution only or reflect "exempt" or "Limited to" status. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: DEA or CDS Agency, Photocopy of the DEA Certificate, visual inspection of the original DEA or CDS Certificate, AMA Masterfile, AOA Official Osteopathic Masterfile. **Criteria**: 1) DEA Certificate must be current at all times and reflect an address in the state of California; 2) If provider does not have a DEA as a result of disciplinary action, including but not limited to, being revoked, or relinquished (voluntary or involuntary) the practitioner may not be eligible to participate in the KHS Network, PAC will review on case by case basis if alternate arrangements mets the satisfaction of this requirement; 3) If a practitioner has a pending DEA, the practitioner may complete the credentialing process if: he/she signs an attestation that the DEA application has been filed; and provides the name of another practitioner with a valid DEA certificate who will write all prescriptions until the practitioner has a valid DEA.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	4) If a practitioner will not be prescribing medications, a statement will be collected from the practitioner to this effect/reason and will be placed in the credentialing file. **Exceptions**: Tele-Remote Radiology, Pathology, CRNAs *Other practitioners who do not prescribe scheduled medications may be exempt on a case by case basis.	
Education and Training ***Verification Time Limit:*** Prior to the credentialing decision. *Note 1: Future dates of program completion do not satisfy this requirement, if not board certified.* *Note 2: Verification of fellowship does not meet the intent of verifying highest level of education and training.* ***Practitioner Type:*** ☒ MD / DO ☒ DC, DPM, DDS, DMD ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** Verification of the highest of the three levels of education and training obtained by the practitioner: 1) Graduation from Medical School 2) Residency* 3) Board Certification (except for dentist). **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: 1. Primary source directly with medical or professional school, residency and fellowship 2. State licensing agency, specialty board or registry if it performs primary source verification for which the organization confirms annually per NCQA requirements. 3. For Medical Practitioners (MDs/DOs): Medical or Professional School directly, AMA Masterfile, AOA Official Osteopathic Masterfile, ABMS Board Certification (including expired board certification) **Both residency and fellowship must be verified if fellowship is to be communicated to members and/or listed in the Provider Directory.* 4. For Chiropractors (DC), the Chiropractic College directly or from the state licensing agency 5. For Dentist (DDS/DMD) the dental school directly 6. For Podiatrist (DPM) confirmation of residency can be verified by the training program if completed, or by the podiatry medical school directly. 7. Non-Physician Practitioners and Behavioral Health Care Professionals, National Student Clearinghouse. 8. FCVS for Closed residency programs **Exceptions**: None – *KHS follows NCQA requirements who only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) , the Accreditation Council for Graduate Medical Education International, the American Osteopathic Association in the US, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Cananda.*	✔ Initial Credentialing Only or ✔ New Educ/Training ✔ New Board Certification
Practitioner Type:	***Advanced Practice Professionals (formerly Mid-Levels): PA, NP, CNM, CRNA***	✔ Initial Credentialing

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
☒ PA, NP, CNM, CRNA **Verification Time Limit:** *Prior to the credentialing decision.*	• ***Education and Training (Board Certification)*** • ***Supervising Physician Form (previously: Provider Information Letter)*** **Requirement:** Successful completion from a relevant professional school. ***Specialty Training:*** Mid-level training is variable. Not only are there differences between Nurse Practitioners and Physician Assistants, but there are significant differences between the programs themselves. In addition, some mid-levels go on to receive formal "specialty" training in areas like OB, pediatrics, surgery, orthopedics, oncology, etc. KHS requires either 6 months formal training in a sub-specialty program or one year of full-time experience in the field which credentialing is requested. ***Supervising Physician Agreement:*** Designated Physician Supervisor(s) with signed supervision agreement per group affiliation **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: 1. Professional School directly 1. State licensing agency, if it performs primary source verification of education and is confirmed annually. 2. AMA Masterfile (PA Only) 3. National Student Clearinghouse or 4. Appropriate board/registry if board performs primary source verification education is confirmed annually. **Exceptions**: None	✔ Recredentialing
Board Certification ***Verification Time Limit:*** 120 calendar days at time of the decision. ***Practitioner Type:*** ☒ MD/DO ☒ DPM ☒ NP, CNM ☒ Other practitioner and non-practitioner types with board certifying agency.	**Requirement:** Board certification if applicable; verification of education is not required if provider meets board certification as highest level of education requirements. Board certification is not required but is verified when indicated on the credentialing application or when newly reported. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: 1. The primary source (appropriate specialty board) 2. MD/DO: American Board of Medical Specialties (Certifacts), AMA Masterfile, AOA Official Osteopathic Masterfile 3. Podiatrist: American Board of Podiatric Surgery Foot & Ankle (ABPS www.abps.org) 2. For non-physician providers appropriate board/registry if indicated on the application or newly reported.	✔ Initial Credentialing ✔ Recredentialing ✔ Credential Expiration ✔ Upon New Certification

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	Criteria: 1) Board Certification (if applicable) is current, with our without Maintenance of Certification (MOC); 2) If Board Certification has expired it may be used for verification of education/training (per NCQA MD/DO/DPM Only)	
Work History ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** A minimum of five (5) years work history as a health professional through the practitioner's application or CV. If the practitioner has fewer than 5-years of work history, the time frame starts at the initial licensure date. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: 1. Documented on application or curriculum vitae/resume in month/year format, unless the practitioner has had continuous employment for 5-years or more with no gap – In this case providing the year meets the intent of this factor. **Criteria**: 1) If practitioner has practiced less than 5-years, work history begins at the time of initial licensure date. 2) If the practitioner has had continuous employment for five years or more with no gap, providing the year is sufficient. 3) If gap in employment exceeds six (6)-months, but less than 1-year, the provider clarifies the gap verbally or in writing/email. 4) If the gap in employment exceeds one (1)-year the provider must clarify in writing and the organization documents review.	✔ Initial Credentialing
Malpractice History (NPDB) **Verification Time Limit:** 120 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirements:** **Initial** - Verification of the past five (5) years of malpractice or professional liability claims history that resulted in settlement or judgment paid on behalf of the practitioner. **Recredentialing** - Verification of the past three (3) years or since last credentialing cycle. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: 1. National Practitioner Data Bank (NPDB) **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ **Ongoing -** Continuous Enrollment

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Sanction & Exclusion Information: ***Verification Time Limit:*** 120 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** Verification of State sanctions, restrictions on licensure and limitations on scope of practice. Regardless of product participation. **State Sanction, restrictions on Licensure and Limitations Required Sources:** • Appropriate State Licensing agency or certification board • NPDB **Verification of Medicare Sanctions from any of the following:** • NPDB or NPDB Continuous Query • AMA Physician Master File • SAM.Gov **Verification of Medicaid Sanctions from any of the following:** • State Medicaid Agency (Medi-Cal Suspending & Ineligible List) • NPDB or NPDB Continous Query • AMA Physician Master File • FSMB • SAM.Gov **Verification of Medicare Exclusions from any of the following:** • NPDB or NPDB Continuous Query • Medicare Exclusion Database (MED) • List of Excluded Individuals and Entities maintained by OIG **Verification of Medicaid Sanctions from any of the following:** • State Medicaid Agency (Medi-Cal Suspending & Ineligible List) • List of Excluded Individuals and Entities maintained by OIG • NPDB or NPDB Continous Query -Evidence of current enrollment in CQ -Report must be reviewed within 120-calendar days of credentialing decision **Exceptions**: None.	✔ Initial Credentialing ✔ Recredentialing ✔ Continuous Query – At least Monthly (every 30-days)

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
CMS / DHCS Requirements: OIG, SAM, MCal Suspended Ineligible, DHCS Restricted Provider List ***Verification Time Limit:*** 120 calendar days at time of the decision. ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** CMS/DHCS **CMS/DHCS Medi-Cal:** • OIG must be verified • Date of query and staff initials must be evident on checklist or OIG Page in credential file. **DHCS Medi-Cal Suspended and Ineligible List:** • Medi-Cal Suspending & Ineligible List must be verified • Date of query and staff initials must be evident on checklist or the Report Page in credential file. **CMS SAM/EPLS Query:** • SAM.Gov database must be verified • Date of query and staff initials must be evident on checklist or the Report Page in credential file. **DHCS Restricted Provider List:** • DHCS Restricted Provider List must be verified • Date of query and staff initials must be evident on checklist or the Report Page in credential file.	✔ Initial Credentialing ✔ Recredentialing ✔ Continuous Query – At least Monthly (every 30-days)
DHCS Medi-Cal Fee-For-Service Enrollment ***Practitioner Type:*** ☒ Practitioner & Provider Types as Per DHCS State Level Resource Listing who have a State Pathway for Enrollment	**Requirement:** All providers must be enrolled in the State Medi-Cal Fee-for-Service Program when there is a state level pathway as defined by the DHCS All Plan Letter 22-013 and as outlined in KHS Policy & Procedure 23.13-P "Medi-Cal Provider Enrollment Policy". **Primary Accepted Source**: 1. CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; 2. Copy of welcome/approval letter from DHCS; 3. Other health plan attestation of enrollment at KHS discretion. **Exceptions:** KHS, at it's discretion, may choose to screen and enroll at the plan level or may choose to accept another Managed Care health plan's approval when there is no state pathway.	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliations

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Hospital Clinical Privileges (CMS/DHCS/DMHC) ***Verification Time Limit:*** 180 calendar days at time of the decision. ***Practitioner Type:*** ☒ MD/DO (including Primary Care & Psychiatry) ☒ DPM ☒ CRNA ☒ NP/PA (designated: Primary Care)	**Requirement:** Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; All Plan Letter (APL) 22-013 and DMHC Tag 6/09/14) **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: 1. Application, Curriculum Vitae, Hospital Listing, Hospital Letter (website) 2. Must include include current status (e.g. unrestricted or restricted), type of admitting privileges (e.g. Active, Courtesy, temporary), and practitioner specialty. 3. Formal inpatient coverage arrangements in a written and dated letter delineating the inpatient coverage is sufficient and Contracted Ambulatory Surgery Centers may also satisfy this requirement if provider does not utilize the hospital. 4. Mid-Levels may not have privileges or coverage arrangements unless they are servicing as Primary Care coverage arrangements must be documented. 5. Behavioral Health Providers (MD/DO-Psychiatrists) are required to have hospital privileges and/or coverage arrangements present in the file. 6. Telehealth providers & Behavioral Health providers (except Psychiatry) are not required to obtain privileges and/or coverage arrangements. 7. Allied Health Providers (Chiropractic, Optometrist, Dermatology, Petc) will not have hospital privileges and documentation is not required. **Exceptions**: *Specialties deemed by KHS not requiring hospital privileges but must have not stating they do not admit as they only see patients in an outpatient setting is sufficient: Dermatology, Podiatry, Ophthalmology, Chiropractor, Psychiatry, Optometry, Physical Medicine &Rehabilitation, Out-Patient Radiology, Pain Medicine, and/or practice limited to outpatient services only, including Mid-Level Providers in a sub-specialty.	✔ Initial Credentialing ✔ Recredentialing ✔ Upon newly reported

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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APP – Advanced Practice Providers (Mid-Levels)

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
Specialty / Scope of Practice ***Practitioner Type:*** ☒ MD/DO	**Requirements:** Completion of accredited residency training or ACGME accredited fellowship in the applicable field of practice is necessary in order to be credentialed as a specialist. Specialists that want to serve as SPD member's primary care physician must have completed a residency in Internal medicine, or a residency in Pediatrics. **Criteria:** Only those specialties and sub-specialties recognized by the ABMS will be listed in the Kern Health Systems Provider Directory. Additionally, the Medical Board of California & CA Business & Professions Code Section 651 recognizes ABMS and 4-additional Boards that meet the equivalent certification requirements as with ABMS. The 4-Boards include: American Board of Facial and Reconstructive Surgery, American Board of Pain Medicine, American Board of Sleep Medicine, and American Board of Spine Surgery.	✔ Initial Credentialing ✔ Upon newly reported
Primary Care Providers ***Practitioner Type:*** ☒ MD/DO	**Requirements/Criteria:** Completion of a Family Practice, Pediatric, Internal Medicine or an Obstetrics and Gynecology residency is necessary in order to be credentialed as a PCP. **Exceptions:** Providers who do not meet the above criteria, must have practiced exclusively in the Primary Care setting for at least five (5) consecutive years to be considered a General Practitioner eligible to be a PCP and have members assigned. PCPs who were credentialed prior to 04/01/02 and who meet the above criteria will be allowed to continue as PCPs. General Practitioner must agree as part of their credentialing to provide evidence of participation in at least twelve hours a year in prior authorized primary care CME activity, upon request.	✔ Initial Credentialing
Residents (Moonlighting) ***Scope of Practice*** ***Practitioner Type:*** ☒ MD/DO	**Requirements:** A. Application Form B. Current and valid Post-Graduate California Licensure *Must apply in advanced for full California Physician & Surgeon's licensure prior to completion of residency otherwise the resident will be terminated upon expiration date of Post-Training License. C. Current and valid DEA D. Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering all of the procedures or services the provider expects to perform for KFHC E. Signed letter of permission to moonlight by Residency Program Director F. Under Existing Contracted Provider Group	

PROVIDER-SPECIFIC CREDENTIALING CRITERIA
Practitioners / Mid-Levels / Behavioral Health & Mental Health Practitioners

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

Data Element	Requirement/Criteria/Verification Source	Credentialing Instance
	Primary Source: applicable state licensing or certifying agency via verbal, written or internet/electronic method; DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile.	
Professional Liability Coverage **Verification Time Limit:** *Prior to the credentialing decision.* ***Practitioner Type:*** ☒ LIPs ☒ APP/Non-Physician Medical Practitioner ☒ Other practitioner and non-practitioner types with State Licensure or professional certification	**Requirement:** Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate, covering designated specialty or services the provider expects to perform for KFHC members. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source:** Copy of Certificate Face Sheet, Federal Tort Letter, or if the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates. **Exceptions**: None	✔ Initial Credentialing ✔ Recredentialing ✔ Changes in Group Affiliations
Facility Site Review ***Verification Time Limit:*** *Prior to the credentialing decision* ☒ PCPs ☒ OB/GYN who are SPD member's PCP ☒ Mobile Clinics	**Requirement:** Satisfactory site audit (is required for all primary care providers and OB/GYNs serving as an SPD member's PCP. It is necessary to have a minimum passing score of 80% and a completed CAP. **Primary Source/Contracted Agent of Primary Source/NCQA Accepted Source**: KHS QI Dept / FSR Database **Exceptions**: As required or determined by QP Policy and Procedure	✔ Initial Credentialing ✔ Recredentialing
Contract: Provider Service Agreement, Facility Agreement and Pharmacy Agreement ☒ All Contract Providers	**Requirement:** Partially signed contract between KHS and the provider to provide health care services to KFHC Members. Support Documents Includes: • Contract pre-review criteria inquiry form • W9 • 274 Group and Site Forms • Roster of Providers, if applicable for Hospital/Facility based providers	✔ Initial Credentialing ✔ Changes in Group Roster

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Urgent Care Center (UCC)	**Policy #**	23.09-P
Policy Owner	Contracting/Quality Performance	**Original Effective Date**	07/2000
Revision Effective Date	~~3/17/2023~~ 02/04/2026	**Approval Date**	**07/2000**
Line of Business	☒ Medi-Cal ☒ Medicare ☒ Corporate		

I. PURPOSE

Urgent Care Centers became prevalent over the years and offered patients extended hours of operation and expanded services for treating conditions typically referred by primary care physicians to emergency rooms, especially minor trauma. This approach to care brought the benefit of greater convenience, reduced waiting times for treatment, and lowered costs of care compared with traditional hospital emergency room visits. Per the American College of Emergency Physicians January 2022 policy statement, an Urgent Care Center is a walk-in clinic focused on the delivery of medical care for minor illnesses and injuries in an ambulatory medical facility outside of traditional hospital-based or free-standing Emergency Department (ED).

II. POLICY

Kern Health Systems will contract with a facility as an Urgent Care Center (UCC) only if the facility meets the requirements set forth in this policy.

III. DEFINITIONS

TERMS	DEFINITIONS
ACLS	Advanced Cardiac Life Support
Emergency Department	A hospital room or area staffed and equipped for the reception and treatment of persons requiring immediate medical care.

Urgent Care	Medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness as to require the services of an emergency department

IV. PROCEDURES

1.0 FACILITY CAPABILITIES

The minimum services available at an UCC must be:

A. Location shall be open at a minimum of twelve (12) hours per day, 8:00 am to 8:00 pm
B. Location shall be open at a minimum of five (5) days per week to include Saturday and/or Sunday
C. Availability of a physician on site during all days and hours of operation
D. Ability and equipment on site to perform plain radiographic exams such as chest x-ray, long bone films, hand and foot films, and abdominal series
E. Ability to cast closed, uncomplicated fractures
F. Availability of splints and crutches
G. Ability to suture lacerations not involving major structures or major nerves, arteries or tendons
H. Ability and equipment to diagnose and treat injuries and illnesses of the eye, such as ER fluorescein staining of the cornea, or a slit lamp which shall be optional
I. Ability and equipment to treat acute asthma attacks
J. Ability and equipment on site to perform laboratory services
K. Equipment and ability to deliver life support services such as intubation, cardiac monitoring, intravenous resuscitation, ACLS interventions, including a physician on staff with ACLS certification on site. Practitioners are required to seek certification and re-certification through programs sponsored by the American Heart Association (AHA).~~.~~ Board certified emergency room physicians are exempt from the ACLS certification requirement.
L. Comply with all state and federal handicapped accessible (basic and limited) requirements

2.0 CREDENTIALING OF FACILITIES

UCCs are credentialed and recredentialed based on the criteria listed ~~in sections 2.0 of this policy and~~ in line with policy ~~4.01~~23.05-P *Credentialing for practitioners and 23.16-I Assessment of Organizational Providers for facilities*. Recredentialing occurs every36-months.

3.1 ENROLLMENT:

KHS requires the provider group to be enrolled in the Medi-Cal Fee-For-Service Program as a "physician group" including rendering providers (non-physician medical practitioners) as defined by the DHCS All Plan Letter 22-013 and in ~~line~~ accordance with policy ~~4.43~~23.13-P *Medi-Cal Provider Enrollment Policy when there is a state pathway for enrollment*.

V. ATTACHMENTS

Attachment A:	
Attachment B:	
Attachment C:	
Attachment D:	

VI. REFERENCES

Reference Type	Specific Reference
Choose an item.	
Choose an item.	
Choose an item.	

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Retired	MM-DD-YYYY		
Revised	2017-2022	**Revision: 2022-08:** Routine review conducted by Provider Network Management Department. **2018-09:** Policy reviewed by Provider Relations Contracting Manager. Added hours of operation, language regarding UCC required to have radiographic equipment on site. Additional language added to have a physician on site during all days and hours of operation. Added handicapped accessible requirements. **2017-02:** Added days of operation. Added required to provide lab services on site	Y. Herrera Cred Mgr
Revised	2/2026	**Formerly P&P #4.31-P Changed to QP 23.09-P** Policy numbers referenced within this policy were re-numbered according to new QP Numbering. Definitions added for Urgent Care, Emergency Department and ACLS	Y.Herrera Cred Mgr
Effective			

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Physician Advisory Committee (PAC)	2/4/2026	2/4/2026
Board of Directors (BOD)	2/20/206	2/20/26
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Human Resources Officer		
Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure:

Last approved version:

Reason for revision:

Director Approval		
Title	**Signature**	**Date Approved**
Jake Hall, Senior Director of Contracting and Quality Performance		

Date posted to public drive: _____

Date posted to website ("P" policies only) : _____

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Clinical Laboratory Improvements Amendments (CLIA) Certification Requirements	**Policy #**	23.14-P
Policy Owner	Contracting/Quality Performance	**Original Effective Date**	02/2002
Revision Effective Date	04/21/2023 2/4/2026	**Approval Date**	**2/4/2026**
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

All contracted providers must have appropriate, current, unrevoked and/or unsuspended CLIA certification for each site location where testing is performed for KHS members, unless the laboratory qualifies for one of the exceptions under the CLIA Regulations. The CLIA regulations established quality standards for laboratory testing to be performed on specimens from humans, such as blood, body fluid, and tissue, for the purpose of a diagnosis, prevention, or treatment of disease, or assessment of health. All Clinical Laboratories must be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 [2].

II. POLICY

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

III. DEFINITIONS

TERMS	DEFINITIONS
CLIA	Clinical Laboratory Improvement Amendments which are federal regulations of 1988 and apply to all U.S. facilities or sites that test human specimens for health or disease assessment.

IV. PROCEDURES

1.0 PROVIDERS REQUIRED TO BE CLIA CERTIFIED

All contracted providers must have appropriate, current, unrevoked and/or unsuspended CLIA certification for each site location where testing is performed for KHS members, unless the laboratory qualifies for one of the exceptions under the CLIA Regulations. The CLIA regulations established quality standards for laboratory testing to be performed on specimens from humans, such as blood, body fluid, and tissue, for the purpose of a diagnosis, prevention, or treatment of disease, or assessment of health. All Clinical Laboratories must be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 [2].

2.0 TYPES OF CLIA CERTIFICATION AND ALLOWED PROCEDURES

The following types of CLIA certification are available:

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

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

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

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

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

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

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

2.1 Procedures Subject to CLIA

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

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

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

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

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

3.0 DOCUMENTATION AND VERIFICATION OF CLIA CERTIFICATION

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

3.1 Initial Verification & Recredentialing

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

3.2 On-going Verification

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

V. ATTACHMENTS

Attachment A:	
Attachment B:	
Attachment C:	
Attachment D:	

VI. REFERENCES

Reference Type	Specific Reference
Choose an item.	
Choose an item.	
Choose an item.	

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Retired	MM-DD-YYYY		
Revised	2014-2023	**Revision 2023-01:** Section 3 – Added CMS' CLIA Data Source Website used to verify certificates. Policy approved by PAC on 2/1/2023 and KHS BOD on 2/16/2023. [1] **Revision 2020-05:** Recommended by QI to be moved to PNM; PNM Revisions based on credentialing requirements; Policy updated to reflect current CMS/CLIA Regulations CMS.Gov. **Revision 2017-04:** Three year review requested by Compliance. **Revision 2014-10:** Policy reformatted. Policy provided to QI Supervisor for review and/or revision. [2] DHS Contract Section 3.25	PNM / Y.Herrera Cred Mgr
Revised	2/4/2026	Formerly P&P #4.47-P Moved to 23.14-P QP Numbering & Added CLIA Definition	Y.Herrera Cred Mgr
Effective			

VIII. APPROVALS

Committees | Board (if applicable)	Date Reviewed	Date Approved
Physician Advisory Committee (PAC)	2/04/2026	2/4/2026
Board of Directors (BOD)	2/20/2026	2/20/2026
Choose an item.		

Choose an item.		
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Human Resources Officer		
Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure:

Last approved version:

Reason for revision:

Director Approval		
Title	**Signature**	**Date Approved**
Jake Hall, Senior Director of Contracting and Quality Performance		

Date posted to public drive: _____

Date posted to website ("P" policies only) : _____

[2] DHS Contract Section 3.25

[2] DHS Contract Section 3.25

KERN HEALTH SYSTEMS

M E M O R A N D U M

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: November 2025 Financial Results

DATE: February 19, 2026

The November results reflect a $13.0 million Net Decrease in Net Position which is a $15.4 million unfavorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $30.1 million favorable variance primarily due to:

   A) $1.9 million unfavorable variance in Family Premium Revenue is primarily due to lower-than-expected budgeted membership.

   B) $2.1 million unfavorable variance in SPD Premium Revenues is primarily due to California becoming a Medicare Part A Buy-In State effective January 1, 2025. Qualifying Medi-Cal members, who are enrolled in Medicare Part B only, were automatically enrolled into Medicare Part A Buy-In by the Department of Health Care Services ("DHCS"). The rate received for members who have Part A **and** Part B is less than the rate for members who have Part B **only**, however, Medicare will now become primary for medical expenses associated with the members having both Part A and Part

   C) $1.0 million favorable variance in Enhanced Care Management Premiums is primarily due to receiving updated rate information from DHCS after the approval of the 2025 Budget partially offset against amounts included in 2C (2) below.

   D) $33.6 million favorable variance in Premium-Hospital Directed Payments is primarily due to receiving updated estimated rate information from DHCS on February 28, 2025 for Calendar Year 2025 offset against amounts included in 2D below.

2) Total Medical Costs reflect a $49.4 million unfavorable variance primarily due to:

   A) $2.0 million unfavorable variance in Inpatient primarily due to higher-than- expected utilization by SPD and Expansion members over the last several months.

   B) $5.0 million unfavorable variance in Outpatient Hospital due to higher-than-expected utilization and usage of chemotherapy drug medications over the last several months.

C) $7.7 million unfavorable variance in Other Medical primarily from:

1) $3.9 million unfavorable variance in Long Term Care expense primarily due to higher-than-expected utilization and facility rate increases mandated by DHCS over the last several months.

2) $3.4 million unfavorable variance in Enhanced Care Management Expense is primarily due to receiving updated rate information from DHCS after the approval of the 2025 Budget, higher than expected engaged members and utilization of program services over the last several months partially offset against amounts included in 1C above.

3) $.9 million unfavorable variance in Community Support Services expenses due to higher-than-expected usage of program services over the last several months. **Medical necessity criteria have been refined to meet the State's updated requirements. The criteria and use of a risk stratification tool have helped to identify the most appropriate members for the services. This will reduce inappropriate utilization and unnecessary costs for these services**. **The CY 2025 funding for these services has been inadequate with minimal savings in reducing medical expenses. After numerous conversations with DHCS, senior management believes that our CY 2026 funding for Community Support Services will be sufficient to continue to maintain all Community Supports Services programs.**

D) $33.6 million unfavorable variance in Hospital Directed Payments is primarily due to receiving updated estimated rate information from DHCS on February 28, 2025 for Calendar Year 2025 offset against amounts included in 1D above.

The November Medical Loss Ratio is 104.2%, which is unfavorable to the 91.8% budgeted amount. The November Administrative Expense Ratio is 4.5%, which is favorable to the 5.8% budgeted amount.

The results for the 11 months ending November 30, 2025 reflect a Net Decrease in Net Position of $45.3 million. This is a $70.3 million unfavorable variance to the budget and includes approximately $42.9 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 97.2%, which is unfavorable to the 91.8% budgeted amount. The year-to-date Administrative Expense Ratio is 5.1 % which is favorable to the 5.8% budgeted amount.

KERN HEALTH SYSTEMS

Financial Packet
November 2025

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MEDI-CAL
STATEMENT OF NET POSITION
AS OF NOVEMBER 30, 2025

ASSETS	November	October	Increase/ (Decrease)
Cash and Cash Equivalents	191,529,019	178,094,487	13,434,533
Short-Term Investments	138,258,599	181,679,372	(43,420,773)
Premiums Receivable	151,167,624	153,472,293	(2,304,669)
Premiums Receivable - MCO Tax	249,000,901	186,937,001	62,063,900
Premiums Receivable - Hospital Directed Payments	979,744,388	921,634,196	58,110,192
Interest Receivable	200,339	403,269	(202,930)
Provider Advance Payment	42,525	56,913	(14,389)
Other Receivables	1,445,608	35,339	1,410,269
Prepaid Expenses & Other Current Assets	7,344,502	7,665,017	(320,516)
Total Current Assets	1,718,733,504	1,629,977,887	88,755,617
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	982,072	1,010,498	(28,426)
Computer Equipment - Net	14,912,482	15,380,212	(467,730)
Building and Improvements - Net	32,215,970	32,279,152	(63,183)
Capital Projects In Process	2,922,498	2,789,771	132,727
Total Capital Assets	55,123,728	55,550,340	(426,612)
Restricted Assets	300,000	300,000	-
Life Insurance Receivables	4,286,966	4,286,966	-
SBITA Asset	8,875,096	8,875,096	-
Total Long-Term Assets	13,462,062	13,462,062	-
Deferred Outflow of Resources	10,107,348	10,107,348	-
Total Assets and Deferred Outflows of Resources	1,797,426,642	1,709,097,636	88,329,005
CURRENT LIABILITIES			
Accrued Salaries and Benefits	9,385,223	10,255,782	(870,560)
Accrued Other Operating Expenses	4,853,679	4,518,000	335,679
MCO Tax Payable	275,108,912	213,034,453	62,074,459
Claims Payable (Reported)	20,084,768	21,337,612	(1,252,844)
IBNR - Inpatient Claims	81,153,376	70,298,746	10,854,630
IBNR - Physician Claims	32,459,349	27,624,554	4,834,796
IBNR - Accrued Other Medical	40,147,815	35,189,383	4,958,432
Risk Pool and Withholds Payable	11,153,880	10,555,570	598,310
Allowance for Claims Processing Expense	4,821,903	4,821,903	-
Other Liabilities	29,177,916	67,464,229	(38,286,313)
SBITA Liability – Current portion	2,217,189	2,217,189	-
Accrued Hospital Directed Payments	980,036,754	921,926,214	58,110,540
Total Current Liabilities	1,490,600,764	1,389,243,636	101,357,128
NONCURRENT LIABILITIES			
Net Pension Liability	13,001,788	13,001,788	-
SBITA Liability, net of current portion	5,491,541	5,491,541	-
Total NonCurrent Liabilities	18,493,329	18,493,329	-
Deferred Inflow of Resources	70,705	70,705	-
NET POSITION:			
Net Position at Beginning of Year	333,567,639	333,567,639	-
Increase (Decrease) in Net Position - Current Year	(45,305,795)	(32,277,672)	(13,028,123)
Total Net Position	288,261,843	301,289,966	(13,028,123)
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	1,797,426,642	1,709,097,636	88,329,005

KERN HEALTH SYSTEMS

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED NOVEMBER 30, 2025

	November	Budget	Variance	Year to Date	Budget	Variance
Family Members	237,734	248,000	(10,266)	2,650,868	2,700,500	(49,632)
Expansion Members	113,468	113,000	468	1,264,788	1,243,000	21,788
SPD Members	47,671	47,000	671	521,074	517,000	4,074
Total Members - MCAL	398,873	408,000	(9,127)	4,436,730	4,460,500	(23,770)
REVENUES						
Medicaid - Family Members	54,076,842	55,969,392	(1,892,549)	603,122,480	609,457,024	(6,334,544)
Medicaid - Expansion Members	48,211,756	47,912,766	298,990	534,233,489	527,040,427	7,193,062
Medicaid - SPD Members	38,296,196	40,402,462	(2,106,266)	416,483,823	444,427,079	(27,943,256)
Premium - MCO Tax	59,136,301	60,379,920	(1,243,619)	650,499,313	660,109,395	(9,610,082)
Premium - Hospital Directed Payments	58,087,932	24,505,142	33,582,790	645,409,866	268,471,785	376,938,081
Investment Earnings And Other Income	1,649,745	2,006,777	(357,032)	21,859,743	21,991,718	(131,975)
Reinsurance Recoveries	1,468,615	276,599	1,192,016	6,563,182	3,023,046	3,540,136
Rate Adjustments - Hospital Directed Payments	24,957	-	24,957	56,624,859	-	56,624,859
Rate/Income Adjustments	632,171	-	632,171	28,038,061	-	28,038,061
Total Revenues	261,584,514	231,453,056	30,131,458	2,962,834,817	2,534,520,474	428,314,343
EXPENSES						
MEDICAL COSTS						
Physician Services	37,756,805	37,085,349	(671,456)	421,644,764	405,848,041	(15,796,723)
Other Professional Services	10,946,249	10,930,111	(16,137)	123,176,104	119,685,835	(3,490,270)
Emergency Room	7,320,640	6,855,872	(464,768)	73,905,686	74,989,489	1,083,803
Inpatient	36,135,732	34,160,140	(1,975,592)	383,360,181	374,508,382	(8,851,800)
Reinsurance Expense	257,831	276,599	18,768	2,879,861	3,023,046	143,185
Outpatient Hospital	20,537,887	15,502,085	(5,035,802)	179,738,095	169,996,761	(9,741,334)
Other Medical	36,851,714	29,124,981	(7,726,733)	386,234,677	319,661,214	(66,573,463)
Pay for Performance Quality Incentive	598,310	611,993	13,684	6,755,095	6,690,758	(64,337)
Risk Corridor Expense	-	-	-	2,708,699	-	(2,708,699)
Hospital Directed Payments	58,087,932	24,505,142	(33,582,790)	645,423,305	268,471,785	(376,951,520)
Hospital Directed Payment Adjustment	22,608	-	(22,608)	57,340,646	-	(57,340,646)
Non-Claims Expense Adjustment	(4,951)	-	4,951	(15,249,399)	-	15,249,399
IBNR, Incentive, Paid Claims Adjustment	(38,786)	-	38,786	(286,414)	-	286,414
Total Medical Costs	208,471,968	159,052,270	(49,419,697)	2,267,631,300	1,742,875,310	(524,755,990)
GROSS MARGIN	53,112,546	72,400,786	(19,288,240)	695,203,517	791,645,164	(96,441,647)
ADMINISTRATIVE COSTS						
Compensation	3,410,552	4,223,118	812,566	43,167,886	46,454,294	3,286,408
Purchased Services	1,583,377	2,343,143	759,766	21,944,383	25,774,570	3,830,187
Supplies	225,190	244,078	18,888	1,865,849	2,684,864	819,015
Depreciation	599,165	766,752	167,587	6,612,303	8,434,272	1,821,969
Other Administrative Expenses	546,113	672,404	126,291	7,300,622	7,396,455	95,833
Administrative Expense Adjustment	74,147	200,000	125,853	1,208,911	2,200,000	991,089
Total Administrative Expenses	6,438,543	8,449,494	2,010,951	82,099,954	92,944,456	10,844,501
TOTAL EXPENSES	214,910,511	167,501,765	(47,408,746)	2,349,731,255	1,835,819,766	(513,911,489)
OPERATING INCOME (LOSS) BEFORE TAX	46,674,003	63,951,292	(17,277,288)	613,103,562	698,700,708	(85,597,145)
MCO TAX	59,136,301	60,379,920	1,243,619	650,499,313	660,109,395	9,610,082
OPERATING INCOME (LOSS) NET OF TAX	(12,462,298)	3,571,372	(16,033,670)	(37,395,750)	38,591,313	(75,987,063)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	(484,972)	(836,276)	351,305	(6,168,701)	(9,163,069)	2,994,368
D-SNP Expenses	(80,854)	(401,853)	320,999	(1,741,344)	(4,403,099)	2,661,755
Total Non-Operating Revenue (Expense)	(565,825)	(1,238,130)	672,304	(7,910,045)	(13,566,168)	5,656,123
NET INCREASE (DECREASE) IN NET POSITION	(13,028,123)	2,333,242	(15,361,365)	(45,305,795)	25,025,145	(70,330,940)
MEDICAL LOSS RATIO	104.2%	91.8%	-12.4%	97.2%	91.8%	-5.4%
ADMINISTRATIVE EXPENSE RATIO	4.5%	5.8%	1.3%	5.1%	5.8%	0.7%

KERN HEALTH SYSTEMS

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED NOVEMBER 30, 2025

	November	Budget	Variance	Year to Date	Budget	Variance
Family Members	237,734	248,000	(10,266)	2,650,868	2,700,500	(49,632)
Expansion Members	113,468	113,000	468	1,264,788	1,243,000	21,788
SPD Members	47,671	47,000	671	521,074	517,000	4,074
Total Members - MCAL	398,873	408,000	(9,127)	4,436,730	4,460,500	(23,770)
REVENUES						
Medicaid - Family Members	227.47	225.68	1.78	227.52	225.68	1.84
Medicaid - Expansion Members	424.89	424.01	0.89	422.39	424.01	(1.62)
Medicaid - SPD Members	803.34	859.63	(56.28)	799.28	859.63	(60.35)
Premium - MCO Tax	148.26	147.99	0.27	146.62	147.99	(1.37)
Premium - Hospital Directed Payments	145.63	60.06	85.57	145.47	60.19	85.28
Investment Earnings And Other Income	4.14	4.92	(0.78)	4.93	4.93	(0.00)
Reinsurance Recoveries	3.68	0.68	3.00	1.48	0.68	0.80
Rate Adjustments - Hospital Directed Payments	0.06	-	0.06	12.76	-	12.76
Rate/Income Adjustments	1.58	-	1.58	6.32	-	6.32
Total Revenues	655.81	567.29	88.52	667.80	568.21	99.58
EXPENSES						
MEDICAL COSTS						
Physician Services	94.66	90.90	(3.76)	95.04	90.99	(4.05)
Other Professional Services	27.44	26.79	(0.65)	27.76	26.83	(0.93)
Emergency Room	18.35	16.80	(1.55)	16.66	16.81	0.15
Inpatient	90.59	83.73	(6.87)	86.41	83.96	(2.44)
Reinsurance Expense	0.65	0.68	0.03	0.65	0.68	0.03
Outpatient Hospital	51.49	38.00	(13.49)	40.51	38.11	(2.40)
Other Medical	92.39	71.38	(21.00)	87.05	71.66	(15.39)
Pay for Performance Quality Incentive	1.50	1.50	(0.00)	1.52	1.50	(0.02)
Risk Corridor Expense	-	-	-	0.61	-	(0.61)
Hospital Directed Payments	145.63	60.06	(85.57)	145.47	60.19	(85.28)
Hospital Directed Payment Adjustment	0.06	-	(0.06)	12.92	-	(12.92)
Non-Claims Expense Adjustment	(0.01)	-	0.01	(3.44)	-	3.44
IBNR, Incentive, Paid Claims Adjustment	(0.10)	-	0.10	(0.06)	-	0.06
Total Medical Costs	522.65	389.83	(132.82)	511.10	390.74	(120.37)
GROSS MARGIN	133.16	177.45	(44.30)	156.69	177.48	(20.79)
ADMINISTRATIVE COSTS						
Compensation	8.55	10.35	1.80	9.73	10.41	0.68
Purchased Services	3.97	5.74	1.77	4.95	5.78	0.83
Supplies	0.56	0.60	0.03	0.42	0.60	0.18
Depreciation	1.50	1.88	0.38	1.49	1.89	0.40
Other Administrative Expenses	1.37	1.65	0.28	1.65	1.66	0.01
Administrative Expense Adjustment	0.19	0.49	0.30	0.27	0.49	0.22
Total Administrative Expenses	16.14	20.71	4.57	18.50	20.84	2.33
TOTAL EXPENSES	538.79	410.54	(128.25)	529.61	411.57	(118.04)
OPERATING INCOME (LOSS) BEFORE TAX	117.01	156.74	(39.73)	138.19	156.64	(18.45)
MCO TAX	148.26	147.99	(0.27)	146.62	147.99	1.37
OPERATING INCOME (LOSS) NET OF TAX	(31.24)	8.75	(40.00)	(8.43)	8.65	(17.08)
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	(0.20)	(2.05)	1.85	(0.39)	(2.05)	1.66
D-SNP Expenses	(1.22)	(0.98)	(0.23)	(1.39)	(0.99)	(0.40)
Total Non-Operating Revenue (Expense)	(1.42)	(3.03)	1.62	(1.78)	(3.04)	1.26
NET INCREASE (DECREASE) IN NET POSITION	(32.66)	5.72	(38.38)	(10.21)	5.61	(15.82)
MEDICAL LOSS RATIO	104.2%	91.8%	-12.4%	97.2%	91.8%	-5.4%
ADMINISTRATIVE EXPENSE RATIO	4.5%	5.8%	1.3%	5.1%	5.8%	0.7%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS
FOR THE MONTH ENDED NOVEMBER 30, 2025

KERN HEALTH SYSTEMS

	2024 - Q4	2025 - Q1	2025 - Q2	2025 - Q3	Rolling 4-Quarter Totals	CURRENT QUARTER 2025 - Q4
Total Members - MCAL	1,209,901	1,215,186	1,213,588	1,208,737	4,847,412	799,219
REVENUES						
Medicaid - Family Members	181,853,744	164,182,925	164,643,931	164,974,083	675,654,683	109,321,541
Medicaid - Expansion Members	146,690,508	146,129,580	146,406,773	145,631,912	584,858,772	96,065,225
Medicaid - SPD Members	72,615,432	112,116,656	113,466,544	114,404,100	412,602,732	76,496,523
Medicaid - LTC Members	12,679,447	-	-	-	12,679,447	-
Premium - MCO Tax	169,305,625	177,408,904	177,408,904	177,408,904	701,532,336	118,272,602
Premium - Hospital Directed Payments	74,054,842	176,821,231	176,863,014	175,783,933	603,523,020	115,941,688
Investment Earnings And Other Income	6,363,381	6,614,108	6,619,093	5,426,773	25,023,355	3,199,769
Reinsurance Recoveries	-	-	1,600,000	3,225,949	4,825,949	1,737,233
Rate Adjustments - Hospital Directed Payments	(45,264)	105,206,644	153,982	(48,766,536)	56,548,825	30,770
Rate/Income Adjustments	29,220	2,557,018	16,334,961	4,913,067	23,834,266	4,233,016
Total Revenues	663,546,935	891,037,065	803,497,202	743,002,184	3,101,083,386	525,298,366
EXPENSES						
MEDICAL COSTS						
Physician Services	117,920,414	113,538,825	120,549,958	112,164,511	464,173,708	75,391,470
Other Professional Services	17,579,841	31,017,823	33,468,699	35,449,266	117,515,629	23,240,316
Emergency Room	20,264,346	20,024,420	20,408,138	19,750,790	80,447,694	13,722,339
Inpatient	109,860,804	98,477,222	112,568,469	101,887,733	422,794,228	70,426,757
Reinsurance Expense	337,245	808,856	768,322	786,038	2,700,461	516,645
Outpatient Hospital	45,089,064	46,204,757	46,499,744	47,887,562	185,681,128	39,146,032
Other Medical	95,537,563	99,350,041	108,019,275	106,965,073	409,871,953	71,900,264
Pay for Performance Quality Incentive	1,814,852	1,822,779	1,920,382	1,814,657	7,372,669	1,197,278
Risk Corridor Expense	(960,173)	-	-	1,591,081	630,908	1,117,618
Hospital Directed Payments	74,054,842	176,821,231	176,863,014	175,797,372	603,536,459	115,941,688
Hospital Directed Payment Adjustment	(45,264)	105,103,291	1,172,910	(48,962,121)	57,268,815	26,567
Non-Claims Expense Adjustment	(1,489,159)	(6,486,815)	(10,264,893)	1,520,018	(16,720,849)	(17,710)
IBNR, Incentive, Paid Claims Adjustment	(3,892,128)	658,346	(3,531,172)	2,647,971	(4,116,983)	(61,536)
Total Medical Costs	476,072,247	687,340,775	608,442,846	559,299,951	2,331,155,820	412,547,727
GROSS MARGIN	187,474,687	203,696,289	195,054,356	183,702,233	769,927,565	112,750,639
ADMINISTRATIVE COSTS						
Compensation	12,349,629	11,773,691	11,672,587	11,888,717	47,684,623	7,832,892
Purchased Services	6,570,351	5,241,893	7,542,567	6,004,661	25,359,472	3,155,261
Supplies	693,365	438,866	353,058	630,525	2,115,813	443,400
Depreciation	2,071,812	1,794,880	1,806,873	1,809,458	7,483,023	1,201,092
Other Administrative Expenses	1,848,717	2,016,475	2,053,315	2,222,027	8,140,534	1,008,806
Administrative Expense Adjustment	1,230,808	776,919	276,996	(308)	2,284,416	155,303
Total Administrative Expenses	24,764,681	22,042,724	23,705,397	22,555,080	93,067,882	13,796,754
TOTAL EXPENSES	500,836,928	709,383,500	632,148,243	581,855,031	2,424,223,702	426,344,481
OPERATING INCOME (LOSS) BEFORE TAX	162,710,007	181,653,565	171,348,959	161,147,153	676,859,684	98,953,885
MCO TAX	169,305,625	177,408,904	177,408,904	177,408,904	701,532,336	118,272,602
OPERATING INCOME (LOSS) NET OF TAX	(6,595,619)	4,244,662	(6,059,945)	(16,261,750)	(24,672,652)	(19,318,717)
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	(4,205,257)	(1,632,695)	(2,512,502)	(2,661,803)	(11,012,256)	(1,103,046)
NET INCREASE (DECREASE) IN NET POSITION	(10,800,875)	2,611,967	(8,572,447)	(18,923,553)	(35,684,908)	(20,421,763)
MEDICAL LOSS RATIO	95.7%	93.9%	95.8%	98.6%	96.0%	101.9%
ADMINISTRATIVE EXPENSE RATIO	5.9%	5.1%	5.3%	5.1%	5.4%	4.7%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS PMPM
FOR THE MONTH ENDED NOVEMBER 30, 2025

	2024 - Q4	2025 - Q1	2025 - Q2	2025 - Q3	Rolling Quarter Totals	CURRENT QUARTER 2025 - Q4
Total Members - MCAL	1,209,901	1,215,186	1,213,588	1,208,737	4,847,412	799,219
REVENUES						
Medicaid - Family Members	228.42	225.55	227.27	228.61	227.48	229.25
Medicaid - Expansion Members	428.47	422.74	421.81	422.25	426.16	422.95
Medicaid - SPD Members	1,039.89	791.89	798.75	804.47	975.26	803.31
Medicaid - LTC Members	8,050.44	-	-	-	4,036.75	-
Premium - MCO Tax	139.93	145.99	146.19	146.77	144.72	147.99
Premium - Hospital Directed Payments	61.21	145.51	145.74	145.43	124.50	145.07
Investment Earnings And Other Income	5.26	5.44	5.45	4.49	5.16	4.00
Reinsurance Recoveries	-	-	1.32	2.67	1.00	2.17
Rate Adjustments - Hospital Directed Payments	(0.04)	86.58	0.13	(40.35)	11.67	0.04
Rate/Income Adjustments	0.02	2.10	13.46	4.06	4.92	5.30
Total Revenues	548.43	733.25	662.08	614.69	639.74	657.26
EXPENSES						
MEDICAL COSTS						
Physician Services	97.46	93.43	99.33	92.79	95.76	94.33
Other Professional Services	14.53	25.53	27.58	29.33	24.24	29.08
Emergency Room	16.75	16.48	16.82	16.34	16.60	17.17
Inpatient	90.80	81.04	92.76	84.29	87.22	88.12
Reinsurance Expense	0.28	0.67	0.63	0.65	0.56	0.65
Outpatient Hospital	37.27	38.02	38.32	39.62	38.31	48.98
Other Medical	78.96	81.76	89.01	88.49	84.55	89.96
Pay for Performance Quality Incentive	1.50	1.50	1.58	1.50	1.52	1.50
Risk Corridor Expense	(0.79)	-	-	1.32	0.13	1.40
Hospital Directed Payments	61.21	145.51	145.74	145.44	124.51	145.07
Hospital Directed Payment Adjustment	(0.04)	86.49	0.97	(40.51)	11.81	0.03
Non-Claims Expense Adjustment	(1.23)	(5.34)	(8.46)	1.26	(3.45)	(0.02)
IBNR, Incentive, Paid Claims Adjustment	(3.22)	0.54	(2.91)	2.19	(0.85)	(0.08)
Total Medical Costs	393.48	565.63	501.36	462.71	480.91	516.19
GROSS MARGIN	154.95	167.63	160.73	151.98	158.83	141.08
ADMINISTRATIVE COSTS						
Compensation	10.21	9.69	9.62	9.84	9.84	9.80
Purchased Services	5.43	4.31	6.22	4.97	5.23	3.95
Supplies	0.57	0.36	0.29	0.52	0.44	0.55
Depreciation	1.71	1.48	1.49	1.50	1.54	1.50
Other Administrative Expenses	1.53	1.66	1.69	1.84	1.68	1.26
Administrative Expense Adjustment	1.02	0.64	0.23	(0.00)	0.47	0.19
Total Administrative Expenses	20.47	18.14	19.53	18.66	19.20	17.26
TOTAL EXPENSES	413.95	583.77	520.89	481.37	500.11	533.45
OPERATING INCOME (LOSS) BEFORE TAX	134.48	149.49	141.19	133.32	139.63	123.81
MCO TAX	139.93	145.99	146.19	146.77	144.72	147.99
OPERATING INCOME (LOSS) NET OF TAX	(5.45)	3.49	(4.99)	(13.45)	(5.09)	(24.17)
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	(3.48)	(1.34)	(2.07)	(2.20)	(2.27)	(1.38)
NET INCREASE (DECREASE) IN NET POSITION	(8.93)	2.15	(7.06)	(15.66)	(7.36)	(25.55)
MEDICAL LOSS RATIO	95.7%	93.9%	95.8%	98.6%	96.0%	101.9%
ADMINISTRATIVE EXPENSE RATIO	5.9%	5.1%	5.3%	5.1%	5.4%	4.7%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
ROLLING 6 MONTHS
FOR THE MONTH ENDED NOVEMBER 30, 2025

KERN HEALTH SYSTEMS

	MAY 2025	JUNE 2025	JULY 2025	AUGUST 2025	SEPTEMBER 2025	OCTOBER 2025	Prior 6 Month YTD	NOVEMBER 2025
Total Members - MCAL	403,890	404,799	405,629	402,071	401,037	400,346	2,417,772	398,873
REVENUES								
Medicaid - Family Members	55,024,952	54,930,744	55,112,034	55,284,966	54,577,083	55,244,699	330,174,477	54,076,842
Medicaid - Expansion Members	48,723,433	48,994,633	49,057,991	48,559,601	48,014,320	47,853,469	291,203,446	48,211,756
Medicaid - SPD Members	37,785,856	38,017,497	38,111,261	37,719,991	38,572,848	38,200,328	228,407,782	38,296,196
Medicaid - LTC Members	-	-	-	-	-	-	-	-
Premium - MCO Tax	59,124,814	59,147,788	59,136,301	(0)	118,272,602	59,136,301	354,817,807	59,136,301
Premium - Hospital Directed Payments	58,890,354	59,075,312	59,035,880	58,451,235	58,296,817	57,853,756	351,603,354	58,087,932
Investment Earnings And Other Income	1,505,898	1,908,507	1,650,374	1,911,358	1,865,041	1,550,024	10,391,203	1,649,745
Reinsurance Recoveries	-	1,600,000	300,000	772,732	2,153,218	268,618	5,094,567	1,468,615
Rate Adjustments - Hospital Directed Payments	78,980	(36,948)	4,261,053	(53,056,519)	28,929	5,813	(48,718,691)	24,957
Rate/Income Adjustments	136,042	9,673,408	4,824,965	147,916	(59,814)	3,600,845	18,323,362	632,171
Total Revenues	261,270,330	273,310,941	271,489,861	149,791,279	321,721,045	263,713,852	1,541,297,308	261,584,514
EXPENSES								
MEDICAL COSTS								
Physician Services	39,419,683	42,112,109	38,137,625	38,251,300	35,775,586	37,634,665	231,330,967	37,756,805
Other Professional Services	10,693,341	11,523,165	11,113,022	12,757,030	11,579,214	12,294,068	69,959,840	10,946,249
Emergency Room	7,074,183	7,003,225	6,580,865	6,307,989	6,861,936	6,401,699	40,229,896	7,320,640
Inpatient	39,326,548	39,527,275	34,361,371	34,046,492	33,479,870	34,291,026	215,032,582	36,135,732
Reinsurance Expense	271,713	255,781	260,984	262,299	262,754	258,815	1,572,346	257,831
Outpatient Hospital	14,357,942	15,379,229	15,553,674	15,218,411	17,115,477	18,608,145	96,232,878	20,537,887
Other Medical	34,883,873	37,645,117	38,154,038	34,707,037	34,103,997	35,048,550	214,542,614	36,851,714
Pay for Performance Quality Incentive	605,835	707,199	608,444	603,107	603,107	598,968	3,726,658	598,310
Risk Corridor Expense	-	-	-	-	1,591,081	1,117,618	2,708,699	-
Hospital Directed Payments	58,890,354	59,075,312	59,035,880	58,464,674	58,296,817	57,853,756	351,616,793	58,087,932
Hospital Directed Payment Adjustment	1,098,088	(37,127)	4,261,156	(53,169,871)	(53,406)	3,959	(47,897,200)	22,608
Non-Claims Expense Adjustment	(10,262,733)	(283)	99,601	6,421	1,413,996	(12,759)	(8,755,757)	(4,951)
IBNR, Incentive, Paid Claims Adjustment	(37,610)	(826,300)	822,578	1,343,361	482,033	(22,750)	1,761,312	(38,786)
Total Medical Costs	196,321,218	212,364,700	208,989,239	148,798,250	201,512,462	204,075,760	1,172,061,629	208,471,968
GROSS MARGIN	64,949,112	60,946,241	62,500,621	993,028	120,208,583	59,638,093	369,235,678	53,112,546
ADMINISTRATIVE COSTS								
Compensation	3,873,266	3,913,252	4,003,904	3,803,698	4,081,115	4,422,340	24,097,575	3,410,552
Purchased Services	2,687,401	2,181,469	2,832,364	1,332,630	1,839,667	1,571,884	12,445,415	1,583,377
Supplies	121,882	108,227	137,483	339,600	153,441	218,210	1,078,844	225,190
Depreciation	605,113	604,495	604,109	603,423	601,927	601,927	3,620,993	599,165
Other Administrative Expenses	836,014	656,092	1,115,773	561,313	544,941	462,693	4,176,825	546,113
Administrative Expense Adjustment	69,345	47,536	(308)	-	-	81,156	197,729	74,147
Total Administrative Expenses	8,193,021	7,511,070	8,693,325	6,640,664	7,221,090	7,358,211	45,617,381	6,438,543
TOTAL EXPENSES	204,514,239	219,875,770	217,682,565	155,438,914	208,733,552	211,433,970	1,217,679,010	214,910,511
OPERATING INCOME (LOSS) BEFORE TAX	56,756,091	53,435,171	53,807,296	(5,647,635)	112,987,493	52,279,882	323,618,297	46,674,003
MCO TAX	59,136,301	59,136,301	59,136,301	(0)	118,272,602	59,136,301	354,817,807	59,136,301
OPERATING INCOME (LOSS) NET OF TAX	(2,380,210)	(5,701,130)	(5,329,005)	(5,647,635)	(5,285,110)	(6,856,419)	(31,199,510)	(12,462,298)
NON-OPERATING REVENUE (EXPENSE)								
Total Non-Operating Revenue (Expense)	(845,044)	(1,155,740)	(1,441,323)	(319,735)	(900,745)	(537,220)	(5,199,807)	(565,825)
NET INCREASE (DECREASE) IN NET POSITION	(3,225,255)	(6,856,869)	(6,770,328)	(5,967,371)	(6,185,854)	(7,393,640)	(36,399,317)	(13,028,123)
MEDICAL LOSS RATIO	95.2%	98.8%	97.7%	99.4%	98.7%	99.7%	98.3%	104.2%
ADMINISTRATIVE EXPENSE RATIO	5.7%	4.8%	5.8%	4.6%	5.0%	5.0%	5.2%	4.5%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
PMPM ROLLING 6 MONTHS
FOR THE MONTH ENDED NOVEMBER 30, 2025

	MAY 2025	JUNE 2025	JULY 2025	AUGUST 2025	SEPTEMBER 2025	OCTOBER 2025	6 Month Prior YTD	NOVEMBER 2025
Total Members - MCAL	403,890	404,799	405,629	402,071	401,037	400,346	2,417,772	398,873
REVENUES								
Medicaid - Family Members	228.41	227.71	228.01	230.12	227.71	231.03	228.83	227.47
Medicaid - Expansion Members	421.48	421.84	420.68	423.75	422.37	421.00	421.85	424.89
Medicaid - SPD Members	797.42	801.74	805.73	798.64	808.99	803.27	802.64	803.34
Medicaid - LTC Members	-	-	-	-	-	-	-	-
Premium - MCO Tax	146.39	146.12	145.79	(0.00)	294.92	147.71	146.75	148.26
Premium - Hospital Directed Payments	145.81	145.94	145.54	145.38	145.37	144.51	145.42	145.63
Investment Earnings And Other Income	3.73	4.71	4.07	4.75	4.65	3.87	4.30	4.14
Reinsurance Recoveries	-	3.95	0.74	1.92	5.37	0.67	2.11	3.68
Rate Adjustments - Hospital Directed Payments	0.20	(0.09)	10.50	(131.96)	0.07	0.01	(20.15)	0.06
Rate/Income Adjustments	0.34	23.90	11.90	0.37	(0.15)	8.99	7.58	1.58
Total Revenues	646.88	675.18	669.31	372.55	802.22	658.71	637.49	655.81
EXPENSES								
MEDICAL COSTS								
Physician Services	97.60	104.03	94.02	95.14	89.21	94.01	95.68	94.66
Other Professional Services	26.48	28.47	27.40	31.73	28.87	30.71	28.94	27.44
Emergency Room	17.52	17.30	16.22	15.69	17.11	15.99	16.64	18.35
Inpatient	97.37	97.65	84.71	84.68	83.48	85.65	88.94	90.59
Reinsurance Expense	0.67	0.63	0.64	0.65	0.66	0.65	0.65	0.65
Outpatient Hospital	35.55	37.99	38.34	37.85	42.68	46.48	39.80	51.49
Other Medical	86.37	93.00	94.06	86.32	85.04	87.55	88.74	92.39
Pay for Performance Quality Incentive	1.50	1.75	1.50	1.50	1.50	1.50	1.54	1.50
Risk Corridor Expense	-	-	-	-	3.97	2.79	1.12	-
Hospital Directed Payments	145.81	145.94	145.54	145.41	145.37	144.51	145.43	145.63
Hospital Directed Payment Adjustment	2.72	(0.09)	10.51	(132.24)	(0.13)	0.01	(19.81)	0.06
Non-Claims Expense Adjustment	(25.41)	(0.00)	0.25	0.02	3.53	(0.03)	(3.62)	(0.01)
IBNR, Incentive, Paid Claims Adjustment	(0.09)	(2.04)	2.03	3.34	1.20	(0.06)	0.73	(0.10)
Total Medical Costs	486.08	524.62	515.22	370.08	502.48	509.75	484.77	522.65
GROSS MARGIN	160.81	150.56	154.08	2.47	299.74	148.97	152.72	133.16
ADMINISTRATIVE COSTS								
Compensation	9.59	9.67	9.87	9.46	10.18	11.05	9.97	8.55
Purchased Services	6.65	5.39	6.98	3.31	4.59	3.93	5.15	3.97
Supplies	0.30	0.27	0.34	0.84	0.38	0.55	0.45	0.56
Depreciation	1.50	1.49	1.49	1.50	1.50	1.50	1.50	1.50
Other Administrative Expenses	2.07	1.62	2.75	1.40	1.36	1.16	1.73	1.37
Administrative Expense Adjustment	0.17	0.12	(0.00)	-	-	0.20	0.08	0.19
Total Administrative Expenses	20.29	18.56	21.43	16.52	18.01	18.38	18.87	16.14
TOTAL EXPENSES	506.36	543.17	536.65	386.60	520.48	528.13	503.64	538.79
OPERATING INCOME (LOSS) BEFORE TAX	140.52	132.00	132.65	(14.05)	281.74	130.59	133.85	117.01
MCO TAX	146.42	146.09	145.79	(0.00)	294.92	147.71	146.75	148.26
OPERATING INCOME (LOSS) NET OF TAX	(5.89)	(14.08)	(13.14)	(14.05)	(13.18)	(17.13)	(12.90)	(31.24)
NON-OPERATING REVENUE (EXPENSE)								
Total Non-Operating Revenue (Expense)	(2.09)	(2.86)	(3.55)	(0.80)	(2.25)	(1.34)	(2.15)	(1.42)
NET INCREASE (DECREASE) IN NET POSITION	(7.99)	(16.94)	(16.69)	(14.84)	(15.42)	(18.47)	(15.05)	(32.66)
MEDICAL LOSS RATIO	95.2%	98.8%	97.7%	99.4%	98.7%	99.7%	98.3%	104.2%
ADMINISTRATIVE EXPENSE RATIO	5.7%	4.8%	5.8%	4.6%	5.0%	5.0%	5.2%	4.5%

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

KERN HEALTH SYSTEMS

	November	Budget	Variance	Year to Date	Budget	Variance
REVENUES						
Premium - Medi-Cal	46,645,725	49,058,617	(2,412,892)	520,001,816	534,204,818	(14,203,002)
Premium - Maternity Kick	3,481,423	3,409,618	71,805	39,074,395	37,127,713	1,946,681
Premium - Enhanced Care Management	2,088,795	1,779,439	309,356	23,287,140	19,376,512	3,910,628
Premium - Major Organ Transplant	159,061	241,039	(81,979)	1,777,539	2,624,705	(847,166)
Premium - Provider Enhancement	1,410,156	1,186,729	223,427	15,732,674	12,922,428	2,810,246
Premium - GEMT	157,937	184,829	(26,893)	1,762,333	2,012,628	(250,295)
Premium - Equity & Practice Transformation	38,213	-	38,213	424,738	-	424,738
Other	95,533	109,120	(13,587)	1,061,846	1,188,220	(126,374)
TOTAL MEDICAID - FAMILY MEMBERS	54,076,842	55,969,392	(1,892,549)	603,122,480	609,457,024	(6,334,544)
Premium - Medi-Cal	44,448,054	44,592,454	(144,400)	494,628,199	490,516,997	4,111,202
Premium - Maternity Kick	648,950	442,636	206,313	4,855,669	4,868,999	(13,329)
Premium - Enhanced Care Management	2,112,305	1,778,641	333,664	23,575,999	19,565,046	4,010,953
Premium - Major Organ Transplant	283,194	422,945	(139,751)	3,149,655	4,652,395	(1,502,740)
Premium - Provider Enhancement	423,272	364,845	58,427	4,720,807	4,013,295	707,512
Premium - GEMT	232,239	261,525	(29,286)	2,592,843	2,876,775	(283,932)
Premium - Equity & Practice Transformation	18,212	-	18,212	202,948	-	202,948
Other	45,530	49,720	(4,190)	507,370	546,920	(39,550)
TOTAL MEDICAID - EXPANSION MEMBERS	48,211,756	47,912,766	298,990	534,233,489	527,040,427	7,193,062
Premium - Medi-Cal	36,659,285	38,844,006	(2,184,721)	398,627,047	427,284,217	(28,657,170)
Premium - Enhanced Care Management	1,343,241	1,014,864	328,377	14,673,210	11,163,505	3,509,706
Premium - Major Organ Transplant	118,279	341,085	(222,806)	1,273,462	3,751,935	(2,478,473)
Premium - Provider Enhancement	31,997	28,525	3,472	350,134	313,775	36,359
Premium - GEMT	138,536	173,842	(35,306)	1,508,459	1,912,262	(403,803)
Premium - Equity & Practice Transformation	3,360	-	3,360	36,351	-	36,351
Premium - Distinct Part Nursing Facility	1,358	-	1,358	13,775	-	13,775
Other	140	140	-	1,386	1,386	-
TOTAL MEDICAID - SPD MEMBERS	38,296,196	40,402,462	(2,106,266)	416,483,823	444,427,079	(27,943,256)

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

	January	February	March	April	May	June
REVENUES						
Premium - Medi-Cal	47,363,308	47,545,964	47,551,546	47,638,089	47,672,367	47,373,580
Premium - Maternity Kick	3,443,250	3,489,058	2,840,108	3,053,880	3,351,633	3,580,674
Premium - Enhanced Care Management	2,125,064	2,131,060	2,130,863	2,133,053	2,132,628	2,122,809
Premium - Major Organ Transplant	160,356	161,697	161,742	162,891	164,567	162,543
Premium - Provider Enhancement	1,429,771	1,437,183	1,437,262	1,441,621	1,445,331	1,434,006
Premium - GEMT	160,977	161,437	161,348	161,465	161,307	160,694
Premium - Equity & Practice Transformation	-	-	-	-	-	-
Other	96,746	97,035	97,150	97,236	97,118	96,437
TOTAL MEDICAID - FAMILY MEMBERS	54,779,472	55,023,433	54,380,020	54,688,236	55,024,952	54,930,744
Premium - Medi-Cal	44,855,744	45,219,120	45,018,916	45,125,766	45,365,301	45,433,984
Premium - Maternity Kick	564,968	511,525	480,986	412,274	206,137	381,735
Premium - Enhanced Care Management	2,153,257	2,165,899	2,154,091	2,150,015	2,149,171	2,170,055
Premium - Major Organ Transplant	285,237	287,671	286,455	287,370	289,211	289,196
Premium - Provider Enhancement	430,414	433,175	430,922	430,557	430,991	434,307
Premium - GEMT	236,976	238,316	236,993	236,445	236,220	238,707
Premium - Equity & Practice Transformation	-	-	-	-	-	-
Other	46,164	46,490	46,262	46,280	46,403	46,649
TOTAL MEDICAID - EXPANSION MEMBERS	48,572,760	48,902,196	48,654,624	48,688,708	48,723,433	48,994,633
Premium - Medi-Cal	37,081,984	34,297,701	35,919,054	36,050,326	36,169,992	36,388,660
Premium - Enhanced Care Management	1,403,572	1,238,016	1,326,920	1,327,850	1,329,835	1,341,543
Premium - Major Organ Transplant	125,409	102,004	114,724	115,251	115,746	116,094
Premium - Provider Enhancement	35,647	27,621	31,770	31,745	31,837	32,025
Premium - GEMT	151,476	120,067	136,547	136,681	137,134	137,832
Premium - Equity & Practice Transformation	-	-	-	-	-	-
Premium - Distinct Part Nursing Facility	1,259	1,293	1,251	1,227	1,206	1,232
Other	112	114	115	110	106	112
TOTAL MEDICAID - SPD MEMBERS	38,799,459	35,786,816	37,530,381	37,663,190	37,785,856	38,017,497

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

	July	August	September	October	November	Year to Date
REVENUES						
Premium - Medi-Cal	47,430,400	47,285,713	46,769,228	46,725,896	46,645,725	520,001,816
Premium - Maternity Kick	3,702,830	4,031,122	3,886,062	4,214,354	3,481,423	39,074,395
Premium - Enhanced Care Management	2,122,439	2,116,979	2,092,576	2,090,874	2,088,795	23,287,140
Premium - Major Organ Transplant	162,658	162,575	159,929	159,520	159,061	1,777,539
Premium - Provider Enhancement	1,436,284	1,432,031	1,415,311	1,413,718	1,410,156	15,732,674
Premium - GEMT	160,596	160,128	158,257	158,186	157,937	1,762,333
Premium - Equity & Practice Transformation	-	-	-	386,525	38,213	424,738
Other	96,828	96,418	95,719	95,626	95,533	1,061,846
TOTAL MEDICAID - FAMILY MEMBERS	55,112,034	55,284,966	54,577,083	55,244,699	54,076,842	603,122,480
Premium - Medi-Cal	45,545,841	44,944,541	44,442,704	44,228,226	44,448,054	494,628,199
Premium - Maternity Kick	335,927	480,986	473,351	358,831	648,950	4,855,669
Premium - Enhanced Care Management	2,167,026	2,138,244	2,113,720	2,102,217	2,112,305	23,575,999
Premium - Major Organ Transplant	290,123	286,297	283,117	281,784	283,194	3,149,655
Premium - Provider Enhancement	434,111	428,354	423,473	421,232	423,272	4,720,807
Premium - GEMT	238,283	235,117	232,413	231,134	232,239	2,592,843
Premium - Equity & Practice Transformation	-	-	-	184,736	18,212	202,948
Other	46,680	46,062	45,542	45,309	45,530	507,370
TOTAL MEDICAID - EXPANSION MEMBERS	49,057,991	48,559,601	48,014,320	47,853,469	48,211,756	534,233,489
Premium - Medi-Cal	36,483,130	36,113,888	36,918,872	36,544,155	36,659,285	398,627,047
Premium - Enhanced Care Management	1,340,261	1,323,952	1,360,266	1,337,755	1,343,241	14,673,210
Premium - Major Organ Transplant	116,793	114,376	118,931	115,854	118,279	1,273,462
Premium - Provider Enhancement	31,932	31,316	32,664	31,580	31,997	350,134
Premium - GEMT	137,816	135,165	140,709	136,496	138,536	1,508,459
Premium - Equity & Practice Transformation	-	-	-	32,991	3,360	36,351
Premium - Distinct Part Nursing Facility	1,194	1,169	1,247	1,339	1,358	13,775
Other	135	124	159	158	140	1,386
TOTAL MEDICAID - SPD MEMBERS	38,111,261	37,719,991	38,572,848	38,200,328	38,296,196	416,483,823

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

KERN HEALTH SYSTEMS

	November	Budget	Variance	Year to Date	Budget	Variance
Physician Services						
Primary Care Physician Services	11,642,661	8,215,225	(3,427,436)	102,807,422	89,759,629	(13,047,793)
Referral Specialty Services	25,177,072	25,010,332	(166,740)	286,544,045	273,921,707	(12,622,338)
Urgent Care & After Hours Advice	928,072	3,850,792	2,922,720	32,193,096	42,066,504	9,873,408
Hospital Admitting Team	9,000	9,000	-	100,200	100,200	-
Total Physician Services	37,756,805	37,085,349	(671,456)	421,644,764	405,848,041	(15,796,723)
Other Professional Services						
Vision Service Capitation	340,003	367,200	27,197	3,777,372	4,014,450	237,078
221 - Business Intelligence	177,177	194,224	17,047	2,171,538	2,128,449	(43,089)
223 - Enterprise Configuration	110,202	135,711	25,510	1,434,852	1,487,223	52,372
310 - Health Servcies - Utilization Management	756,459	780,258	23,798	8,646,822	8,550,631	(96,191)
311 - Health Services - Quality Improvement	232,377	287,955	55,577	2,693,108	3,155,615	462,507
312 - Health Services Education	285,744	358,716	72,973	3,610,908	3,931,075	320,166
313 - Pharmacy	106,556	128,716	22,159	1,333,961	1,410,562	76,601
314 - Enhanced Care Management	344,417	398,100	53,683	4,385,625	4,362,671	(22,954)
316 - Population Health Management	455,330	614,560	159,229	5,864,764	6,734,793	870,029
317 - In Lieu of Services	67,411	131,060	63,649	1,388,711	1,436,251	47,540
321 - Homeless Management Information Services	20,015	42,845	22,831	268,553	469,532	200,979
330 - Member Services	824,995	1,094,219	269,223	11,516,851	11,991,246	474,395
331 - Member Outreach	101,692	253,844	152,152	1,358,602	2,781,807	1,423,205
410 - Member Engagement	47,894	106,259	58,365	628,848	1,164,466	535,618
601 - Behavioral Health	121,103	178,092	56,989	1,652,767	1,951,662	298,896
602 - Quality & Health Equity	72,711	82,649	9,938	871,691	905,726	34,035
605 - Quality Performance	131,980	188,075	56,096	1,671,383	2,061,068	389,686
Behavior Health Treatment	3,887,059	2,851,787	(1,035,273)	39,167,921	31,182,710	(7,985,211)
Mental Health Services	659,292	681,771	22,479	7,011,514	7,476,254	464,740
Other Professional Services	2,203,830	2,054,070	(149,761)	23,720,315	22,489,642	(1,230,673)
Total Other Professional Services	10,946,249	10,930,111	(16,137)	123,176,104	119,685,835	(3,490,270)
Emergency Room	7,320,640	6,855,872	(464,768)	73,905,686	74,989,489	1,083,803
Inpatient Hospital	36,135,732	34,160,140	(1,975,592)	383,360,181	374,508,382	(8,851,800)
Reinsurance Expense Premium	257,831	276,599	18,768	2,879,861	3,023,046	143,185
Outpatient Hospital	20,537,887	15,502,085	(5,035,802)	179,738,095	169,996,761	(9,741,334)
Other Medical						
Ambulance and NEMT	4,568,473	5,067,222	498,749	65,934,176	55,606,379	(10,327,797)
Home Health Services & CBAS	1,618,518	1,321,074	(297,445)	17,176,165	14,516,698	(2,659,467)
Utilization and Quality Review Expenses	1,003,384	1,825,490	822,106	13,336,137	20,005,050	6,668,913
Long Term/SNF/Hospice	15,396,429	11,526,866	(3,869,563)	125,241,641	126,730,979	1,489,338
Provider Enhancement Expense - Prop. 56	1,772,799	1,666,244	(106,555)	19,767,927	16,387,023	(3,380,904)
Provider Enhancement Expense - GEMT	584,807	424,037	(160,770)	5,978,840	6,461,582	482,741
Enhanced Care Management	7,694,367	4,344,297	(3,350,071)	60,886,776	47,599,811	(13,286,966)
Community Support Services	948,675	-	(948,675)	41,951,699	-	(41,951,699)
Major Organ Transplant	529,617	954,816	425,199	5,935,260	10,477,583	4,542,323
Cal AIM Incentive Programs	-	-	-	1,503,032	-	(1,503,032)
Student Behavioral Health Incentive	-	-	-	1,321,164	-	(1,321,164)
Housing and Homelessness Incentive	-	-	-	1,325,000	-	(1,325,000)
Equity & Practice Transformation Expense	59,786	-	(59,786)	664,037	-	(664,037)
Distinct Part Nursing Facility Expense	1,358	-	(1,358)	13,775	-	(13,775)
DME/Rebates	2,673,501	1,994,935	(678,566)	25,199,046	21,876,109	(3,322,937)
Total Other Medical	36,851,714	29,124,981	(7,726,733)	386,234,677	319,661,214	(66,573,463)
Pay for Performance Quality Incentive	598,310	611,993	13,684	6,755,095	6,690,758	(64,337)
Risk Corridor Expense	-	-	-	2,708,699	-	(2,708,699)
Hospital Directed Payments	58,087,932	24,505,142	(33,582,790)	645,423,305	268,471,785	(376,951,520)
Hospital Directed Payment Adjustment	22,608	-	(22,608)	57,340,646	-	(57,340,646)
Non-Claims Expense Adjustment	(4,951)	-	4,951	(15,249,399)	-	15,249,399
IBNR, Incentive, Paid Claims Adjustment	(38,786)	-	38,786	(286,414)	-	286,414
Total Medical Costs	208,471,968	159,052,270	(49,419,697)	2,267,631,300	1,742,875,310	(524,755,990)

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

	November	Budget	Variance	Year to Date	Budget	Variance
TOTAL MEMBERS - MCAL	398,873	408,000	(9,127)	4,436,730	4,460,500	(23,770)
Physician Services						
Primary Care Physician Services	29.19	20.14	(9.05)	23.17	20.12	(3.05)
Referral Specialty Services	63.12	61.30	(1.82)	64.58	61.41	(3.17)
Urgent Care & After Hours Advice	2.33	9.44	7.11	7.26	9.43	2.17
Hospital Admitting Team	0.02	0.02	(0.00)	0.02	0.02	(0.00)
Total Physician Services	94.66	90.90	(3.76)	95.04	90.99	(4.05)
Other Professional Services						
Vision Service Capitation	0.85	0.90	0.05	0.85	0.90	0.05
221 - Business Intelligence	0.44	0.48	0.03	0.49	0.48	(0.01)
223 - Enterprise Configuration	0.28	0.33	0.06	0.32	0.33	0.01
310 - Health Servcies - Utilization Management	1.90	1.91	0.02	1.95	1.92	(0.03)
311 - Health Services - Quality Improvement	0.58	0.71	0.12	0.61	0.71	0.10
312 - Health Services Education	0.72	0.88	0.16	0.81	0.88	0.07
313 - Pharmacy	0.27	0.32	0.05	0.30	0.32	0.02
314 - Enhanced Care Management	0.86	0.98	0.11	0.99	0.98	(0.01)
316 - Population Health Management	1.14	1.51	0.36	1.32	1.51	0.19
317 - In Lieu of Services	0.17	0.32	0.15	0.31	0.32	0.01
321 - Homeless Management Information Services	0.05	0.11	0.05	0.06	0.11	0.04
330 - Member Services	2.07	2.68	0.61	2.60	2.69	0.09
331 - Member Outreach	0.25	0.62	0.37	0.31	0.62	0.32
410 - Member Engagement	0.12	0.26	0.14	0.14	0.26	0.12
601 - Behavioral Health	0.30	0.44	0.13	0.37	0.44	0.07
602 - Quality & Health Equity	0.18	0.20	0.02	0.20	0.20	0.01
605 - Quality Performance	0.33	0.46	0.13	0.38	0.46	0.09
Behavior Health Treatment	9.75	6.99	(2.76)	8.83	6.99	(1.84)
Mental Health Services	1.65	1.67	0.02	1.58	1.68	0.10
Other Professional Services	5.53	5.03	(0.49)	5.35	5.04	(0.30)
Total Other Professional Services	27.44	26.79	(0.65)	27.76	26.83	(0.93)
Emergency Room	18.35	16.80	(1.55)	16.66	16.81	0.15
Inpatient Hospital	90.59	83.73	(6.87)	86.41	83.96	(2.44)
Reinsurance Expense Premium	0.65	0.68	0.03	0.65	0.68	0.03
Outpatient Hospital	51.49	38.00	(13.49)	40.51	38.11	(2.40)
Other Medical						
Ambulance and NEMT	11.45	12.42	0.97	14.86	12.47	(2.39)
Home Health Services & CBAS	4.06	3.24	(0.82)	3.87	3.25	(0.62)
Utilization and Quality Review Expenses	2.52	4.47	1.96	3.01	4.48	1.48
Long Term/SNF/Hospice	38.60	28.25	(10.35)	28.23	28.41	0.18
Provider Enhancement Expense - Prop. 56	4.44	4.08	(0.36)	4.46	3.67	(0.78)
Provider Enhancement Expense - GEMT	1.47	1.04	(0.43)	1.35	1.45	0.10
Enhanced Care Management	19.29	10.65	(8.64)	13.72	10.67	(3.05)
Community Support Services	2.38	-	(2.38)	9.46	-	(9.46)
Major Organ Transplant	1.33	2.34	1.01	1.34	2.35	1.01
Cal AIM Incentive Programs	-	-	-	0.34	-	(0.34)
Student Behavioral Health Incentive	-	-	-	0.30	-	(0.30)
Housing and Homelessness Incentive	-	-	-	0.30	-	(0.30)
Equity & Practice Transformation Expense	0.15	-	(0.15)	0.15	-	(0.15)
Distinct Part Nursing Facility Expense	0.00	-	(0.00)	0.00	-	(0.00)
DME/Rebates	6.70	4.89	(1.81)	5.68	4.90	(0.78)
Total Other Medical	92.39	71.38	(21.00)	87.05	71.66	(15.39)
Pay for Performance Quality Incentive	1.50	1.50	(0.00)	1.52	1.50	(0.02)
Risk Corridor Expense	-	-	-	0.61	-	(0.61)
Hospital Directed Payments	145.63	60.06	(85.57)	145.47	60.19	(85.28)
Hospital Directed Payment Adjustment	0.06	-	(0.06)	12.92	-	(12.92)
Non-Claims Expense Adjustment	(0.01)	-	0.01	(3.44)	-	3.44
IBNR, Incentive, Paid Claims Adjustment	(0.10)	-	0.10	(0.06)	-	0.06
Total Medical Costs	522.65	389.83	(132.82)	511.10	390.74	(120.37)

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

	January	February	March	April	May	June
Physician Services						
Primary Care Physician Services	6,633,777	10,235,649	8,511,088	8,021,079	8,209,102	10,026,387
Referral Specialty Services	25,541,006	24,175,932	26,067,518	27,364,943	29,514,962	29,048,662
Urgent Care & After Hours Advice	3,948,407	4,291,828	4,106,619	3,623,145	1,686,319	3,028,060
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300	9,000
Total Physician Services	36,132,491	38,711,809	38,694,525	39,018,167	39,419,683	42,112,109
Other Professional Services						
Vision Service Capitation	344,606	343,774	343,775	345,653	344,127	343,908
221 - Business Intelligence	211,963	188,504	191,787	186,842	193,999	194,435
223 - Enterprise Configuration	142,213	117,289	130,628	128,689	138,241	135,954
310 - Health Servcies - Utilization Management	826,640	762,266	757,294	734,148	748,550	710,325
311 - Health Services - Quality Improvement	306,121	220,471	220,433	238,693	248,061	241,982
312 - Health Services Education	321,705	307,110	316,293	312,444	315,011	323,825
313 - Pharmacy	140,301	111,951	115,447	113,186	123,215	119,553
314 - Enhanced Care Management	411,824	347,498	371,602	395,870	390,150	390,990
316 - Population Health Management	593,720	502,067	520,999	496,916	507,502	519,902
317 - In Lieu of Services	134,223	120,595	127,368	125,560	133,141	134,784
321 - Homeless Management Information Services	44,251	23,122	20,283	21,008	21,840	22,122
330 - Member Services	1,080,746	1,029,669	1,011,284	1,016,232	1,067,629	1,025,969
331 - Member Outreach	83,414	78,217	82,465	117,142	86,498	86,260
410 - Member Engagement	59,841	54,424	57,455	57,181	58,977	57,105
601 - Behavioral Health	170,807	146,523	140,152	147,490	160,019	150,152
602 - Quality & Health Equity	82,237	78,819	78,678	79,984	78,183	73,359
605 - Quality Performance	154,331	142,203	160,748	156,090	148,645	139,390
Behavior Health Treatment	3,181,908	3,355,677	2,493,778	3,786,771	2,901,828	3,914,355
Mental Health Services	974,251	506,210	300,821	550,412	609,128	555,723
Other Professional Services	2,180,697	1,568,304	2,126,040	2,241,884	2,418,598	2,383,070
Total Other Professional Services	11,445,798	10,004,694	9,567,330	11,252,193	10,693,341	11,523,165
Emergency Room	7,289,728	6,508,981	6,225,711	6,330,730	7,074,183	7,003,225
Inpatient Hospital	33,857,875	31,406,220	33,213,126	33,714,646	39,326,548	39,527,275
Reinsurance Expense Premium	269,619	269,619	269,619	240,829	271,713	255,781
Outpatient Hospital	16,019,765	15,697,949	14,487,044	16,762,573	14,357,942	15,379,229
Other Medical						
Ambulance and NEMT	5,965,805	7,090,416	6,724,343	5,827,057	6,396,406	6,536,276
Home Health Services & CBAS	1,636,266	1,531,236	1,185,227	1,395,613	1,130,422	1,646,789
Utilization and Quality Review Expenses	936,126	930,163	1,665,464	773,340	1,444,299	972,636
Long Term/SNF/Hospice	10,523,545	10,822,106	9,460,426	10,684,436	10,165,912	11,159,610
Provider Enhancement Expense - Prop. 56	1,801,039	1,803,328	1,805,739	1,809,345	1,813,309	1,805,939
Provider Enhancement Expense - GEMT	549,430	519,819	534,888	534,592	534,661	536,894
Enhanced Care Management	5,134,027	5,521,997	5,331,279	5,330,372	5,331,053	5,352,687
Community Support Services	590,845	3,824,743	4,662,690	6,140,445	5,298,573	6,510,178
Major Organ Transplant	542,452	574,592	534,775	537,237	541,047	533,290
Cal AIM Incentive Programs	275,000	188,015	390,633	125,018	90,000	-
Student Behavioral Health Incentive	-	-	-	-	-	-
Housing and Homelessness Incentive	-	-	-	-	-	200,000
Equity & Practice Transformation Expense	-		-	-	-	-
Distinct Part Nursing Facility Expense	1,259	1,293	1,251	1,227	1,206	1,232
DME/Rebates	2,339,823	1,958,689	1,991,312	2,331,626	2,136,985	2,389,588
Total Other Medical	30,295,617	34,766,397	34,288,028	35,490,308	34,883,873	37,645,117
Pay for Performance Quality Incentive	606,662	608,318	607,800	607,349	605,835	707,199
Risk Corridor Expense	-	-	-	-	-	-
Hospital Directed Payments	59,831,392	58,045,936	58,943,903	58,897,348	58,890,354	59,075,312
Hospital Directed Payment Adjustment	103,134,648	1,953,159	15,484	111,948	1,098,088	(37,127)
Non-Claims Expense Adjustment	(350,170)	(2,753,743)	(3,382,901)	(1,877)	(10,262,733)	(283)
IBNR, Incentive, Paid Claims Adjustment	388,615	248,637	21,094	(2,667,286)	(37,610)	(826,300)
Total Medical Costs	298,922,038	195,467,975	192,950,763	199,756,928	196,321,218	212,364,700

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

	July	August	September	October	November	Year to Date
Physician Services						
Primary Care Physician Services	9,216,722	9,577,793	10,189,013	10,544,151	11,642,661	102,807,422
Referral Specialty Services	25,977,509	26,256,618	22,742,517	24,677,307	25,177,072	286,544,045
Urgent Care & After Hours Advice	2,934,095	2,407,589	2,835,055	2,403,907	928,072	32,193,096
Hospital Admitting Team	9,300	9,300	9,000	9,300	9,000	100,200
Total Physician Services	38,137,625	38,251,300	35,775,586	37,634,665	37,756,805	421,644,764
Other Professional Services						
Vision Service Capitation	342,449	344,852	345,490	338,736	340,003	3,777,372
221 - Business Intelligence	203,605	188,920	211,041	223,265	177,177	2,171,538
223 - Enterprise Configuration	137,093	118,366	129,610	146,567	110,202	1,434,852
310 - Health Servcies - Utilization Management	791,938	758,725	881,480	918,998	756,459	8,646,822
311 - Health Services - Quality Improvement	228,544	216,012	261,284	279,131	232,377	2,693,108
312 - Health Services Education	333,163	346,379	352,281	396,952	285,744	3,610,908
313 - Pharmacy	113,809	122,168	127,755	140,020	106,556	1,333,961
314 - Enhanced Care Management	411,433	391,539	441,586	488,716	344,417	4,385,625
316 - Population Health Management	565,114	513,656	575,146	614,411	455,330	5,864,764
317 - In Lieu of Services	133,606	136,171	137,205	138,646	67,411	1,388,711
321 - Homeless Management Information Services	23,226	21,901	24,334	26,452	20,015	268,553
330 - Member Services	1,061,079	1,033,664	1,106,665	1,258,918	824,995	11,516,851
331 - Member Outreach	84,852	80,192	96,102	461,767	101,692	1,358,602
410 - Member Engagement	55,111	55,771	58,621	66,468	47,894	628,848
601 - Behavioral Health	158,413	133,836	153,441	170,830	121,103	1,652,767
602 - Quality & Health Equity	83,714	72,204	84,617	87,186	72,711	871,691
605 - Quality Performance	141,810	170,657	157,585	167,942	131,980	1,671,383
Behavior Health Treatment	3,582,170	4,843,499	3,550,384	3,670,491	3,887,059	39,167,921
Mental Health Services	703,273	689,979	729,471	732,954	659,292	7,011,514
Other Professional Services	1,958,620	2,518,539	2,155,116	1,965,617	2,203,830	23,720,315
Total Other Professional Services	11,113,022	12,757,030	11,579,214	12,294,068	10,946,249	123,176,104
Emergency Room	6,580,865	6,307,989	6,861,936	6,401,699	7,320,640	73,905,686
Inpatient Hospital	34,361,371	34,046,492	33,479,870	34,291,026	36,135,732	383,360,181
Reinsurance Expense Premium	260,984	262,299	262,754	258,815	257,831	2,879,861
Outpatient Hospital	15,553,674	15,218,411	17,115,477	18,608,145	20,537,887	179,738,095
Other Medical						
Ambulance and NEMT	5,807,437	5,548,491	5,936,856	5,532,616	4,568,473	65,934,176
Home Health Services & CBAS	1,686,511	1,887,076	1,728,134	1,730,373	1,618,518	17,176,165
Utilization and Quality Review Expenses	1,266,051	1,689,659	1,362,068	1,292,945	1,003,384	13,336,137
Long Term/SNF/Hospice	10,761,685	12,559,642	11,260,496	12,447,354	15,396,429	125,241,641
Provider Enhancement Expense - Prop. 56	1,807,377	1,797,523	1,778,220	1,773,309	1,772,799	19,767,927
Provider Enhancement Expense - GEMT	537,034	555,602	551,640	539,474	584,807	5,978,840
Enhanced Care Management	6,587,375	5,019,062	4,330,252	5,254,304	7,694,367	60,886,776
Community Support Services	4,917,304	2,803,270	3,111,631	3,143,346	948,675	41,951,699
Major Organ Transplant	731,538	344,643	533,878	532,190	529,617	5,935,260
Cal AIM Incentive Programs	434,367	-	-	-	-	1,503,032
Student Behavioral Health Incentive	-	-	1,318,248	2,916	-	1,321,164
Housing and Homelessness Incentive	1,125,000	-	-	-	-	1,325,000
Equity & Practice Transformation Expense	-	-	-	604,252	59,786	664,037
Distinct Part Nursing Facility Expense	1,194	1,169	1,247	1,339	1,358	13,775
DME/Rebates	2,491,164	2,500,899	2,191,326	2,194,133	2,673,501	25,199,046
Total Other Medical	38,154,038	34,707,037	34,103,997	35,048,550	36,851,714	386,234,677
Pay for Performance Quality Incentive	608,444	603,107	603,107	598,968	598,310	6,755,095
Risk Corridor Expense	-	-	1,591,081	1,117,618	-	2,708,699
Hospital Directed Payments	59,035,880	58,464,674	58,296,817	57,853,756	58,087,932	645,423,305
Hospital Directed Payment Adjustment	4,261,156	(53,169,871)	(53,406)	3,959	22,608	57,340,646
Non-Claims Expense Adjustment	99,601	6,421	1,413,996	(12,759)	(4,951)	(15,249,399)
IBNR, Incentive, Paid Claims Adjustment	822,578	1,343,361	482,033	(22,750)	(38,786)	(286,414)
Total Medical Costs	208,989,239	148,798,250	201,512,462	204,075,760	208,471,968	2,267,631,300

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

	January	February	March	April	May	June
Physician Services						
Primary Care Physician Services	16.40	25.24	21.00	19.81	20.33	24.77
Referral Specialty Services	63.15	59.61	64.33	67.58	73.08	71.76
Urgent Care & After Hours Advice	9.76	10.58	10.13	8.95	4.18	7.48
Hospital Admitting Team	0.02	0.02	0.02	0.02	0.02	0.02
Total Physician Services	89.34	95.46	95.49	96.37	97.60	104.03
Other Professional Services						
Vision Service Capitation	0.85	0.85	0.85	0.85	0.85	0.85
221 - Business Intelligence	0.52	0.46	0.47	0.46	0.48	0.48
223 - Enterprise Configuration	0.35	0.29	0.32	0.32	0.34	0.34
310 - Health Servcies - Utilization Management	2.04	1.88	1.87	1.81	1.85	1.75
311 - Health Services - Quality Improvement	0.76	0.54	0.54	0.59	0.61	0.60
312 - Health Services Education	0.80	0.76	0.78	0.77	0.78	0.80
313 - Pharmacy	0.35	0.28	0.28	0.28	0.31	0.30
314 - Enhanced Care Management	1.02	0.86	0.92	0.98	0.97	0.97
316 - Population Health Management	1.47	1.24	1.29	1.23	1.26	1.28
317 - In Lieu of Services	0.33	0.30	0.31	0.31	0.33	0.33
321 - Homeless Management Information Services	0.11	0.06	0.05	0.05	0.05	0.05
330 - Member Services	2.67	2.54	2.50	2.51	2.64	2.53
331 - Member Outreach	0.21	0.19	0.20	0.29	0.21	0.21
410 - Member Engagement	0.15	0.13	0.14	0.14	0.15	0.14
601 - Behavioral Health	0.42	0.36	0.35	0.36	0.40	0.37
602 - Quality & Health Equity	0.20	0.19	0.19	0.20	0.19	0.18
605 - Quality Performance	0.38	0.35	0.40	0.39	0.37	0.34
Behavior Health Treatment	7.87	8.27	6.15	9.35	7.18	9.67
Mental Health Services	2.41	1.25	0.74	1.36	1.51	1.37
Other Professional Services	5.39	3.87	5.25	5.54	5.99	5.89
Total Other Professional Services	28.30	24.67	23.61	27.79	26.48	28.47
Emergency Room	18.02	16.05	15.36	15.64	17.52	17.30
Inpatient Hospital	83.72	77.44	81.97	83.27	97.37	97.65
Reinsurance Expense Premium	0.67	0.66	0.67	0.59	0.67	0.63
Outpatient Hospital	39.61	38.71	35.75	41.40	35.55	37.99
Other Medical						
Ambulance and NEMT	14.75	17.48	16.60	14.39	15.84	16.15
Home Health Services & CBAS	4.05	3.78	2.93	3.45	2.80	4.07
Utilization and Quality Review Expenses	2.31	2.29	4.11	1.91	3.58	2.40
Long Term/SNF/Hospice	26.02	26.69	23.35	26.39	25.17	27.57
Provider Enhancement Expense - Prop. 56	4.45	4.45	4.46	4.47	4.49	4.46
Provider Enhancement Expense - GEMT	1.36	1.28	1.32	1.32	1.32	1.33
Enhanced Care Management	12.69	13.62	13.16	13.16	13.20	13.22
Community Support Services	1.46	9.43	11.51	15.17	13.12	16.08
Major Organ Transplant	1.34	1.42	1.32	1.33	1.34	1.32
Cal AIM Incentive Programs	0.68	0.46	0.96	0.31	0.22	-
Student Behavioral Health Incentive	-	-	-	-	-	-
Housing and Homelessness Incentive	-	-	-	-	-	0.49
Equity & Practice Transformation Expense	-	-	-	-	-	-
Distinct Part Nursing Facility Expense	0.00	0.00	0.00	0.00	0.00	0.00
DME	5.79	4.83	4.91	5.76	5.29	5.90
Total Other Medical	74.91	85.73	84.62	87.65	86.37	93.00
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.50	1.75
Risk Corridor Expense	-	-	-	-	-	-
Hospital Directed Payments	147.94	143.13	145.47	145.46	145.81	145.94
Hospital Directed Payment Adjustment	255.01	4.82	0.04	0.28	2.72	(0.09)
Non-Claims Expense Adjustment	(0.87)	(6.79)	(8.35)	(0.00)	(25.41)	(0.00)
IBNR, Incentive, Paid Claims Adjustment	0.96	0.61	0.05	(6.59)	(0.09)	(2.04)
Total Medical Costs	739.10	481.99	476.19	493.35	486.08	524.62

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED NOVEMBER 30, 2025

	July	August	September	October	November	Year to Date
Physician Services						
Primary Care Physician Services	22.72	23.82	25.41	26.34	29.19	23.17
Referral Specialty Services	64.04	65.30	56.71	61.64	63.12	64.58
Urgent Care & After Hours Advice	7.23	5.99	7.07	6.00	2.33	7.26
Hospital Admitting Team	0.02	0.02	0.02	0.02	0.02	0.02
Total Physician Services	94.02	95.14	89.21	94.01	94.66	95.04
Other Professional Services						
Vision Service Capitation	0.84	0.86	0.86	0.85	0.85	0.85
221 - Business Intelligence	0.50	0.47	0.53	0.56	0.44	0.49
223 - Enterprise Configuration	0.34	0.29	0.32	0.37	0.28	0.32
310 - Health Servcies - Utilization Management	1.95	1.89	2.20	2.30	1.90	1.95
311 - Health Services - Quality Improvement	0.56	0.54	0.65	0.70	0.58	0.61
312 - Health Services Education	0.82	0.86	0.88	0.99	0.72	0.81
313 - Pharmacy	0.28	0.30	0.32	0.35	0.27	0.30
314 - Enhanced Care Management	1.01	0.97	1.10	1.22	0.86	0.99
316 - Population Health Management	1.39	1.28	1.43	1.53	1.14	1.32
317 - In Lieu of Services	0.33	0.34	0.34	0.35	0.17	0.31
321 - Homeless Management Information Services	0.06	0.05	0.06	0.07	0.05	0.06
330 - Member Services	2.62	2.57	2.76	3.14	2.07	2.60
331 - Member Outreach	0.21	0.20	0.24	1.15	0.25	0.31
410 - Member Engagement	0.14	0.14	0.15	0.17	0.12	0.14
601 - Behavioral Health	0.39	0.33	0.38	0.43	0.30	0.37
602 - Quality & Health Equity	0.21	0.18	0.21	0.22	0.18	0.20
605 - Quality Performance	0.35	0.42	0.39	0.42	0.33	0.38
Behavior Health Treatment	8.83	12.05	8.85	9.17	9.75	8.83
Mental Health Services	1.73	1.72	1.82	1.83	1.65	1.58
Other Professional Services	4.83	6.26	5.37	4.91	5.53	5.35
Total Other Professional Services	27.40	31.73	28.87	30.71	27.44	27.76
Emergency Room	16.22	15.69	17.11	15.99	18.35	16.66
Inpatient Hospital	84.71	84.68	83.48	85.65	90.59	86.41
Reinsurance Expense Premium	0.64	0.65	0.66	0.65	0.65	0.65
Outpatient Hospital	38.34	37.85	42.68	46.48	51.49	40.51
Other Medical						
Ambulance and NEMT	14.32	13.80	14.80	13.82	11.45	14.86
Home Health Services & CBAS	4.16	4.69	4.31	4.32	4.06	3.87
Utilization and Quality Review Expenses	3.12	4.20	3.40	3.23	2.52	3.01
Long Term/SNF/Hospice	26.53	31.24	28.08	31.09	38.60	28.23
Provider Enhancement Expense - Prop. 56	4.46	4.47	4.43	4.43	4.44	4.46
Provider Enhancement Expense - GEMT	1.32	1.38	1.38	1.35	1.47	1.35
Enhanced Care Management	16.24	12.48	10.80	13.12	19.29	13.72
Community Support Services	12.12	6.97	7.76	7.85	2.38	9.46
Major Organ Transplant	1.80	0.86	1.33	1.33	1.33	1.34
Cal AIM Incentive Programs	1.07	-	-	-	-	0.34
Student Behavioral Health Incentive	-	-	3.29	0.01	-	0.30
Housing and Homelessness Incentive	2.77	-	-	-	-	0.30
Equity & Practice Transformation Expense	-	-	-	1.51	0.15	0.15
Distinct Part Nursing Facility Expense	0.00	0.00	0.00	0.00	0.00	0.00
DME	6.14	6.22	5.46	5.48	6.70	5.68
Total Other Medical	94.06	86.32	85.04	87.55	92.39	87.05
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.50	1.52
Risk Corridor Expense	-	-	3.97	2.79	-	0.61
Hospital Directed Payments	145.54	145.41	145.37	144.51	145.63	145.47
Hospital Directed Payment Adjustment	10.51	(132.24)	(0.13)	0.01	0.06	12.92
Non-Claims Expense Adjustment	0.25	0.02	3.53	(0.03)	(0.01)	(3.44)
IBNR, Incentive, Paid Claims Adjustment	2.03	3.34	1.20	(0.06)	(0.10)	(0.06)
Total Medical Costs	515.22	370.08	502.48	509.75	522.65	511.10

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED NOVEMBER 30, 2025

	November	Budget	Variance	Year to Date	Budget	Variance
110 - Executive	568,466	650,390	81,924	6,791,252	7,154,293	363,042
112 - Government Relations	53,542	62,942	9,400	610,016	692,361	82,345
210 - Accounting	332,618	370,068	37,450	4,000,235	4,070,743	70,508
220 - Management Information Systems (MIS)	275,056	508,775	233,719	3,398,353	5,596,520	2,198,167
221 - Business Intelligence	284,908	246,484	(38,424)	4,132,950	2,711,325	(1,421,624)
222 - MIS Development	450,991	515,722	64,731	6,016,019	5,672,947	(343,072)
223 - Enterprise Configuration	208,966	322,452	113,485	2,760,935	3,546,967	786,032
224 - Cyber Security	138,654	43,744	(94,911)	749,796	481,180	(268,617)
225 - Infrastructure	683,636	1,140,153	456,517	8,496,707	12,541,681	4,044,974
226 - Technical Administrative Services	52,094	94,102	42,008	671,370	1,035,126	363,755
230 - Claims	770,687	823,338	52,650	10,505,340	9,056,711	(1,448,629)
240 - Project Development	208,279	216,007	7,728	2,411,308	2,376,076	(35,232)
310 - Health Services - Utilization Management	45,111	50,148	5,036	562,587	551,624	(10,963)
311 - Health Services - Quality Improvement	7,434	11,596	4,161	87,776	127,551	39,775
312 - Health Services - Education	0	648	648	415	7,132	6,717
313 - Pharmacy	0	11,450	11,450	32,583	125,950	93,367
314 - Enhanced Care Management	20,986	22,583	1,597	269,441	248,409	(21,032)
316 - Population Health Management	-	2,454	2,454	1,555	26,996	25,440
317 - Community Support Services	27,040	3,150	(23,890)	79,984	34,654	(45,330)
320 - Provider Network Management	241,711	326,776	85,066	3,040,010	3,594,540	554,529
321 - Homeless Management Information Serv	54	1,854	1,800	1,835	20,396	18,561
322 - Delegation & Oversight	18,230	30,422	12,192	324,968	334,639	9,670
330 - Member Services	137,617	229,307	91,690	1,536,123	2,522,401	986,278
340 - Corporate Services	883,370	1,128,044	244,674	9,921,106	12,408,489	2,487,383
360 - Audit & Investigative Services	274,900	306,189	31,289	3,304,512	3,368,078	63,567
410 - Member Engagement	53,564	62,873	9,309	712,263	691,607	(20,657)
420 - Sales/Marketing/Public Relations	7,842	329,532	321,689	2,581,384	3,624,848	1,043,464
510 - Human Resourses	347,188	460,498	113,309	4,850,565	5,065,473	214,908
520 - Legal	95,708	122,824	27,116	744,084	1,351,059	606,975
601 - Behavioral Health	5,507	3,350	(2,157)	22,228	36,850	14,622
602 - Quality & Health Equity	6,165	35,573	29,408	182,268	391,303	209,035
603 - Medicare	76	-	(76)	76	-	(76)
604 - Clinical Operations, Strategy & Analytics	0	-	(0)	0	-	(0)
605 - Quality Performance	163,995	116,048	(47,947)	2,090,997	1,276,530	(814,467)
Administrative Expense Adjustment	74,147	200,000	125,853	1,208,911	2,200,000	991,089
Total Administrative Expenses	6,438,543	8,449,494	2,010,951	82,099,954	92,944,456	10,844,501

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED NOVEMBER 30, 2025

	January	February	March	April	May	June
110 - Executive	682,639	453,118	564,215	590,083	706,155	707,525
112 - Government Relations	64,745	54,023	53,593	52,753	52,122	50,607
210 - Accounting	373,730	270,170	370,641	425,988	328,977	293,602
220 - Management Information Systems (MIS)	354,906	282,955	322,843	190,927	363,642	398,515
221 - Business Intelligence	288,258	333,566	445,959	820,670	390,607	(16,886)
222 - MIS Development	390,138	339,566	481,800	492,554	674,896	841,641
223 - Enterprise Configuration	233,790	188,775	205,405	192,961	272,681	361,934
224 - Cyber Security	31,621	51,523	39,996	64,290	59,425	41,757
225 - Infrastructure	767,910	644,388	845,020	1,162,292	828,314	698,614
226 - Technical Administrative Services	70,628	64,258	67,549	47,750	79,438	79,715
230 - Claims	885,033	986,246	941,807	907,411	964,739	875,316
240 - Project Development	214,035	237,465	220,963	149,624	421,861	297,080
310 - Health Services - Utilization Managemen	30,019	52,541	40,446	52,147	64,953	50,249
311 - Health Services - Quality Improvement	(15,100)	31,947	7,052	8,308	8,591	7,744
312 - Health Services - Education	-	-	-	-	-	246
313 - Pharmacy	10,795	10,500	10,500	357	(0)	67
314 - Enhanced Care Management	18,954	44,579	20,337	23,983	22,006	27,607
316 - Population Health Management	103	-	-	1,030	48	5
317 - Community Support Services	-	-	883	-	0	1,310
320 - Provider Network Management	297,212	274,630	285,138	289,369	327,952	266,832
321 - Homeless Management Information Serv	73	-	54	1,964	-	(901)
322 - Delegation & Oversight	50,538	1,369	26,376	45,370	45,974	36,047
330 - Member Services	174,446	228,649	118,453	159,275	190,289	178,853
340 - Corporate Services	1,085,693	680,455	851,850	876,263	885,564	887,141
360 - Audit & Investigative Services	286,424	338,436	269,614	283,804	324,297	279,420
410 - Member Engagement	67,809	62,520	64,681	66,137	67,561	62,705
420 - Sales/Marketing/Public Relations	139,774	226,357	228,233	118,236	308,542	369,105
510 - Human Resourses	727,474	317,319	475,133	432,281	477,233	428,938
520 - Legal	35,231	100,899	142,724	118,635	47,741	53,469
601 - Behavioral Health	307	200	(0)	76	15,950	(0)
602 - Quality & Health Equity	10,624	9,938	10,083	72,665	10,603	14,026
603 - Medicare	-	-	-	-	-	-
604 - Clinical Operations, Strategy & Analytics	-	-	-	-	-	-
605 - Quality Performance	212,721	179,458	198,076	193,987	183,516	171,252
Administrative Expense Adjustment	202,969	198,773	375,177	160,116	69,345	47,536
Total Administrative Expenses	7,693,499	6,664,623	7,684,602	8,001,306	8,193,021	7,511,070

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED NOVEMBER 30, 2025

	July	August	September	October	November	YTD TOTALS
110 - Executive	649,999	586,896	739,099	543,058	568,466	6,791,252
112 - Government Relations	51,463	55,517	61,783	59,866	53,542	610,016
210 - Accounting	385,487	342,404	363,072	513,547	332,618	4,000,235
220 - Management Information Systems (MIS)	331,263	291,676	286,783	299,787	275,056	3,398,353
221 - Business Intelligence	564,816	516,199	214,200	290,653	284,908	4,132,950
222 - MIS Development	568,876	562,724	488,230	724,603	450,991	6,016,019
223 - Enterprise Configuration	238,908	268,167	302,450	286,898	208,966	2,760,935
224 - Cyber Security	47,881	76,238	133,671	64,739	138,654	749,796
225 - Infrastructure	748,388	641,138	815,232	661,776	683,636	8,496,707
226 - Technical Administrative Services	98,333	96,432	(37,555)	52,729	52,094	671,370
230 - Claims	1,599,045	793,646	810,304	971,107	770,687	10,505,340
240 - Project Development	245,517	(187,245)	328,707	275,021	208,279	2,411,308
310 - Health Services - Utilization Managemen	64,004	55,256	50,160	57,700	45,111	562,587
311 - Health Services - Quality Improvement	7,312	6,911	8,357	9,222	7,434	87,776
312 - Health Services - Education	(0)	169	(0)	-	0	415
313 - Pharmacy	(0)	0	(0)	364	0	32,583
314 - Enhanced Care Management	19,956	22,214	23,216	25,602	20,986	269,441
316 - Population Health Management	0	186	0	184	-	1,555
317 - Community Support Services	(0)	25,688	24,336	728	27,040	79,984
320 - Provider Network Management	289,066	188,330	275,617	304,153	241,711	3,040,010
321 - Homeless Management Information Serv	(0)	-	91	500	54	1,835
322 - Delegation & Oversight	(3,994)	31,710	24,090	49,258	18,230	324,968
330 - Member Services	180,533	202,243	168,633	(202,868)	137,617	1,536,123
340 - Corporate Services	932,377	906,946	963,014	968,432	883,370	9,921,106
360 - Audit & Investigative Services	315,648	258,896	314,342	358,732	274,900	3,304,512
410 - Member Engagement	62,404	63,798	65,372	75,711	53,564	712,263
420 - Sales/Marketing/Public Relations	630,980	136,181	190,630	225,505	7,842	2,581,384
510 - Human Resourses	427,918	443,736	368,921	404,423	347,188	4,850,565
520 - Legal	46,903	33,920	32,629	36,226	95,708	744,084
601 - Behavioral Health	188	-	0	-	5,507	22,228
602 - Quality & Health Equity	14,276	9,651	11,529	12,708	6,165	182,268
603 - Medicare	-	-	-	-	76	76
604 - Clinical Operations, Strategy & Analytics	-	0	-	(0)	0	0
605 - Quality Performance	176,086	211,038	194,177	206,691	163,995	2,090,997
Administrative Expense Adjustment	(308)	-	-	81,156	74,147	1,208,911
Total Administrative Expenses	8,693,325	6,640,664	7,221,090	7,358,211	6,438,543	82,099,954

KHS - GROUP HEALTH PLAN
STATEMENT OF NET POSITION
AS OF NOVEMBER 30, 2025

ASSETS	November 2025	October 2025	Increase/ (Decrease)
Cash and Cash Equivalents	1,289,659	1,289,659	-
Interest Receivable	9,200	4,600	4,600
Other Receivable	125	125	-
Total Current Assets	1,298,984	1,294,384	4,600
CURRENT LIABILITIES			
Other Liabilities	-	-	-
Total Current Liabilities	-	-	-
NET POSITION:			
Net Position at Beginning of Year	1,245,606	1,245,606	-
Increase (Decrease) in Net Position - Current Year	53,378	48,778	4,600
Total Net Position	1,298,984	1,294,384	4,600
TOTAL LIABILITIES AND NET POSITION	1,298,984	1,294,384	4,600

KERN HEALTH SYSTEMS

KHS - GROUP HEALTH PLAN
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED NOVEMBER 30, 2025

	November	Budget	Variance	Year to Date	Budget	Variance
REVENUES						
Premium	-	-	-	-	-	-
Interest	4,600	-	4,600	50,468	-	50,468
Other Investment Income	-	-	-	2,911	-	2,911
Total Revenues	4,600	-	4,600	53,378	-	53,378
EXPENSES						
MEDICAL COSTS						
IBNR and Paid Claims Adjustment	-	-	-	-	-	-
Total Medical Costs	-	-	-	-	-	-
GROSS MARGIN	4,600	-	4,600	53,378	-	53,378
ADMINISTRATIVE COSTS						
Management Fee Expense and Other Admin Exp	-	-	-	-	-	-
Total Administrative Expenses	-	-	-	-	-	-
TOTAL EXPENSES	-	-	-	-	-	-
OPERATING INCOME (LOSS) BEFORE TAX	4,600	-	4,600	53,378	-	53,378
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	-	-	-	-	-	-
NET INCREASE (DECREASE) IN NET POSITION	4,600	-	4,600	53,378	-	53,378
MEDICAL LOSS RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ADMINISTRATIVE EXPENSE RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

MEDI-CAL	2025 MEMBER MONTHS	JAN'25	FEB'25	MAR'25	APR'25	MAY'25	JUN'25	JUL'25	AUG'25	SEP'25	OCT'25	NOV'25	DEC'25
ADULT AND FAMILY													
ADULT (SEE COMMENT)	**812,723**	74,604	74,605	74,309	74,397	74,422	74,237	74,479	73,525	73,180	72,725	72,240	0
CHILD	**1,832,397**	167,252	167,669	167,854	167,367	165,950	166,463	166,724	166,226	165,994	165,893	165,005	0
SUB-TOTAL ADULT & FAMILY	**2,645,120**	**241,856**	**242,274**	**242,163**	**241,764**	**240,372**	**240,700**	**241,203**	**239,751**	**239,174**	**238,618**	**237,245**	**0**
OTHER MEMBERS													
FULL DUALS - FAMILY	**5,744**	566	526	545	541	533	534	510	494	504	502	489	0
FULL DUALS - CHILD	**4**	0	0	0	0	0	0	0	0	0	4	0	0
SUBTOTAL OTHER MEMBERS	**5,748**	**566**	**526**	**545**	**541**	**533**	**534**	**510**	**494**	**504**	**506**	**489**	**0**
TOTAL FAMILY	**2,650,868**	**242,422**	**242,800**	**242,708**	**242,305**	**240,905**	**241,234**	**241,713**	**240,245**	**239,678**	**239,124**	**237,734**	**0**
SPD MEMBERS													
SPD (AGED AND DISABLED)	**229,744**	23,226	18,391	20,998	21,034	20,905	20,961	20,698	20,780	20,834	20,976	20,941	0
OTHER MEMBERS													
BCCTP - TABACCO SETTLEMENT	**80**	0	0	0	12	9	13	11	11	10	14	0	0
FULL DUALS - BCCTP	**21**	2	1	2	2	2	2	2	2	2	2	2	0
SPD FULL DUALS	**281,780**	23,272	27,695	25,425	25,375	25,671	25,597	25,812	25,590	25,927	25,610	25,806	0
EXPANDION FULL DUALS	**3,797**	*366*	*333*	*322*	*326*	*293*	*357*	*297*	*367*	*400*	*397*	*339*	*0*
LONG TERM CARE (LTC)													
LTC	**563**	48	52	54	52	52	46	49	51	56	59	44	0
LTC DUALS	**5,089**	465	467	462	451	453	443	431	429	451	498	539	0
TOTAL LTC	**5,652**	**513**	**519**	**516**	**503**	**505**	**489**	**480**	**480**	**507**	**557**	**583**	**0**
TOTAL SPD	**521,074**	**47,379**	**46,939**	**47,263**	**47,252**	**47,385**	**47,419**	**47,300**	**47,230**	**47,680**	**47,556**	**47,671**	**0**
ACA OE - MEDI-CAL OPTIONAL EXPANSION													
ACA Expansion Adult-Citizen	**1,264,788**	*114,640*	*115,806*	*115,229*	*115,342*	*115,600*	*116,146*	*116,616*	*114,596*	*113,679*	*113,666*	*113,468*	*0*
TOTAL EXPANSION	**1,264,788**	**114,640**	**115,806**	**115,229**	**115,342**	**115,600**	**116,146**	**116,616**	**114,596**	**113,679**	**113,666**	**113,468**	**0**
TOTAL CLASSIC MEMBERS	**4,436,730**	**404,441**	**405,545**	**405,200**	**404,899**	**403,890**	**404,799**	**405,629**	**402,071**	**401,037**	**400,346**	**398,873**	**0**
GRAND TOTAL	**4,436,730**	**404,441**	**405,545**	**405,200**	**404,899**	**403,890**	**404,799**	**405,629**	**402,071**	**401,037**	**400,346**	**398,873**	**0**

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: Reports on Accounts Payable, Administrative Contracts and IT Technology Consulting Resources

DATE: February 19, 2026

Attached for your review are the following items:

1) Accounts Payable Vendor Report listing of payments over $20,000 for the month of November 2025.

2) Administrative Contract Report listing contracts between $50,000 and $200,000 for the period ending November 30, 2025.

3) IT Technology Consulting Resources Report for the period ending November 30, 2025.

Requested Action

Receive and file.

KERN·HEALTH SYSTEMS

November AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
WT/ACH	BCI HOLDINGS	919,391.16	10,341,385.82	NOV. 2025 EMPLOYEE HMO HEALTH BENEFITS & RX CLAIMS PREMIUM	VARIOUS
T1845	DEPARTMENT OF MANAGED HEALTH CARE	585,253.13	1,206,183.72	FINAL INSTALLMENT ANNUAL ASSESMENT 2025-2026	ADMINISTRATION
T4350	COMPUTER ENTERPRISE	364,085.52	5,100,244.73	OCT. 2025 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T4737	TEKSYSTEMS, INC	263,652.82	2,646,503.03	OCT. 2025 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T1180	LANGUAGE LINE SERVICES INC.	203,342.00	2,565,918.94	OCT. 2025 INTERPRETATION SERVICES	HEALTH SERVICES - WELLNESS & PREVENTION
WT/ACH	USPS	150,000.00	235,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC ****	126,498.08	205,408.30	JUL. - OCT. 2025 EDI CLAIMS	CLAIMS
T4331	COTIVITI, INC	77,000.00	394,868.11	HEDIS INTELLIGENCE IMPLEMENTATION FEE, ANNL MEDI-CAL REPORTING FEE 2025-2026	CAPITAL PROJECT/QUALITY PERFORMANCE
WT/ACH	HELPCARE AI	73,999.60	174,000.40	CLOUD BASED AI PLATFORM 2025- 2026	MIS INFRASTRUCTURE
T4237	CITIUS HEALTHCARE CONSULTING, LLC	72,640.00	512,740.00	SEPT. - OCT. 2025 PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE/COMMUNITY SUPPORT SERVICES
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC.	64,761.70	786,988.51	OCT. 2025 PROFESSIONAL SERVICES & OCT. 2025 EDI CLAIMS	MIS INFRASTRUCTURE/CLAIMS
T5658	THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	64,215.57	576,531.29	SEPT. 2025 VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T5886	US POSTAL SERVICE	60,000.00	540,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5564	CLARISHEALTH, INC. ****	56,360.54	624,657.91	OCT. 2025 CLINICAL AUDIT & DATA MINING CONTINGENCY FEE	CLAIMS
T1272	COFFEY COMMUNICATIONS INC.	50,381.05	285,317.55	WINTER 2025 ISSUE FAMILY HEALTH	MARKETING & PUBLIC AFFAIRS
T5890	DELTA DENTAL OF CALIFORNIA	49,527.57	557,067.55	NOV. 2025 EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM	VARIOUS

KERN·HEALTH SYSTEMS

November AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T5520	BG HEALTHCARE CONSULTING, INC	48,737.50	540,575.00	OCT. 2025 CONSULTING SERVICES	HEALTH SERVICES - QI
T6276	KFORCE INC	44,891.92	395,517.47	OCT. 2025 PROFESSIONAL SERVICES	VARIOUS
T1189	APPLE ONE EMPLOYMENT SERVICES	41,375.73	183,036.34	OCT-NOV. 2025 TEMPORARY HELP - (1) FINANCE; (1) CS; (2) MS; (1) HE; (1) COMPLIANCE	VARIOUS
T5292	ALL'S WELL HEALTH CARE SERVICES	41,223.20	1,198,952.83	OCT. 2025 TEMPORARY HELP - (4) UM	VARIOUS
WT/ACH	PAYPRO ACH	40,954.40	473,972.39	OCT. & NOV. 2025 EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T2584	UNITED STATES POSTAL SVC - HASLER ****	40,000.00	280,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T6462	BAKER TILLY US, LLP ****	39,900.00	39,900.00	2025 AUDIT PROGRESS BILLING	FINANCE
T6272	KEY STAFFING INC	39,602.23	359,589.86	OCT. & NOV. 2025 TEMPORARY HELP - (1) FINANCE; (2) MS; (1) CLAIMS; (1) COMPLIANCE; (1) PHM; (1) PNM; (1) HE.	VARIOUS
T4460	PAYSPAN, INC	38,350.74	539,020.80	OCT. 2025 ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T2941	KERN PRINT SERVICES INC.	37,752.19	239,065.83	MEMBER MATERIAL - (300K) ENVELOPES	CORPORATE SERVICES
T3011	OFFICE ALLY, INC	34,707.54	583,998.66	OCT. 2025 EDI CLAIMS	CLAIMS
T5076	MERIDIAN HEALTH SYSTEMS, PMC ****	33,210.00	250,410.00	OCT. 2025 PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T5337	CAZADOR CONSULTING GROUP INC	33,197.76	891,343.21	OCT. 2025 TEMPORARY HELP - (6) MS; (1) ME; (1) MKT; (1) UM	VARIOUS
T6020	ALLMED HEALTHCARE MANAGEMENT, LLC	32,062.50	187,335.00	SEPT. 2025 MEDICAL REVIEWS	HEALTH SERVICES - QI
T5882	RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC	31,405.00	321,370.00	NOV. 2025 JANITORIAL SERVICES & FLOOR CLEANING	CORPORATE SERVICES
T5319	CITIUSTECH INC. ****	28,208.00	105,874.00	FAST + MAINTENANCE & SUBSCRIPTION Q3 2025	INFRASTRUCTURE

KERN·HEALTH SYSTEMS

November AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4657	DAPONDE SIMPSON ROWE PC	27,134.00	307,688.50	SEPT. & OCT. 2025 LEGAL FEES	LEGAL
WT/ACH	INCOMM HEALTHCARE ACH	26,567.01	1,276,567.01	FUNDING FOR MEMBER REWARDS	MEMBER ENGAGEMENT
T5962	GeBBS SOFTWARE INTERNATIONAL, INC	25,000.00	185,000.00	OCT. 2025 PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE
T5026	TEL-TEC SECURITY SYSTEMS ****	24,676.62	31,250.35	2025-2026 MONITORING, HOSTED ACCESS & MAINTENANCE, EQUIPMENT - (2) CAMERAS INSTALLED	CAPITAL PROJECT/CORPORATE SERVICES
T6202	KRAMER WORKPLACE INVESTIGATIONS ****	24,490.50	98,065.00	JUL. - OCT. 2025 CONSULTING	HUMAN RESOURCES
T2969	AMERICAN BUSINESS MACHINES INC ****	22,622.27	119,423.35	OCT. & NOV. 2025 HARDWARE & MAINTENANCE	MIS INFRASTRUCTURE
T4521	PAYSCALE, INC. ****	21,420.00	21,420.00	COMPENSATION SALARY ANALYSIS YR 2 OF 3	HUMAN RESOURCES
T1022	UNUM LIFE INSURANCE CO.	21,189.80	221,466.86	NOV. 2025 EMPLOYEE PREMIUM	VARIOUS
		3,979,787.65			
	TOTAL VENDORS OVER $20,000	3,979,787.65			
	TOTAL VENDORS UNDER $20,000	594,350.19			
	TOTAL VENDOR EXPENSES- NOVEMBER	$ **4,574,137.84**			

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

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
WT/ACH	BCI HOLDINGS	10,341,385.82	2025 EMPLOYEE HMO HEALTH BENEFITS & RX CLAIMS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE	5,100,244.73	PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
WT/ACH	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	3,247,818.56	PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM	HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI
T4737	TEKSYSTEMS, INC.	2,646,503.03	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T1180	LANGUAGE LINE SERVICES INC.	2,565,918.94	INTERPRETATION SERVICES	HEALTH SERVICES - WELLNESS & PREVENTION
T1408	DELL MARKETING LP.	2,145,832.81	VLA ENTERPRISE LICENSE, EA RENEWAL & COMPUTER EQUIPMENT	MIS INFRASTRUCTURE
T2686	ALLIANT INSURANCE SERVICES INC.	1,853,888.95	2025-2026 INSURANCE PREMIUMS	ADMINISTRATION
T2704	MCG HEALTH LLC	1,672,813.17	ANNUAL HEALTH CARE MANAGEMENT & SOFTWARE LICENSE	UTILIZATION MANAGEMENT
T3130	OPTUMINSIGHT, INC.	1,482,371.30	CLAIMS EDIT SOFTWARE LICENSE YEAR 3 OF 5	MIS INFRASTRUCTURE
WT/ACH	INCOMM HEALTHCARE ACH	1,276,567.01	FUNDING FOR MEMBER REWARDS	MEMBER ENGAGEMENT
T1845	DEPARTMENT OF MANAGED HEALTH CARE	1,206,183.72	2025-2026 ANNUAL ASSESMENT	ADMINISTRATION
T5292	ALL'S WELL HEALTH CARE SERVICES	1,198,952.83	TEMPORARY HELP	VARIOUS
T5684	REBELLIS GROUP LLC	1,081,225.69	PROFESSIONAL SERVICES	MEDICARE
T5337	CAZADOR CONSULTING GROUP INC	891,343.21	TEMPORARY HELP	VARIOUS
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC	786,988.51	PROFESSIONAL SERVICES & EDI CLAIMS	MIS INFRASTRUCTURE/CLAIMS
T2458	HEALTHCARE FINANCIAL, INC.	667,807.37	CONSULTING SERVICES	ADMINISTRATION
T5564	CLARISHEALTH, INC	624,657.91	CONSULTING SERVICES	ADMINISTRATION
WT/ACH	PENN MUTUAL LIFE	600,000.00	CAP-EX FUNDING - EXECUTIVE BENEFIT PROGRAM	ADMINISTRATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T3011	OFFICE ALLY, INC	583,998.66	EDI CLAIMS	CLAIMS
T5658	THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	576,531.29	VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T5111	ENTISYS 360, E360	573,241.13	VMWARE VSPHERE ENTERPRISE PLUS 2025	TECHNICAL ADMINISTRATIVE SERVICES
T5890	DELTA DENTAL OF CALIFORNIA	557,067.55	EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM	VARIOUS
T5520	BG HEALTHCARE CONSULTING, INC	540,575.00	CONSULTING SERVICES	HEALTH SERVICES - QI
T5886	US POSTAL SERVICE	540,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T4460	PAYSPAN, INC	539,020.80	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T4237	CITIUS HEALTHCARE CONSULTING, LLC	512,740.00	PROFESSIONAL SERVICES	PROJECT MANAGEMENT/ENTERPRISE CONFIGURATION
WT/ACH	PAYPRO ACH	473,972.39	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5877	TGN CONSULTING LLC	451,369.74	LEADERSHIP DEVELOPMENT CONSULTING	HUMAN RESOURCES
T4733	UNITED STAFFING ASSOCIATES	445,667.19	TEMPORARY HELP	VARIOUS
T1183	MILLIMAN USA	423,108.89	ACTUARIAL SERVICES	VARIOUS
T6276	KFORCE INC	395,517.47	PROFESSIONAL SERVICES	VARIOUS
T4331	COTIVITI, INC	394,868.11	MEDICAL RECORD RETRIEVAL/ HANDLING	QUALITY PERFORMANCE
T5340	GARTNER INC	386,099.99	EXECUTIVE PROGRAM LICENSE & 2025 ON SITE TRAINING	TECHNICAL ADMINISTRATIVE SERVICES/HUMAN RESOURCES
T5930	DAYFORCE US, INC	379,394.99	2025 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T6246	UNIVERSAL HEALTHCARE MSO, LLC	375,848.04	D-SNP PSA IMPLEMENTATION FEES	CAPITAL PROJECT
T5298	TOTALMED, INC	372,853.75	TEMPORARY HELP	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report
Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T6272	KEY STAFFING INC	359,589.86	TEMPORARY HELP	VARIOUS
T5882	RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC	321,370.00	JANITORIAL SERVICES	CORPORATE SERVICES
T4657	DAPONDE SIMPSON ROWE PC	307,688.50	2025 LEGAL FEES	LEGAL
T6127	MANIFEST MEDEX	303,609.75	2025 QTR. 1 - 3 HIE SUBSCRIPTION FEE	MIS INFRASTRUCTURE
T1272	COFFEY COMMUNICATIONS INC.	285,317.55	WINTER ISSUE OF FAMILY HEALTH & WEBSITE ASSIST. MODULES	HEALTH SERVICES - WELLNESS & PREVENTION
T1128	HALL LETTER SHOP, INC	285,053.73	M-CAL RENEWALS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS & ENVELOPES	VARIOUS
T2584	UNITED STATES POSTAL SVC. - HASLER	280,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T3449	CDW GOVERNMENT	278,031.96	NUTANIX CODES, ADOBE LICENSE RENEWAL & NESSUS VULNERABILITY SCANNER TOOL	MIS INFRASTRUCTURE
T2413	TREK IMAGING INC	277,888.67	MARKETING PROMOTIONAL SUPPLIES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS
T5467	MOSS ADAMS LLP	251,157.13	AUDIT SERVICES	FINANCE
T5076	MERIDIAN HEALTH SYSTEMS, PC.	250,410.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
WT/ACH	USPS	235,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T2941	KERN PRINT SERVICES INC.	239,065.83	OFFICE SUPPLIES	CORPORATE SERVICES
T5738	INSURICA - WALTER MORTENSEN INSURANCE	228,091.00	WORKERS COMPENSATION AUDIT	ADMINISTRATION
T1022	UNUM LIFE INSURANCE CO.	221,466.86	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5121	TPX COMMUNICATIONS	219,953.35	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T2469	DST HEALTH SOLUTIONS, LLC	218,725.00	2025 ACG LICENSE FEE & SUPPORT	BUSINESS INTELLIGENCE
T6054	WEBMD IGNITE	207,239.75	2025 LICENSE FEES	HEALTH SERVICES - WELLNESS & PREVENTION

KERN·HEALTH SYSTEMS

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	205,408.30	2025 EDI CLAIMS	CLAIMS
T4514	A.J. KLEIN, INC T. DENATALE, B. GOLDNER	191,828.58	LEGAL FEES	LEGAL
T6020	ALLMED HEALTHCARE MANAGEMENT, LLC	187,335.00	2025 MEDICAL REVIEWS	HEALTH SERVICES - QI
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	186,482.09	PMPY DUES 2025-2026	ADMINISTRATION
T4484	JACOBSON SOLUTIONS	186,085.54	TEMPORARY HELP	CLAIMS
T5962	GeBBS SOFTWARE INTERNATIONAL, INC.	185,000.00	CONSULTING SERVICES	BUSINESS INTELLIGENCE
T1189	APPLE ONE EMPLOYMENT SERVICES	183,036.34	TEMPORARY HELP	VARIOUS
T2167	PG&E	178,688.05	UTILITIES	CORPORATE SERVICES
T5757	BITFOCUS, INC	176,303.40	HMIS LICENSES & HEALTH CHECK TRAINING	HOMELESS MANAGEMENT INFORMATION SERVICES
T4353	TWE SOLUTIONS, INC.	174,459.58	CRITICAL START MDR SERVICES SECURITY MONITORING	CYBER SECURITY
WT/ACH	HELPCARE AI ACH	174,000.40	CLOUD BASED AI PLATFORM 2025- 2026	MIS INFRASTRUCTURE
T5329	RELAY NETWORK, LLC	171,428.07	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T4785	COMMGAP	169,765.00	INTERPRETATION SERVICES	HEALTH SERVICES - WELLNESS & PREVENTION
T5583	THE MILHALIK GROUP, LLC	168,837.50	CONSULTING SERVICES	HEALTH SERVICES - QI
T1097	NCQA (NATIONAL COMMITTEE FOR QUALITY ASSURANCE)	167,636.00	POPULATION HEALTH PROGRAM ACCREDIATION	HEALTH SERVICES - QI
T5865	HARTE-HANKS RESPONSE MANAGEMENT/AUSTIN, INC	160,182.28	PROFESSIONAL SERVICES	MEMBER SERVICES
T4165	SHI INTERNATIONAL CO.	159,850.39	APC SMART-UPS BATTERIES SERVICE , FLEX LICENSE & SUPPORT, ENTW ON-PREMISES CALLING MAINTENANCE	MIS INFRASTRUCTURE
T2918	STINSON'S	159,298.20	OFFICE SUPPLIES	VARIOUS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	155,719.01	DEC. 2024-JUL. 2025 ONSITE SECURITY	CORPORATE SERVICES

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5509	NGUYEN CAO LUU-TRONG	148,800.00	CONSULTING SERVICES	HEALTH SERVICES - UM
T4963	LINKEDIN CORPORATION	142,532.00	2025 LEARNING HUB YEAR 1 OF 2, RECRUITMENT JOB SLOTS YEAR 1 OF 3	HUMAN RESOURCES
T1231	COUNTY OF KERN	139,145.59	REIMB M-CAL ELIGIBILITY STAFF SERVICES	MEMBER OUTREACH
T4708	HEALTH MANAGEMENT ASSOCIATES, INC. / WAKELY CONSULTING GROUP, LLC	138,070.75	PROFESSIONAL SERVICES	FINANCE
T5480	PRESS GANEY ASSOCIATES LLC	132,316.50	2025 ECM SURVEY, MEMBER SATISFACTION SURVEY, PROVIDER SATISFACTION SURVEY, CAHPS SURVEY	VARIOUS
T6261	RUSSELL REYNOLDS ASSOCIATES, INC	129,888.00	RECRUITMENT SERVICE FEE & ADMIN CHARGE FOR CIO ROLE	HUMAN RESOURCES
T1005	COLONIAL LIFE & ACCIDENT	126,431.22	LIFE INSURANCE PREMIUM	VARIOUS
T5064	QUEST DIAGNOSTICS CLINICAL LABORATORIES, INC.	124,842.33	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T6179	BPM LLP	121,734.63	CONSULTING SERVICES - ERP SOFTWARE ADVISORY	CAPITAL PROJECT
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS, INC	120,000.00	PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM	HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI
T6100	SYMPLR	119,919.13	SOFTWARE LICENSE 2026/2026	HEALTH SERVICES - UM
T2969	AMERICAN BUSINESS MACHINES INC	119,423.35	HARDWARE AND MAINTENANCE	MIS INFRASTRUCTURE
T4503	VISION SERVICE PLAN	119,169.79	EMPLOYEE HEALTH BENEFITS	VARIOUS
T2509	UNITED STATES POSTAL SERVICE	117,573.72	PERMIT 162 SUMMER & FALL 2025 ISSUE OF FAMILY HEALTH	HEALTH SERVICES - WELLNESS & PREVENTION
T5963	ANTAGE INCORPORATED	112,880.00	PROFESSIONAL SERVICES	ENTERPRISE DEVELOPMENT
T6358	KENNADAY LEAVITT PC	111,737.66	2025 PROFESSIONAL SERVICES	LEGAL
T6022	BAKERSFIELD AMERICAN INDIAN HEALTH PROJECT	110,746.91	CONTRACTOR SERVICES	HEALTH SERVICES - UM
T5967	SAI360 INC	110,700.00	PROFESSIONAL SERVICES & 2 YR POLICY MANAGEMENT SYSTEM	AUDIT & INVESTIGATIVE SERVICES

KERN·HEALTH SYSTEMS

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2961	SOLUTION BENCH, LLC	110,624.00	SCANFINITY ANNUAL RENEWAL 2025-2026 & M-FILES ANNUAL RENEWAL FEES 2025-2026	MIS INFRASTRUCTURE
T2446	AT&T MOBILITY	107,165.30	CELLULAR PHONE/INTERNET USAGE	MIS INFRASTRUCTURE
T5319	CITIUSTECH INC.	105,874.00	FAST + MAINTENANCE & SUBSCRIPTION Q3 2024	INFRASTRUCTURE
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	105,000.00	2025 MEMBER DUES	ADMINISTRATION
T5426	UNIVERSAL HEALTHCARE SERVICES, INC	100,000.00	INITIAL 50% COMPREHENSIVE OBESITY MANAGEMENT PROGRAM	HEALTH SERVICES - UM
T4217	CONTEXT 4 HEALTHCARE, INC	99,598.24	ANNUAL RENEWAL AMA FEES 2025-2026	MIS INFRASTRUCTURE
T6202	KRAMER WORKPLACE INVESTIGATIONS	98,065.00	CONSULTING SERVICES	HUMAN RESOURCES
T6361	NEMT SOLUTIONS LLC	97,829.95	2025 NON-MEDICAL TRANSPORTATION	TECHNICAL ADMINISTRATIVE SERVICES
T5022	SVAM INTERNATIONAL INC	95,204.00	PROFESSIONAL SERVICES	VARIOUS
T5863	MANNA HAGOS	94,668.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T5571	GHA TECHNOLOGIES INC	80,374.17	FORTINET SECURITY	MIS INFRASTRUCTURE
T6218	CLOUDERA, INC.	77,940.10	ANNUAL RENEWAL - METADATA PLATFORM	BUSINESS INTELLIGENCE
T6313	mPULSE MOBILE, INC	76,685.40	H30 PORTAL IMPLEMENTATION	CAPITAL PROJECT
T6274	PANDANAI, INC	72,000.00	2025/2026 AI SOFTWARE SUBSCRIPTION	COMPLIANCE
T5275	CREATIVE FINANCIAL STAFFING, LLC	71,508.24	TEMPORARY HELP	VARIOUS
T5850	SERRANO ADVISORS LLC	70,200.00	2025 -2027 BOARD OF DIRECTORS STRATEGIC PLANNING	ADMINISTRATION
T5562	JDM SOLUTIONS INC.	69,440.00	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T4960	ZELIS CLAIMS INTEGRITY, LLC	69,305.63	2025 CLAIMS EVALUATION SERVICES	CLAIMS
T4182	THE LAMAR COMPANIES	67,506.12	OUTDOOR ADVERTISEMENT - BILLBOARDS	MARKETING & PUBLIC AFFAIRS

KERN·HEALTH SYSTEMS

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T6215	BPO USA, P.C.	67,357.27	PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE
T5400	CENTRO DE UNIDAD POPULAR BENITO JUAREZ, INC.	66,500.55	COMMUNITY HEALTH GRANT	GRANTS
T5550	CHARTER COMMUNICATIONS OPERATING, LLC	64,554.65	INTERNET SERVICES	MIS INFRASTRUCTURE
T4228	THE SSI GROUP, LLC	64,430.60	2025 EDI CLAIMS	CLAIMS
T6458	UPGUARD, INC	63,998.40	OCT. 2025 - OCT. 2027 CYBER SECURITY LICENSE	CYBER SECURITY
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	61,206.00	2025 ANNUAL DUES ASSESSMENT	ADMINISTRATION
WT/ACH	SDL LIMITED	49,290.00	TRADOS SOFTWARE LICENSE	MIS INFRASTRUCTURE
T6285	MERSMAN ENTERPRISES (MEI)	59,750.00	TGI TRAINING DEVELOPMENT CONSULTING	HEALTH EQUITY
T4607	AGILITY RECOVERY SOLUTIONS INC.	56,994.48	PROFESSIONAL SERVICES	CORPORATE SERVICES
T2933	SIERRA PRINTERS, INC.	55,130.91	MEMBER HANDBOOKS & FLYERS	MEMBER SERVICES/COMMUNITY SUPPORT SERVICES
T2441	LAURA J. BREZINSKI	55,000.00	MARKETING MATERIALS	MARKETING & PUBLIC AFFAIRS
T5977	IMAGENET, LLC	55,000.00	KIOSK SERVICES	CORPORATE SERVICES
T5171	ASPHALT DR. LLC	54,511.43	BUILDING MAINTENANCE	CORPORATE SERVICES
T5931	SPROUT SOCIAL, INC	54,000.00	2025-2026 SOCIAL MEDIA VIGILANCE MANAGEMENT	MIS INFRASTRUCTURE
T5109	RAND EMPLOYMENT SOLUTIONS	53,696.52	TEMPORARY HELP	VARIOUS
T5201	JAC SERVICES, INC.	52,632.57	AC PREVENTATIVE MAINTENANCE & REPAIRS	CORPORATE SERVICES
T6192	LANG SPECIALTY TRAILERS	51,676.95	MOBILE LAUNDRY TRAILER	MEMBER ENGAGEMENT
T5436	THE BEACON STUDIOS, LLC	50,186.62	VIDEO SERVICES	MARKETING & PUBLIC AFFAIRS
T6116	SIERRA SANDS UNIFIED SCHOOL DISTRICT	48,000.00	2025-2026 ELEMENTARY SCHOOL GRANT	HEALTH SERVICES - WELLNESS & PREVENTION

KERN·HEALTH SYSTEMS

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4993	LEGALSHIELD	47,826.15	EMPLOYEE PREMIUM	VARIOUS
T5742	MICHAEL NGUYEN	47,500.00	PROFESSIONAL SERVICES	QUALITY & HEALTH EQUITY
T5398	GOLDEN EMPIRE GLEANERS	45,638.20	FOOD BASKETS FOR MEMBERS	ENHANCED CARE MANAGEMENT
T5988	WASCO UNION HIGH SCHOOL DISTRICT	45,300.00	SCHOOL WELLNESS GRANT 2025-2026	HEALTH SERVICES - WELLNESS & PREVENTION
T6340	CITIGUARD, INC	44,957.92	ONSITE SECURITY	CORPORATE SERVICES
T6414	BAKER TILLY ADVISORY GROUP LP	43,047.38	ENTERPRISE WIDE RISK PROGRAM ASSISTANCE	COMPLIANCE
T5435	TEGRIA SERVICES GROUP - US, INC.	42,875.00	PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE
T2726	DST PHARMACY SOLUTIONS, INC.	42,000.00	PHARMACY CLAIMS	PHARMACY
T5012	KERN MEDICAL CENTER FOUNDATION	42,000.00	PHYSICIAN'S MIXER CME SPONSORSHIP	ADMINISTRATION
T6142	GREAT PLACE TO WORK INSTITUTE, INC	41,995.00	EMPLOYEE ENGAGEMENT SURVEY ACCELERATE PACKAGE	HUMAN RESOURCES
T5159	AT&T CORP	41,901.68	INTERNET SERVICES	MIS INFRASTRUCTURE
T6362	ARRIVE TRANSPORT SOLUTIONS LLC	40,000.00	2025 NON MEDICAL TRANSPORT	TECHNICAL ADMINISTRATIVE SERVICES
T6462	BAKER TILLY US, LLP	39,900.00	PROGRESS BILLING FOR 2025 AUDIT	FINANCE
T5851	ABSORB SOFTWARE NORTH AMERICA, LLC	39,548.96	DAYFORCE LEARNING LICENSE	MIS INFRASTRUCTURE
T1918	PUBLIC RISK, INNOVATION, SOLUTIONS AND MANAGEMENT	39,154.00	MR OCIP DEDUCTIBLE LOSS FUND CONTRIBUTION	ADMINISTRATION
T2869	COMMUNITY ACTION PARTNERSHIP OF KERN	38,800.00	2025 COMMUNITY GRANTS & RENT FOR MOJAVE & RIDGECREST OFFICES	MARKETING & PUBLIC AFFAIRS/CORPORATE SERVICES
T2641	MARANATHA GARDENING & LANDSCAPING, INC	36,975.00	2025 GARDENING & LANDSCAPE REPAIRS	CORPORATE SERVICES
T2787	SAGE SOFTWARE, INC.	35,968.95	ACCOUNTING SOFTWARE- PREMIUM LICENSE RENEWAL	FINANCE
WT/ACH	COLABS HOLDING	35,650.00	INTEL AGREE YR 3	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1347	ADVANCED DATA STORAGE	35,052.52	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T3118	AMERICAN ACADEMY HOLDINGS LLC dba AAPC	34,440.17	2025 CPC TRAINING PACKAGE & AAPC MEMBERS	CLAIMS
T6062	PTO EXCHANGE	34,285.81	OTHER OUTSOURCE SERVICES -TRANSACTION FEES	EMPLOYEE DEDUCTION
T5321	TYK TECHNOLOGIES LTD	34,000.00	SELF MANAGED ARCHITECTURE PLAN 2024/2025	MIS INFRASTRUCTURE
T5887	PREPARIS INC	33,305.34	DISASTER RECOVERY	CORPORATE SERVICES
T4766	RICHLAND SCHOOL DISTRICT	33,000.00	SCHOOL WELLNESS GRANT 2025-2026 & COMMUNITY SPONSORSHIPS	HEALTH EDUCATION/ MARKETING & PUBLIC AFFAIRS
T3081	ST. VINCENT DE PAUL STORE, INC.	32,594.38	COMMUNITY HEALTH PARTNERSHIP	COMMUNITY GRANTS
T5627	DOCUSIGN, INC.	32,379.42	eSIGNATURE SUPPORT & (20) IAM ENTERPRISE LICENSES	MIS INFRASTRUCTURE/HUMAN RESOURCES
T1957	FRIENDS OF MERCY FOUNDATION ****	32,000.00	2025 SPONSORSHIP & FOUNDATION GRANT	MARKETING & PUBLIC AFFAIRS/GRANTS
T2580	GOLDEN EMPIRE TRANSIT DISTRICT	32,000.00	MARKETING - BUS ADVERTISING	MARKETING & PUBLIC AFFAIRS
T3088	GLEN BROWN CONSULTING	31,387.50	CONSULTING SERVICES	CAPITAL PROJECT
T5026	TEL-TEC SECURITY SYSTEMS ****	31,250.35	2025-2026 MONITORING, HOSTED ACCESS & MAINTENANCE, (2) CAMERAS INSTALLED	CAPITAL PROJECT/CORPORATE SERVICES
T5936	AXIOS HQ INC	30,240.00	2024/2026 COMMUNICATIONS SOFTWARE	MIS INFRASTRUCTURE
T2135	BAKERSFIELD CITY SCHOOL DISTRICT	30,000.00	2025-2026 ELEMENTARY SCHOOL WELLNESS GRANT	HEALTH SERVICES - WELLNESS & PREVENTION
T4652	BAKERSFIELD SYMPHONY ORCHESTRA	30,000.00	2025 SPONSORSHIP	MARKETING & PUBLIC AFFAIRS
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT	30,000.00	SCHOOL WELLNESS GRANT 2025-2026	HEALTH EDUCATION
T6223	WASCO UNION ELEMENTARY SCHOOL DISTRICT	30,000.00	SCHOOL WELLNESS GRANT 2025-2026	HEALTH SERVICES - WELLNESS & PREVENTION
T2955	DELTA ELECTRIC INC.	29,651.77	ELECTRICAL REPAIR	CORPORATE SERVICES
T5592	BRAND CO MARKETING	29,602.45	THE RACK WEB HOSTING FEE & STORE MERCHANDISE	HUMAN RESOURCES

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4024	QUADIENT INC.	29,549.17	POSTAGE METER RENTAL & SUPPORT	CORPORATE SERVICES
T5420	PAYPRO ADMINISTRATORS	29,190.20	PROFESSIONAL SERVICES	HUMAN RESOURCES
T4934	APPLE INC.	28,795.54	COMPUTER EQUIPMENT	CAPITAL PROJECT
T6442	STALWART LAW GROUP, APC	28,000.00	LEGAL FEES	LEGAL
T6252	TRISCENDNP, LLP	27,716.00	CAP-EX FUNDING - EXECUTIVE BENEFIT PROGRAM	ADMINISTRATION
T4424	GUROCK SOFTWARE GmbH	27,611.00	HOSTED SOFTWARE RENEWAL	PROJECT MANAGEMENT
T6311	JMP OFFICE TECHNOLOGIES	27,479.02	POSTAGE METER MAINTENANCE & SUPPORT	CORPORATE SERVICES
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	27,084.90	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T4544	BARNES WEALTH MANAGEMENT GROUP	27,030.00	RETIREMENT PLAN CONSULTANTS	ADMINISTRATION
T6004	ALLIED NETWORK SOLUTIONS, INC.	26,885.35	APEXSQL AUDIT LICENSES 2025/2027	ENTERPRISE DEVELOPMENT
T2938	SAP AMERICA, INC	26,584.72	2025/2026 ENTERPRISE SUPPORT & MAINTENANCE	MIS INFRASTRUCTURE
T4216	NEXSTAR BROADCASTING INC ****	26,436.21	2025 TELEVISION ADVERTISING	MARKETING & PUBLIC AFFAIRS
T3109	HEALTH INDUSTRY COLLABORATION EFFORT	26,000.00	2026 HICE DUES	ADMINISTRATION
T6121	JACKSON UTILIZATION MANAGEMENT CONSULTING	25,620.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UTIL REVIEW
T4230	COFFEE BREAK SERVICES, INC.	24,997.03	COFFEE SUPPLIES	CORPORATE SERVICES
T4466	MENTORS MOVING & STORAGE	24,313.06	2025 STORAGE FEES	CORPORATE SERVICES
T5536	CALIFORNIA STATE UNIVERSITY BAKERSFIELD FOUNDATION	23,300.00	COMMUNITY SCHOLARSHIPS	MARKETING & PUBLIC AFFAIRS
T2578	AMERICAN STROKE ASSOC/AMERICAN HEART ASSOC WESTERN STATES	23,000.00	GO RED FOR WOMEN & HEART WALK SPONSORSHIP	MARKETING & PUBLIC AFFAIRS
T5656	MELODY OUTLAND	22,942.50	PROFESSIONAL SERVICES	HEALTH SERVICES - UM

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Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4731	GO TO TECHNOLOGIES, INC	22,737.00	LOGMEIN SUBSCRIPTION RENEWAL	INFRASTRUCTURE
T5759	SHELLBY ROSE P DUMLAO	22,435.00	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T3031	THOMSON REUTERS-WEST OR WEST, A THOMSON REUTERS BUSINESS ****	22,243.44	LEGAL TOOL SUBSCRIPTION	LEGAL
T5500	MAGDALENE HOPE INC	21,500.00	COMMUNITY GRANTS	MARKETING & PUBLIC AFFAIRS
T4521	PAYSCALE, INC. ****	21,420.00	COMPENSATION SALARY ANALYSIS YR 2 OF 3	HUMAN RESOURCES
T1007	FEDERAL EXPRESS CORP ****	21,003.80	2025 SHIPPING EXPENSE	VARIOUS
T5318	CANONICAL GROUP LIMITED	20,720.00	UBUNTU PRO LICENSE & SUPPORT	INFRASTRUCTURE
T4249	LOTUS BAKERSFIELD CORP ****	20,500.00	2025 RADIO ADVERTISING	MARKETING & PUBLIC AFFAIRS
T5511	BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	20,000.00	COMMUNITY HEALTH PARTNERSHIP	COMMUNITY GRANTS
		63,113,519.79		
	TOTAL VENDORS OVER $20,000	63,113,519.79		
	TOTAL VENDORS UNDER $20,000	2,890,241.78		
	TOTAL VENDOR EXPENSES- NOVEMBER	**66,003,761.57**		

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

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
January 2025							
LinkedIn	$180,900.00	Yes	HR	Devin Brown	Online Training Course Licenses	1/1/2025	12/31/2026
LinkedIn	$188,659.83	Yes	HR	Devin Brown	Hiring Enterprise Program	1/1/2025	1/1/2028
MetaStar	$56,700.00	Yes	QP	Kailey Collier	NCQA HEDIS Compliance Audit	1/1/2025	12/31/2027
Cloudera	$77,940.10	Yes	IT	Cesar Delgado	Data Lineage Software	1/1/2025	12/31/2025
Gartner	$184,800.00	Yes	HR	Devin Brown	HR licensing	1/1/2025	12/31/2025
Adobe	$89,807.52	Yes	IT	Cesar Delgado	Pro DC, Photoshop, InDesign, etc.	1/27/2025	12/26/2026
February 2025							
Sprout Social	$54,000.00	Yes	IT	Cesar Delgado	Social Media Vigilance, social management and support	2/26/2025	2/25/2026
LifeSigns	$120,000.00	Yes	HE	Isabel Silva	ASL Interpreting Services	2/23/2025	2/22/2027
Serrano	$70,950.00	Yes	EXEC	Emily Duran	Professional Resources	2/24/2025	5/31/2025
The Granger Network	$175,200.00	Yes	HR	Devin Brown	2026-2028 Strategic Plan	2/3/2025	5/31/2025
Quest Diagnostics	$125,510.00	Yes	QP	Jake Hall	Laboratory Data	2/21/2025	2/20/2026
Serrano Advisors, LLC	$70,950.00	Yes	EXEC	Jermy McGuire	Strategic Planning Resource	2/24/2025	5/31/2025
March 2025							
Health Management Associates	$199,000.00	Yes	ACCT	Veronica Baker	Actuarial Services	3/1/2025	2/28/2026
Mersman Enterprise Inc.	$100,000.00	Yes	HEQ	Traco Matthews	Health Equity Program	3/3/2025	12/31/2025
CDW	$113,327.83	Yes	IT	Cesar Delgado	2 Nutanix Nodes with support & Maintenance for 3 years	3/25/2025	3/24/2028
April 2025							
SHI	$110,516.75	Yes	IT	Cesar Delgado	Manage KHS inbound calls	4/15/2025	4/14/2025
Citius Healthcare	$160,888.00	Yes	PNM	Amisha Pannu	Consulting Services -Transitional Rent Consultant	4/15/2025	9/30/2025
SHI	$110,516.75	Yes	IT	Cesar Delgado	Cisco UCCX License Renewal	4/22/2025	4/23/2026
E360	$158,488.00	Yes	IT	Cesar Delgado	Citrix Licensing	4/2/2025	4/2/2028
Anthony C. Dike, dba Meridian Health Systems	$199,000.00	Yes	UM	Christine Pence	UM Authorization Reviews	4/18/2025	4/17/2026
Nguyen Luu-Trong (1099)	$199,000.00	Yes	UM	Christine Pence	UM Authorization Reviews	4/18/2025	4/17/2026
Panda Ai	$100,000.00	Yes	COMP	Deb Murr	Ai Compliance Tool	4/1/2025	1/31/2026
Cognizant	$64,500.00	Yes	IT	Cesar Delgado	Zelis Payment Integrity Interface	4/21/2025	3/30/2028
May 2025							
Shellby Dumlao, RN	$90,000.00	Yes	PHM	Michelle Curioso	1099 RN consultant to support the PHM department	5/16/2025	5/15/2026
June 2025							
Symplr	$75,905.00	No	QP	Jake Hall	Professional Services	6/3/2025	7/31/2027
Relay Network	$100,000.00	Yes	ME	Louie Iturriria	Text Messaging Services	6/1/2025	12/31/2025
TWE	$115,000.00	Yes	IT	Cesar Delgado	Critical Start 24x7 Security	6/23/2025	6/22/2026
ImageNet	$75,092.00	Yes	COSA	Josh Hosch	HRA OCR	6/19/2025	4/4/2027
WebMD Ignite	$147,249.28	Yes	HED	Isabel Silva	Care and Digital Core Tools	6/5/2025	6/4/2026
Context4Healthcare	$99,548.24	Yes	IT	Cesar Delgado	AMA&CPT Codes	6/27/2025	6/27/2026
Thomson Reuters	$77,927.28	Yes	HR	Devin Brown	Practical Law Subscription	6/19/2025	6/18/2028
Precision Health Strategies	$199,000.00	Yes	EXEC	Emily Duran	Health Services Consulting	6/23/2025	12/31/2025
July 2025							
Blackhawk Network, Inc.	$195,000.00	Yes	ME	Louie Iturriria	Amendment No.3 - Extension for Member Gift Cards.	7/1/2025	6/30/2026
CDW-G	$55,942.65	Yes	IT	Cesar Delgado	Juniper switches support	7/1/2025	7/30/2026
Bakersfield American Indian Health Project	$90,000.00	Yes	HE	Isabel Silva	Tribal Liaison	7/1/2025	6/30/2026
CHC	$79,200.00	Yes	HE	Isabel Silva	DEEP and DPP Program	7/1/2025	6/30/2026
Helpcare AI	$174,000.00	Yes	IT	Cesar Delgado	AI Digital Worker Platform	7/28/2025	4/30/2026
August 2025							
CommGap	$198,558.00	Yes	HED	Isabel Silva	Interpreting Services - Amendment No.1	8/18/2025	7/6/2026
Wanda Jackson	$100,000.00	Yes	UM	Christine Pence	1099 RN	8/27/2026	9/26/2025
Manna Hagos	$198,000.00	Yes	UM	Christine Pence	1099 MD	8/22/2025	8/21/2026

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
Symplr	$72,508.40	Yes	UM	Christine Pence	Hayes Knowledge Center (Year 2)	8/1/2025	7/31/2026
September 2025							
Wanda Jackson	$100,000.00	Yes	UM	Christine Pence	RN 1099	9/27/2025	9/26/2026
Melinda Doty	$145,600.00	Yes	UM	Christine Pence	RN 1099	9/10/2025	9/9/2026
Gartner	$112,653.34	Yes	CPL	Deb Murr	Compliance Licenses	9/1/2025	12/31/2026
October 2025							
Meridian Health Services	$199,260.00	Yes	UM	Christine Pence	24/7 Physician on call	10/1/2025	3/31/2026
Integrity Advantage	$82,292.00	Yes	CPL	Deborah Murr	FWA Support	10/1/2025	9/30/2026
Finthrive	$197,511.00	Yes	CLM	Robin Dow Morales	Encounter Submission Platform	10/23/2025	10/22/2027
UpGuard	$63,998.40	Yes	MIS	Cesar Delgado	Risk Assessment Tool	10/23/2025	10/22/2027
American Business Machines	$130,000.00	Yes	MIS	Cesar Delgado	Printer Support and Maintenance	10/1/2025	9/30/2027
Kern County Public Health Department	$196,253.00	Yes	HE	Isabel Silva	Community Health Assessment & Community Health Improvement Pla	10/1/2025	12/31/2027
November 2025							
Health Literacy Innovations	$53,625.00	Yes	HE	Isabel Silva	Health Literacy Advisor Licenses	11/11/2025	11/10/2026
Cotiviti	$199,420.00	Yes	MIS	Cesar Delgado	FHIR Solution	11/10/2025	11/9/2026

2025 PROJECT CONSULTING PROFESSIONAL SERVICES

ITEM	PROJECT	CAP/EXP	BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YTD TOTAL	REMAINING BALANCE
1	Behavioral Health 2025	CAP	$ 699,218	$ 13,613	$ 17,810	$ 12,845	$ 19,978	$ 27,358	$ 17,370	$ 16,720	$ 15,397	$ 19,920	$ 24,623	$ 14,989	$ -	$ 200,624	$ 498,594
2	Closed Loop Referral (CLR) Mgmnt	CAP	$ 1,000,267	$ 19,193	$ 13,571	$ 19,685	$ 17,668	$ 18,546	$ 14,447	$ 15,569	$ 10,303	$ 10,611	$ 11,262	$ 16,615	$ -	$ 167,472	$ 832,795
3	Medicare Advantage DSNP Software Modules	CAP	$ 4,122,638	$ 25,050	$ 30,431	$ 34,859	$ 48,603	$ 65,807	$ 68,007	$ 74,917	$ 67,042	$ 49,344	$ 80,357	$ 56,441	$ -	$ 600,858	$ 3,521,780
4	Accounting System Upgrade/Implementation	CAP	$ 401,757	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 401,757
5	Member & Provider Portal Implementation	CAP	$ 1,116,483	$ -	$ -	$ 9,885	$ 29,951	$ 44,832	$ 19,913	$ 17,248	$ 21,975	$ 20,284	$ 26,263	$ 25,285	$ -	$ 215,635	$ 900,849
6	Member Engagement	CAP	$ 713,511	$ 22,472	$ 21,934	$ 42,365	$ 52,079	$ 33,257	$ 27,791	$ 40,058	$ 38,008	$ 28,288	$ 26,999	$ 20,345	$ -	$ 353,594	$ 359,917
7	Text Messaging - Automate and Customize	CAP	$ 415,138	$ 145	$ 1,778	$ 5,710	$ 2,234	$ 5,998	$ 2,746	$ 3,237		$ 1,460	$ 2,442	$ 7,886	$ -	$ 33,636	$ 381,503
8	Webex Calling Migration	CAP	$ 644,373	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 644,373
	Capital Totals		***$ 9,113,386***	***$ 80,473***	***$ 85,524***	***$ 125,348***	***$ 170,512***	***$ 195,799***	***$ 150,274***	***$ 167,749***	***$ 152,724***	***$ 129,907***	***$ 171,946***	***$ 141,562***	***$ -***	***$ 1,571,818***	***$ 7,541,568***
9	IT Staff Augmentation	EXP	$ 7,530,807	$ 444,724	$ 407,044	$ 489,431	$ 666,909	$ 674,614	$ 645,862	$ 618,997	$ 595,384	$ 420,046	$ 400,676	$ 292,987	$ -	$ 5,656,674	$ 1,874,133
10	PM Staff Augmentation	EXP	$ 277,624	$ 163,713	$ 143,280	$ 151,971	$ 127,243	$ 89,468	$ 80,766	$ 74,765	$ 68,562	$ 72,995	$ 76,091	$ 32,125	$ -	$ 1,080,978	$ (803,355)
11	NCQA (The Mihalik Group)	EXP	$ 350,000	$ 17,800	$ 22,823	$ 32,990	$ 14,250	$ 23,215	$ 2,400	$ 1,230	$ -	$ -	$ -	$ -	$ -	$ 114,708	$ 235,293
12	DSNP (Rebellis)	EXP	$ 3,000,000	$ 163,994	$ 73,994	$ 100,875	$ 151,681	$ 159,513	$ 121,925	$ 56,063	$ 1,056	$ -	$ -	$ -	$ -	$ 829,100	$ 2,170,900
	Operating Expense Totals		***$ 11,158,431***	***$ 790,231***	***$ 647,140***	***$ 775,267***	***$ 960,083***	***$ 946,809***	***$ 850,953***	***$ 751,054***	***$ 665,003***	***$ 493,041***	***$ 476,767***	***$ 325,113***	***$ -***	***$ 7,681,460***	***$ 3,476,971***

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Traco Matthews, Chief Health Equity Officer

SUBJECT: Chief Health Equity Officer Report

DATE: February 19, 2026

BACKGROUND

Over the past two months, the Health Equity Office and its partner teams continued advancing strategic priorities while responding to evolving operational and community needs. Across community engagement, health equity, marketing and communication and member engagement, teams demonstrated strong collaboration, adaptability and progress toward shared goals.

Community engagement exemplified service and partnership during a period of heightened community need, working alongside community partners to support large-scale food distributions while maintaining consistent outreach across Kern County. Staffing transitions and cross-training strengthened coverage and positioned the team for continued regional engagement.

Health equity advanced disparity program development, analytics and planning efforts. Dashboard enhancements, grievance trending and completion of regulatory deliverables strengthened data-informed decision-making, while ongoing collaboration and statewide learning supported future equity-focused initiatives.

Marketing and communication reinforced organizational visibility and alignment through successful enrollment campaigns, digital engagement and county collaboration initiatives. Internally, consistent communications and progress on major infrastructure projects supported transparency and readiness for upcoming milestones.

Member engagement sustained strong performance across programs and outreach, while expanding staffing and cross-training to support operational continuity. Continued progress on key initiatives positioned the team for upcoming program launches focused on improving member access and experience.

Together, these efforts reflect strong cross-functional collaboration and a shared commitment to advancing health and equity for the communities we serve.

REQUESTED ACTION

Receive and file.



HEALTH EQUITY DIVISION

FEBRUARY 2026
BOARD REPORT

Kern Family Health Care®

CHEO SUMMARY

Our Work Together

Over the past two months, the Health Equity Office and its partner teams continued advancing strategic priorities while responding to evolving operational and community needs. Across community engagement, health equity, marketing and communication and member engagement, teams demonstrated strong collaboration, adaptability and progress toward shared goals.

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Together, these efforts reflect strong cross-functional collaboration and a shared commitment to advancing health and equity for the communities we serve.

Sincerely,

Traco Matthews
Chief Health Equity Executive Officer





COMMUNITY ENGAGEMENT

129
Volunteer Hours

43
Health Fair Hours

86
Sponsored Event Hours

Praises and Progress

During November and December, the Community Engagement team demonstrated exceptional dedication and adaptability, particularly during the government shutdown. Team members exemplified collaboration and service while representing Kern Family Health Care at Community Action Partnership of Kern (CAPK) distribution sites, stepping in wherever needed — from bagging and distributing food to confirming eligibility, managing registration, directing traffic and supporting a KFHC-sponsored luncheon. Through this partnership, more than 819,000 pounds of food were distributed to the community, reinforcing KFHC's commitment to meeting members where they are.

In December, staffing capacity was strengthened with the hiring of a Ridgecrest representative and a Northeast Kern representative, both of whom began in January, along with cross-training staff across all community engagement functions to ensure continuity and flexibility.

Priorities

Looking ahead, the team will focus on strengthening regional coverage and long-term engagement strategy. Priorities include interviewing and hiring a community navigator to support the Lamont and Arvin sites, a key step in expanding localized outreach. The team will also initiate development of the Community Engagement Marketing Plan for state approval, which will guide future engagement efforts. Additional priorities include onboarding and training new staff, finalizing and implementing the in-house transportation feasibility analysis and continuing to build capacity to support sustained, high-impact community presence across Kern County.

Total membership renewals by CE navigators **572**



HEALTH EQUITY

Praises and Progress

During November and December, the Health Equity team advanced key program development, data analytics and collaborative initiatives. Progress continued on health equity office disparity program revisions, including Native pre- and postnatal and Black care measures, along with chlamydia and cervical cancer intervention development. The team strengthened analytics and reporting through ongoing TGI provider training and enhancements to ACG and business intelligence dashboards, including grievance trending following NCQA accreditation. Collaboration with business intelligence supported EPT Kern data requirements and expanded appointment data discussions.

Additional accomplishments included completing 2026 planning for the Kern Health Equity Partnership steering committee, participating in Prosperity Neighborhood Initiative health care and workforce subcommittees, submitting required 2025 DHCS medical audit deliverables, meeting EPT milestones and finalizing and submitting a transportation magnet for approval. The team also collected population health management SOGI data and engaged in statewide learning related to California's birthing pathways.

Priorities

In the coming months, the health equity team will focus on completing key planning and implementation efforts. Priorities include finalizing the Health Equity Office Program Evaluation and Disparity Program development, advancing DEI training updates and pilot rollout planning and continuing dashboard enhancements to support data-informed decision-making. The team will also finalize the community reinvestment plan report, complete grievance trending and EQIHEC reviews, develop transportation training materials and plan a cervical cancer screening event in collaboration with quality and provider partners. Additional priorities include supporting promatora Medi-Cal renewal training and finalizing and distributing the HEO work plan and JEDI 2026 calendar.





MARKETING AND COMMUNICATIONS

Praises and Progress

During November and December, the Marketing and Communication team advanced a wide range of external marketing, internal communications, multimedia and branding initiatives. Digital engagement continued to grow, with increased impressions and higher engagement rates driven by targeted social media content aligned with key observances, campaigns and organizational priorities. The team successfully supported the Medicare D-SNP annual enrollment period through paid digital advertising, direct mail, sales event promotion and ongoing website enhancements, resulting in strong enrollment outcomes.

County collaboration efforts also progressed, including the installation of a self-service kiosk at KFHC and continued coordination with DHS and CalSAWS in preparation for the January 2026 go-live. Additionally, the team completed the first draft of the 2026 Community Report and advanced foundational infrastructure projects, including intranet vendor onboarding, testing a new internal newsletter platform and finalizing the 2026 internal communications strategy.

Priorities

In the coming months, the team will focus on advancing strategic communications and operational readiness for 2026. Priorities include finalizing and publishing the 2026–2028 strategic plan booklet and 2026 Community Report, and supporting Medi-Cal renewals and Medicare D-SNP marketing efforts. The team will continue intranet implementation, complete the rollout of the new internal newsletter platform, advance 2026 Connect Week planning and begin development of a digital signage proposal. Other priorities include strengthening provider communications through updated bulletins and newsletters, supporting anniversary and Go Red for Women planning, advancing brand development in partnership with Purveyor Branding Co. and coordinating the announcement strategy for the mobile laundry unit.

As of November
Choice Rate
72%

As of November
Market Share
85%

MEMBER ENGAGEMENT

Praises and Progress

During November and December, the Member Engagement team sustained strong momentum across program implementation, outreach and operational readiness. Expansion and project milestones remained consistently high, while progress continued on the transportation feasibility study, text messaging program and member rewards initiative. The team participated in five community events each month and successfully completed the member handbook, posting it on time to meet state requirements. Staffing capacity was strengthened with the hiring of a Ridgecrest representative and a Northeast Kern representative scheduled to begin in January, along with cross-training staff across all member engagement functions. Additional progress included completing medical impact document reviews for the D-SNP line, advancing the mobile washer and dryer unit initiative in coordination with Legal and updating Medi-Cal renewal messaging for AI calls supporting the UIS population.

Priorities

In the coming months, the team will focus on finalizing implementation efforts and preparing for program launches. Priorities include completing the in-house transportation program documentation and feasibility analysis, onboarding and training new staff and supporting the February launch of the Member and Provider Portal. The team will also finalize updates to Medi-Cal renewal letters and text messaging, complete coordination with mPulse to launch the text messaging program manager and support updates to Medi-Cal new member files to exclude D-SNP populations. Additional priorities include completing the 2025 Member Satisfaction Survey review and advancing provider directory process development.

98.4%
Retention Rate

9
Presentations

548
Disenrollments

1,500
Member Interactions



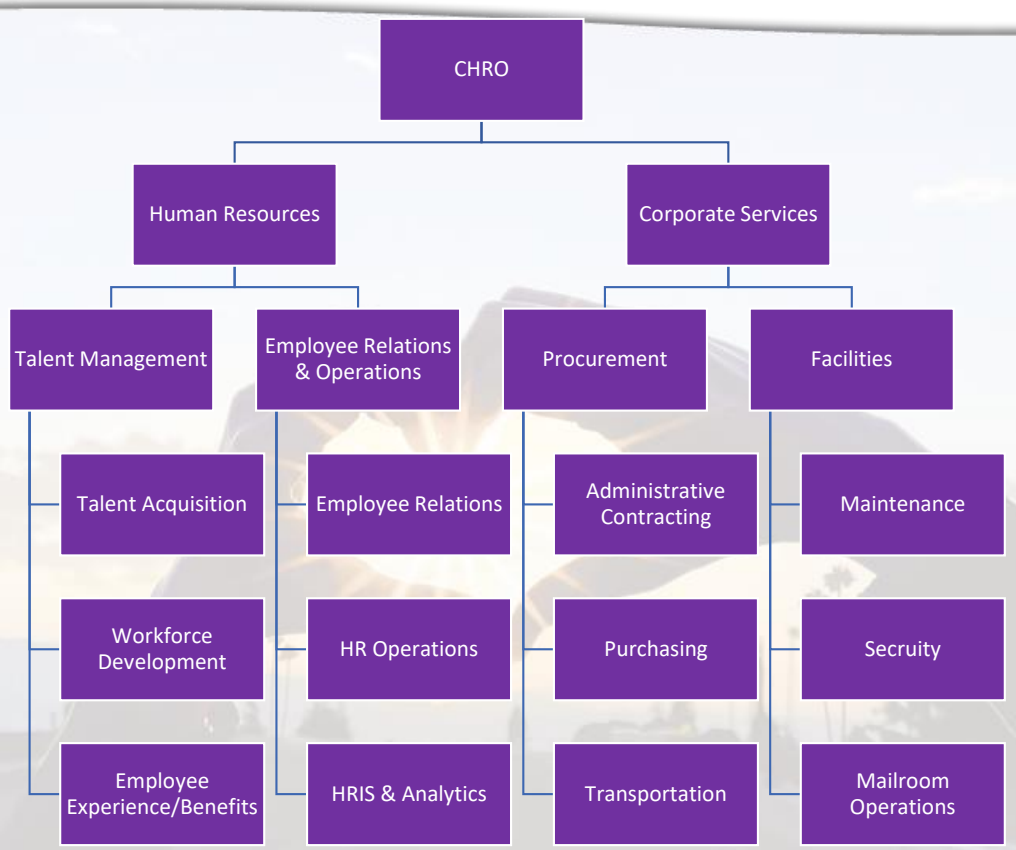
Chief Human Resources Officer Quarterly Report – Q1 2026

By Devin Brown, CHRO



KHS Board of Directors Meeting, February 19, 2026

CHRO's Org Structure Overview



Key Accomplishments in 2025

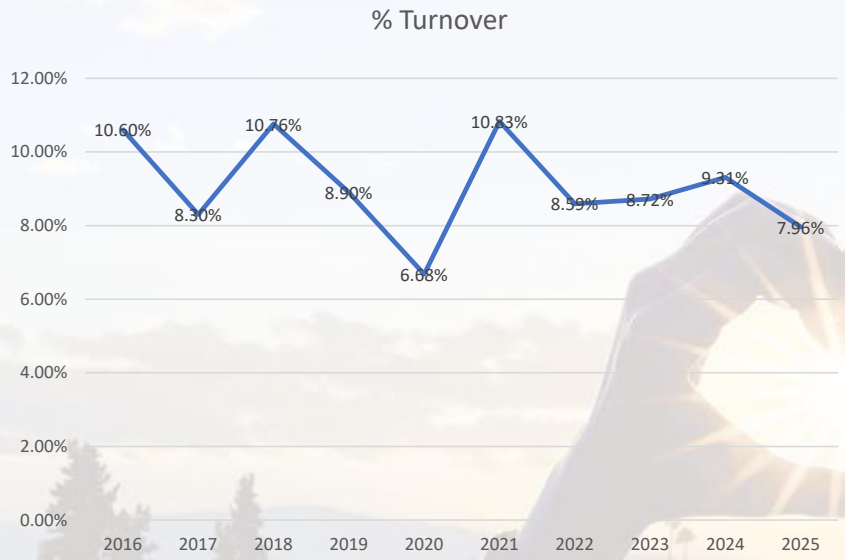
- We received certification as a **Great Place To Work** and are listed as one of **Fortune's Best Healthcare Workplaces**.
- We implemented an in-house transportation program with a savings estimated at **$3.8 million**.
- We negotiated contract savings totaling **$3.39 million**.



Other Notable Achievements in 2025

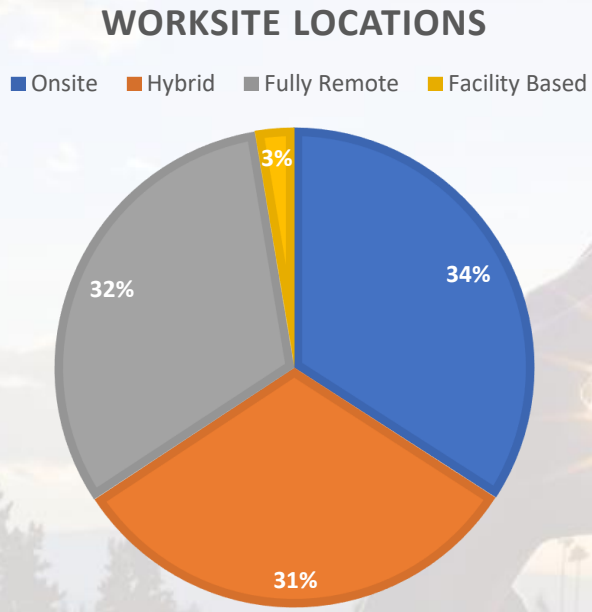
- Created and held **KHS Connect Week** dedicated to informing and celebrating our workforce.
- Connected 30 employees within our inaugural **KHS Mentorship Program**.
- Provided 30 student members growth and development through our **KHS Externship Program**.
- Conducted a pilot **Talent Readiness and Succession Planning** review for our Chief Medical Officer role.
- Implemented three key policies ensuring strong Employee Relations practices within KHS and **trained 588 individuals**.
- Completed an **HR Data Project** establishing the basis for future people analytics dashboards and reporting.
- Migrated all administrative contracting to **DocuSign** platform.

KHS Employee Turnover



- KHS recorded its lowest turnover rate in five years (7.96%).
- The drop is consistent with national trends in turnover as employees are sticking with their jobs.
- The national turnover rate for white collar professionals in 2025 was 9.9%.
- Health Care continues to be an industry reporting difficulty in filling roles according to Mercer.

KHS Worksite Demographics



- We currently have 42 employees working fully remote in 18 different states.
- Since March 2025, we are only allowing fully remote assignments for hard-to-fill roles.
- The KHS Buck Owens Boulevard facility has total workspace capacity for 555 employees.
  - 28 shared hybrid workspaces.
  - 32 vacant offices/cubicles.
- We continue to utilize hybrid work with shared workspaces as we continue to hire for our 39 unfilled FTES.

Strategic HR Activities in 2026

- **People Analytics Platform** – enhance organizational capacity for data-drive people decisions through accessible dashboard.
- **Talent & Succession Readiness** – complete talent readiness profiles and succession plans for all critical roles.
- **Leadership & Supervisory Academy** – plan and conduct new leadership academy for all KHS leaders and supervisors.
- **AI Strategy for HR Function** – build a strategic roadmap for deployment of AI technologies in support of the HR function.
- **Paid Work Experience Partnership** – utilize partnership with County Employers' Training Resource department to provide low-cost talent pool for entry-level roles.



Strategic CS Activities in 2026

- **ERP Implementation** – implement and consolidate purchasing and contracting programs into one ERP platform.
- **Physical Security Assessment** – complete a comprehensive security readiness assessment and implement standard operating security measures.
- **Mailroom Optimization** – work with key stakeholder to develop efficiencies within the organizations returned mail requirements.
- **Employee Travel Process Improvement** – review and complete a full LSS process improvement project on our employee travel process and implement policy changes.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Chief Compliance and Fraud Prevention Officer Report

DATE: February 19, 2026

BACKGROUND

Kern Health Systems (KHS) is required to implement an effective Compliance Program that meets the regulatory requirements set forth in both the Department of Health Care Services (DHCS) contract and the Department of Managed Health Care (DMHC) Knox-Keene license.

The principles outlined in the regulatory guidelines are applicable to all KHS relevant decisions, situations, communications, and developments that align with requirements defined by the Office of Inspector General (OIG). The Governing Board is required to exercise reasonable oversight with respect to the implementation and effectiveness of the Compliance program.

DISCUSSION

Regulatory filings, e.g., reports, financial data, quality performance, and surveys are filed in response to new services, programs, and oversight requirements that are mandated under our contract and license. In January 2026, a total of 122 reports have been filed, which exceeded the monthly filings for both DMHC and DHCS for the preview eight months in 2025.

All Plan Letters (APL) and Guidance Letter (GL) received from DHCS and DMHC will begin to be delivered by the regulators as new policy and benefits are outlined at the Federal and State levels. Compliance meets with organizational stakeholders to ensure each component of any APL/GL is defined, assigned, and monitored for implementation.

Privacy Protections and Fraud Prevention remain a key focus for KHS's Compliance department. Suspected violations are promptly investigated and reported to DHCS for probable violations of policies, regulations, statutes, or program requirements. During the period from December 1, 2025 to January 31, 2026, the Compliance Department investigated and reviewed sixty-four (64) allegations of privacy concerns. Two (2) of the cases were sent to the State for their review. DHCS has close one (1) case. Currently, three (3) total cases are still under review by the State.

Fraud, waste, and abuse (FWA) cases in 2025 have exceeded the volume of cases in 2024 by 30%. Potential Member FWA cases, while increasing, remains at approximately 1 per 1,000 members. Services not rendered and excessive or unnecessary services represent the majority of provider cases reviewed, while transportation and identity theft represent the majority of the member cases reviewed. To date, there have been 44 cases reported for review in 2026.

The OIG reports alarming totals of improper payments across Medicare, Medicaid, and CHIP, with limited improvement in high-risk service areas such as skilled nursing, outpatient hospital services, and hospice care. Improper payments continue to be one of the most reliable entry points for audits, extrapolated recoveries, and False Claims Act investigations. The OIG scrutiny increasingly focuses on whether organizations have formalized, repeatable processes to identify, investigate, and resolve errors. Provider education and post-payment corrections alone are no longer viewed as sufficient risk mitigation if they are not paired with documented controls and accountability. Compliance teams are expected to demonstrate a defensible lifecycle for overpayment management, from identification and investigation through repayment, root cause analysis, corrective action tracking, and in some instances, arbitration and litigation.

REQUESTED ACTION

Receive and file.

Compliance
Key Performance Indicators
February 2026

KERN HEALTH SYSTEMS

Compliance Communications

Department of Managed Health Care (DMHC)

- 2023 DMHC Medical Audit / 2025 DMHC Follow Up Audit
  - No updates
  - Follow Up Audit Period: 11/01/2024 – 06/30/2025
  - Awaiting additional requests and/or preliminary audit report

Department of Health Care Services (DHCS)

- 2023 Focused Audit (Behavioral Health & Transportation)
  - No update
  - Awaiting formal closure/acceptance of CAP
- 2025 Focused Audit (Information Systems Security)
  - No update
  - Audit period: 05/01/2024 – 04/30/2025
  - Submitted numerous pre-audit deliverables
  - Awaiting Preliminary Audit Report (which will require response within 15 days and any additional supporting documentation to address preliminary findings).
- 2025 Routing Medical Audit
  - Entrance letter and pre-audit deliverables request received on 11/10/2025
  - Audit Period: 11/01/2024 – 12/31/2025
  - Numerous pre-audit deliverables submitted timely
  - Virtual interview sessions held 01/26/2026 – 02/01/2026
  - High volume of additional documentation requests submitted throughout the audit
  - Preliminary Audit anticipated to take at least two months to receive

DSNP:

- Reported 746 enrolled members as of 01/01/2026
  - This is the currently active members with a 01/01/2026 effective date
  - Does not include enrollments that were subsequently cancelled prior to the effective date
  - Does not include members with future effective dates
- DSNP operations successfully launched 01/01/2026 (member customer service; benefits; claims; utilization management; appeals/grievances; etc.).
- Challenges experienced regarding data discrepancies between CMS and DHCS systems regarding aligned DSNP and Medi-Cal enrollment effective dates and low-income subsidy levels (impacting member copayments for prescription drugs).
- Ongoing daily collaboration between KHS and delegates, Universal Health Care, MSO and MedImpact (Pharmacy Benefit Manager) to work through any process questions/concerns and perform oversight.

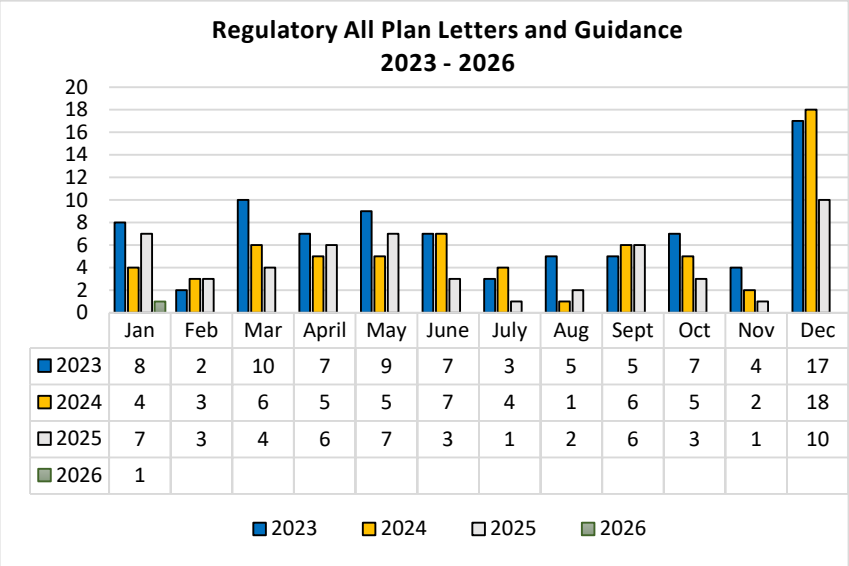
Enterprise Risk Management (ERM) Project:

- Project ongoing
  - Revisiting Enterprise Risk Management Training content and launch due to changes in human resources personnel and system limitations.
  - Enterprise Risk Register finalized and will be assigned to various KHS Committees for review, action, remediation, reporting, and monitoring. Prioritization of identified critical risk areas in progress.
- Project will continue throughout 2026

Compliance Capsules:

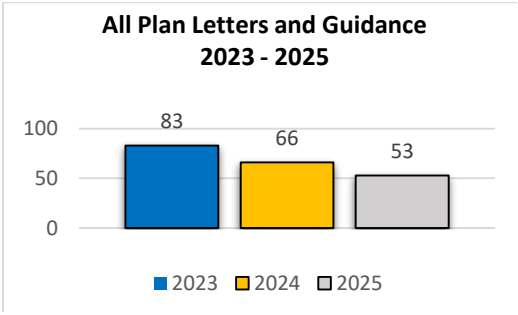
- December: Regulatory Audits – Stakeholder Responsibilities
- November: HIPAA Safeguards

All Plan Letter (APLs) & Guidance Letters

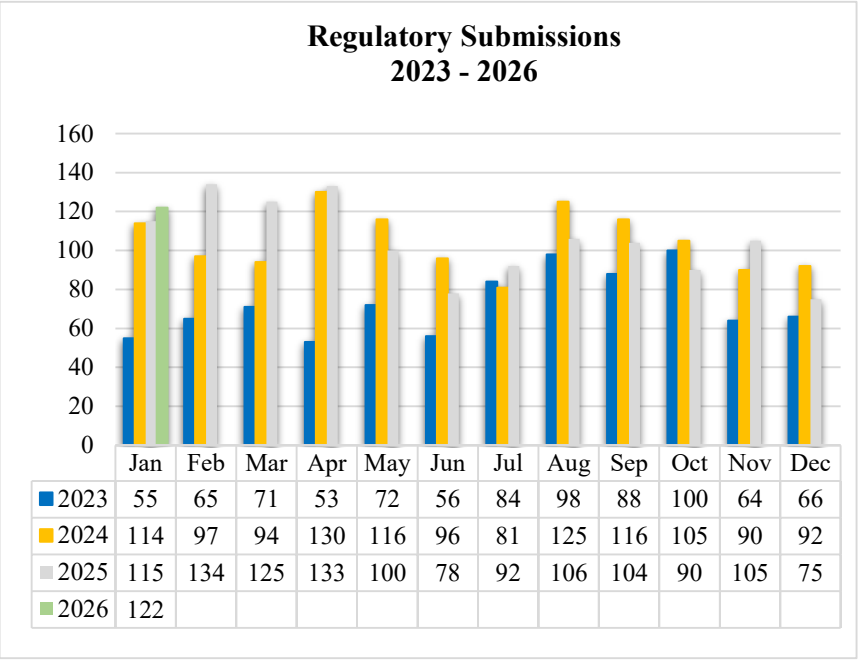


	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2023	8	2	10	7	9	7	3	5	5	7	4	17
2024	4	3	6	5	5	7	4	1	6	5	2	18
2025	7	3	4	6	7	3	1	2	6	3	1	10
2026	1											

All Plan Letters & Guidance Letters		
2023	2024	2025
83	66	53

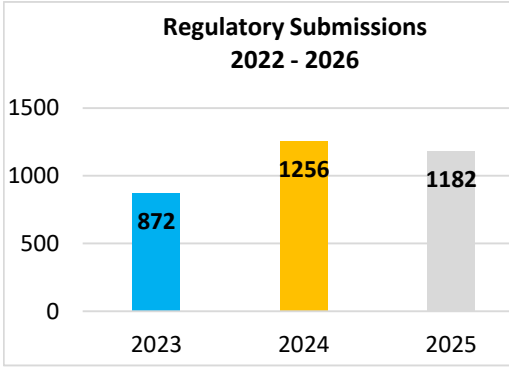


Regulatory Reports & Filings

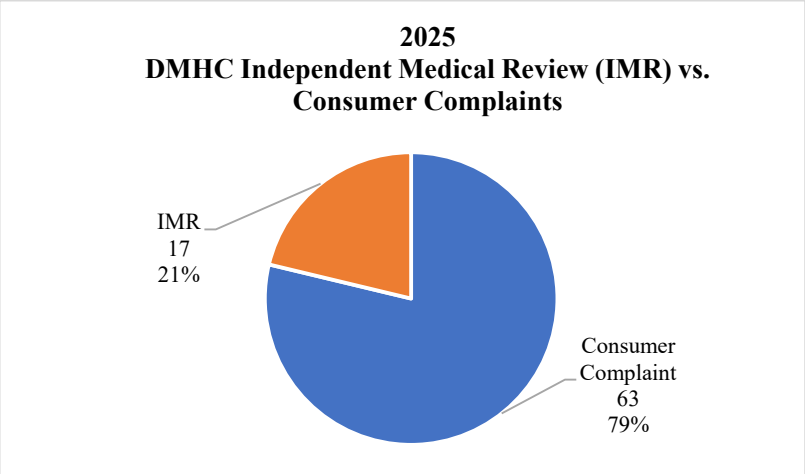


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	55	65	71	53	72	56	84	98	88	100	64	66
2024	114	97	94	130	116	96	81	125	116	105	90	92
2025	115	134	125	133	100	78	92	106	104	90	105	75
2026	122											

Regulatory Submissions		
Regulatory Agency	**December 2025**	**January 2026**
DHCS	55	114
DMHC	20	8
Total	**75**	**122**



DMHC Consumer Complaints & Independent Medical Reviews (IMR)



Consumer Complaints (Closed by DMHC without going to IMR)	
Decision	
Closed (KHS Overturned original decision)	17
Closed (KHS Upheld original decision)	24
Non-KHS Member	1
Services Never Denied	4
Return To Plan	7
Potential Quality Issue	2
Misdirected	5
Illegible - Withdrawn	1
Duplicate	2
Grand Total	**63**

Independent Medical Reviews (IMR)		
Decision	**KHS**	**DMHC**
Upheld	16	8
Overturned	1	8
Withdrawn	0	1
Grand Total	**17**	**17**

Of the cases that were sent over for Independent Medical Review, about 50% are overturned.

Note: DMHC does not necessarily adhere to the same criteria and guidelines as KHS.

HIPPA Breach Activity

Summary of potential Protected Health Information (PHI) disclosures for December 1, 2025 through January 31, 2026:

The Plan is dedicated to ensuring the privacy and security of the PHI and personally identifiable information (PII) that may be created, received, maintained, transmitted, used, or disclosed in relation to the Plan's members. The Plan strictly complies with the standards and requirements of Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

During the period from December 1, 2025 to January 31, 2026, the Compliance Department investigated and reviewed sixty-four (64) allegations of privacy concerns. Two (2) of the cases were sent to the State for their review. DHCS has close one (1) case. Currently, three (3) total cases are still under review by the State.

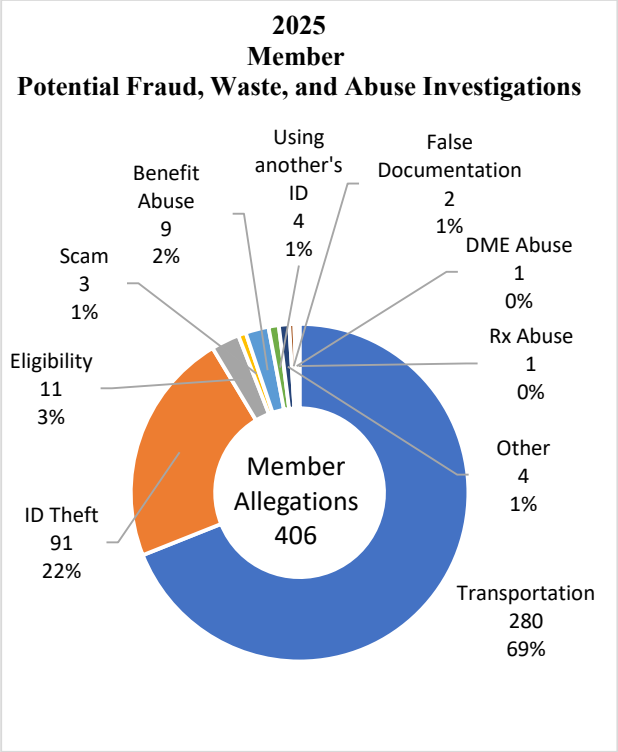
2025 Reporting Timeliness		
Reported Timely	**24 hour Timely?** Y/N	**10 day Timely?** Y/N
Yes	16	20
No	4	0
Total	**20**	**20**

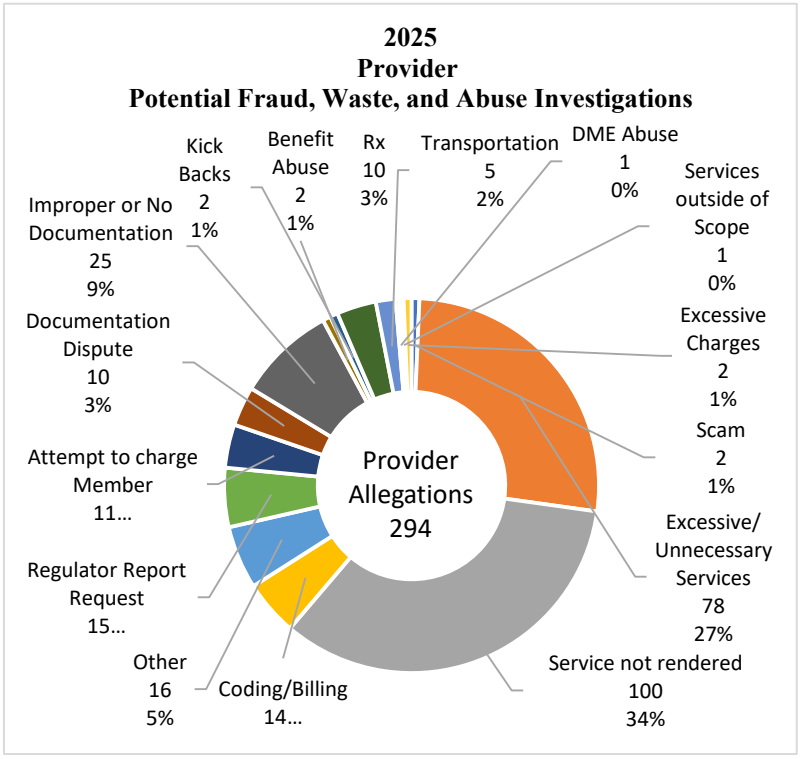
2025 Breach Determination	
Yes	2
No	15
Under Review	3
Total	**20**

Root Cause for late submissions:

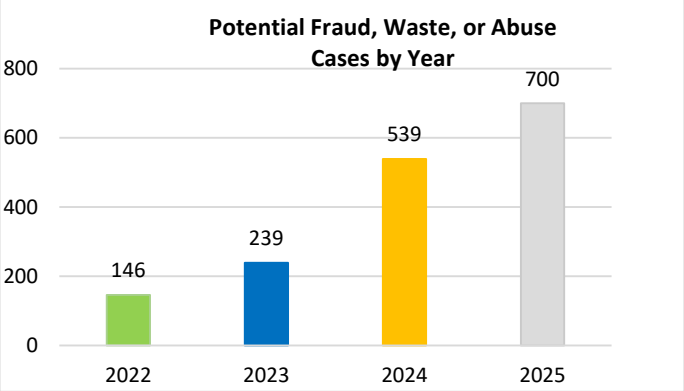
* Three (3) reported to Compliance late by the Member Services team
* One (1) reported late due to technical issue with reporting portal

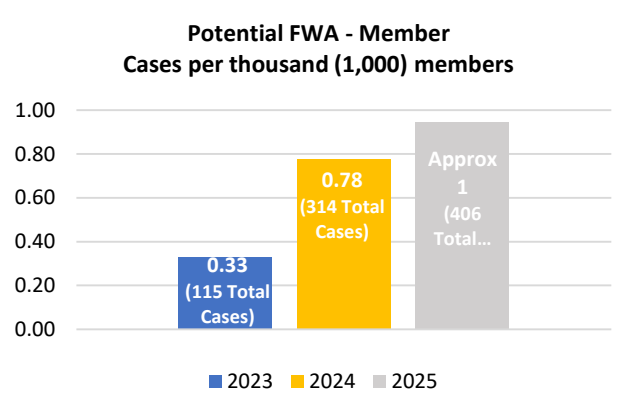
Fraud, Waste, and Abuse (FWA)

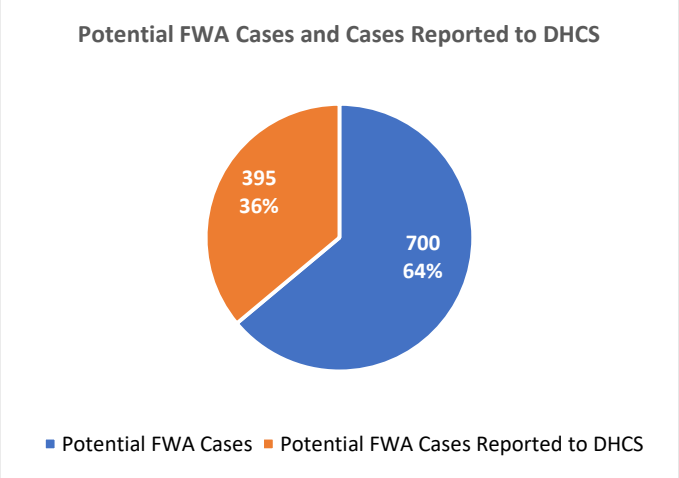




2025 cases have exceeded the volume of cases in 2024 by 30%. Potential Member FWA cases, while increasing, remains at approximately 1 per 1,000 members.







Potential FWA Allegations for January 2026:

- Member: 22
- Provider: 22

One (1) of the 395 cases was reported late, due to late receipt.

All Plan Letters (APLs) & Guidance Letters August – September 2025	
Department of Health Care Services (DHCS)	
APL 25-017 2025-2027 Medi-Cal Managed Care Health Plan MEDS/834 Cutoff and Processing Schedule (Issued 12/26/2025)	This APL provides KHS with the 2025-2027 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
APL 26-001 Initial Health Assessment (Issued 1/7/2026)	This APL provides guidance to KHS regarding the requirements of the Initial Health Appointment (IHA) beginning January 1, 2023. This APL supersedes APL 22-030. This APL update provides technical fixes only.
Department of Managed Health Care (DMHC)	
APL 25-017 Introduction of a New Independent Medical Review Organization (Issued 12/8/2025)	This APL informs KHS under the Department's jurisdiction and subject to independent medical reviews (IMR) set forth in Health and Safety Code section 1370.4 and 1374.29 et seq., and Title 28 of the California Code of Regulations section 1300.74.30, of the addition of Managed Medical Review Organization, Inc. (MMRO) to perform contracted IMRs for the Department
APL 25-018 Notice of Rate Changes for Independent Medical Reviews (Issued December 5, 2025)	This APL informs KHS under the Department's jurisdiction and subject to independent medical reviews (IMR) set forth in Health and Safety Code section 1370.4 and 1374.29 et seq., and Title 28 of the California Code of Regulations section 1300.74.30 of an upcoming rate increase by MAXIMUS Federal Services, Inc. (Maximus) to complete IMRs for the Department.
APL 25-019 Notice of amendments to rules 1300.51, 1300.67,1.3, and 1300.67.2 and Incorporated Documents-Network Adequacy Standards and methodology for RY 2026 (Issued December 12, 2025)	This APL provides notice to KHS of new and amended network adequacy requirements, standards, and methodologies. This includes updates to network adequacy standards that were previously released in APL 24-021 (December 12, 2024) and APL 23-023 (December 14, 2023), as well as new network standards addressing the availability of mental health networks, requirements for arranging out-of-network care, and the accuracy of network data reported to the DMHC. The amendments also include updates to block transfer filing requirements. Amendments are set forth in Rules 1300.67.2 and 1300.67.1.3. Additionally, Rule 1300.51 is updated to revise citations relevant to the recent re-lettering in sections of Rule 1300.67.2

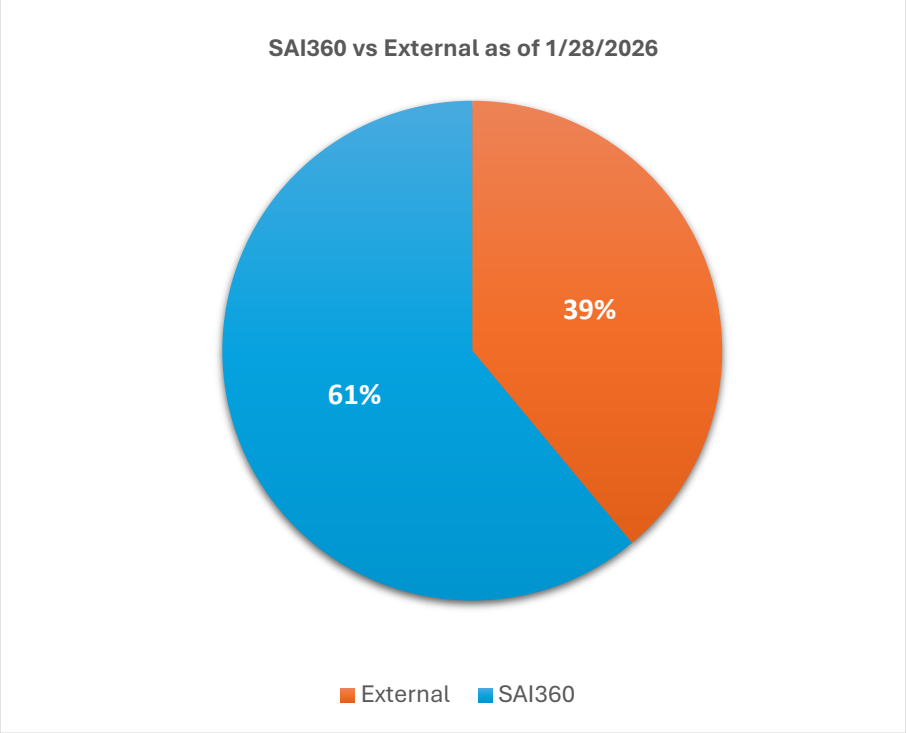
Internal Audit and Monitoring Activity

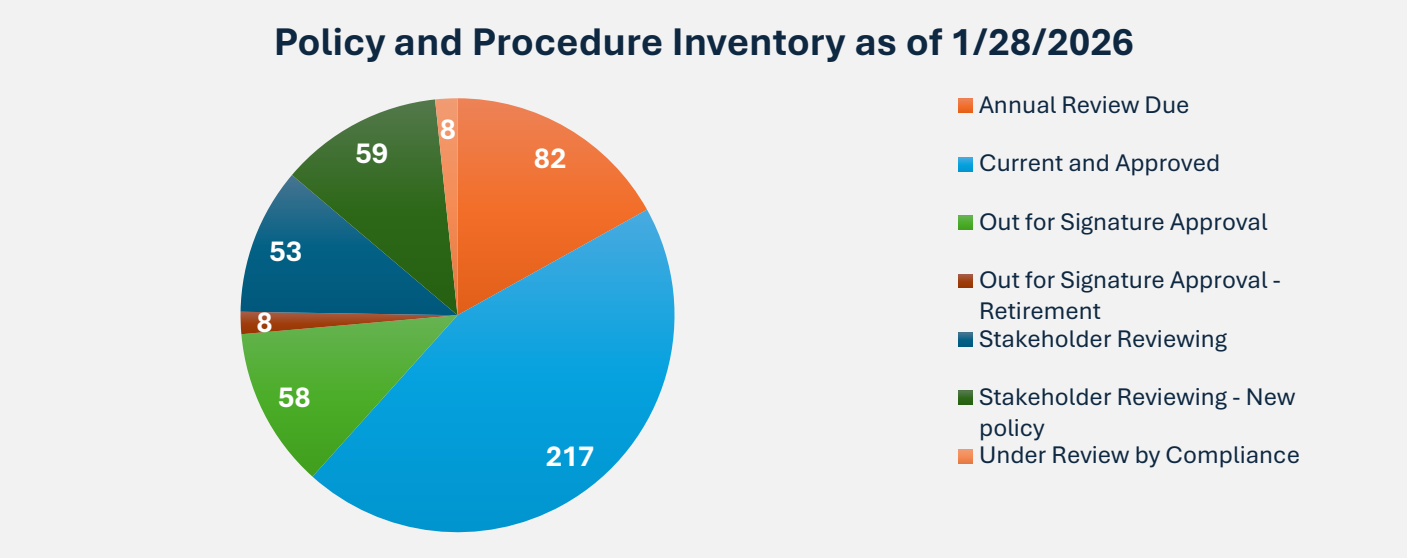
The Compliance Department conducts internal audits and monitoring activities related to regulatory All Plan Letters, guidance, previous regulatory audit findings, and contractual obligations. From the published requirements, the Compliance Department conducts a risk analysis and identifies those that pose a higher degree of risk to the Plan.

In 2025, Compliance conducted internal audits of Exempt, Expedited, and Standard Grievances (previous audit findings), Utilization Management Notice of Action Letters; the Provider Manual; and the KHS Website. A second semi-annual audit of all grievance types was also completed in the third quarter. The following audits are currently underway and planned to be complete in Q1: Notice of Action (NOA); Notice of Appeal Resolutions (NAR), and Post-Stabilization/Concurrent Inpatient Reviews (DMHC audit finding); Discrimination and Language (public & website posting; outgoing letters); Provider Directory data elements; Provider Training; New Member Enrollment Packets; retrospective APLs. Due to staffing constraints, these audits have recently resumed but are sometimes delayed due to the volume of DMHC Consumer Complaints/IMRs and regulatory audit activity. An additional Compliance Analyst was hired in January 2026 and is currently in training to assist with monitoring and auditing activities.

Policies

Compliance has recently implemented a new Policy Management Platform, SAI360, and is in the process of converting existing policies into the new platform. As a result, some policies are currently being worked within the platform, while older policies being reviewed and updated to a new format continue to be worked outside of the platform. The below reflects the current policy statuses of those being managed through each method, as well as the overall policy inventory. With the introduction of the dual special needs plan, we are also implementing numerous new policies specific to this line of business.





Regulatory Reports & Filings	
Regulatory Reports & Filings Submission to Government Agencies	KHS is required to submit various types of information to both DHCS and DMHC with cadences ranging from daily, weekly, monthly, quarterly, or annually. In some cases, KHS is required under statute or regulation to submit reports or documentation to establish initial or ongoing compliance with the law (e.g., timely access reporting, financial reporting). In other cases, plans are required to submit reports or documentation when they are planning to make an operational, business, product, or other change that affects the scope or applicability of their license. Additionally, key personnel and Board member filings are required to allow the regulatory agencies to review and advise on the individuals who provide leadership at KHS as well as the makeup of our Board of Directors. These submissions often reflect an amendment or material modification to the plan's license and, in some cases, are subject to Department approval prior to making the requested change to plan operations. Sources for this data include: **DMHC** 1. DMHC Portal Submissions (Ad Hoc) 2. Regulatory Calendar **DHCS** 1. Regulatory Calendar 2. DHCS Clarification Log 3. DHCS Portal Submissions (Ad Hoc) The volumes do not currently include: 1. DSNP Filings 2. Regulatory Audit Filings Reporting is being expanded upon to include the categories of filings and the additional types of filings not currently included.
Regulatory Submission Volume	Regulatory submissions to both DHCS and DMHC continue to increase annually. As demonstrated in the graphs above, submissions to date continue to increase steadily year after year. Volumes are expected to significantly increase further due to the introduction of the Dual Special Needs Plan (D-SNP) and required submissions to the Centers for Medicare and Medicaid Services (CMS).

DMHC Consumer Complaints & Independent Medical Reviews
KHS addresses and tracks enrollee complaints and requests for independent medical review (IMR) received from the DMHC. For December and January, a total of twenty-five (25) Consumer Complaints/IMRs were received, of which fourteen (14) were closed following KHS' response with no further action needed; five (5) were sent to IMR; two (2) were overturned and required KHS to authorize the services initially denied; and eight are pending KHS response and/or DMHC review.

Fraud, Waste, and Abuse (FWA)

The Plan investigates and reports information and evidence of alleged fraud, waste, & abuse cases to appropriate state and federal officials. Information compiled during an investigation is forwarded to the appropriate state and federal agencies as required. For 2025, the volumes continue to trend up, with 30% more cases received in 2025 versus the previous year, 2024.

The Compliance team is currently evaluating all open investigations to determine potential financial impact. However, until the investigation is complete, it is often unable to make this determination. Additional discussion and legal input is also required regarding extrapolating findings based on a small sample of medical records reviewed across the entire claims universe for potential refund requests and/or recoupment.

DHCS Medical Audits

1. **Limited Scope Medical Audit and Focused Transportation/Behavioral Health Audit – 2023:**

   DHCS conducted a routine limited scope medical survey and a focused Transportation/Behavioral Health audit of KHS in November/December 2023. The survey period covered 11/01/2022 – 10/31/2023:

   - For the Focused Audit on Behavioral Health and Transportation, the final audit report was received on 08/30/2024.
     - The findings included four (4) items under Behavioral Health, and three (3) under Transportation.
       - The Behavioral Health findings are related to the coordination with the specialty mental health and substance use disorder benefits, which are carved out from KHS Medi-Cal benefits. During the audit period, KHS had already created a separate Behavioral Health Department and implemented corrective actions; however, since some of these actions were implemented during the audit period, DHCS still documented findings.
       - The Transportation preliminary findings were focused on our oversight and monitoring to ensure members receive door-to-door service, we are monitoring no show rates, and monitoring level of service modifications.
     - Corrective Action Plan (CAP) submitted to DHCS 10/07/2024, with thirty (33) actions taken across the seven (7) findings.
     - CAP updates were submitted monthly, with the last submission on 05/02/2025.
     - KHS received a request to summarize the corrective actions on a separate DHCS template, which was submitted in early August.
     - Awaiting formal closure of CAP from DHCS.

2. **2025 Focused Audit (Information Systems Security)**

   Received notification of DHCS focused audit on 07/11/2025

   - Audit period: 05/01/2024 – 04/30/2025
   - Submitted Pre-Audit deliverables on 07/30/2025
   - Virtual interviews conducted the first two weeks in August
   - Additional Supporting documentation submitted
   - Audit closing session was held on 10/13/2025
   - Additional supporting documentation was submitted on 10/17/2025
   - Awaiting Preliminary Audit Report, which will require a response and any additional supporting documentation within fifteen (15) days after receipt.

3. **2025 Routine Medical Audit:**
   - Audit period: 11/01/2024 – 12/31/2025
   - Virtual interviews conducted 01/26/2026 – 02/06/2026
   - Numerous pre-audit and additional document requests submitted throughout (to current)
   - Awaiting Preliminary Audit Report, which will require a response and any additional supporting documentation within fifteen (15) days of receipt.

4. **HSAG Network Adequacy Audit:**
   - CY 2024
   - KHS was evaluated across twenty-four (24) different areas regarding the adequacy of our provider network.
   - HSAG did not have any findings and rated us at a level of "high confidence" across all twenty-four (24) areas.

5. **2024-2025 HSAG Encounter Data Validation Audit (EDV)**
   - Vendor is contracted by DHCS to conduct this audit. 411 medical records are submitted and reviewed to see our ability to submit those records.
   - Draft report was provided for feedback which showed decrease in scores.
   - Encounter accuracy scores declined when compared to 2023-2024. However, KHS scored higher than statewide averages where scores are provided.
   - Awaiting the Final Report.

DMHC Routine Medical Audits

1. **DMHC Routine Medical Audit –2023:**

DMHC conducted a routine audit of KHS in January 2023. The audit period covered 09/01/2020 – 08/31/2022. The Audit Report was received on 03/07/2024.

- DMHC issued the final audit report on 10/08/2024
  - Four (4) of the twenty-four (24) findings from the preliminary report were removed from the final report.
  - Any supporting documentation KHS submitted after 04/21/2024 was not considered in issuance of the final report.
  - Of the twenty (20) findings in the final report:
    - Four (4) were considered 'corrected'.
    - Sixteen (16) were determined to be "not corrected". Although DMHC recognized steps were taken to correct the deficiencies, the effectiveness of the corrective actions will be re-assessed in a follow up survey, conducted in November 2025.

      Four (4) findings are being referred to the Office of Enforcement:

      - The Plan fails to consistently ensure its delegate complies with required utilization management notification standards.
      - The Plan failed to consistently demonstrate that for concurrent review denials, care was not discontinued until the enrollee's treating provider had been notified and agreed to an appropriate care plan. Section 1367.01(h)(3).
      - The Plan inappropriately denies post-stabilization care and is operating at variance with policies filed with the Department.
      - The Plan improperly denied payment for emergency services and treatment. Section 1371.4(b) and (c).
  - Two (2) – not able to remediate as these were pharmacy-related and Pharmacy is now carved out

2. **DMHC Follow Up Audit to the 2023 DMHC Routine Survey**

- Notification of DMHC Follow Up Audit received 07/11/2025:
- Audit period: 11/01/2024 – 06/30/2025
- Submitted Pre-Audit deliverables on 07/28/2025
- Numerous additional deliverables submitted from 08/01/2025 – 09/30/2025
- File orientation session held with auditors on 10/09/2025
- Interviews held 11/10/2025
- Two (2) follow up documentation requests were submitted on 11/26/2025
- Awaiting additional requests and/or receipt of Preliminary Audit Report

Center for Medicare and Medicaid Services (CMS) Annual Compliance Audit and Investigation Standards Scores for CY2024

CMS requires the Department of Health Care Services (DHCS) to review, and report Managed Care Plans (MCPs) compliance with Federal Standards set forth in California Code of Regulations 42 CFR Subpart D and the Quality Assurance and Performance Improvement (QAPI) requirements described in 42 CFR 438.330. As such, CMS is requiring states to correspond its audit categories to specific CFR elements. CMS required states to develop a compliance scoring methodology to be able to draw comparisons across MCPs pertaining to their overall compliance status. Year over year, KHS has been compliant, with the previous two years achieving 100% compliance with California Code of Regulations.

					Compliance Score %		
Standard Number	CFR	Compliance Review Standard	Total Points Available	Total Points Scored	KHS 2024	2023	2022
1	§438.206	Availability of Services	30	30	100%	100%	80%
2	§438.207	Assurance of Adequate Capacity and Services	8	8	100%	100%	100%
3	§438.208	Coordination and Continuity of Care	36	36	100%	100%	89%
4	§438.210	Coverage and Authorization of Services	36	36	100%	100%	83%
5	§438.214	Provider Selection	8	8	100%	100%	75%
6	§438.224	Confidentiality	12	12	100%	100%	83%
7	§438.228	Grievance and Appeal Systems	80	80	100%	100%	80%
8	§438.230	Sub-contractual Relationships and Delegation	20	20	100%	100%	70%
9	§438.236	Practice Guidelines	12	12	100%	100%	83%
10	§438.242	Health Information Systems	22	22	100%	100%	100%
11	§438.330	QAPI Program	30	30	100%	100%	100%
12	§438.56	Disenrollment: Requirements and Limitations	2	2	100%	100%	100%
13	§438.100	Enrollee Rights	18	18	100%	100%	78%
14	§438.114	Emergency and Post-stabilization Services	16	16	100%	100%	100%
Total Points			**330**	**330**	**100%**	**100%**	**85%**

In an effort for DHCS to be fully compliant with all CMS requirements, the process commenced with the July 1, 2022-June 30, 2023 Audits & Investigations (A&I) medical audit cycle, with MCP scoring subsequently reflected in the External Quality Review Organization (EQRO) Technical Report.

KERN HEALTH SYSTEMS

Compliance Capsule – January 2026

Regulatory Audits – Stakeholder Responsibilities

Regulatory audits (DHCS, DMHC, and soon – CMS!) are a routine and essential part of our operating environment, helping to ensure that we meet legal, ethical, and organizational standards. Successful audits are dependent not only on our compliance with regulatory requirements, but they also rely heavily on coordination, preparedness, and clear communication across multiple teams and roles throughout the organization. This overview provides practical guidance to help staff approach audits with confidence and consistency, thereby supporting a smooth, accurate, and professional audit process.

Pre-Audit Deliverables:

- Understand the Request: Review it carefully to ensure your deliverables fully address what is being asked
- Quality Check your Work: Verify that data is accurate, complete, and formatted correctly – no inappropriate blank cells, incorrect dates (e.g. letter dates before decision dates or received dates, typos or invalid dates), or other errors
- Follow Naming and Filing Conventions: Use the proper file names and place deliverables in the correct folders for submission
- Ideally, format any excel documents in 'print-ready' formatting (all columns on one page if possible, etc.)

Audit Preparation:

- Review Requested Materials in detail
  - Familiarize yourself with the documents requested by the auditor, as well as the deliverables your team provided. Be ready to address any discrepancies or issues.
- Clarify Team Responsibilities
  - Coordinate with your team to determine who will address each topic. This ensures everyone is prepared and helps the team respond to questions clearly, confidently, and efficiently.



During the Audit:

- Keep your answers short & concise:
  - Answer only the question being asked
- Be truthful
  - Although we should position our answers in the best possible light, if we do have to answer that we are not doing something that we know we should be doing, be honest
- If you do not know the answer, admit it, and tell the auditor we will research the answer and get back to them
- If you do not understand the question, do not hesitate to ask the auditor to clarify
- Be aware of body language and facial expressions
- Silence is okay! Do not feel like you need to fill any silence by expanding on your answers
- Do not point fingers, place blame, or put another team member 'on the spot'
- During the interviews, be ready to access and display the actual samples submitted to DHCS.

For more information or any questions regarding stakeholder responsibilities for regulatory audits, please feel free to reach out to Deborah Murr, Chief Compliance & Fraud Prevention Officer, Jane MacAdam, Director of Compliance & Regulatory Affairs, or Sandeep Dhaliwal, Compliance Manager, Audits & Investigations.

KERN HEALTH SYSTEMS

Compliance Capsule – December 2025

HIPAA Safeguards

HIPAA requires covered entities to employ administrative, physical, and technical safeguards to protect individual's protected health information (PHI). These safeguards are measures that are meant to keep information from getting into the wrong hands. These safeguards include organizational and individual responsibilities that we all must follow to protect our members' information.



Some examples of administrative safeguards are policies and procedures that are implemented to protect information, requiring training of all staff upon hire and on an annual basis, and designating a Privacy Officer to oversee the Privacy Program of KHS.

Physical safeguards are things like locked doors and cabinets that contain member PHI; proper storage and disposal of personal devices, servers, and workstations; and evaluating the surroundings of workstations both in the office and at remote worksites to protect member information.

Technical safeguards are used to protect electronic PHI. These safeguards include encryption of devices and emails that contain member information, automatic log-off at workstations, password protection, and multi-factor authentication to ensure proper access to the KHS system.

While KHS has administrative responsibilities to safeguard our members' information, there are many things that we all must do on an individual level to protect our members' PHI. Here are some things we can all do to protect our members' Information:

- Always ensure that emails being sent outside of KHS are encrypted if containing PHI.
- Never leave documents or devices unprotected, unlocked, or unattended.
- Always verify those to whom you are giving out information.
- And remember, when in doubt, do not give it out.



<u>Avoid Unauthorized Access to Member Information</u>

As part of our ongoing commitment to protecting member privacy, please remember that staff may not access member information for friends, relatives, or acquaintances **under any circumstances**. This includes accessing DHCS Medi-Cal eligibility systems, as well as any KHS internal systems for non-business purposes.



Even if someone you know reaches out for help, the correct protocol is to refer them to Member Services through standard channels. Accessing or viewing member information without a legitimate business need is a HIPAA violation and a breach of our organizational safeguards.

We are all responsible for protecting our members' information. It can be so easy to forget to do the right things like encrypting emails, closing our screens when we leave our workstations, or to leave documents unlocked or unattended just for a moment, but these simple errors could lead to a HIPAA breach. If you are ever unsure of whether or not to release information, the HIPAA Team is always here to help.

For more information about HIPAA Privacy and Security, please refer to our KHS Policy 14.03 regarding Protected Health Information. You can always reach out to Deborah Murr, Chief Compliance & Fraud Prevention Officer or Jane MacAdam, Director of Compliance & Regulatory Affairs with any questions.

Chief Compliance and Fraud Prevention Officer (CCFPO)Report



Kern Health Systems Board of Directors Meeting

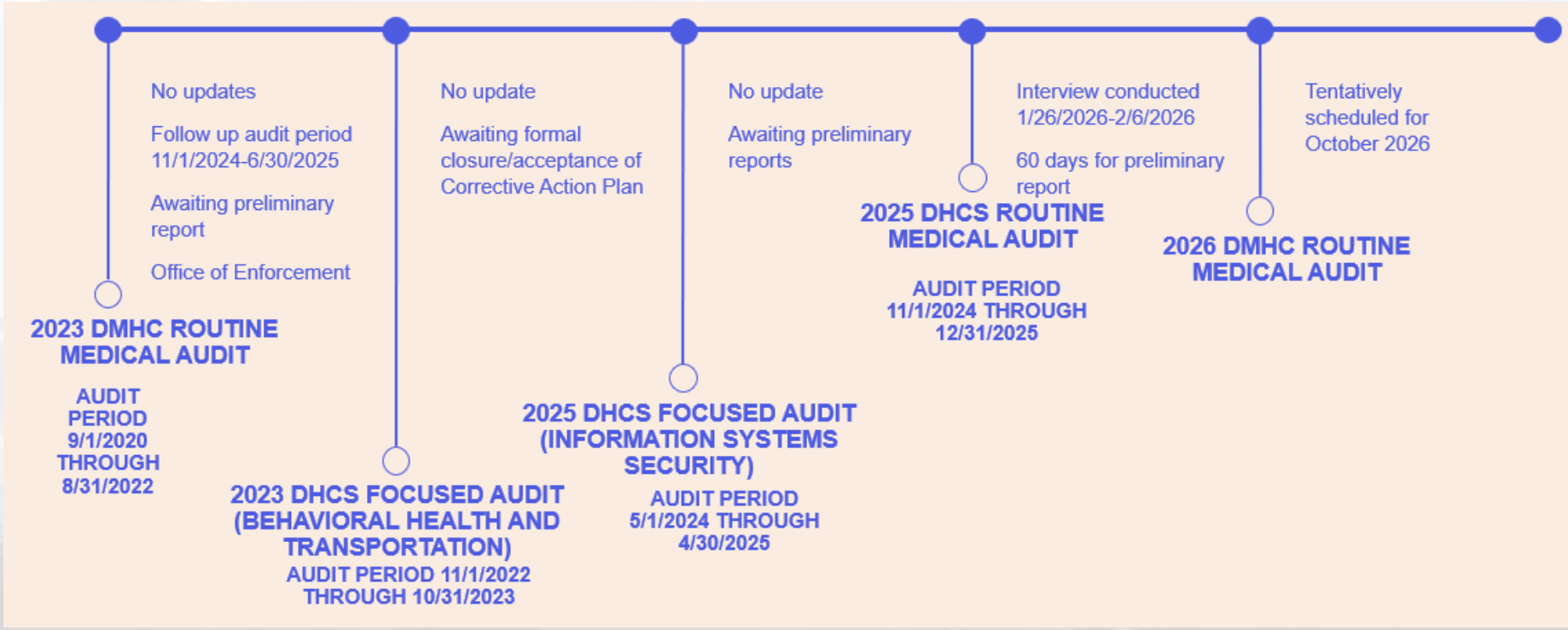
February 19, 2026

KERN HEALTH SYSTEMS

Agenda

- Regulatory Audit Timelines
- Enterprise Risk Management
- CCFPO Key Performance Indicators (KPI)
- Fraud Waste and Abuse

Regulatory Audit Timelines



Enterprise Risk Register

Risk Universe
Clinical/Safety/Quality
Financial
Hazards
Human Capital
Legal/Regulatory
Operational
Strategic
Technology

Risk Response
Accept
Avoid
Exploit
Mitigate
Transfer

Likelihood
E/1
D/2
C/3
B/4
A/5

Magnitude
Insignificant/1
Minor/2
Moderate/3
Major/4
Critical/5

Control Factor
1 - extremely well controlled with proactive monitoring to prevent and detect risk occurrence
2- controls are in place and monitoring occurs
3 - controls are in place and providing a stable framework to address the risk
4 - fundamental controls are in place but not fully addressing the risk
5 - controls are minimal or non-existent

Planned Activities for 2026

Organizational Training

Risk Roadmap, Testing Plan, and Remediation

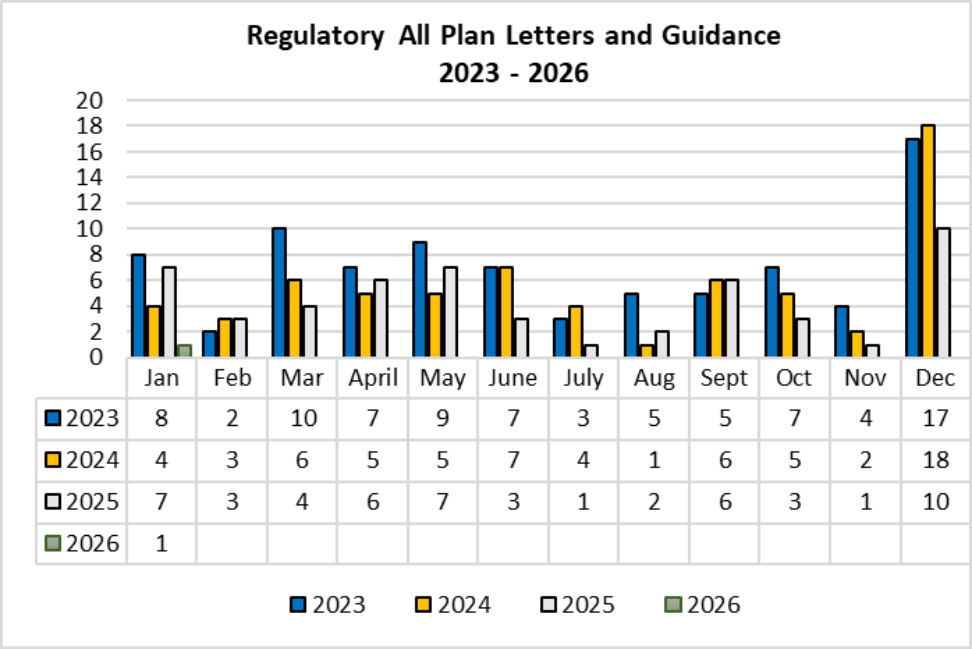
SAI360 Integration

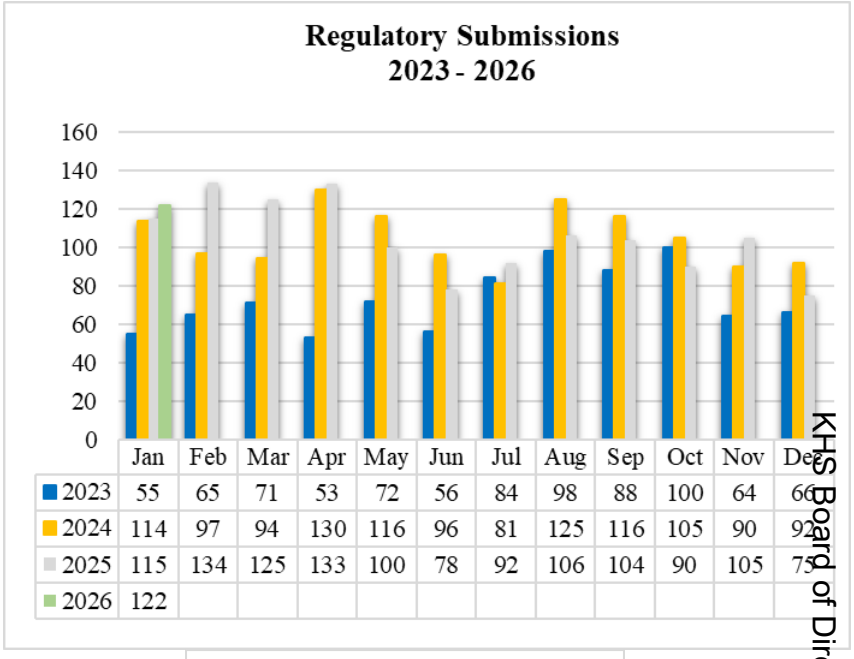
Stress Testing Validation

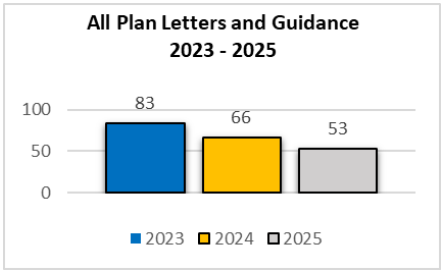
146 total risks identified

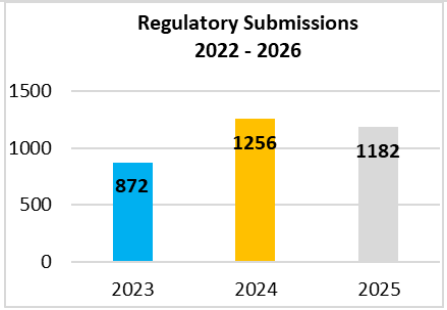
- 14 red critical 10%
- 23 orange major 16%
- 21 yellow moderate 14%
- 40 blue minor 27%
- 54 green insignificant 37%

Compliance Key Performance Indicators

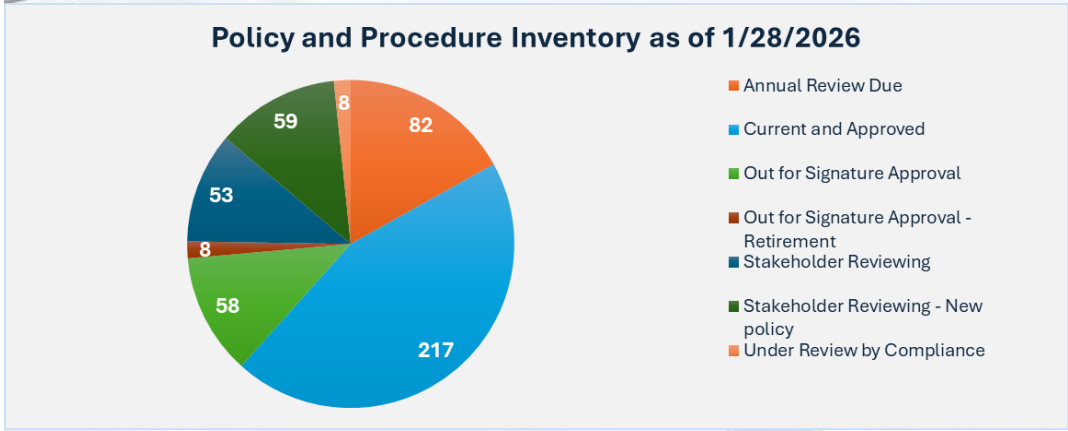


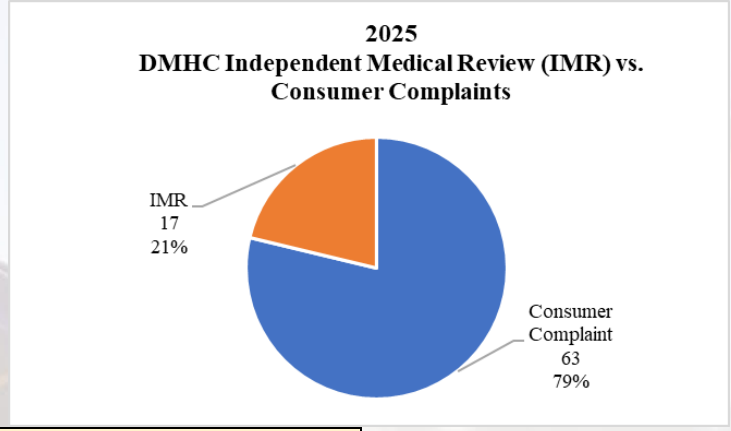


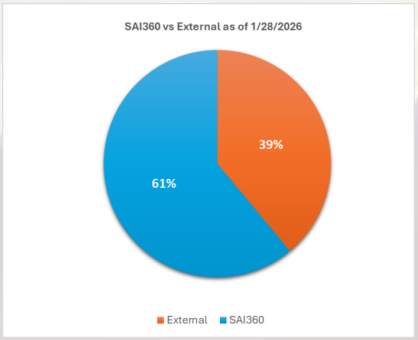




Compliance Key Performance Indicators







Consumer Complaints (Closed by DMHC without going to IMR)	
Decision	
Closed (KHS Overturned original decision)	17
Closed (KHS Upheld original decision)	24
Non-KHS Member	1
Services Never Denied	4
Return To Plan	7
Potential Quality Issue	2
Misdirected	5
Illegible - Withdrawn	1
Duplicate	2
Grand Total	**63**

Independent Medical Reviews (IMR)		
Decision	**KHS**	**DMHC**
Upheld	16	8
Overturned	1	8
Withdrawn	0	1
Grand Total	**17**	**17**

Compliance Key Performance Indicators

Privacy and Security (HIPAA)

2025 Reporting Timeliness		
Reported Timely	**24 hour Timely?** Y/N	**10 day Timely?** Y/N
Yes	16	20
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Total	**20**	**20**

2025 Breach Determination	
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Total	**20**

Root Cause for late submissions:

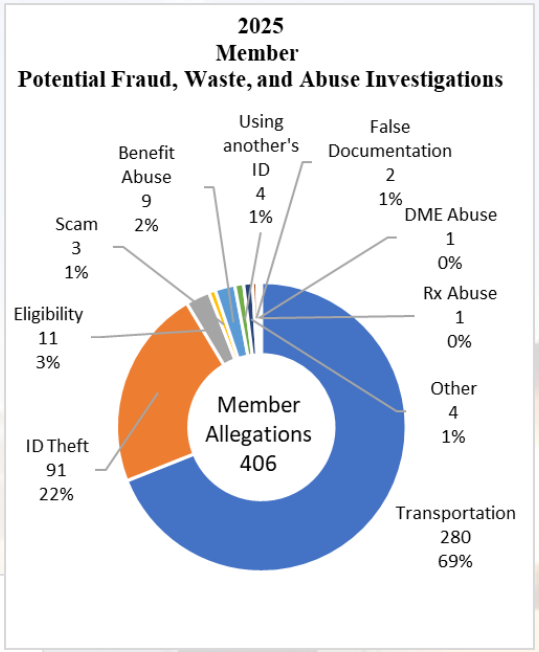
***** Three (3) reported to Compliance late by the Member Services team

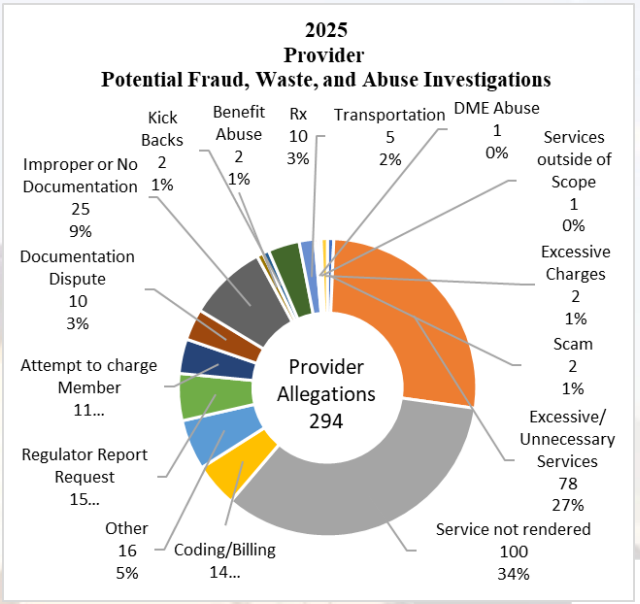
* One (1) reported late due to technical issue with reporting portal

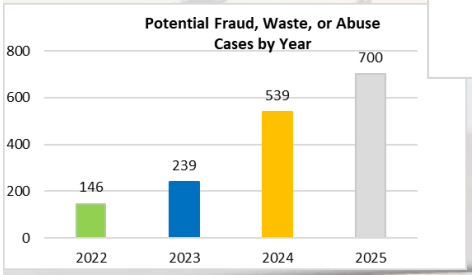
April Board of Directors

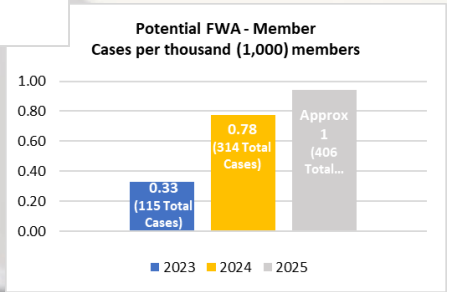
2026 Compliance Program-Medi-Cal
2026 Compliance Program-Medicare Advantage (D-SNP)
2025 Compliance Workplan End of Year Summary
2026 Compliance Workplan Outline
2026 Code of Conduct
2026 Anti-Fraud Plan

Compliance Key Performance Indicators





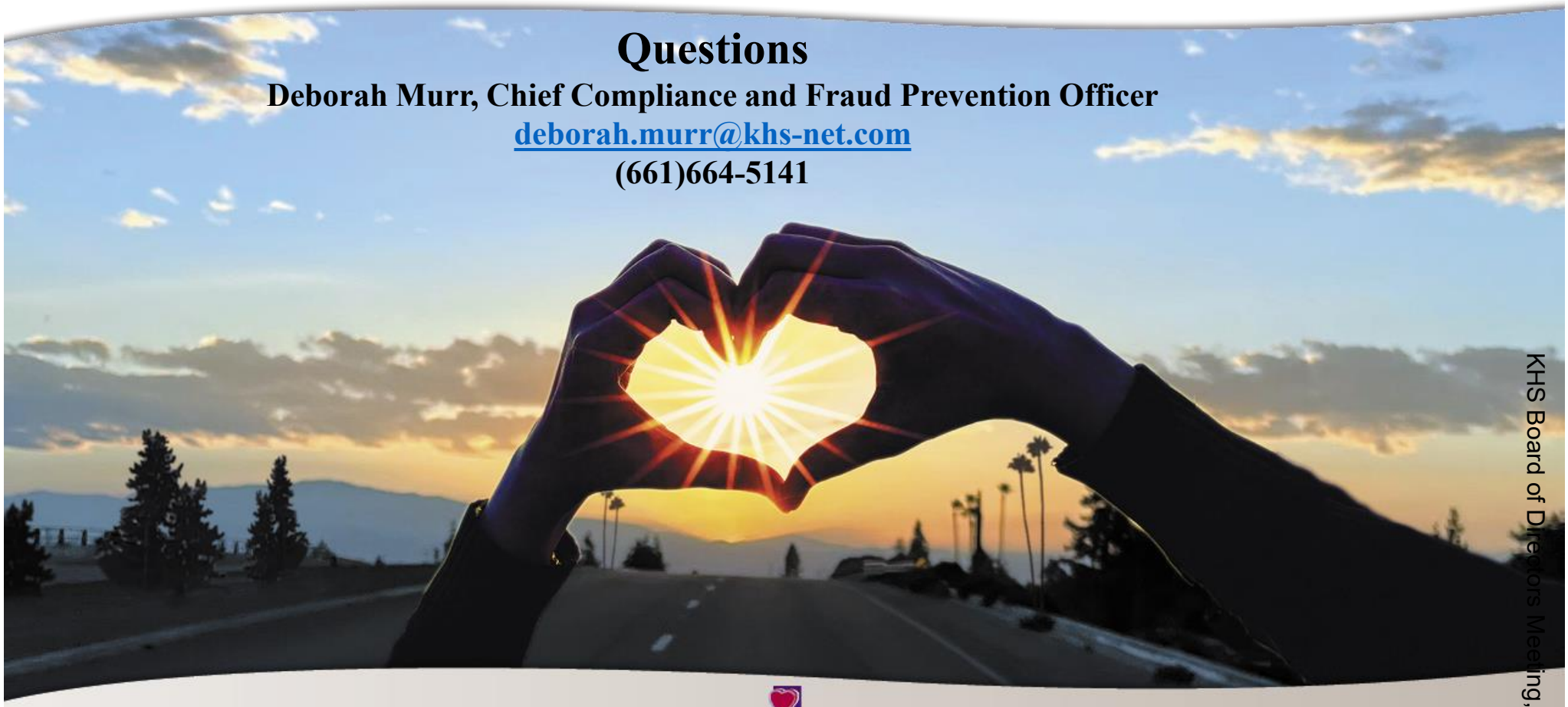




You + Us = a better day!

Questions

Deborah Murr, Chief Compliance and Fraud Prevention Officer
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(661)664-5141



KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Alan Avery, Chief Operating Officer

SUBJECT: 4th Quarter 2025 Operations Report

DATE: February 19, 2026

I am pleased to provide the following operational report highlighting activities and the performance metrics for the 4th quarter of 2025. All Operational Departments continue to meet or exceed all regulatory requirements and performance metrics during the quarter.

CLAIMS

We continue to receive a high volume of claims during the quarter with an overall 8% increase in claims volume during the 4th quarter compared to the 4th quarter of 2024.

With the continual increase in claims volume, management is closely monitoring the daily incoming claims inventory and making adjustments to resources as needed to ensure we meet our performance and regulatory metrics. We are confident that we have the appropriate systems in place to manage the increased number of claim receipts and changing regulatory requirements. Year to date 99% of claims continue to be submitted electronically with only 1% of the claims received via paper. These paper claims are then converted 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 of provider claims continued at 89% during the quarter, meaning claims were received and processed without any manual intervention but heavily monitored with ongoing audits by claims staff members to ensure accuracy and quality metrics are met.

The Claims Department Provider Call Center continued to manage incoming provider calls seeking clarification regarding claim payment and processing questions. During the 4th Quarter the provider call volume was slightly lower than the previous quarters with just over 6,100 incoming calls, due to the Thanksgiving, Christmas and New Years holiday season. We continue to receive positive feedback from providers regarding this service.

MEMBER SERVICES

The volume of member calls into Member Services being handled by Member Service Representatives (MSR) was similar to previous quarters. However, beginning with this report, I will provide additional information regarding the incoming and outbound calls being handled by our artificial intelligent (Ai) agent. Going forward I will report both performance indicators to reflect a true picture of the phone activity in Member Services. We are grateful for the implementation of this advanced new technology, as we believe it will enhance our ability to serve the members when needed and handle increased incoming and outbound calls without additional staff. Incoming and Outbound call type activity includes (1) Medi-Cal renewals (2) New Member Orientation (3) Gaps in Care-HEDIS/MCAS measures and (4) Fit for Life calls. The Ai agent is able to make outbound and receive

inbound calls for all of these call types not only during our office hours, but when the office is closed as well. This allows members who may be working and unable to call us during work hours, can contact us 24/7 and the Ai agent can assist them or refer their question to an MSR for follow-up at a scheduled convenient time for the member.

Key performance indicators (abandonment rate, average talk time) are all aligned with normal trends with the exception of average speed to answer, which has increased slightly over the past two quarters. Management is not concerned with this slight increase as it still meets the needs of our members but will continue to monitor its performance and adjust as needed. The top five reasons members call Member Services continue to remain the same: (1) New Member questions (2) PCP changes (3) Making demographic changes (4) Requesting replacement ID Cards (5) Checking referral status.

Member walk-in visits continued to remain strong during the 4th quarter. The Department of Healthcare Services has allowed us to install one of their document kiosks where Medi-Cal members can upload enrollment documents needed to renew their coverage. Previously, they had to do this only at DHS sites, sometimes waiting over an hour to do so. They can now visit us and use the kiosk to upload required documentation for their renewal. In addition to requesting assistance with their Medi-Cal renewal, visitors sometimes need assistance with general plan questions along with seeking ID card replacements and other issues.

We continue to successfully manage incoming phone activity by encouraging members to obtain their own personal account on the KHS Member Portal. During the 4th quarter an additional 4,000 members created new online accounts. Currently over 106,000 (27%) of our members have online member portal accounts which allows them to perform all of the top five reasons and other service functions they would normally call Member Services to perform.

PROVIDER RELATIONS

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

The Primary Care Provider (PCP) network continued to grow slightly during the 4th quarter, with a net increase of 21 new PCPs for a total of 572 PCP providers while the specialty provider network had an increase of 43 specialists during the same time period. Our complete contracted provider network consists of 4,880 unique providers at the close of the 4th Quarter. It is noteworthy that our overall provider network continues to grow during the past twelve months. At the end of the 4th Quarter 2024 our complete provider network consisted of 4,409 providers compared to the current network of 4,880 providers, a 11% overall increase.

The Department monitors network capacity/adequacy via a Full-Time Equivalency (FTE) provider to member ratio, which is a regulatory requirement. For PCPs, the regulatory standard is one FTE PCP for every 2,000 members. As of the 4th Quarter of 2025, the Plan maintained a network of one FTE PCP for every 1,312 members, meeting the requirement. The Plan is also required to maintain a network of one FTE physician for every 1,200 members. As of the 4th Quarter, the Plan maintained a network of one FTE Physician for every 303 members, exceeding the requirement. PNM 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. During the 4th Quarter, the PCPs provided visits on average within 1.9 days. Non-urgent appointments with a specialist must be available within 15 days. Our specialist appointment is currently 10.6 days.

GRIEVANCE REPORT

Total Grievances for the 4th quarter continued to increase in the same categories that we experienced in the 2nd and 3rd quarters, specifically Access to Care, Medical Necessity, Quality of Service and Exempt Grievances. Medical Necessity grievance growth was impacted by the changes made to the guidelines for several of the Community Support Services benefit, primarily medically tailored meals and personal homemaker services. In addition, changes to the oversight of the ABA Therapy referrals also started to impact Medical Necessity grievances. Changes were also implemented to the medical transportation procedures which impacted Access to Care and Quality of Service. We anticipate this increase in grievances will gradually level out during 2026 as members and providers become accustomed to the new plan procedures for both community support services, ABA therapy and the transportation benefit. The volume of Exempt grievances, those grievances requiring less investigation and easily resolved, also increased due to these three areas.

DHCS requires health plans to forward copies of all member discrimination grievances within 10 days to their 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 identified 81 grievances classified as discrimination during the 4th Quarter, following similar trends throughout 2025. All discrimination grievances were reported timely to DHCS Office of Civil Rights.

Part two of the required Grievance Report is the disposition of the formal grievances for the 4th Quarter of 2025. Following the review and investigation of the 587 Potential Inappropriate Care by the Quality Department, 490 of the decisions were upheld, 94 were overturned and ruled in favor of the members and 3 grievances were still under review by the Quality Department. The remaining 2,349 grievances were reviewed and managed by the Grievance Coordinators, 1,724 of the decisions were upheld by the Plan, 599 were overturned and ruled in favor of the member and 26 were still under review. The primary reason for overturning the original decision of the grievance occurs when we receive additional supporting documentation from the member or the provider.

To fully comprehend 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 4th Quarter of 2025, there was over 1.6 million medical encounters provided to our 400,000 members many of whom are new to managed care. In total, KHS received 3.34 grievances per 1,000 members per month, within the range of the other LHPC Plan averages of 1.00 – 3.99 per month.

REQUESTED ACTION

Receive and file.

4th Quarter 2025 Operational Report

Alan Avery
Chief Operating Officer

4th Quarter 2025 Claims Department Indicators

Activity	Goal	4th Quarter 2025	Status	3rd Quarter 2025	2nd Quarter 2025	1st Quarter 2025	4th Quarter 2024
Claims Received		**1,660,459**		1,747,043	1,751,764	1,659,951	1,529,137
Electronic	95%	**99%**		99%	99%	99%	99%
Paper	5%	**1%**		1%	1%	1%	1%
Claims Processed Within 30 days	90%	**93%**		98%	99%	99%	98%
Claims Processed within 45 days	95%	**99%**		99%	99%	99%	99%
Claims Processed within 90 days	99%	**100%**		99%	100%	99%	99%
Claims Inventory-Under 30 days	96%	**98%**		98%	99%	99%	99%
31-45 days	<3%	**1%**		1%	<1%	<1%	<1%
Over 45 days	<1%	**1%**		1%	<1%	<1%	<1%
Auto Adjudication	85%	**89%**		89%	89%	88%	88%
Audited Claims with Errors	<3%	**<3%**		2%	2%	2%	2%
Claims Disputes	<5%	**<1%**		<1%	<1%	<1%	<1%
Provider Calls		**6,159**		9,274	8,921	8,736	8,060

KERN HEALTH SYSTEMS

4th Quarter 2025 Member Service Indicators

Activity	Goal	4th Quarter 2025	Status	3rd Quarter 2025	2nd Quarter 2025	1st Quarter 2025	4th Quarter 2024
Incoming Calls Handled by MSR Handled by Ai		**72,261** 64,983 7,278		70,159	76,764	77,449	68,844
Abandonment Rate	<5%	**4%**		3%	2%	1%	2%
Avg. Answer Speed	<2:00	**:42**		:46	:20	:11	:18
Average Talk Time	<9:00	**8:31**		8:28	8:01	7:57	8:02
Top Reasons for Member Calls	Trend	**1. New Member** **2. Demographic changes** **3. PCP Change** **4. ID Card** **5. Referrals**		1. New Member 2. Demographic changes 3. PCP Change 4. ID Card 5. Referrals	1. New Member 2. Demographic changes 3. PCP Change 4. ID Card 5. Referrals	1. New Member 2. Demographic changes 3. PCP Change 4. ID Card 5. Referrals	1. New Member 2. Demographic changes 3. PCP Change 4. ID Card 5. Referrals
Outbound Calls Made by MSR Made by Ai	Trend	**236,478** 49,605 186,873		55,079	69,300	69,357	61,622
# of Walk Ins	Trend	**1561**		1887	1524	1542	1343
Member Portal Accounts-Q/Total	4%	**3963** **106,809** **(26.91%)**		4500 102,847 (25.68%)	4194 98,269 (24.27%)	4277 94,074 (23.25%)	3677 89,798 (22.24%)

HEALTH SYSTEMS

4th Quarter 2025 Provider Network Indicators

Activity	Goal	4th Quarter 2025	Status	3rd Quarter 2025	2nd Quarter 2025	1st Quarter 2025	4th Quarter 2024
# of PCP		**572**		551	538	517	505
% Growth		**3.63**		2.42%	4.06%	2.38%	2.85
# of Specialist		**782**		739	682	574	559
% Growth		**5.58%**		8.36%	18.8%	2.68%	2.01%
FTE PCP Ratio	1:2000	**1:1,312**		1:1,378	1:1,431	1:1,483	1:1,514
FTE Physician Ratio	1:1200	**1:303**		1:292	1:283	1:180	1:256
PCP	< 10 days	**1.9 days**		2.2 days	2.5 days	3.6 days	1.3 days
Specialty	< 15 days	**10.6 days**		9.2 days	6.7 days	7.1 days	3.5 days

KERN HEALTH SYSTEMS

4th Quarter 2025 Grievance Report

Category	Q4 2025	Status	Issue	Q3 2025	Q2 2025	Q1 2025	Q4 2024
Access to Care	897		Appointment Availability	800	832	713	603
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	385		Questioning denial of service	299	220	192	241
Other Issues	201		Miscellaneous	172	165	141	134
Potential Inappropriate Care	587		Questioning services provided. All PIC identified cases forwarded to Quality Dept.	513	493	535	476
Quality of Service	785		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	687	702	654	509
Discrimination (New Category)	81		Alleging discrimination based on the protected characteristics	61	78	81	71
Total Formal Grievances	2936			2532	2490	2316	2034
Exempt	1088		Exempt Grievances-	981	985	683	644
Total Grievances (Formal & Exempt)	4024			3513	3475	2999	2678

KHS Grievances per 1,000 members – 3.34
LHPC Average 1.0 – 3.99/month

KERN HEALTH SYSTEMS

Additional Insights-Formal Grievance Detail

Issue	20254th 2026 Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	**323**	**223**	**0**	**98**	**2**
Coverage Dispute	**0**	**0**	**0**	**0**	**0**
Specialist Access	**574**	**329**	**0**	**238**	**7**
Medical Necessity	**385**	**332**	**0**	**53**	**0**
Other Issues	**201**	**166**	**0**	**32**	**3**
Potential Inappropriate Care	**587**	**490**	**0**	**94**	**3**
Quality of Service	**785**	**598**	**0**	**176**	**11**
Discrimination	**81**	**76**	**0**	**2**	**3**
Total	**2936**	**2214**	**0**	**693**	**29**

KERN HEALTH SYSTEMS

Questions

For additional information, please contact:

Alan Avery
Chief Operating Officer
(661) 664-5005

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Martha Tasinga, Chief Medical Officer

SUBJECT: Chief Medical Officer Report

DATE: February 19, 2026

BACKGROUND

The Chief Medical Officer's February report provides a fourth quarter 2025 update on utilization trends, medical management oversight, and quality performance.

The report highlights Utilization Management activity, including processing 95,445 referrals in Q4 with strong compliance in prior authorization turnaround times and timely member and provider notifications

Emergency room utilization remains stable with slight seasonal fluctuation, while outpatient physician and hospital services continue to trend above projections. Although cost per bed day remains elevated, inpatient admissions per 1,000 members and average length of stay continue to trend below projected levels

Additionally, the presentation outlines priorities focused on monitoring over-and under-utilization, strengthening hospitalist collaboration and ensuring appropriate oversight of ABA services in alignment with regulatory requirements. Updates on MCAS quality performance demonstrate continued progress, with multiple measures trending higher year-over-year and advancing toward Minimum Performance Levels

Supporting utilization and quality dashboards are included as attachments.

REQUESTED ACTION

Receive and File.

KERN HEALTH SYSTEMS

MARTHA TASINGA MD. MPH. MBA

FEBRUARY 19, 2026



CHIEF MEDICAL OFFICER REPORT

AGENDA

-Utilization Management

- Outpatient Prior Authorization
- Outpatient Physician Services
- Outpatient Hospital
- Inpatient Hospital Utilization
- Emergency Room Utilization

-ABA Services

-MCAS

OUTPATIENT PRIOR AUTHORIZATION

4th Quarter 2025
- 95,445 referrals processed

Compliance TAT of decision.

Urgent: Response back to Provider in 3 business days
- Compliance 93%

Routine: Response back to Provider in 5 business days
- compliance 94%

Member and provider notification with 48 hours of decision
- Member notification 97%
- Provider notification 100%

OUTPATIENT PHYSICIAN SERVICES

Utilization of physicians' outpatient services:

- Professional service visits per member month per month continue trend upwards for all AID codes
- Projected cost per visit is stable even though it is higher than budget

Drivers of increase in utilization:

- 2.08 visits per 1,000 members due to symptoms related to upper respiratory infections(Possibly FLU)
- Increase utilization for preventive service
- Diabetes
- Hypertension
- Kidney disease
- Pervasive developmental disorders; Autistic disorder is now the 7th most common diagnosis in outpatient professional services

Refer to **Attachment A** for details

OUTPATIENT HOSPITAL

- Includes Observation level of care, outpatient elective surgeries
- Visits per member per month are have been above projections for all Aid groups
- Working with our Hospitalist teams to develop strategies for appropriate utilization of Hospital outpatient services
- Ambulatory surgeries(outpatient facility of the hospital cost at least 3 times the cost of same procedure done at a free-standing surgery center)

Refer to **Attachment B** for details

INPATIENT HOSPITAL UTILIZATION

- Cost per bed day continue to be higher than projected for all AID codes
- Admission per 1,000 member continue to trend down and the ALOS is lower than projected for all AID codes
- Top Inpatient diagnosis
  - Maternity
  - Members dual diagnosis(medical diagnosis and mental health/SUD)
  - Complications of chronic conditions and social issues:
    - Sequalae of Cerebrovascular diseases,
    - Alzheimer disease,
    - Disorders of muscle wasting and metabolic encephalopathy
- Serious challenges for the caregiver and higher rates of readmission(“social admits”)
- End of life issues
- Higher risk of readmissions
- Placement challenges (Mental health, Substance use diagnoses, homelessness)
- Fragmented Mental health services
- Increase need for community level facilities for members

Refer to **Attachment B & E** for details

INPATIENT: 1ST QUARTER VS. 4TH QUARTER

	1st Qtr	4th Qtr
Acute admits	54/1,000	52/1,000
Acute Length of Stay	3 days	2.8 days
SNFs admits	2/1,000	2/1,000
SNFs Lenth of Stay	32 days	15 days
Re-admit %	15.54	15.02
LTAC admits	6/1,000	2/1,000

EMERGENCY ROOM UTILIZATION

- Stable
- The slight increase in utilization for December possibly due to FLU
- Most ER visits occurring at BMH
- Implemented Pilot program for hospitalist to see patients in ER prior to admission(15.6% reduction in admissions that do not meet medical necessity criteria)

Refer to **Attachment D & F** for details

APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

OVERVIEW OF ABA SERVICES

- ABA services represent a structured, evidence-based approach to behavior modification that can lead to meaningful improvements in the lives of individuals with autism and other developmental challenges.

- By focusing on specific behaviors and employing positive reinforcement, ABA helps individuals develop essential skills and enhance their quality of life.

MCP REQUIREMENTS - APL 23-010

- The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without a diagnosis of Autism Spectrum Disorder.
- Behavioral Health Treatment (BHT) services must be provided, observed and directed under an MCP-approved behavioral treatment plan. The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline
- The BHT plan must identify the Medically Necessary services. The Provider of BHT services must review, revise, and/or modify no less than once every six months the behavioral treatment plan.
- The BHT plan helps facilitate communication with all team members participating in the plan of care, ensuring appropriate utilization reviews and regulatory reimbursement compliance.
- The Plan must have written documentation that detects under and over-utilization of health care services

CONTRACTUAL REQUIREMENT:
MONITORING OF OVER AND UNDER-UTILIZATION OF HEALTH CARE SERVICES

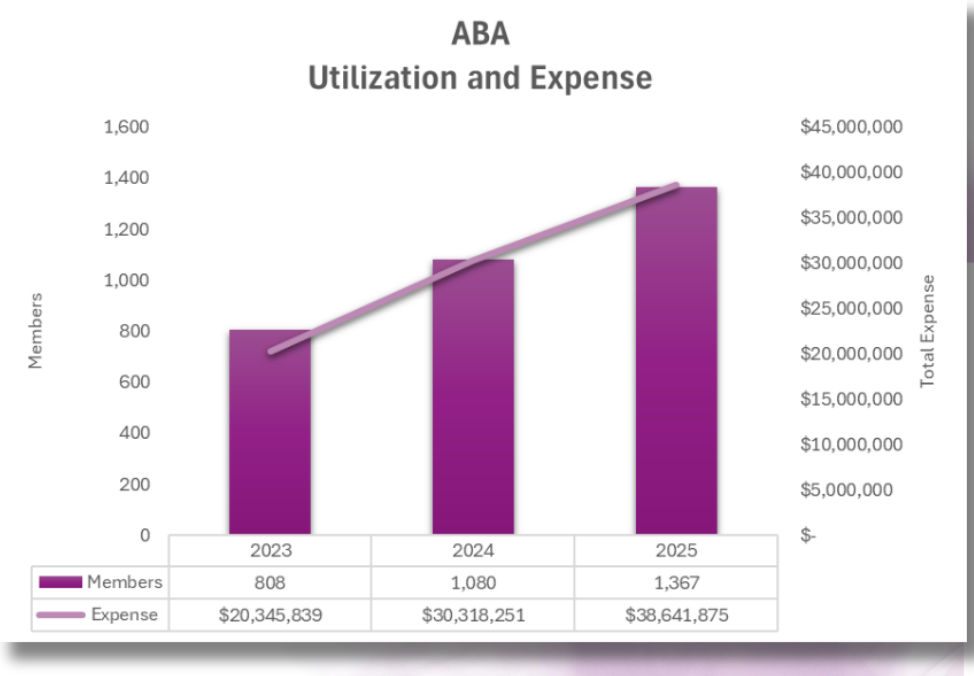
MONITORING OVER AND UNDER UTILIZATION

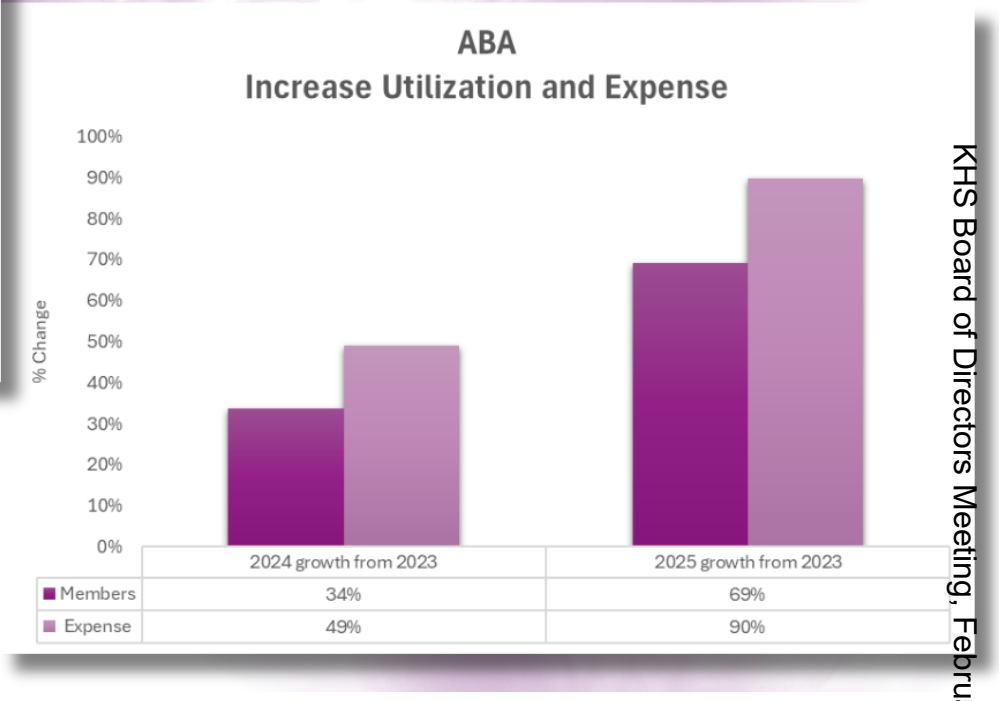
- Identified ABA services for potential over/inappropriate utilization
- Random sample sent to AMR (Independent organization)
- 50% of files did not have documentation to support medical necessity for services billed and paid for by KHS
- KHS added codes for ABA services to PA list
- KHS identified ALLmed through RFP process
- AllMed provides clinical expertise by using board-certified BCBA PHD
- Behavior analysts (BCBAs) and psychiatrists (with training and expertise in ABA services) to review for medical necessity and alignment with APL 23-010 and MCG guidelines

DOCUMENTATION AND MEDICAL NECESSITY

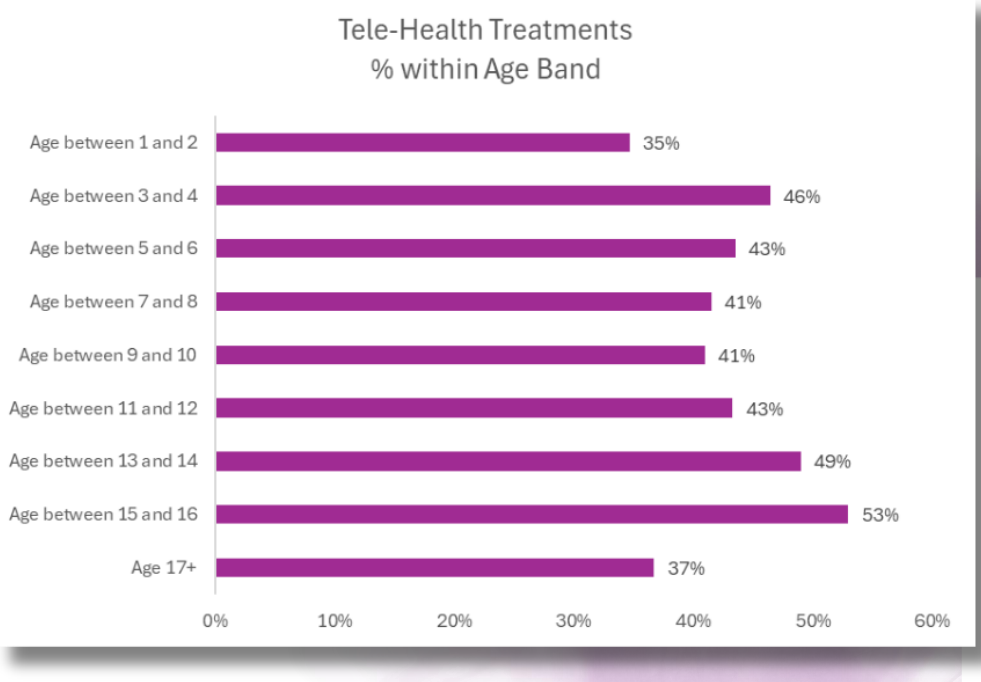
- Treatment is consistent with the symptoms or diagnosis of the illness, injury, or symptoms under review by the provider of care.
- Treatment is necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational).
- Treatment is not furnished primarily for the convenience of the patient, the attending provider, or other provider or supplier.
- Treatment is furnished at the most appropriate level that can be provided safely and effectively to the patient and is neither more or less than what the patient is requiring at that specific point in time.
- Payment of medical care and/or treatment must not be related to monetary status.
- Documentation of all medical care should accurately reflect the need for and outcome of the treatment.
- Treatment or medical services deemed to be medically necessary by the provider of those services (e.g., dentist, therapist, clinician, etc.) does not imply or infer that the service(s) provided will be covered by or deemed medically necessary service payable by the plan.

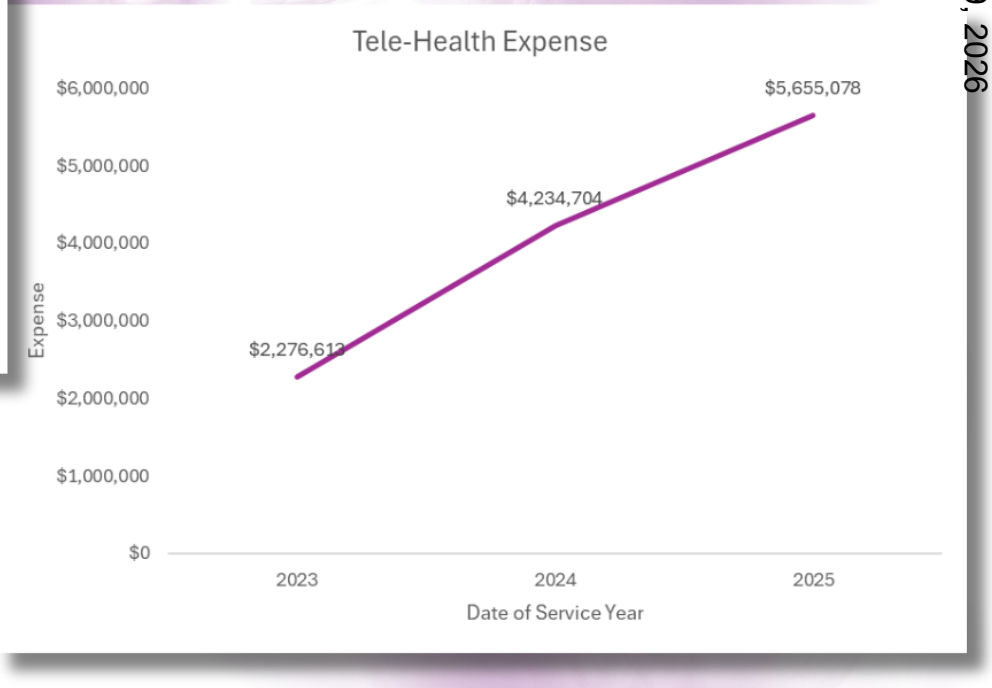
ABA UTILIZATION AND EXPENSE





TELEHEALTH TREATMENTS





CONCERNS

- KHS clinical directors voice concerns regarding over utilization of services
- KHS Provider Network Management and Behavioral Health Departments responded to concerns timely and educated the providers on requirements of documentation from the All Plan Letter and Milliman Care Guidelines
- KHS implemented review of the Notice of Action
- KHS ensured that the All Plan Letter and the Milliman Care Guidelines were referenced and included with the Notice of Action, along with the detailed document from ALLmed outlining where documentation is missing to support medical necessity
- Response to Department Health Care Services
- Utilization Management controls are not intended to reduce services, intent is to ensure medically necessary care is provided in compliance with evidenced based criteria and regulatory requirement.

KHS OVERSIGHT OF ALLmed

- To monitor AllMed's activities, KHS is sending all upheld appeals from AllMed to AMR
- Independent Medical Review Organization, AMR, to review for appropriateness of the decision
- If AMR overturns the decision, KHS honors the decision by AMR
- KHS sends the AMR overturned decisions to AllMed for educational purposes and are discuss at weekly KHS/ALLMED JOM

Feedback from BCBAs during peer-to-peer conversations

- Treating BCBAs do not know why things are denied
- They do not get the detailed report from Allmed sent to them through the portal
- They are told that their goals are not specific and they are not following standards defined by CARB for setting SMART goals
- Overall providers are appreciative of the peer-to-peer conversations
- KHS plans to provide a refresher to network providers on goals setting and documentation of progress towards goals

PROVIDER COLLABORATION

- KHS Provider Network Management, Behavioral Health Department and Utilization Management teams have ongoing communication with ABA providers
- KHS facilitated group and individual trainings
- Individual provider phone and email communications
- Provided education on requirements to demonstrate medical necessity
- Addressed concerns regarding denials
- Augmented peer to peer process, challenges
- Provided appeal process education
- Offering case specific concerns and issue resolution

KHS Staff, in collaboration with Kern Autism Network, hosted a Parent Support Group meeting Wednesday February 11, 2026.

MCAS
QUALITY PERFORMANCE

KHS MCAS MY2026 vs. MY2025 Comparison

- 9 measures are trending higher than the previous year at the same point in time

Dashboard is underway 2026 measure alignment

Rates are solely based on administrative data. While we are still early in the year, we anticipate significant rate changes in the coming months.

MY2026 Trending Performance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
84.52%	41.50%	16.90%	50.01%	9.54%	14.87%
HITS FOR MPL (32)	HITS FOR MPL 5,390	HITS FOR MPL 13,041	HITS FOR MPL 1,504	HITS FOR MPL 3,685	HITS FOR MPL 1,438
+4.62 % change Feb'25 79.89%	+0.56 % change Feb'25 40.94%	-5.66 % change Feb'25 22.56%	+3.70 % change Feb'25 46.30%	+3.11 % change Feb'25 6.43%	-19.30 % change Feb'25 34.17%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
13.24%	20.00%	23.02%	92.99%	25.93%	64.18%
HITS FOR MPL 689	HITS FOR MPL 21	HITS FOR MPL 47	HITS FOR MPL 13,918	HITS FOR MPL 670	HITS FOR MPL 375
+0.78 % change Feb'25 12.47%	+3.57 % change Feb'25 16.43%	+9.11 % change Feb'25 13.91%	-4.85 % change Feb'25 88.14%	+0.29 % change Feb'25 25.63%	-3.20 % change Feb'25 67.38%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
52.30%	35.65%	14.80%	11.47%	56.47%	3.60%
HITS FOR MPL 578	HITS FOR MPL 971	HITS FOR MPL 6,972	HITS FOR MPL 3,417	HITS FOR MPL 1,025	HITS FOR MPL 78,443
-6.95 % change Feb'25 59.25%	+5.64 % change Feb'25 30.00%	-2.02 % change Feb'25 16.82%	-13.48 % change Feb'25 24.94%	-1.03 % change Feb'25 57.50%	-2.45 % change Feb'25 6.05%

Measure rates are thru claims and standard supplemental data. No medical record reviews are included.

KERN HEALTH SYSTEMS

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.

AMR

Hits needed for MPL

0

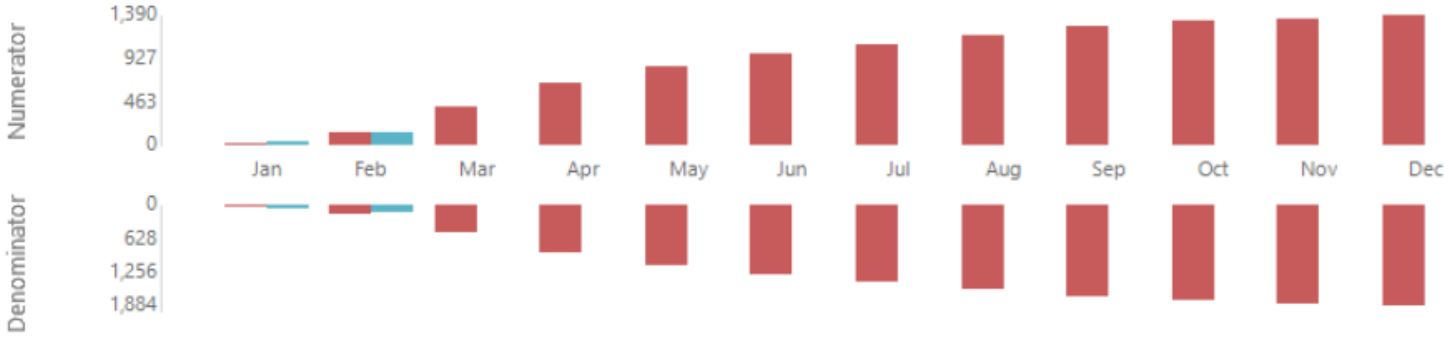
Rate: 84.52%
Prior Year: 79.89%
+4.62% change

131

155



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	52.94%	79.89%	78.56%	75.48%	74.80%	75.87%	75.82%	75.13%	75.07%	74.38%	73.75%	73.78%
2026	84.91%	84.52%										
MPL	63.66%	63.66%	63.66%	63.66%	63.66%	63.66%	63.66%	63.66%	63.66%	63.66%	63.66%	63.66%



Breast Cancer Screening - ECDS

Members 42–74 years of age by the end of the measurement period who were recommended for routine breast cancer screening and also meet the criteria for participation.

BCSE

Hits needed for MPL

5,390

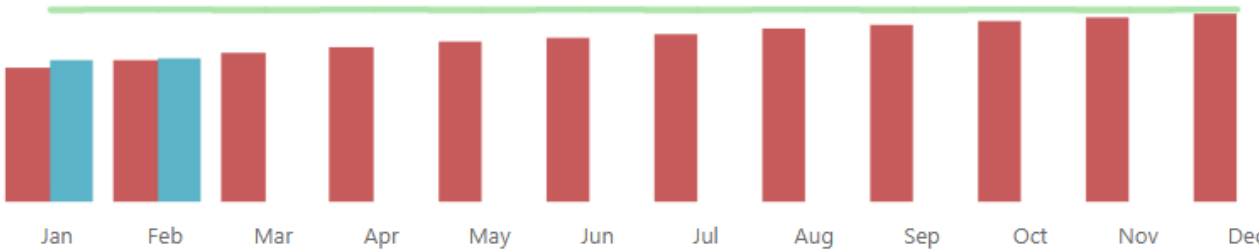
Rate: 41.50%

MPL: 55.87%



15,572

37,520



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	39.02%	40.94%	42.98%	44.78%	46.30%	47.46%	48.70%	50.11%	51.16%	52.21%	53.16%	54.29%
2026	40.92%	41.50%										
MPL	55.87%	55.87%	55.87%	55.87%	55.87%	55.87%	55.87%	55.87%	55.87%	55.87%	55.87%	55.87%



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.

CBP

Hits needed for MPL

13,041

Rate: 16.90%

Prior Year: 22.56%

-5.66% change

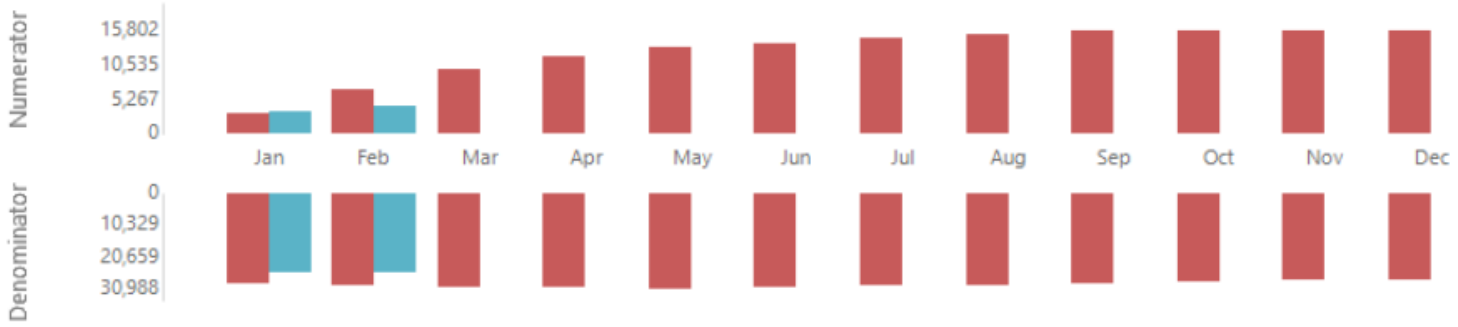




	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	10.99%	22.56%	32.06%	38.27%	42.30%	45.56%	48.48%	51.22%	53.43%	54.95%	55.77%	56.56%
2026	13.45%	16.90%										
MPL	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%	67.88%

4,324

25,583



Cervical Cancer Screening

The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) test ing performed within the last 5 years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrH PV) cotesting within the last 5 years.

CCS

Hits needed for MPL

1,504

Rate: 50.01%

MPL: 52.32%



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	45.81%	46.30%	47.70%	48.96%	50.43%	50.80%	51.80%	52.94%	53.94%	54.97%	55.76%	56.65%
2026	49.86%	50.01%										
MPL	52.32%	52.32%	52.32%	52.32%	52.32%	52.32%	52.32%	52.32%	52.32%	52.32%	52.32%	52.32%

32,513

65,019



Developmental Screening in the First 3 Years of Life

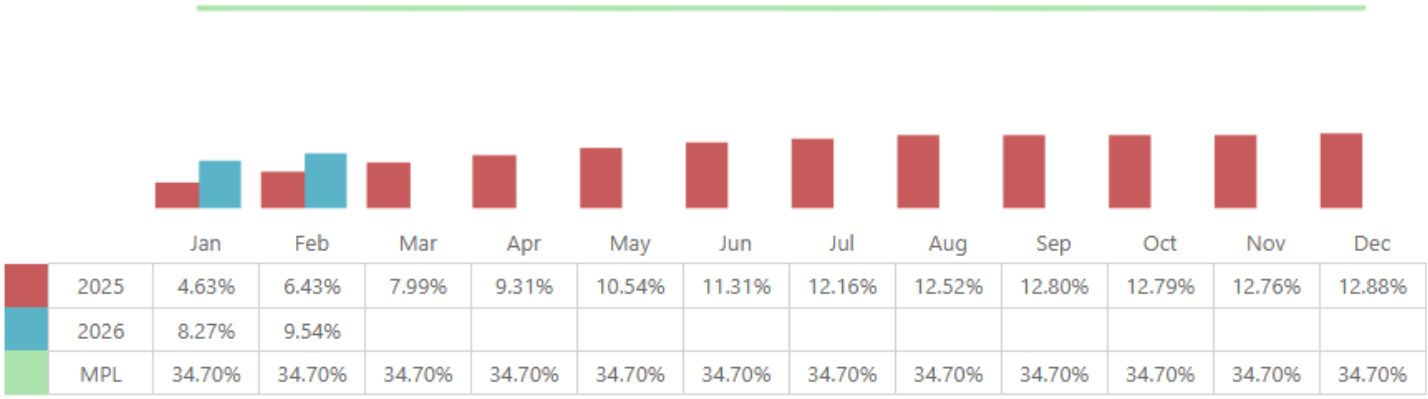
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.

CDEV

Hits needed for MPL

3,685

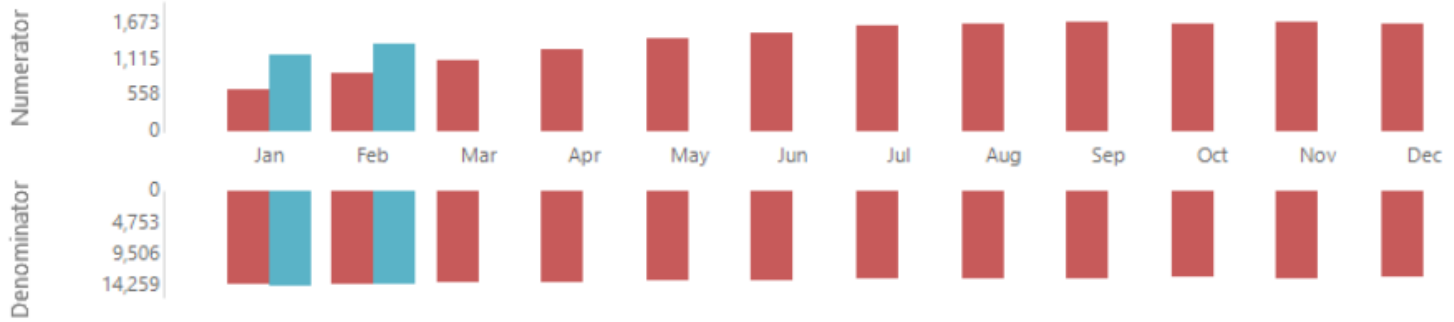
Rate: 9.54%
Prior Year: 6.43%
+3.11% change



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	4.63%	6.43%	7.99%	9.31%	10.54%	11.31%	12.16%	12.52%	12.80%	12.79%	12.76%	12.88%
2026	8.27%	9.54%										
MPL	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%

1,344

14,089



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.

CIS

Hits needed for MPL

689

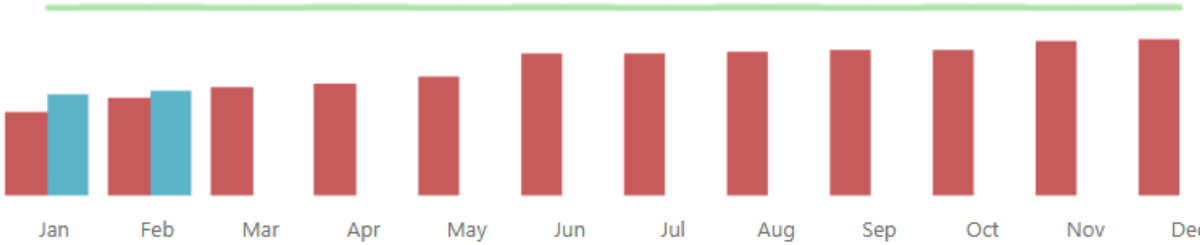
Rate: 13.24%

MPL: 23.89%



858

6,478



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	10.61%	12.47%	13.82%	14.27%	15.05%	17.93%	18.05%	18.15%	18.31%	18.46%	19.51%	19.72%
	2026	12.78%	13.24%										
	MPL	23.89%	23.89%	23.89%	23.89%	23.89%	23.89%	23.89%	23.89%	23.89%	23.89%	23.89%	23.89%



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.

FUA 30 Day Follow-up

Hits needed for MPL

21

Rate: 20.00%

MPL: 39.10%

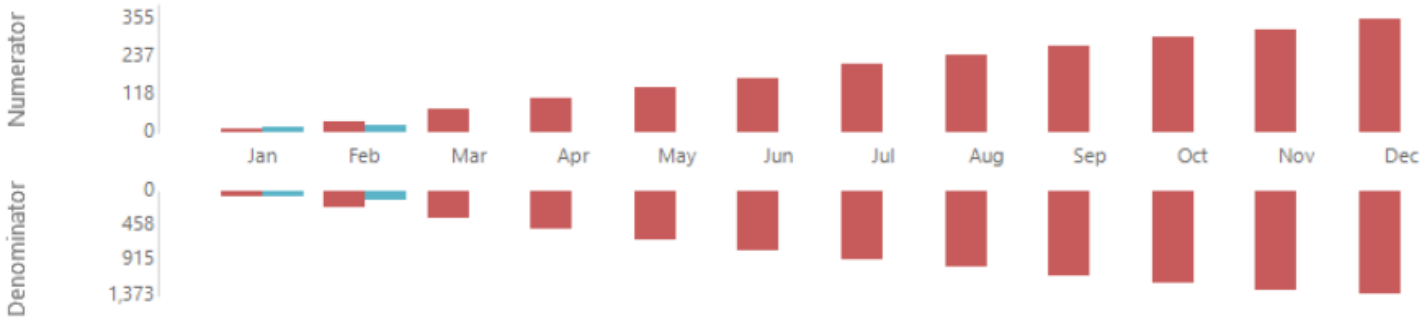




		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	16.25%	16.43%	19.51%	21.14%	21.36%	21.65%	23.75%	23.90%	24.28%	24.15%	24.45%	25.86%
	2026	20.24%	20.00%										
	MPL	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%	39.10%

23

115



Follow-Up After Emergency Department Visit for Mental Illness

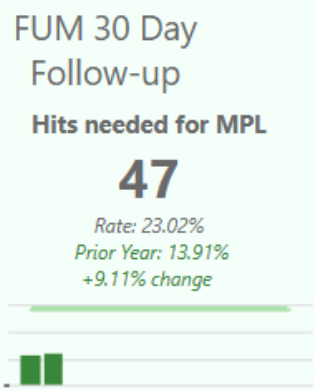
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.

FUM 30 Day Follow-up

Hits needed for MPL

47

Rate: 23.02%
Prior Year: 13.91%
+9.11% change

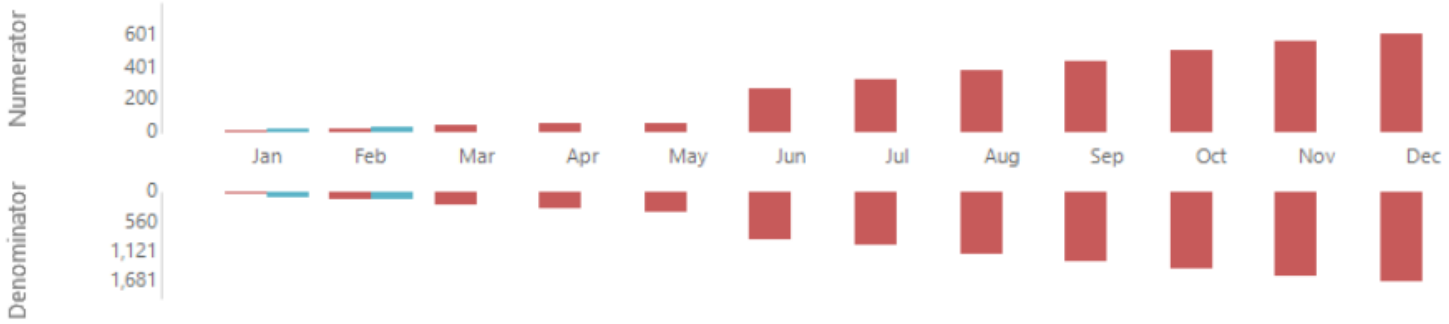




		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	9.80%	13.91%	17.83%	17.03%	17.26%	30.56%	32.83%	33.39%	33.46%	35.12%	35.64%	35.75%
	2026	22.43%	23.02%										
	MPL	57.13%	57.13%	57.13%	57.13%	57.13%	57.13%	57.13%	57.13%	57.13%	57.13%	57.13%	57.13%

32

139



Glycemic Status Assessment for Patients With Diabetes

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic index (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% during the measurement year.
Inverted Measure - a lower rate is desired for this measure.

GSD HBA1C
>9%

Hits needed for MPL

13,918

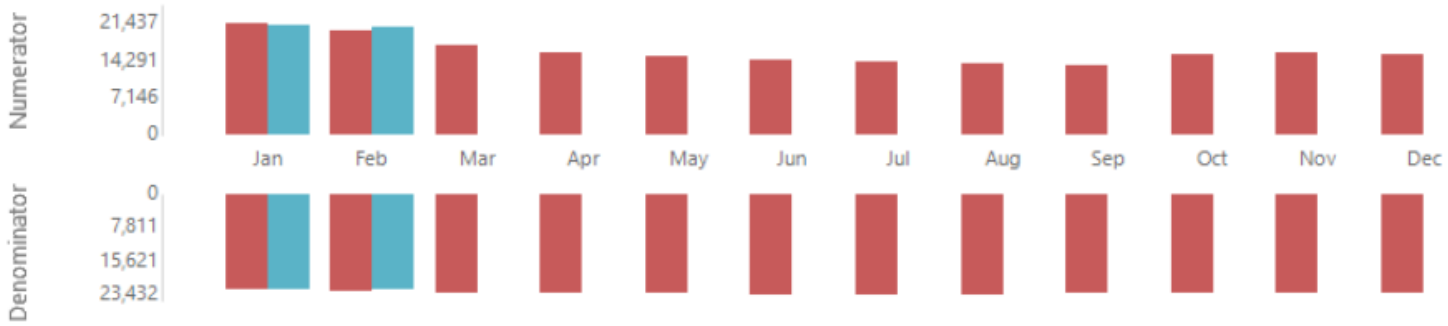
Rate: 92.99%
MPL: 30.41%





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	96.31%	88.14%	74.38%	67.74%	64.57%	61.03%	59.85%	58.81%	57.11%	67.10%	67.71%	66.49%
2026	94.02%	92.99%										
MPL	30.41%	30.41%	30.41%	30.41%	30.41%	30.41%	30.41%	30.41%	30.41%	30.41%	30.41%	30.41%

20,682
22,242



Immunizations for Adolescents

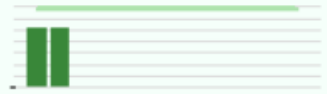
The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

IMA

Hits needed for MPL

670

Rate: 25.93%
Prior Year: 25.63%
+0.29% change





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	23.52%	25.63%	27.62%	28.83%	30.65%	32.07%	33.33%	34.84%	35.59%	36.20%	37.26%	37.35%
	2026	25.69%	25.93%										
	MPL	34.14%	34.14%	34.14%	34.14%	34.14%	34.14%	34.14%	34.14%	34.14%	34.14%	34.14%	34.14%

2,117

8,165



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.

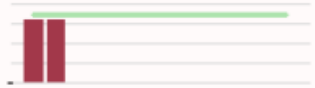
LSC

Hits needed for MPL

375

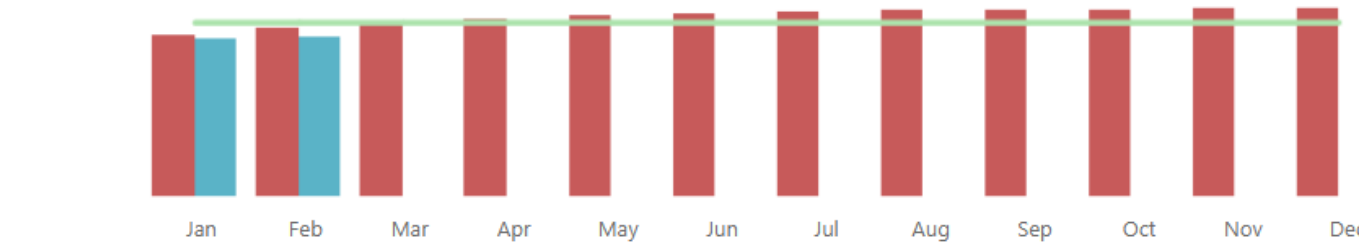
Rate: 64.18%

MPL: 69.96%



4,169

6,496



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	64.57%	67.38%	69.66%	71.31%	72.55%	73.44%	73.99%	74.42%	74.74%	74.87%	75.12%	75.27%
2026	63.42%	64.18%										
MPL	69.96%	69.96%	69.96%	69.96%	69.96%	69.96%	69.96%	69.96%	69.96%	69.96%	69.96%	69.96%



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.

PPC Post

Hits needed for MPL

578

Rate: 52.30%

MPL: 82.48%

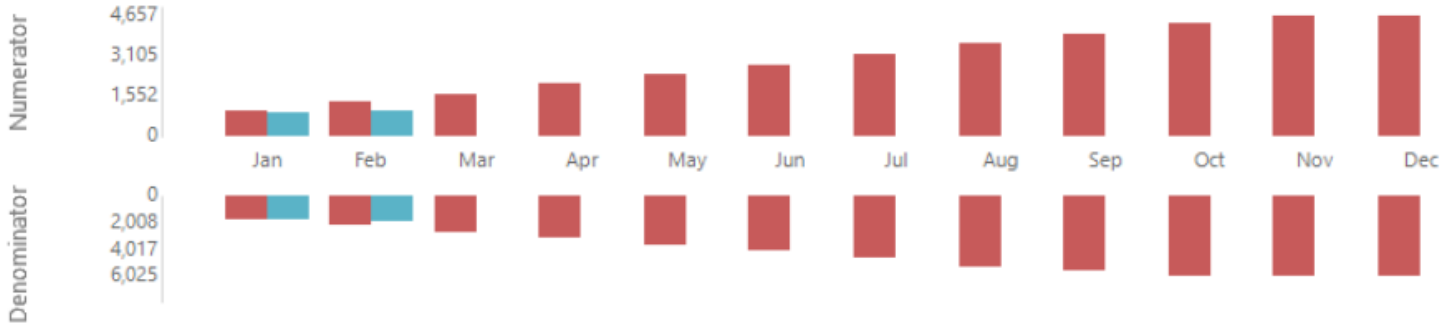




		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	53.97%	59.25%	60.25%	64.83%	65.32%	65.48%	66.72%	67.60%	70.48%	72.42%	76.61%	77.29%
	2026	50.39%	52.30%										
	MPL	82.48%	82.48%	82.48%	82.48%	82.48%	82.48%	82.48%	82.48%	82.48%	82.48%	82.48%	82.48%

1,002

1,916



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.

PPC Pre

Hits needed for MPL

971

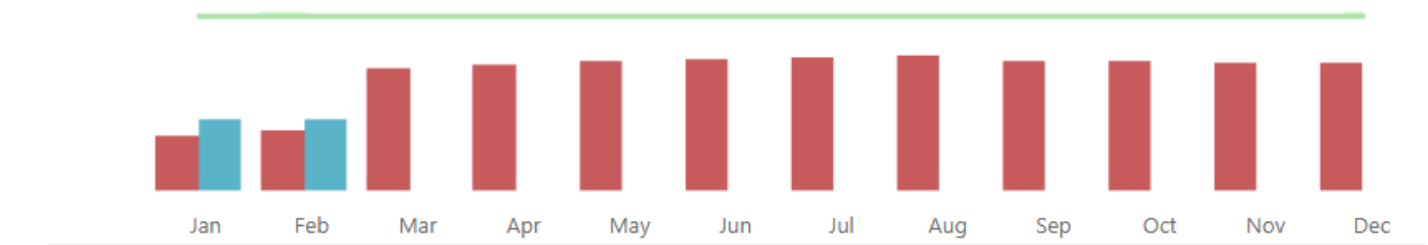
Rate: 35.65%

MPL: 86.37%

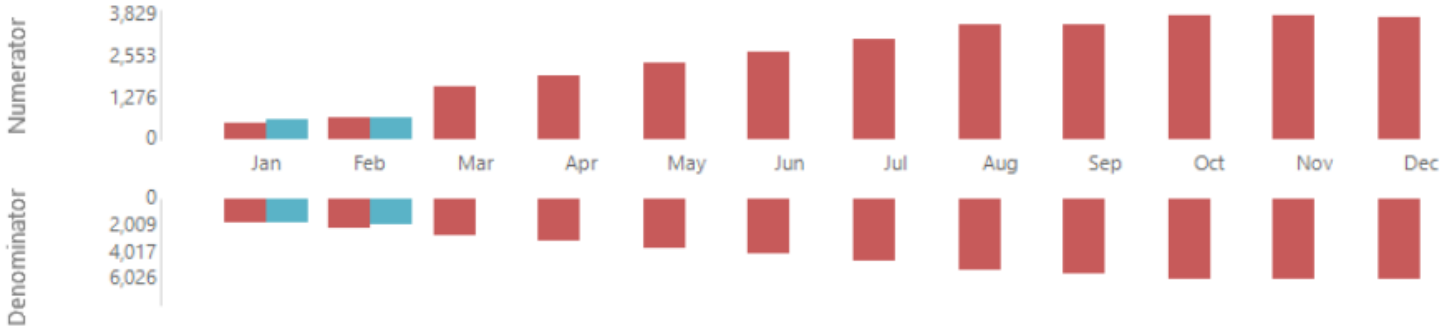


683

1,916



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	27.34%	30.00%	60.25%	61.72%	63.46%	64.71%	65.78%	66.53%	63.55%	63.60%	63.22%	62.74%
	2026	35.42%	35.65%										
	MPL	86.37%	86.37%	86.37%	86.37%	86.37%	86.37%	86.37%	86.37%	86.37%	86.37%	86.37%	86.37%



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.

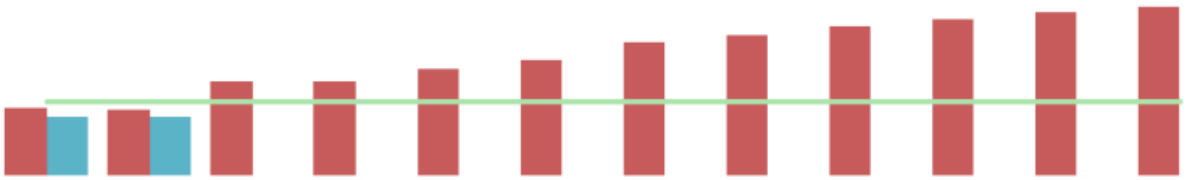
TFLCH

Hits needed for MPL

6,969

Rate: 14.81%

MPL: 19.00%



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	16.98%	16.82%	23.76%	23.94%	26.90%	29.40%	33.94%	35.64%	37.61%	39.39%	41.23%	42.74%
	2026	14.93%	14.81%										
	MPL	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%	19.00%

24,605

166,184



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.

W30 0 - 15 Months

Hits needed for MPL

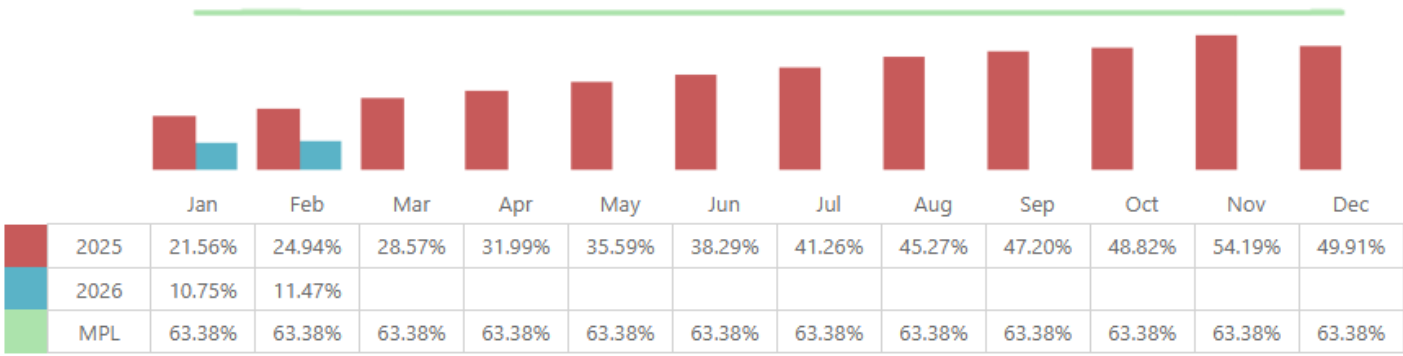
3,417

Rate: 11.47%

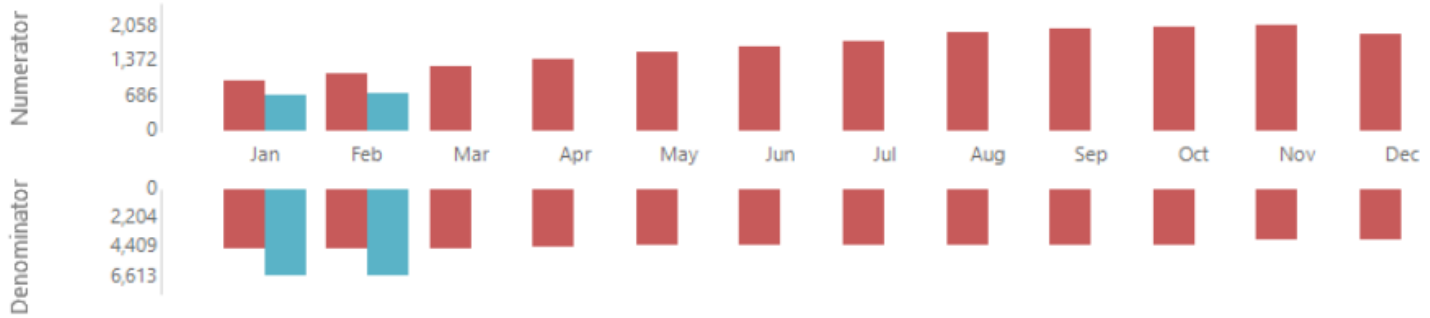
MPL: 63.38%

755

6,584



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	21.56%	24.94%	28.57%	31.99%	35.59%	38.29%	41.26%	45.27%	47.20%	48.82%	54.19%	49.91%
2026	10.75%	11.47%										
MPL	63.38%	63.38%	63.38%	63.38%	63.38%	63.38%	63.38%	63.38%	63.38%	63.38%	63.38%	63.38%



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.

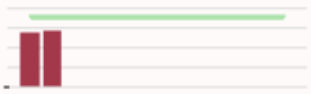
W30 15 - 30 Months

Hits needed for MPL

1,025

Rate: 56.47%

MPL: 72.32%

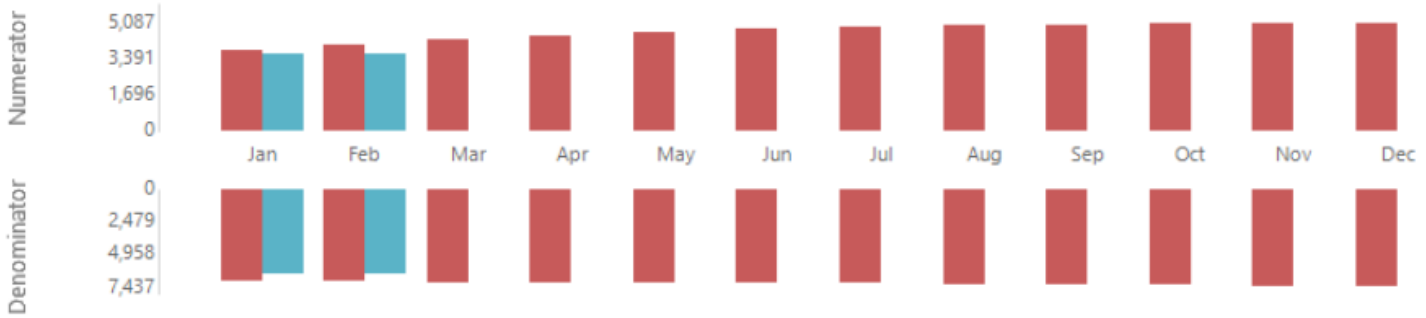


3,656

6,474



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2025	53.86%	57.50%	60.60%	63.14%	65.28%	66.60%	67.69%	68.33%	68.61%	68.68%	68.40%	68.23%
2026	55.48%	56.47%										
MPL	72.32%	72.32%	72.32%	72.32%	72.32%	72.32%	72.32%	72.32%	72.32%	72.32%	72.32%	72.32%



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.

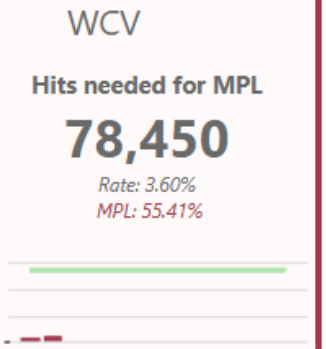
WCV

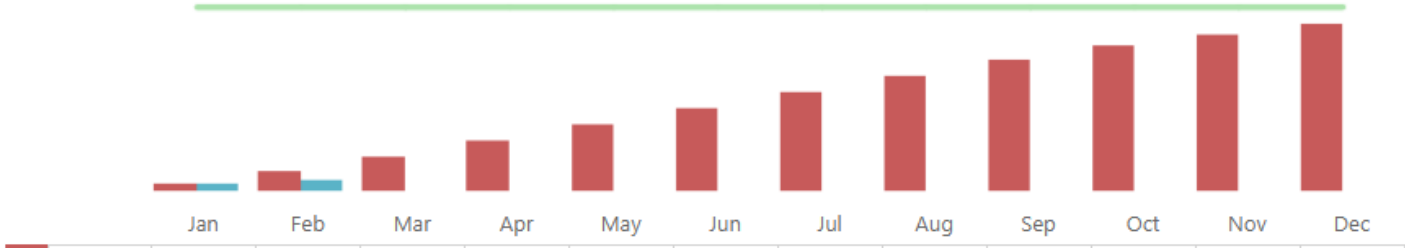
Hits needed for MPL

78,450

Rate: 3.60%

MPL: 55.41%

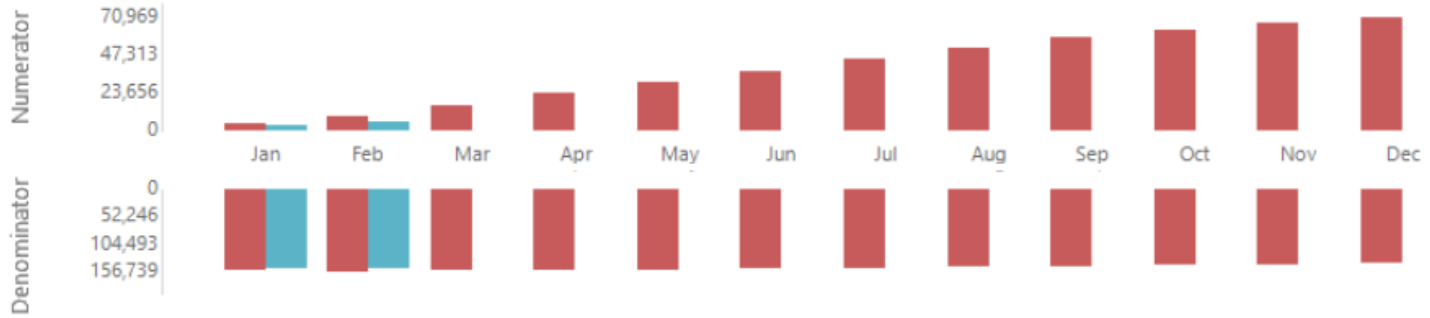




		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2025	2.64%	6.05%	10.36%	15.30%	20.23%	24.71%	29.93%	34.74%	39.54%	43.75%	46.90%	49.93%
	2026	2.56%	3.60%										
	MPL	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%	55.41%

5,445

151,409



QUESTIONS?

THANK YOU

Martha Tasinga, MD
Chief Medical Officer



Business Intelligence

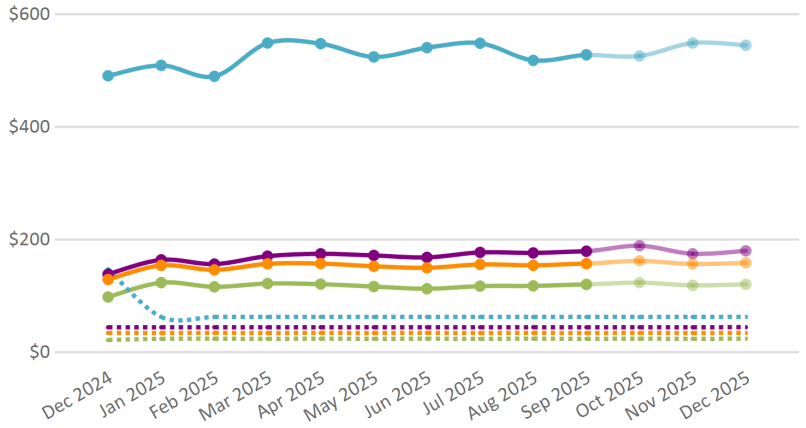
KERN HEALTH SYSTEMS

Physician Services

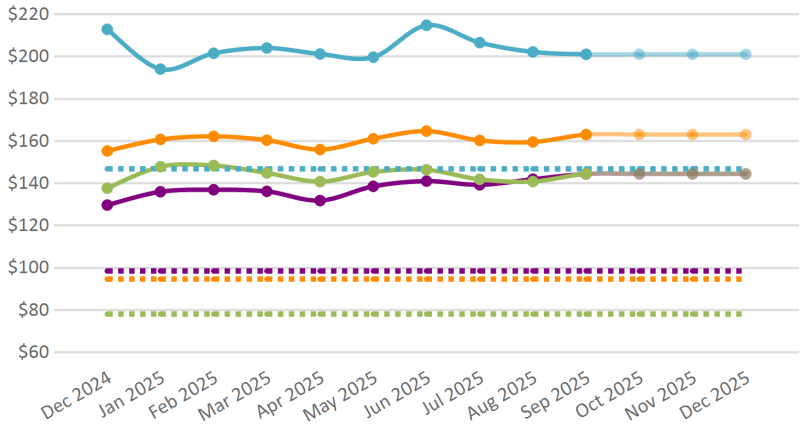
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

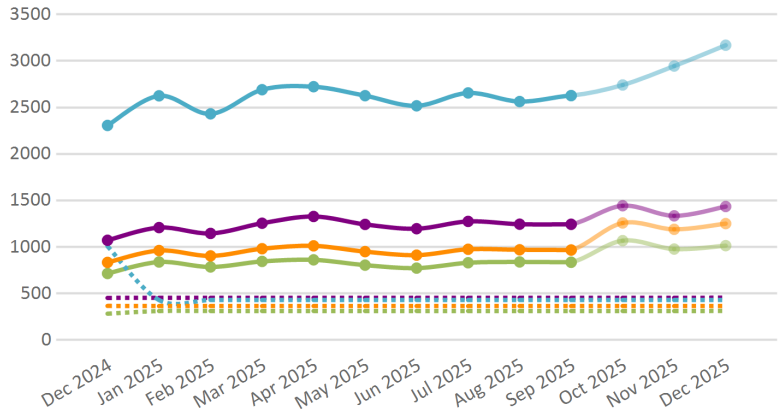
Professional Services Incurred by Aid Group PMPM



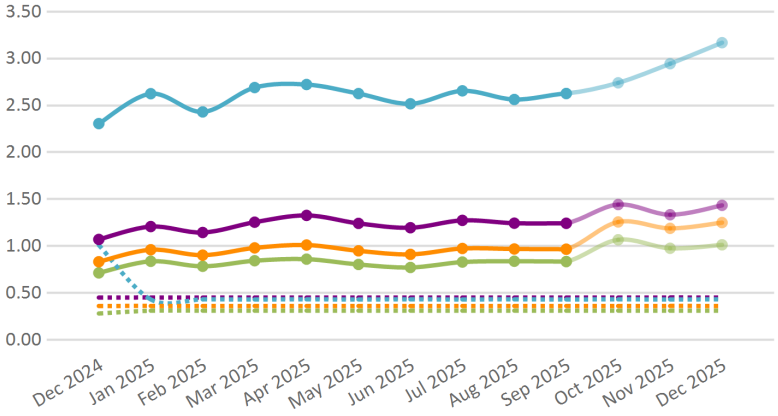
Cost per Professional Service Visit by Aid Group



Professional Service Visits per 1,000 per Month by Aid Group



Professional Service Visits per Member per Month by Aid Group



Services provided through: 12/31/2025 Claims Paid through: 1/31/2026

Business Intelligence

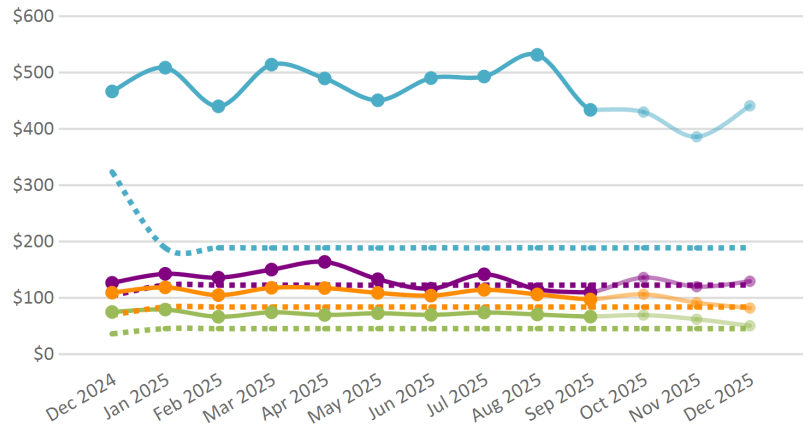
KERN HEALTH SYSTEMS

Inpatient

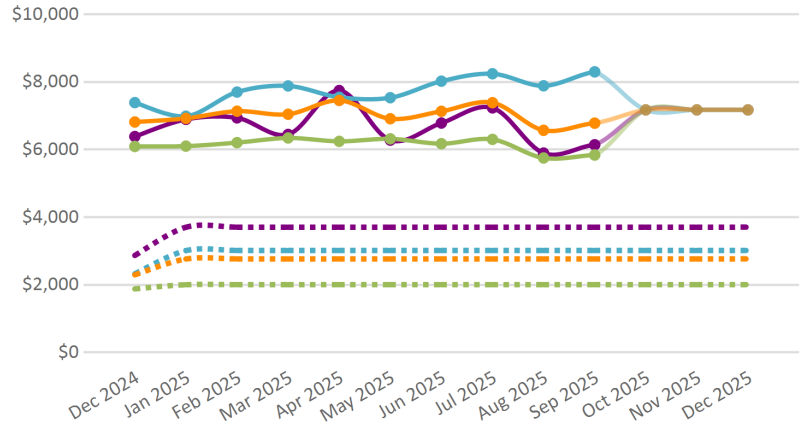
(Includes: Inpatient Hospital Claims)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

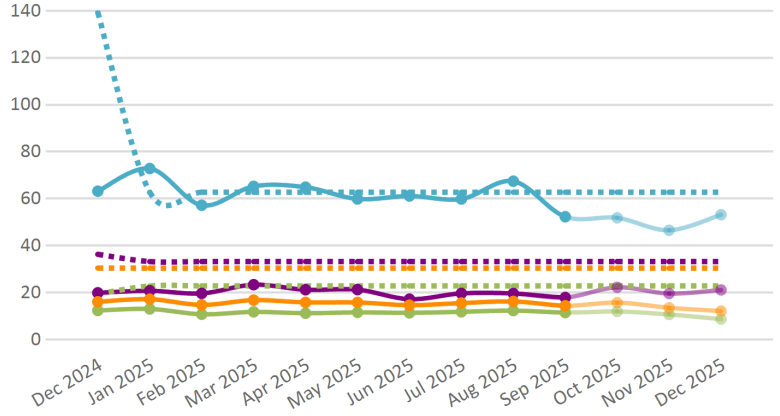
Inpatient Services Incurred by Aid Group PMPM



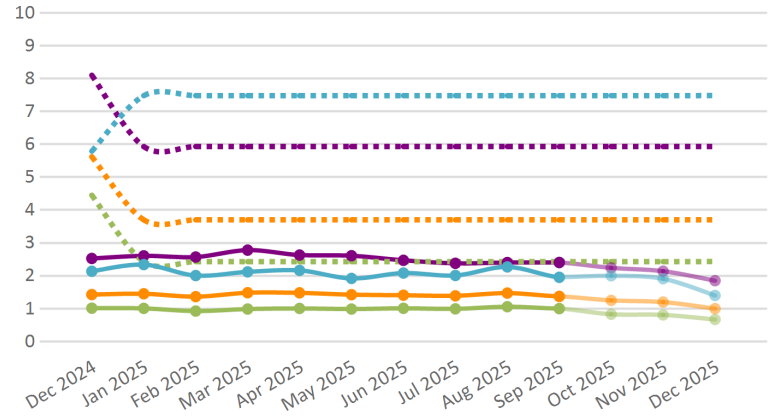
Cost Per Bed Day by Aid Group



Incurred Bed Days per 1,000 per Month by Aid Group



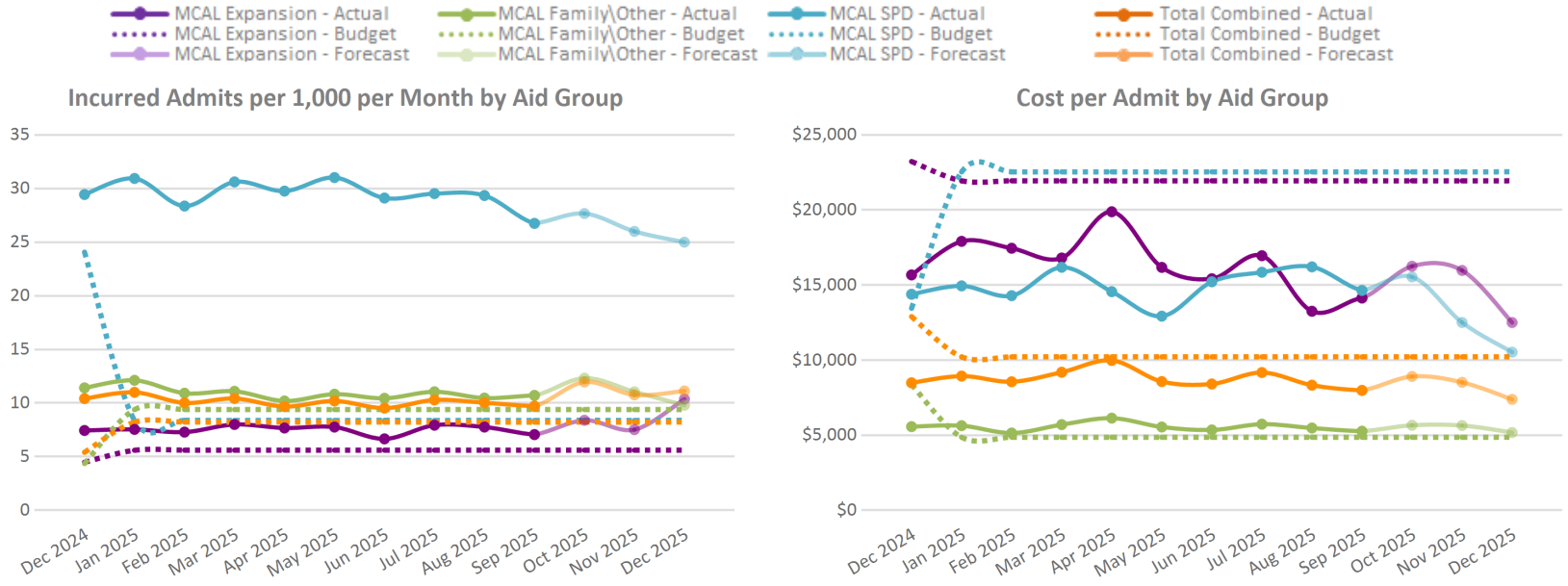
Average Length of Stay in Days by Aid Group



Services provided through: 12/31/2025 Claims Paid through: 1/31/2026

Inpatient

(Includes: Inpatient Hospital Claims)



Services provided through: 12/31/2025 Claims Paid through: 1/31/2026

Business Intelligence

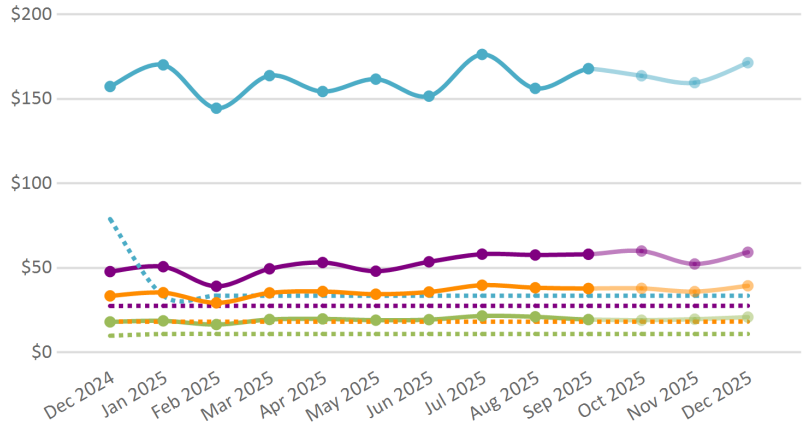
KERN HEALTH SYSTEMS

Outpatient Hospital

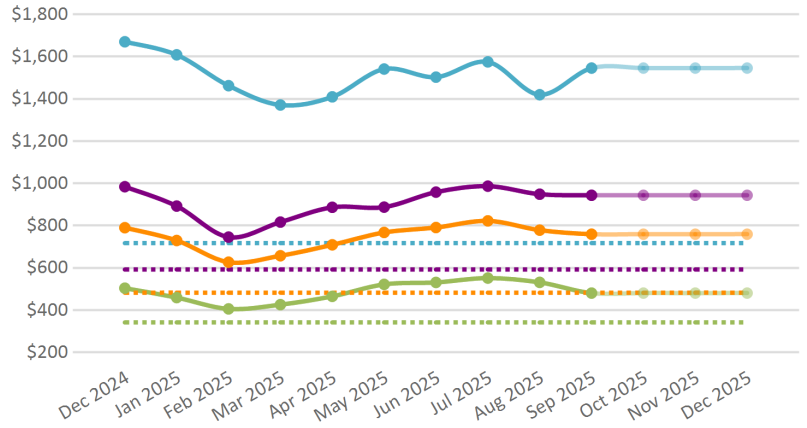
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

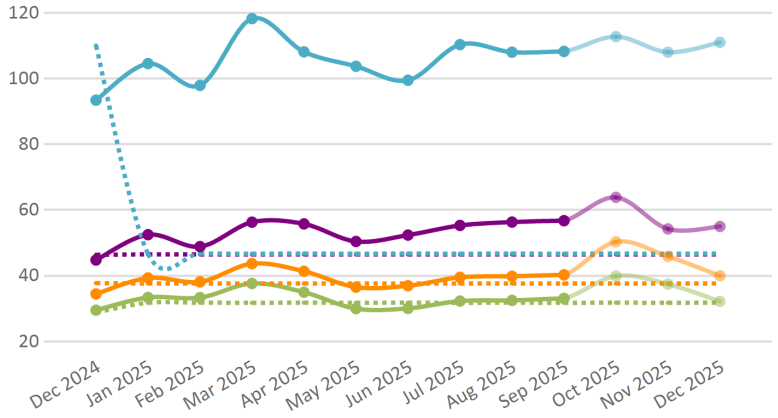
Outpatient Services Incurred by Aid Group PMPM



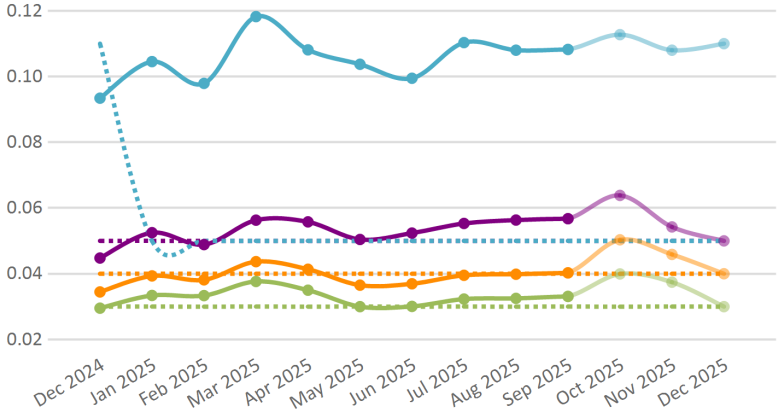
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group

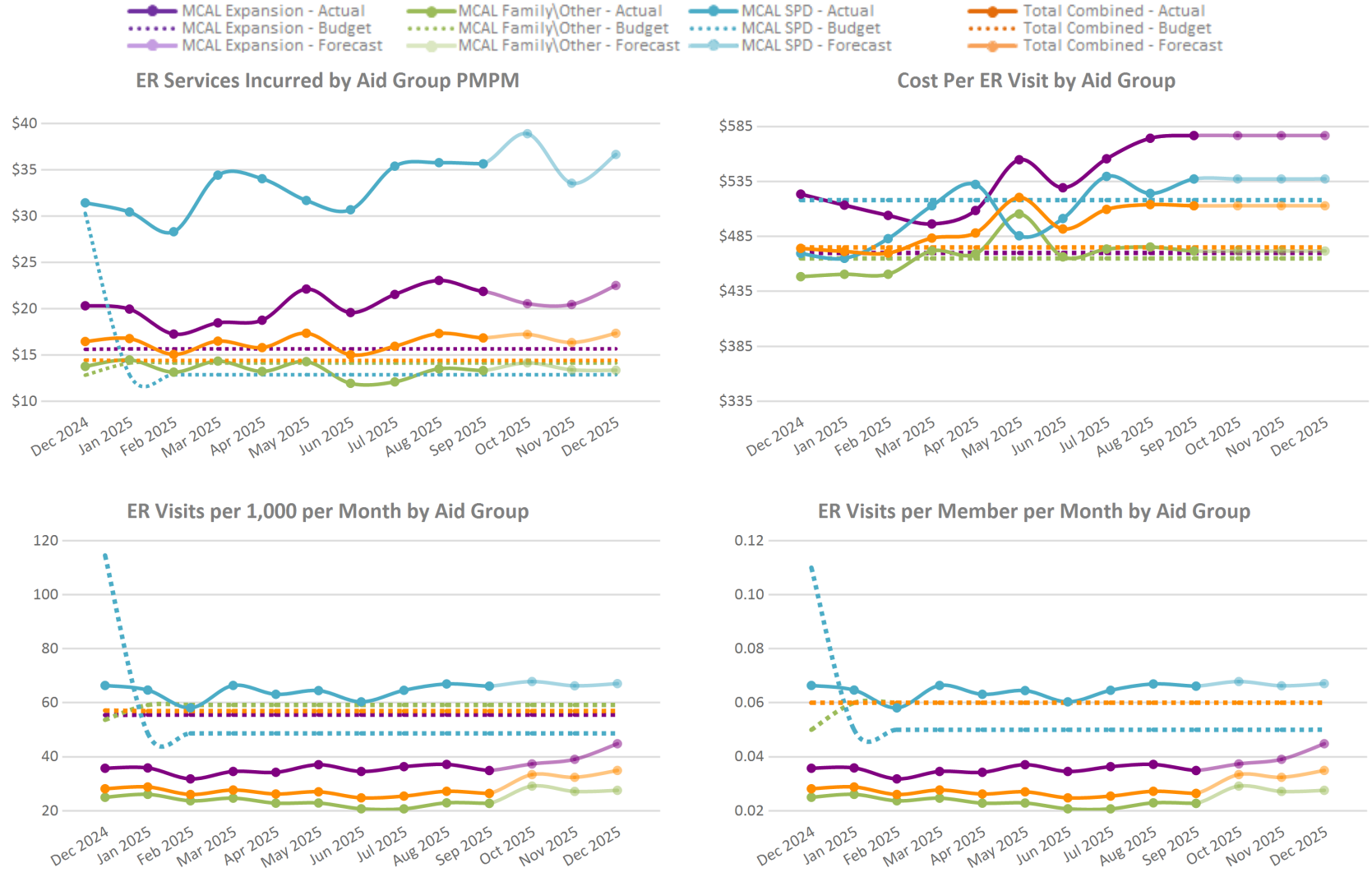


Outpatient Visits per Member per Month by Aid Group



Services provided through: 12/31/2025 Claims Paid through: 1/31/2026

Emergency Room

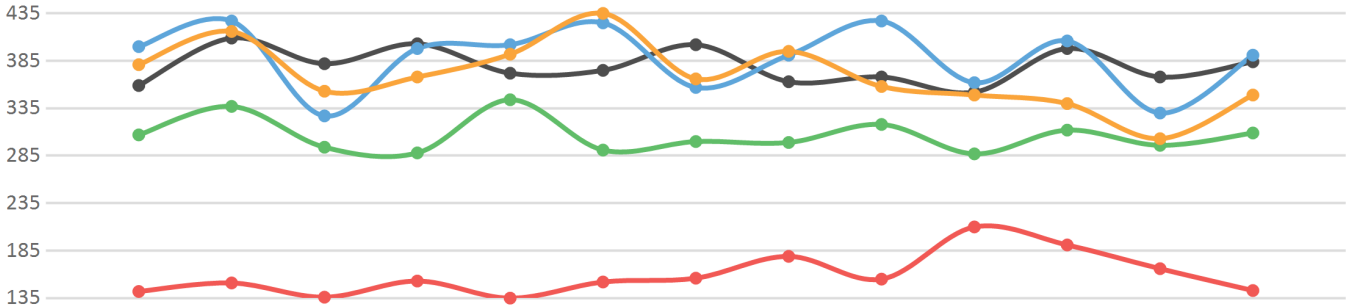


Services provided through: 12/31/2025 Claims Paid through: 1/31/2026

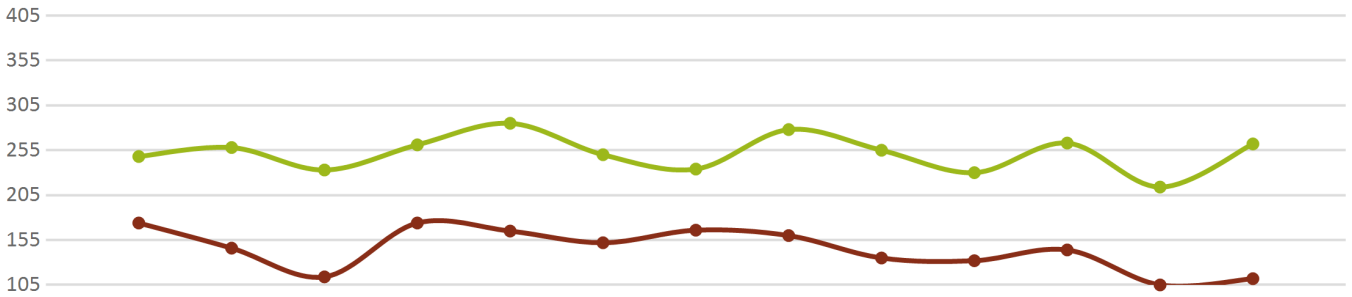
Business Intelligence

KERN HEALTH SYSTEMS

Inpatient Admits by Hospital



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
KERN COUNTY HOSPITAL AUTHORITY	381	416	353	368	392	435	366	395	358	349	340	303	349
BAKERSFIELD MEMORIAL HOSPITAL	359	409	382	403	372	375	402	363	368	352	398	368	384
ADVENTIST HEALTH BAKERSFIELD	400	427	327	398	402	425	357	391	427	362	406	330	391
MERCY HOSPITAL	307	337	294	288	344	291	300	299	318	287	312	296	309
GOOD SAMARITAN HOSPITAL	142	151	136	153	135	152	156	179	155	210	191	166	143

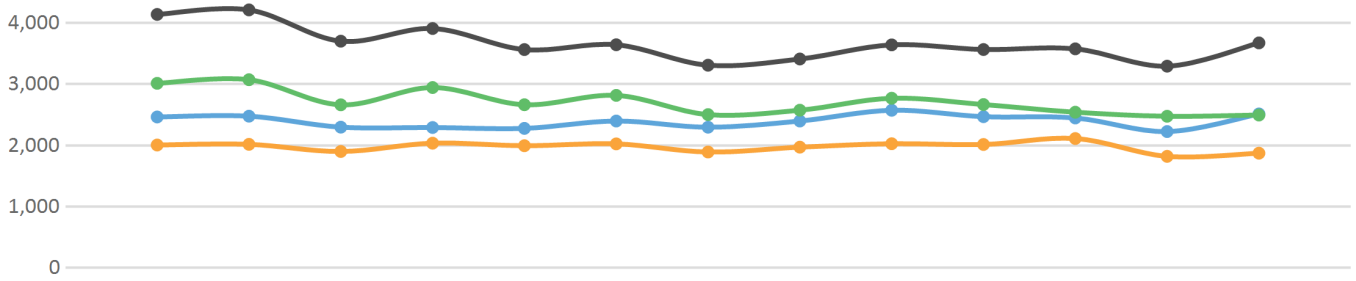


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
OUT OF AREA	248	258	233	261	285	250	234	278	255	230	263	214	262
OTHER LOCAL HOSPITALS	174	146	114	174	165	152	166	160	135	132	144	105	112

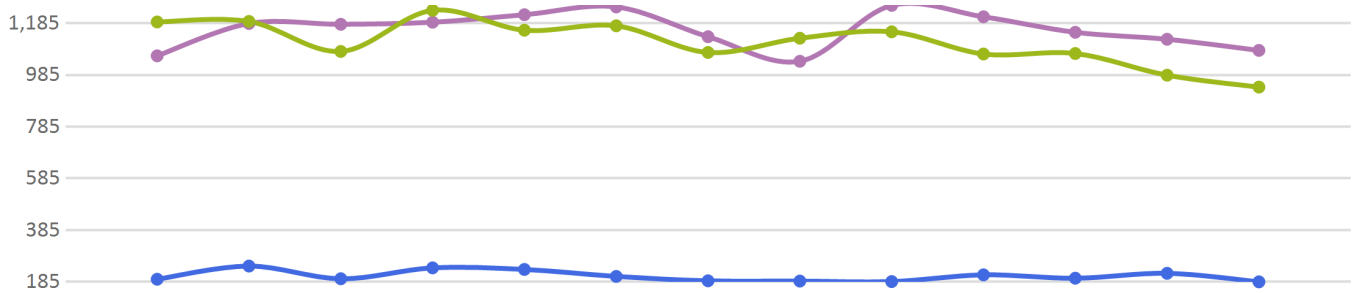
Business Intelligence

KERN HEALTH SYSTEMS

Emergency Visits by Hospital

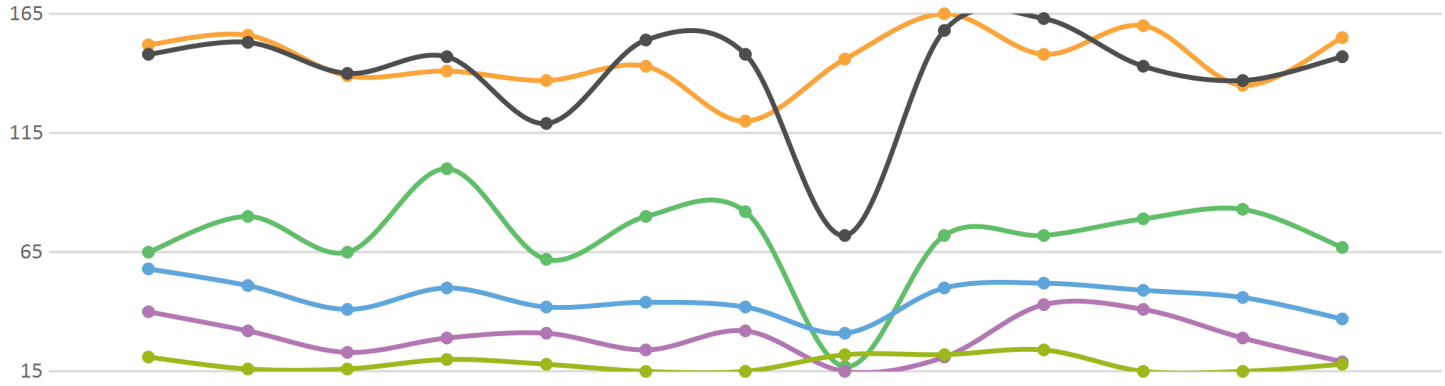


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
BAKERSFIELD MEMORIAL	4,140	4,214	3,703	3,910	3,566	3,645	3,311	3,412	3,643	3,567	3,578	3,295	3,675
MERCY HOSPITAL	3,015	3,074	2,664	2,946	2,665	2,818	2,504	2,576	2,771	2,668	2,543	2,477	2,497
ADVENTIST HEALTH	2,465	2,478	2,299	2,293	2,279	2,399	2,298	2,399	2,575	2,470	2,449	2,227	2,515
KERN MEDICAL	2,007	2,018	1,902	2,037	1,996	2,026	1,893	1,972	2,028	2,016	2,113	1,822	1,874

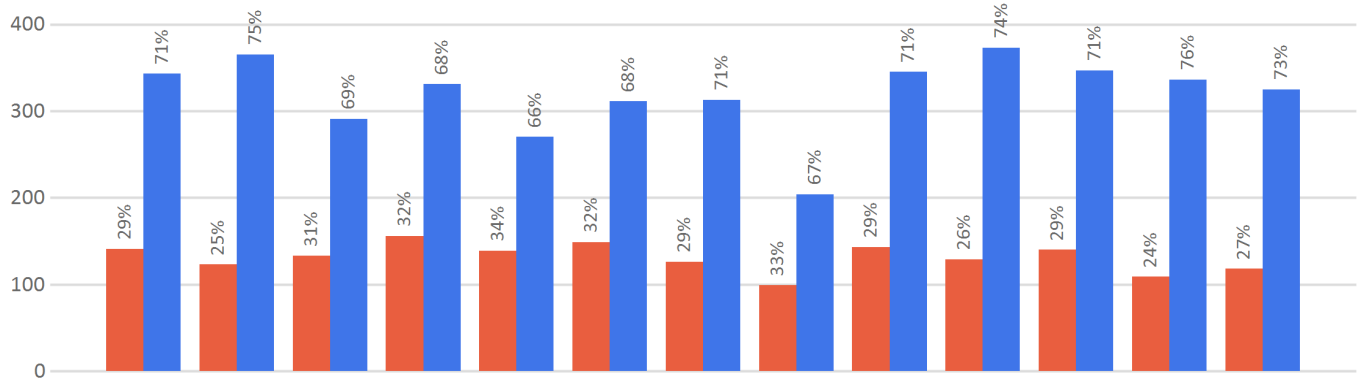


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
DELANO REGIONAL HOSPITAL	1,059	1,184	1,181	1,189	1,218	1,248	1,133	1,038	1,254	1,210	1,150	1,123	1,080
OUT OF AREA	1,190	1,192	1,076	1,235	1,158	1,175	1,072	1,127	1,152	1,066	1,068	984	938
KERN VALLEY HEALTHCARE	195	246	197	239	233	206	189	188	186	212	199	218	185

Obstetrics Metrics



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
KERN MEDICAL	152	156	139	141	137	143	120	146	165	148	160	135	155
BAKERSFIELD MEMORIAL	148	153	140	147	119	154	148	72	158	163	143	137	147
MERCY HOSPITAL	65	80	65	100	62	80	82	17	72	72	79	83	67
ADVENTIST HEALTH	58	51	41	50	42	44	42	31	50	52	49	46	37
DELANO REGIONAL HOSPITAL	40	32	23	29	31	24	32	15	21	43	41	29	19
OTHER	21	16	16	20	18	15	15	22	22	24	15	15	18



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
VAGINAL DELIVERY	343	365	291	331	270	311	313	204	345	373	347	336	325
C-SECTION DELIVERY	141	123	133	156	139	149	126	99	143	129	140	109	118



KERN HEALTH SYSTEMS

BOARD OF DIRECTOR'S MEETING

2026

Chief Executive Officer's Report

Emily Duran

February 19, 2026

KHS CORPORATE STRATEGIC PLAN

The Kern Health Systems (KHS) Strategic Plan serves as the organization's guiding framework, focusing on strengthening the provider network, elevating member engagement, developing and supporting our workforce, and ensuring long-term financial sustainability. With early initiatives underway and alignment occurring across departmental goals, budgeting, and project selection. Leadership continues to monitor key milestones and outcomes, making adjustments as needed to respond to emerging challenges and opportunities. For the new quarterly 2026-2028 strategic plan, status updates will be provided as initiatives advance and measurable outcomes are realized.

LEGISLSTIVE SUMMARY

Federal –

- On January 29, CMS released its final rule titled "Medicaid Program: Preserving Medicaid Funding for Vulnerable Populations - Closing a Health Care-Related Tax Loophole." The regulation becomes effective on April 3, 2026, and its primary impact with be on California's MCO Tax structure. As outlined in HR 1, there are new requirements in how a State can structure these types of taxes to gain federal approval. KHS staff are currently examining and assessing any differences between this final rule and the proposed version published in May 2025, which we previously responded to through our healthcare trade association. The most important update at this time is that California's transition period has been extended to December 31, 2026, rather than ending on June 30, 2026. This date was assumed in the State's January draft budget release and is now confirmed.

State –

2026 State Legislation: The State Legislature resumed its session on January 6, with the deadline for new bill introductions set for February 20. Legislative policy committees will convene from now through late April to evaluate the merits of proposed bills. Staff are actively monitoring developments and assessing the potential impacts of relevant legislation. The 2026 bill tracking document is available in **Attachment A: Bill Tracking.** Additional bills are anticipated to be added as the introduction deadline approaches. On February 12, KHS Government Relations staff participated in a virtual legislative session for the Local Health Plans of California (LHPC) Legislative Briefing Day. During this event, LHPC and KHS staff engaged with Legislative and Regulatory personnel regarding key priorities for 2026.

2025-2026 January Draft Budget Proposal: On January 9, 2026, the Governor released the proposed State Budget for fiscal year 2026-2027. This initial draft marks the beginning of a six-month process to establish state spending, effective July 1, 2026. The Governor's Administration anticipates a budget shortfall of $2.9 billion for the upcoming fiscal year, which is considerably lower than the California Legislative Analyst's Office (LAO) estimate of an $18 billion deficit.

Despite this projected shortfall, the Governor's proposal largely preserves funding levels for healthcare programs, including Medi-Cal. Significant reductions to the Medi-Cal program are not included in the budget, apart from those already expected due to recent federal actions. The following items are noted for attention:

- Confirmation that H.R. 1 eligibility changes (e.g. community engagement requirements and 6-month redeterminations) will be applied both to the SIS and UIS populations.
- CMS guidance regarding emergency Medicaid and risk-based payments is not addressed in this budget, however DHCS will need to contend with the federal guidance and will continue to track and engage on the state's interpretation of this guidance and impact on the Medi-Cal program.
- The Governor's budget assumes a transition time of the MCO tax through the end of the calendar year. As noted above, that was confirmed via CMS rule-making.
- DHCS includes a $120 million GF savings for Medi-Cal efficiencies related to oversight, monitoring, and enforcement of managed care plans, enhanced program integrity and aligning provider payments with value. LHPC understands DHCS has engaged a consultant for this work, but details of the proposal are still unclear.

While the proposed budget is technically balanced in 2026–27 and includes a $4.5 billion discretionary reserve, the longer-term outlook is far less certain. The Administration projects a $22 billion deficit in 2027–28, with additional shortfalls in the years that follow, driving a wide divergence in estimates.
Between now and May the Governor's Administration, Legislators, and other Stakeholders will engage in additional State Budget conversations via the legislative process. Then in May the Governor's Administration will release an updated budget proposal with the latest revenue and spending projections. As always, the KHS Government Relations team will be highly actively engaged in this process, along with our Trade Associations and other partners.

MEDICARE D-SNP

Update:

KHS went live with the D-SNP line of business January 1, 2026 with over 700 members. Sales and marketing activities are ongoing as the Centers for Medicare and Medicaid Services (CMS) allows Dual Special Needs Plans (D-SNP) who have a matching Medi-Cal plan to enroll members monthly through a Special Enrollment Period (SEP). Currently, KHS has over 800 members enrolled in the D-SNP line of business. Daily D-SNP in-patient census is being reviewed with KHS administrative partner, Universal Health Care MSO, ensuring the appropriate level of care is being delivered to D-SNP members and assisting members through their transition of every level of care. KHS continues to work through eligibility issues where CMS does not report the appropriate low income subsidy level due to timing issues of the members date of birth driving the eligibility for Medicare. Not having the appropriate level of low income subsidy impacts the members ability to receive prescriptions at the appropriate cost. KHS implemented a process to work through the eligibility issues until the appropriate level of low income subsidy is reflected from CMS.

HEALTHY HEARTS CLASS SERIES

KHS' Wellness and Prevention Department successfully launched its new Healthy Hearts class series in December as part of its broader heart disease prevention strategy and officially expanded the program to a new site in February. The Healthy Hearts program is designed to educate KHS members and the broader community on key behaviors and health factors that support ideal cardiovascular health with a strong emphasis on understanding and managing cholesterol and high blood pressure.

Classes are offered in both English and Spanish and are delivered as a two-session series that covers the causes of high cholesterol and hypertension, along with practical strategies to support heart health and effective self-management. During the initial pilot at the Shafter Senior Center on December 1 and 2, 2025, a total of 20 participants completed the class series. Pre- and post-test results demonstrated a 14 percentage-point increase in participant knowledge reflecting improved health literacy related to cardiovascular risk factors and prevention.

Building on the success of the pilot, the program officially launched at the East Niles Senior Center in Bakersfield on February 5 and 6, 2026. A total of 16 participants completed the class series including members from other KHS programs, such as the Diabetes Education Empowerment Program (DEEP) and Diabetes Prevention Program (DPP) highlighting strong cross-program interest and engagement.

Pre- and post-test results from the East Niles senior center further demonstrated the program's effectiveness demonstrating a 13 percentage-point gain in knowledge. These results indicate meaningful learning and improved understanding of cholesterol and blood pressure management among participants.

Overall, the Healthy Hearts classes were very well received. Participants expressed appreciation for the focus on topics they regularly discuss with their healthcare providers, particularly cholesterol and hypertension and valued the practical tools provided, such as the blood pressure monitoring booklet. Feedback also indicated a strong desire for a longer class series reflecting high engagement and perceived value of the content.

These outcomes underscore the early success of the Healthy Hearts program and demonstrate its potential to support cardiovascular health education, self-management and prevention efforts among KFHC members.









CEO Engagement and Federal Advocacy

On January 10, Government Relations staff and I, attended a healthcare roundtable at Kern Medical. The event was hosted by Congressman Vince Fong and David Valadao, with Dr. Mehmet Oz, head of the Centers for Medicare and Medicaid Services (CMS), present to discuss healthcare issues in the Central Valley. The following topics were addressed during this meeting:

- Healthcare Challenges Facing the Central Valley
- Healthcare Provisions in H.R. 1 (the One Big Beautiful Bill Act) including Medicaid Work Requirements, Changes to Provider Taxes, Implementation Timelines, and Other Provisions
- The Rural Health Transformation Program (RHTP)
- Other CMS Rulemaking and Federal Policymaking Impacting Providers

I provided the managed care perspective on the primary challenges and opportunities encountered by healthcare systems in delivering quality care to residents of Kern County. Additionally, our Government Relations team maintains ongoing communication with the Association for Community Affiliated Plans (ACAP), our national healthcare trade association, to stay abreast of significant legislative developments on Capitol Hill. In February, members of the Government Relations team will attend ACAP's annual legislative fly-in in Washington DC, offering further opportunities to engage with Kern County's congressional representatives on matters related to healthcare policy.









KHS FEBRUARY 2026 ENROLLMENT:

MEMBER DEMOGRAPHICS

Member Age	
0-5	12%
6 - 18	30%
19-44	35%
45-64	17%
65+	6%

Ethnicity	
Hispanic	63%
Caucasian	15%
Unknown	13%
African American	5%
Asian Indian	2%
Filipino	1%
Other	1%

Language	
English	68%
Spanish	31%
Other	1%

Percentage Increase in Membership from previous month

	Enrollment Type						
	FAMILY-ADULT	FAMILY-CHILD	FAMILY-OTHERS'	Seniors & Persons with Disabilities (SPDs)	Adult Expansion	Long Term Care	Total KHS Medi-Cal Managed Care Enrollment
2026-01	71,306	164,536	25,320	20,013	112,349	591	394,115
2026-02	70,233	163,554	25,046	19,843	110,826	584	390,086
% Change	-1.5%	-0.6%	-1.1%	-0.8%	-1.4%	-1.2%	-1.0%

Enrollment Update: The "automated discontinuance process" for Medi-Cal Redeterminations continues when beneficiaries do not complete the Annual Eligibility Redetermination process. Most of the Public Health Emergency (PHE) eligibility flexibilities expired on June 30, 2025. Many fewer Medi-Cal eligibles go through the ex parte process – or "happy path" – for Medi-Cal renewals (the Kern County auto-renewal rate dropped from 80% to less than 40%). Rather, they need to complete the manual Medi-Cal redetermination process (more than 60% in Kern County).

COMMUNITY EVENTS

KHS will share sponsorship in the following events in February and March:

Organization Name	Event Name	Purpose	Donated Amount
Boys & Girls Clubs of Kern County	Youth of the Year Legacy Gala	The gala honors exceptional young people who have demonstrated strong character, leadership skills, academic excellence, and a commitment to community service. Proceeds directly fund essential youth development programs, such as mentorship, academic support, and leadership training.	$1,500
Garden Pathways, Inc.	Heart of the Country	The event raises funds to support mentoring and education programs for at-risk and low-income families and youth in the local community.	$2,500
Links for Life, Inc.	Love Links Luncheon	Proceeds benefit KC community with breast cancer services.	$2,500
CityServe Network	The Mayor's Ball	CityServe Bakersfield helps families move from dependency to sustainability through programs like job training and housing. This event unites leaders to foster community growth and support the needy.	$5,000
California State University Bakersfield Foundation	Alumni Hall of Fame	Recognize graduates of CSUB whose career accomplishments, community service, and/or support of the university. This is a professional recruitment opportunity and focuses on educational advancement.	$2,500
Bakersfield City School District Education Foundation	Student 5k Pajama Run	Promote wellness through exercise with the participation of 125 students from 42 schools in the district.	$3,779
Bakersfield West Rotary	31st Annual Cioppino Feed	Supports numerous Kern County nonprofits and charitable causes including the Bakersfield West Rotary Stroope Family Foundation, which focuses on youth education, health, public safety, and welfare along with their Breast Cancer Fund.	$2,500
Kern Medical Foundation	Valley Fever Walk	Funds raised support: community education and awareness initiatives, patient and survivor support efforts, outreach to high-risk populations, continued research and advocacy.	$10,000
Kern Community Foundation	Blue Zones Project Bakersfield - Inaugural Volunteer Big Kern	Hosted by the Kern Community Foundation and Blue Zones Project Bakersfield, the event is a single day of dedicated service designed to directly impact local nonprofits through hands-on actions rather than monetary donations. The event helps local organizations advance their missions, increase community visibility, and connect with new long-term supporters.	$2,500
Kern County Superintendent of Schools Educational Services	Leaders in Life 2026 Conference	Through this conference students develop essential skills in leadership, collaboration, and dedication, which they not only teach to their peers but also internalize through the process.	$5,000

Organization Name	Event Name	Purpose	Donated Amount
The Motherhood Project Inc.	Maternal Mental Health Gala	This initiative aims to improve the care and support for mothers and child-bearing individuals by implementing a comprehensive strategy that prioritizes mental health and well-being. The initiative is supported by the Department of Health and Human Services and focuses on evidence-based practices and trauma-informed care to ensure that all mothers receive the support they need during and after pregnancy.	$1,500
Bakersfield ARC, Inc.	A Night for Bakersfield ARC	This event directly sustains programs that are essential to the lives of individuals with intellectual and developmental disabilities; programs that provide stability, connection, and opportunity, and that prevent cycles of isolation and hardship.	$1,500
California Cardiovascular Institute	2nd Annual Pathways to Health Symposium	The event aims to empower healthcare providers with the latest science and practical tools, especially concerning dementia prevention, by featuring expert speakers like Max Lugavere, offering Continuing Medical Education (CME) credits, and fostering community among medical professionals to improve patient outcomes, focusing on evidence-based lifestyle choices.	$3,500
Active Bakersfield Alliance	Bakersfield Marathon	Proceeds support the wellbeing of youth in our community; CSUB Scholarships, Healthy Kids in Healthy Homes and Downtown Elementary School.	$3,000
Kern Economic Development Foundation	Career & STEM 2026 Expo	Over 600 employers from a wide array of Kern County companies gather at the Career Technical Education Center (CTEC) in Bakersfield to engage with thousands of middle school and high school students from the community. Anticipating 3,000 7th-12th grade students from across Kern County along with 150 exhibitors.	$1,500
Links Foundation, Inc.	4th Annual Black Family Wellness Expo	The Expo serves as a trusted, family-centered space where African American and other underserved communities can access vital health, education, and economic resources in a culturally affirming environment.	$2,500

KHS will also participate in the following evens in February and March:

Organization Name	Event Name	Location	Date	Time
Taft United Methodist Church	TUMC Food Distribution	630 North Street Taft, CA 93268	2/5/2026	12:00pm - 2:00pm
American Heart Association	Kern County Go Red for Women	7001 Stockdale Hwy., Bakersfield, CA 93309	2/6/2026	10:00am - 1:30pm
The Project Food Box	Community Medi-Cal Enrollment Event	801 4th St., Bakersfield, CA 93304	2/6/2026	2:00pm - 5:00pm
Raices of Kern	Salud del Valle Health & Resource Fair	1101 Planz Rd., Bakersfield, CA 93304	2/7/2026	10:00am - 2:00pm

Organization Name	Event Name	Location	Date	Time
Norris School District	Social Emotional Learning/Self-Care Family Fair	7110 Old Farm Rd., Bakersfield, CA 93312	2/7/2026	1:00pm - 3:00pm
California Department of Corrections and Rehabilitation	2026 Parole and Community Team (PACT) Meeting	3201 F St., Bakersfield, CA 93301	2/11/2026	10:00am-12:00pm
Skye's the Limit Institute of Wellness	The Family Anthem Love is Action	712 17th St., Bakersfield, CA 93301	2/16/2026	12:00pm - 3:00pm
GFUSD State Preschool	Math & Literacy Preschool Event	400 Berkshire Rd., Bakersfield, CA 93307	2/21/2026	9:00am - 10:00am
Safe Haven Kids' League	Annual Kids winter coat and resource giveaway	10441 South Loop Blvd., California City, CA 93505	2/21/2026	12:00pm-4:00pm
Palm Avenue Middle School	College and Career Fair	1017 Palm Ave., Wasco, CA 93280	2/27/2026	8:15am-12:30pm
Valley Fever Institute	Valley Fever Walk	11298 Stockdale Hwy., Bakersfield, CA 93311	3/7/2026	9:00am - 12:00pm
California Department of Corrections and Rehabilitation	2026 Parole and Community Team (PACT) Meeting	3201 F St. Bakersfield, CA 93301	3/11/2026	10:00am-12:00pm

Medi-Cal Renewal Updates

As anticipated, in July 2025 we experienced a substantial increase in the number of members who need to renew their Medi-Cal. This workload continues each month. We collaborate closely with the county to ensure continuity of care for our members. We are having bi-weekly meetings with Kern County Human Services (KCHS) leadership due to the increase in this critical work. KFHC continues direct outreach activities to members who must complete the Medi-Cal renewal process or those in a hold status who have 90 days (from disenrollment date) to complete their renewal to be retroactively enrolled to their disenrollment date. The daily data KCHS provides KFHC power these activities. Member communications include: text messages, mail, phone calls, in person, and the KFHC member portal. We continue experiencing great success with our AI phone outreach campaign that allows us to attempt multiple phone calls per week to all members who must renew their Medi-Cal, including daily calls to those nearing their disenroll date and those who have disenrolled and are in the 90 day grace period. We are also working closely with safety net providers by sharing renewal data and supporting renewal assistance efforts. KFHC shares the data with member facing staff (screen pop) and providers (KFHC provider portal) and works with local Medi-Cal enrollment entities, school districts, and community-based organizations to support Medi-Cal renewal efforts. KCHS installed a kiosk at KFHC that allows members to scan their documents directly to their case file.

We created messaging specific for unsatisfactory immigration status (UIS) members as they are no longer be able to reenroll in full scope Medi-Cal if they don't complete the renewal process. Kern County Human Services (KCHS) now provides missing documents data to KFHC for members with an incomplete renewal. Although these members return their renewal, when the information is not complete the renewal is not processed. KFHC will begin including what documents and/or information is missing in the outreach to these members so that their renewal can be processed. KCHS is also providing more eligibility status data that includes disenrollment reason so we have more information on reasons members disenroll. This month, KFHC members with Medi-Cal questions who call KCHS will be transferred to the KFHC call center for assistance. The goal is to answer more calls timely and to ensure all questions are addressed by KFHC staff (45 KFHC staff members have limited access to CalSAWS) and/or the KCHS staff that are located in the KFHC office (2 Human Services Technicians are located at KFHC). KCHS will also designate two additional Human Services Technicians at their call center to handle any calls that need to be warm transferred back to KCHS and to process demographic updates we provide.

Below are KFHC Medi-Cal Redetermination Trending Rates.



KFHC Media Clips

We compiled local media coverage that KFHC received in December 2025 – January 2026. Please see **Attachment B: Public Relations and Publicity Media Clips.**

KHS MEMBER ENGAGEMENT | COMMUNITY HIGHLIGHTS

PAY FOR PERFORMANCE PROVIDER DINNER 2026

Kern Family Health Care hosted a Pay for Performance Provider Dinner to educate and engage our provider network on the 2026 Pay for Performance measures. The event brought together providers serving nearly 400,000 Kern County residents and provided an opportunity to share program updates, discuss quality performance strategies, and highlight key initiatives supporting the Medicare Dual-Eligible Special Needs Plan (D-SNP). The evening reinforced collaboration, alignment, and our shared commitment to improving health outcomes across the community. Leadership expressed appreciation for the provider network's continued partnership and critical role in advancing quality care.













SCHOOL WELLNESS - WASCO UNION HIGH SCHOOL

Kern Health Systems partnered with Wasco Union High School through the School Wellness Grant to support the creation of the Tiger Wellness Center, a newly opened student resource hub providing food, clothing, hygiene products, mental health support, and other basic necessities at no cost to students. The center, made possible by a $50,000 KHS grant, was recently featured in The Bakersfield Californian and local news outlets, highlighting its mission to reduce stigma and provide discreet, dignified access to essential resources for students in need. Early use of the center shows positive community engagement, and plans are underway to expand its offerings and serve an increasing number of students throughout the school year. This work reflects KHS's commitment to addressing social determinants of health and supporting youth wellness beyond the classroom.















KHS ORGANIZATIONAL HIGHLIGHTS

KHS EMPLOYEE WELLNESS CHALLENGE

Kern Health Systems launched the 2026 6-Week Employee Wellness Challenge as a positive and engaging way to support staff wellbeing at the start of the new year. The initiative encouraged employees at all fitness levels to build sustainable habits through structured milestones, educational weekly check-ins, and practical strategies focused on nutrition, mindset, and everyday movement. Throughout the challenge, participants received ongoing encouragement, evidence-based wellness tips, and meal inspiration designed to support consistency and long-term success. This program reflects KHS's continued commitment to fostering a supportive workplace culture that prioritizes employee health, connection, and engagement.





ATTACHMENT A

Bill Tracking:

Title	Description	Status
AB 96	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including behavioral and mental health services that are rendered by Medi-Cal enrolled providers. Existing law authorizes a county, or an agency representing the county, to develop a peer support specialist certification program, subject to department approval. Existing law imposes specified requirements on applicants for certification as a peer support specialist, including that the applicant be at least 18 years of age and possess a high school diploma or equivalent degree. This bill would remove the requirement of possessing a high school diploma or equivalent degree from the requirements necessary for an applicant to receive certification. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB96	01/06/26 - Re-referred to Com. on HEALTH.
AB 277	Behavioral health centers, facilities, and programs: background checks-This bill amended to require a person who provides behavioral health treatment for a behavioral health center, facility, or program to undergo a background check. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB227	01/06/26 - Re-referred to Com. on HUM. S.

AB 1126	This bill would require the department, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services. The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under specified circumstances, including if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified. The bill would require the department to take the actions that it deems necessary to provide clarification regarding the conditions for billing plans to providers that render services to enrollees who also have other health care coverage. The bill would specify the intent of the Legislature that the department offer educational resources to an enrollee who needs assistance with understanding continuity of care and coordinating Medi-Cal and their other health care coverage when requested by the enrollee. The bill would require the department, annually from 2027 through 2030, to update the legislative health committees on the effectiveness of implementing these provisions. The bill would authorize the department to implement these provisions through plan letters or similar instructions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB1126	01/06/26 - Re-referred to Com. on HEALTH.

AB 1366	The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, pharmacist services are a benefit under the Medi-Cal program, subject to federal approval, and the rate of reimbursement for pharmacist services is 85% of the fee schedule for physician services, except for medication therapy management (MTM) pharmacist services. Existing law requires the department to implement an MTM reimbursement methodology relating to the dispensing of qualified specialty drugs by an eligible contracting pharmacy, which would be intended to supplement Medi-Cal payments to eligible pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories. This bill would additionally require the rate of reimbursement for advanced practice pharmacist services to be the same as the fee schedule for physician services, including MTM pharmacist services. The bill would require the department to implement an MTM reimbursement methodology relating to the use of drugs to ensure that Medi-Cal payments are only made to eligible advanced practice pharmacists or pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories. This bill would additionally require those health care service plans and disability insurers to pay or reimburse the cost of the service performed by a an advanced practice pharmacist enrolled as a provider with the plan or insurer. The bill would authorize payment or reimbursement if the coverage otherwise provides reimbursement for similar services performed by other licensed health care providers, among other requirements. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB1366	01/06/26 - Re-referred to Com. on HEALTH.
SB 903	This bill would prohibit a licensed professional, as defined, from engaging in the use of artificial intelligence to assist in providing supplementary support in therapy or psychotherapy where the client's therapeutic session is recorded or transcribed unless the patient or their authorized representative is informed that artificial intelligence will be used and provides consent, as specified. The bill would also prohibit an individual, corporation, or entity from providing, advertising, or otherwise offering therapy or psychotherapy, including through the use of internet-based artificial intelligence, to the public in this state unless the therapy or psychotherapy services are conducted by an individual who is a licensed professional. The bill would additionally prohibit a licensed professional from allowing artificial intelligence to make independent therapeutic decisions or take other specified actions related to communications with clients, as specified. The bill would authorize the department to investigate actual, alleged, or suspected violations of these provisions and impose civil penalties, as prescribed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB903	01/22/26 - From printer. May be acted upon on or after February 21.

Kern Family Health Care

Public Relations and Publicity
Media Clips Report
December 2025-January 2026

Features

Autism Behavior Services, Inc. in Action: Advocating for Autism Care in Kern County

Featured On: Presswire | December 01, 2025

"On October 21, ABSI representatives attended the Kern County Board of Supervisors meeting to bring attention to recent service denials affecting local families within the autism community." **Click here to read more.**

Families Demand Action as Kern Health Systems Denies Critical Autism Services; Advocates Urge State Intervention

Featured On: Presswire | December 22, 2025

"A recent Kern Health Systems (KHS) Board meeting on December 18 was marked by emotional pleas from families whose children with autism are facing a widespread loss of essential services." **Click here to read more.**

Concerns raised over autism therapy denials after Kern Health Systems review changes

Featured On: 23ABC | January 05, 2026

"Administrative changes to the review process for autism therapy at Kern Health Systems are raising concerns among families who say treatment delays could lead to developmental regression in their children." **Click here to read more.**

American Heart Association announces 2026 Kern County Go Red for Women Ambassador class

Featured On: AHA Newsroom | January 15, 2026

"Emily Duran - 2026 Kern County Go Red for Women chair and women's health advocate – Emily Duran is the chief executive officer of Kern Family Health Care and is passionate about expanding access to heath care, educating the community about good health and well-being, and advocating for underserved populations." **Click here to read more.**

Kern County residents invited to support Go Red for Women on Feb. 6

Featured On: AHA Newsroom | January 16, 2026

"The ambassador class includes Emily Duran, 2026 Kern County Go Red for Women volunteer chair and chief executive officer at Kern Family Health Care, who urges women to take action." **Click here to read more.**

Helpful handouts: New wellness center at Wasco Union High makes assorted necessities available to students for free

Featured On: The Bakersfield Californian | January 16, 2026

"Funded by a $50,000 grant from local Medi-Cal administrator Kern Health Systems' health plan, and stocked largely by community donations, the center has already served 12 students, said world history teacher Allie Rios, who helps coordinate the school's Stripes program supporting student achievement." **Click here to read more.**

Kern Family Health Care committed to everyone's well-being

Featured On: The Daily Independent | January 22, 2026

"Mary Allen, Engagement Rep for Kern Family Health Care, spoke to the Rotary Club of China Lake during their weekly luncheon on Wednesday about the services that KFHC provides under Medi-Cal." **Click here to read more.**

Changes to Medi-Cal, CalFresh start this year

Featured On: The Bakersfield Californian | January 23, 2026

"Kern Family Health Care has about 394,000 people enrolled in Medi-Cal, said Jeremy McGuire, senior director of government relations. Work or community engagement requirements for Medi-Cal won't start until next year, but HR 1 did change the categories of non-citizens who are eligible to receive funding through the program." **Click here to read more.**

Wasco High School opens Tiger Wellness Center to help students

Featured On: 23ABC | January 26, 2026

"The Tiger Wellness Center provides students with mental health resources, clothing, food, and hygiene products at no cost. The center was established through a Kern Family Health Care grant and is open to all Wasco High School students in need." **Click here to read more.**

Limited-edition shaker cups offered Feb. 2-7 as HCBB donation campaign promotes wellness

Featured On: BakersfieldNow | January 30, 2026

"Houchin Community Blood Bank (HCBB) will partner with Kern Family Health Care to offer donors a limited-edition shaker cup starting Feb. 2, as part of the blood bank's annual "Resolve to Get Fit" donation campaign." **Click here to read more.**

Mentions

EQT Partners lines up $1 billion CitiusTech exit

By: Healthworld from the Economic Times | December 08, 2025

"CitiusTech counts DaVita, MultiPlan, Centra Health, Watson Health Imaging, Vital Images, NantHealth, Novant Health, **Kern Health Systems** and Santa Clara Family Health Plan, among its major clients." **Click here to read more.**

Medicare Advantage 2026 Spotlight: A First Look at Plan Offerings

By: Kaiser Family Foundation | December 09, 2025

"Entrants and Exiting Firms in Medicare Advantage Markets, by Plan Type and Plan Locations: 2026 **Kern Health Systems (KHS)**" **Click here to read more.**

The KCVCC motivates veterans to keep their head held high this holiday season

By: 23ABC | December 11, 2025

"Anthony Roberts Navy Veteran & Facility Manager at **Kern Family Health Care** said "One of things I've learned and pride myself on is paying it forward. Whatever information I come across I always try to share especially if it can help someone." **Click here to read more.**

California's Maternal Care Network: What Pregnant People in Kern County Should Know

By: Observer Group | December 11, 2025

"If you live in Bakersfield or elsewhere in Kern County and are pregnant or have recently given birth, these local resources are available:

- **Kern Family Health Care (KFHC)** is the county's main Medi-Cal health plan. To apply for or renew Medi-Cal through KFHC or the county office, call 877-410-8812 (TTY 711) or visit BenefitsCal online." **Click here to read more.**

Healthy News to Use: January 2026

By: Kern County Family Magazine | December 30, 2025

"Ultra-Processed Foods Linked to Rising Cancer Risk

- Nutrition advice floods social media daily, but one issue deserves sharper focus: ultra-processed foods." **Click here to read more.**

Dr. Oz brings $50B rural health plan to Central Valley as Medicare chief

By: The Business Journal | January 12, 2026

"Representatives from Kern Medical, **Kern Family Healthcare,** Kaweah Health Medical Center and other organizations attended." **Click here to read more.**

Local families gather to honor loved ones lost to addiction

By: Eyewitness News | January 22, 2026

"The event also featured local resources such as the Mission at Kern, **Kern Family Health Care,** Team Challenge, and Bakersfield Recovery Services, offering support to those in need." **Click here to read more.**

End of Document

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***December 3, 2025***
CALL TO ORDER: ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics Gohar Gevorgyan, MD – Network Provider, FP	Miguel Lascano – Network Provider, OB/GYN Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	David Hair, MD - Network Provider, Ophthalmology Ashok Parmar, MD– Network Provider, Pain Medicine		
Members Excused=E Absent=A	Martha Tasinga, MD – KHS Chief Medical Officer (E)		
Staff Present:	Alan Avery, Chief Operating Officer Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator	Jake Hall, Deputy Director of Contracting Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement	John Paul Miller MD, QI Medical Director Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:02 AM.		N/A
Public Presentation	There were no requests for public or committee member presentations.		
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of November 5, 2025 for review and approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of November 5, 2025, seconded by Dr. Lascano. Motion carried.	12/3/25

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Committee Announcements	There were no committee announcements	☑ **CLOSED** – Informational Only	N/A
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 12/03/2025:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on **12/03/2025** Credentialing Reports, all files met clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers pre-approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. Comprehensive Reviews, if any, regarding mental health & behavioral health providers were reviewed under the Initial Credentialing Report below.	☑ **ACTION**: Dr. Patel moved to approve the Behavioral/Mental Health Credentialing Report dated 12/03/2025, seconded by Dr. Parmar. Motion carried.	12/3/25
	INITIAL CREDENTIALING REPORT Initial Applicants List Dated **12/03/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted] **RECREDENTIALING REPORT** Recredentialing Providers Lists Dated **12/03/2025** were presented: • Recredentialing files meeting clean file review, report dated **12/03/2025**, were accepted as presented with no additional questions or alternative actions.	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 12/03/2025, seconded by Dr. Patel. Motion carried. ☑ **ACTION**: Dr. Amin moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointment), seconded by Dr. Patel. Motion carried.	12/3/25

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Member Grievances: Magdee Hugais presented the Member & Quality Grievances of .99 or higher; there were 3 providers listed over .99, however, it was reported there were no QOC concerns identified. The following recredentialing applications were presented for comprehensive review: • [redacted] • [redacted] • [redacted] • [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **December 3, 2025**, were accepted as presented with no additional questions or comments by the	**ACTION**: Dr. Amin moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointments), seconded by Dr. Patel. Motion carried.	12/3/25

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** Yolanda Herrera, KHS Credentialing Manager, reported on the November 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. The following new events were reported: [redacted] [redacted] [redacted] [redacted] [redacted]: 9/18/2025 Provider Appealed Adverse	☑ **ACTION**: Dr. Patel moved to approve the monthly monitoring report as presented with stated actions as stated below, seconded by Dr. Amin. Motion carried. [redacted] – **Action: No additional action necessary.** [redacted] **Action: Medicare Agreement not extended to this provider. Continue to monitor Suspended and Ineligible Report.** [redacted] **Action: No additional action necessary. Provider explanation accepted.** [redacted] **Action: No additional action necessary. Provider previously disclosed and provided explanation during original findings as this is an update on the provider's appeal of this adverse action. Continue monthly monitoring of provider [redacted].**	12/3/25

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Reason/Allegation: Health Plan Termination with Anthem BC • PAC 12/3/2025. [redacted] Monthly monitoring includes state and federal websites including OIG, SAM, NPDB Continuous Query, DHCS Restricted Providers, DHCS Suspended & Ineligible resulted in no new findings or updates. • **License Expirations included 5-Providers with expired licenses: 1-KHS Term letter for non-renewal of license and 4-providers termed by the group. Credentialing Staff will continue to monitor.** • **DEA Expirations included: 1-expired DEA who was terminated by the group practice.**	[redacted] No additional actions on license or DEA expirations.	
OLD BUSINESS	**Level 2 Potential Quality Issues (PQIs)** Level 2 PQI Report for November 2025 PENDING: [redacted]	☐ **PENDING**: Case #3 pending response from CSS oversight and Case #4 Pending AMR Independent review report.	Pending

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		
NEW BUSINESS	**Delegated Credentialing – 3rd Quarter 2025 HICE Reports** Yolanda Herrera KHS Credentialing Manager informed the committee that the delegates have submitted their 3rd Quarter HICE Credentialing Updates and Rosters indicating initial appointments, recredentialing and terminations during the reporting period. There were no significant changes in the provider network or to the delegates credentialing programs.	☑ **ACTION**: Dr. Amin moved to approve the 3rd Quarter Delegation HICE Reports, seconded by Dr. Lascano. Motion carried	*12/3/25*
	QI Track and Trend November Report 2025 Magdee Hugais. Director of Quality Improvement, presented the Potential Quality Issues (PQI) Track and Trend Report data for 11/1/2025-11/30/2025. The report was accepted as presented with no quality of care issues to present for further action or discussion by the committee.	☑ **CLOSED** – Informational Only	*N/A*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Quality Improvement Revised Policy and Procedures No QI Policy and Procedures presented for review	**N/A**	*N/A*
	Credentialing Revised Policy and Procedures No Credentialing Policy and Procedures presented for review	**N/A**	*N/A*
	Pharmacy Clinical Criteria – Annual Review Bruce Weada, Director of Pharmacy, presented the Pharmacy Clinical Criteria for annual review and approval of all criteria it uses for making medical determinations. Pharmacy Criteria references Medicaid criteria, Milliman Care Guidelines as well as meeting the California Code of Regulations. The following Criteria have had no changes since last year, or its creation: • Abatacept (Orencia) Criteria • Alpha-1 Proteinase Inhibitor (Aralast NP, Glassia, Prolastin-C, and Zemaira) Criteria • Amphotericin B Criteria - Fungizone, Abelcet, Ambisome • Botulinum Toxin Criteria – Anal Fissure Management • Botulinum Toxin Criteria - Cervical Dystonia and Spasticity • Botulinum Toxin Criteria - Chronic Migraine Management • Botulinum Toxin Criteria – Overactive Bladder (OAB) and Neurogenic Bladder Dysfunction • Burosumab-twza (Crysvita) Criteria • C1 Inhibitor (Berinert, Cinryze, Haegarda) Criteria • Calcitonin Gene-Related Peptide (CGRP) Criteria – erenumab (Aimovig), fremanezumab (Ajovy), galcanezumab (Emgality), eptinezumab (Vyepti) • Cantharidin (Ycanth) Criteria • Certolizumab (Cimzia) Criteria • Colony Stimulating Factors Criteria – filgrastim (Neupogen), filgrastim-aafi (Nivestym), filgrastim-ayow (Releuko), tbo-filgrastim (Granix), filgrastim-sndz (Zarxio), pegfilgrastim	☑ **APPROVED**: Dr. Amin moved to approve the annual review and approval of all Pharmacy Criteria as presented, seconded by Dr. Lascano. Motion carried.	12/3/25

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	(Neulasta), sargramostim (Leukine) • Erythropoiesis Stimulating Agents (ESAs) – Retacrit, Procrit, Epo, Epogen, NeoRecormon, Aranesp, (Epoetin and Darbepoetin) • Exagamglogene Autotemcel (Casgevy) Criteria – Sickle Cell Disease • Exagamglogene Autotemcel (Casgevy) Criteria – β-Thalassemia • Fabry Disease Criteria – Agalsidase Beta (Fabrazyme), Pegunigalsidase Alfa-iwx (Elfabrio) • Gaucher Disease Criteria – Cerezyme (Imiglucerase), Elelyso (Taliglucerase Alfa), Vpriv (Velaglucerase Alfa) • Givosiran (Givlaari) Criteria • Golimumab (Simponi Aria) Criteria • Gonadotropin Releasing Hormones (GnRH) Analogs Criteria for Non-Oncology Uses • Guselkumab (Tremfya) Criteria for Intravenous (IV) Use • Hyaluronic Acid Derivatives Criteria – Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz, SynoJoynt, Synvisc, Synvisc One, Triluron, TriVisc, and Visco-3 • Icatibant (Firazyr, Sajazir) Criteria • Immune Globulin Criteria – IVIG and SCIG • Inebilizumab-cdon (Uplizna) Criteria • Infliximab Criteria – Avsola, Inflectra, Remicade, Renflexis, and Zymfentra • IV Iron Criteria • IV Magnesium Criteria • Lanadelumab-flyo (Takhzyro) Criteria • Lecanemab-irmb (Leqembi) Criteria • Lovotibeglogene Autotemcel (Lyfgenia) Criteria • Luspatercept-aamt (Reblozyl) Criteria • Medical Injection Drug Criteria for Hyaluronan or Derivative Injections • Medical Supplies and Devices Criteria		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Mirikizumab (Omvoh) Criteria • Multiple Sclerosis (MS) Treatment Criteria • Myasthenia Gravis (MG) Treatment Criteria • Neuromyelitis Optica Spectrum Disorder (NMOSD) Treatment Criteria • Nusinersen (Spinraza) Criteria – Spinal Muscular Atrophy • Omalizumab (Xolair) Criteria – Idiopathic Urticaria • Oncology Criteria • Osteoporosis Criteria – Zoledronic acid (Zometa, Reclast) and Denosumab (Prolia) • PCSK9 Inhibitor Criteria – alirocumab (Praluent), evolocumab (Repatha) • Pegloticase (Krystexxa) Criteria • Primary Hyperoxaluria Type 1 Criteria – Lumasiran (Oxlumo) and Nedosiran (Rivfluza) • Pulmonary Arterial Hypertension (PAH) Prostanoids Criteria – nebulized iloprost (Ventavis), epoprostenol (Flolan, Veletri), treprostinil SQ (Remodulin), inhaled treprostinil (Tyvaso, Tyvaso DPI) • Recombinant Human Parathyroid Hormone Criteria – teriparatide (Forteo), abaloparatide (Tymlos) • Risankizumab (Skyrizi) Criteria for Intravenous (IV) Use • Rituximab Criteria for Non-Oncology Uses • Somatostatin Analogs Criteria for Non-Oncology Uses – Octreotide (Sandostatin LAR), Lanreotide (Somatuline) • Step Therapy Criteria • Tardive Dyskinesia VMAT2 Inhibitor Criteria – Deutetrabenazine (Austedo), Tetrabenazine (Xenazine), and Valbenazine (Ingrezza) • Teprotumumab-trbw (Tepezza) Criteria • Thrombopoietin-Receptor (TPO) Agonists – Eltrombopag (Promacta), Romiplostim (Nplate) • Tildrakizumab-asmn (Ilumya) Criteria • Tocilizumab Criteria – Actemra, Tyenne, and Tofidence • Ustekinumab Criteria for Intravenous (IV) Use – Stelara,		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Stegeyma, Wezlana, and Yesintek • Vedolizumab (Entyvio) Criteria		
OPEN FORUM	Dr. Tasinga informed the members that effective 1/1/2026 GL-1 weight loss medications, some over-the-counter medications such cough and cold meds will not be covered by Medi-Cal. Members informed the Executives that the new DSNP pre-authorization process is not being thoroughly communicated to the providers by Universal MSO nor KHS PR Representatives.	Informational only. This feedback will be taken back and review with the DSNP Team.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 4, 2026 @ 7:00 am.	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:30 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

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For Signature Only – Physician Advisory Committee Minutes 12/03/2025:

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

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KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***DECEMBER 4, 2025***
CALL TO ORDER: ***12:37 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Parikshat Sharma, MD – Outpatient Specialist		
Members Virtual Remote:	Maninder Khalsa, MD – KHS UM Medical Director	Ashok Parmar, MD –Specialist Pain Medicine	Karan Srivastava, MD – Orthopedic Surgeon
Members Excused=E Absent=A	Philipp Melendez, MD – OB/GYN (A)		
Staff Present:	Linda Corbin, Health Services Consultant (Remote) Amy Daniel, Executive Health Services Coordinator Dan Diaz, CCM Manager, RN Erin Endes, Health Services Manager (Remote)	Alma Garcia, NCQA Accreditation Specialist Jiwan Gill-Sharma, UM Inpatient Clinical Supervisor Loni Hill-Pirtle, Director of Enhanced Case Mgmt. Kulwant Kaur, UM Outpatient Clinical Supervisor RN	Christine Pence, Senior Director of Health Services Melinda Santiago, Director of Behavioral Health Nate Scott, Director of Member Services Isabel Silva, Director of Health & Wellness

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were met as the composition described in the committee charter.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:03 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of August 13, 2025 were presented for review and approval.	☑ **ACTION**: Dr. Sharma moved to approve minutes of August 13, 2025, seconded by Dr. Parmar. Motion carried.	12/04/25
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	UM Report 3rd Quarter 2025 Dr. Khalsa presented the 3rd Quarter 2025 UM Report. The following highlights were noted: • UM Timeliness of Decisions – KHS remains consistent with Urgent compliance at 99.4% and Routine compliance timelines at 99%. • UM Referral Notification is compliance remains at 100% for member notification and 100% provider notification and MD Signature. • Outpatient Referrals – slightly decreased in numbers to 100776 from last quarter which was 103228. • Adult & Pediatric Referrals – remain consistent in comparison to past quarters. • Denial Percentage – 3rd Quarter denied referrals are 6.3% for Sept, 6.6% for August and 3.7% July. • Quarterly Clinical Audits were also completed with no significant issue to report.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/4/25*
	D-SNP Policies Christine Pence reported the D-SNP Policy and Procedures were previously sent electronically for review: • Separate policies from Medi-cal • 002 Separation of Financial Decision Making • 003 Application of Medical Necessity and Clinical Criteria • 005 Referral Processing Turn Around Times • 006 Adverse Determinations • 007 Specialty Referrals and Use of Board Certified Practitioners • 008 Standing Referrals • 013 Reopening Service Determinations • 016 Emergency and Post Stabilization Requirements • 017 Inter-Rater Reliability Audits • 018 Downgrading UM Referral Requests • 019 Canceling, Withdrawing, or Dismissing a UM Service Request • 020 Request for Medical Policies • 022 Medicare Certified Facilities • 023 Reconstructive Procedures	☑ **ACTION**: Dr. Sharma moved to approve the D-SNP Policy and Procedures as listed, seconded by Dr. Parmar. Motion carried.	*12/4/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• 027 Second and Third Opinions • 030 Retrospective Review • 032 Direct Access to Women's Services • 5 Discharge Planning • 11 Onsite Facility Review • 13 Interdisciplinary Care Rounds • 16 UM Monthly Audits • Concurrent Review • Medical Director Referral • Medical Director Peer –to Peer • Requests for Experimental Treatment • Lack of Clinical Information • Organization Determination Mail • Termination of Medicare Services • Continuity of Care Dr. Srivastava requested additional information regarding what services are being overutilized. Dr. Khalsa explained KHS's processes for identifying potential overutilization. Additional discussion ensued regarding the DSNP Line of Business and how membership is fluctuating for both Medi-Cal and DSNP. Christine informed the members that DSNP enrollment is steadily increasing to about 300+ members to date. Medi-Cal enrollment is seeing some changes primarily due to the State removing the auto-renewal process that was in place during the pandemic. DHCS is expected to provide guidance regarding DHCS's plans to comply with H.R. 1. Christine described the efforts KHS is undertaking to ensure members maintain their insurance coverage. Nate also provided an update that KHS is looking to get a scanner for our building to be able to upload documents from our office to the County Office as a way to renew member's state benefits without having to go to the county office.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED

	<u>UM/Internal Auditing Activities</u>
	Christine Pence reported on the UM Auditing Activities that included the following items:
	• 3rd Quarterly audits of the NOA Team are done to monitor for accuracy and ensure appropriate processing of referrals that were previously denied or modified and to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process
	  • July - 1 NOA Finding with formatting error and grammatical error.
	  • August there were no errors
	  • September there were 2-NOA formatting and verbiage errors and 1-timeframe error
	  • Errors will be discussed during staff 1:1 meetings.
		☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*12/4/25*

	<u>Epidural Steroid Injection Authorization Protocol</u> Christine Pence reported the Epidural Steroid Injection Authorization Protocol was submitted to the Physician Advisory Committee and approved as presented.	☑ **CLOSED**: Protocol accepted as presented with no further discussion or questions from the committee members.	*12/4/25*
OPEN FORUM	**<u>Open Forum</u>**	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 25, 2026 at 12:00 PM	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 1:24 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Utilization Management Committee Minutes 12/04/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***Compliance Committee***
DATE OF MEETING: ***December 8, 2025***
CALL TO ORDER: ***3:03 PM by Jane MacAdam***

Members Present On-Site:	N/A		
Members Virtual Remote:	N/A		
Members Excused=E Absent=A	N/A		
Staff Present:	Anchondo Linda, Senior Regulatory and Government Program Manager Beale Karen, Compliance Analyst Lead Bercian Elia, Compliance Specialist Bowe Brandon, Compliance Analyst I Camarena Stephanie, Compliance Supervisor Chatman Tiffany, HE Manager of Wellness & Prevention Del Hoyo Galvan Flor, Manager of Member Wellness & Prevention Dhaliwal Sandeep, Compliance Manager, Audits and Investigations Fowler Heather, Senior Regulatory and Governmental Program Manager Gonzalez Amanda, Director of Utilization Management Harness Jared, Compliance Analyst I	Hasting Russell, PHM Manager of Case Management Herrera Yolanda, Credentialing Manager Hill-Pirtle Loni, Director Enhanced Care Management Hugais Magdee, Director of Quality Improvement Kelly Christina, Pharmacy Administrative and Support Supervisor Lara Leticia, Assistant Controller MacAdam Jane, Director of Compliance and Regulatory Affairs McGuire Melissa, Senior Director of Delegation Oversight Murr Deborah, Chief Compliance and Fraud Prevention Officer Onaindia Kristie, Provider Relations Manager	Panero Greg, Network Analytics Program Manager Pollock Jeff, Compliance Manager Pruitt Heather, Compliance Analyst I Rangel Cassandra, Compliance Specialist Reyes Paola, Compliance Analyst I Rystedt Rebecca, Compliance Analyst I Salinas Adriana, Director of Community & Social Services Sanders Amy, Member Services Manager Santiago Melinda, Director of Behavioral Health Scott Nate, Senior Director Member Services Silva Isabel, HE Senior Director of Wellness and Prevention Van Peursem Mindy, Compliance Analyst I Wearda Bruce, Director of Pharmacy

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
1. Action Items: Jane MacAdam (From 09/19/2025 Meeting; Minutes Attached)	A. Jiva Grievance Module update (Amy Sanders) 1. Nate reported that the Grievance team is actively working within JIVA to resolve system issues. Although progress has taken longer than anticipated, efforts to implement process improvements are ongoing. 2. Nate reported that a process is being developed in collaboration with Corporate Services to ensure letters are mailed promptly, with mail dates and print dates aligned to meet regulatory requirements. He noted that three meetings have been held on this topic, with Sandeep actively participating. a. Jane confirmed that the Corporate Services team did send a list of letters to Compliance asking for the regulatory requirements. b. Nate stated there was a proposal in the meetings to find a way to prioritize which letters should be mailed out and printed on the same day that are sent to Corporate Services. 3. Amy recommended designating all letters generated from JIVA as high priority to ensure timely distribution. She also suggested implementing an assessment within JIVA to trigger letter generation promptly. a. Jane confirmed that all letters issued in JIVA from all departments are high priority.	☑ ***Action Item***: 1. Per Jane, continue discussion with the Corporate Services team to develop a solution that ensures letters are generated and mailed timely resolving the issue between the mail date versus the printed date.	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	b. Nate suggested adding another machine and one full-time employee to complete the letter fulfillment process. c. Amy noted that a report generated from JIVA's Grievance Module includes both the date and time each letter was created. She expressed concern that if these timestamps are provided to the regulators, they will indicate non-compliance. d. Bruce stated he would ask Sandeep to put in the efforts to hopefully do whatever it takes in order to send the letters to the printers sooner if possible. e. Amy clarified that the issue is not sending the letters to the printer, but rather the timing of when the print job is initiated. Bruce agreed, noting that both aspects are equally important. f. Nate noted, a positive outcome from the meetings is that letters submitted on Friday will no longer wait until Monday for processing. The team will work within available resources to ensure timely handling.		
	B. Per Jane, Robin will provide Claims Audits in upcoming Compliance Committee Meetings in 2026.	N/A	N/A
	C. Kalpna reported no Corrective Action Plans (CAPs) have been issued at this time. Providers for IHA and lead screening are trending; expects finding by next quarter.	☑ ***Action Item***: 2. Jane will schedule time with Magdee to go over CAP form.	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	1. Magdee sent a draft process and form, however, will take additional time to review to include DMHC requirement on a potential CAP form that was not included in the meeting. Magdee is requesting time finish and review CAP form.		
	D. Amy to confirm grievance resolution timeliness and whether improved over previously reported 25% untimely. 1. Jane reported that acknowledgment letters are currently being sent in a timely manner, with a 91% completion rate. She noted that while improvements are still needed, delays are primarily due to provider response times or delays in requesting those responses, in order to close out a grievance. 2. Amy mentioned that the team is currently working to manage bandwidth challenges, as several employees are on or preparing for leave. As a result, responsibilities are being shifted to other staff, particularly team leads, to perform final resolution reviews and ensure letters are sent out in a timely manner. 3. Amy noted that there has been improvement in the last quarter, due to increased usage of JIVA. She is hoping that continued use of the Grievance Module will improve letter timeliness.	☑ ***Action Item***: 3. Amy will provide a data update to confirm whether the use of the Grievance Module has resulted in improvements.	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	4. Amy noted they have recognized a key issue which is the provider responses and are tracking and trending to identify which providers they are in order to put on CAPs if necessary. a. During the DHCS audit sample review, a trend was identified showing that all were out of compliance.		
	E. Member Services and Compliance to collaborate on bringing reading level on grievance resolution letters down to sixth (6^{th}) grade reading level. 1. Per Jane, will potentially look into using AI tools in letters or suggesting language to use. 2. Amy stated they are building templates for common grievance scenarios. They are trying to build templates where language is reduced such as using shorter paragraphs and sentences. 3. Amy also stated the Help Center will be updated for readability tools and also play with using AI to utilize it in bringing the language level down.	N/A	N/A
2. 09/19/2025 Meeting Minutes	Included in the packet.	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
3. Enterprise Risk Management (ERM): Jane MacAdam	A. Enterprise Risk Management (ERM) Project Update 1. Jane noted that a risk register has been developed, incorporating input from executive and director-level meetings. 2. This year's project is expected to conclude by year-end, with a finalized list of all identified risks to be completed. a. Owners will be assigned to each identified risk and divided up to be tracked in various committees such as Compliance Committee, Health Equity Committee, Finance Committee, etc.	N/A	N/A
4. Governance & Compliance Committee Meetings: Deb Murr	A. Governance & Compliance Committee Meetings 1. Meeting held in September and there was a lot of discussion regarding the work that has been accomplished internally with the NEMT. Deb presented at the Department of Justice (DOJ) in three (3) different meetings across the state. 2. Several other plans are also seeing the same things in regard to fraud, waste, and abuse. The DOJ and other health plans praised the internal work and appreciated the plan sharing the work that has been done. 3. The November 20th meeting focused on regulatory audits. Devin presented on HR and Respectful Workplace, highlighting increased emphasis on	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	training, policy development, and auditing organizational practices. 4. Per Deb, Governance and compliance meetings serve as a key forum for elevating topics to the board, including major priorities like MCAS. These meetings were effective and successful throughout the year.		
5. Compliance & Ethics Week: Jane MacAdam	A. Conducted the week of 11/03/2025 – 11/07/2025, with a Compliance "Meet & Greet" followed by fun and educational activities to focus on Compliance & Ethics, including: 1. Daily videos on variety of topics: a. Kickoff, HIPAA, D-SNP, Regulatory Oversight, All Plan Letters, FWA b. Daily scavenger hunt c. Daily Games: HIPAA Hippo, Scandalous (Compliance red flags), Two Truths & a Lie, Complex (APLs and application to scenarios), 10 Days to Deadline (FWA) 2. Jane complimented the Compliance team for all their contributions and participation.	N/A	N/A
6. Regulatory Audits: Jane MacAdam	A. 2023 DHCS Focused Audit (Behavioral Health (BH)/Transportation): 1. There is no update.	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2. Currently awaiting formal closure of CAP and waiting to hopefully receive a formal notification that it has been closed.		
	B. 2023 DMHC Medical Audit / 2025 Follow Up Audit: 1. Interview sessions were completed on 11/10/2025. 2. Two (2) follow up requests for UM narratives received and provided to DMHC on 11/26/2025. 3. Amy asked if there were any Grievance follow ups, Jane stated no.	N/A	N/A
	C. 2025 DHCS Focused Audit 1. Closing Session was held on 10/13/2025 regarding security, privacy, and interoperability. 2. Additional supporting documentation was submitted on 10/17/2025. They will not be requesting additional information. 3. Awaiting Preliminary Audit Report (after which we will have fifteen (15) days to respond/provide any additional documentation) in case to dispute any potential findings.	N/A	N/A
	D. 2025 DHCS Routine Medical Audit 1. Entrance letter and pre-audit deliverables request received on 11/10/2025. 2. Audit period: 11/01/2024 – 12/31/2025.	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	3. Required data universes submitted on 11/25/2025. 4. Remaining pre-audit deliverables due to DHCS 12/15/2025. 5. Verification Study requests received on 12/03/2025 (due to DHCS 12/18/2025). 6. Entrance Conference is scheduled for 01/26/2026. 7. Onsite Interviews are scheduled for 01/26/2026 – 02/06/2026. 8. Per Jane, many deliverables have been due to DHCS by 12/15/2025 and everybody has been providing their deliverables on time to Compliance by 12/10/2025. 9. Sample requests have been received from DHCS and sent to the appropriate teams to gather sample documents. There will be clarification on questions that have been asked regarding the samples. 10. Deb commented that the Compliance group gathered to ask each other what the main focuses of the audit are. Areas that were brought up were IHAS, HRAS, PHM, and ECM. a. Amy commented when she was looking through the deliverables that were provided last year, there were no IHA requests, however that is a focus this year. b. Amy also reviewed the inquiry log sample		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	request, and they are all looking for Grievances and sent back three (3) to be re-opened. c. Jane informed Amy that last year it was not a full scope audit and is not sure how they determine which areas they will or will not review.		
	E. 2024-2025 HSAG Encounter Data Validation Audit (EDV) 1. Vendor is contracted by DHCS to conduct this audit. 411 medical records are submitted and reviewed to see our ability to submit those records. 2. Draft report was provided for feedback which showed decrease in scores. 3. Encounter accuracy scores declined when compared to 2023-2024. Jane noted the health plan's scores are higher than statewide averages which these scores are provided. 4. Still waiting for the Final Report to be provided and it will be reviewed upon receipt and shared.	N/A	N/A
	F. HSAG Network Adequacy Data Validation Audit (NAV) 1. Received final report which is included in the packet on page thirty-two (32). 2. There was one recommendation that was made and	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	it is being discussed with the PNM team. It was regarding calculation of network adequacy and using real member data. 3. Recommendation: HSAG recommends that KHS consider performing separate analyses using actual member enrollment and the DMHC population points data to assess ongoing compliance with both actual and anticipated membership. 4. Recommendations are being looked at and reviewed, however, there were no findings.		
7. DSNP: **Jane MacAdam**	A. DSNP Update: 1. Annual Enrollment Period (AEP) began 10/15/2025 and ended on 12/07/2025. There was high enrollment compared to other health plans. 2. The KHS Medicare website was launched. 3. Enrollment processing and oversight ongoing. There is continued talk with UHC regarding enrollment processing. 4. Special Enrollment Period (SEP) and for dual-eligible members is ongoing after 12/07/2025. Members can enroll or disenroll throughout the year even though the annual enrollment period is over. 5. Initial Enrollment Period (IEP) for members turning	☑ ***Action Item***: 4. Jane will double check the process on the grievance process for a member that is enrolled and showing active as to whether it will count as a grievance on the Medicare side.	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	65/becoming Medicare-eligible is also ongoing. 6. Implementation activities are ongoing. 7. It was originally projected that there would be two thousand (2000) enrollments by the end of 2026 and so far, it has been around six hundred (600). a. Heather Fowler asked if there is money being spent on advertising marketing. Jane answered yes there is via billboards, commercials, mailing, and radio. b. Nate also stated that overtime is being offered to Members Services workers in order to assist in outreaching and Member Services has been successful in getting ahold of many members. c. Amy mentioned that a prospective D-SNP member complained about there not being available D-SNP appointments. Amy wanted to verify that the sales team would have to follow up with the member. Jane stated that it is correct as it would not be processed as a grievance under Medi-Cal and would have to be under Medicare which would be resolved until they enroll.		
8. Compliance Training Status: Jane MacAdam	A. Compliance Training Status: 1. There are currently nineteen (19) outstanding trainings for HIPAA.	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2. There are currently seventy-two (72) outstanding trainings for FWA. There will be a push for these trainings to be completed as they are a requirement for a DHCS audit. 3. There are currently forty-four (44) outstanding trainings for Code of Conduct. a. Nate asked if they will be sharing a list of names with employees that have outstanding trainings and Jane stated yes, Sandeep will be reaching out to the Chiefs and Directors of those employees. b. Jane confirmed all trainings are overdue, however, they will need to be completed by end of the year, 12/31/2025.		
9. Reports **Amy Sanders**	A. Member Services Quarterly Grievance Audits: Amy Sanders 1. The goal for 2025 Q3 is to audit thirty (30) case files per quarter with an average score of 90% or above. 2. Q3 monthly audit average is 92.54%. a. July 88.53% b. August 94.59% c. September 94.5% 3. Trends identified: a. Mailing the resolution letter after the 30th day	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	of the grievance, even though resolved prior to day thirty in the process. b. Acknowledgement letter sent past fifth (5th) day of grievance receipt. c. Expedited case delayed; delayed letter not sent timely. Expedited case not sent to DMHC timely. d. Sending request for response to providers after the fifth (5th) day (not regulatory) e. Documenting the incorrect closure date on the resolution letter. (not regulatory) f. Not documenting QNXT/Call Log (not regulatory) g. Typos in requests for response to providers, case file checklist, logs, etc. 4. Q3 goal of 90% met for two (2) of three (3) months. a. Individual scores are shared with staff during their monthly one-on-ones. b. Common deficiencies will be shared with staff during team meetings in an effort to reduce the number of errors.		
Magdee Hugais	B. Quality Improvement: 1. IHA Audits a. Q3 findings: Audited forty-five (46) provider groups. i. Eighteen (18) scored 100%. ii. Eleven (11) regions received between	☑ ***Action Item***: 5. Magdee will try to begin providing tracking and trending for the IHA audits beginning next quarter. 6. Amy will take a look and get back to Magdee regarding the findings for the three (3) exempt grievance cases. 7. Magdee will discuss with Dr. Tasinga and Dr. Miller regarding how to follow up with gold cards.	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	90-99% overall score. iii. Thirteen (13) regions received between 80-89% overall score. iv. Four (4) regions received 79% or below overall score. v. Zero (0) regions were not audited due to insufficient number of members' records to review.		
	2. Corrective Action Plan: a. Provider educational letters sent to each PCP region. b. PCP regions with an overall score of 79% or below will be added to the track and trend list. Consistent trends will be sent to Dr. Miller for CAP. i. Deb asked if these are being tracked and trending each quarter, Magdee stated yes, they are and would like to summarize in one page and then have the reports filed at the end. ii. Deb commented it would be helpful to see if the same providers show up every quarter because other actions can be considered. iii. Jane also commented that one of the findings in the last DMHC audit was that there were not any tracking and		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	trending for audits being conducted and no action taken for repeated non-improvement. 3. Exempt Grievance Audits a. Shared with MS/Grievance b. 90% for Q3 c. Thirty (30) exempt grievance cases audited: d. Twenty-seven (27) exempt grievance cases reviewed did not involve concerns about the potential quality of care. e. Three (3) exempt grievance cases reviewed involved concerns about the quality of care received and were incorrectly classified as exempt. i. Corrective Action Plan: ii. Under Quality Improvement Management review. iii. Under Grievance Management review. iv. Amy asked if those three (3) cases were followed up as exempt and Magdee confirmed yes and should have been quality of care.		
	4. NAR Audits a. July: Eleven (11) findings i. Two (2) Spelling, grammar, verbiage, and format error ii. One (1) Sixth grade readability		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	iii. One (1) Criteria error iv. Seven (7) Overall process b. August: Eight (8) findings v. Four (4) Spelling, grammar, verbiage, and format error vi. Two (2) Criteria vii. One (1) Overall process viii. One (1) Hierarchy error c. September: Five (5) findings ix. Two (2) Spelling, grammar, verbiage, and format error x. One (1) Sixth grade readability xi. Two (2) Overall process d. Total number of appeals audited: Thirty (30) e. Number of appeals with deficiencies: Nineteen (19) f. Percentage of accuracy rate: 37% i. Corrective action plan: Findings tickets sent to QI RNs and Medical Directors via email for educational purposes and corrections, when applicable.		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	5. Gold Card Audits a. Aggregated findings i. Centric Health: 80% met criteria for medical necessity. ii. Comprehensive Cardiovascular Medical Group: 40% met criteria for medical necessity. iii. Hao Bui MD Inc: 66% met criteria for medical necessity. iv. Kern Endocrine Center, Jasleen Duggal MD Inc: 100% met criteria for medical necessity. v. Rheumatology Services Medical Group: 0% b. Corrective Action Plan: To be determined per Dr. Miller c. Jane had a question regarding Rheumatology Services Medical Group where none of the providers met the criteria, per Magdee, that one specifically is being followed up on. Deb pointed out the volume size is small. d. Deb then added that she knows it has been discussed for certain providers that if they are not performing how they are supposed to then they should not be on the gold card list anymore? Magdee verified, yes, a gold card policy was just published and will be submitted to the executives. e. Magdee mentioned that he is uncertain whether any gold cards have ever been approved by a		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	specific committee. Deb added that the process was taken to UM years ago. 6. CBCC Audits a. 100% met criteria. b. Corrective Action Plan (CAP): under Medical Director review c. Deb inquired if another provider besides CBCC can access the criteria since the utilization by CBCC is historically low? Magdee stated he would discuss with Dr. Miller to see which providers would benefit the most from accessing the criteria.		
	7. Lead Screening Audits a. One (1) PCP regions received a 100% overall score. b. Three (3) PCP region received a 90-99% overall score. c. Two (3) PCP regions received an 80-89% overall score. d. Eleven (11) PCP regions received 79% and/or less. e. Corrective Action Plan: f. Provider educational letters sent to each PCP region. g. PCP regions with an overall score of less than 80% will be added to the track and trend list. Consistent trends will be sent to Dr. Miller for CAP		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	h. Magdee noted that the same providers are not audited each quarter, and trends can only be observed over two quarters since the providers being audited alternate. 8. Telehealth Audit a. Telehealth audits are currently not complete and have been de-escalated to weekly instead of daily as to make space for other audits.		
Amanda Gonzalez	C. UM Audits 1. Q3 2025 audit results compared to the average total of 2024. a. 5.3% reduction in overall referrals processed compared to quarter two of 2025. b. The percentage of modified and delayed referrals remained consistent with an increase in the percentage of denied referrals. c. The increase in percentage of denied referrals is related to changes in Community Support Services guidelines. 2. Q3 2025 improvements a. The errors in mailing notification to members more than 2 days after the decision, missing criteria, errors in referral processing and missing signatures improved. b. Errors in NOA increased but improved from Quarter 1 and 2024.	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	3. Requested Action a. Review the internal audit results for 2025 UM Quarter 3. 4. Corrective Action Plan (CAP) Progress Update (11/01/2024 – 06/30/2025) a. Staff has completed retraining September 15, 2025, with a supplemental session held on September 23, 2025, to ensure full participation. b. Quarterly audits are in the preparatory phase which will be fully operational once the reporting enhancements are completed. c. Daily monitoring implementation has been partially implemented with "Not to Print" daily report being active that identifies which letters have been generated but not set to print. UM is collaborating with BI to enhance the report to flag letters that were never generated. This upgraded version is in development and remains a departmental priority. d. Daily monitoring results are ongoing with UM reviewing interim report daily and communicating any deficiencies for correction. e. Daily monitoring will cover: i. Missing print indicators ii. Missing letter generation		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	f. Next steps i. Finalize the enhanced daily monitoring report with BI. ii. Begin quarterly audit activities once reporting enhancements are completed to ensure accurate trending and comprehensive review. iii. Maintain daily monitoring and immediate remediation processes.		
Flor Del Hoyo Galvan	5. Health Education 1. Service Audit a. Areas at 100% i. Facilitator checklist/agenda. ii. Participants signed in. iii. Covered SMART goals. iv. Providing examples for difficult concepts. v. Demonstrating activities. vi. Completed all activities. vii. Checked for participant questions. viii. Engaged participants in various ways. b. Areas below 80% i. None 2. Health Education – Service Audit Score Q2 2025 –	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Q3 2025 a. Class ended on time i. 100% Q2 ii. 88% Q3 b. Implemented the teach back method i. 100% Q2 ii. 92% Q3 c. Discussed common myths about the topic i. 100% Q2 ii. 92% Q3 3. Satisfaction Survey – Member Satisfaction with Class Q2 and Q3 2025 a. Satisfied with reward i. 98% Q2 ii. 97% Q3 b. Facilitator was effective i. 98% Q2 ii. 100% Q3 c. Presentation was interesting i. 98% Q2 ii. 100% Q3		
	4. Class Effectiveness a. Breathe Better Program, Q3 2025		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	i. 88% Pre-Test ii. 95% Post-Test b. Chart Fresh Start, Q3 2025 i. 89% Pre-Test ii. 96% Post-Test		
	c. Nutrition Education Q3 2025 i. 87% A+E Pre-Test ii. 91% A+E Post-Test iii. 85% EHBA Pre-Test iv. 86% EHBA Post-Test d. Diabetes Prevention Program Q3 2025 i. 62% Pre-Test ii. 73% Post-Test e. Deep, Q3 2025 i. 65% Pre-Test ii. 77% Post-Test f. Asthma Follow Up Call Results by Quarter i. 77.3% Q3 2024 ii. 84.1% Q4 2024 iii. 100% Q1 2025 iv. 100% Q2 2025		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	v. 100 % Q3 2025		
	g. Diabetes Management, Average Weight Comparison at Class 1 and Class 6 by Quarter i. Class 1: 219 Q4 2024 ii. Class 6: 211.2 Q4 2024 iii. Average weight loss trend: -3.56% iv. Class 1: 197 Class 1 Q1 2025 v. Class 6: 195.1 Class 6 Q1 2025 vi. Average weight loss trend: -0.96% vii. Class 1: 187.5 Class 1 Q2 2025 viii. Class 6: 185.8 Class 6 Q2 2025 ix. Average weight loss trend: -0.91% x. Class 1: 177 Class 1 Q3 2025 xi. Class 6: 177 Class 6 Q3 2025 xii. Average weight loss trend: -0.0% h. Diabetes Prevention Program Weight Loss by month Q3 i. July: 72.8 ii. August: 59.7 iii. September: 64.1		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
MOU Status **Jane MacAdam and Tiffany Chatman**	D. MOU Status 1. Tiffany noted they are currently working with the learning development team to ensure all staff complete the MOU training in Dayforce. It is a regulatory requirement for all staff to be aware of how to locate MOUs. 2. Working closely with the ECM team to release the Correctional Facilities MOU that will be released in 2026. a. Jane asked if there are any other MOUs that DHCS expects to be completed. Tiffany confirmed to Jane that as of that moment, no additional MOUs have been executed. 3. In-Home Supportive Services, Social Services and Child Welfare, and Kern Regional Center are in "Other Party Review" status.	N/A	N/A
Jane MacAdam	F. Compliance: Jane MacAdam 1. 2025 Compliance Oversight Audit- Grievances 1st Quarter, 2025 – Utilization Management a. Thirty (30) standard NOA case files were reviewed for the period of January 1st through March 31, 2025 b. Summary of Results: i. Statement of Action to be taken (30/30 = 100%)	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	ii. Clear and Concise Explanation (22/30 = 73%) iii. Description of Criteria used (13/30 = 43%) iv. Clinical reasons for decision explicitly stated (25/30 = 83%) v. Correct Regulatory Template used (30/30 = 100%) vi. Correct Attachments (0%) vii. Member notifications are at sixth grade reading level (0%) c. Follow- Ups/ Next Steps: i. Review opportunities for elements 2-4 in NOA letters. ii. Recommend utilizing HLA language software and/or Microsoft Word tool for letters sent to members. iii. Verify attachments are accurate and match DHCS templates.		
	2. All Plan Letters & Guidance Letters Received a. Forty-Three (43) in 2025 i. Jane stressed that although there have been less APLs, the volume of work has not decreased. 3. Regulatory Reports & Filings a. 1182 in 2025 for DHCS and DMHC combined.		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	i. DSNP submissions are not included in this number.		
	4. DMHC Consumer Complaints & Independent Medical Reviews (IMR) a. IMR - Ten (15%) b. Consumer Complaint – Fifty-Seven (85%) i. Upheld – Thirty-Five (35) (KHS) Forty-Five (45) (DMHC) ii. Overturned – Sixteen (16) (KHS) Four (4) (DMHC) iii. Return to Plan – Eight (8) (KHS) Zero (0) (DMHC) iv. Duplicate – One (1) (KHS) One (1) (DMHC) v. Misdirected – Four (4) (KHS) One (1) (DMHC) vi. Services Never Denied – Three (3) (KHS) Zero (0) (DMHC) vii. In Process Zero (0) (KHS) Sixteen (16) (DMHC) viii. Grand Total: Sixty-Seven (67) c. IMRs and Consumer Complaints have significantly increased due to changes in Community Supports denials and ABA denials.		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	5. HIPPA Breach Activity a. From October 1st to November 30th, 2025, the Compliance Department investigated and reviewed sixty-one (61) allegations of privacy concerns. i. One (1) case was sent to the State for review and closed. ii. Four (4) cases are still under review by the State.		
	6. Policy and Procedure Inventory a. Policy and Procedure Inventory as of 12/03/2025 i. Annual Review Due – Thirteen (13) ii. Current and Approved – Forty-Four (44) iii. Out for Signature Approval – Retirement – One (1) iv. Retired- Twenty-Six (26) v. Stakeholder Reviewing – Thirty-Two (32) vi. Under Review by Compliance – Zero (0) vii. Grand Total: One Hundred Twenty- Two (122) b. D-SNP Policy and Procedures as of 12/03/2025 i. Current and Approved – Fifteen (15) ii. Out for Signature Approval – Forty-Nine		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	(49) iii. Stakeholder Reviewing – New Policy – Thirty-Nine (39) iv. Under Review by Compliance – Fourteen (14) v. Grand Total: One Hundred Seventeen (117) c. P&P Project – Phase 1 as of 07/10/2024 i. Annual Review Due – Thirteen (13) ii. Current and Approved – Forty-Four (44) iii. Out for Signature Approval – Six (6) iv. Out for Signature Approval – Retirement – One (1) v. Retired – Twenty-Six (26) vi. Stakeholder Reviewing – Thirty-Two (32) vii. Under Review by Compliance – Zero (0) viii. Grand Total: One Hundred Twenty-Two (122) d. P&P Project – Phase 2 ix. Annual Review Due – Seventy-One (71) x. Current and Approved – Four (4) xi. Out for Signature Approval – Two (2) xii. Out for Signature Approval – Retirement – One (1)		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	xiii. Retired – Zero (0) xiv. Stakeholder Reviewing – Six (6) xv. Stakeholder Reviewing – New Policy – Six (6) xvi. Under Review by Compliance – One (1) xvii. Grand Total: Ninety-One (91) e. SAI360 Integration as of 12/03/2025 i. SAI360 – Two Hundred Seventy (270) ii. External – Two Hundred Two (202) iii. Total Policies- Four Hundred Seventy-Two (472) 7. APL Status a. Status report is attached to the agenda. 8. Compliance Capsules a. Copies of the Compliance Capsules are attached to the agenda.		
OPEN FORUM	N/A	N/A	N/A
NEXT MEETING	Next meeting is scheduled for Wednesday, February 11, 2026: 3:00 – 4:30 PM	N/A	N/A

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	Meeting Adjournment 4:30 PM	N/A	N/A

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KERN HEALTH SYSTEMS

COMMITTEE: COMMUNITY ADVISORY COMMITTEE (CAC)
DATE OF MEETING: December 9, 2025
CALL TO ORDER: 11:11 AM by Rukiyah Polk - Chair

Members Present:	*Ashton Chase* *Beatriz Basulto* *Evelin Torres* *Lourdes Bucher* *Jessika Lopez* *Rukiyah Polk* *Tammy Torres*	**Members Absent:**	Alyssa Olivera *Rocio Castro* *Jay Tamsi* *Jasmine Ochoa* *Jennifer Slayton* *Michelle Bravo*	**Staff Present:**	*Amy Sanders, Member Services Manager* *Anastasia Lester, Sr. Health Equity Analyst* *Nate Scott, Sr. Director of Member Services* *Daisy Torrez, Member Engagement Supervisor* *Cynthia Cardona, Cultural & Linguistic Services Manager* *Cynthia Jimenez, Cultural & Linguistics Specialist* *Lela Criswell, Member Engagement Manager* *Isabel Silva, Sr. Director of Wellness & Prevention* *Vanessa Nevarez, Health Equity Coordinator* *Diana Alvarado, Cultural & Linguistics Specialist* *Tara Gray, Tribal Liaison* *Hernan Hernandez, Director of Govt. Relations & Strategic Development* *Stella Sanchez, Medicare Sales Manager* *Stephanie Rico, Member Engagement Rep*

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	7 committee members present; Alyssa Olivera, Rocio Castro, Jay Tamsi, Jasmine Ochoa, Jennifer Slayton, and Michelle Bravo were absent.	Committee quorum requirements met.	N/A
Call to Order	Rukiyah Polk, Chair, called meeting to order at 11:11 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

KERN HEALTH SYSTEMS

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Rukiyah gave the opportunity for member updates. • There were no committee announcements.	• N/A	N/A
Committee Minutes	**Approval of Minutes** CA-3) The Committee's Chairperson, Rukiyah Polk, presented the CAC Minutes for approval.	**Action:** • Tammy T. first, Evelin T. second. All aye's. Motion carried.	12/9/25
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** CA-4) November 2025 Medi-Cal Membership Enrollment Report	N/A	N/A
	5) 3rd Quarter 2025 Operational Board Update • Amy S. presented the grievance trends that were identified in the 3rd quarter when compared to the previous four quarters. There was an increase in the plan's grievance volume which can be attributed to changes in the criteria for several Community Support Services (CSS) benefits and Applied Behavioral Analysis (ABA) therapy services. After a comprehensive evaluation of CSS, the analysis identified a less-than-favorable return on	• Lourdes B. first, Ashton C. second. All aye's. Motion carried.	12/9/25

KERN HEALTH SYSTEMS

	investment. In response, KHS implemented additional oversight for the Medically Tailored Meals (MTM) program to better align the service with DHCS eligibility requirements. The refinements ensure that only members with medically sensitive conditions are approved for the benefit. KHS anticipated an increase in grievances from members who are no longer qualified under the updated criteria and additional oversight. After a comprehensive evaluation of ABA, the analysis identified possible overuse of the services. Most of the records in the sample analysis did not meet medical necessity. To prevent overuse and establish a process, KHS partnered with AllMed, an organization with trained providers who review ABA services for other health plans in California. Amy S. added that the increase in transportation grievances is due to changes in how the plan schedules rides for members. Members are required to schedule two days in advance. Ashton C. stated that there have been a lot of grievances for MTM patients and asked if there will be any changes. Amy S. responded that she would take the question back to the specialist for review and response. Ashton C. added that she would like to know how to better serve her patients and whoever is doing the review is denying services and being told they are not giving the correct diagnosis. Amy S. replied		

	that it's possible there is not enough documentation but assured the committee that she will take the question back for a response. A motion to approve was requested. 6) 3rd Quarter 2025 Grievance Summary Report • Amy S. presented the Grievance Summary Report which gives a more in-depth look at data than the Operational Board Report. Amy S. shared that 4,024 were received during Q3 with Access to Care Grievances at 22.3%, Quality of Service Grievances at 19.5%, and Quality of Care Grievances at 14.6%. Standard Grievances were at 73% (resolved within 30 days) and Exempt Grievances were at 27% (resolved within one business day). Resolution Outcomes closed in favor of the enrollee were at 44.26%, closed in favor of the plan or provider at 55.02%, and remained open at time of reporting at .72%. A motion to approve was requested. 7) 2026-2027 CAC • Anastasia L. presented the new protocol required by the DHCS for the 2026 contract for CAC. The contract states that the CAC is to be comprised of members representing not only the demographic composition of the membership, but those representing specialty	• Tammy T. first, Evelin T. second. All aye's. Motion carried. • Tammy T. first, Evelin T. second. All aye's. Motion carried.	12/9/25 12/9/25

KERN HEALTH SYSTEMS

	populations outlined in the contract. Anastasia L. announced that Tara G., the KHS Bakersfield American Indian Health Project (BAIHP) liaison, will be joining the CAC in 2026. She was unable to find two LGBTQ+ representatives to add to the ballot and asked the committee if they would give KHS permission to locate and fill the slot on the committee's behalf. The committee voted yes. The voting ballot was handed to the committee and the committee voted. Anastasia L. welcomed back and introduced Beatriz B., Evelin T., Tammy T., Rukiyah P., Jennifer S., Lourdes B., Ashton C., Elena A., Terra A., Kassandra M., Sofia G., Gayla H., Jasmine O., Jay T. to the 2026-2027 CAC. Tammy T. asked if the meeting cadence will remain the same, Anastasia L. responded yes. A motion to approve was requested. 8) H.R.1 • Hernan H. gave a presentation about H.R.1 and the 2025 State Budget Summary. The recap included major legislative changes, the bills that were introduced and passed, and the changes to Medi-Cal and Medicaid. Beatriz B. added that the most important thing is to get this information to the community. Beatriz B. confirmed with Hernan H. that members will	• Tammy T. first, Beatriz B. second. All aye's. Motion carried.	12/9/25

	be exempt if they don't enroll. A motion to receive and file was requested. 9) Medicare Presentation • Stella S. presented Kern Family Health Care's new Medicare D-NSP (Dual Special Needs Plan). With Medicare D-SNP, members will be able to have their Medicare and Med-Cal under one plan, instead of two, effective January 1, 2026. D-SNP fliers were handed to the committee. Tammy T. asked what the difference is between Medicare and Medi-Cal. Stella S. responded that Medicare is funded by the federal government and at least ten years of working experience is required to qualify. Medi-Cal is funded through the State and qualification is based on income. Stella S. added that new benefits have been added to the Medicare plan such as hearing aids, dental, and vision. Jessika L. asked if additional items for hearing challenges were covered. Stella S. replied that only hearing aids are covered at this time. Beatriz B. asked what happens to the members coverage that did not make the change during the enrollment period. Stella S. replied that they still have the opportunity to enroll in the plan because Medicare has an open enrollment period in January. A motion to receive and file was requested.	• Ashton C. first, Tammy T. second. All aye's. Motion carried.	12/9/25

KERN HEALTH SYSTEMS

Open Forum	There were no items to present.	N/A	N/A
Next Meeting	Rukiyah P. thanked those who have participated in the CAC for the last two years. The next meeting will be held on Tuesday, January 27, 2026, at 11:00am.	N/A N/A	N/A N/A
Adjournment	The Committee adjourned at 12:34pm. ***Respectfully submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	Lourdes B. first, Tammy T. second. All aye's. Motion carried.	N/A

SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, December 12, 2025

8:30 A.M.

COMMITTEE RECONVENED

Members: Elliott, Bowers, Turnipseed, Watson
ROLL CALL: 3 Present; 1 Absent – Bowers

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

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

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

DIRECTOR ELLIOT REPORTED THAT THE COMMITTEE HAS BEEN IN DISCUSSION ABOUT "BUMPING" UP EMILY'S SIGNATURE AUTHORITY; CURRENTLY IT'S $200,000 PER CONTRACT; THIS WOULD PREVENT MANY ITEMS GOING TO THE BOARD FOR APPROVAL

FINANCIAL MATTERS

CA-3) Minutes for Kern Health Systems Finance Committee meeting on October 17, 2025 - APPROVED
Turnipseed-Watson: 3 Ayes; 1 Absent - Bowers

NOTE: DIRECTOR BOWERS ARRIVED AT 8:36 AM; AFTER THE CONSENT VOTE

NOTE: DIRECTOR BOWERS LEFT THE DAIS AT 8:52 AM; AND DID NOT VOTE ON ITEM 4

4) Presentation by Baker Tilly (formerly Moss Adams) on 2025 Audit Planning (Fiscal Impact: None) – STELIAN DAMU, ASHLEY MERDA, BAKER TILLY, HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Turnipseed: 3 Ayes; 1 Absent - Bowers

5) Report on Kern Health Systems investment portfolio for the third quarter ending September 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Turnipseed: 3 Ayes; 1 Absent - Bowers

NOTE: DIRECTOR BOWERS RETURNED TO THE DAIS AT 8:59 AM; AFTER THE VOTE ON ITEM 5

6) Proposed reinsurance policy with Partner RE to mitigate costs incurred by Kern Health Systems for members with high dollar inpatient admissions from January 1, 2026 through December 31, 2026 (Fiscal Impact: $5,900,000 estimated; Budgeted) – DAVE KALB, JENN DUNCAN, PARTNER RE, HEARD; APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Turnipseed: All Ayes

7) Proposed Kern Health Systems 2026 Operating and Capital Budgets (Fiscal Impact: None) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Watson: All Ayes

8) Proposed Budget Request for 2026 Project Consulting Professional Services, from January 1, 2026 through December 31, 2026 (Fiscal Impact: $7,800,010 Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Watson: All Ayes

9) Proposed Increase in the Not-to Exceed amount with Cognizant by $600,840 from $6,607,387 to $7,208,227 to adjust maintenance and support fees with Cognizant, reflecting corrected membership counts and ensuring accurate annual billing for the contract term from September 11, 2025, through September 10, 2029 (Fiscal Impact: $600,840 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Watson: All Ayes

10) Proposed Increase in the Not-to Exceed amount with Crowe by $300,000 from $1,585,000 to $1,885,000 for additional Implementation Costs, the Crowe Government Accelerator Software and Expense Management and Crowe Contract Manager modules relating to the new Accounting Enterprise Resource Planning System from January 1, 2026, through November 30, 2030 (Fiscal Impact: $300,000 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Bowers: All Ayes

11) Proposed New Agreement with DELL, with a Not-to-Exceed amount of $2,000,000 for the replacement of core server infrastructure with Dell hardware, enabling flexible scaling of compute and storage resources, for a three (3) year term from January 1, 2026 through December 31, 2029 (Fiscal Impact: $2,000,000 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Watson: All Ayes

12) Proposed New Agreement with Microsoft, with a Not-to-Exceed amount of $225,000 for Unified Support Services, which provide enterprise-wide access to Microsoft experts, proactive optimization, and rapid issue resolution to ensure reliability and maximize value across all Microsoft technologies, for a one (1) year term from January 1, 2026 through December 31, 2026 (Fiscal Impact: $225,000 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Turnipseed: All Ayes

13) Proposed Contract Extension with Zipari increasing the Not-to Exceed amount by $237,456 from $2,709,572 to $2,947,028 for the Member and Provider Portal for four (4) months from January 1, 2026, through April 30, 2026 (Fiscal Impact: $237,456 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Turnipseed: All Ayes

CA-14) Proposed Contract Extension with CitiusTech increasing the Not-to Exceed amount by $37,500 from $853,880 to $891,380 for FHIR licensing, software and support for three (3) months from December 18, 2025, through March 31, 2026 (Fiscal Impact: $37,500 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Watson: 3 Ayes; 1 Absent – Bowers

15) Report on Kern Health Systems financial statements for September 2025 and October 2025 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Turnipseed: All Ayes

16) Report on Tangible Net Equity and Liquidity Test as of September 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Turnipseed: All Ayes

17) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for September 2025 and October 2025 and IT Technology Consulting Resources for the period ended September 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Bowers: All Ayes

ADJOURN TO FRIDAY, FEBRUARY 13, 2026 AT 8:30 A.M.

KERN HEALTH SYSTEMS

COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***December 16, 2025***
CALL TO ORDER: ***7:17 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Cassandra Mulder – KC Public Health Satya Arya, MD - ENT. Danielle Colayco, PharmD – Komoto Pharmacy	Chan Park, MD – Vanguard Family Medicine Todd Jeffries – Bakersfield Community Healthcare Dr. James Miller, Quality Improvement Medical Officer	Rukiyah Polk - CAC Chair Maggie Vasquez – KC Public Health Traco Matthews – KHS Chief Health Equity Officer (Non-Voting)
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Philipp Melendez, MD – OB/GYN (A)	Allen Kennedy – Quality Team DME Martha Tasinga, KHS Chief Medical Officer	
Staff Present:	Adriana Salinas – Director of Community & Social Services Alma Garcia - NCQA Accreditation Specialist Anastasia Lester - Sr. Health Equity Analyst Ann StoryGarza - Assistant General Counsel Amy Sanders - Member Services Manger Aurora De La Torre – Quality Performance Manager	Maninder Khalsa - Medical Director Vanessa Nevarez – Health Equity Coordinator Steve Pocasangre – NCQA Accreditation Specialist Isabel Silva – Sr. Director of Wellness & Prevention Michelle Curioso – Director of Pop Health Management Nate Scott – Sr. Director of Member Services	Marilu Rodriguez – Sr. Health Equity Analyst Melinda Santiago - Director of Behavioral Health Magdee Hugais - Director of Quality Improvement Christine Pence – Senior Director of Health Services Greg Panero – Provider Network Program Manager Pawan Gill - Health Equity Manager Sukhpreet Sidhu – Pop Health Medical Director

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	7 of 11 committee members present; Allen Kennedy, Philipp Melendez, Debra Cox, and Martha Tasinga were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:17 am.	N/A	N/A
Public Presentation	There were no public presentations.	N/A	N/A

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • Danielle C. thanked Pawan G. for her support for the Komoto vaccine coloring books and added that there	• N/A	• N/A

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	are 9 languages available. • Magdee H. announced that the EQIHEC needs to fill two positions for 2026 and asked for recommendations for a Federally Qualified Health Provider (FQHC) and a Participating Primary Care Physician (PCP).	• N/A	• N/A
Committee Minutes	**Approval of Minutes** • CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes from September 23, 2025, for approval.	**Action:** • James M., Todd J. second. All aye's. Motion carried.	12/16/25
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** • CA-4) Health Equity Transformation Steering Committee (HETSC) Minutes from August 12, 2025. • CA-5) Behavioral Health Advisory Committee (BHAC) Minutes from July 16, 2025. • CA-6) Pharmacy Drug Utilization Review (DUR) Minutes from August 25, 2025. • CA-7) Physician Advisory Committee (PAC) Redacted Minutes from August 6, 2025. • CA-8) Physician Advisory Committee (PAC) Redacted Minutes from September 10, 2025. • CA-9) Population Health Management Committee (PHMC) Minutes from September 3, 2025. • CA-10) Utilization Management Committee (UMC) Minutes from August 13, 2025. • CA-11) Quality Improvement Workgroup (QIW) Minutes from September 11, 2025. • CA-12) Network Adequacy Committee (NAC) Minutes from July 25, 2025. • CA-13a) Wellness & Prevention (W&P) Q3 2025 Activities Report. • CA-13b) Cultural & Linguistics (C&L) Q3 2025 Activities Report. • A motion to approve Consent Agenda Items was requested.	**Action:** • Satya A. first, Todd J. second. All aye's. Motion carried.	12/16/25

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	14) Health Equity Transformation Steering Committee (HETSC) • Pawan G. provided an update of the following previously added work plan programs: the 2026 EPT (Equity and Practice Transformation) Payment Program, the Intimate Partner Violence Program, the Cervical Cancer Screening Program (for the Asian and Pacific Islander community), and the Chlamydia Screening Measure Interventions (for Hispanic and rural communities). She advised that no additional programs were added for 2025 and the 2026 work plan will be presented at the first meeting of next quarter. EPT Payment Program highlights include data exchange enhancements with the 12 practices. The practices are improving the capture and sharing of clinical data such as blood pressure, BMI, and visit scheduling; workflow improvements include pre-visit screenings, preventive care prompts, vitals capture, and behavioral health screening integration. The KHS Health Equity department continues to receive positive engagement from the 12 practices. Pawan G. also provided an update on the Q3 Regional Access Committee (RAC) on which the topic was transportation access. The key findings were low awareness of available transportation benefits, confusion about eligibility and how to schedule rides, access challenges in low-mobility or rural areas, and underutilization even among those aware of the benefit. Cassandra M. commented that Uber drivers may deny rides without car seats and that public health offers them for free. A motion to approve was requested. **15) Quality Improvement Workgroup (QIW)** • Magdee H. reintroduced the QIW for the new members of the EQIHEC. He outlined the department's core responsibilities; including maintaining the Quality Program Description, Annual Workplan, and Annual Evaluation; overseeing member safety through review of Quality of Care concerns, Potential Quality Issues,	Action: • Satya A. first, Chan P. second. All aye's. Motion carried. • Chan P. first, Satya A. second. All aye's. Motion carried.	12/16/25 12/16/25

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	and Provider Preventable Conditions; conducting clinical reviews for member and provider appeals; supporting NCQA accreditation and continuous compliance; and performing clinical network and delegate audits to ensure compliance with DHCS requirements, evidence-based standards, and KHS policies. The QIW is currently focusing on sampling IHA's, lead screening, and telehealth services. A motion to approve was requested. **16) Quality Performance (QP)** • Aurora D. presented the Q3 QP report including trending performance for MY2025 vs MY2024. Some key highlights included: •Purchased multiple lead screening machines for providers in rural regions. • 5 mobile unit providers deployed across Kern County. • Partnerships with more than 15 school districts. • Weekend and evening clinics with two local pediatricians. • Streamline member rewards for behavioral health and children's services. • Dedicated outreach team focused on children's health, specifically driven by need for annual well-care visits. Aurora D. also presented the QP site review updates. For 2025 YTD, 100% of the initial and periodic site reviews passed. Highlights included: • YTD there were 40 site reviews completed by early September 2025. • All site reviews completed timely and thoroughly for Q3 2025. • There are no open CAPs pending follow-up actions. • CMT participates in multiple statewide workgroups focused on updating CDPH training to supplement provider education of children's screenings. • Collaborating with PNM and Learning & Development to share with PCPs. • Traco M. asked for projections on expected performance and which measures may be difficult to meet. Aurora D. anticipates meeting approximately 12-	• Rukiyah P. first, Chan P. second. All aye's. Motion carried.	12/16/25

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	13 measures at minimum. She added that her personal goal is to meet 14 measures. The measures she identified as challenging are FUA, FUM, and WCV due to large denominators and have historical difficultly improving performance in these areas. Cassandra M. expressed appreciation to Aurora D. for her ongoing support and collaboration with the Childhood Lead Poisoning Prevention Program and highlighted the favorable outcomes of the partnership such as improved communication and engagement with providers, access to data and statistics to better target outreach efforts, and increased provider contacts and inquiries regarding affected children. The partnership is highly effective and valuable, with strong communication and coordination supporting improved care and outreach. A motion to approve was requested. **17) Behavioral Health Advisory Committee (BHAC)** • Melinda S. provided a quick overview of the BHAC and shared Q3 updates. The subcommittee focuses on quality monitoring and performance, clinical guidelines and innovation, care coordination and integration, member experience and engagement, and governance and compliance. Q3 accomplishments and initiatives include the completion of audit tool development, enhanced reporting and tracking processes, expansion of Behavioral Health Treatment services, and finalization of policies and procedures. Melinda S. also shared that there are ongoing efforts to expand and strengthen the provider network. The department is actively working to clean and validate network data, confirm active providers, and address service gaps. A data exchange highlight includes their partnership with KBHRS (Kern Behavioral Health & Recovery Services) that is nearing go-live after a three-year development effort. Final testing is underway and the key benefits would include real-time enrollment visibility, improved coordination between medical and behavioral health providers, and enhanced whole-person car planning. This current shift in focus is to	• Todd J. first, Maggie V. second. All aye's. Motion carried.	12/16/25

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	support ABA (Applied Behavioral Analysis) program needs which allow CHWs (Community Health Workers) to reallocate efforts to higher-need areas and hard-to-reach populations. The departments are seeing a continued growth in non-specialty behavioral health enrollment. Melinda S. shared the new behavioral health features of the provider portal which include behavioral health conditions, utilization patterns, gaps in care, assigned providers/teams, and records and coordination tools which align with NCQA care integration standards. A motion to approve was requested. **18) Population Health Management (PHM)** • Michelle C. shared that PHM submitted three initiatives that demonstrate a holistic, integrated approach to address complex needs of underserved and vulnerable members. The initiatives are the PCCP (Palliative Care Coordination Program), the High Resource Utilizer Initiative, and the Birthing Care Pathway. The PCCP was presented as a best practice at the Coalition for Compassionate Care of California (CCCC) Annual Summit. The PCCP consists of trained social workers that initiate conversations about palliative care, educate members, and support symptom management and quality of life. A one-year program evaluation showed a 15% reduction in emergency department visits. The next evaluation phase will assess inpatient admissions, urgent care, and outpatient utilization. The High Resource Utilizer Initiative consists of weekly interdisciplinary care team meetings that include physicians, nurses, pharmacy, social workers, behavioral health, and other specialists. The meeting reviews consist of medical complexity, family supports, housing stability, and care readiness and connects members to ECM (Enhanced Care Management), CCM (Complex Care Management), BH, Palliative Care, and Community Services. The third, and final, initiative is the Birthing Care Pathway which is a DHCS requirement for health plans that	• Todd J. first, Satya A. second. All aye's. Motion carried.	12/16/25

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	aims to address high maternal and infant morbidity/mortality rates statewide. Todd J. shared the positive and effective collaboration between palliative care and hospice services. He stressed the importance of the program and thanked Michelle C. and her team for doing a great job. Michelle C. added that she would like to strengthen her collaboration with public health to leverage their maternal, child, and adolescent health programs to avoid duplication of services. A motion to approve was requested. • Satya A. left the meeting at 8:20am. **19) Utilization Management (UM)** • Dr. Khalsa presented the Q3 UM report and emphasized the departments focus on directing care to the most appropriate provider or setting to improve outcomes and reduce unnecessary cost. Timeliness remains strong with performance near 99% compliance. There is a slight increase in referrals due to expanded review of community supports applications and medically tailored meals requests. The UM audit and compliance review showed improvements in mailing notifications within two days of a decision and referral processing accuracy. The ongoing focus is reducing missing criteria documentation. A policy update was provided and showed that 29 new DSNP policies were approved to support the new Medicare-Medi-Cal (DSNP) line of business. Policies will be available upon request and posted online. Traco M. acknowledged the team' strong performance and significant policy work this quarter and praised UM presentations that clearly state key objectives and clearly track progress and outcomes. A motion to approve was requested. **20) Network Adequacy Committee (NAC)** • Greg P. shared Q3 provider network management activities and network adequacy performance whose	• Chan P. first, Cassandra M. second. All aye's. Motion carried. • Danielle C. first, Rukiyah P. second. All aye's. Motion carried.	12/16/25 12/16/25

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	responsibilities include establishing network standards, monitoring network compliance, promoting health equity, and steering continuous improvement initiatives. His review included the after-hours survey results, provider accessibility monitoring survey, access grievance review, geographic accessibility and DHCS network certification, network adequacy and provider counts, and recent network provider reporting.
	• After-Hours Survey:
	  ○ 149 PCP Offices Contacted
	  ○ 145 Compliant with Emergency Access Standards
	  ○ 143 Compliant with Urgent Care Access Standards
	  ○ 3% Non-Compliant for Emergency Access Standards
	  ○ 4% Non-Compliant for Urgent Access Standards
	  ○ All non-compliant providers received outreach letters and direct plan follow-up to correct messaging/answering services
	  ○ Outreach has been successful
	• Provider Accessibility Monitoring Survey:
	  ○ Random sample of PCPs, Non-Physician Mental Health, Ancillary, OB/GYN providers addressed for appointment availability
	  ○ Plan-wide compliance achieved for all urgent and non-urgent regulatory standards
	• Provider Accessibility Monitoring Survey by Region:
	  ○ Southern region below 80% non-urgent compliance
	  ○ Eastern and Central regions improved to above 80% compliance this quarter
	  ○ Identified challenges with rural provider availability and repeat sampling
	  ○ Plan will update sampling methodology to better represent the network
	• Access Grievance Review:
	  ○ Overall grievances declined from previous quarter
	  ○ Grievances per 1,000 members decreased		

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	○ Slight decline grievances resolved in favor of members ○ Most common grievance types: timely access, technology issues, provider availability ○ Continued travel challenges for desert-area members noted, though overall grievances decreased • Geographic Accessibility & DHCS Network Certification: ○ Under review ○ Approved in Q3 ○ Further discussion scheduled for next quarter • Network Adequacy & Provider Counts: ○ PCP count, including both mid-level and physicians, continues to grow ○ Total Specialists Count: 3,612 ○ Increased mental health providers which consist of LCSWs, MFTs, and psychologists • Maggie V. asked where doulas are counted in the provider counts. Greg P. responded that doulas are not counted but can be. He added that they are a new provider benefit and it would be beneficial to see; they will be in the next report. A motion to approve was requested. **21) Member Services** **a) Operation Board Update- Grievance Report** • Amy S. presented the grievance trends that were identified in the 3rd quarter when compared to the previous four quarters. The overall volume of grievance and appeals increased 13.6% in the second quarter and there was also an increase in appeals of 43% from the previous quarter which can be attributed to changes in the criteria for several Community Support Services (CSS) benefits and Applied Behavioral Analysis (ABA) therapy services. After a comprehensive evaluation of CSS, the analysis identified a less-than-favorable return on investment. In response,	• Danielle C. first, Chan P. second. All aye's. Motion carried.	12/16/25

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	KHS implemented additional oversight for the Medically Tailored Meals (MTM) program to better align the service with DHCS eligibility requirements. The refinements ensure that only members with medically sensitive conditions are approved for the benefit. KHS anticipated an increase in grievances from members who are no longer qualified under the updated criteria and additional oversight. After a comprehensive evaluation of ABA, the analysis identified possible overuse of the services. Most of the records in the sample analysis did not meet medical necessity. To prevent overuse and establish a process, KHS partnered with AllMed, an organization with trained providers who review ABA services for other health plans in California. Amy S. also shared that the volume of exempt grievances increased as well, up 9.5% from the previous quarter, which can be attributed to the changes in scheduling criteria for transportation. It is taking time for members to get used to the new criteria and scheduling time. A motion to approve was requested. **21) Member Services** **b) Grievance Summary Report** • Amy S. presented the Grievance Summary Report which gives a more in-depth look at data than the Operational Board Report. Amy S. shared that 4,024 were received during Q3 with Access to Care Grievances at 22.3%, Quality of Service Grievances at 19.5%, and Quality of Care Grievances at 14.6%. Standard Grievances were at 73% (resolved within 30 days) and Exempt Grievances were at 27% (resolved within one business day). Resolution Outcomes closed in favor of the enrollee were at 44.26%, closed in	• Cassandra M. first, Danielle C. second, All aye's. Motion carried.	12/16/25

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	favor of the plan or provider at 55.02%, and remained open at time of reporting at .72%. A motion to approve was requested. **22) Wellness & Prevention** • Isabel S. provided a Q3 update on activities and outcomes supporting the W&P department roadmap goals, with emphasis on member engagement, preventative care, and community health initiatives. The key highlights and updates for member communications and outreach included their member newsletter, text message campaigns, and digital campaigns. • Member Newsletter: o 66,000 newsletters distributed o 3,500 large-font newsletters (English and Spanish) to support visually impaired members o First-ever newsletter digital distribution for members opted into SMS o 17,000 members received the newsletter digitally, reducing paper mailings o Fall issues, mailed mid-September, focused on pediatric preventative care, sick visits, member portal access, and Kern Regional Center resources • Test Message Campaigns: o Topics included immunizations, obesity, and health literacy o 46,000 texts sent o 10% click rate which is consistent with the national benchmark • Digital Campaigns (Facebook): o Pediatric immunization post at 5.6% engagement o Well-child visit post at 5.4% engagement o Pain management/fibromyalgia post at 1.5% engagement (intended for a targeted audience) o Engagement rate exceeds the 1% benchmark which indicates a strong community interest	• Chan P. first, Danielle C. second. All aye's. Motion carried.	12/16/25

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	• Isabel S. also shared updates of their partnerships with Kick It California for nicotine replacement therapy and the Motherhood Project for a postpartum support group.
	• Kick It California:
	  ○ 1,000 members referred
	  ○ 1,000 outreach attempts
	  ○ 14 members enrolled
	  ○ Challenges with cessation engagement were acknowledged
	• Postpartum Support Group:
	  ○ 12 members participated
	  ○ Weekly sessions for 6 weeks
	  ○ Topics included mindfulness and relaxation, maternal mental health, infant nutrition, wellness exams, and care seat safety
	  ○ Participants received diaper bags, resources, and educational materials
	• Isabel S. also shared updates for the following community health and wellness initiatives: the Comprehensive Obesity Management Program, the Live Better Program, Read Your Beats Kern, and a 2 Year School Wellness Grant.
	• Comprehensive Obesity Management Program:
	  ○ 20,000 referrals, 1,000 active participants
	  ○ Provider led obesity medicine training and medication management
	  ○ 250 members lost 5% body weight
	  ○ 200 members lost 10% body weight
	• Live Better Program:
	  ○ 4th site launched in Shafter
	  ○ 69 pilot participants
	  ○ Average of 11 visits per month
	• Read Your Beats Kern:
	  ○ Blood pressure (BP) self-monitoring stations located at Library & Learning Center and Beale library
	  ○ Utilization and BP data being tracked
	• School Wellness Grant:
	  ○ Serving 10 schools countywide
	  ○ Wasco Union High School and Clemens		

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	Elementary opened "Wellness Corners/Caring Closets" ○ Basic hygiene products include food, clothing, diapers, menstrual products and laundry services ○ Addresses students' and families' basic needs to support overall wellness • Rukiyah P. suggested that the department collaborate with her non-profit, Period Poverty. • Cassandra M. shared her involvement with a drinking and driving program that focuses on the importance of seat belt use. She asked if one of the department posts could be about seat belt use and drinking and driving causing a strain on the medical system. Isabel S. will investigate and advise. • A motion to approve was requested.		

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Next Meeting	The next meeting will be held on Tuesday, March 17, 2026, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:25am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	N/A	N/A

For Signature Only – EQIHEC Minutes 12/16/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

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