KERN HEALTH SYSTEMS

# REGULAR MEETING OF THE BOARD OF DIRECTORS

**Thursday, October 23, 2025**
**at**
**8:00 A.M.**

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

**The public is invited.**

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

# AGENDA

## BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
**2900 Buck Owens Boulevard**
Bakersfield, California 93308

**Regular Meeting**
**Thursday, October 23, 2025**

**8:00 A.M.**

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

**PLEASE SILENCE CELL PHONES AND OTHER ELECTRONIC DEVICES DURING THE MEETING.**

BOARD TO RECONVENE

Directors: Watson, Thygerson, Patel, Elliott, Acharya, Alva, Bowers, Hoffmann, Johnson, Ma, Meave, Singh, 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 August 14, 2025 (Fiscal Impact: None) –
APPROVE

4) Report on Kern Health Systems Nominating Committee Recommendations (Fiscal Impact: None) –
APPROVE

5) Report on Board Referral for Staff to review Legislative Sponsorship for Transitional Rent Requirement Exemption (Fiscal Impact: None) –
RECEIVE AND FILE

CA-6) Report on Kern Health Systems 2026-2028 Strategic Plan (Fiscal Impact: None) –
RECEIVE AND FILE

7) Proposed Memorandum of Understanding with Carelon Behavioral Health, Inc. to coordinate components of the California Children and Youth Behavioral Health Initiative (Fiscal Impact: Total contract not to exceed amount is unknown and dependent on the amount of claims received) -
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-8) Proposed Contract Extension with Edifecs increasing the Not-to-Exceed amount by $988,852 from $1,045,332 to $2,034,184 for the Electronic Data Interchange (EDI) platform to process a wide range of electronic transactions, including claims, laboratory data, pharmacy records, and eligibility files, for a three (3) year term from December 20, 2025 through December 19, 2028 (Fiscal Impact: $988,852 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-9) Proposed Increase in the Not-to-Exceed amount with ZeOmega by $72,313 from $3,918,001 to $3,990,314 for the True-Up of the higher than expected additional member population being managed in Jiva that is above the current contracted amount from November 12, 2024, through November 11, 2025 (Fiscal Impact: $72,313 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-10) Proposed Contract Extension with TriZetto Provider Solutions, LLC increasing the Not-to Exceed amount by $719,452, from an estimated $285,000 to $1,004,452 for the processing of standard electronic health care claims from September 6, 2025, through September 5, 2028 (Fiscal Impact: $719,452 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-11) Proposed Increase in the Not-to-Exceed amount with mPulse by $386,880 from $5,966,116 to $6,352,996 for enhancing the texting Program Manager with two (2) Activators in the Provider and Member Portal for a three (3) year term from January 1, 2026, through December 31, 2028 (Fiscal Impact: $386,880 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-12) Proposed Increase in the Not-to-Exceed amount with Symplr by $197,077 from $157,672 to $354,749 for year 3 of a 3-year subscription to the Hayes Knowledge Center from August 1, 2024, through July 31, 2027 and years 2 and 3 of a 3-year term of the licensing agreement for the KHS Network Provider credentialing system migration from on-premises to the Symplr cloud solution from June 3, 2025, through July 31, 2027 (Fiscal Impact: $197,077 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-13) Proposed New Agreement with Zelis Healthcare, LLC, with a Not-to-Exceed amount of $1,950,000 ($123,959 for D-SNP and $1,826,041 for Medi-Cal), for the migration of services for electronic payment processing from on-premises to the cloud version, and also adding provider payment services for D-SNP, for a three (3) year term from December 20, 2025 through December 19, 2028 (Fiscal Impact: $1,950,000 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

14) Proposed New Agreement with Helpcare AI, with a Not-to-Exceed amount of $1,480,000 for an Artificial Intelligence calling agent for member outreach, for a one (1) year term from October 24, 2025 through October 23,2026 (Fiscal Impact: $1,480,000 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-15) Proposed Increase in the Not-to-Exceed amount with Carenet Health by $200,000 from $1,495,200 to $1,695,200 for 24/7/365 Nurse Triage Services for the remaining term of the contract through November 1, 2025 (Fiscal Impact: $200,000 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-16) Proposed New Agreement with Carenet Health, with a Not-to-Exceed amount of $1,671,600 for 24/7/365 Nurse Triage Services, for a three (3) year term from November 2, 2025 through November 1, 2028 (Fiscal Impact: $1,671,600 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

17) Report on Kern Health Systems financial statements for July 2025 and August 2025 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-18) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for July 2025 and August 2025 and IT Technology Consulting Resources for the period ended July 31, 2025 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-19) 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-20) Proposed revisions to policy and procedure – QP 23.06-P, 23.10-P, 23.23-P, 23.09-P, 23.14-P, 23.22-I, New P&P Monitoring Provider Exclusions (Medicare) and Quality Improvement 2.70-I Potential Quality Issue (Fiscal Impact: None) –
APPROVE

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

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

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

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

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

CA-26) Miscellaneous Documents – RECEIVE AND FILE

A) Minutes for Kern Health Systems Fraud, Waste, and Abuse (FWA) Committee meeting on August 4, 2025
B) Minutes for Kern Health Systems Physician Advisory Committee meeting on August 6, 2025
C) Minutes for Kern Health Systems Finance Committee meeting on August 8, 2025
D) Minutes for Kern Health Systems Utilization Management Committee meeting on August 13, 2025
E) Minutes for Kern Health Systems Drug Utilization Review Committee meeting on August 25, 2025
F) Minutes for Kern Health Systems Physician Advisory Committee meeting on September 10, 2025
G) Minutes for Kern Health Systems Compliance Committee meeting on September 19, 2025
H) Minutes for Kern Health Systems Community Advisory Committee meeting on September 23, 2025
I) Minutes for Kern Health Systems Executive Quality Improvement Health Equity Committee Meeting on September 23, 2025
J) Minutes for Kern Health Systems Governance and Compliance Committee meeting on September 25, 2025
K) Minutes for Kern Health Systems 2025 Delegated Entity Oversight Committee meeting on October 1, 2025

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

28) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
(Government Code § 54956.9 (e)(3).) Number of cases: six (6)
Significant exposure to litigation in the opinion of the Board of Directors on the advice of legal counsel, based on the receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection.

29) CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION
(Government Code § 54956.9 (d) (1) and (g))
Name of case: *Michelle Oxford v. Kern Health Systems*, BCV-24-101473

30) CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION
(Government Code § 54956.9 (d) (1) and (g))
Name of case: *Aliya Varela v. Kern Health Systems*, BCV-24-100659

31) CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION
(Government Code § 54956.9 (d) (1) and (g))
Name of case: *Keck Medical Center of USC, Inc. dba Keck Hospital of USC, et al. v. Kern Health Systems et al.*, JAMS Ref No. 5220002483

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

ADJOURN TO DECEMBER 18, 2025 AT 8:00 A.M.

**AMERICANS WITH DISABILITIES ACT**
**(Government Code Section 54953.2)**

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

# SUMMARY

## BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
**2900 Buck Owens Boulevard**
Bakersfield, California 93308

**Regular Meeting**
**Thursday, August 14, 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 – Acharya, Bowers, Meave, Singh, Tamsi

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

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

BOARD ACTION SHOWN IN CAPS

ADJOURNED TO CLOSED SESSION

NOTE: DIRECTOR MEAVE ARRIVED DURING THE CLOSED SESSION

NOTE: DIRECTOR SINGH ARRIVED DURING THE CLOSED SESSION

NOTE: DIRECTOR MEAVE ARRIVED DURING THE CLOSED SESSION

CLOSED SESSION

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

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

8:30 A.M.

BOARD RECONVENED

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

Item No. 1 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **INITIAL CREDENTIALING FOR AUGUST 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 BOWEN, LUCIO, SHEN, MOIR; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON BARNES; DIRECTOR MEAVE ABSTAINED FROM VOTING ON ZAMORA; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON JHON, OTA, ZAMORA
Item No. 1 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **RECREDENTIALING FOR AUGUST 2025** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON CROSBY, POPA, SCHLAERTH, ABUHAMAD, ADVENTIST HEALTH DELANO D/P SNF, HUYNH, LEUNG, MITCHELL; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON MYERS, ROSALES, SAITO; DIRECTOR MEAVE ABSTAINED FROM VOTING ON BAINS, DE JESUS, MYERS, ROSDALES, SAITO; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON BAINS, HUYNH, IRANI, TRACY

Item No. 2 concerning a CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION (Government Code § 54956.9 (d)(2).) Number of cases: 1
Significant exposure to litigation in the opinion of the Board of Directors on the advice of legal counsel, based on the receipt of a claim pursuant to the Government Claims Act or some other written communication from a potential plaintiff threatening litigation, which non-exempt claim or communication is available for public inspection. (Government Code § 54956.9 (e) (3).) – HEARD; GENERAL COUNSEL REPORTED THAT THE BOARD MET IN CLOSED SESSION TO DISCUSS THE CLAIM OF A FORMER EMPLOYEE REGARDING IMPROPER TERMINATION AND REPORTED THAT THE BOARD APPROVED THE SETTLEMENT AMOUNT

PUBLIC PRESENTATIONS

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

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

DIRECTOR WATSON REPORTED THAT THE NOMINATING COMMITTEE WILL RECONVENE TO REVIEW THE CURRENT OFFICER ROSTER AND DISCUSS AND DEVELOP A SLATE OF OFFICERS; DIRECTOR WATSON ALSO ANNOUNCED THAT SHE ALONG WITH EMILY DURAN AND TROY SZABO, GENERAL COUNSEL WILL BE VISTING COUNTY OFFICIALS

DEPARTMENTAL MATTERS

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on June 19, 2025 (Fiscal Impact: None) – APPROVED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

6) Appreciation recognition of Timothy McGlew for 12 years of dedicated service as a member of the Kern Health Systems Board of Directors (Fiscal Impact: None) – RECEIVED AND FILED
**Elliott-Hoffmann: 12 Ayes; 2 Absent – Acharya, Bowers**

7) Report on National Committee for Quality Assurance (NCQA) (Fiscal Impact: None) – RECEIVED AND FILED
**Meave-Tamsi: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-8) Report on Kern Health Systems Provider Network Capacity Study (Fiscal Impact: None) – RECEIVED AND FILED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-9) Report on Kern Health Systems investment portfolio for the second quarter ending June 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-10) Proposed renewal and binding of insurance coverages for Primary and Excess General Liability from September 29, 2024 through September 29, 2026, Employed Lawyers Professional Liability Insurance from August 15, 2025 through August 15, 2026 and Earthquake Insurance from October 15, 2025 through October 15, 2026 (Fiscal Impact: $950,000 Estimated; Budgeted) – APPROVED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-11) Proposed Contract Extension and Retroactive Approval with the Periscope Group increasing the current Not-to Exceed amount by $569,910, which includes a retroactive amount of $99,000 and $470,910 for the two (2) year extension, from $304,650 to $874,560 to perform in-home functional mobility need assessments for KHS' members from September 5, 2025, through September 4, 2027 (Fiscal Impact $569,910 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-12) Proposed increase in the Not-to Exceed amount with Cognizant by $250,000 from $6,607,387 to $6,857,387 for processing claims and integrating authorization data using the Health Process Automation (HPA) tool from September 11, 2025, through September 10, 2026 (Fiscal Impact $250,000 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-13) Proposed increase in the Not-to Exceed amount with CommGap by $198,558 from $190,000 to $388,558 for in-person interpreting services from August 14, 2025, through July 5, 2026 (Fiscal Impact $198,558 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

14) Report on Kern Health Systems financial statements for May 2025 and June 2025 (Fiscal Impact: None) – RECEIVED AND FILED
**Tamsi-Singh: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-15) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for May 2025 and June 2025 and IT Technology Consulting Resources for the period ended May 31, 2025 (Fiscal Impact: None) – RECEIVED AND FILED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-16) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

NOTE: DIRECTOR BOWERS ARRIVED AT 9:27 AM; DURING THE DISCUSSION OF ITEM 17

17) Report on 2025 Great Place to Work Trust Index Survey (Fiscal Impact: None) – RECEIVED AND FILED
**Elliott-Patel: 13 Ayes; 1 Absent – Acharya**

CA-18) Kern Health Systems Chief Health Equity Officer report (Fiscal Impact: None) – RECEIVED AND FILED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

CA-19) Kern Health Systems Chief Compliance and Fraud Prevention Officer report (Fiscal Impact: None) – RECEIVED AND FILED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

20) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) – RECEIVED AND FILED
**Meave-Patel: 13 Ayes; 1 Absent – Acharya**

21) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) – RECEIVED AND FILED
**Bowers-Hoffmann: 13 Ayes; 1 Absent – Acharya**

CA-22) Miscellaneous Documents – RECEIVED AND FILED
**Thygerson-Patel: 12 Ayes; 2 Absent – Acharya, Bowers**

A) Minutes for Kern Health Systems Utilization Management Committee meeting on May 14, 2025
B) Minutes for Kern Health Systems Drug Utilization Review Committee meeting on May 19, 2025
C) Minutes for Kern Health Systems Physician Advisory Committee meeting on June 4, 2024
D) Minutes for Kern Health Systems Finance Committee meeting on June 13, 2025
E) Minutes for Kern Health Systems Executive Quality Improvement Health Equity Committee Meeting on June 17, 2025
F) Minutes for Kern Health Systems Community Advisory Committee meeting on June 24, 2025
G) Minutes for Kern Health Systems Delegation Oversight Committee meeting on July 1, 2025

ADJOURN TO OCTOBER 23, 2025 AT 8:00 A.M.

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

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Kristen Watson, Chairman

**SUBJECT:** Report on Nominating Committee Recommendations

**DATE:** October 23, 2025

The KHS bylaws allow all officers to serve a term not to exceed three (3) years in their respective positions. The Chairman, Vice Chairman, and Secretary's terms have expired, and new officers will need to be elected at the October meeting and seated at the December Board meeting.

At the KHS Board of Director's meeting on August 14th, I announced that the Nominating Committee will reconvene to review the current officer roster and to develop a recommended slate of officers. The Nominating Committee met on September 10th and determined that a call for nominations to the full board would be appropriate. Following is the list of members whom were nominated to serve:

***Chair***
Michael Bowers
Ross Elliott
Scott Thygerson

***Vice Chair***
Kimberly Hoffmann
Michael Turnipseed
Olga Meave
Russell Johnson
Scott Thygerson
Vijaykumar Patel

***Secretary***
Jay Tamsi
Kimberly Hoffmann
Olga Meave
Sarabjeet Singh
Vijaykumar Patel

***An official ballot is attached for you to cast your vote for your choice to serve. Please complete and return it to the Board Clerk for tabulation. A recommended slate of officers will be presented to this Board for approval.***

**Requested Action**

Approve the recommended slate of officer to be seated at the December 18th board meeting.

KERN HEALTH SYSTEMS

**OFFICIAL BALLOT**
KHS BOARD OF DIRECTORS
(To ensure confidentiality, do NOT sign this ballot)

**Choose one for each position:**

***Chair***
____Michael Bowers
____Ross Elliott
____Scott Thygerson

***Vice Chair***
____Kimberly Hoffmann
____Michael Turnipseed
____Olga Meave
____Russell Johnson
____Scott Thygerson
____Vijaykumar Patel

***Secretary***
____Jay Tamsi
____Kimberly Hoffmann
____Olga Meave
____Sarabjeet Singh
____Vijaykumar Patel

***Please complete and return it to the Board Clerk.***

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Emily Duran, Chief Executive Officer

**SUBJECT:** Board Referral for Staff to review Legislative Sponsorship for Transitional Rent Requirement Exemption

**DATE:** October 23, 2025

## Background

Transitional Rent is the newest Community Support and covers up to six months of rental assistance for permanent or temporary housing to Medi-Cal Members who are experiencing or at risk of homelessness and meet eligibility criteria. Transitional Rent will be optional for Medi-Cal managed care plans (MCPs) to offer beginning on July 1, 2025. Beginning on January 1, 2026, however, MCPs must cover Transitional Rent for qualifying Members. Department of Health Care Services (DHCS) will make payments to MCPs for Transitional Rent, which are separate from, and in addition to, usual capitation payments. These separate payments are intended to cover the cost of rental assistance or temporary housing as well as MCP administration of the new Transitional Rent service.

In addition, DHCS expects Health Plans and County Behavioral Health Departments to collaborate to ensure that members who are receiving Transitional Rent and are also eligible for Behavioral Health Services Administration (BHSA) housing interventions, are seamlessly transitioned to BHSA Housing Interventions. In this model, the health plan will be responsible for covering the first six months of rent through the Transitional Rent program, and the County Behavioral Health Department will take over coverage for the remaining needs under the BHSA Housing Interventions. The full requirements for Transitional Rent are laid out in DHCS' Community Supports Policy Guide (pg. 57).

At a recent Kern Health Systems (KHS) Board of Directors meeting, it was requested to have Staff review the possibility of legislative exemption from these requirements. In follow up to that referral, Staff has provided the following summary information:

## Current Environment and Political Considerations

Upon receiving the referral from the KHS Board of Directors, KHS' Government Relations staff proceeded to meet with our Trade Associations and their lobbyists to ascertain the feasibility of legislative exemption. Based on those conversations, below is a summary of considerations:

**Timing**: At the time of the referral, the legislative session had nearly concluded, making it impractical to pursue any new legislation for exemption from the Transitional Rent requirement. The implementation of Transitional Rent is still set for January 1, 2026, and seeking legislative change at this stage would not be feasible.

**Gathering Support:** For any proposed legislation to progress in future sessions, it necessitates bipartisan support, including buy-in from legislators across party lines. The Transitional Rent initiative remains a priority for the current administration and is supported by DHCS, emphasizing the importance of collaboration rather than opposition.

**Potential Exposure:** Attempting to introduce legislation could inadvertently jeopardize Kern Family Health Care, exposing it to potential backlash from both the department and the Governor's office. There is no clear path to halt the initiative before its launch, and our best strategy is to align with the current policies and requirements.

**Advocacy Efforts**

I believe it is prudent to share with the Board our ongoing advocacy efforts related to Transitional Rent. We have remained actively engaged with DHCS, participating in the Transitional Rent Workgroup and dedicating significant hours to discussions about the rollout. Our feedback has focused on key areas, including.

- Timeline of rollout
- Sustainability of the program
- Appropriate payment models
- Effective utilization controls
- Tactical implementation considerations

Furthermore, we are actively collaborating with our County Behavioral Health Department on developing a flex pool model for housing, which will allow us to contract with them to provide all of our Transitional Rent services to the population. This partnership is intended to enhance service delivery and better meet the needs of those we serve.

Additionally, we are collaborating closely with the County Behavioral Health Directors Association (CBHDA) to further understand county-level concerns and our interactions with the BHSA. These actions reflect our commitment to ensuring the program is designed thoughtfully and aligns with the cost-effectiveness expectations of the Centers for Medicare & Medicaid Services (CMS).

For further reference, I have attached our comment letter from March 2025, which outlines our continued advocacy efforts. While it provides insights into specific policies, it highlights the comprehensive nature of our engagement.

In conclusion, it is not recommended to pursue legislation for exemption at this time, and rather to continue to adopt a collaborative strategy with our local partners to ensure practical implementation of the program seems most beneficial. The strategy would enable us to comply with the new policy without excessive expenditure of time, resources, or funds, ultimately achieving our intended outcomes within the established framework.

Thank you for your attention to this important matter. I look forward to discussing this further during our next board meeting.

**Requested Action**

Receive and file.

**Transitional Rent Feedback (as proposed 3/5/25)**
**3/7/25**

We thank DHCS for the ongoing dialogue and robust stakeholder engagement on Transitional Rent; through the various iterations of proposed policy, it is clear the Department is being responsive to feedback. LHPC has been working with our members to coalesce around priority policies and this feedback is reflective of the proposed policies presented during the February 5th MCP Workgroup, February 27th MCP-County Behavioral Health Workgroup, and March 5th MCP Workgroup meetings. Our ultimate goal is to ensure that this initiative is sustainable and results in better outcomes for members.

**Payment Model**

LHPC and local plans are requesting clarity as to how DHCS intends to operationalize and separate the transitional rent payment and administrative payment. In the meeting on March 5th, DHCS clarified that the transitional rent payment for a member would be tied to the zip code that they are housed in but the administrative payment would be tied to the county in which the member is enrolled with the plan. How does DHCS intend to separate and pay for these separately when the administrative payment is tied to the zip code for the transitional rent payment?

*Administrative Rates*

DHCS provided clarity on their intent to provide plans transitional rent administrative rates publicly. Plans were vocal that there are concerns with posting these rates publicly as it has not been the norm for DHCS to post plans administrative rates. If DHCS is going to move forward with posting the rates publicly, LHPC is requesting that DHCS has a clear message, both in writing and in public transitional rent forums, that clarifies those administrative rates are inclusive of both the plans and providers and that those rates are not intended to be fully passed on to the transitional rent providers.

**Permanent vs Interim Settings**

LHPC strongly recommends that the Department prioritize permanent placement for the initial roll-out of Transitional Rent. We support that the program has been deliberately built to incentivize permanent setting placement. This is aligned with what we are hearing on the ground in terms of need and is also most advantageous to member outcomes.

*Permanent Settings*

To ensure plans and their Transitional Rent providers have flexibility when negotiating with landlords, we recommend that DHCS allow month to month leases for the purposes of defining permanent settings. Putting term requirements on the lease may create a barrier in getting members placed, particularly those settings that cross both interim and permanent settings.

*Interim Settings*
While directionally, we agree with the approach for specialized policies for interim settings, these policies need significant additional consideration. We recommend DHCS pause roll-out of interim settings to focus on refining the other key policies.

Interim Settings: In-Person Visits
The current proposal states that MCPs must ensure weekly in-person visits via ECM Providers are provided for members in interim settings. We agree that members in interim settings should be connected to supportive services, but there are a number of considerations that need to be fleshed out on this proposed policy.

Provision of transitional rent cannot be conditioned on participation in ECM or Community Supports; so, it is not appropriate for the Department to require MCPs ensure weekly in-person visits are occurring via the ECM Provider. Member choice is acknowledged in the proposal, but the policy does not align with truly allowing members to opt-out of ECM. We recommend the Department leverage the existing trusted relationship—whether that is with the plan ECM/CS provider, Transitional Rent Provider or County staff.

It is not possible, under the current case loads, for ECM providers to make weekly in-person visits to these members. Additionally, it may not be necessary for each member in an interim setting to have that level of support and frequency. There should be a process to determine appropriate frequency. We also recommend the Department allow for member choice in determining whether in-person or telephonic touches are best for the member.

If DHCS moves forward with the weekly in-person requirement for ECM providers, there needs to be additional discussion about appropriate rates; highlighting that plans would need to renegotiate contracts under these terms.

We understand DHCS is finalizing guidance outlining distinct roles and interaction between Transitional Rent Providers, MCPs Housing Trio providers, ECM providers, and similar services provided by the counties. While doing that work, we recommend the Department consider how all of these different roles could play a part in providing the necessary support in interim settings and how the required Housing Support Plan can be leveraged to determine frequency of in-person visits.

Interim Settings: Special Authorization Requirements
LHPC is supportive of the approach to coordinate with County Behavioral Health Departments during the authorization process, however there are a host of operational issues to tease out first. Most notably, what is reasonable to expect in terms of turn-around times for authorizations? That is a question that both MCPs and County Behavioral Health Departments will need to provide input on before finalizing.

Flex Pool Alignment

We understand that, in at least one area with a significant unhoused population, the Flex Pool does not work with interim housing settings. We recommend DHCS analyze whether interim settings will create unintended barriers in leveraging Flex Pool models.

**Standardized Referrals and Authorization Process**

LHPC is supportive of DHCS' intention to develop statewide authorization and referral standards. It is critical that these policies are set from the outset of launch. Below we have provided responses and recommendations to DHCS' targeted questions:

*At what stage should the service be authorized for a member? Upon determining a member's eligibility or when a housing unit has been identified?*

Members should be authorized for services when housing has been identified and imminent. This will ensure alignment with other CS services. However, the additional requirements around interim settings may necessitate slightly different policies for interim settings.

*What should the referral standards contain?*

Member consent, clinical risk factors and the modified HUD definition of Homelessness. Additionally, referral standards should contain timeline and urgency protocols.

*How should DHCS ensure referral standards and data elements build on what's required under the ECM POF and other CS to minimize duplication and admin burden?*

Integrated communication through systems like HMIS to enable tracking and duplication of services.

**Presumptive Authorization**

We thank the Department for thorough consideration of our previous feedback related to presumptive authorization for counties and are pleased to see many of our key priorities reflected in the proposed policy, including: only available to county behavioral health departments that are contracted with the MCP, conditioned on commitment for BHSA to kick-in on month two in the event a member is ineligible to receive transitional rent, and conditioned on a commitment to coordinate BHSA housing interventions on month seven.

We recommend DHCS require counties that leverage presumptive authorization to pay for the first 30 days if a member is not actually eligible to receive Transitional Rent. It is critical that MCPs are not financially responsible for those first 30 days. From a member perspective, they would inappropriately lose a month of future Transitional Rent, STPHS or Recuperative Care. From an oversight perspective, these payments would not be deemed permissible under Medi-Cal.

**Right of First Refusal**

LHPC appreciates DHCS' responsiveness to prior feedback as reflected in the proposed policy. However, we have a few recommendations and requests for reconsideration.

***Naming***

Right of first refusal is a legal term of art that causes unnecessary confusion and implies counties have an exclusive right to contract with MCPs. We recommend DHCS consider renaming this policy "Contracting Expectations". The definition used in the proposal is simple to understand and clearly articulates that plans are required to offer contracts with all county behavioral health departments.

***Entity***

Contracts are executed at various levels depending on how a county is organized, for example some counties will contract at the County Health Agency level, as opposed to a specific Department level. To enable plans and counties to maintain existing contract management relationships, we request that the requirement be written as "MCPs will be required to extend a contract to all County Behavioral Health Departments, *or their designated county department or agency,* to serve as Transitional Rent Providers in the counties in which they operate."

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

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

**SUBJECT:** Report on KHS 2026-2028 Strategic Plan

**DATE:** October 23, 2025

## Background

In Q1 2025 Kern Health Systems (KHS) leadership began the process of developing the 2026-2028 KHS Strategy. This included work on a comprehensive landscape analysis with input from the KHS Board of Directors, Executives, and Senior Management. Then in April, a Board and Executive strategy session was held to begin shaping the 2026-2028 KHS Strategy. The outputs of that session were utilized in additional internal work efforts to refine the strategies and key outcomes. In June, management provided the Board of Directors with an update on the four key Strategic Goals and their desired outcomes.

Since June, management has undertaken further steps to identify Key Activities to support the upcoming Strategy. This includes items that will impact the 2026 KHS Budget and Project Portfolios as well as planning for future years. Attached is an overview of the Key Activities supporting the 2026-2028 KHS Strategy.

## Requested Action

Receive and file.

Kern Family Health Care™
The Friendly Face
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# Kern Health Systems 2026-2028 Strategic Planning

Board of Directors Meeting

October 23, 2025

# Background

- In Q1 2025 KHS conducted a comprehensive landscape analysis including input from the Board, Executives, and Senior Management.
- In April, a Board and Executive strategy session was held to begin shaping the 2026-2028 KHS strategy.
- Following the April session there was an internal work effort to further refine the strategies and key outcomes to directly support the strategy.
- At the June Board of Directors meeting, staff provided an update including the four key strategic goals and desired outcomes.
- The strategy is a foundational input into setting budgets, goals, and selecting projects for 2026.

# Core Components

- Four Chain-Linked Levers/Goals:
  - **Provider Network**: Develop, strengthen, and align our clinical partners so they see KHS as the faster-paying, lower-burden collaborator.
  - **Member (Patient) Engagement**: Activate KHS members into proactive co-managers of their own health through culturally competent and generationally-tuned engagement.
  - **Talent Agility**: Attract, grow and keep the high-performing people (or talent) who can operationalize policy into action.
  - **Financial Innovation & Responsibility**: Steward reserves, optimize the medical-loss ratio, and seed diverse revenue streams to finance the other three levers.

# Goal: Provider Network is Developed, Strengthened & Aligned

**Strategy:** We must keep the provider network adequate, and quality high so providers see KHS as the faster-paying, low-admin-burden, collaborative partner of choice.

## Examples of Key Activities to support this goal:

- Targeted and population-specific Quality Performance initiatives
- Provider network analytics monitoring optimization
- Targeted Provider Network maintenance and support
- Provider education and orientation enhancements
- Claims Dispute Workflow efficiencies
- Develop and implement High-Performing Provider benefits
- Claims system (QNXT) efficiencies for Claims Examiners
- Adoption of Health Information Exchange (Manifest Medex)
- Evaluate and modify services that require Prior Authorization
- Enhance Prior Auth processes to reduce admin burden

# Goal: Best-in-Class Member Engagement

**Strategy:** Utilize our trusted brand to steer behavior through incentives, personalized reminders, and culturally competent & generationally-tuned navigation.

## Examples of Key Activities to support this goal :

- Continue to deploy HelpCare AI for additional use-cases for member outreach
- Integration of DHCS' Medi-Cal CONNECT Risk Stratification, Segmentation & Tiering
- Phased deployment of Closed Loop Referrals
- Member Eligibility Redetermination Efforts
- Member Texting program improvements
- Chronic Condition Programs
- Complex Case Management program PCP engagement
- Open Authorizations workgroup and analytics
- Member Engagement Representatives Program
- Community-Based and Wellness Prevention Initiatives
- Culturally Responsive Initiatives
- Develop Customer Relationship Management (CRM) tool to improve service

# Goal: Talent Developed, Retained & Agile

**Strategy:** Win in a competitive talent landscape with a high-performing, high-trust culture where context is rich, freedom to act is paired with accountability to outcomes, and impact is rewarded.

**Examples of Key Activities to support this goal :**

- MIS work model transformation
- Enabling Technology enhancements including Artificial Intelligence and other automations
- Employee Key Performance Indicator development, standardization and reporting
- Develop talent-readiness profiles and succession plans
- Leadership Development & Learning Program Impact
- Human Resources Information System (HRIS) enhancements / modules
- Corporate Services cycle-time enhancements

# Goal: Financial Innovation & Responsibility

**Strategy:** We must steward reserves, optimize Medical Loss Ratio targets, and pilot D-SNP/other product lines that diversify cash while rewarding value over volume and aligning to KHS' mission.

**Examples of Key Activities to support this goal :**

- Continuous monitoring of Medical Loss Ratio to identify outliers and areas for intervention
- Develop and implement programs and pilots based on Medical Loss Ratio analysis
- Innovation in financial arrangements with providers and partners
- Implementation of D-SNP Operational enhancements after initial product launch
- Develop and oversee D-SNP STARS and Risk Adjustment Programs
- Conduct Annual Reserve Actuarial Analysis

# Next Steps

- This Strategy is driving 2026 departmental goals and objectives, project planning, and the budgeting process.
- Staff will continue to monitor impacts resulting from State and Federal changes. Activities to support these strategic goals will be evaluated and updated accordingly.
- Staff will develop a tracking document to monitor progress on Key Activities, including deliverables and due dates.
- Leadership will provide quarterly updates to the KHS Board of Directors beginning in 2026.

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Ann StoryGarza, Assistant General Counsel

**SUBJECT:** California Children and Youth Behavioral Health Initiative ("CYBHI")

**DATE:** October 23, 2025

## Background

The California Children and Youth Behavioral Health Initiative (CYBHI) is a state-led program aimed at improving behavioral health services for children, youth, and young adults enrolled in Medi-Cal. The initiative seeks to address challenges related to access, coordination, and quality of care by developing a more integrated behavioral health system tailored to the unique needs of younger populations. Managed Care Organizations (MCOs) are responsible for administering Medi-Cal benefits through managed care contracts, and are tasked with implementing the program's requirements, which include ensuring access to a broad array of behavioral health services for eligible children and youth. This involves coordinating with county behavioral health systems, providers, schools, and families to facilitate service delivery.

Under CYBHI, the Department of Health Care Services (DHCS) has introduced changes to reimbursement methodologies, including new fee schedules for behavioral health services that MCOs are required to incorporate. These adjustments necessitate operational updates by MCOs in claims processing, provider contracting, and compliance reporting. MCOs are also expected to participate in data sharing and care coordination efforts that support the goals of CYBHI, although the extent and specifics of their involvement can vary across regions.

## Discussion

The managed care plan will be required to participate in the CYBHI program and pay claims submitted by Carelon Behavioral Health, Inc., irrespective of whether a Memorandum of Understanding (MOU) is formally executed. This obligation is driven by state program requirements and the operational necessity to ensure continuity of behavioral health services for eligible members.

**Legal and Compliance Considerations**

While the Board should be aware of potential legal complexities associated with entering into the MOU, it is important to note that further negotiation with Carelon Behavioral Health, Inc., is unlikely at this stage. The Department of Health Care Services (DHCS) has set a required structure and timeline, limiting opportunities for substantive amendments, e.g., prohibits termination without cause and requires approval from DHCS to terminate only with cause and unilateral breach responsibility to KHS. Currently, claims from Carelon are being received that require payment; however, without an executed MOU, Kern Health Systems is unable to access certain essential information necessary for proper claims adjudication. This creates a risk of non-compliance and delayed provider payments if the MOU is not finalized.

**Financial Impact**

Total contract not to exceed amount is unknown and dependent on the amount of claims received.

**Requested Action**

Approve; Authorize Chief Executive Officer to sign and enter into the MOU with Carelon Behavioral Health, Inc, to coordinate components of the CYBHI program including claims processing and payment remittance to Providers under the terms specified in the MOU. The MOU has a term that is required by DHCS and shall run concurrently with the CYBHI Fee schedule program

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Cesar Delgado, Chief Information Officer

**SUBJECT:** Contract Extension with Edifecs for the Edifecs Electronic Data Interchange (EDI) Platform

**DATE:** October 23, 2025

## Background

Kern Health Systems (KHS) utilizes the Edifecs Electronic Data Interchange (EDI) platform to process a wide range of electronic transactions, including claims, laboratory data, pharmacy records, and eligibility files. Originally licensed in 2017, the core platform has supported the transformation of over twenty million transactions annually. The current agreement, effective from December 20, 2020 through December 19, 2025, is approaching its expiration date.

## Discussion

KHS is seeking to extend the current Edifecs Master License and Services Agreement (MSLA) which will accommodate a significant increase in transaction volume. Under the extended agreement, the Edifecs platform will support up to 25 million transactions per year over a three (3) year term. The extension will continue to provide licensing for the Enterprise EDI Management software, technical maintenance and support access for users, coverage for one production and two non-production environments, and connectivity with 150 trading partners. The Edifecs platform has proven to be a stable and efficient solution since its initial deployment, and its continued use is critical to sustaining current operations. Failure to enter into a new agreement would require KHS to identify and implement an alternative EDI solution, which would likely result in significantly higher costs and operational disruption.

## Financial Impact

Cost for a three (3) year extension not-to-exceed $988,852 in budgeted expenses.

## Requested Action

Approve; Authorize the CEO to amend and extend the contract, with legal approval, with Edifecs for the licensing, maintenance and support of the Electronic Data Interchange (EDI) platform for a three (3) year term from December 20, 2025 through December 19, 2028 and increase the not-to-exceed amount by $988,852 from $1,045,332 to $2,034,184 for the entire term of the contract.

Docusign Envelope ID: A2017220-70DA-413D-8490-5B1E70E19EA3

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

Department Name: MIS

Department Head: Cesar Delgado

Vendor Name: Edifecs

Contact Name & Email Address: Mitch Baum, mitch.baum@edifecs.com

| **Description of Contract** | |
|---|---|
| Type of Agreement:<br>☐ New agreement<br>☒ Amendment No. 2<br>☐ Memorandum of Understanding ("MOU") | Background:<br>Kern Health Systems (KHS) has relied on the Edifecs Electronic Data Interchange (EDI) platform since 2017 to process a broad spectrum of electronic transactions, including claims, laboratory data, pharmacy records, and eligibility files. The platform has enabled the transformation of over twenty million transactions annually, supporting the organization's operational efficiency and stability. With the current agreement set to expire on December 19, 2025, KHS is seeking to extend its partnership with Edifecs to accommodate a significant increase in transaction volume and to ensure continuity in its critical data processing functions. The Edifecs platform has consistently proven to be a reliable and effective solution, and its continued use is essential for sustaining current operations. Transitioning to an alternative EDI solution would likely result in higher costs and considerable operational disruption for KHS.<br><br>Brief Explanation of Services to be Provided:<br>Under the extension, Edifecs will continue to provide licensing for the Enterprise EDI Management software, along with ongoing technical maintenance and support. The platform will support up to 25 million transactions per year over the three-year agreement. Services include user access for KHS staff, coverage for one production and two non-production environments, and connectivity with 150 trading partners. These provisions are designed to ensure that KHS can continue to efficiently process its growing volume of electronic transactions while maintaining the high standards of reliability and performance established by Edifecs since its initial deployment. |

☐ 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:

Edifecs is deeply embedded in Kern Health Systems (KHS) operations. Switching vendors would cause significant operational disruption and increased costs, making Edifecs the only practical choice for continued service.

☐ Board of Directors Approval Required

☐ Regulatory Approval Required

☐ Retroactive Agreement

**Exhibits Required:**

Docusign Envelope ID: A2017220-70DA-413D-8490-5B1E70E19EA3

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

Other Exhibits required:

| Fiscal Impact | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: 225 GL# 5402

Maximum Cost of Agreement not to exceed: $988,852

Note:

**Contract Terms and Conditions**

Effective date: 12/20/2025 Termination date: 12/19/2028

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: A2017220-70DA-413D-8490-5B1E70E19EA3

| Approvals | |
|---|---|
| **Contract Owner:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Department Head<br>Date: 10/6/2025 | **Approved as to Form:**<br>KHS Legal Counsel<br>Date: |
| **Compliance DMHC/DHCS Review:**<br>DocuSigned by:<br>Deborah Murr<br>BD08CF3F87CF4C4...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/6/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/6/2025 |
| **Reviewed as to Budget:**<br>Chief Financial Officer or Controller<br>Date: | **IT Approval:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Chief Information Officer or IT Director<br>Date: 10/6/2025 |
| Chief Executive Officer<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| KHS Board Chairman<br>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 ZeOmega for True-Up Costs

**DATE:** October 23, 2025

## Background

Kern Health Systems (KHS) entered into a five-year agreement with ZeOmega, Inc. for the JIVA Medical Management Platform, effective November 13, 2022 through November 12, 2027. The platform supports clinical, behavioral, and social service workflows and integrates with KHS' core claims system, QNXT.

The agreement includes tiered pricing based on the number of members managed within the platform. The contracted base population is 365,000 members, with provisions for annual true-up adjustments if the actual member count exceeds this threshold. ZeOmega reviews the member population each year and bills accordingly at the contract anniversary.

## Discussion

For the license term beginning November 12, 2024 through November 11, 2025, the member population has been determined to be 401,599 lives, exceeding the contracted base of 365,000.

Per the pricing terms in the Master Software License Agreement (MSLA), the following true-up rates apply:

- 35,000 members (from 365,001 to 400,000) will be billed at $0.165 PMPM
- 1,599 members (above 400,000) will be billed at a discounted rate of $0.157 PMPM

This adjustment ensures accurate billing aligned with actual utilization and licensing terms.

## Financial Impact

Cost not-to-exceed $72,313 in budgeted expenses.

## Requested Action

Approve; Authorize the CEO to amend the contract, with legal approval, with ZeOmega for the True-Up of the higher than expected additional member population being managed in Jiva that is above the current contracted amount from November 12, 2024, through November 11, 2025 and to increase the not-to-exceed amount by $72,313 from $3,918,001 to $3,990,314.

Docusign Envelope ID: 30575D29-13C7-412C-B82D-BA9BD5750B28

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

Department Name: MIS

Department Head: Cesar Delgado

Vendor Name: ZeOmega Inc.

Contact Name & Email Address: Casey Ballard, cballard@zeomega.com

| **Description of Contract** | |
|---|---|
| Type of Agreement:<br>☐ New agreement<br>☒ Amendment No. 2<br>☐ Memorandum of Understanding ("MOU") | Background:<br>Kern Health Systems (KHS) entered into a five-year agreement with ZeOmega, Inc. for the JIVA Medical Management Platform, effective November 13, 2022 through November 12, 2027. The JIVA platform supports clinical, behavioral, and social service workflows and integrates with KHS's core claims system, QNXT. The agreement includes tiered pricing based on the number of members managed within the platform, with a contracted base population of 365,000 members. Annual true-up adjustments are required if the actual member count exceeds this threshold, ensuring that licensing and billing accurately reflect utilization. For the license term beginning November 12, 2024 through November 11, 2025, the member population has been determined to be 401,599 lives, exceeding the contracted base.<br><br>Brief Explanation of Services to be Provided:<br>Under the terms of the Master Software License Agreement (MSLA), ZeOmega will provide true-up billing for the additional member population managed in the JIVA platform. Specifically, 35,000 members (from 365,001 to 400,000) will be billed at $0.165 PMPM, and 1,599 members (above 400,000) will be billed at a discounted rate of $0.157 PMPM. This adjustment ensures accurate billing aligned with actual utilization and licensing terms for the period of the agreement. |

☐ 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): Kern Health Systems (KHS) already has an agreement in place with ZeOmega, Inc. for the JIVA Medical Management Platform. This action is solely to amend the existing contract for true-up costs associated with a higher-than-expected member population, in accordance with the terms of the current agreement.

☐ 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")

☐ Vendor Data Transfer Checklist

☐ Medi-Cal Requirements

☐ D-SNP Requirements

☐ DMHC Administrative Services Requirements

Docusign Envelope ID: 30575D29-13C7-412C-B82D-BA9BD5750B28

| |
|---|
| Other Exhibits required: |

| Fiscal Impact | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: 225 GL# 5400-Jiva

Maximum Cost of Agreement not to exceed: $72,313

Note:

**Contract Terms and Conditions**

Effective date: 11/13/2022 Termination date: 11/12/2027

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 30575D29-13C7-412C-B82D-BA9BD5750B28

| Approvals | |
|---|---|
| **Contract Owner:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Department Head<br>Date: 10/6/2025 | **Approved as to Form:**<br>Signed by:<br>Ann StoryGarza<br>E325942D8E45475...<br>KHS Legal Counsel<br>Date: 10/13/2025 |
| **Compliance DMHC/DHCS Review:**<br>DocuSigned by:<br>Deborah Murr<br>BD08CF3F87CF4C4...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/6/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/6/2025 |
| **Reviewed as to Budget:**<br>DocuSigned by:<br>Robert Landis<br>018DB2ACA6904FF...<br>Chief Financial Officer or Controller<br>Date: 10/13/2025 | **IT Approval:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Chief Information Officer or IT Director<br>Date: 10/6/2025 |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Robin Dow-Morales, Senior Director of Claims

**SUBJECT:** Contract Extension with TriZetto Provider Solutions, LLC for the Clearing House Platform

**DATE:** October 23, 2025

## Background

Kern Health Systems (KHS) relies on electronic claims processing to ensure timely and accurate reimbursement for providers. Currently, 99% of all claims are submitted electronically, which greatly reduces manual entry and minimizes the risk of errors. This high level of efficiency is driven by provider generated electronic submissions that streamline workflows and lower administrative costs.

To support this process, KHS uses four clearinghouses that receive claims directly from providers or through other intermediaries, converting them into the required formats for KHS systems. At the center of this infrastructure is Cognizant's TriZetto platform, which powers QNXT. QNXT is KHS' core system for eligibility, provider contracts, authorizations, claims, and payments. Maintaining this solution is critical to operational continuity, compliance with HIPAA transaction standards, and sustaining the automation that supports our claims operations.

## Discussion

TriZetto Provider Solutions, LLC (TPS), a Cognizant company, currently processes about 17% of KHS's total claims volume as part of our multi clearinghouse strategy. The existing contract, which was based on an estimated claims amount of $285,000 over three years, is now up for renewal and the extension will establish a set not-to-exceed amount for claims processing. The original $285,000 approved request was based on conservative estimates and lower claim utilization assumptions. However, when Change Healthcare experienced a breach, many providers transitioned to TPS, resulting in a significant increase in claims volume. The proposed extension reflects these updated utilization patterns and projected growth, ensuring continued budget alignment and operational transparency.

Under the proposed three (3) year extension, TPS will continue delivering HIPAA compliant transaction services including claims submission, eligibility verification, and claim status inquiries at the following per claim rates:

| | | Extension | | | |
|---|---|---|---|---|---|
| | Current | Year 1 | Year 2 | Year 3 | Contract Total |
| Claims | 1,079,350 | 1,116,000 | 1,171,800 | 1,230,390 | |
| Cost per Claim | $ 0.198 | $ 0.198 | $ 0.207 | $ 0.208 | |
| **Totals** | $ 213,711.30 | $ 220,968 | $ 242,563 | $ 255,921 | **$ 719,452** |

**Financial Impact**

Cost for a three (3) year extension not-to-exceed $719,452 in budgeted expenses.

**Requested Action**

Approve; Authorize the CEO to amend and extend the contract, with legal approval, with TriZetto Provider Solutions, LLC for the utilization of the TPS clearing house platform for a three (3) year term from September 6, 2025, through September 5, 2028 and increase the not-to-exceed amount by $719,452 from an estimated amount of $285,000 to a new not-to-exceed amount of $1,004,452 for the entire term of the contract.

Docusign Envelope ID: 76AB68AA-83F9-4E40-9C55-74BC668E3800

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

| | | | |
|---|---|---|---|
| Department Name: | Claims | Department Head: | Robin Dow-Morales |
| Vendor Name: | Cognizant/Trizetto | Contact Name & Email Address: | Christopher Donahue, christopher.donahue@cognizant.com |

**Description of Contract**

Type of Agreement:

☐ New agreement

☒ Amendment No. 2

☐ Memorandum of Understanding ("MOU")

Background:

Currently, 99% of all claims are submitted electronically. Costs and keystroke errors are kept to a minimum by having the claim submission created by the provider in an electronic format. KHS has 4 different Clearinghouses that accept claims directly from providers or from other clearinghouses and submits them to KHS in required formats.

Brief Explanation of Services to be Provided:

Vendor provides KHS with standard electronic transaction processing services for healthcare claims. Currently, the vendor is responsible for submitting 17% of the total claims volume.

☐ 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 active agreement with this clearinghouse vendor, as well as with three additional vendors

☐ Board of Directors Approval Required

☐ Regulatory Approval Required

☐ Retroactive Agreement

**Exhibits Required:**

☒ HIPAA Business Associate Agreement ("BAA")

☒ Vendor Data Transfer Checklist

☒ DMHC Administrative Services Requirements

Docusign Envelope ID: 76AB68AA-83F9-4E40-9C55-74BC668E3800

☒ Medi-Cal Requirements

Other Exhibits required:

| Fiscal Impact | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: 230 GL# 5642

Maximum Cost of Agreement not to exceed: $719,452

Note: Year 1 $0.198, Year 2 $0.207, and Year 3 $0.208

**Contract Terms and Conditions**

Effective date: 9/6/2025 Termination date: 9/5/2028

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 76AB68AA-83F9-4E40-9C55-74BC668E3800

| Approvals | |
|---|---|
| **Contract Owner: Robin Dow-Morales**<br>Signed by:<br>Robin Dow-Morales<br>030089ED75BE41E...<br>Department Head<br>Date: 10/06/2025 | **Approved as to Form:**<br>KHS Legal Counsel<br>Date: |
| **Compliance DMHC/DHCS Review:**<br>Signed by:<br>Deborah Murr<br>F00A348898D04C7...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/8/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/7/2025 |
| **Reviewed as to Budget:**<br>DocuSigned by:<br>Robert Landis<br>018DB2ACA6904FF...<br>Chief Financial Officer or Controller<br>Date: 10/9/2025 | **IT Approval:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Chief Information Officer or IT Director<br>Date: 10/8/2025 |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Cesar Delgado, Chief Information Officer

**SUBJECT:** Increase the Not-to-Exceed amount with mPulse for the Texting Program Manager and Activators

**DATE:** October 23, 2025

## Background

In 2021, Kern Health Systems (KHS) received approval from the Department of Health Care Services (DHCS) to use the Relay Network platform for text messaging as a communication tool for member outreach, engagement, and regulatory compliance. Relay Network's agreement is set to end in December 2025. KHS conducted a competitive procurement process, and in February 2025, the KHS Board of Directors approved an agreement with mPulse, a digital engagement solutions platform, for their Member and Provider Portal platform which includes a text message component. However, that approval did not include the Program Manager licensing and activation modules ("activators") required to enable the texting functionality needed to continue text message outreach campaigns.

## Discussion

Implementation of the mPulse Member and Provider Portal is currently in progress. The current agreement with Relay Network will terminate on December 31, 2025. To maintain continuity of member communications, align with long-term strategic member engagement goals, and to eliminate the need for an additional third-party texting platform, Senior management is requesting to amend the existing mPulse agreement to include the texting Program Manager and two activators for their texting solution. The Program Manager will enable KHS to continue unlimited customized outreach campaigns. In addition, the activators will support targeted outreach to members who visit the emergency department. This includes required follow-ups after discharge for behavioral health and substance use disorder visits, as well as diversion outreach to approximately 90,000 members. Diversion efforts inform members when they have used the emergency department for non-emergency care and guide them toward more appropriate options such as their primary care provider or urgent care. These services will support KHS' strategic goals to improve engagement and the overall member experience.

By consolidating texting services under mPulse, KHS will avoid reliance on a separate third-party platform and achieve estimated savings of $600,000 over the three-year period of the contract. This approach strengthens member engagement capabilities while ensuring fiscal responsibility.

**Financial Impact**

Cost for a three (3) year amendment will increase the not-to-exceed amount by $386,880, which includes $287,580 for the Program Manager and $99,300 for the Activators, in budgeted expenses.

**Requested Action**

Approve; Authorize the CEO to amend the contract, with legal approval, with mPulse for the texting Program Manager and two (2) Activators for a three (3) year term from January 1, 2026, through December 31, 2028 and increase the not-to-exceed amount by $386,880 from $5,966,116 to $6,352,996 for the entire term of the contract.

Docusign Envelope ID: EE28549F-A864-4EA9-97F4-74646AC89C12

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

Department Name: MIS

Department Head: Cesar Delgado

Vendor Name: mPulse Inc.

Contact Name & Email Address: Brian Johnson, brian.johnson@mpulse.com

| **Description of Contract** | |
|---|---|
| Type of Agreement:<br>☐ New agreement<br>☒ Amendment No. 2<br>☐ Memorandum of Understanding ("MOU") | Background:<br>In 2021, Kern Health Systems (KHS) received approval from the Department of Health Care Services (DHCS) to use the Relay Network platform for text messaging as a communication tool for member outreach, engagement, and regulatory compliance. The Relay Network agreement is set to end in December 2025. After a competitive procurement process, the KHS Board of Directors approved an agreement with mPulse in February 2025 for their Member and Provider Portal platform, which includes a text message component. However, the initial approval did not include the Program Manager licensing and activation modules ("activators") required to enable the texting functionality needed for ongoing outreach campaigns. To maintain continuity of member communications, align with long-term strategic engagement goals, and eliminate the need for an additional third-party texting platform, senior management is requesting to amend the existing mPulse agreement to include these components. By consolidating texting services under mPulse, KHS will avoid reliance on a separate third-party platform and achieve estimated savings of $600,000 over the three-year contract period, strengthening member engagement capabilities while ensuring fiscal responsibility.<br><br>Brief Explanation of Services to be Provided:<br>With the proposed amendment, mPulse will provide the texting Program Manager and two activators for its texting solution. The Program Manager will enable KHS to continue unlimited customized outreach campaigns, while the activators will support targeted outreach to members who visit the emergency department. This includes required follow-ups after discharge for behavioral health and substance use disorder visits, as well as diversion outreach to approximately 90,000 members. Diversion efforts will inform members when they have used the emergency department for non-emergency care and guide them toward more appropriate options such as their primary care provider or urgent care. These services are designed to support KHS's strategic goals to improve engagement and overall member experience. |

☐ 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): KHS conducted a competitive procurement process and selected mPulse for its Member and Provider Portal platform, which includes the required texting functionality. The current request is to amend the existing agreement to add the Program Manager and activators, ensuring continuity of service and eliminating the need for an additional third-party texting platform.

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

☐ Board of Directors Approval Required

Docusign Envelope ID: EE28549F-A864-4EA9-97F4-74646AC89C12

☐ Regulatory Approval Required

☐ Retroactive Agreement

**Exhibits Required:**

☐ HIPAA Business Associate Agreement ("BAA")

☐ D-SNP Requirements

☐ Vendor Data Transfer Checklist

☐ DMHC Administrative Services Requirements

☐ Medi-Cal Requirements

Other Exhibits required:

| **Fiscal Impact** | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: 225 GL# 5407

Maximum Cost of Agreement not to exceed: $386,880

Note:

**Contract Terms and Conditions**

Effective date: 1/1/2026 Termination date: 12/31/2028

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: EE28549F-A864-4EA9-97F4-74646AC89C12

| Approvals | |
|---|---|
| **Contract Owner:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Department Head<br>Date: 10/6/2025 | **Approved as to Form:**<br>KHS Legal Counsel<br>Date: |
| **Compliance DMHC/DHCS Review:**<br>DocuSigned by:<br>Deborah Murr<br>BD08CF3F87CF4C4...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/6/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/6/2025 |
| **Reviewed as to Budget:**<br>Chief Financial Officer or Controller<br>Date: | **IT Approval:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Chief Information Officer or IT Director<br>Date: 10/6/2025 |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Christine Pence, Senior Director of Health Services

**SUBJECT:** Increase the Not-to Exceed Amount with Symplr for the Hayes Knowledge Center and Credentialing Platform

**DATE:** October 23, 2025

## Background

Kern Health Systems (KHS) utilizes Symplr for credentialing and for access to the Hayes Knowledge Center. Hayes provides clinical evidence research to support defensible, evidence-based decisions regarding new and emerging health technologies and treatments. The subscription includes unlimited licenses to evaluated content, covering clinical trial data, safety considerations, regulatory approvals, and efficacy ratings. This resource supports consistent application of evidence-based decision making and strengthens communication with providers and stakeholders.

In addition, KHS is transitioning its credentialing software from an on-premises system to Symplr's cloud-based platform. Credentialing is the process and software KHS uses to verify and maintain provider qualifications, licenses, and compliance requirements, ensuring that all contracted providers meet established standards.

## Discussion

The Master Agreement with Symplr, executed in 2024, established a multi-year subscription for credentialing services and the Hayes Knowledge Center. The combination of the remaining contract term and annual license renewals increases the total contract value beyond the original approval amount.

KHS is also transitioning its credentialing software from an on-premise system to Symplr's cloud-based platform. This modernization reduces infrastructure and maintenance burdens, improves data security, and increases accessibility for staff and providers. Together with continued access to Hayes' evidence-based research services, the agreement supports both operational efficiency and high-quality clinical decision-making.

## Financial Impact

Cost to increase the existing not-to-exceed amount by $197,077 in budgeted expenses.

## Requested Action

Approve; Authorize the CEO to amend the contract, with legal approval, with Symplr for year 3 of a 3-year subscription to the Hayes Knowledge Center from August 1, 2024, through July 31, 2027 and years 2 and 3 of a 3-year term of the licensing agreement for the KHS Network Provider credentialing system migration from on-premises to the Symplr cloud solution from June 3, 2025, through July 31, 2027 and to increase the not-to-exceed amount by $197,077, from $157,672 to $354,749, for the remaining term of the contract through July 31, 2027.

Docusign Envelope ID: 9D57EDF3-D1FF-433E-ADD0-6B5FEB72E766

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

| | | | |
|---|---|---|---|
| Department Name: | Utilization Management | Department Head: | Christine Pence/Yolanda Herrera |
| Vendor Name: | Symplr | Contact Name & Email Address: | Jim Gifford JGifford@symplr.com |

| **Description of Contract** | |
|---|---|
| Type of Agreement: Continuation<br>☐ New agreement<br>☒ Amendment No.1<br>☐ Memorandum of Understanding ("MOU") | Background:<br>KHS uses Symplr for credentialing and to access the Hayes Knowledge Center, which provides clinical evidence to support evidence-based decisions on new health technologies and treatments. The Hayes subscription offers unlimited access to evaluated research, including clinical data, safety, regulatory, and efficacy information, enhancing communication and consistency in decision-making. KHS is also transitioning from an on-premise credentialing system to Symplr's cloud-based platform, which helps verify and maintain provider qualifications, licenses, and compliance to ensure all contracted providers meet established standards. |
| | Brief Explanation<br>The contract amendment with Symplr extends the Hayes Knowledge Center subscription through July 31, 2027, and continues the migration of KHS's credentialing system to Symplr's cloud platform through the same period. The update covers year 3 of the Hayes subscription and years 2 and 3 of the credentialing platform agreement. |

☐ 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 Symplr for the Hayes Knowledge Center and credentialing platform.

☐ Board of Directors Approval Required

☐ Regulatory Approval Required

Docusign Envelope ID: 9D57EDF3-D1FF-433E-ADD0-6B5FEB72E766

☐ Retroactive Agreement

**Exhibits Required:**

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

Other Exhibits required:

| **Fiscal Impact** | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: 310 GL# 5645-CLNC

Maximum Cost of Agreement not to exceed: $197,077

Cost contains:
MSA: Year 3 - $76,650 (Under UM)
Licensing Year 2 - $58,745 (Under MIS 225 GL# 5406)
Licensing Year 3 (5% increase) - $61,682 (Under MIS 225 GL# 5406)

Note: Aggregate = $354,749

**Contract Terms and Conditions**

Effective date: 8/1/24 Termination date: 7/31/27

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 9D57EDF3-D1FF-433E-ADD0-6B5FEB72E766

| Approvals | |
|---|---|
| **Contract Owner:**<br>Signed by:<br>Christine Pence<br>2F9D6624757043F...<br>Department Head<br>Date: 10/13/2025 | **Approved as to Form:**<br>Signed by:<br>Ann StoryGarza<br>E325942D8E45475...<br>KHS Legal Counsel<br>Date: 10/8/2025 |
| **Compliance DMHC/DHCS Review:**<br>DocuSigned by:<br>Deborah Murr<br>BD08CF3F87CF4C4...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/8/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/13/2025 |
| **Reviewed as to Budget:**<br>DocuSigned by:<br>Robert Landis<br>018DB2ACA6904FF...<br>Chief Financial Officer or Controller<br>Date: 10/8/2025 | **IT Approval:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Chief Information Officer or IT Director<br>Date: 10/13/2025 |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Veronica Barker, Controller

**SUBJECT:** New Agreement with Zelis Healthcare, LLC fka PaySpan Inc. for the Claims Payment Platform

**DATE:** October 23, 2025

## Background

Kern Health Systems (KHS) currently processes approximately 627,000 claims per month and issues over 100,000 payments annually to various providers. Since 2015, KHS has outsourced the provider payment process. In 2021, KHS published a Request for Proposal (RFP) for the provider payment services. PaySpan, Inc., now Zelis Healthcare, LLC was awarded the contract for these services.

## Discussion

KHS currently contracts with Zelis Healthcare, LLC for its on-premises PaySpan provider payment platform. The existing agreement, approved by the Board of Directors in February 2024, is set to expire on February 15, 2027.

Following that approval, KHS was informed in August 2024 that the PaySpan platform will be sunsetting on December 31, 2025, and the current agreement will be terminated early. As a result, KHS must transition to Zelis Healthcare's new, web-based payment platform, which replaces PaySpan and provides enhanced functionality.

The proposed three (3) year agreement with Zelis maintains a not-to-exceed amount of $1.95 million, consistent with the amount previously approved under the prior three (3) year agreement. No changes to existing rates have been made. The new platform offers a modernized, technology-driven solution that enhances efficiency and transparency in the claims settlement process between healthcare payers and providers.

In addition, KHS will expand utilization of the Zelis platform to include its Dual Eligible Special Needs Plan (D-SNP) population beginning January 1, 2026, further supporting streamlined payment operations and improved provider experience.

**Financial Impact**

Cost for a three (3) year agreement not-to-exceed $1,950,000 in budgeted expenses.

**Requested Action**

Approve; Authorize the CEO to enter into, sign, and/or amend a new contract, with legal approval, under Zelis Healthcare, LLC for the claims payment platform for a three (3) year term from December 20, 2025 through December 19, 2028 with a total not-to-exceed amount of $1,950,000 ($123,959 for D-SNP and $1,826,041 for Medi-Cal) for the entire term of the contract.

Docusign Envelope ID: F5C041A7-EF54-4649-98A5-BD9AAB5EF7D1

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

Department Name: Accounting

Department Head: Veronica Barker

Vendor Name: Zelis Healthcare

Contact Name & Email Address: Brian Ridder, brian.ridder@Zelis.com

| **Description of Contract** | |
|---|---|
| Type of Agreement:<br>☒ New agreement<br>☐ Amendment No.<br>☐ Memorandum of Understanding ("MOU") | Background:<br>KHS currently processes around 627,000 claims per month and issues over 100,000 provider payments annually. In 2021, KHS awarded a contract for provider payment services to PaySpan, Inc. (now Zelis Healthcare, LLC) through a competitive RFP process. As the current PaySpan platform is scheduled to sunset in December 2025, KHS will transition to Zelis Healthcare's new web-based payment platform under a new three-year agreement. This change will result in the early termination of the existing contract. The new platform will offer enhanced functionality and will also be used for D-SNP payments beginning January 1, 2026. |
| | Brief Explanation of Services to be Provided:<br>Zelis will provide KHS with the Zelis Claims Payment Platform for the claims settlement process between healthcare payers and providers with print and mail services along with EFT payments. |

☒ 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.)*

An RFQ was performed in 2021, and KHS selected the most qualified and competitive proposal.

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

☐ Board of Directors Approval Required

☐ Regulatory Approval Required

☐ Retroactive Agreement

Docusign Envelope ID: F5C041A7-EF54-4649-98A5-BD9AAB5EF7D1

**Exhibits Required:**

☒ HIPAA Business Associate Agreement ("BAA")
☒ DMHC Administrative Services Requirements
☒ Vendor Data Transfer Checklist
☒ 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- Accounting GL# 5495- Other Outside Services

Maximum Cost of Agreement not to exceed: $1,950,000

Note: Zelis Provider Payment platform cost are: Medi-Cal – $1,826,041; D-SNP – $123,959.

**Contract Terms and Conditions**

Effective date: 12/20/2025 Termination date: 12/19/2028

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: F5C041A7-EF54-4649-98A5-BD9AAB5EF7D1

| Approvals | |
|---|---|
| **Contract Owner:**<br>DocuSigned by:<br>Veronica Barker<br>1088C33433C1403...<br>Department Head<br>Date: 10/9/2025 | **Approved as to Form:**<br><br>KHS Legal Counsel<br>Date: |
| **Compliance DMHC/DHCS Review:**<br>Signed by:<br>Deborah Murr<br>F00A348898D04C7...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/9/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/9/2025 |
| **Reviewed as to Budget:**<br><br>Chief Financial Officer or Controller<br>Date: | **IT Approval:**<br><br>Chief Information Officer or IT Director<br>Date: |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Cesar Delgado, Chief Information Officer

**SUBJECT:** New Agreement with Helpcare AI for AI Digital Worker Calling Platform

**DATE:** October 23, 2025

## Background

As part of KHS' (Kern Health Systems) 2026 -2028 Strategic Plan to achieve "Best-in Class Member Engagement", KHS is modernizing member outreach to stay ahead of changes in the healthcare landscape and better serve our members. By implementing an Artificial Intelligence (AI) driven, multilingual, HIPAA-compliant platform, KHS is enhancing communication with members through faster, more consistent, and personalized outreach. This investment strengthens compliance, supports improved quality measures, and creates a seamless and engaging experience for our members. The initiative positions KHS for long-term efficiency, innovation, and stronger relationships with the communities we serve.

## Discussion

In May 2025, KHS launched a pilot program to implement a digital worker solution to enhance healthcare administrative workflows and member outreach. Following the success of this pilot, KHS issued a Request for Quotations (RFQ) in August 2025 and received seven proposals. After a comprehensive evaluation process, Helpcare AI, the incumbent vendor from the pilot phase, was selected in September 2025 for its demonstrated performance, ability to automate outbound and interactive calls, and strong integration with existing KHS workflows.

Helpcare AI's platform offers scalable, multilingual communication, robust reporting, and strong security standards, with a proven record of reliable support and successful project delivery in healthcare. The new Professional Services Agreement (PSA) will formalize and expand these services based on the positive results and operational efficiencies achieved during the pilot.

Under the proposed PSA, services will be provided on a pay as you go model, ensuring KHS only pays for minutes actually utilized. KHS anticipates using up to 4 million minutes, supporting approximately 889,000 calls based on an average handle time of 4.5 minutes per call. The total projected investment is $1.48 million, calculated at $0.37 per minute.

When compared to traditional staffing costs, estimated at $2.87 million annually (based on $35 per hour for equivalent call volume), the digital solution represents an estimated $1.39 million in savings, or a 48% reduction in total cost. The pay as you go structure also ensures that if minutes

are not used, no costs are incurred, maintaining fiscal flexibility and alignment with realized operational savings.

This model provides both efficiency and scalability, allowing KHS to extend member engagement capacity without additional staffing costs while preserving service quality, compliance, and measurable value for the organization.

**Financial Impact**

Cost for a one (1) year term not-to-exceed $1,480,000 in budgeted expenses.

**Requested Action**

Approve; Authorize the CEO to enter into, sign, and/or amend a new contract, with legal approval, under Helpcare AI for AI Calling Agent services for a one (1) year term from October 24, 2025 through October 23, 2026, with a total not-to-exceed amount of $1,480,000 for the entire term of the contract.

Docusign Envelope ID: ADAA5043-2B83-4A06-BEFB-B0FCFD350866

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

Department Name: MIS

Department Head: Cesar Delgado

Vendor Name: Helpcare AI

Contact Name & Email Address: Huzaifa Sial, hsial@helpcare.ai

| **Description of Contract** | |
|---|---|
| Type of Agreement:<br>☒ New agreement<br>☐ Amendment No.<br>☐ Memorandum of Understanding ("MOU") | Background:<br>Kern Health Systems (KHS) is modernizing its member outreach to keep pace with changes in the healthcare landscape and better serve its members. By implementing an Artificial Intelligence (AI) driven, multilingual, HIPAA-compliant platform, KHS aims to enhance communication with members through faster, more consistent, and personalized outreach. This initiative strengthens compliance, supports improved quality measures, and creates a seamless and engaging experience for members. The investment in Helpcare AI positions KHS for long-term efficiency, innovation, and stronger relationships with the communities it serves.<br><br>Brief Explanation of Services to be Provided:<br>Under the new agreement, Helpcare AI will deliver an AI Digital Worker platform that automates outbound and interactive calls for member outreach, appointment reminders, and engagement. The platform uses natural language processing to engage members, is cloud-based, secure, and HIPAA-compliant, and supports scalable, multilingual communication. Helpcare AI will help KHS streamline outreach, support redetermination and HEDIS measures, and reach a broader member population, improving engagement and member experience. The solution reduces reliance on manual calls and temporary staff, lowers operational costs, and provides robust reporting and security standards. |

☐ 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): Kern Health Systems (KHS) conducted a competitive Request for Quotes (RFQ) process in August 2025 to select an AI Digital Worker platform. Seven proposals were received and evaluated in September. After reviewing responses and scoring vendors, Helpcare AI was selected for its ability to automate member outreach, support key initiatives, and integrate with existing workflows.

☐ 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")

☐ Vendor Data Transfer Checklist

☐ D-SNP Requirements

☐ DMHC Administrative Services Requirements

Docusign Envelope ID: ADAA5043-2B83-4A06-BEFB-B0FCFD350866

☐ Medi-Cal Requirements

Other Exhibits
required:

| Fiscal Impact | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: 225 GL# 5307

Maximum Cost of Agreement not to exceed: $1,480,000

Note:

**Contract Terms and Conditions**

Effective date: 10/24/2025 Termination date: 10/23/2026

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: ADAA5043-2B83-4A06-BEFB-B0FCFD350866

| Approvals | |
|---|---|
| **Contract Owner:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Department Head<br>Date: 10/6/2025 | **Approved as to Form:**<br>KHS Legal Counsel<br>Date: |
| **Compliance DMHC/DHCS Review:**<br>DocuSigned by:<br>Deborah Murr<br>BD08CF3F87CF4C4...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/6/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/6/2025 |
| **Reviewed as to Budget:**<br>Chief Financial Officer or Controller<br>Date: | **IT Approval:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Chief Information Officer or IT Director<br>Date: 10/6/2025 |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

# AI Digital Worker Calling Platform

Cesar Delgado
Chief Information Officer
October 23, 2025

# Agenda

- Overview
- Sequence of Events
- Enhancing Service with AI Calling Agents
- Calling Agent Workflow
- Value of a Calling Agent
- Scoring Matrix
- Cost Analysis
- Finance Committee Request

# Overview

Kern Health Systems (KHS) continues to modernize member outreach to stay ahead of constant changes in the healthcare landscape and better serve our members. Through the implementation of a multilingual, HIPAA-compliant digital communication platform, KHS is enhancing how we connect with members while delivering faster, more consistent and personalized engagement.

Following a successful pilot and a competitive RFQ process, KHS identified a proven vendor solution that supports this transformation. This approach strengthens compliance, improves quality measures, and creates a more seamless member experience. With this investment, KHS is positioning itself for long-term efficiency, innovation, and stronger relationships with the communities we serve.

# Sequence of Events

- **May 2025**
  - Pilot Program was initiated to implement an AI Digital Worker for healthcare administrative workflows and patient outreach.
- **August 2025**
  - KHS issued a RFQ for the selection of an AI Digital Worker Platform to continue enhancing operational efficiency.
- **September 2025**
  - KHS Posted an RFQ for the procurement of an AI Digital Worker. Seven proposals were received.
- **October 2025**
  - After evaluation, Helpcare AI, the incumbent from the pilot phase, was selected as the preferred vendor based on demonstrated results, system integration, and value. The proposed increase in services reflects actual utilization and the strong performance achieved to date.

# Enhancing Service with AI Calling Agents

## WHAT IT IS

- AI-driven platform for automated outbound and interactive calls
- Uses natural language to engage with members
- Cloud-based, secure, and HIPAA-compliant

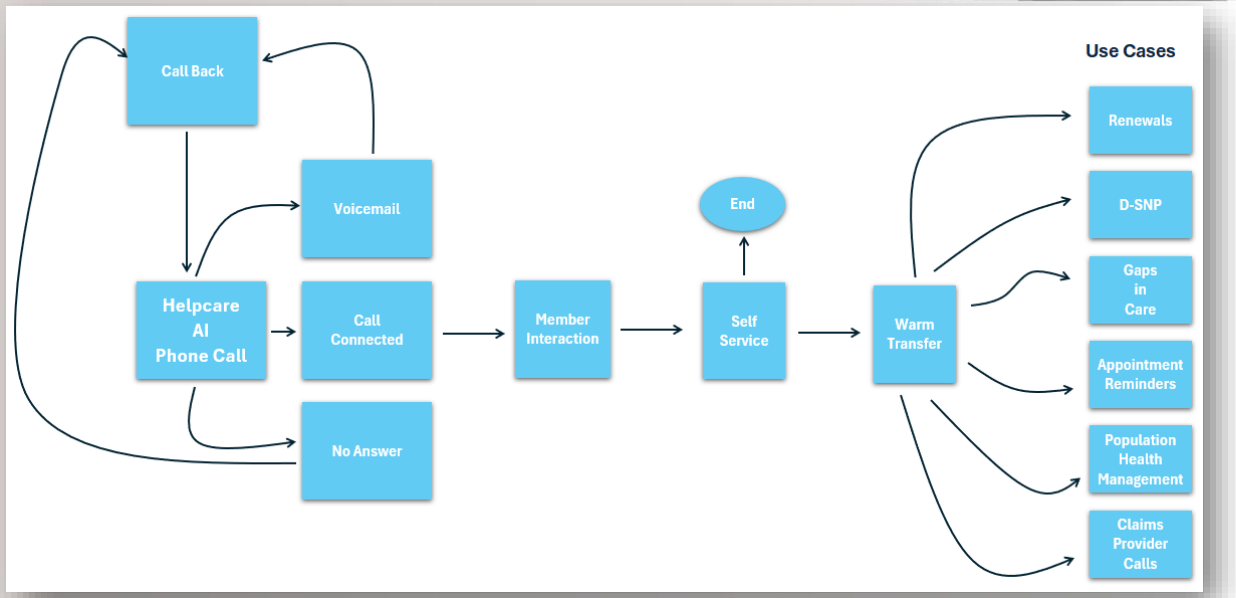
## BENEFITS

- Consistent, 24/7 communication
- Scalable without additional staff
- Multilingual support
- Reduces administrative burden

## KHS IMPACT

- Streamlined outreach & appointment reminders
- Supports redetermination & HEDIS measures
- Reaches broader member population
- Improves engagement and member experience

# Calling Agent Workflow




- Current calling agent automates member outreach, reducing reliance on manual calls and temporary staff, and improving engagement rates.
- Failure to implement an AI agent platform would leave KHS exposed to rising staffing expenses, continued reliance on temporary resources, and limited capacity to scale operations effectively.
- Failure to modernize outreach could result in missed HEDIS targets, regulatory challenges, lost opportunities to improve member health outcomes, and a decline in member renewals.

# Value of a Calling Agent

- Expands capacity for proactive outreach without increasing staff levels
- Improves coordination across delegated and in-house services
- Supports key engagement initiatives, including:
  - Appointment reminders and follow-ups
  - Population health management
  - Member and provider inbound call support
  - Gaps in Care outreach
  - Renewal Support
- Reduces reliance on temporary staffing through automation and consistency
- Strengthens continuity of service delivery and member experience

# Scoring Matrix

| Scoring Criteria<br>Each category is scored on a 0-5 scale | Total Possible Score | Helpcare AI | Vendor B | Vendor C |
|---|---|---|---|---|
| Technical Fit & Integration | 30 | **30** | 24 | 24 |
| Healthcare / Medicaid Experience | 20 | **20** | 20 | 16 |
| Implementation & Support | 20 | **20** | 16 | 16 |
| Financial Value | 15 | **12** | 6 | 9 |
| Risk & Transition Impact | 15 | **15** | 6 | 6 |
| Totals | 100 | **97** | 72 | 71 |

| Evaluation Criteria | Description |
|---|---|
| Technical Fit & Integration | Ability to integrate with KHS systems (Cisco UCCX, Dynamics 365, QNXT, ZeOmega Jiva). |
| Healthcare / Medicaid Experience | Demonstrated Medi-Cal/Medicaid deployments and compliance with CalAIM/NCQA standards. |
| Implementation & Support | Strong training, change management, and vendor support approach. |
| Financial Value | Competitive pricing including license, setup, and per-minute call costs. |
| Risk & Transition Impact | Member experience continuity, vendor stability, and minimal operational disruption. |

# Cost Analysis

## Cost Comparison

| Cost Type | Helpcare AI | Vendor B | Vendor C |
|---|---|---|---|
| Implementation | $ - | $ 100,000 | $ 75,000 |
| Call Costs[(1)] | $ 380,000 | $ 297,000 | $ 1,800,000 |
| Support Costs | $ - | | $ 2,236,000 |
| **Totals** | **$ 380,000** | $ 397,000 | $ 4,111,000 |

(1) Pursuant to the RFQ, call costs were estimated at a pool of 1,000,000 minutes.

## Anticipated Savings

| | |
|---|---|
| Average Handle Time [Minutes] | 4.5 |
| AI Investment | $1,480,000 |
| Cost per Minute | $0.37 |
| Available Minutes | 4,000,000 |
| Call Capacity | 888,889 [(1)] |

| | Without AI | With AI | $ Savings[(4)] | % Change[(4)] |
|---|---|---|---|---|
| Calls per Hour | 13.3 | - | | |
| Call Daily Capacity [Calls per Hour x 6] | 86.7 | - | | |
| Total Hours Needed | 82,051 | - | | |
| Total FTE's Needed | 39 | - | | |
| Total Cost[(2)] | $2,871,795 | $1,480,000 [(3)] | $1,391,795 | -48% |

(1) Call capacity based on 4.5-minute average handle time.
(2) Manual staffing cost: 82,051 hours × $35/hr.
(3) Digital worker cost: $1.48M ($0.37/min × 4M minutes) while the RFQ cost comparison uses a 1 million minute baseline for vendor evaluation, the anticipated savings are modeled on a full 4 million minute potential annual call capacity, which includes an additional $0.01 savings per minute,
(4) Savings: $1.39M (48%) reduction in total cost.

# Board of Directors Request

Approve; Authorize the CEO to enter into, sign, and/or amend a new contract, with legal approval, under Helpcare AI for AI Calling Agent services for a one (1) year term from October 24, 2025 through October 23, 2026, with a total not-to-exceed amount of $1,480,000 for the entire term of the contract.

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

# Questions

Please contact: Cesar Delgado

Name: Cesar Delgado
Title: Chief Information Officer
Phone Number:
e-Mail: Cesar.Delgado@khs-net.com

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Christine Pence, Senior Director for Health Services

**SUBJECT:** Request to Increase the Not-To-Exceed Amount with Carenet Health for 24/7/365 Nurse Triage Services

**DATE:** October 23, 2025

## Background

Kern Health Systems (KHS) is required to comply with mandated regulatory standards outlined in its agreements with the Department of Health Care Services and the Knox-Keene licensure through the Department of Managed Health Care. To meet these obligations, KHS provides 24/7/365 access to a Nurse Triage service that supports members with health and benefit-related questions. Additionally, members have access to an audio health library, offering another source of health education in both English and Spanish, focused on specific disease processes. These services are designed to be seamless to the membership, complementing internal business hours support provided by KHS staff and extending coverage after hours. KHS has maintained a contract with Health Dialog since October 2016, which was acquired by Carenet Health in May 2024, to provide 24/7/365 Nurse Triage Services.

## Discussion

The existing contract with Carenet Health for 24/7/365 Nurse Triage Services is for a three (3) year term from November 1, 2022 through November 1, 2025 was approved by the Board of Directors at the not-to-exceed amount of $1,495,200. Due to an increase in membership and to support continued service delivery, KHS is requesting approval to increase the current not-to-exceed amount by $200,000 to cover additional projected expenses through the remaining term of the current contract.

## Financial Impact

Cost for projected expenses through the remaining term of the contract not-to-exceed $200,000 in budgeted expenses.

## Requested Action

Approve; Authorize the CEO to amend the existing contract, with legal approval, with Carenet Health for 24/7/365 Nurse Triage Services to increase the current not-to-exceed amount by $200,000, from $1,495,200 to $1,695,200 for the remaining term of the contract through November 1, 2025.

Docusign Envelope ID: 7A5109E3-DAF8-4135-BF10-63781E1BAE89

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

| | | | |
|---|---|---|---|
| Department Name: | Utilization Management | Department Head:<br>Contract Owner: | Dr. Martha Tasinga<br>Christine Pence |
| Vendor Name: | Carenet Health | Contact Name & Email Address: | Ramona Forbis<br>rforbis@carenethealth.com |

| **Description of Contract** | |
|---|---|
| Type of Agreement:<br>☐ New agreement<br>☐ Amendment No.<br>☐ Memorandum of Understanding ("MOU") | Background:<br>KHS issued an RFP in June 2025, for 24/7/365 Nurse Triage services. KHS is required to comply with regulatory requirements with DHCS and DMHC. To meet these obligations KHS provides 24/7/365 Nurse Triage services to support our members with health and benefit-related questions. Additionally, members have access to an audio health library, offering another source of health education in both English and Spanish, focused on specific disease processes. These services are designed to be seamless to the membership, complementing internal business hours support provided by KHS staff and extending coverage after hours.<br><br>Brief Explanation of Services to be Provided:<br>Carenet Health will provide KHS with 24/7/365 Nurse Triage services. |

☐ 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 holds in existing contract with vendor through 11/1/25.

☐ Board of Directors Approval Required

☐ Regulatory Approval Required

☐ Retroactive Agreement

**Exhibits Required:**

☐ HIPAA Business Associate Agreement ("BAA")

☐ DMHC Administrative Services Requirements

Docusign Envelope ID: 7A5109E3-DAF8-4135-BF10-63781E1BAE89

☐ Vendor Data Transfer Checklist ☐ Insurance Exhibit

☐ Medi-Cal Requirements

Other Exhibits required:

| Fiscal Impact | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: GL# 6186

Maximum Cost of Agreement not to exceed: $1,695,200 for remainder of term

Note: Increasing the NTE by $200,000, from $1,495,200 to $1,695,200.

**Contract Terms and Conditions**

Effective date: 11/2/2022 Termination date: 11/1/2025

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 7A5109E3-DAF8-4135-BF10-63781E1BAE89

| Approvals | |
|---|---|
| **Contract Owner:**<br>Signed by:<br>Christine Pence<br>2F9D6624757043F...<br><br>Department Head<br>Date: 10/2/2025 | **Approved as to Form:**<br>Signed by:<br>Ann StoryGarza<br>E325942D8E45475...<br><br>KHS Legal Counsel<br>Date: 10/7/2025 |
| **Compliance DMHC/DHCS Review:**<br>DocuSigned by:<br>Deborah Murr<br>BD08CF3F87CF4C4...<br><br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/7/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br><br>Director of Procurement and Business Optimization<br><br>Date: 10/2/2025 |
| **Reviewed as to Budget:**<br>DocuSigned by:<br>Robert Landis<br>018DB2ACA6904FF...<br><br>Chief Financial Officer or Controller<br>Date: 10/7/2025 | **IT Approval:**<br>DocuSigned by:<br><br>CB0457C562F24EE...<br><br>Chief Information Officer or IT Director<br>Date: 10/3/2025 |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Christine Pence, Senior Director for Health Services

**SUBJECT:** New Agreement with Carenet Health for 24/7/365 Nurse Triage Services

**DATE:** October 23, 2025

## Background

In June 2025, Kern Health Systems (KHS) issued a Request for Proposal (RFP) for 24/7/365 Nurse Triage Services. KHS is required to comply with mandated regulatory standards outlined in its agreements with the Department of Health Care Services and the Knox-Keene licensure through the Department of Managed Health Care. To meet these obligations, KHS provides 24/7/365 access to a Nurse Triage service that supports members with health and benefit-related questions. Additionally, members have access to an audio health library, offering another source of health education in both English and Spanish, focused on specific disease processes. These services are designed to be seamless to the membership, complementing internal business hours support provided by KHS staff and extending coverage after hours. KHS has maintained a contract with Health Dialog since October 2016, which was acquired by Carenet Health in May 2024, to provide 24/7/365 Nurse Triage Services.

## Discussion

In response to the recent RFP, KHS received a total of five proposals. After a thorough evaluation, the two highest-scoring vendors were selected for further assessment. Following a comprehensive review, Senior Management is recommending to continue the engagement with Carenet Health for the provision of 24/7/365 Nurse Triage Services. Carenet Health has demonstrated seamless integration with KHS' core systems, ensuring efficient and effective service delivery. Additionally, their proposal offers competitive costs, aligning with KHS' budgetary requirements. Carenet Health has maintained a long-standing and trusted relationship with KHS.

## Financial Impact

Cost for a three (3) year term not-to-exceed $1,671,600 in budgeted expenses.

## Requested Action

Approve; Authorize the CEO to enter into, sign, and/or amend a new contract, with legal approval, with Carenet Health for 24/7/365 Nurse Triage Services for a three (3) year term from November 2, 2025 through November 1, 2028 with a total not-to-exceed amount of $1,671,600 for the entire term of the contract.

Docusign Envelope ID: 680DB24B-0388-422C-852E-576EB4FB9F91

KERN HEALTH SYSTEMS

**AGREEMENT AT A GLANCE**

| | | | |
|---|---|---|---|
| Department Name: | Utilization Management | Department Head:<br>Contract Owner: | Dr. Martha Tasinga<br>Christine Pence |
| Vendor Name: | Carenet Health | Contact Name & Email Address: | Ramona Forbis<br>rforbis@carenethealth.com |

| **Description of Contract** | |
|---|---|
| Type of Agreement:<br>☒ New agreement<br>☐ Amendment No.<br>☐ Memorandum of Understanding ("MOU") | Background:<br>KHS issued an RFP in June 2025, for 24/7/365 Nurse Triage services. KHS is required to comply with regulatory requirements with DHCS and DMHC. To meet these obligations KHS provides 24/7/365 Nurse Triage services to support our members with health and benefit-related questions. Additionally, members have access to an audio health library, offering another source of health education in both English and Spanish, focused on specific disease processes. These services are designed to be seamless to the membership, complementing internal business hours support provided by KHS staff and extending coverage after hours. |
| | Brief Explanation of Services to be Provided:<br>Carenet Health will provide KHS with 24/7/365 Nurse Triage services. |

☒ 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):
An RFP was conducted in June 2025, A total of five (5) proposals were received. After a comprehensive review.
The recommendation from the scoring committee is to continue engagement w/Carenet Health based on seamless integration with KHS' core systems and competitive costs.

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

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

Docusign Envelope ID: 680DB24B-0388-422C-852E-576EB4FB9F91

**Exhibits Required:**

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

Other Exhibits required:

| **Fiscal Impact** | | |
|---|---|---|
| KHS Governing Board previously approved this expense in KHS' FY 2025 Administrative Budget | ☐ No | ☒ Yes |
| Will this require additional funds? | ☒ No | ☐ Yes |
| Capital project | ☒ No | ☐ Yes |

Project Type:

Budget Cost Center: GL# 6186

Maximum Cost of Agreement not to exceed: $1,671,600 per three years

Note: PMPM for three years will be $0.114.

**Contract Terms and Conditions**

Effective date: 11/02/2025 Termination date: 11/01/2028

Explain extension provisions, termination conditions and required notice:

Docusign Envelope ID: 680DB24B-0388-422C-852E-576EB4FB9F91

| Approvals | |
|---|---|
| **Contract Owner:**<br>Signed by:<br>Christine Pence<br>2F9D6624757043F...<br>Department Head<br>Date: 10/2/2025 | **Approved as to Form:**<br>KHS Legal Counsel<br>Date: |
| **Compliance DMHC/DHCS Review:**<br>Signed by:<br>Deborah Murr<br>F00A348898D04C7...<br>Chief Compliance and Fraud Prevention Officer or<br>Director of Compliance and Regulatory Affairs<br>Date: 10/13/2025 | **Purchasing:**<br>Signed by:<br>Alonso Hurtado<br>75A924007C46480...<br>Director of Procurement and Business Optimization<br>Date: 10/2/2025 |
| **Reviewed as to Budget:**<br>Chief Financial Officer or Controller<br>Date: | **IT Approval:**<br>DocuSigned by:<br>CB0457C562F24EE...<br>Chief Information Officer or IT Director<br>Date: 10/13/2025 |
| _____<br>Chief Executive Officer<br><br>_____<br>Date | |
| | |
| **Board of Directors approval is required on all contracts over $100,000 if not budgeted and $200,000 if budgeted.** | |
| _____<br>KHS Board Chairman<br><br>_____<br>Date | |

# 24/7/365 Nurse Triage Services

Christine Pence

Senior Director for Health Services

October 23, 2025

# Agenda

- Overview
- RFP Timeline
- RFP Committee Selection Criteria
- Scoring Matrix
- Cost Analysis
- Requested Action

# Overview

In June 2025, Kern Health Systems (KHS) issued a Request for Proposal (RFP) for 24/7/365 Nurse Triage Services in order to comply with mandated regulatory standards outlined in its agreements with the Department of Health Care Services and its Knox Keene licensure through the Department of Managed Health Care. To meet these obligations, KHS provides continuous access to Nurse Triage Services that support members with health and benefit related questions, as well as an audio health library available in English and Spanish that offers health education focused on specific disease processes. These services are designed to be seamless to members, complementing internal business hours support provided by KHS staff and extending coverage after hours.

# RFP Timeline

- June 2025
  - KHS issued an RFP for 24/7/365 Nurse Triage Services.
- July 2025
  - Five (5) proposals were received. All proposals were scored based on meeting basic requirements outlined in RFP.
- August 2025
  - Of the five (5) proposals received, KHS selected the two highest-scoring vendors for further assessment.
- September 2025
  - KHS completed its final evaluation and selection.
- October 2025
  - Board approval request

# RFP Committee Selection Criteria

- A total of five proposals were received in response to the RFP.
  - Two highest-scoring vendors were considered.
- The recommendation is based on the following:
  - Pricing
  - Relevant experience
  - Ability to meet RFP requirements
  - Demonstrated use of technology-enabled security tools
- Scoring Criteria:
  - Live Capability & Member Experience
  - Language Access & Accessibility
  - Technology, Reliability & Disaster Recovery
  - Reporting & Analytics
  - Data Integration Readiness
  - Service Level Agreement (SLA) Approach & Feasibility
  - Compliance & Security
  - Implementation & Change Management
  - Team Fit & Communication

# Scoring Matrix

| Scoring Criteria<br>Each category is scored on a 0-5 scale | Total Possible Score | Carenet | Vendor B |
|---|---|---|---|
| Live Capability & Member Experience | 25 | **21** | 19 |
| Language Access & Accessibility | 10 | **9** | 8 |
| Technology, Reliability & Disaster Recovery | 15 | **12** | 11 |
| Reporting & Analytics | 15 | **11** | 12 |
| Data Integration Readiness | 10 | **8** | 8 |
| SLA Approach & Feasibility | 15 | **12** | 12 |
| Compliance & Security | 20 | **14** | 15 |
| Implementation & Change Management | 10 | **8** | 7 |
| Team Fit & Communication | 5 | **3** | 4 |
| | 125 | **99** | 96 |

| Evaluation Criteria | Description |
|---|---|
| Live Capability & Member Experience | Ability to triage a wide range of clinical and non-clinical calls, provide timely access to licensed nurses, coordinate warm hand-offs, demonstrate cultural competence and empathy, and show operational transparency. |
| Language Access & Accessibility | Support for multiple languages, interpreter services, and accommodations for members with hearing, vision, or other accessibility needs |
| Technology, Reliability & Disaster Recovery | System reliability and uptime, effective call routing and queue management, and demonstrated business continuity and disaster recovery processes. |
| Reporting & Analytics | Availability and clarity of operational and clinical reports, flexibility for ad-hoc data queries, and options for provider notifications. |
| Data Integration Readiness | Capability for accurate member-to-provider matching and secure methods of data exchange, including encryption and access controls. |
| SLA Approach & Feasibility | Ability to meet service levels (≥80% calls answered in 30 seconds), maintain low abandonment rates, and ensure timely access to clinicians. |
| Compliance & Security | HIPAA and PHI safeguards, incident response and breach notification practices, physician support model, and recognized industry accreditations. |
| Implementation & Change Management | Feasibility and risk management of the implementation plan, along with effective training and ramp-up to steady state. |
| Team Fit & Communication | Clarity, responsiveness, and collaboration style demonstrated in interactions. |

# Cost Analysis

| Year | Current PMPM | Current Total Cost | Carenet PMPM (1) | Proposed Total Cost | Vendor B PMPM | Vendor B Total Cost |
|---|---|---|---|---|---|---|
| Year 1 | $ 0.116 | $ 515,717 | $ 0.114 | $ 547,200 | $ 0.21 | $ 1,008,000 |
| Year 2 | $ 0.118 | $ 570,440 | $ 0.114 | $ 547,200 | $ 0.21 | $ 1,008,000 |
| Year 3 | $ 0.122 | $ 403,322 | $ 0.114 | $ 547,200 | $ 0.21 | $ 1,008,000 |
| Additional Fees | $ - | $ 200,000 (2) | $ - | $ 30,000 (3) | $ - | $ - |
| **Totals** | | $ 1,689,479 | | $ 1,671,600 | | $ 3,024,000 |

(1) Cost estimates are calculated using current membership. Projections are subject to revision as membership levels fluctuate. (PMPM rate will remain unchanged for membership levels of 300,000 or higher.)
(2) Additional fees in current cost include $200,000 for projected expenses through the term of the current contract.
(3) Additional fees in proposed cost include clinical and non-clinical overage fees, after hours provider survey fees, and ad hoc reporting.

# Board of Directors Request

Approve; Authorize the CEO to enter into, sign, and/or amend a new contract, with legal approval, with Carenet Health for 24/7/365 Nurse Triage Services for a three (3) year term from November 2, 2025 through November 1, 2028 with a total not-to-exceed amount of $1,671,600 for the entire term of the contract.

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

## Questions

Please contact:

Christine Pence
Senior Director of Health Services
661-377-9447
Christine.pence@khs-net.com

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Robert Landis, Chief Financial Officer

**SUBJECT:** July 2025 Financial Results

**DATE:** October 23, 2025

The July results reflect a $6.8 million Net Decrease in Net Position which is a $9.1 million unfavorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $40.9 million favorable variance primarily due to:

   A) $2.3 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 B.

   B) The $1.1 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 2B (1) below.

   C) $34.6 million favorable variance in Premium-Hospital Directed Payments is primarily due to receiving updated rate information from DHCS on February 28, 2025 for Calendar Year 2025 offset against amounts included in 2C below.

   D) $4.3 million favorable variance Rate Adjustment in Hospital Directed Payments is due to KHS receiving updated Hospital Directed Payment rates from DHCS on August 8, 2025 for the 2023 period offset against amounts included in 2D below.

   E) $4.8 million favorable variance in Rate/Income Adjustments is primarily due to accruing approximately $3.5 million relating to the 2024 Quality Withold Program. This accrual represents 50% of the expected amount of approximately $7 million to be eventually earned. (During Calendar 2024 DHCS withheld .5% of all Managed Care Plans monthly revenue that was to be earned back upon meeting certain quality measures. This amount increased to 1% in 2025). KHS received preliminary information from DHCS, subject to a final calculation, whereby KHS believes it has earned very close to 100% of the 2024 quality withhold amount.

2) Total Medical Costs reflect a $50.4 million unfavorable variance primarily due to

A) $1.2 million unfavorable variance in Physician Services is primarily due to higher-than-expected utilization of Primary Care and Referral Specialty Services by Expansion members over the last several months.

B) $9.1 million unfavorable variance in Other Medical primarily from:

1) $2.3 million unfavorable variance in Enhance Care Management expenses is due to receiving updated rate information from DHCS after the approval of the 2025 Budget along with higher-than-expected engagement utilization partially offset against amounts included in 1B above.

2) $4.9 million unfavorable variance in Community Support Services expenses is 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**.

(A key feature of CalAIM was the introduction of Community Support Services, formerly referred to as In Lieu of Services (ILOS). Community Support Services are designed to help improve the overall health and well-being of Medi-Cal managed care plan (MCP) members by addressing the members' health-related social needs, helping the members live healthier lives, and avoiding higher, costlier levels of care. Services include support to secure and maintain housing, access to medically tailored meals to support short-term recovery, personal care, and a variety of other community-based services. The range of services and resources are designed to address the unique needs of Medi-Cal members in the community, with a focus on promoting health, stability, and independence. Members may receive a Community Supports Service if they meet the eligibility criteria and if the MCP determines it is a medically appropriate and cost-effective alternative to services covered under Medi-Cal) **The funding for these services is inadequate with minimal savings in reducing medical expenses.**

3) $1.1 million unfavorable variance in Housing and Homelessness Incentive Program ("HHIP") is primarily due to timing. Revenue for the final submission for the HHIP program was recorded in April 2024. The corresponding provider expenses are not recognized until milestones are completed, documentation is submitted and reviewed, and reimbursements are processed. The $1.1 million recorded for July 2025 reflects payments to providers meeting their milestones.

C) $34.6 million unfavorable variance in Hospital Directed Payments is primarily due to receiving updated rate information from DHCS for Calendar Year 2024 offset against amounts included in 1C above.

D) $4.3 million unfavorable variance in Hospital Directed Payment Adjustment is due to KHS receiving updated Hospital Directed Payment rates from DHCS on August 8, 2025 for the 2023 period offset against amounts included in 1D above.

The July Medical Loss Ratio is 97.7%, which is unfavorable to the 91.8% budgeted amount. The July Administrative Expense Ratio is 5.8%, which is equal to the 5.8% budgeted amount.

The results for the 7 months ending July 31, 2025 reflect a Net Decrease in Net Position of $12.7 million. This is a $28.5 million unfavorable variance to the budget and includes approximately $41.5 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 95.3%, which is unfavorable to the 91.8% budgeted amount. The year-to-date Administrative Expense Ratio is 5.3 % which is favorable to the 5.8% budgeted amount.

KERN HEALTH SYSTEMS

# Financial Packet
# July 2025

**KHS – Medi-Cal Line of Business**


| | |
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| Statement of Revenue, Expenses, and Changes in Net Position | Page 2 |
| Statement of Revenue, Expenses, and Changes in Net Position - PMPM | Page 3 |
| Statement of Revenue, Expenses, and Changes in Net Position by Quarter | Page 4 |
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| Schedule of Medical Costs by Month – PMPM | Page 13 |
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| Schedule of Administrative Expenses by Department by Month | Page 15 |


**KHS Group Health Plan – Healthy Families Line of Business**


| | |
|---|---|
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| Statement of Revenue, Expenses, and Changes in Net Position | Page 17 |


**KHS Administrative Analysis and Other Reporting**


| | |
|---|---|
| Monthly Member Count | Page 18 |

**MEDI-CAL**
**STATEMENT OF NET POSITION**
**AS OF JULY 31, 2025**

| ASSETS | July | June | Increase/ (Decrease) |
|---|---|---|---|
| Cash and Cash Equivalents | 202,238,845 | 202,041,096 | 197,749 |
| Short-Term Investments | 167,665,423 | 185,529,847 | (17,864,424) |
| Premiums Receivable | 147,406,856 | 142,497,254 | 4,909,602 |
| Premiums Receivable - MCO Tax | 63,099,463 | 188,463,335 | (125,363,872) |
| Premiums Receivable - Hospital Directed Payments | 923,477,395 | 860,181,451 | 63,295,944 |
| Interest Receivable | 593,281 | 279,994 | 313,287 |
| Provider Advance Payment | 119,242 | 122,812 | (3,570) |
| Other Receivables | 1,994,879 | 2,311,828 | (316,949) |
| Prepaid Expenses & Other Current Assets | 6,920,132 | 6,092,526 | 827,607 |
| Total Current Assets | 1,513,515,517 | 1,587,520,144 | (74,004,627) |
| Land | 4,090,706 | 4,090,706 | - |
| Furniture and Equipment - Net | 1,093,575 | 1,121,805 | (28,230) |
| Computer Equipment - Net | 16,855,846 | 17,352,781 | (496,935) |
| Building and Improvements - Net | 32,515,984 | 32,594,927 | (78,944) |
| Capital Projects In Process | 2,257,464 | 2,090,720 | 166,744 |
| Total Capital Assets | 56,813,575 | 57,250,939 | (437,364) |
| Restricted Assets | 300,000 | 300,000 | - |
| Life Insurance Receivables | 3,786,511 | 3,786,511 | - |
| SBITA Asset | 8,875,096 | 8,875,096 | - |
| Total Long-Term Assets | 12,961,607 | 12,961,607 | - |
| Deferred Outflow of Resources | 8,565,202 | 6,846,742 | 1,718,460 |
| Total Assets and Deferred Outflows of Resources | 1,591,855,901 | 1,664,579,432 | (72,723,531) |
| **CURRENT LIABILITIES** | | | |
| Accrued Salaries and Benefits | 9,496,882 | 8,917,174 | 579,708 |
| Accrued Other Operating Expenses | 5,750,335 | 5,819,231 | (68,896) |
| MCO Tax Payable | 85,310,314 | 199,703,288 | (114,392,975) |
| Claims Payable (Reported) | 21,658,584 | 36,407,049 | (14,748,465) |
| IBNR - Inpatient Claims | 58,223,302 | 58,963,231 | (739,929) |
| IBNR - Physician Claims | 32,033,895 | 32,033,719 | 175 |
| IBNR - Accrued Other Medical | 36,398,558 | 34,123,858 | 2,274,701 |
| Risk Pool and Withholds Payable | 8,750,389 | 9,503,172 | (752,783) |
| Allowance for Claims Processing Expense | 4,821,903 | 4,821,903 | - |
| Other Liabilities | 60,058,495 | 61,460,270 | (1,401,775) |
| SBITA Liability – Current portion | 2,217,189 | 2,217,189 | - |
| Accrued Hospital Directed Payments | 927,735,190 | 864,438,154 | 63,297,036 |
| Total Current Liabilities | 1,252,455,035 | 1,318,408,238 | (65,953,203) |
| **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 | (12,730,808) | (5,960,480) | (6,770,328) |
| Total Net Position | 320,836,831 | 327,607,159 | (6,770,328) |
| TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION | 1,591,855,901 | 1,664,579,432 | (72,723,531) |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION**
**FOR THE MONTH ENDED JULY 31, 2025**

| | July | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| Family Members | 241,713 | 246,000 | (4,287) | 1,694,087 | 1,711,500 | (17,413) |
| Expansion Members | 116,616 | 113,000 | 3,616 | 809,379 | 791,000 | 18,379 |
| SPD Members | 47,300 | 47,000 | 300 | 330,937 | 329,000 | 1,937 |
| Total Members - MCAL | 405,629 | 406,000 | (371) | 2,834,403 | 2,831,500 | 2,903 |
| REVENUES | | | | | | |
| Medicaid - Family Members | 55,112,034 | 55,518,026 | (405,991) | 383,938,891 | 386,256,507 | (2,317,616) |
| Medicaid - Expansion Members | 49,057,991 | 47,912,766 | 1,145,225 | 341,594,344 | 335,389,362 | 6,204,981 |
| Medicaid - SPD Members | 38,111,261 | 40,402,462 | (2,291,200) | 263,694,461 | 282,817,232 | (19,122,771) |
| Premium - MCO Tax | 59,136,301 | 60,083,940 | (947,639) | 413,954,108 | 419,033,685 | (5,079,577) |
| Premium - Hospital Directed Payments | 59,035,880 | 24,426,249 | 34,609,631 | 412,720,126 | 170,569,557 | 242,150,569 |
| Investment Earnings And Other Income | 1,650,374 | 2,000,753 | (350,379) | 14,883,575 | 13,973,647 | 909,929 |
| Reinsurance Recoveries | 300,000 | 275,178 | 24,822 | 1,900,000 | 1,918,783 | (18,783) |
| Rate Adjustments - Hospital Directed Payments | 4,261,053 | - | 4,261,053 | 109,621,679 | - | 109,621,679 |
| Rate/Income Adjustments | 4,824,965 | - | 4,824,965 | 23,716,944 | - | 23,716,944 |
| Total Revenues | 271,489,861 | 230,619,373 | 40,870,488 | 1,966,024,127 | 1,609,958,773 | 356,065,354 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 38,137,625 | 36,933,291 | (1,204,334) | 272,226,408 | 257,734,733 | (14,491,676) |
| Other Professional Services | 11,113,022 | 10,890,447 | (222,576) | 75,599,544 | 76,024,887 | 425,343 |
| Emergency Room | 6,580,865 | 6,824,955 | 244,091 | 47,013,422 | 47,612,376 | 598,954 |
| Inpatient | 34,361,371 | 34,069,001 | (292,370) | 245,407,062 | 238,004,531 | (7,402,531) |
| Reinsurance Expense | 260,984 | 275,178 | 14,193 | 1,838,163 | 1,918,783 | 80,620 |
| Outpatient Hospital | 15,553,674 | 15,463,818 | (89,857) | 108,258,176 | 108,045,822 | (212,353) |
| Other Medical | 38,154,038 | 29,073,084 | (9,080,954) | 245,523,378 | 203,239,136 | (42,284,242) |
| Pay for Performance Quality Incentive | 608,444 | 608,999 | 556 | 4,351,605 | 4,247,277 | (104,328) |
| Hospital Directed Payments | 59,035,880 | 24,426,249 | (34,609,631) | 412,720,126 | 170,569,557 | (242,150,569) |
| Hospital Directed Payment Adjustment | 4,261,156 | - | (4,261,156) | 110,537,356 | - | (110,537,356) |
| Non-Claims Expense Adjustment | 99,601 | - | (99,601) | (16,652,106) | - | 16,652,106 |
| IBNR, Incentive, Paid Claims Adjustment | 822,578 | - | (822,578) | (2,050,272) | - | 2,050,272 |
| Total Medical Costs | 208,989,239 | 158,565,022 | (50,424,217) | 1,504,772,861 | 1,107,397,101 | (397,375,760) |
| GROSS MARGIN | 62,500,621 | 72,054,351 | (9,553,730) | 461,251,266 | 502,561,673 | (41,310,406) |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 4,003,904 | 4,223,117 | 219,213 | 27,450,182 | 29,561,822 | 2,111,640 |
| Purchased Services | 2,832,364 | 2,343,143 | (489,221) | 15,616,824 | 16,401,999 | 785,175 |
| Supplies | 137,483 | 244,079 | 106,596 | 929,407 | 1,708,552 | 779,144 |
| Depreciation | 604,109 | 766,752 | 162,643 | 4,205,862 | 5,367,264 | 1,161,402 |
| Other Administrative Expenses | 1,115,773 | 672,406 | (443,368) | 5,185,563 | 4,706,839 | (478,724) |
| Administrative Expense Adjustment | (308) | 200,000 | 200,308 | 1,053,608 | 1,400,000 | 346,392 |
| Total Administrative Expenses | 8,693,325 | 8,449,496 | (243,829) | 54,441,447 | 59,146,476 | 4,705,030 |
| TOTAL EXPENSES | 217,682,565 | 167,014,518 | (50,668,046) | 1,559,214,308 | 1,166,543,577 | (392,670,731) |
| OPERATING INCOME (LOSS) BEFORE TAX | 53,807,296 | 63,604,855 | (9,797,559) | 406,809,820 | 443,415,196 | (36,605,377) |
| MCO TAX | 59,136,301 | 60,083,940 | 947,639 | 413,954,108 | 419,033,685 | 5,079,577 |
| OPERATING INCOME (LOSS) NET OF TAX | (5,329,005) | 3,520,915 | (8,849,920) | (7,144,288) | 24,381,511 | (31,525,800) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Provider Grants/CalAIM/Home Heath | (1,250,501) | (833,660) | (416,840) | (4,200,097) | (5,821,888) | 1,621,791 |
| D-SNP Expenses | (190,822) | (400,596) | 209,774 | (1,386,423) | (2,797,572) | 1,411,149 |
| Total Non-Operating Revenue (Expense) | (1,441,323) | (1,234,256) | (207,066) | (5,586,519) | (8,619,460) | 3,032,941 |
| NET INCREASE (DECREASE) IN NET POSITION | (6,770,328) | 2,286,658 | (9,056,986) | (12,730,808) | 15,762,052 | (28,492,859) |
| MEDICAL LOSS RATIO | 97.7% | 91.8% | -5.9% | 95.3% | 91.8% | -3.5% |
| ADMINISTRATIVE EXPENSE RATIO | 5.8% | 5.8% | 0.0% | 5.3% | 5.8% | 0.5% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION**
**FOR THE MONTH ENDED JULY 31, 2025**

| | July | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| Family Members | 241,713 | 246,000 | (4,287) | 1,694,087 | 1,711,500 | (17,413) |
| Expansion Members | 116,616 | 113,000 | 3,616 | 809,379 | 791,000 | 18,379 |
| SPD Members | 47,300 | 47,000 | 300 | 330,937 | 329,000 | 1,937 |
| Total Members - MCAL | 405,629 | 406,000 | (371) | 2,834,403 | 2,831,500 | 2,903 |
| REVENUES | | | | | | |
| Medicaid - Family Members | 228.01 | 225.68 | 2.32 | 226.63 | 225.68 | 0.95 |
| Medicaid - Expansion Members | 420.68 | 424.01 | (3.33) | 422.04 | 424.01 | (1.96) |
| Medicaid - SPD Members | 805.73 | 859.63 | (53.89) | 796.81 | 859.63 | (62.82) |
| Premium - MCO Tax | 145.79 | 147.99 | (2.20) | 146.05 | 147.99 | (1.94) |
| Premium - Hospital Directed Payments | 145.54 | 60.16 | 85.38 | 145.61 | 60.24 | 85.37 |
| Investment Earnings And Other Income | 4.07 | 4.93 | (0.86) | 5.25 | 4.94 | 0.32 |
| Reinsurance Recoveries | 0.74 | 0.68 | 0.06 | 0.67 | 0.68 | (0.01) |
| Rate Adjustments - Hospital Directed Payments | 10.50 | - | 10.50 | 38.68 | - | 38.68 |
| Rate/Income Adjustments | 11.90 | - | 11.90 | 8.37 | - | 8.37 |
| Total Revenues | 669.31 | 568.03 | 101.28 | 693.63 | 568.59 | 125.04 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 94.02 | 90.97 | (3.05) | 96.04 | 91.02 | (5.02) |
| Other Professional Services | 27.40 | 26.82 | (0.57) | 26.67 | 26.85 | 0.18 |
| Emergency Room | 16.22 | 16.81 | 0.59 | 16.59 | 16.82 | 0.23 |
| Inpatient | 84.71 | 83.91 | (0.80) | 86.58 | 84.06 | (2.53) |
| Reinsurance Expense | 0.64 | 0.68 | 0.03 | 0.65 | 0.68 | 0.03 |
| Outpatient Hospital | 38.34 | 38.09 | (0.26) | 38.19 | 38.16 | (0.04) |
| Other Medical | 94.06 | 71.61 | (22.45) | 86.62 | 71.78 | (14.84) |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | (0.00) | 1.54 | 1.50 | (0.04) |
| Hospital Directed Payments | 145.54 | 60.16 | (85.38) | 145.61 | 60.24 | (85.37) |
| Hospital Directed Payment Adjustment | 10.51 | - | (10.51) | 39.00 | - | (39.00) |
| Non-Claims Expense Adjustment | 0.25 | - | (0.25) | (5.87) | - | 5.87 |
| IBNR, Incentive, Paid Claims Adjustment | 2.03 | - | (2.03) | (0.72) | - | 0.72 |
| Total Medical Costs | 515.22 | 390.55 | (124.67) | 530.90 | 391.10 | (139.80) |
| GROSS MARGIN | 154.08 | 177.47 | (23.39) | 162.73 | 177.49 | (14.76) |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 9.87 | 10.40 | 0.53 | 9.68 | 10.44 | 0.76 |
| Purchased Services | 6.98 | 5.77 | (1.21) | 5.51 | 5.79 | 0.28 |
| Supplies | 0.34 | 0.60 | 0.26 | 0.33 | 0.60 | 0.28 |
| Depreciation | 1.49 | 1.89 | 0.40 | 1.48 | 1.90 | 0.41 |
| Other Administrative Expenses | 2.75 | 1.66 | (1.09) | 1.83 | 1.66 | (0.17) |
| Administrative Expense Adjustment | (0.00) | 0.49 | 0.49 | 0.37 | 0.49 | 0.12 |
| Total Administrative Expenses | 21.43 | 20.81 | (0.62) | 19.21 | 20.89 | 1.68 |
| TOTAL EXPENSES | 536.65 | 411.37 | (125.29) | 550.10 | 411.99 | (138.12) |
| OPERATING INCOME (LOSS) BEFORE TAX | 132.65 | 156.66 | (24.01) | 143.53 | 156.60 | (13.08) |
| MCO TAX | 145.79 | 147.99 | 2.20 | 146.05 | 147.99 | 1.94 |
| OPERATING INCOME (LOSS) NET OF TAX | (13.14) | 8.67 | (21.81) | (2.52) | 8.61 | (11.13) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Provider Grants/CalAIM/Home Heath | (0.47) | (2.05) | 1.58 | (0.49) | (2.06) | 1.57 |
| D-SNP Expenses | (3.08) | (0.99) | (2.10) | (1.48) | (0.99) | (0.49) |
| Total Non-Operating Revenue (Expense) | (3.55) | (3.04) | (0.51) | (1.97) | (3.04) | 1.07 |
| NET INCREASE (DECREASE) IN NET POSITION | (16.69) | 5.63 | (22.32) | (4.49) | 5.57 | (10.06) |
| MEDICAL LOSS RATIO | 97.7% | 91.8% | -5.9% | 95.3% | 91.8% | -3.5% |
| ADMINISTRATIVE EXPENSE RATIO | 5.8% | 5.8% | 0.0% | 5.3% | 5.8% | 0.5% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY QUARTER**
**ROLLING 4 QUARTERS**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | 2024 - Q3 | 2024 - Q4 | 2025 - Q1 | 2025 - Q2 | Rolling 4-Quarter Totals | CURRENT QUARTER 2025 - Q3 |
|---|---|---|---|---|---|---|
| Total Members - MCAL | 1,204,552 | 1,209,901 | 1,215,186 | 1,213,588 | 4,843,227 | 405,629 |
| REVENUES | | | | | | |
| Medicaid - Family Members | 157,352,051 | 181,853,744 | 164,182,925 | 164,643,931 | 668,032,651 | 55,112,034 |
| Medicaid - Expansion Members | 115,764,407 | 146,690,508 | 146,129,580 | 146,406,773 | 554,991,267 | 49,057,991 |
| Medicaid - SPD Members | 63,945,176 | 72,615,432 | 112,116,656 | 113,466,544 | 362,143,808 | 38,111,261 |
| Medicaid - LTC Members | 12,158,979 | 12,679,447 | - | - | 24,838,426 | - |
| Premium - MCO Tax | 304,000,610 | 169,305,625 | 177,408,904 | 177,408,904 | 828,124,042 | 59,136,301 |
| Premium - Hospital Directed Payments | 73,636,849 | 74,054,842 | 176,821,231 | 176,863,014 | 501,375,937 | 59,035,880 |
| Investment Earnings And Other Income | 10,624,397 | 6,363,381 | 6,614,108 | 6,619,093 | 30,220,979 | 1,650,374 |
| Reinsurance Recoveries | - | - | - | 1,600,000 | 1,600,000 | 300,000 |
| Rate Adjustments - Hospital Directed Payments | (8,849,506) | (45,264) | 105,206,644 | 153,982 | 96,465,856 | 4,261,053 |
| Rate/Income Adjustments | 2,310,217 | 29,220 | 2,557,018 | 16,334,961 | 21,231,416 | 4,824,965 |
| Total Revenues | 730,943,182 | 663,546,935 | 891,037,065 | 803,497,202 | 3,089,024,383 | 271,489,861 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 100,828,569 | 117,920,414 | 113,538,825 | 120,549,958 | 452,837,766 | 38,137,625 |
| Other Professional Services | 27,259,189 | 17,579,841 | 31,017,823 | 33,468,699 | 109,325,551 | 11,113,022 |
| Emergency Room | 19,085,229 | 20,264,346 | 20,024,420 | 20,408,138 | 79,782,132 | 6,580,865 |
| Inpatient | 98,069,526 | 109,860,804 | 98,477,222 | 112,568,469 | 418,976,021 | 34,361,371 |
| Reinsurance Expense | 337,661 | 337,245 | 808,856 | 768,322 | 2,252,085 | 260,984 |
| Outpatient Hospital | 46,542,079 | 45,089,064 | 46,204,757 | 46,499,744 | 184,335,645 | 15,553,674 |
| Other Medical | 93,132,007 | 95,537,563 | 99,350,041 | 108,019,275 | 396,038,888 | 38,154,038 |
| Pay for Performance Quality Incentive | 1,809,795 | 1,814,852 | 1,822,779 | 1,920,382 | 7,367,808 | 608,444 |
| Risk Corridor Expense | 2,133,095 | (960,173) | - | - | 1,172,922 | - |
| Hospital Directed Payments | 73,636,849 | 74,054,842 | 176,821,231 | 176,863,014 | 501,375,937 | 59,035,880 |
| Hospital Directed Payment Adjustment | (6,489,175) | (45,264) | 105,103,291 | 1,172,910 | 99,741,761 | 4,261,156 |
| Non-Claims Expense Adjustment | (4,294,448) | (1,489,159) | (6,486,815) | (10,264,893) | (22,535,315) | 99,601 |
| IBNR, Incentive, Paid Claims Adjustment | (6,331,814) | (3,892,128) | 658,346 | (3,531,172) | (13,096,768) | 822,578 |
| Total Medical Costs | 445,718,563 | 476,072,247 | 687,340,775 | 608,442,846 | 2,217,574,432 | 208,989,239 |
| GROSS MARGIN | 285,224,619 | 187,474,687 | 203,696,289 | 195,054,356 | 871,449,951 | 62,500,621 |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 11,047,726 | 12,349,629 | 11,773,691 | 11,672,587 | 46,843,633 | 4,003,904 |
| Purchased Services | 6,652,421 | 6,570,351 | 5,241,893 | 7,542,567 | 26,007,232 | 2,832,364 |
| Supplies | 707,109 | 693,365 | 438,866 | 353,058 | 2,192,398 | 137,483 |
| Depreciation | 2,283,774 | 2,071,812 | 1,794,880 | 1,806,873 | 7,957,339 | 604,109 |
| Other Administrative Expenses | 1,588,772 | 1,848,717 | 2,016,475 | 2,053,315 | 7,507,279 | 1,115,773 |
| Administrative Expense Adjustment | (2,309) | 1,230,808 | 776,919 | 276,996 | 2,282,415 | (308) |
| Total Administrative Expenses | 22,277,493 | 24,764,681 | 22,042,724 | 23,705,397 | 92,790,295 | 8,693,325 |
| TOTAL EXPENSES | 467,996,056 | 500,836,928 | 709,383,500 | 632,148,243 | 2,310,364,727 | 217,682,565 |
| OPERATING INCOME (LOSS) BEFORE TAX | 262,947,125 | 162,710,007 | 181,653,565 | 171,348,959 | 778,659,656 | 53,807,296 |
| MCO TAX | 304,000,610 | 169,305,625 | 177,408,904 | 177,408,904 | 650,715,139 | 59,136,301 |
| OPERATING INCOME (LOSS) NET OF TAX | (41,053,485) | (6,595,619) | 4,244,662 | (6,059,945) | 127,944,517 | (5,329,005) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Total Non-Operating Revenue (Expense) | (1,249,113) | (4,205,257) | (1,632,695) | (2,512,502) | (9,599,567) | (1,441,323) |
| NET INCREASE (DECREASE) IN NET POSITION | (42,302,598) | (10,800,875) | 2,611,967 | (8,572,447) | 118,344,951 | (6,770,328) |
| MEDICAL LOSS RATIO | 104.5% | 95.7% | 93.9% | 95.8% | 97.2% | 97.7% |
| ADMINISTRATIVE EXPENSE RATIO | 6.2% | 5.9% | 5.1% | 5.3% | 5.6% | 5.8% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY QUARTER**
**ROLLING 4 QUARTERS PMPM**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | 2024 - Q3 | 2024 - Q4 | 2025 - Q1 | 2025 - Q2 | Rolling Quarter Totals | CURRENT QUARTER 2025 - Q3 |
|---|---|---|---|---|---|---|
| Total Members - MCAL | 1,204,552 | 1,209,901 | 1,215,186 | 1,213,588 | 4,843,227 | 405,629 |
| REVENUES | | | | | | |
| Medicaid - Family Members | 197.65 | 228.42 | 225.55 | 227.27 | 219.41 | 76.07 |
| Medicaid - Expansion Members | 343.25 | 428.47 | 422.74 | 421.81 | 404.40 | 141.34 |
| Medicaid - SPD Members | 918.71 | 1,039.89 | 791.89 | 798.75 | 855.99 | 268.28 |
| Medicaid - LTC Members | 7,764.35 | 8,050.44 | - | 1.00 | 7,907.81 | - |
| Premium - MCO Tax | 252.38 | 139.93 | 145.99 | 146.19 | 170.99 | 145.79 |
| Premium - Hospital Directed Payments | 61.13 | 61.21 | 145.51 | 145.74 | 103.52 | 145.54 |
| Investment Earnings And Other Income | 8.82 | 5.26 | 5.44 | 5.45 | 6.24 | 4.07 |
| Reinsurance Recoveries | - | - | - | 1.32 | 0.33 | 0.74 |
| Rate Adjustments - Hospital Directed Payments | (7.35) | (0.04) | 86.58 | 0.13 | 19.92 | 10.50 |
| Rate/Income Adjustments | 1.92 | 0.02 | 2.10 | 13.46 | 4.38 | 11.90 |
| Total Revenues | 606.82 | 548.43 | 733.25 | 662.08 | 637.80 | 669.31 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 83.71 | 97.46 | 93.43 | 99.33 | 93.50 | 94.02 |
| Other Professional Services | 22.63 | 14.53 | 25.53 | 27.58 | 22.57 | 27.40 |
| Emergency Room | 15.84 | 16.75 | 16.48 | 16.82 | 16.47 | 16.22 |
| Inpatient | 81.42 | 90.80 | 81.04 | 92.76 | 86.51 | 84.71 |
| Reinsurance Expense | 0.28 | 0.28 | 0.67 | 0.63 | 0.46 | 0.64 |
| Outpatient Hospital | 38.64 | 37.27 | 38.02 | 38.32 | 38.06 | 38.34 |
| Other Medical | 77.32 | 78.96 | 81.76 | 89.01 | 81.77 | 94.06 |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | 1.50 | 1.58 | 1.52 | 1.50 |
| Risk Corridor Expense | 1.77 | (0.79) | - | - | 0.24 | - |
| Hospital Directed Payments | 61.13 | 61.21 | 145.51 | 145.74 | 103.52 | 145.54 |
| Hospital Directed Payment Adjustment | (5.39) | (0.04) | 86.49 | 0.97 | 20.59 | 10.51 |
| Non-Claims Expense Adjustment | (3.57) | (1.23) | (5.34) | (8.46) | (4.65) | 0.25 |
| IBNR, Incentive, Paid Claims Adjustment | (5.26) | (3.22) | 0.54 | (2.91) | (2.70) | 2.03 |
| Total Medical Costs | 370.03 | 393.48 | 565.63 | 501.36 | 457.87 | 515.22 |
| GROSS MARGIN | 236.79 | 154.95 | 167.63 | 160.73 | 179.93 | 154.08 |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 9.17 | 10.21 | 9.69 | 9.62 | 9.67 | 9.87 |
| Purchased Services | 5.52 | 5.43 | 4.31 | 6.22 | 5.37 | 6.98 |
| Supplies | 0.59 | 0.57 | 0.36 | 0.29 | 0.45 | 0.34 |
| Depreciation | 1.90 | 1.71 | 1.48 | 1.49 | 1.64 | 1.49 |
| Other Administrative Expenses | 1.32 | 1.53 | 1.66 | 1.69 | 1.55 | 2.75 |
| Administrative Expense Adjustment | (0.00) | 1.02 | 0.64 | 0.23 | 0.47 | (0.00) |
| Total Administrative Expenses | 18.49 | 20.47 | 18.14 | 19.53 | 19.16 | 21.43 |
| TOTAL EXPENSES | 388.52 | 413.95 | 583.77 | 520.89 | 477.03 | 536.65 |
| OPERATING INCOME (LOSS) BEFORE TAX | 218.29 | 134.48 | 149.49 | 141.19 | 160.77 | 132.65 |
| MCO TAX | 252.38 | 139.93 | 145.99 | 146.19 | 134.36 | 145.79 |
| OPERATING INCOME (LOSS) NET OF TAX | (34.08) | (5.45) | 3.49 | (4.99) | 26.42 | (13.14) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Total Non-Operating Revenue (Expense) | (1.04) | (3.48) | (1.34) | (2.07) | (1.98) | (3.55) |
| NET INCREASE (DECREASE) IN NET POSITION | (35.12) | (8.93) | 2.15 | (7.06) | 24.44 | (16.69) |
| MEDICAL LOSS RATIO | 104.5% | 95.7% | 93.9% | 95.8% | 97.2% | 97.7% |
| ADMINISTRATIVE EXPENSE RATIO | 6.2% | 5.9% | 5.1% | 5.3% | 5.6% | 5.8% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY MONTH**
**ROLLING 6 MONTHS**
**FOR THE MONTH ENDED JULY 31, 2025**

| | JANUARY 2025 | FEBRUARY 2025 | MARCH 2025 | APRIL 2025 | MAY 2025 | JUNE 2025 | Prior 6 Month YTD | JULY 2025 |
|---|---|---|---|---|---|---|---|---|
| Total Members - MCAL | 404,441 | 405,545 | 405,200 | 404,899 | 403,890 | 404,799 | 2,428,774 | 405,629 |
| REVENUES | | | | | | | | |
| Medicaid - Family Members | 54,779,472 | 55,023,433 | 54,380,020 | 54,688,236 | 55,024,952 | 54,930,744 | 328,826,856 | 55,112,034 |
| Medicaid - Expansion Members | 48,572,760 | 48,902,196 | 48,654,624 | 48,688,708 | 48,723,433 | 48,994,633 | 292,536,353 | 49,057,991 |
| Medicaid - SPD Members | 38,799,459 | 35,786,816 | 37,530,381 | 37,663,190 | 37,785,856 | 38,017,497 | 225,583,200 | 38,111,261 |
| Medicaid - LTC Members | - | - | - | - | - | - | - | - |
| Premium - MCO Tax | 59,136,301 | 59,136,301 | 59,136,301 | 59,136,301 | 59,124,814 | 59,147,788 | 354,817,807 | 59,136,301 |
| Premium - Hospital Directed Payments | 59,831,392 | 58,045,936 | 58,943,903 | 58,897,348 | 58,890,354 | 59,075,312 | 353,684,246 | 59,035,880 |
| Investment Earnings And Other Income | 1,729,314 | 2,419,799 | 2,464,994 | 3,204,688 | 1,505,898 | 1,908,507 | 13,233,201 | 1,650,374 |
| Reinsurance Recoveries | - | - | - | - | - | 1,600,000 | 1,600,000 | 300,000 |
| Rate Adjustments - Hospital Directed Payments | 103,134,648 | 1,953,159 | 118,837 | 111,950 | 78,980 | (36,948) | 105,360,626 | 4,261,053 |
| Rate/Income Adjustments | 520,492 | 1,370,485 | 666,041 | 6,525,510 | 136,042 | 9,673,408 | 18,891,979 | 4,824,965 |
| Total Revenues | 366,503,837 | 262,638,127 | 261,895,101 | 268,915,931 | 261,270,330 | 273,310,941 | 1,694,534,267 | 271,489,861 |
| EXPENSES | | | | | | | | |
| MEDICAL COSTS | | | | | | | | |
| Physician Services | 36,132,491 | 38,711,809 | 38,694,525 | 39,018,167 | 39,419,683 | 42,112,109 | 234,088,783 | 38,137,625 |
| Other Professional Services | 11,445,798 | 10,004,694 | 9,567,330 | 11,252,193 | 10,693,341 | 11,523,165 | 64,486,522 | 11,113,022 |
| Emergency Room | 7,289,728 | 6,508,981 | 6,225,711 | 6,330,730 | 7,074,183 | 7,003,225 | 40,432,558 | 6,580,865 |
| Inpatient | 33,857,875 | 31,406,220 | 33,213,126 | 33,714,646 | 39,326,548 | 39,527,275 | 211,045,690 | 34,361,371 |
| Reinsurance Expense | 269,619 | 269,619 | 269,619 | 240,829 | 271,713 | 255,781 | 1,577,178 | 260,984 |
| Outpatient Hospital | 16,019,765 | 15,697,949 | 14,487,044 | 16,762,573 | 14,357,942 | 15,379,229 | 92,704,501 | 15,553,674 |
| Other Medical | 30,295,617 | 34,766,397 | 34,288,028 | 35,490,285 | 34,883,873 | 37,645,117 | 207,369,317 | 38,154,038 |
| Pay for Performance Quality Incentive | 606,662 | 608,318 | 607,800 | 607,349 | 605,835 | 707,199 | 3,743,161 | 608,444 |
| Risk Corridor Expense | - | - | - | - | - | - | - | - |
| Hospital Directed Payments | 59,831,392 | 58,045,936 | 58,943,903 | 58,897,348 | 58,890,354 | 59,075,312 | 353,684,246 | 59,035,880 |
| Hospital Directed Payment Adjustment | 103,134,648 | 1,953,159 | 15,484 | 111,948 | 1,098,088 | (37,127) | 106,276,200 | 4,261,156 |
| Non-Claims Expense Adjustment | (350,170) | (2,753,743) | (3,382,901) | (1,877) | (10,262,733) | (283) | (16,751,708) | 99,601 |
| IBNR, Incentive, Paid Claims Adjustment | 388,615 | 248,637 | 21,094 | (2,667,263) | (37,610) | (826,300) | (2,872,826) | 822,578 |
| Total Medical Costs | 298,922,038 | 195,467,975 | 192,950,763 | 199,756,928 | 196,321,218 | 212,364,700 | 1,295,783,622 | 208,989,239 |
| GROSS MARGIN | 67,581,799 | 67,170,152 | 68,944,338 | 69,159,003 | 64,949,112 | 60,946,241 | 398,750,645 | 62,500,621 |
| ADMINISTRATIVE COSTS | | | | | | | | |
| Compensation | 4,200,484 | 3,708,197 | 3,865,011 | 3,886,069 | 3,873,266 | 3,913,252 | 23,446,278 | 4,003,904 |
| Purchased Services | 1,498,800 | 1,740,859 | 2,002,235 | 2,673,698 | 2,687,401 | 2,181,469 | 12,784,460 | 2,832,364 |
| Supplies | 95,074 | 163,332 | 180,460 | 122,949 | 121,882 | 108,227 | 791,924 | 137,483 |
| Depreciation | 812,433 | 385,016 | 597,431 | 597,265 | 605,113 | 604,495 | 3,601,753 | 604,109 |
| Other Administrative Expenses | 883,740 | 468,446 | 664,289 | 561,209 | 836,014 | 656,092 | 4,069,790 | 1,115,773 |
| Administrative Expense Adjustment | 202,969 | 198,773 | 375,177 | 160,116 | 69,345 | 47,536 | 1,053,915 | (308) |
| Total Administrative Expenses | 7,693,499 | 6,664,623 | 7,684,602 | 8,001,306 | 8,193,021 | 7,511,070 | 45,748,121 | 8,693,325 |
| TOTAL EXPENSES | 306,615,537 | 202,132,598 | 200,635,365 | 207,758,234 | 204,514,239 | 219,875,770 | 1,341,531,743 | 217,682,565 |
| OPERATING INCOME (LOSS) BEFORE TAX | 59,888,301 | 60,505,529 | 61,259,736 | 61,157,697 | 56,756,091 | 53,435,171 | 353,002,524 | 53,807,296 |
| MCO TAX | 59,136,301 | 59,136,301 | 59,136,301 | 59,136,301 | 59,136,301 | 59,136,301 | 354,817,807 | 59,136,301 |
| OPERATING INCOME (LOSS) NET OF TAX | 751,999 | 1,369,228 | 2,123,435 | 2,021,395 | (2,380,210) | (5,701,130) | (1,815,283) | (5,329,005) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | | | |
| Total Non-Operating Revenue (Expense) | (623,936) | (600,969) | (407,789) | (511,718) | (845,044) | (1,155,740) | (4,145,196) | (1,441,323) |
| NET INCREASE (DECREASE) IN NET POSITION | 128,064 | 768,258 | 1,715,645 | 1,509,677 | (3,225,255) | (6,856,869) | (5,960,480) | (6,770,328) |
| MEDICAL LOSS RATIO | 94.2% | 94.4% | 93.2% | 93.4% | 95.2% | 98.8% | 94.9% | 97.7% |
| ADMINISTRATIVE EXPENSE RATIO | 5.3% | 4.6% | 5.3% | 5.3% | 5.7% | 4.8% | 5.2% | 5.8% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY MONTH**
**PMPM ROLLING 6 MONTHS**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | JANUARY 2025 | FEBRUARY 2025 | MARCH 2025 | APRIL 2025 | MAY 2025 | JUNE 2025 | 6 Month Prior YTD | JULY 2025 |
|---|---|---|---|---|---|---|---|---|
| Total Members - MCAL | 404,441 | 405,545 | 405,200 | 404,899 | 403,890 | 404,799 | 2,428,774 | 405,629 |
| REVENUES | | | | | | | | |
| Medicaid - Family Members | 225.97 | 226.62 | 224.06 | 225.70 | 228.41 | 227.71 | 226.41 | 228.01 |
| Medicaid - Expansion Members | 423.70 | 422.28 | 422.24 | 422.12 | 421.48 | 421.84 | 422.27 | 420.68 |
| Medicaid - SPD Members | 818.92 | 762.41 | 794.08 | 797.07 | 797.42 | 801.74 | 795.32 | 805.73 |
| Medicaid - LTC Members | - | - | - | - | - | - | - | - |
| Premium - MCO Tax | 146.22 | 145.82 | 145.94 | 146.05 | 146.39 | 146.12 | 146.09 | 145.79 |
| Premium - Hospital Directed Payments | 147.94 | 143.13 | 145.47 | 145.46 | 145.81 | 145.94 | 145.62 | 145.54 |
| Investment Earnings And Other Income | 4.28 | 5.97 | 6.08 | 7.91 | 3.73 | 4.71 | 5.45 | 4.07 |
| Reinsurance Recoveries | - | - | - | - | - | 3.95 | 0.66 | 0.74 |
| Rate Adjustments - Hospital Directed Payments | 255.01 | 4.82 | 0.29 | 0.28 | 0.20 | (0.09) | 43.38 | 10.50 |
| Rate/Income Adjustments | 1.29 | 3.38 | 1.64 | 16.12 | 0.34 | 23.90 | 7.78 | 11.90 |
| Total Revenues | 906.20 | 647.62 | 646.34 | 664.16 | 646.88 | 675.18 | 697.69 | 669.31 |
| EXPENSES | | | | | | | | |
| MEDICAL COSTS | | | | | | | | |
| Physician Services | 89.34 | 95.46 | 95.49 | 96.37 | 97.60 | 104.03 | 96.38 | 94.02 |
| Other Professional Services | 28.30 | 24.67 | 23.61 | 27.79 | 26.48 | 28.47 | 26.55 | 27.40 |
| Emergency Room | 18.02 | 16.05 | 15.36 | 15.64 | 17.52 | 17.30 | 16.65 | 16.22 |
| Inpatient | 83.72 | 77.44 | 81.97 | 83.27 | 97.37 | 97.65 | 86.89 | 84.71 |
| Reinsurance Expense | 0.67 | 0.66 | 0.67 | 0.59 | 0.67 | 0.63 | 0.65 | 0.64 |
| Outpatient Hospital | 39.61 | 38.71 | 35.75 | 41.40 | 35.55 | 37.99 | 38.17 | 38.34 |
| Other Medical | 74.91 | 85.73 | 84.62 | 87.65 | 86.37 | 93.00 | 85.38 | 94.06 |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.75 | 1.54 | 1.50 |
| Risk Corridor Expense | - | - | - | - | - | - | - | - |
| Hospital Directed Payments | 147.94 | 143.13 | 145.47 | 145.46 | 145.81 | 145.94 | 145.62 | 145.54 |
| Hospital Directed Payment Adjustment | 255.01 | 4.82 | 0.04 | 0.28 | 2.72 | (0.09) | 43.76 | 10.51 |
| Non-Claims Expense Adjustment | (0.87) | (6.79) | (8.35) | (0.00) | (25.41) | (0.00) | (6.90) | 0.25 |
| IBNR, Incentive, Paid Claims Adjustment | 0.96 | 0.61 | 0.05 | (6.59) | (0.09) | (2.04) | (1.18) | 2.03 |
| Total Medical Costs | 739.10 | 481.99 | 476.19 | 493.35 | 486.08 | 524.62 | 533.51 | 515.22 |
| GROSS MARGIN | 167.10 | 165.63 | 170.15 | 170.81 | 160.81 | 150.56 | 164.18 | 154.08 |
| ADMINISTRATIVE COSTS | | | | | | | | |
| Compensation | 10.39 | 9.14 | 9.54 | 9.60 | 9.59 | 9.67 | 9.65 | 9.87 |
| Purchased Services | 3.71 | 4.29 | 4.94 | 6.60 | 6.65 | 5.39 | 5.26 | 6.98 |
| Supplies | 0.24 | 0.40 | 0.45 | 0.30 | 0.30 | 0.27 | 0.33 | 0.34 |
| Depreciation | 2.01 | 0.95 | 1.47 | 1.48 | 1.50 | 1.49 | 1.48 | 1.49 |
| Other Administrative Expenses | 2.19 | 1.16 | 1.64 | 1.39 | 2.07 | 1.62 | 1.68 | 2.75 |
| Administrative Expense Adjustment | 0.50 | 0.49 | 0.93 | 0.40 | 0.17 | 0.12 | 0.43 | (0.00) |
| Total Administrative Expenses | 19.02 | 16.43 | 18.96 | 19.76 | 20.29 | 18.56 | 18.84 | 21.43 |
| TOTAL EXPENSES | 758.12 | 498.42 | 495.15 | 513.11 | 506.36 | 543.17 | 552.35 | 536.65 |
| OPERATING INCOME (LOSS) BEFORE TAX | 148.08 | 149.20 | 151.18 | 151.04 | 140.52 | 132.00 | 145.34 | 132.65 |
| MCO TAX | 146.22 | 145.82 | 145.94 | 146.05 | 146.42 | 146.09 | 146.09 | 145.79 |
| OPERATING INCOME (LOSS) NET OF TAX | 1.86 | 3.38 | 5.24 | 4.99 | (5.89) | (14.08) | (0.75) | (13.14) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | | | |
| Total Non-Operating Revenue (Expense) | (1.54) | (1.48) | (1.01) | (1.26) | (2.09) | (2.86) | (1.71) | (3.55) |
| NET INCREASE (DECREASE) IN NET POSITION | 0.32 | 1.89 | 4.23 | 3.73 | (7.99) | (16.94) | (2.45) | (16.69) |
| MEDICAL LOSS RATIO | 94.2% | 94.4% | 93.2% | 93.4% | 95.2% | 98.8% | 94.9% | 97.7% |
| ADMINISTRATIVE EXPENSE RATIO | 5.3% | 4.6% | 5.3% | 5.3% | 5.7% | 4.8% | 5.2% | 5.8% |

**MEDI-CAL**
**SCHEDULE OF REVENUES - ALL COA**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | July | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| **REVENUES** | | | | | | |
| Premium - Medi-Cal | 47,430,400 | 48,662,983 | (1,232,583) | 332,575,254 | 338,563,801 | (5,988,547) |
| Premium - Maternity Kick | 3,702,830 | 3,382,121 | 320,709 | 23,461,433 | 23,530,487 | (69,054) |
| Premium - Enhanced Care Management | 2,122,439 | 1,765,089 | 357,351 | 14,897,917 | 12,280,282 | 2,617,635 |
| Premium - Major Organ Transplant | 162,658 | 239,095 | (76,438) | 1,136,454 | 1,663,463 | (527,009) |
| Premium - Provider Enhancement | 1,436,284 | 1,177,159 | 259,125 | 10,061,457 | 8,189,867 | 1,871,590 |
| Premium - GEMT | 160,596 | 183,339 | (22,742) | 1,127,825 | 1,275,546 | (147,721) |
| Other | 96,828 | 108,240 | (11,412) | 678,550 | 753,060 | (74,510) |
| TOTAL MEDICAID - FAMILY MEMBERS | 55,112,034 | 55,518,026 | (405,991) | 383,938,891 | 386,256,507 | (2,317,616) |
| Premium - Medi-Cal | 45,545,841 | 44,592,454 | 953,387 | 316,564,674 | 312,147,180 | 4,417,494 |
| Premium - Maternity Kick | 335,927 | 442,636 | (106,709) | 2,893,551 | 3,098,454 | (204,902) |
| Premium - Enhanced Care Management | 2,167,026 | 1,778,641 | 388,385 | 15,109,513 | 12,450,484 | 2,659,029 |
| Premium - Major Organ Transplant | 290,123 | 422,945 | (132,822) | 2,015,263 | 2,960,615 | (945,352) |
| Premium - Provider Enhancement | 434,111 | 364,845 | 69,266 | 3,024,476 | 2,553,915 | 470,561 |
| Premium - GEMT | 238,283 | 261,525 | (23,242) | 1,661,940 | 1,830,675 | (168,735) |
| Other | 46,680 | 49,720 | (3,040) | 324,927 | 348,040 | (23,113) |
| TOTAL MEDICAID - EXPANSION MEMBERS | 49,057,991 | 47,912,766 | 1,145,225 | 341,594,344 | 335,389,362 | 6,204,981 |
| Premium - Medi-Cal | 36,483,130 | 38,844,010 | (2,360,881) | 252,390,846 | 271,908,215 | (19,517,369) |
| Premium - Enhanced Care Management | 1,340,261 | 1,014,864 | 325,397 | 9,307,996 | 7,104,049 | 2,203,948 |
| Premium - Major Organ Transplant | 116,793 | 341,085 | (224,292) | 806,022 | 2,387,595 | (1,581,573) |
| Premium - Provider Enhancement | 31,932 | 28,525 | 3,407 | 222,577 | 199,675 | 22,902 |
| Premium - GEMT | 137,816 | 173,842 | (36,026) | 957,553 | 1,216,894 | (259,341) |
| Premium - Distinct Part Nursing Facility | 1,194 | - | 1,194 | 8,662 | - | 8,662 |
| Other | 135 | 135 | - | 805 | 805 | - |
| TOTAL MEDICAID - SPD MEMBERS | 38,111,261 | 40,402,462 | (2,291,200) | 263,694,461 | 282,817,232 | (19,122,771) |

**MEDI-CAL**
**SCHEDULE OF REVENUES - ALL COA**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | Year to Date |
|---|---|---|---|---|---|---|---|---|
| **REVENUES** | | | | | | | | |
| Premium - Medi-Cal | 47,363,308 | 47,545,964 | 47,551,546 | 47,638,089 | 47,672,367 | 47,373,580 | 47,430,400 | 332,575,254 |
| Premium - Maternity Kick | 3,443,250 | 3,489,058 | 2,840,108 | 3,053,880 | 3,351,633 | 3,580,674 | 3,702,830 | 23,461,433 |
| Premium - Enhanced Care Management | 2,125,064 | 2,131,060 | 2,130,863 | 2,133,053 | 2,132,628 | 2,122,809 | 2,122,439 | 14,897,917 |
| Premium - Major Organ Transplant | 160,356 | 161,697 | 161,742 | 162,891 | 164,567 | 162,543 | 162,658 | 1,136,454 |
| Premium - Provider Enhancement | 1,429,771 | 1,437,183 | 1,437,262 | 1,441,621 | 1,445,331 | 1,434,006 | 1,436,284 | 10,061,457 |
| Premium - GEMT | 160,977 | 161,437 | 161,348 | 161,465 | 161,307 | 160,694 | 160,596 | 1,127,825 |
| Other | 96,746 | 97,035 | 97,150 | 97,236 | 97,118 | 96,437 | 96,828 | 678,550 |
| TOTAL MEDICAID - FAMILY MEMBERS | 54,779,472 | 55,023,433 | 54,380,020 | 54,688,236 | 55,024,952 | 54,930,744 | 55,112,034 | 383,938,891 |
| Premium - Medi-Cal | 44,855,744 | 45,219,120 | 45,018,916 | 45,125,766 | 45,365,301 | 45,433,984 | 45,545,841 | 316,564,674 |
| Premium - Maternity Kick | 564,968 | 511,525 | 480,986 | 412,274 | 206,137 | 381,735 | 335,927 | 2,893,551 |
| Premium - Enhanced Care Management | 2,153,257 | 2,165,899 | 2,154,091 | 2,150,015 | 2,149,171 | 2,170,055 | 2,167,026 | 15,109,513 |
| Premium - Major Organ Transplant | 285,237 | 287,671 | 286,455 | 287,370 | 289,211 | 289,196 | 290,123 | 2,015,263 |
| Premium - Provider Enhancement | 430,414 | 433,175 | 430,922 | 430,557 | 430,991 | 434,307 | 434,111 | 3,024,476 |
| Premium - GEMT | 236,976 | 238,316 | 236,993 | 236,445 | 236,220 | 238,707 | 238,283 | 1,661,940 |
| Other | 46,164 | 46,490 | 46,262 | 46,280 | 46,403 | 46,649 | 46,680 | 324,927 |
| TOTAL MEDICAID - EXPANSION MEMBERS | 48,572,760 | 48,902,196 | 48,654,624 | 48,688,708 | 48,723,433 | 48,994,633 | 49,057,991 | 341,594,344 |
| Premium - Medi-Cal | 37,081,984 | 34,297,701 | 35,919,054 | 36,050,326 | 36,169,992 | 36,388,660 | 36,483,130 | 252,390,846 |
| Premium - Enhanced Care Management | 1,403,572 | 1,238,016 | 1,326,920 | 1,327,850 | 1,329,835 | 1,341,543 | 1,340,261 | 9,307,996 |
| Premium - Major Organ Transplant | 125,409 | 102,004 | 114,724 | 115,251 | 115,746 | 116,094 | 116,793 | 806,022 |
| Premium - Provider Enhancement | 35,647 | 27,621 | 31,770 | 31,745 | 31,837 | 32,025 | 31,932 | 222,577 |
| Premium - GEMT | 151,476 | 120,067 | 136,547 | 136,681 | 137,134 | 137,832 | 137,816 | 957,553 |
| Premium - Distinct Part Nursing Facility | 1,259 | 1,293 | 1,251 | 1,227 | 1,206 | 1,232 | 1,194 | 8,662 |
| Other | 112 | 114 | 115 | 110 | 106 | 112 | 135 | 805 |
| TOTAL MEDICAID - SPD MEMBERS | 38,799,459 | 35,786,816 | 37,530,381 | 37,663,190 | 37,785,856 | 38,017,497 | 38,111,261 | 263,694,461 |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | July | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | |
| Primary Care Physician Services | 9,216,722 | 8,171,018 | (1,045,703) | 60,853,804 | 56,965,039 | (3,888,765) |
| Referral Specialty Services | 25,977,509 | 24,923,645 | (1,053,863) | 187,690,530 | 174,010,411 | (13,680,120) |
| Urgent Care & After Hours Advice | 2,934,095 | 3,829,328 | 895,233 | 23,618,474 | 26,695,683 | 3,077,209 |
| Hospital Admitting Team | 9,300 | 9,300 | - | 63,600 | 63,600 | - |
| Total Physician Services | 38,137,625 | 36,933,291 | (1,204,334) | 272,226,408 | 257,734,733 | (14,491,676) |
| **Other Professional Services** | | | | | | |
| Vision Service Capitation | 342,449 | 365,400 | 22,951 | 2,408,291 | 2,548,350 | 140,059 |
| 221 - Business Intelligence | 203,605 | 193,641 | (9,964) | 1,371,135 | 1,352,427 | (18,707) |
| 310 - Health Servcies - Utilization Management | 791,938 | 777,916 | (14,022) | 5,331,160 | 5,433,114 | 101,954 |
| 311 - Health Services - Quality Improvement | 228,544 | 287,090 | 58,546 | 1,704,304 | 2,005,094 | 300,789 |
| 312 - Health Services Education | 333,163 | 357,640 | 24,476 | 2,229,552 | 2,497,824 | 268,272 |
| 313 - Pharmacy | 113,809 | 128,330 | 14,520 | 837,461 | 896,278 | 58,817 |
| 314 - Enhanced Care Management | 411,433 | 396,905 | (14,528) | 2,719,366 | 2,772,063 | 52,697 |
| 316 - Population Health Management | 565,114 | 612,715 | 47,601 | 3,706,221 | 4,279,321 | 573,100 |
| 317 - In Lieu of Services | 133,606 | 130,667 | (2,939) | 909,278 | 912,601 | 3,323 |
| 321 - Homeless Management Information Services | 23,226 | 42,717 | 19,491 | 175,852 | 298,343 | 122,491 |
| 330 - Member Services | 1,061,079 | 1,090,934 | 29,855 | 7,292,608 | 7,619,297 | 326,689 |
| 331 - Member Outreach | 84,852 | 253,082 | 168,230 | 618,849 | 1,767,574 | 1,148,725 |
| 410 - Member Engagement | 55,111 | 105,940 | 50,829 | 400,094 | 739,908 | 339,814 |
| 601 - Behavioral Health | 158,413 | 177,557 | 19,144 | 1,073,556 | 1,240,096 | 166,540 |
| 602 - Quality & Health Equity | 83,714 | 82,401 | (1,313) | 554,974 | 575,503 | 20,529 |
| 604 - Clinical Operations, Strategy, and Analytics | 137,093 | 135,304 | (1,790) | 930,108 | 944,989 | 14,881 |
| 605 - Quality Performance | 141,810 | 187,511 | 45,701 | 1,043,219 | 1,309,613 | 266,394 |
| Behavior Health Treatment | 3,582,170 | 2,838,191 | (743,979) | 23,216,488 | 19,795,957 | (3,420,531) |
| Mental Health Services | 703,273 | 680,082 | (23,191) | 4,199,817 | 4,751,703 | 551,886 |
| Other Professional Services | 1,958,620 | 2,046,424 | 87,804 | 14,877,212 | 14,284,832 | (592,380) |
| Total Other Professional Services | 11,113,022 | 10,890,447 | (222,576) | 75,599,544 | 76,024,887 | 425,343 |
| Emergency Room | 6,580,865 | 6,824,955 | 244,091 | 47,013,422 | 47,612,376 | 598,954 |
| Inpatient Hospital | 34,361,371 | 34,069,001 | (292,370) | 245,407,062 | 238,004,531 | (7,402,531) |
| Reinsurance Expense Premium | 260,984 | 275,178 | 14,193 | 1,838,163 | 1,918,783 | 80,620 |
| Outpatient Hospital | 15,553,674 | 15,463,818 | (89,857) | 108,258,176 | 108,045,822 | (212,353) |
| **Other Medical** | | | | | | |
| Ambulance and NEMT | 5,807,437 | 5,057,545 | (749,892) | 44,347,739 | 35,352,006 | (8,995,733) |
| Home Health Services & CBAS | 1,686,511 | 1,319,975 | (366,536) | 10,212,064 | 9,234,052 | (978,012) |
| Utilization and Quality Review Expenses | 1,266,051 | 1,820,011 | 553,960 | 7,988,081 | 12,711,308 | 4,723,228 |
| Long Term/SNF/Hospice | 10,761,685 | 11,522,172 | 760,487 | 73,577,720 | 80,630,557 | 7,052,837 |
| Provider Enhancement Expense - Prop. 56 | 1,807,377 | 1,657,152 | (150,225) | 12,646,076 | 10,396,284 | (2,249,792) |
| Provider Enhancement Expense - GEMT | 537,034 | 422,621 | (114,414) | 3,747,318 | 4,106,960 | 359,642 |
| Enhanced Care Management | 6,587,375 | 4,330,664 | (2,256,712) | 38,588,791 | 30,243,074 | (8,345,718) |
| Community Support Services | 4,917,304 | - | (4,917,304) | 31,944,777 | - | (31,944,777) |
| Major Organ Transplant | 731,538 | 952,969 | 221,431 | 3,994,931 | 6,661,089 | 2,666,158 |
| Cal AIM Incentive Programs | 434,367 | - | (434,367) | 1,503,032 | - | (1,503,032) |
| Housing and Homelessness Incentive | 1,125,000 | - | (1,125,000) | 1,325,000 | - | (1,325,000) |
| Distinct Part Nursing Facility Expense | 1,194 | - | (1,194) | 8,662 | - | (8,662) |
| DME/Rebates | 2,491,164 | 1,989,977 | (501,187) | 15,639,187 | 13,903,806 | (1,735,381) |
| Total Other Medical | 38,154,038 | 29,073,084 | (9,080,954) | 245,523,378 | 203,239,136 | (42,284,242) |
| Pay for Performance Quality Incentive | 608,444 | 608,999 | 556 | 4,351,605 | 4,247,277 | (104,328) |
| Hospital Directed Payments | 59,035,880 | 24,426,249 | (34,609,631) | 412,720,126 | 170,569,557 | (242,150,569) |
| Hospital Directed Payment Adjustment | 4,261,156 | - | (4,261,156) | 110,537,356 | - | (110,537,356) |
| Non-Claims Expense Adjustment | 99,601 | - | (99,601) | (16,652,106) | - | 16,652,106 |
| IBNR, Incentive, Paid Claims Adjustment | 822,578 | - | (822,578) | (2,050,272) | - | 2,050,272 |
| Total Medical Costs | 208,989,239 | 158,565,022 | (50,424,217) | 1,504,772,861 | 1,107,397,101 | (397,375,760) |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | July | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| TOTAL MEMBERS - MCAL | 405,629 | 406,000 | (371) | 2,834,403 | 2,831,500 | 2,903 |
| **Physician Services** | | | | | | |
| Primary Care Physician Services | 22.72 | 20.13 | (2.60) | 21.47 | 20.12 | (1.35) |
| Referral Specialty Services | 64.04 | 61.39 | (2.65) | 66.22 | 61.46 | (4.76) |
| Urgent Care & After Hours Advice | 7.23 | 9.43 | 2.20 | 8.33 | 9.43 | 1.10 |
| Hospital Admitting Team | 0.02 | 0.02 | (0.00) | 0.02 | 0.02 | 0.00 |
| Total Physician Services | 94.02 | 90.97 | (3.05) | 96.04 | 91.02 | (5.02) |
| **Other Professional Services** | | | | | | |
| Vision Service Capitation | 0.84 | 0.90 | 0.06 | 0.85 | 0.90 | 0.05 |
| 221 - Business Intelligence | 0.50 | 0.48 | (0.02) | 0.48 | 0.48 | (0.01) |
| 310 - Health Servcies - Utilization Management | 1.95 | 1.92 | (0.04) | 1.88 | 1.92 | 0.04 |
| 311 - Health Services - Quality Improvement | 0.56 | 0.71 | 0.14 | 0.60 | 0.71 | 0.11 |
| 312 - Health Services Education | 0.82 | 0.88 | 0.06 | 0.79 | 0.88 | 0.10 |
| 313 - Pharmacy | 0.28 | 0.32 | 0.04 | 0.30 | 0.32 | 0.02 |
| 314 - Enhanced Care Management | 1.01 | 0.98 | (0.04) | 0.96 | 0.98 | 0.02 |
| 316 - Population Health Management | 1.39 | 1.51 | 0.12 | 1.31 | 1.51 | 0.20 |
| 317 - In Lieu of Services | 0.33 | 0.32 | (0.01) | 0.32 | 0.32 | 0.00 |
| 321 - Homeless Management Information Services | 0.06 | 0.11 | 0.05 | 0.06 | 0.11 | 0.04 |
| 330 - Member Services | 2.62 | 2.69 | 0.07 | 2.57 | 2.69 | 0.12 |
| 331 - Member Outreach | 0.21 | 0.62 | 0.41 | 0.22 | 0.62 | 0.41 |
| 410 - Member Engagement | 0.14 | 0.26 | 0.13 | 0.14 | 0.26 | 0.12 |
| 601 - Behavioral Health | 0.39 | 0.44 | 0.05 | 0.38 | 0.44 | 0.06 |
| 602 - Quality & Health Equity | 0.21 | 0.20 | (0.00) | 0.20 | 0.20 | 0.01 |
| 604 - Clinical Operations, Strategy, and Analytics | 0.34 | 0.33 | (0.00) | 0.33 | 0.33 | 0.01 |
| 605 - Quality Performance | 0.35 | 0.46 | 0.11 | 0.37 | 0.46 | 0.09 |
| Behavior Health Treatment | 8.83 | 6.99 | (1.84) | 8.19 | 6.99 | (1.20) |
| Mental Health Services | 1.73 | 1.68 | (0.06) | 1.48 | 1.68 | 0.20 |
| Other Professional Services | 4.83 | 5.04 | 0.21 | 5.25 | 5.04 | (0.20) |
| Total Other Professional Services | 27.40 | 26.82 | (0.57) | 26.67 | 26.85 | 0.18 |
| Emergency Room | 16.22 | 16.81 | 0.59 | 16.59 | 16.82 | 0.23 |
| Inpatient Hospital | 84.71 | 83.91 | (0.80) | 86.58 | 84.06 | (2.53) |
| Reinsurance Expense Premium | 0.64 | 0.68 | 0.03 | 0.65 | 0.68 | 0.03 |
| Outpatient Hospital | 38.34 | 38.09 | (0.26) | 38.19 | 38.16 | (0.04) |
| **Other Medical** | | | | | | |
| Ambulance and NEMT | 14.32 | 12.46 | (1.86) | 15.65 | 12.49 | (3.16) |
| Home Health Services & CBAS | 4.16 | 3.25 | (0.91) | 3.60 | 3.26 | (0.34) |
| Utilization and Quality Review Expenses | 3.12 | 4.48 | 1.36 | 2.82 | 4.49 | 1.67 |
| Long Term/SNF/Hospice | 26.53 | 28.38 | 1.85 | 25.96 | 28.48 | 2.52 |
| Provider Enhancement Expense - Prop. 56 | 4.46 | 4.08 | (0.37) | 4.46 | 3.67 | (0.79) |
| Provider Enhancement Expense - GEMT | 1.32 | 1.04 | (0.28) | 1.32 | 1.45 | 0.13 |
| Enhanced Care Management | 16.24 | 10.67 | (5.57) | 13.61 | 10.68 | (2.93) |
| Community Support Services | 12.12 | - | (12.12) | 11.27 | - | (11.27) |
| Major Organ Transplant | 1.80 | 2.35 | 0.54 | 1.41 | 2.35 | 0.94 |
| Cal AIM Incentive Programs | 1.07 | - | (1.07) | 0.53 | - | (0.53) |
| Distinct Part Nursing Facility Expense | 0.00 | - | (0.00) | 0.00 | - | (0.00) |
| DME/Rebates | 6.14 | 4.90 | (1.24) | 5.52 | 4.91 | (0.61) |
| Total Other Medical | 94.06 | 71.61 | (22.45) | 86.62 | 71.78 | (14.84) |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | (0.00) | 1.54 | 1.50 | (0.04) |
| Hospital Directed Payments | 145.54 | 60.16 | (85.38) | 145.61 | 60.24 | (85.37) |
| Hospital Directed Payment Adjustment | 10.51 | - | (10.51) | 39.00 | - | (39.00) |
| Non-Claims Expense Adjustment | 0.25 | - | (0.25) | (5.87) | - | 5.87 |
| IBNR, Incentive, Paid Claims Adjustment | 2.03 | - | (2.03) | (0.72) | - | 0.72 |
| Total Medical Costs | 515.22 | 390.55 | (124.67) | 530.90 | 391.10 | (139.80) |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | Year to Date |
|---|---|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | | | |
| Primary Care Physician Services | 6,633,777 | 10,235,649 | 8,511,088 | 8,021,079 | 8,209,102 | 10,026,387 | 9,216,722 | 60,853,804 |
| Referral Specialty Services | 25,541,006 | 24,175,932 | 26,067,518 | 27,364,943 | 29,514,962 | 29,048,662 | 25,977,509 | 187,690,530 |
| Urgent Care & After Hours Advice | 3,948,407 | 4,291,828 | 4,106,619 | 3,623,145 | 1,686,319 | 3,028,060 | 2,934,095 | 23,618,474 |
| Hospital Admitting Team | 9,300 | 8,400 | 9,300 | 9,000 | 9,300 | 9,000 | 9,300 | 63,600 |
| Total Physician Services | 36,132,491 | 38,711,809 | 38,694,525 | 39,018,167 | 39,419,683 | 42,112,109 | 38,137,625 | 272,226,408 |
| **Other Professional Services** | | | | | | | | |
| Vision Service Capitation | 344,606 | 343,774 | 343,775 | 345,653 | 344,127 | 343,908 | 342,449 | 2,408,291 |
| 221 - Business Intelligence | 211,963 | 188,504 | 191,787 | 186,842 | 193,999 | 194,435 | 203,605 | 1,371,135 |
| 310 - Health Servcies - Utilization Management | 826,640 | 762,266 | 757,294 | 734,148 | 748,550 | 710,325 | 791,938 | 5,331,160 |
| 311 - Health Services - Quality Improvement | 306,121 | 220,471 | 220,433 | 238,693 | 248,061 | 241,982 | 228,544 | 1,704,304 |
| 312 - Health Services Education | 321,705 | 307,110 | 316,293 | 312,444 | 315,011 | 323,825 | 333,163 | 2,229,552 |
| 313 - Pharmacy | 140,301 | 111,951 | 115,447 | 113,186 | 123,215 | 119,553 | 113,809 | 837,461 |
| 314 - Enhanced Care Management | 411,824 | 347,498 | 371,602 | 395,870 | 390,150 | 390,990 | 411,433 | 2,719,366 |
| 316 - Population Health Management | 593,720 | 502,067 | 520,999 | 496,916 | 507,502 | 519,902 | 565,114 | 3,706,221 |
| 317 - In Lieu of Services | 134,223 | 120,595 | 127,368 | 125,560 | 133,141 | 134,784 | 133,606 | 909,278 |
| 321 - Homeless Management Information Services | 44,251 | 23,122 | 20,283 | 21,008 | 21,840 | 22,122 | 23,226 | 175,852 |
| 330 - Member Services | 1,080,746 | 1,029,669 | 1,011,284 | 1,016,232 | 1,067,629 | 1,025,969 | 1,061,079 | 7,292,608 |
| 331 - Member Outreach | 83,414 | 78,217 | 82,465 | 117,142 | 86,498 | 86,260 | 84,852 | 618,849 |
| 410 - Member Engagement | 59,841 | 54,424 | 57,455 | 57,181 | 58,977 | 57,105 | 55,111 | 400,094 |
| 601 - Behavioral Health | 170,807 | 146,523 | 140,152 | 147,490 | 160,019 | 150,152 | 158,413 | 1,073,556 |
| 602 - Quality & Health Equity | 82,237 | 78,819 | 78,678 | 79,984 | 78,183 | 73,359 | 83,714 | 554,974 |
| 604 - Clinical Operations, Strategy, and Analytics | 142,213 | 117,289 | 130,628 | 128,689 | 138,241 | 135,954 | 137,093 | 930,108 |
| 605 - Quality Performance | 154,331 | 142,203 | 160,748 | 156,090 | 148,645 | 139,390 | 141,810 | 1,043,219 |
| Behavior Health Treatment | 3,181,908 | 3,355,677 | 2,493,778 | 3,786,771 | 2,901,828 | 3,914,355 | 3,582,170 | 23,216,488 |
| Mental Health Services | 974,251 | 506,210 | 300,821 | 550,412 | 609,128 | 555,723 | 703,273 | 4,199,817 |
| Other Professional Services | 2,180,697 | 1,568,304 | 2,126,040 | 2,241,884 | 2,418,598 | 2,383,070 | 1,958,620 | 14,877,212 |
| Total Other Professional Services | 11,445,798 | 10,004,694 | 9,567,330 | 11,252,193 | 10,693,341 | 11,523,165 | 11,113,022 | 75,599,544 |
| Emergency Room | 7,289,728 | 6,508,981 | 6,225,711 | 6,330,730 | 7,074,183 | 7,003,225 | 6,580,865 | 47,013,422 |
| Inpatient Hospital | 33,857,875 | 31,406,220 | 33,213,126 | 33,714,646 | 39,326,548 | 39,527,275 | 34,361,371 | 245,407,062 |
| Reinsurance Expense Premium | 269,619 | 269,619 | 269,619 | 240,829 | 271,713 | 255,781 | 260,984 | 1,838,163 |
| Outpatient Hospital | 16,019,765 | 15,697,949 | 14,487,044 | 16,762,573 | 14,357,942 | 15,379,229 | 15,553,674 | 108,258,176 |
| **Other Medical** | | | | | | | | |
| Ambulance and NEMT | 5,965,805 | 7,090,416 | 6,724,343 | 5,827,057 | 6,396,406 | 6,536,276 | 5,807,437 | 44,347,739 |
| Home Health Services & CBAS | 1,636,266 | 1,531,236 | 1,185,227 | 1,395,613 | 1,130,422 | 1,646,789 | 1,686,511 | 10,212,064 |
| Utilization and Quality Review Expenses | 936,126 | 930,163 | 1,665,464 | 773,340 | 1,444,299 | 972,636 | 1,266,051 | 7,988,081 |
| Long Term/SNF/Hospice | 10,523,545 | 10,822,106 | 9,460,426 | 10,684,436 | 10,165,912 | 11,159,610 | 10,761,685 | 73,577,720 |
| Provider Enhancement Expense - Prop. 56 | 1,801,039 | 1,803,328 | 1,805,739 | 1,809,345 | 1,813,309 | 1,805,939 | 1,807,377 | 12,646,076 |
| Provider Enhancement Expense - GEMT | 549,430 | 519,819 | 534,888 | 534,592 | 534,661 | 536,894 | 537,034 | 3,747,318 |
| Enhanced Care Management | 5,134,027 | 5,521,997 | 5,331,279 | 5,330,372 | 5,331,053 | 5,352,687 | 6,587,375 | 38,588,791 |
| Community Support Services | 590,845 | 3,824,743 | 4,662,690 | 6,140,445 | 5,298,573 | 6,510,178 | 4,917,304 | 31,944,777 |
| Major Organ Transplant | 542,452 | 574,592 | 534,775 | 537,237 | 541,047 | 533,290 | 731,538 | 3,994,931 |
| Cal AIM Incentive Programs | 275,000 | 188,015 | 390,633 | 125,018 | 90,000 | - | 434,367 | 1,503,032 |
| Housing and Homelessness Incentive | - | - | - | - | - | 200,000 | 1,125,000 | 1,325,000 |
| Distinct Part Nursing Facility Expense | 1,259 | 1,293 | 1,251 | 1,227 | 1,206 | 1,232 | 1,194 | 8,662 |
| DME/Rebates | 2,339,823 | 1,958,689 | 1,991,312 | 2,331,626 | 2,136,985 | 2,389,588 | 2,491,164 | 15,639,187 |
| Total Other Medical | 30,295,617 | 34,766,397 | 34,288,028 | 35,490,308 | 34,883,873 | 37,645,117 | 38,154,038 | 245,523,378 |
| Pay for Performance Quality Incentive | 606,662 | 608,318 | 607,800 | 607,349 | 605,835 | 707,199 | 608,444 | 4,351,605 |
| Hospital Directed Payments | 59,831,392 | 58,045,936 | 58,943,903 | 58,897,348 | 58,890,354 | 59,075,312 | 59,035,880 | 412,720,126 |
| Hospital Directed Payment Adjustment | 103,134,648 | 1,953,159 | 15,484 | 111,948 | 1,098,088 | (37,127) | 4,261,156 | 110,537,356 |
| Non-Claims Expense Adjustment | (350,170) | (2,753,743) | (3,382,901) | (1,877) | (10,262,733) | (283) | 99,601 | (16,652,106) |
| IBNR, Incentive, Paid Claims Adjustment | 388,615 | 248,637 | 21,094 | (2,667,286) | (37,610) | (826,300) | 822,578 | (2,050,272) |
| Total Medical Costs | 298,922,038 | 195,467,975 | 192,950,763 | 199,756,928 | 196,321,218 | 212,364,700 | 208,989,239 | 1,504,772,861 |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | Year to Date |
|---|---|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | | | |
| Primary Care Physician Services | 16.40 | 25.24 | 21.00 | 19.81 | 20.33 | 24.77 | 22.72 | 21.47 |
| Referral Specialty Services | 63.15 | 59.61 | 64.33 | 67.58 | 73.08 | 71.76 | 64.04 | 66.22 |
| Urgent Care & After Hours Advice | 9.76 | 10.58 | 10.13 | 8.95 | 4.18 | 7.48 | 7.23 | 8.33 |
| Hospital Admitting Team | 0.02 | 0.02 | 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 | 94.02 | 96.04 |
| **Other Professional Services** | | | | | | | | |
| Vision Service Capitation | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.84 | 0.85 |
| 221 - Business Intelligence | 0.52 | 0.46 | 0.47 | 0.46 | 0.48 | 0.48 | 0.50 | 0.48 |
| 310 - Health Servcies - Utilization Management | 2.04 | 1.88 | 1.87 | 1.81 | 1.85 | 1.75 | 1.95 | 1.88 |
| 311 - Health Services - Quality Improvement | 0.76 | 0.54 | 0.54 | 0.59 | 0.61 | 0.60 | 0.56 | 0.60 |
| 312 - Health Services Education | 0.80 | 0.76 | 0.78 | 0.77 | 0.78 | 0.80 | 0.82 | 0.79 |
| 313 - Pharmacy | 0.35 | 0.28 | 0.28 | 0.28 | 0.31 | 0.30 | 0.28 | 0.30 |
| 314 - Enhanced Care Management | 1.02 | 0.86 | 0.92 | 0.98 | 0.97 | 0.97 | 1.01 | 0.96 |
| 316 - Population Health Management | 1.47 | 1.24 | 1.29 | 1.23 | 1.26 | 1.28 | 1.39 | 1.31 |
| 317 - In Lieu of Services | 0.33 | 0.30 | 0.31 | 0.31 | 0.33 | 0.33 | 0.33 | 0.32 |
| 321 - Homeless Management Information Services | 0.11 | 0.06 | 0.05 | 0.05 | 0.05 | 0.05 | 0.06 | 0.06 |
| 330 - Member Services | 2.67 | 2.54 | 2.50 | 2.51 | 2.64 | 2.53 | 2.62 | 2.57 |
| 331 - Member Outreach | 0.21 | 0.19 | 0.20 | 0.29 | 0.21 | 0.21 | 0.21 | 0.22 |
| 410 - Member Engagement | 0.15 | 0.13 | 0.14 | 0.14 | 0.15 | 0.14 | 0.14 | 0.14 |
| 601 - Behavioral Health | 0.42 | 0.36 | 0.35 | 0.36 | 0.40 | 0.37 | 0.39 | 0.38 |
| 602 - Quality & Health Equity | 0.20 | 0.19 | 0.19 | 0.20 | 0.19 | 0.18 | 0.21 | 0.20 |
| 604 - Clinical Operations, Strategy, and Analytics | 0.35 | 0.29 | 0.32 | 0.32 | 0.34 | 0.34 | 0.34 | 0.33 |
| 605 - Quality Performance | 0.38 | 0.35 | 0.40 | 0.39 | 0.37 | 0.34 | 0.35 | 0.37 |
| Behavior Health Treatment | 7.87 | 8.27 | 6.15 | 9.35 | 7.18 | 9.67 | 8.83 | 8.19 |
| Mental Health Services | 2.41 | 1.25 | 0.74 | 1.36 | 1.51 | 1.37 | 1.73 | 1.48 |
| Other Professional Services | 5.39 | 3.87 | 5.25 | 5.54 | 5.99 | 5.89 | 4.83 | 5.25 |
| Total Other Professional Services | 28.30 | 24.67 | 23.61 | 27.79 | 26.48 | 28.47 | 27.40 | 26.67 |
| Emergency Room | 18.02 | 16.05 | 15.36 | 15.64 | 17.52 | 17.30 | 16.22 | 16.59 |
| Inpatient Hospital | 83.72 | 77.44 | 81.97 | 83.27 | 97.37 | 97.65 | 84.71 | 86.58 |
| Reinsurance Expense Premium | 0.67 | 0.66 | 0.67 | 0.59 | 0.67 | 0.63 | 0.64 | 0.65 |
| Outpatient Hospital | 39.61 | 38.71 | 35.75 | 41.40 | 35.55 | 37.99 | 38.34 | 38.19 |
| **Other Medical** | | | | | | | | |
| Ambulance and NEMT | 14.75 | 17.48 | 16.60 | 14.39 | 15.84 | 16.15 | 14.32 | 15.65 |
| Home Health Services & CBAS | 4.05 | 3.78 | 2.93 | 3.45 | 2.80 | 4.07 | 4.16 | 3.60 |
| Utilization and Quality Review Expenses | 2.31 | 2.29 | 4.11 | 1.91 | 3.58 | 2.40 | 3.12 | 2.82 |
| Long Term/SNF/Hospice | 26.02 | 26.69 | 23.35 | 26.39 | 25.17 | 27.57 | 26.53 | 25.96 |
| Provider Enhancement Expense - Prop. 56 | 4.45 | 4.45 | 4.46 | 4.47 | 4.49 | 4.46 | 4.46 | 4.46 |
| Provider Enhancement Expense - GEMT | 1.36 | 1.28 | 1.32 | 1.32 | 1.32 | 1.33 | 1.32 | 1.32 |
| Enhanced Care Management | 12.69 | 13.62 | 13.16 | 13.16 | 13.20 | 13.22 | 16.24 | 13.61 |
| Community Support Services | 1.46 | 9.43 | 11.51 | 15.17 | 13.12 | 16.08 | 12.12 | 11.27 |
| Major Organ Transplant | 1.34 | 1.42 | 1.32 | 1.33 | 1.34 | 1.32 | 1.80 | 1.41 |
| Cal AIM Incentive Programs | 0.68 | 0.46 | 0.96 | 0.31 | 0.22 | - | 1.07 | 0.53 |
| Housing and Homelessness Incentive | - | - | - | - | - | 0.49 | 2.77 | 0.47 |
| Distinct Part Nursing Facility Expense | 0.00 | 0.00 | 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 | 6.14 | 5.52 |
| Total Other Medical | 74.91 | 85.73 | 84.62 | 87.65 | 86.37 | 93.00 | 94.06 | 86.62 |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.75 | 1.50 | 1.54 |
| Hospital Directed Payments | 147.94 | 143.13 | 145.47 | 145.46 | 145.81 | 145.94 | 145.54 | 145.61 |
| Hospital Directed Payment Adjustment | 255.01 | 4.82 | 0.04 | 0.28 | 2.72 | (0.09) | 10.51 | 39.00 |
| Non-Claims Expense Adjustment | (0.87) | (6.79) | (8.35) | (0.00) | (25.41) | (0.00) | 0.25 | (5.87) |
| IBNR, Incentive, Paid Claims Adjustment | 0.96 | 0.61 | 0.05 | (6.59) | (0.09) | (2.04) | 2.03 | (0.72) |
| Total Medical Costs | 739.10 | 481.99 | 476.19 | 493.35 | 486.08 | 524.62 | 515.22 | 530.90 |

KERN HEALTH SYSTEMS

**MEDI-CAL**
**SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT**
**FOR THE MONTH ENDED JULY 31, 2025**

| | July | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| 110 - Executive | 649,999 | 650,390 | 392 | 4,353,733 | 4,552,732 | 198,999 |
| 112 - Government Relations | 51,463 | 62,942 | 11,478 | 379,307 | 440,593 | 61,286 |
| 210 - Accounting | 385,487 | 370,068 | (15,419) | 2,448,593 | 2,590,473 | 141,879 |
| 220 - Management Information Systems (MIS) | 331,263 | 508,775 | 177,511 | 2,245,051 | 3,561,422 | 1,316,371 |
| 221 - Business Intelligence | 564,816 | 246,484 | (318,332) | 2,826,990 | 1,725,389 | (1,101,601) |
| 222 - MIS Development | 568,876 | 515,722 | (53,154) | 3,789,472 | 3,610,057 | (179,415) |
| 223 - Enterprise Configuration | 238,908 | 321,789 | 82,881 | 1,693,664 | 2,252,524 | 558,860 |
| 224 - Cyber Security | 47,881 | 43,744 | (4,138) | 336,494 | 306,205 | (30,289) |
| 225 - Infrastructure | 748,388 | 1,140,153 | 391,765 | 5,694,925 | 7,981,070 | 2,286,145 |
| 226 - Technical Administrative Services | 98,333 | 94,102 | (4,231) | 507,671 | 658,716 | 151,045 |
| 230 - Claims | 1,599,045 | 823,337 | (775,708) | 7,159,596 | 5,763,360 | (1,396,237) |
| 240 - Project Development | 245,517 | 216,007 | (29,510) | 1,786,545 | 1,512,048 | (274,497) |
| 310 - Health Services - Utilization Managemen | 64,004 | 50,148 | (13,857) | 354,359 | 351,033 | (3,325) |
| 311 - Health Services - Quality Improvement | 7,312 | 11,596 | 4,284 | 55,853 | 81,169 | 25,316 |
| 312 - Health Services - Education | (0) | 648 | 648 | 246 | 4,538 | 4,293 |
| 313 - Pharmacy | (0) | 11,450 | 11,450 | 32,219 | 80,150 | 47,931 |
| 314 - Enhanced Care Management | 19,956 | 22,583 | 2,626 | 177,423 | 158,078 | (19,345) |
| 316 - Population Health Management | 0 | 2,454 | 2,454 | 1,186 | 17,179 | 15,993 |
| 317 - Community Support Services | (0) | 3,150 | 3,150 | 2,193 | 22,052 | 19,860 |
| 320 - Provider Network Management | 289,066 | 326,776 | 37,710 | 2,030,199 | 2,287,434 | 257,235 |
| 321 - Homeless Management Information Serv | (0) | 1,854 | 1,854 | 1,190 | 12,979 | 11,789 |
| 322 - Delegation & Oversight | (3,994) | 30,422 | 34,416 | 201,680 | 212,952 | 11,272 |
| 330 - Member Services | 180,533 | 229,310 | 48,777 | 1,230,498 | 1,605,170 | 374,672 |
| 340 - Corporate Services | 932,377 | 1,128,044 | 195,668 | 6,199,344 | 7,896,311 | 1,696,967 |
| 360 - Audit & Investigative Services | 315,648 | 306,189 | (9,459) | 2,097,642 | 2,143,323 | 45,681 |
| 410 - Member Engagement | 62,404 | 62,873 | 470 | 453,818 | 440,113 | (13,705) |
| 420 - Sales/Marketing/Public Relations | 630,980 | 329,532 | (301,448) | 2,021,226 | 2,306,721 | 285,495 |
| 510 - Human Resourses | 427,918 | 460,498 | 32,579 | 3,286,297 | 3,223,483 | (62,814) |
| 520 - Legal | 46,903 | 122,824 | 75,921 | 545,602 | 859,765 | 314,163 |
| 601 - Behavioral Health | 188 | 3,350 | 3,162 | 16,722 | 23,450 | 6,728 |
| 602 - Quality & Health Equity | 14,276 | 35,573 | 21,297 | 142,214 | 249,011 | 106,796 |
| 604 - Clinical Operations, Strategy & Analytics | 0 | 662 | 662 | 790 | 4,637 | 3,847 |
| 605 - Quality Performance | 176,086 | 116,048 | (60,038) | 1,315,096 | 812,337 | (502,759) |
| Administrative Expense Adjustment | (308) | 200,000 | 200,308 | 1,053,608 | 1,400,000 | 346,392 |
| Total Administrative Expenses | 8,693,325 | 8,449,496 | (243,829) | 54,441,447 | 59,146,476 | 4,705,030 |

**MEDI-CAL**
**SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT**
**FOR THE MONTH ENDED JULY 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | YTD TOTALS |
|---|---|---|---|---|---|---|---|---|
| 110 - Executive | 682,639 | 453,118 | 564,215 | 590,083 | 706,155 | 707,525 | 649,999 | 4,353,733 |
| 112 - Government Relations | 64,745 | 54,023 | 53,593 | 52,753 | 52,122 | 50,607 | 51,463 | 379,307 |
| 210 - Accounting | 373,730 | 270,170 | 370,641 | 425,988 | 328,977 | 293,602 | 385,487 | 2,448,593 |
| 220 - Management Information Systems (MIS) | 354,906 | 282,955 | 322,843 | 190,927 | 363,642 | 398,515 | 331,263 | 2,245,051 |
| 221 - Business Intelligence | 288,258 | 333,566 | 445,959 | 820,670 | 390,607 | (16,886) | 564,816 | 2,826,990 |
| 222 - MIS Development | 390,138 | 339,566 | 481,800 | 492,554 | 674,896 | 841,641 | 568,876 | 3,789,472 |
| 223 - Enterprise Configuration | 233,790 | 188,775 | 205,373 | 192,961 | 272,496 | 361,361 | 238,908 | 1,693,664 |
| 224 - Cyber Security | 31,621 | 51,523 | 39,996 | 64,290 | 59,425 | 41,757 | 47,881 | 336,494 |
| 225 - Infrastructure | 767,910 | 644,388 | 845,020 | 1,162,292 | 828,314 | 698,614 | 748,388 | 5,694,925 |
| 226 - Technical Administrative Services | 70,628 | 64,258 | 67,549 | 47,750 | 79,438 | 79,715 | 98,333 | 507,671 |
| 230 - Claims | 885,033 | 986,246 | 941,807 | 907,411 | 964,739 | 875,316 | 1,599,045 | 7,159,596 |
| 240 - Project Development | 214,035 | 237,465 | 220,963 | 149,624 | 421,861 | 297,080 | 245,517 | 1,786,545 |
| 310 - Health Services - Utilization Management | 30,019 | 52,541 | 40,446 | 52,147 | 64,953 | 50,249 | 64,004 | 354,359 |
| 311 - Health Services - Quality Improvement | (15,100) | 31,947 | 7,052 | 8,308 | 8,591 | 7,744 | 7,312 | 55,853 |
| 312 - Health Services - Education | - | - | - | - | - | 246 | (0) | 246 |
| 313 - Pharmacy | 10,795 | 10,500 | 10,500 | 357 | (0) | 67 | (0) | 32,219 |
| 314 - Enhanced Care Management | 18,954 | 44,579 | 20,337 | 23,983 | 22,006 | 27,607 | 19,956 | 177,423 |
| 316 - Population Health Management | 103 | - | - | 1,030 | 48 | 5 | 0 | 1,186 |
| 317 - Community Support Services | - | - | 883 | - | 0 | 1,310 | (0) | 2,193 |
| 320 - Provider Network Management | 297,212 | 274,630 | 285,138 | 289,369 | 327,952 | 266,832 | 289,066 | 2,030,199 |
| 321 - Homeless Management Information Serv | 73 | - | 54 | 1,964 | - | (901) | (0) | 1,190 |
| 322 - Delegation & Oversight | 50,538 | 1,369 | 26,376 | 45,370 | 45,974 | 36,047 | (3,994) | 201,680 |
| 330 - Member Services | 174,446 | 228,649 | 118,453 | 159,275 | 190,289 | 178,853 | 180,533 | 1,230,498 |
| 340 - Corporate Services | 1,085,693 | 680,455 | 851,850 | 876,263 | 885,564 | 887,141 | 932,377 | 6,199,344 |
| 360 - Audit & Investigative Services | 286,424 | 338,436 | 269,614 | 283,804 | 324,297 | 279,420 | 315,648 | 2,097,642 |
| 410 - Member Engagement | 67,809 | 62,520 | 64,681 | 66,137 | 67,561 | 62,705 | 62,404 | 453,818 |
| 420 - Sales/Marketing/Public Relations | 139,774 | 226,357 | 228,233 | 118,236 | 308,542 | 369,105 | 630,980 | 2,021,226 |
| 510 - Human Resourses | 727,474 | 317,319 | 475,133 | 432,281 | 477,233 | 428,938 | 427,918 | 3,286,297 |
| 520 - Legal | 35,231 | 100,899 | 142,724 | 118,635 | 47,741 | 53,469 | 46,903 | 545,602 |
| 601 - Behavioral Health | 307 | 200 | (0) | 76 | 15,950 | (0) | 188 | 16,722 |
| 602 - Quality & Health Equity | 10,624 | 9,938 | 10,083 | 72,665 | 10,603 | 14,026 | 14,276 | 142,214 |
| 604 - Clinical Operations, Strategy & Analytics | - | - | 32 | 0 | 185 | 573 | 0 | 790 |
| 605 - Quality Performance | 212,721 | 179,458 | 198,076 | 193,987 | 183,516 | 171,252 | 176,086 | 1,315,096 |
| Administrative Expense Adjustment | 202,969 | 198,773 | 375,177 | 160,116 | 69,345 | 47,536 | (308) | 1,053,608 |
| Total Administrative Expenses | 7,693,499 | 6,664,623 | 7,684,602 | 8,001,306 | 8,193,021 | 7,511,070 | 8,693,325 | 54,441,447 |

**KHS - GROUP HEALTH PLAN**
**STATEMENT OF NET POSITION**
**AS OF JULY 31, 2025**

| ASSETS | July 2025 | June 2025 | Increase/ (Decrease) |
|---|---|---|---|
| Cash and Cash Equivalents | 1,274,847 | 1,261,104 | 13,743 |
| Interest Receivable | 4,500 | 13,743 | (9,243) |
| Other Receivable | 125 | 125 | - |
| Total Current Assets | 1,279,472 | 1,274,972 | 4,500 |
| **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 | 33,866 | 29,366 | 4,500 |
| Total Net Position | 1,279,472 | 1,274,972 | 4,500 |
| TOTAL LIABILITIES AND NET POSITION | 1,279,472 | 1,274,972 | 4,500 |

**KHS - GROUP HEALTH PLAN**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION**
**FOR THE MONTH ENDED JULY 31, 2025**

| | July | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| **REVENUES** | | | | | | |
| Premium | - | - | - | - | - | - |
| Interest | 4,500 | - | 4,500 | 31,915 | - | 31,915 |
| Other Investment Income | - | - | - | 1,950 | - | 1,950 |
| Total Revenues | 4,500 | - | 4,500 | 33,866 | - | 33,866 |
| **EXPENSES** | | | | | | |
| **MEDICAL COSTS** | | | | | | |
| IBNR and Paid Claims Adjustment | - | - | - | - | - | - |
| Total Medical Costs | - | - | - | - | - | - |
| GROSS MARGIN | 4,500 | - | 4,500 | 33,866 | - | 33,866 |
| **ADMINISTRATIVE COSTS** | | | | | | |
| Management Fee Expense and Other Admin Exp | - | - | - | - | - | - |
| Total Administrative Expenses | - | - | - | - | - | - |
| TOTAL EXPENSES | - | - | - | - | - | - |
| OPERATING INCOME (LOSS) BEFORE TAX | 4,500 | - | 4,500 | 33,866 | - | 33,866 |
| **NON-OPERATING REVENUE (EXPENSE)** | | | | | | |
| Total Non-Operating Revenue (Expense) | - | - | - | - | - | - |
| NET INCREASE (DECREASE) IN NET POSITION | 4,500 | - | 4,500 | 33,866 | - | 33,866 |
| 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) | **521,053** | 74,604 | 74,605 | 74,309 | 74,397 | 74,422 | 74,237 | 74,479 | 0 | 0 | 0 | 0 | 0 |
| CHILD | **1,169,279** | 167,252 | 167,669 | 167,854 | 167,367 | 165,950 | 166,463 | 166,724 | 0 | 0 | 0 | 0 | 0 |
| **SUB-TOTAL ADULT & FAMILY** | **1,690,332** | **241,856** | **242,274** | **242,163** | **241,764** | **240,372** | **240,700** | **241,203** | **0** | **0** | **0** | **0** | **0** |
| **OTHER MEMBERS** | | | | | | | | | | | | | |
| FULL DUALS - FAMILY | **3,755** | 566 | 526 | 545 | 541 | 533 | 534 | 510 | 0 | 0 | 0 | 0 | 0 |
| FULL DUALS - CHILD | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **SUBTOTAL OTHER MEMBERS** | **3,755** | **566** | **526** | **545** | **541** | **533** | **534** | **510** | **0** | **0** | **0** | **0** | **0** |
| **TOTAL FAMILY** | **1,694,087** | **242,422** | **242,800** | **242,708** | **242,305** | **240,905** | **241,234** | **241,713** | **0** | **0** | **0** | **0** | **0** |
| **SPD MEMBERS** | | | | | | | | | | | | | |
| **SPD (AGED AND DISABLED)** | **146,213** | 23,226 | 18,391 | 20,998 | 21,034 | 20,905 | 20,961 | 20,698 | 0 | 0 | 0 | 0 | 0 |
| **OTHER MEMBERS** | | | | | | | | | | | | | |
| BCCTP - TABACCO SETTLEMENT | **45** | 0 | 0 | 0 | 12 | 9 | 13 | 11 | 0 | 0 | 0 | 0 | 0 |
| FULL DUALS - BCCTP | **13** | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 |
| SPD FULL DUALS | **178,847** | 23,272 | 27,695 | 25,425 | 25,375 | 25,671 | 25,597 | 25,812 | 0 | 0 | 0 | 0 | 0 |
| EXPANDION FULL DUALS | **2,294** | *366* | *333* | *322* | *326* | *293* | *357* | *297* | *0* | *0* | *0* | *0* | *0* |
| **LONG TERM CARE (LTC)** | | | | | | | | | | | | | |
| LTC | **353** | 48 | 52 | 54 | 52 | 52 | 46 | 49 | 0 | 0 | 0 | 0 | 0 |
| LTC DUALS | **3,172** | 465 | 467 | 462 | 451 | 453 | 443 | 431 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL LTC** | **3,525** | **513** | **519** | **516** | **503** | **505** | **489** | **480** | **0** | **0** | **0** | **0** | **0** |
| **TOTAL SPD** | **330,937** | **47,379** | **46,939** | **47,263** | **47,252** | **47,385** | **47,419** | **47,300** | **0** | **0** | **0** | **0** | **0** |
| **ACA OE - MEDI-CAL OPTIONAL EXPANSION** | | | | | | | | | | | | | |
| ACA Expansion Adult-Citizen | **809,379** | *114,640* | *115,806* | *115,229* | *115,342* | *115,600* | *116,146* | *116,616* | *0* | *0* | *0* | *0* | *0* |
| **TOTAL EXPANSION** | **809,379** | **114,640** | **115,806** | **115,229** | **115,342** | **115,600** | **116,146** | **116,616** | **0** | **0** | **0** | **0** | **0** |
| **TOTAL CLASSIC MEMBERS** | **2,834,403** | **404,441** | **405,545** | **405,200** | **404,899** | **403,890** | **404,799** | **405,629** | **0** | **0** | **0** | **0** | **0** |
| **GRAND TOTAL** | **2,834,403** | **404,441** | **405,545** | **405,200** | **404,899** | **403,890** | **404,799** | **405,629** | **0** | **0** | **0** | **0** | **0** |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Robert Landis, Chief Financial Officer

**SUBJECT:** August 2025 Financial Results

**DATE:** October 23, 2025

The August results reflect a $6.0 million Net Decrease in Net Position which is a $8.3 million unfavorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $81.0 million unfavorable variance primarily due to:

   A) $2.7 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 B.

   B) $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.

   C) $60.2 million unfavorable variance in Premium-MCO Tax is from DHCS suspending the payment and collection of the MCO Tax due to the passage of HR1 (One Big Beautiful Bill) and the related forthcoming CMS final rule which will impact the MCO tax. The suspension of the MCO Tax is pending CMS approval for the determination of a transition period. This amount is offset against amounts included in item 3 below.
   **(The MCO tax is used as a mechanism to generate new state funds that can be used to match with federal funds to bring additional federal dollars for Medi-Cal related programs)**

   D) $34.0 million favorable variance in Premium-Hospital Directed Payments is primarily due to receiving updated rate information from DHCS on February 28, 2025 for Calendar Year 2025 offset against amounts included in 2D below.

   E) $53.1 million unfavorable variance in Rate Adjustment- Hospital Directed Payments is due to KHS receiving updated final Designated Public Hospital (DPH) Quality Incentive Pool (QIP) rates from DHCS on August 29, 2025 for calendar year 2024 offset against amounts included in 2E below.

**(DPH Quality QIP payments are tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. To receive QIP payments the DPH and University of California (UC) systems must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments will be limited to a predetermined pool of funds).**

2) Total Medical Costs reflect a $9.9 million favorable variance primarily due to:

   A) $1.3 million unfavorable variance in Physician Services is primarily due to higher-than-expected utilization of Primary Care and Referral Specialty Services by Expansion members over the last several months.

   B) $1.9 million unfavorable in Other Professional Services is primarily due to higher-than-expected utilization of Behaviral Health Treatment (Autism) services over the last several months.

   C) $5.6 million unfavorable variance in Other Medical primarily from:

      1) $1.0 million unfavorable variance in Long Term/ SNF/Hospice is primarily due to retroactive rate adjustments from DHCS publishing updated rates relating to calendar years 2024 and 2025.

      2) $.7 million unfavorable variance in Enhance Care Management expenses due to receiving updated rate information from DHCS after the approval of the 2025 Budget offset against amounts included in 1B above.

      3) $2.8 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**.

(A key feature of CalAIM was the introduction of Community Support Services, formerly referred to as In Lieu of Services (ILOS). Community Support Services are designed to help improve the overall health and well-being of Medi-Cal managed care plan (MCP) members by addressing the members' health-related social needs, helping the members live healthier lives, and avoiding higher, costlier levels of care. Services include support to secure and maintain housing, access to medically tailored meals to support short-term recovery, personal care, and a variety of other community-based services. The range of services and resources are designed to address the unique needs of Medi-Cal members in the community, with a focus on promoting health, stability, and independence. Members may receive a Community Supports Service if they meet the eligibility criteria and if the MCP determines it is a medically appropriate and cost-effective alternative to services covered under Medi-Cal) **The funding for these services is inadequate with minimal savings in reducing medical expenses.**

   D) $34.0 million unfavorable variance in Hospital Directed Payments is primarily due to receiving updated rate information from DHCS on February 28, 2025 for Calendar Year 2024 offset against amounts included in 1D above.

E) $53.2 million favorable variance in Hospital Directed Payment Adjustment due to KHS receiving updated final Designated Public Hospital (DPH) Quality Incentive Pool (QIP) rates from DHCS on August 29, 2025 for calendar year 2024 offset against amounts included in 1E above.

F) $1.3 million unfavorable variance in IBNR, Incentive, Paid Claims adjustment due from higher-than-expected inpatient claim payments relating to Calendar Year 2024.

3) $60.2 million favorable variance in Premium-MCO Tax is from DHCS suspending the payment and collection of the MCO Tax due to the passage of HR1 (One Big Beautiful Bill). The suspension of the MCO Tax is pending CMS approval for the determination of a transition period. This amount is offset against amounts included in 1C above.

The August Medical Loss Ratio is 99.4%, which is unfavorable to the 91.8% budgeted amount. The August Administrative Expense Ratio is 4.6%, which is favorable to the 5.8% budgeted amount.

The results for the 8 months ending August 31, 2025 reflect a Net Decrease in Net Position of $18.7 million. This is a $36.8 million unfavorable variance to the budget and includes approximately $40.4 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 95.8%, which is unfavorable to the 91.8% budgeted amount. The year-to-date Administrative Expense Ratio is 5.2 % which is favorable to the 5.8% budgeted amount.

# Financial Packet
# August 2025

**KHS – Medi-Cal Line of Business**


| | |
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**KHS Group Health Plan – Healthy Families Line of Business**


| | |
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**KHS Administrative Analysis and Other Reporting**


| | |
|---|---|
| Monthly Member Count | Page 18 |

**MEDI-CAL**
**STATEMENT OF NET POSITION**
**AS OF AUGUST 31, 2025**

| ASSETS | August | July | Increase/ (Decrease) |
|---|---|---|---|
| Cash and Cash Equivalents | 259,709,416 | 202,238,845 | 57,470,571 |
| Short-Term Investments | 152,860,118 | 167,665,423 | (14,805,305) |
| Premiums Receivable | 146,092,546 | 147,406,856 | (1,314,310) |
| Premiums Receivable - MCO Tax | (23,102) | 63,099,463 | (63,122,566) |
| Premiums Receivable - Hospital Directed Payments | 928,872,544 | 923,477,395 | 5,395,149 |
| Interest Receivable | 186,291 | 593,281 | (406,990) |
| Provider Advance Payment | 91,668 | 119,242 | (27,574) |
| Other Receivables | 1,938,956 | 1,994,879 | (55,923) |
| Prepaid Expenses & Other Current Assets | 8,608,919 | 6,920,132 | 1,688,787 |
| Total Current Assets | 1,498,337,357 | 1,513,515,517 | (15,178,160) |
| Land | 4,090,706 | 4,090,706 | - |
| Furniture and Equipment - Net | 1,065,974 | 1,093,575 | (27,601) |
| Computer Equipment - Net | 16,370,702 | 16,855,846 | (485,145) |
| Building and Improvements - Net | 32,437,040 | 32,515,984 | (78,944) |
| Capital Projects In Process | 2,465,839 | 2,257,464 | 208,375 |
| Total Capital Assets | 56,430,261 | 56,813,575 | (383,314) |
| Restricted Assets | 300,000 | 300,000 | - |
| Life Insurance Receivables | 3,786,511 | 3,786,511 | - |
| SBITA Asset | 8,875,096 | 8,875,096 | - |
| Total Long-Term Assets | 12,961,607 | 12,961,607 | - |
| Deferred Outflow of Resources | 8,565,202 | 8,565,202 | - |
| Total Assets and Deferred Outflows of Resources | 1,576,294,427 | 1,591,855,901 | (15,561,474) |
| **CURRENT LIABILITIES** | | | |
| Accrued Salaries and Benefits | 7,877,967 | 9,496,882 | (1,618,916) |
| Accrued Other Operating Expenses | 4,961,402 | 5,750,335 | (788,933) |
| MCO Tax Payable | 85,216,089 | 85,310,314 | (94,225) |
| Claims Payable (Reported) | 26,933,167 | 21,658,584 | 5,274,583 |
| IBNR - Inpatient Claims | 63,924,524 | 58,223,302 | 5,701,222 |
| IBNR - Physician Claims | 32,883,878 | 32,033,895 | 849,984 |
| IBNR - Accrued Other Medical | 36,108,244 | 36,398,558 | (290,315) |
| Risk Pool and Withholds Payable | 9,353,496 | 8,750,389 | 603,107 |
| Allowance for Claims Processing Expense | 4,821,903 | 4,821,903 | - |
| Other Liabilities | 60,533,081 | 60,058,495 | 474,586 |
| SBITA Liability – Current portion | 2,217,189 | 2,217,189 | - |
| Accrued Hospital Directed Payments | 908,029,993 | 927,735,190 | (19,705,197) |
| Total Current Liabilities | 1,242,860,932 | 1,252,455,035 | (9,594,103) |
| **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 | (18,698,178) | (12,730,808) | (5,967,371) |
| Total Net Position | 314,869,460 | 320,836,831 | (5,967,371) |
| TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION | 1,576,294,427 | 1,591,855,901 | (15,561,474) |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION**
**FOR THE MONTH ENDED AUGUST 31, 2025**

| | August | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| Family Members | 240,245 | 246,500 | (6,255) | 1,934,332 | 1,958,000 | (23,668) |
| Expansion Members | 114,596 | 113,000 | 1,596 | 923,975 | 904,000 | 19,975 |
| SPD Members | 47,230 | 47,000 | 230 | 378,167 | 376,000 | 2,167 |
| Total Members - MCAL | 402,071 | 406,500 | (4,429) | 3,236,474 | 3,238,000 | (1,526) |
| REVENUES | | | | | | |
| Medicaid - Family Members | 55,284,966 | 55,630,867 | (345,901) | 439,223,856 | 441,887,374 | (2,663,518) |
| Medicaid - Expansion Members | 48,559,601 | 47,912,766 | 646,835 | 390,153,945 | 383,302,129 | 6,851,816 |
| Medicaid - SPD Members | 37,719,991 | 40,402,462 | (2,682,471) | 301,414,451 | 323,219,694 | (21,805,243) |
| Premium - MCO Tax | (0) | 60,157,935 | (60,157,935) | 413,954,108 | 479,191,620 | (65,237,512) |
| Premium - Hospital Directed Payments | 58,451,235 | 24,445,972 | 34,005,263 | 471,171,361 | 195,015,529 | 276,155,832 |
| Investment Earnings And Other Income | 1,911,358 | 2,002,259 | (90,901) | 16,794,933 | 15,975,906 | 819,028 |
| Reinsurance Recoveries | 772,732 | 275,533 | 497,199 | 2,672,732 | 2,194,316 | 478,416 |
| Rate Adjustments - Hospital Directed Payments | (53,056,519) | - | (53,056,519) | 56,565,160 | - | 56,565,160 |
| Rate/Income Adjustments | 147,916 | - | 147,916 | 23,864,860 | - | 23,864,860 |
| Total Revenues | 149,791,279 | 230,827,794 | (81,036,515) | 2,115,815,406 | 1,840,786,567 | 275,028,839 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 38,251,300 | 36,971,305 | (1,279,995) | 310,477,708 | 294,706,038 | (15,771,670) |
| Other Professional Services | 12,757,030 | 10,900,363 | (1,856,667) | 88,356,574 | 86,925,249 | (1,431,324) |
| Emergency Room | 6,307,989 | 6,832,684 | 524,695 | 53,321,412 | 54,445,061 | 1,123,649 |
| Inpatient | 34,046,492 | 34,091,786 | 45,293 | 279,453,554 | 272,096,316 | (7,357,238) |
| Reinsurance Expense | 262,299 | 275,533 | 13,234 | 2,100,462 | 2,194,316 | 93,854 |
| Outpatient Hospital | 15,218,411 | 15,473,385 | 254,974 | 123,476,586 | 123,519,207 | 42,621 |
| Other Medical | 34,707,037 | 29,086,058 | (5,620,979) | 280,230,415 | 232,325,194 | (47,905,221) |
| Pay for Performance Quality Incentive | 603,107 | 609,748 | 6,641 | 4,954,711 | 4,857,024 | (97,687) |
| Hospital Directed Payments | 58,464,674 | 24,445,972 | (34,018,702) | 471,184,800 | 195,015,529 | (276,169,271) |
| Hospital Directed Payment Adjustment | (53,169,871) | - | 53,169,871 | 57,367,485 | - | (57,367,485) |
| Non-Claims Expense Adjustment | 6,421 | - | (6,421) | (16,645,686) | - | 16,645,686 |
| IBNR, Incentive, Paid Claims Adjustment | 1,343,361 | - | (1,343,361) | (706,911) | - | 706,911 |
| Total Medical Costs | 148,798,250 | 158,686,834 | 9,888,584 | 1,653,571,111 | 1,266,083,935 | (387,487,176) |
| GROSS MARGIN | 993,028 | 72,140,960 | (71,147,931) | 462,244,295 | 574,702,632 | (112,458,337) |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 3,803,698 | 4,223,118 | 419,420 | 31,253,880 | 33,784,940 | 2,531,060 |
| Purchased Services | 1,332,630 | 2,343,143 | 1,010,512 | 16,949,455 | 18,745,142 | 1,795,687 |
| Supplies | 339,600 | 244,079 | (95,522) | 1,269,007 | 1,952,630 | 683,623 |
| Depreciation | 603,423 | 766,752 | 163,329 | 4,809,285 | 6,134,016 | 1,324,731 |
| Other Administrative Expenses | 561,313 | 672,406 | 111,093 | 5,746,876 | 5,379,245 | (367,631) |
| Administrative Expense Adjustment | - | 200,000 | 200,000 | 1,053,608 | 1,600,000 | 546,392 |
| Total Administrative Expenses | 6,640,664 | 8,449,497 | 1,808,833 | 61,082,111 | 67,595,973 | 6,513,863 |
| TOTAL EXPENSES | 155,438,914 | 167,136,331 | 11,697,417 | 1,714,653,222 | 1,333,679,908 | (380,973,313) |
| OPERATING INCOME (LOSS) BEFORE TAX | (5,647,635) | 63,691,462 | (69,339,098) | 401,162,184 | 507,106,659 | (105,944,475) |
| MCO TAX | (0) | 60,157,935 | 60,157,935 | 413,954,108 | 479,191,620 | 65,237,512 |
| OPERATING INCOME (LOSS) NET OF TAX | (5,647,635) | 3,533,527 | (9,181,163) | (12,791,924) | 27,915,039 | (40,706,963) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Provider Grants/CalAIM/Home Heath | (244,761) | (834,314) | 589,554 | (4,444,857) | (6,656,202) | 2,211,345 |
| D-SNP Expenses | (74,975) | (400,910) | 325,936 | (1,461,397) | (3,198,482) | 1,737,085 |
| Total Non-Operating Revenue (Expense) | (319,735) | (1,235,225) | 915,489 | (5,906,255) | (9,854,684) | 3,948,430 |
| NET INCREASE (DECREASE) IN NET POSITION | (5,967,371) | 2,298,303 | (8,265,674) | (18,698,178) | 18,060,354 | (36,758,533) |
| MEDICAL LOSS RATIO | 99.4% | 91.8% | -7.6% | 95.8% | 91.8% | -4.0% |
| ADMINISTRATIVE EXPENSE RATIO | 4.6% | 5.8% | 1.2% | 5.2% | 5.8% | 0.6% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION**
**FOR THE MONTH ENDED AUGUST 31, 2025**

| | August | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| Family Members | 240,245 | 246,500 | (6,255) | 1,934,332 | 1,958,000 | (23,668) |
| Expansion Members | 114,596 | 113,000 | 1,596 | 923,975 | 904,000 | 19,975 |
| SPD Members | 47,230 | 47,000 | 230 | 378,167 | 376,000 | 2,167 |
| Total Members - MCAL | 402,071 | 406,500 | (4,429) | 3,236,474 | 3,238,000 | (1,526) |
| REVENUES | | | | | | |
| Medicaid - Family Members | 230.12 | 225.68 | 4.44 | 227.07 | 225.68 | 1.38 |
| Medicaid - Expansion Members | 423.75 | 424.01 | (0.26) | 422.26 | 424.01 | (1.75) |
| Medicaid - SPD Members | 798.64 | 859.63 | (60.98) | 797.04 | 859.63 | (62.59) |
| Premium - MCO Tax | (0.00) | 147.99 | (147.99) | 127.90 | 147.99 | (20.09) |
| Premium - Hospital Directed Payments | 145.38 | 60.14 | 85.24 | 145.58 | 60.23 | 85.35 |
| Investment Earnings And Other Income | 4.75 | 4.93 | (0.17) | 5.19 | 4.93 | 0.26 |
| Reinsurance Recoveries | 1.92 | 0.68 | 1.24 | 0.83 | 0.68 | 0.15 |
| Rate Adjustments - Hospital Directed Payments | (131.96) | - | (131.96) | 17.48 | - | 17.48 |
| Rate/Income Adjustments | 0.37 | - | 0.37 | 7.37 | - | 7.37 |
| Total Revenues | 372.55 | 567.84 | (195.29) | 653.74 | 568.49 | 85.25 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 95.14 | 90.95 | (4.19) | 95.93 | 91.01 | (4.92) |
| Other Professional Services | 31.73 | 26.82 | (4.91) | 27.30 | 26.85 | (0.45) |
| Emergency Room | 15.69 | 16.81 | 1.12 | 16.48 | 16.81 | 0.34 |
| Inpatient | 84.68 | 83.87 | (0.81) | 86.35 | 84.03 | (2.31) |
| Reinsurance Expense | 0.65 | 0.68 | 0.03 | 0.65 | 0.68 | 0.03 |
| Outpatient Hospital | 37.85 | 38.06 | 0.21 | 38.15 | 38.15 | (0.00) |
| Other Medical | 86.32 | 71.55 | (14.77) | 86.59 | 71.75 | (14.84) |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | (0.00) | 1.53 | 1.50 | (0.03) |
| Hospital Directed Payments | 145.41 | 60.14 | (85.27) | 145.59 | 60.23 | (85.36) |
| Hospital Directed Payment Adjustment | (132.24) | - | 132.24 | 17.73 | - | (17.73) |
| Non-Claims Expense Adjustment | 0.02 | - | (0.02) | (5.14) | - | 5.14 |
| IBNR, Incentive, Paid Claims Adjustment | 3.34 | - | (3.34) | (0.22) | - | 0.22 |
| Total Medical Costs | 370.08 | 390.37 | 20.29 | 510.92 | 391.01 | (119.91) |
| GROSS MARGIN | 2.47 | 177.47 | (175.00) | 142.82 | 177.49 | (34.66) |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 9.46 | 10.39 | 0.93 | 9.66 | 10.43 | 0.78 |
| Purchased Services | 3.31 | 5.76 | 2.45 | 5.24 | 5.79 | 0.55 |
| Supplies | 0.84 | 0.60 | (0.24) | 0.39 | 0.60 | 0.21 |
| Depreciation | 1.50 | 1.89 | 0.39 | 1.49 | 1.89 | 0.41 |
| Other Administrative Expenses | 1.40 | 1.65 | 0.26 | 1.78 | 1.66 | (0.11) |
| Administrative Expense Adjustment | - | 0.49 | 0.49 | 0.33 | 0.49 | 0.17 |
| Total Administrative Expenses | 16.52 | 20.79 | 4.27 | 18.87 | 20.88 | 2.00 |
| TOTAL EXPENSES | 386.60 | 411.16 | 24.56 | 529.79 | 411.88 | (117.91) |
| OPERATING INCOME (LOSS) BEFORE TAX | (14.05) | 156.68 | (170.73) | 123.95 | 156.61 | (32.66) |
| MCO TAX | (0.00) | 147.99 | 147.99 | 127.90 | 147.99 | 20.09 |
| OPERATING INCOME (LOSS) NET OF TAX | (14.05) | 8.69 | (22.74) | (3.95) | 8.62 | (12.57) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Provider Grants/CalAIM/Home Heath | (0.19) | (2.05) | 1.87 | (0.45) | (2.06) | 1.60 |
| D-SNP Expenses | (0.61) | (0.99) | 0.38 | (1.37) | (0.99) | (0.39) |
| Total Non-Operating Revenue (Expense) | (0.80) | (3.04) | 2.24 | (1.82) | (3.04) | 1.22 |
| NET INCREASE (DECREASE) IN NET POSITION | (14.84) | 5.65 | (20.50) | (5.78) | 5.58 | (11.35) |
| MEDICAL LOSS RATIO | 99.4% | 91.8% | -7.6% | 95.8% | 91.8% | -4.0% |
| ADMINISTRATIVE EXPENSE RATIO | 4.6% | 5.8% | 1.2% | 5.2% | 5.8% | 0.6% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY QUARTER**
**ROLLING 4 QUARTERS**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | 2024 - Q3 | 2024 - Q4 | 2025 - Q1 | 2025 - Q2 | Rolling 4-Quarter Totals | CURRENT QUARTER 2025 - Q3 |
|---|---|---|---|---|---|---|
| Total Members - MCAL | 1,204,552 | 1,209,901 | 1,215,186 | 1,213,588 | 4,843,227 | 807,700 |
| REVENUES | | | | | | |
| Medicaid - Family Members | 157,352,051 | 181,853,744 | 164,182,925 | 164,643,931 | 668,032,651 | 110,397,000 |
| Medicaid - Expansion Members | 115,764,407 | 146,690,508 | 146,129,580 | 146,406,773 | 554,991,267 | 97,617,592 |
| Medicaid - SPD Members | 63,945,176 | 72,615,432 | 112,116,656 | 113,466,544 | 362,143,808 | 75,831,252 |
| Medicaid - LTC Members | 12,158,979 | 12,679,447 | - | - | 24,838,426 | - |
| Premium - MCO Tax | 304,000,610 | 169,305,625 | 177,408,904 | 177,408,904 | 828,124,042 | 59,136,301 |
| Premium - Hospital Directed Payments | 73,636,849 | 74,054,842 | 176,821,231 | 176,863,014 | 501,375,937 | 117,487,116 |
| Investment Earnings And Other Income | 10,624,397 | 6,363,381 | 6,614,108 | 6,619,093 | 30,220,979 | 3,561,732 |
| Reinsurance Recoveries | - | - | - | 1,600,000 | 1,600,000 | 1,072,732 |
| Rate Adjustments - Hospital Directed Payments | (8,849,506) | (45,264) | 105,206,644 | 153,982 | 96,465,856 | (48,795,466) |
| Rate/Income Adjustments | 2,310,217 | 29,220 | 2,557,018 | 16,334,961 | 21,231,416 | 4,972,881 |
| Total Revenues | 730,943,182 | 663,546,935 | 891,037,065 | 803,497,202 | 3,089,024,383 | 421,281,139 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 100,828,569 | 117,920,414 | 113,538,825 | 120,549,958 | 452,837,766 | 76,388,925 |
| Other Professional Services | 27,259,189 | 17,579,841 | 31,017,823 | 33,468,699 | 109,325,551 | 23,870,052 |
| Emergency Room | 19,085,229 | 20,264,346 | 20,024,420 | 20,408,138 | 79,782,132 | 12,888,854 |
| Inpatient | 98,069,526 | 109,860,804 | 98,477,222 | 112,568,469 | 418,976,021 | 68,407,864 |
| Reinsurance Expense | 337,661 | 337,245 | 808,856 | 768,322 | 2,252,085 | 523,283 |
| Outpatient Hospital | 46,542,079 | 45,089,064 | 46,204,757 | 46,499,744 | 184,335,645 | 30,772,085 |
| Other Medical | 93,132,007 | 95,537,563 | 99,350,041 | 108,019,275 | 396,038,888 | 72,861,076 |
| Pay for Performance Quality Incentive | 1,809,795 | 1,814,852 | 1,822,779 | 1,920,382 | 7,367,808 | 1,211,550 |
| Risk Corridor Expense | 2,133,095 | (960,173) | - | - | 1,172,922 | - |
| Hospital Directed Payments | 73,636,849 | 74,054,842 | 176,821,231 | 176,863,014 | 501,375,937 | 117,500,554 |
| Hospital Directed Payment Adjustment | (6,489,175) | (45,264) | 105,103,291 | 1,172,910 | 99,741,761 | (48,908,715) |
| Non-Claims Expense Adjustment | (4,294,448) | (1,489,159) | (6,486,815) | (10,264,893) | (22,535,315) | 106,022 |
| IBNR, Incentive, Paid Claims Adjustment | (6,331,814) | (3,892,128) | 658,346 | (3,531,172) | (13,096,768) | 2,165,939 |
| Total Medical Costs | 445,718,563 | 476,072,247 | 687,340,775 | 608,442,846 | 2,217,574,432 | 357,787,490 |
| GROSS MARGIN | 285,224,619 | 187,474,687 | 203,696,289 | 195,054,356 | 871,449,951 | 63,493,650 |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 11,047,726 | 12,349,629 | 11,773,691 | 11,672,587 | 46,843,633 | 7,807,602 |
| Purchased Services | 6,652,421 | 6,570,351 | 5,241,893 | 7,542,567 | 26,007,232 | 4,164,994 |
| Supplies | 707,109 | 693,365 | 438,866 | 353,058 | 2,192,398 | 477,083 |
| Depreciation | 2,283,774 | 2,071,812 | 1,794,880 | 1,806,873 | 7,957,339 | 1,207,531 |
| Other Administrative Expenses | 1,588,772 | 1,848,717 | 2,016,475 | 2,053,315 | 7,507,279 | 1,677,086 |
| Administrative Expense Adjustment | (2,309) | 1,230,808 | 776,919 | 276,996 | 2,282,415 | (308) |
| Total Administrative Expenses | 22,277,493 | 24,764,681 | 22,042,724 | 23,705,397 | 92,790,295 | 15,333,989 |
| TOTAL EXPENSES | 467,996,056 | 500,836,928 | 709,383,500 | 632,148,243 | 2,310,364,727 | 373,121,479 |
| OPERATING INCOME (LOSS) BEFORE TAX | 262,947,125 | 162,710,007 | 181,653,565 | 171,348,959 | 778,659,656 | 48,159,660 |
| MCO TAX | 304,000,610 | 169,305,625 | 177,408,904 | 177,408,904 | 650,715,139 | 59,136,301 |
| OPERATING INCOME (LOSS) NET OF TAX | (41,053,485) | (6,595,619) | 4,244,662 | (6,059,945) | 127,944,517 | (10,976,641) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Total Non-Operating Revenue (Expense) | (1,249,113) | (4,205,257) | (1,632,695) | (2,512,502) | (9,599,567) | (1,761,058) |
| NET INCREASE (DECREASE) IN NET POSITION | (42,302,598) | (10,800,875) | 2,611,967 | (8,572,447) | 118,344,951 | (12,737,699) |
| MEDICAL LOSS RATIO | 104.5% | 95.7% | 93.9% | 95.8% | 97.2% | 98.5% |
| ADMINISTRATIVE EXPENSE RATIO | 6.2% | 5.9% | 5.1% | 5.3% | 5.6% | 5.2% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY QUARTER**
**ROLLING 4 QUARTERS PMPM**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | 2024 - Q3 | 2024 - Q4 | 2025 - Q1 | 2025 - Q2 | Rolling Quarter Totals | CURRENT QUARTER 2025 - Q3 |
|---|---|---|---|---|---|---|
| Total Members - MCAL | 1,204,552 | 1,209,901 | 1,215,186 | 1,213,588 | 4,843,227 | 807,700 |
| REVENUES | | | | | | |
| Medicaid - Family Members | 197.65 | 228.42 | 225.55 | 227.27 | 219.41 | 229.06 |
| Medicaid - Expansion Members | 343.25 | 428.47 | 422.74 | 421.81 | 404.40 | 422.20 |
| Medicaid - SPD Members | 918.71 | 1,039.89 | 791.89 | 798.75 | 855.99 | 802.19 |
| Medicaid - LTC Members | 7,764.35 | 8,050.44 | - | - | 7,907.81 | - |
| Premium - MCO Tax | 252.38 | 139.93 | 145.99 | 146.19 | 170.99 | 73.22 |
| Premium - Hospital Directed Payments | 61.13 | 61.21 | 145.51 | 145.74 | 103.52 | 145.46 |
| Investment Earnings And Other Income | 8.82 | 5.26 | 5.44 | 5.45 | 6.24 | 4.41 |
| Reinsurance Recoveries | - | - | - | 1.32 | 0.33 | 1.33 |
| Rate Adjustments - Hospital Directed Payments | (7.35) | (0.04) | 86.58 | 0.13 | 19.92 | (60.41) |
| Rate/Income Adjustments | 1.92 | 0.02 | 2.10 | 13.46 | 4.38 | 6.16 |
| Total Revenues | 606.82 | 548.43 | 733.25 | 662.08 | 637.80 | 521.58 |
| EXPENSES | | | | | | |
| MEDICAL COSTS | | | | | | |
| Physician Services | 83.71 | 97.46 | 93.43 | 99.33 | 93.50 | 94.58 |
| Other Professional Services | 22.63 | 14.53 | 25.53 | 27.58 | 22.57 | 29.55 |
| Emergency Room | 15.84 | 16.75 | 16.48 | 16.82 | 16.47 | 15.96 |
| Inpatient | 81.42 | 90.80 | 81.04 | 92.76 | 86.51 | 84.69 |
| Reinsurance Expense | 0.28 | 0.28 | 0.67 | 0.63 | 0.46 | 0.65 |
| Outpatient Hospital | 38.64 | 37.27 | 38.02 | 38.32 | 38.06 | 38.10 |
| Other Medical | 77.32 | 78.96 | 81.76 | 89.01 | 81.77 | 90.21 |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | 1.50 | 1.58 | 1.52 | 1.50 |
| Risk Corridor Expense | 1.77 | (0.79) | - | - | 0.24 | - |
| Hospital Directed Payments | 61.13 | 61.21 | 145.51 | 145.74 | 103.52 | 145.48 |
| Hospital Directed Payment Adjustment | (5.39) | (0.04) | 86.49 | 0.97 | 20.59 | (60.55) |
| Non-Claims Expense Adjustment | (3.57) | (1.23) | (5.34) | (8.46) | (4.65) | 0.13 |
| IBNR, Incentive, Paid Claims Adjustment | (5.26) | (3.22) | 0.54 | (2.91) | (2.70) | 2.68 |
| Total Medical Costs | 370.03 | 393.48 | 565.63 | 501.36 | 457.87 | 442.97 |
| GROSS MARGIN | 236.79 | 154.95 | 167.63 | 160.73 | 179.93 | 78.61 |
| ADMINISTRATIVE COSTS | | | | | | |
| Compensation | 9.17 | 10.21 | 9.69 | 9.62 | 9.67 | 9.67 |
| Purchased Services | 5.52 | 5.43 | 4.31 | 6.22 | 5.37 | 5.16 |
| Supplies | 0.59 | 0.57 | 0.36 | 0.29 | 0.45 | 0.59 |
| Depreciation | 1.90 | 1.71 | 1.48 | 1.49 | 1.64 | 1.50 |
| Other Administrative Expenses | 1.32 | 1.53 | 1.66 | 1.69 | 1.55 | 2.08 |
| Administrative Expense Adjustment | (0.00) | 1.02 | 0.64 | 0.23 | 0.47 | (0.00) |
| Total Administrative Expenses | 18.49 | 20.47 | 18.14 | 19.53 | 19.16 | 18.98 |
| TOTAL EXPENSES | 388.52 | 413.95 | 583.77 | 520.89 | 477.03 | 461.96 |
| OPERATING INCOME (LOSS) BEFORE TAX | 218.29 | 134.48 | 149.49 | 141.19 | 160.77 | 59.63 |
| MCO TAX | 252.38 | 139.93 | 145.99 | 146.19 | 134.36 | 73.22 |
| OPERATING INCOME (LOSS) NET OF TAX | (34.08) | (5.45) | 3.49 | (4.99) | 26.42 | (13.59) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | |
| Total Non-Operating Revenue (Expense) | (1.04) | (3.48) | (1.34) | (2.07) | (1.98) | (2.18) |
| NET INCREASE (DECREASE) IN NET POSITION | (35.12) | (8.93) | 2.15 | (7.06) | 24.44 | (15.77) |
| MEDICAL LOSS RATIO | 104.5% | 95.7% | 93.9% | 95.8% | 97.2% | 98.5% |
| ADMINISTRATIVE EXPENSE RATIO | 6.2% | 5.9% | 5.1% | 5.3% | 5.6% | 5.2% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY MONTH**
**ROLLING 6 MONTHS**
**FOR THE MONTH ENDED AUGUST 31, 2025**

| | FEBRUARY 2025 | MARCH 2025 | APRIL 2025 | MAY 2025 | JUNE 2025 | JULY 2025 | Prior 6 Month YTD | AUGUST 2025 |
|---|---|---|---|---|---|---|---|---|
| Total Members - MCAL | 405,545 | 405,200 | 404,899 | 403,890 | 404,799 | 405,629 | 2,429,962 | 402,071 |
| REVENUES | | | | | | | | |
| Medicaid - Family Members | 55,023,433 | 54,380,020 | 54,688,236 | 55,024,952 | 54,930,744 | 55,112,034 | 329,159,419 | 55,284,966 |
| Medicaid - Expansion Members | 48,902,196 | 48,654,624 | 48,688,708 | 48,723,433 | 48,994,633 | 49,057,991 | 293,021,584 | 48,559,601 |
| Medicaid - SPD Members | 35,786,816 | 37,530,381 | 37,663,190 | 37,785,856 | 38,017,497 | 38,111,261 | 224,895,002 | 37,719,991 |
| Medicaid - LTC Members | - | - | - | - | - | - | - | - |
| Premium - MCO Tax | 59,136,301 | 59,136,301 | 59,136,301 | 59,124,814 | 59,147,788 | 59,136,301 | 354,817,807 | (0) |
| Premium - Hospital Directed Payments | 58,045,936 | 58,943,903 | 58,897,348 | 58,890,354 | 59,075,312 | 59,035,880 | 352,888,734 | 58,451,235 |
| Investment Earnings And Other Income | 2,419,799 | 2,464,994 | 3,204,688 | 1,505,898 | 1,908,507 | 1,650,374 | 13,154,261 | 1,911,358 |
| Reinsurance Recoveries | - | - | - | - | 1,600,000 | 300,000 | 1,900,000 | 772,732 |
| Rate Adjustments - Hospital Directed Payments | 1,953,159 | 118,837 | 111,950 | 78,980 | (36,948) | 4,261,053 | 6,487,032 | (53,056,519) |
| Rate/Income Adjustments | 1,370,485 | 666,041 | 6,525,510 | 136,042 | 9,673,408 | 4,824,965 | 23,196,452 | 147,916 |
| Total Revenues | 262,638,127 | 261,895,101 | 268,915,931 | 261,270,330 | 273,310,941 | 271,489,861 | 1,599,520,290 | 149,791,279 |
| EXPENSES | | | | | | | | |
| MEDICAL COSTS | | | | | | | | |
| Physician Services | 38,711,809 | 38,694,525 | 39,018,167 | 39,419,683 | 42,112,109 | 38,137,625 | 236,093,918 | 38,251,300 |
| Other Professional Services | 10,004,694 | 9,567,330 | 11,252,193 | 10,693,341 | 11,523,165 | 11,113,022 | 64,153,746 | 12,757,030 |
| Emergency Room | 6,508,981 | 6,225,711 | 6,330,730 | 7,074,183 | 7,003,225 | 6,580,865 | 39,723,694 | 6,307,989 |
| Inpatient | 31,406,220 | 33,213,126 | 33,714,646 | 39,326,548 | 39,527,275 | 34,361,371 | 211,549,186 | 34,046,492 |
| Reinsurance Expense | 269,619 | 269,619 | 240,829 | 271,713 | 255,781 | 260,984 | 1,568,544 | 262,299 |
| Outpatient Hospital | 15,697,949 | 14,487,044 | 16,762,573 | 14,357,942 | 15,379,229 | 15,553,674 | 92,238,411 | 15,218,411 |
| Other Medical | 34,766,397 | 34,288,028 | 35,490,285 | 34,883,873 | 37,645,117 | 38,154,038 | 215,227,738 | 34,707,037 |
| Pay for Performance Quality Incentive | 608,318 | 607,800 | 607,349 | 605,835 | 707,199 | 608,444 | 3,744,943 | 603,107 |
| Risk Corridor Expense | - | - | - | - | - | - | - | - |
| Hospital Directed Payments | 58,045,936 | 58,943,903 | 58,897,348 | 58,890,354 | 59,075,312 | 59,035,880 | 352,888,734 | 58,464,674 |
| Hospital Directed Payment Adjustment | 1,953,159 | 15,484 | 111,948 | 1,098,088 | (37,127) | 4,261,156 | 7,402,709 | (53,169,871) |
| Non-Claims Expense Adjustment | (2,753,743) | (3,382,901) | (1,877) | (10,262,733) | (283) | 99,601 | (16,301,936) | 6,421 |
| IBNR, Incentive, Paid Claims Adjustment | 248,637 | 21,094 | (2,667,263) | (37,610) | (826,300) | 822,578 | (2,438,864) | 1,343,361 |
| Total Medical Costs | 195,467,975 | 192,950,763 | 199,756,928 | 196,321,218 | 212,364,700 | 208,989,239 | 1,205,850,823 | 148,798,250 |
| GROSS MARGIN | 67,170,152 | 68,944,338 | 69,159,003 | 64,949,112 | 60,946,241 | 62,500,621 | 393,669,467 | 993,028 |
| ADMINISTRATIVE COSTS | | | | | | | | |
| Compensation | 3,708,197 | 3,865,011 | 3,886,069 | 3,873,266 | 3,913,252 | 4,003,904 | 23,249,699 | 3,803,698 |
| Purchased Services | 1,740,859 | 2,002,235 | 2,673,698 | 2,687,401 | 2,181,469 | 2,832,364 | 14,118,025 | 1,332,630 |
| Supplies | 163,332 | 180,460 | 122,949 | 121,882 | 108,227 | 137,483 | 834,333 | 339,600 |
| Depreciation | 385,016 | 597,431 | 597,265 | 605,113 | 604,495 | 604,109 | 3,393,429 | 603,423 |
| Other Administrative Expenses | 468,446 | 664,289 | 561,209 | 836,014 | 656,092 | 1,115,773 | 4,301,823 | 561,313 |
| Administrative Expense Adjustment | 198,773 | 375,177 | 160,116 | 69,345 | 47,536 | (308) | 850,639 | - |
| Total Administrative Expenses | 6,664,623 | 7,684,602 | 8,001,306 | 8,193,021 | 7,511,070 | 8,693,325 | 46,747,948 | 6,640,664 |
| TOTAL EXPENSES | 202,132,598 | 200,635,365 | 207,758,234 | 204,514,239 | 219,875,770 | 217,682,565 | 1,252,598,771 | 155,438,914 |
| OPERATING INCOME (LOSS) BEFORE TAX | 60,505,529 | 61,259,736 | 61,157,697 | 56,756,091 | 53,435,171 | 53,807,296 | 346,921,519 | (5,647,635) |
| MCO TAX | 59,136,301 | 59,136,301 | 59,136,301 | 59,136,301 | 59,136,301 | 59,136,301 | 354,817,807 | (0) |
| OPERATING INCOME (LOSS) NET OF TAX | 1,369,228 | 2,123,435 | 2,021,395 | (2,380,210) | (5,701,130) | (5,329,005) | (7,896,288) | (5,647,635) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | | | |
| Total Non-Operating Revenue (Expense) | (600,969) | (407,789) | (511,718) | (845,044) | (1,155,740) | (1,441,323) | (4,962,583) | (319,735) |
| NET INCREASE (DECREASE) IN NET POSITION | 768,258 | 1,715,645 | 1,509,677 | (3,225,255) | (6,856,869) | (6,770,328) | (12,858,871) | (5,967,371) |
| MEDICAL LOSS RATIO | 94.4% | 93.2% | 93.4% | 95.2% | 98.8% | 97.7% | 95.5% | 99.4% |
| ADMINISTRATIVE EXPENSE RATIO | 4.6% | 5.3% | 5.3% | 5.7% | 4.8% | 5.8% | 5.3% | 4.6% |

**MEDI-CAL - ALL COA**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES**
**IN NET POSITION BY MONTH**
**PMPM ROLLING 6 MONTHS**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | FEBRUARY 2025 | MARCH 2025 | APRIL 2025 | MAY 2025 | JUNE 2025 | JULY 2025 | 6 Month Prior YTD | AUGUST 2025 |
|---|---|---|---|---|---|---|---|---|
| Total Members - MCAL | 405,545 | 405,200 | 404,899 | 403,890 | 404,799 | 405,629 | 2,429,962 | 402,071 |
| REVENUES | | | | | | | | |
| Medicaid - Family Members | 226.62 | 224.06 | 225.70 | 228.41 | 227.71 | 228.01 | 226.75 | 230.12 |
| Medicaid - Expansion Members | 422.28 | 422.24 | 422.12 | 421.48 | 421.84 | 420.68 | 421.77 | 423.75 |
| Medicaid - SPD Members | 762.41 | 794.08 | 797.07 | 797.42 | 801.74 | 805.73 | 793.12 | 798.64 |
| Medicaid - LTC Members | - | - | - | - | - | - | - | - |
| Premium - MCO Tax | 145.82 | 145.94 | 146.05 | 146.39 | 146.12 | 145.79 | 146.02 | (0.00) |
| Premium - Hospital Directed Payments | 143.13 | 145.47 | 145.46 | 145.81 | 145.94 | 145.54 | 145.22 | 145.38 |
| Investment Earnings And Other Income | 5.97 | 6.08 | 7.91 | 3.73 | 4.71 | 4.07 | 5.41 | 4.75 |
| Reinsurance Recoveries | - | - | - | - | 3.95 | 0.74 | 0.78 | 1.92 |
| Rate Adjustments - Hospital Directed Payments | 4.82 | 0.29 | 0.28 | 0.20 | (0.09) | 10.50 | 2.67 | (131.96) |
| Rate/Income Adjustments | 3.38 | 1.64 | 16.12 | 0.34 | 23.90 | 11.90 | 9.55 | 0.37 |
| Total Revenues | 647.62 | 646.34 | 664.16 | 646.88 | 675.18 | 669.31 | 658.25 | 372.55 |
| EXPENSES | | | | | | | | |
| MEDICAL COSTS | | | | | | | | |
| Physician Services | 95.46 | 95.49 | 96.37 | 97.60 | 104.03 | 94.02 | 97.16 | 95.14 |
| Other Professional Services | 24.67 | 23.61 | 27.79 | 26.48 | 28.47 | 27.40 | 26.40 | 31.73 |
| Emergency Room | 16.05 | 15.36 | 15.64 | 17.52 | 17.30 | 16.22 | 16.35 | 15.69 |
| Inpatient | 77.44 | 81.97 | 83.27 | 97.37 | 97.65 | 84.71 | 87.06 | 84.68 |
| Reinsurance Expense | 0.66 | 0.67 | 0.59 | 0.67 | 0.63 | 0.64 | 0.65 | 0.65 |
| Outpatient Hospital | 38.71 | 35.75 | 41.40 | 35.55 | 37.99 | 38.34 | 37.96 | 37.85 |
| Other Medical | 85.73 | 84.62 | 87.65 | 86.37 | 93.00 | 94.06 | 88.57 | 86.32 |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | 1.50 | 1.50 | 1.75 | 1.50 | 1.54 | 1.50 |
| Risk Corridor Expense | - | - | - | - | - | - | - | - |
| Hospital Directed Payments | 143.13 | 145.47 | 145.46 | 145.81 | 145.94 | 145.54 | 145.22 | 145.41 |
| Hospital Directed Payment Adjustment | 4.82 | 0.04 | 0.28 | 2.72 | (0.09) | 10.51 | 3.05 | (132.24) |
| Non-Claims Expense Adjustment | (6.79) | (8.35) | (0.00) | (25.41) | (0.00) | 0.25 | (6.71) | 0.02 |
| IBNR, Incentive, Paid Claims Adjustment | 0.61 | 0.05 | (6.59) | (0.09) | (2.04) | 2.03 | (1.00) | 3.34 |
| Total Medical Costs | 481.99 | 476.19 | 493.35 | 486.08 | 524.62 | 515.22 | 496.24 | 370.08 |
| GROSS MARGIN | 165.63 | 170.15 | 170.81 | 160.81 | 150.56 | 154.08 | 162.01 | 2.47 |
| ADMINISTRATIVE COSTS | | | | | | | | |
| Compensation | 9.14 | 9.54 | 9.60 | 9.59 | 9.67 | 9.87 | 9.57 | 9.46 |
| Purchased Services | 4.29 | 4.94 | 6.60 | 6.65 | 5.39 | 6.98 | 5.81 | 3.31 |
| Supplies | 0.40 | 0.45 | 0.30 | 0.30 | 0.27 | 0.34 | 0.34 | 0.84 |
| Depreciation | 0.95 | 1.47 | 1.48 | 1.50 | 1.49 | 1.49 | 1.40 | 1.50 |
| Other Administrative Expenses | 1.16 | 1.64 | 1.39 | 2.07 | 1.62 | 2.75 | 1.77 | 1.40 |
| Administrative Expense Adjustment | 0.49 | 0.93 | 0.40 | 0.17 | 0.12 | (0.00) | 0.35 | - |
| Total Administrative Expenses | 16.43 | 18.96 | 19.76 | 20.29 | 18.56 | 21.43 | 19.24 | 16.52 |
| TOTAL EXPENSES | 498.42 | 495.15 | 513.11 | 506.36 | 543.17 | 536.65 | 515.48 | 386.60 |
| OPERATING INCOME (LOSS) BEFORE TAX | 149.20 | 151.18 | 151.04 | 140.52 | 132.00 | 132.65 | 142.77 | (14.05) |
| MCO TAX | 145.82 | 145.94 | 146.05 | 146.42 | 146.09 | 145.79 | 146.02 | (0.00) |
| OPERATING INCOME (LOSS) NET OF TAX | 3.38 | 5.24 | 4.99 | (5.89) | (14.08) | (13.14) | (3.25) | (14.05) |
| NON-OPERATING REVENUE (EXPENSE) | | | | | | | | |
| Total Non-Operating Revenue (Expense) | (1.48) | (1.01) | (1.26) | (2.09) | (2.86) | (3.55) | (2.04) | (0.80) |
| NET INCREASE (DECREASE) IN NET POSITION | 1.89 | 4.23 | 3.73 | (7.99) | (16.94) | (16.69) | (5.29) | (14.84) |
| MEDICAL LOSS RATIO | 94.4% | 93.2% | 93.4% | 95.2% | 98.8% | 97.7% | 95.5% | 99.4% |
| ADMINISTRATIVE EXPENSE RATIO | 4.6% | 5.3% | 5.3% | 5.7% | 4.8% | 5.8% | 5.3% | 4.6% |

**MEDI-CAL**
**SCHEDULE OF REVENUES - ALL COA**
**FOR THE MONTH ENDED AUGUST 31, 2025**

| | August | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| **REVENUES** | | | | | | |
| Premium - Medi-Cal | 47,285,713 | 48,761,891 | (1,476,178) | 379,860,967 | 387,325,693 | (7,464,726) |
| Premium - Maternity Kick | 4,031,122 | 3,388,995 | 642,126 | 27,492,555 | 26,919,482 | 573,072 |
| Premium - Enhanced Care Management | 2,116,979 | 1,768,676 | 348,302 | 17,014,896 | 14,048,958 | 2,965,938 |
| Premium - Major Organ Transplant | 162,575 | 239,581 | (77,006) | 1,299,029 | 1,903,045 | (604,016) |
| Premium - Provider Enhancement | 1,432,031 | 1,179,551 | 252,480 | 11,493,489 | 9,369,418 | 2,124,070 |
| Premium - GEMT | 160,128 | 183,711 | (23,584) | 1,287,953 | 1,459,258 | (171,305) |
| Other | 96,418 | 108,460 | (12,042) | 774,968 | 861,520 | (86,552) |
| TOTAL MEDICAID - FAMILY MEMBERS | 55,284,966 | 55,630,867 | (345,901) | 439,223,856 | 441,887,374 | (2,663,518) |
| Premium - Medi-Cal | 44,944,541 | 44,592,454 | 352,087 | 361,509,215 | 356,739,634 | 4,769,581 |
| Premium - Maternity Kick | 480,986 | 442,636 | 38,350 | 3,374,537 | 3,541,090 | (166,552) |
| Premium - Enhanced Care Management | 2,138,244 | 1,778,641 | 359,603 | 17,247,757 | 14,229,125 | 3,018,633 |
| Premium - Major Organ Transplant | 286,297 | 422,945 | (136,648) | 2,301,560 | 3,383,560 | (1,082,000) |
| Premium - Provider Enhancement | 428,354 | 364,845 | 63,509 | 3,452,830 | 2,918,760 | 534,070 |
| Premium - GEMT | 235,117 | 261,525 | (26,408) | 1,897,056 | 2,092,200 | (195,144) |
| Other | 46,062 | 49,720 | (3,658) | 370,989 | 397,760 | (26,771) |
| TOTAL MEDICAID - EXPANSION MEMBERS | 48,559,601 | 47,912,766 | 646,835 | 390,153,945 | 383,302,129 | 6,851,816 |
| Premium - Medi-Cal | 36,113,888 | 38,844,021 | (2,730,133) | 288,504,734 | 310,752,236 | (22,247,502) |
| Premium - Enhanced Care Management | 1,323,952 | 1,014,864 | 309,088 | 10,631,949 | 8,118,913 | 2,513,036 |
| Premium - Major Organ Transplant | 114,376 | 341,085 | (226,709) | 920,398 | 2,728,680 | (1,808,282) |
| Premium - Provider Enhancement | 31,316 | 28,525 | 2,791 | 253,892 | 228,200 | 25,692 |
| Premium - GEMT | 135,165 | 173,842 | (38,677) | 1,092,718 | 1,390,736 | (298,018) |
| Premium - Distinct Part Nursing Facility | 1,169 | - | 1,169 | 9,831 | - | 9,831 |
| Other | 124 | 124 | - | 929 | 929 | - |
| TOTAL MEDICAID - SPD MEMBERS | 37,719,991 | 40,402,462 | (2,682,471) | 301,414,451 | 323,219,694 | (21,805,243) |

**MEDI-CAL**
**SCHEDULE OF REVENUES - ALL COA**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | August | Year to Date |
|---|---|---|---|---|---|---|---|---|---|
| **REVENUES** | | | | | | | | | |
| Premium - Medi-Cal | 47,363,308 | 47,545,964 | 47,551,546 | 47,638,089 | 47,672,367 | 47,373,580 | 47,430,400 | 47,285,713 | 379,860,967 |
| Premium - Maternity Kick | 3,443,250 | 3,489,058 | 2,840,108 | 3,053,880 | 3,351,633 | 3,580,674 | 3,702,830 | 4,031,122 | 27,492,555 |
| Premium - Enhanced Care Management | 2,125,064 | 2,131,060 | 2,130,863 | 2,133,053 | 2,132,628 | 2,122,809 | 2,122,439 | 2,116,979 | 17,014,896 |
| Premium - Major Organ Transplant | 160,356 | 161,697 | 161,742 | 162,891 | 164,567 | 162,543 | 162,658 | 162,575 | 1,299,029 |
| Premium - Provider Enhancement | 1,429,771 | 1,437,183 | 1,437,262 | 1,441,621 | 1,445,331 | 1,434,006 | 1,436,284 | 1,432,031 | 11,493,489 |
| Premium - GEMT | 160,977 | 161,437 | 161,348 | 161,465 | 161,307 | 160,694 | 160,596 | 160,128 | 1,287,953 |
| Other | 96,746 | 97,035 | 97,150 | 97,236 | 97,118 | 96,437 | 96,828 | 96,418 | 774,968 |
| TOTAL MEDICAID - FAMILY MEMBERS | 54,779,472 | 55,023,433 | 54,380,020 | 54,688,236 | 55,024,952 | 54,930,744 | 55,112,034 | 55,284,966 | 439,223,856 |
| Premium - Medi-Cal | 44,855,744 | 45,219,120 | 45,018,916 | 45,125,766 | 45,365,301 | 45,433,984 | 45,545,841 | 44,944,541 | 361,509,215 |
| Premium - Maternity Kick | 564,968 | 511,525 | 480,986 | 412,274 | 206,137 | 381,735 | 335,927 | 480,986 | 3,374,537 |
| Premium - Enhanced Care Management | 2,153,257 | 2,165,899 | 2,154,091 | 2,150,015 | 2,149,171 | 2,170,055 | 2,167,026 | 2,138,244 | 17,247,757 |
| Premium - Major Organ Transplant | 285,237 | 287,671 | 286,455 | 287,370 | 289,211 | 289,196 | 290,123 | 286,297 | 2,301,560 |
| Premium - Provider Enhancement | 430,414 | 433,175 | 430,922 | 430,557 | 430,991 | 434,307 | 434,111 | 428,354 | 3,452,830 |
| Premium - GEMT | 236,976 | 238,316 | 236,993 | 236,445 | 236,220 | 238,707 | 238,283 | 235,117 | 1,897,056 |
| Other | 46,164 | 46,490 | 46,262 | 46,280 | 46,403 | 46,649 | 46,680 | 46,062 | 370,989 |
| TOTAL MEDICAID - EXPANSION MEMBERS | 48,572,760 | 48,902,196 | 48,654,624 | 48,688,708 | 48,723,433 | 48,994,633 | 49,057,991 | 48,559,601 | 390,153,945 |
| Premium - Medi-Cal | 37,081,984 | 34,297,701 | 35,919,054 | 36,050,326 | 36,169,992 | 36,388,660 | 36,483,130 | 36,113,888 | 288,504,734 |
| Premium - Enhanced Care Management | 1,403,572 | 1,238,016 | 1,326,920 | 1,327,850 | 1,329,835 | 1,341,543 | 1,340,261 | 1,323,952 | 10,631,949 |
| Premium - Major Organ Transplant | 125,409 | 102,004 | 114,724 | 115,251 | 115,746 | 116,094 | 116,793 | 114,376 | 920,398 |
| Premium - Provider Enhancement | 35,647 | 27,621 | 31,770 | 31,745 | 31,837 | 32,025 | 31,932 | 31,316 | 253,892 |
| Premium - GEMT | 151,476 | 120,067 | 136,547 | 136,681 | 137,134 | 137,832 | 137,816 | 135,165 | 1,092,718 |
| Premium - Distinct Part Nursing Facility | 1,259 | 1,293 | 1,251 | 1,227 | 1,206 | 1,232 | 1,194 | 1,169 | 9,831 |
| Other | 112 | 114 | 115 | 110 | 106 | 112 | 135 | 124 | 929 |
| TOTAL MEDICAID - SPD MEMBERS | 38,799,459 | 35,786,816 | 37,530,381 | 37,663,190 | 37,785,856 | 38,017,497 | 38,111,261 | 37,719,991 | 301,414,451 |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | August | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | |
| Primary Care Physician Services | 9,577,793 | 8,182,070 | (1,395,723) | 70,431,597 | 65,147,109 | (5,284,489) |
| Referral Specialty Services | 26,256,618 | 24,945,317 | (1,311,302) | 213,947,149 | 198,955,727 | (14,991,421) |
| Urgent Care & After Hours Advice | 2,407,589 | 3,834,619 | 1,427,030 | 26,026,062 | 30,530,302 | 4,504,240 |
| Hospital Admitting Team | 9,300 | 9,300 | - | 72,900 | 72,900 | - |
| Total Physician Services | 38,251,300 | 36,971,305 | (1,279,995) | 310,477,708 | 294,706,038 | (15,771,670) |
| **Other Professional Services** | | | | | | |
| Vision Service Capitation | 344,852 | 365,850 | 20,998 | 2,753,143 | 2,914,200 | 161,057 |
| 221 - Business Intelligence | 188,920 | 193,787 | 4,867 | 1,560,055 | 1,546,214 | (13,841) |
| 223 - Enterprise Configuration | 118,366 | 135,406 | 17,040 | 1,048,473 | 1,080,395 | 31,921 |
| 310 - Health Servcies - Utilization Management | 758,725 | 778,501 | 19,776 | 6,089,885 | 6,211,615 | 121,730 |
| 311 - Health Services - Quality Improvement | 216,012 | 287,306 | 71,294 | 1,920,317 | 2,292,400 | 372,083 |
| 312 - Health Services Education | 346,379 | 357,909 | 11,530 | 2,575,931 | 2,855,733 | 279,802 |
| 313 - Pharmacy | 122,168 | 128,426 | 6,258 | 959,629 | 1,024,704 | 65,075 |
| 314 - Enhanced Care Management | 391,539 | 397,204 | 5,665 | 3,110,905 | 3,169,266 | 58,361 |
| 316 - Population Health Management | 513,656 | 613,176 | 99,521 | 4,219,877 | 4,892,497 | 672,620 |
| 317 - In Lieu of Services | 136,171 | 130,765 | (5,406) | 1,045,449 | 1,043,366 | (2,083) |
| 321 - Homeless Management Information Services | 21,901 | 42,749 | 20,848 | 197,753 | 341,092 | 143,340 |
| 330 - Member Services | 1,033,664 | 1,091,755 | 58,091 | 8,326,272 | 8,711,053 | 384,781 |
| 331 - Member Outreach | 80,192 | 253,273 | 173,080 | 699,041 | 2,020,847 | 1,321,806 |
| 410 - Member Engagement | 55,771 | 106,020 | 50,249 | 455,865 | 845,928 | 390,063 |
| 601 - Behavioral Health | 133,836 | 177,691 | 43,855 | 1,207,392 | 1,417,787 | 210,395 |
| 602 - Quality & Health Equity | 72,204 | 82,463 | 10,259 | 627,177 | 657,966 | 30,788 |
| 605 - Quality Performance | 170,657 | 187,652 | 16,995 | 1,213,875 | 1,497,265 | 283,390 |
| Behavior Health Treatment | 4,843,499 | 2,841,590 | (2,001,910) | 28,059,987 | 22,637,547 | (5,422,440) |
| Mental Health Services | 689,979 | 680,504 | (9,475) | 4,889,796 | 5,432,207 | 542,411 |
| Other Professional Services | 2,518,539 | 2,048,336 | (470,204) | 17,395,751 | 16,333,167 | (1,062,584) |
| Total Other Professional Services | 12,757,030 | 10,900,363 | (1,856,667) | 88,356,574 | 86,925,249 | (1,431,324) |
| Emergency Room | 6,307,989 | 6,832,684 | 524,695 | 53,321,412 | 54,445,061 | 1,123,649 |
| Inpatient Hospital | 34,046,492 | 34,091,786 | 45,293 | 279,453,554 | 272,096,316 | (7,357,238) |
| Reinsurance Expense Premium | 262,299 | 275,533 | 13,234 | 2,100,462 | 2,194,316 | 93,854 |
| Outpatient Hospital | 15,218,411 | 15,473,385 | 254,974 | 123,476,586 | 123,519,207 | 42,621 |
| **Other Medical** | | | | | | |
| Ambulance and NEMT | 5,548,491 | 5,059,964 | (488,527) | 49,896,230 | 40,411,970 | (9,484,260) |
| Home Health Services & CBAS | 1,887,076 | 1,320,249 | (566,827) | 12,099,140 | 10,554,301 | (1,544,838) |
| Utilization and Quality Review Expenses | 1,689,659 | 1,821,381 | 131,721 | 9,677,740 | 14,532,689 | 4,854,949 |
| Long Term/SNF/Hospice | 12,559,642 | 11,523,345 | (1,036,297) | 86,137,362 | 92,153,902 | 6,016,540 |
| Provider Enhancement Expense - Prop. 56 | 1,797,523 | 1,659,425 | (138,098) | 14,443,599 | 11,890,559 | (2,553,040) |
| Provider Enhancement Expense - GEMT | 555,602 | 422,975 | (132,627) | 4,302,920 | 4,695,084 | 392,165 |
| Enhanced Care Management | 5,019,062 | 4,334,072 | (684,990) | 43,607,854 | 34,577,146 | (9,030,708) |
| Community Support Services | 2,803,270 | - | (2,803,270) | 34,748,047 | - | (34,748,047) |
| Major Organ Transplant | 344,643 | 953,431 | 608,788 | 4,339,574 | 7,614,520 | 3,274,946 |
| Cal AIM Incentive Programs | - | - | - | 1,503,032 | - | (1,503,032) |
| Housing and Homelessness Incentive | - | - | - | 1,325,000 | - | (1,325,000) |
| Distinct Part Nursing Facility Expense | 1,169 | - | (1,169) | 9,831 | - | (9,831) |
| DME/Rebates | 2,500,899 | 1,991,216 | (509,682) | 18,140,085 | 15,895,022 | (2,245,064) |
| Total Other Medical | 34,707,037 | 29,086,058 | (5,620,979) | 280,230,415 | 232,325,194 | (47,905,221) |
| Pay for Performance Quality Incentive | 603,107 | 609,748 | 6,641 | 4,954,711 | 4,857,024 | (97,687) |
| Hospital Directed Payments | 58,464,674 | 24,445,972 | (34,018,702) | 471,184,800 | 195,015,529 | (276,169,271) |
| Hospital Directed Payment Adjustment | (53,169,871) | - | 53,169,871 | 57,367,485 | - | (57,367,485) |
| Non-Claims Expense Adjustment | 6,421 | - | (6,421) | (16,645,686) | - | 16,645,686 |
| IBNR, Incentive, Paid Claims Adjustment | 1,343,361 | - | (1,343,361) | (706,911) | - | 706,911 |
| Total Medical Costs | 148,798,250 | 158,686,834 | 9,888,584 | 1,653,571,111 | 1,266,083,935 | (387,487,176) |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | August | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| TOTAL MEMBERS - MCAL | 402,071 | 406,500 | (4,429) | 3,236,474 | 3,238,000 | (1,526) |
| **Physician Services** | | | | | | |
| Primary Care Physician Services | 23.82 | 20.13 | (3.69) | 21.76 | 20.12 | (1.64) |
| Referral Specialty Services | 65.30 | 61.37 | (3.94) | 66.11 | 61.44 | (4.66) |
| Urgent Care & After Hours Advice | 5.99 | 9.43 | 3.45 | 8.04 | 9.43 | 1.39 |
| Hospital Admitting Team | 0.02 | 0.02 | (0.00) | 0.02 | 0.02 | (0.00) |
| Total Physician Services | 95.14 | 90.95 | (4.19) | 95.93 | 91.01 | (4.92) |
| **Other Professional Services** | | | | | | |
| Vision Service Capitation | 0.86 | 0.90 | 0.04 | 0.85 | 0.90 | 0.05 |
| 221 - Business Intelligence | 0.47 | 0.48 | 0.01 | 0.48 | 0.48 | (0.00) |
| 223 - Enterprise Configuration | 0.29 | 0.33 | 0.04 | 0.32 | 0.33 | 0.01 |
| 310 - Health Servcies - Utilization Management | 1.89 | 1.92 | 0.03 | 1.88 | 1.92 | 0.04 |
| 311 - Health Services - Quality Improvement | 0.54 | 0.71 | 0.17 | 0.59 | 0.71 | 0.11 |
| 312 - Health Services Education | 0.86 | 0.88 | 0.02 | 0.80 | 0.88 | 0.09 |
| 313 - Pharmacy | 0.30 | 0.32 | 0.01 | 0.30 | 0.32 | 0.02 |
| 314 - Enhanced Care Management | 0.97 | 0.98 | 0.00 | 0.96 | 0.98 | 0.02 |
| 316 - Population Health Management | 1.28 | 1.51 | 0.23 | 1.30 | 1.51 | 0.21 |
| 317 - In Lieu of Services | 0.34 | 0.32 | (0.02) | 0.32 | 0.32 | (0.00) |
| 321 - Homeless Management Information Services | 0.05 | 0.11 | 0.05 | 0.06 | 0.11 | 0.04 |
| 330 - Member Services | 2.57 | 2.69 | 0.11 | 2.57 | 2.69 | 0.12 |
| 331 - Member Outreach | 0.20 | 0.62 | 0.42 | 0.22 | 0.62 | 0.41 |
| 410 - Member Engagement | 0.14 | 0.26 | 0.12 | 0.14 | 0.26 | 0.12 |
| 601 - Behavioral Health | 0.33 | 0.44 | 0.10 | 0.37 | 0.44 | 0.06 |
| 602 - Quality & Health Equity | 0.18 | 0.20 | 0.02 | 0.19 | 0.20 | 0.01 |
| 605 - Quality Performance | 0.42 | 0.46 | 0.04 | 0.38 | 0.46 | 0.09 |
| Behavior Health Treatment | 12.05 | 6.99 | (5.06) | 8.67 | 6.99 | (1.68) |
| Mental Health Services | 1.72 | 1.67 | (0.04) | 1.51 | 1.68 | 0.17 |
| Other Professional Services | 6.26 | 5.04 | (1.22) | 5.37 | 5.04 | (0.33) |
| Total Other Professional Services | 31.73 | 26.82 | (4.91) | 27.30 | 26.85 | (0.45) |
| Emergency Room | 15.69 | 16.81 | 1.12 | 16.48 | 16.81 | 0.34 |
| Inpatient Hospital | 84.68 | 83.87 | (0.81) | 86.35 | 84.03 | (2.31) |
| Reinsurance Expense Premium | 0.65 | 0.68 | 0.03 | 0.65 | 0.68 | 0.03 |
| Outpatient Hospital | 37.85 | 38.06 | 0.21 | 38.15 | 38.15 | (0.00) |
| **Other Medical** | | | | | | |
| Ambulance and NEMT | 13.80 | 12.45 | (1.35) | 15.42 | 12.48 | (2.94) |
| Home Health Services & CBAS | 4.69 | 3.25 | (1.45) | 3.74 | 3.26 | (0.48) |
| Utilization and Quality Review Expenses | 4.20 | 4.48 | 0.28 | 2.99 | 4.49 | 1.50 |
| Long Term/SNF/Hospice | 31.24 | 28.35 | (2.89) | 26.61 | 28.46 | 1.85 |
| Provider Enhancement Expense - Prop. 56 | 4.47 | 4.08 | (0.39) | 4.46 | 3.67 | (0.79) |
| Provider Enhancement Expense - GEMT | 1.38 | 1.04 | (0.34) | 1.33 | 1.45 | 0.12 |
| Enhanced Care Management | 12.48 | 10.66 | (1.82) | 13.47 | 10.68 | (2.80) |
| Community Support Services | 6.97 | - | (6.97) | 10.74 | - | (10.74) |
| Major Organ Transplant | 0.86 | 2.35 | 1.49 | 1.34 | 2.35 | 1.01 |
| Cal AIM Incentive Programs | - | - | - | 0.46 | - | (0.46) |
| Distinct Part Nursing Facility Expense | 0.00 | - | (0.00) | 0.00 | - | (0.00) |
| DME/Rebates | 6.22 | 4.90 | (1.32) | 5.60 | 4.91 | (0.70) |
| Total Other Medical | 86.32 | 71.55 | (14.77) | 86.59 | 71.75 | (14.84) |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | (0.00) | 1.53 | 1.50 | (0.03) |
| Hospital Directed Payments | 145.41 | 60.14 | (85.27) | 145.59 | 60.23 | (85.36) |
| Hospital Directed Payment Adjustment | (132.24) | - | 132.24 | 17.73 | - | (17.73) |
| Non-Claims Expense Adjustment | 0.02 | - | (0.02) | (5.14) | - | 5.14 |
| IBNR, Incentive, Paid Claims Adjustment | 3.34 | - | (3.34) | (0.22) | - | 0.22 |
| Total Medical Costs | 370.08 | 390.37 | 20.29 | 510.92 | 391.01 | (119.91) |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | August | Year to Date |
|---|---|---|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | | | | |
| Primary Care Physician Services | 6,633,777 | 10,235,649 | 8,511,088 | 8,021,079 | 8,209,102 | 10,026,387 | 9,216,722 | 9,577,793 | 70,431,597 |
| Referral Specialty Services | 25,541,006 | 24,175,932 | 26,067,518 | 27,364,943 | 29,514,962 | 29,048,662 | 25,977,509 | 26,256,618 | 213,947,149 |
| Urgent Care & After Hours Advice | 3,948,407 | 4,291,828 | 4,106,619 | 3,623,145 | 1,686,319 | 3,028,060 | 2,934,095 | 2,407,589 | 26,026,062 |
| Hospital Admitting Team | 9,300 | 8,400 | 9,300 | 9,000 | 9,300 | 9,000 | 9,300 | 9,300 | 72,900 |
| Total Physician Services | 36,132,491 | 38,711,809 | 38,694,525 | 39,018,167 | 39,419,683 | 42,112,109 | 38,137,625 | 38,251,300 | 310,477,708 |
| **Other Professional Services** | | | | | | | | | |
| Vision Service Capitation | 344,606 | 343,774 | 343,775 | 345,653 | 344,127 | 343,908 | 342,449 | 344,852 | 2,753,143 |
| 221 - Business Intelligence | 211,963 | 188,504 | 191,787 | 186,842 | 193,999 | 194,435 | 203,605 | 188,920 | 1,560,055 |
| 223 - Enterprise Configuration | 142,213 | 117,289 | 130,628 | 128,689 | 138,241 | 135,954 | 137,093 | 118,366 | 1,048,473 |
| 310 - Health Servcies - Utilization Management | 826,640 | 762,266 | 757,294 | 734,148 | 748,550 | 710,325 | 791,938 | 758,725 | 6,089,885 |
| 311 - Health Services - Quality Improvement | 306,121 | 220,471 | 220,433 | 238,693 | 248,061 | 241,982 | 228,544 | 216,012 | 1,920,317 |
| 312 - Health Services Education | 321,705 | 307,110 | 316,293 | 312,444 | 315,011 | 323,825 | 333,163 | 346,379 | 2,575,931 |
| 313 - Pharmacy | 140,301 | 111,951 | 115,447 | 113,186 | 123,215 | 119,553 | 113,809 | 122,168 | 959,629 |
| 314 - Enhanced Care Management | 411,824 | 347,498 | 371,602 | 395,870 | 390,150 | 390,990 | 411,433 | 391,539 | 3,110,905 |
| 316 - Population Health Management | 593,720 | 502,067 | 520,999 | 496,916 | 507,502 | 519,902 | 565,114 | 513,656 | 4,219,877 |
| 317 - In Lieu of Services | 134,223 | 120,595 | 127,368 | 125,560 | 133,141 | 134,784 | 133,606 | 136,171 | 1,045,449 |
| 321 - Homeless Management Information Services | 44,251 | 23,122 | 20,283 | 21,008 | 21,840 | 22,122 | 23,226 | 21,901 | 197,753 |
| 330 - Member Services | 1,080,746 | 1,029,669 | 1,011,284 | 1,016,232 | 1,067,629 | 1,025,969 | 1,061,079 | 1,033,664 | 8,326,272 |
| 331 - Member Outreach | 83,414 | 78,217 | 82,465 | 117,142 | 86,498 | 86,260 | 84,852 | 80,192 | 699,041 |
| 410 - Member Engagement | 59,841 | 54,424 | 57,455 | 57,181 | 58,977 | 57,105 | 55,111 | 55,771 | 455,865 |
| 601 - Behavioral Health | 170,807 | 146,523 | 140,152 | 147,490 | 160,019 | 150,152 | 158,413 | 133,836 | 1,207,392 |
| 602 - Quality & Health Equity | 82,237 | 78,819 | 78,678 | 79,984 | 78,183 | 73,359 | 83,714 | 72,204 | 627,177 |
| 605 - Quality Performance | 154,331 | 142,203 | 160,748 | 156,090 | 148,645 | 139,390 | 141,810 | 170,657 | 1,213,875 |
| Behavior Health Treatment | 3,181,908 | 3,355,677 | 2,493,778 | 3,786,771 | 2,901,828 | 3,914,355 | 3,582,170 | 4,843,499 | 28,059,987 |
| Mental Health Services | 974,251 | 506,210 | 300,821 | 550,412 | 609,128 | 555,723 | 703,273 | 689,979 | 4,889,796 |
| Other Professional Services | 2,180,697 | 1,568,304 | 2,126,040 | 2,241,884 | 2,418,598 | 2,383,070 | 1,958,620 | 2,518,539 | 17,395,751 |
| Total Other Professional Services | 11,445,798 | 10,004,694 | 9,567,330 | 11,252,193 | 10,693,341 | 11,523,165 | 11,113,022 | 12,757,030 | 88,356,574 |
| Emergency Room | 7,289,728 | 6,508,981 | 6,225,711 | 6,330,730 | 7,074,183 | 7,003,225 | 6,580,865 | 6,307,989 | 53,321,412 |
| Inpatient Hospital | 33,857,875 | 31,406,220 | 33,213,126 | 33,714,646 | 39,326,548 | 39,527,275 | 34,361,371 | 34,046,492 | 279,453,554 |
| Reinsurance Expense Premium | 269,619 | 269,619 | 269,619 | 240,829 | 271,713 | 255,781 | 260,984 | 262,299 | 2,100,462 |
| Outpatient Hospital | 16,019,765 | 15,697,949 | 14,487,044 | 16,762,573 | 14,357,942 | 15,379,229 | 15,553,674 | 15,218,411 | 123,476,586 |
| **Other Medical** | | | | | | | | | |
| Ambulance and NEMT | 5,965,805 | 7,090,416 | 6,724,343 | 5,827,057 | 6,396,406 | 6,536,276 | 5,807,437 | 5,548,491 | 49,896,230 |
| Home Health Services & CBAS | 1,636,266 | 1,531,236 | 1,185,227 | 1,395,613 | 1,130,422 | 1,646,789 | 1,686,511 | 1,887,076 | 12,099,140 |
| Utilization and Quality Review Expenses | 936,126 | 930,163 | 1,665,464 | 773,340 | 1,444,299 | 972,636 | 1,266,051 | 1,689,659 | 9,677,740 |
| Long Term/SNF/Hospice | 10,523,545 | 10,822,106 | 9,460,426 | 10,684,436 | 10,165,912 | 11,159,610 | 10,761,685 | 12,559,642 | 86,137,362 |
| Provider Enhancement Expense - Prop. 56 | 1,801,039 | 1,803,328 | 1,805,739 | 1,809,345 | 1,813,309 | 1,805,939 | 1,807,377 | 1,797,523 | 14,443,599 |
| Provider Enhancement Expense - GEMT | 549,430 | 519,819 | 534,888 | 534,592 | 534,661 | 536,894 | 537,034 | 555,602 | 4,302,920 |
| Enhanced Care Management | 5,134,027 | 5,521,997 | 5,331,279 | 5,330,372 | 5,331,053 | 5,352,687 | 6,587,375 | 5,019,062 | 43,607,854 |
| Community Support Services | 590,845 | 3,824,743 | 4,662,690 | 6,140,445 | 5,298,573 | 6,510,178 | 4,917,304 | 2,803,270 | 34,748,047 |
| Major Organ Transplant | 542,452 | 574,592 | 534,775 | 537,237 | 541,047 | 533,290 | 731,538 | 344,643 | 4,339,574 |
| Cal AIM Incentive Programs | 275,000 | 188,015 | 390,633 | 125,018 | 90,000 | - | 434,367 | - | 1,503,032 |
| Housing and Homelessness Incentive | - | - | - | - | - | 200,000 | 1,125,000 | - | 1,325,000 |
| Distinct Part Nursing Facility Expense | 1,259 | 1,293 | 1,251 | 1,227 | 1,206 | 1,232 | 1,194 | 1,169 | 9,831 |
| DME/Rebates | 2,339,823 | 1,958,689 | 1,991,312 | 2,331,626 | 2,136,985 | 2,389,588 | 2,491,164 | 2,500,899 | 18,140,085 |
| Total Other Medical | 30,295,617 | 34,766,397 | 34,288,028 | 35,490,308 | 34,883,873 | 37,645,117 | 38,154,038 | 34,707,037 | 280,230,415 |
| Pay for Performance Quality Incentive | 606,662 | 608,318 | 607,800 | 607,349 | 605,835 | 707,199 | 608,444 | 603,107 | 4,954,711 |
| Hospital Directed Payments | 59,831,392 | 58,045,936 | 58,943,903 | 58,897,348 | 58,890,354 | 59,075,312 | 59,035,880 | 58,464,674 | 471,184,800 |
| Hospital Directed Payment Adjustment | 103,134,648 | 1,953,159 | 15,484 | 111,948 | 1,098,088 | (37,127) | 4,261,156 | (53,169,871) | 57,367,485 |
| Non-Claims Expense Adjustment | (350,170) | (2,753,743) | (3,382,901) | (1,877) | (10,262,733) | (283) | 99,601 | 6,421 | (16,645,686) |
| IBNR, Incentive, Paid Claims Adjustment | 388,615 | 248,637 | 21,094 | (2,667,286) | (37,610) | (826,300) | 822,578 | 1,343,361 | (706,911) |
| Total Medical Costs | 298,922,038 | 195,467,975 | 192,950,763 | 199,756,928 | 196,321,218 | 212,364,700 | 208,989,239 | 148,798,250 | 1,653,571,111 |

**MEDI-CAL**
**SCHEDULE OF MEDICAL COSTS - ALL COA**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | August | Year to Date |
|---|---|---|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | | | | |
| Primary Care Physician Services | 16.40 | 25.24 | 21.00 | 19.81 | 20.33 | 24.77 | 22.72 | 23.82 | 21.76 |
| Referral Specialty Services | 63.15 | 59.61 | 64.33 | 67.58 | 73.08 | 71.76 | 64.04 | 65.30 | 66.11 |
| Urgent Care & After Hours Advice | 9.76 | 10.58 | 10.13 | 8.95 | 4.18 | 7.48 | 7.23 | 5.99 | 8.04 |
| Hospital Admitting Team | 0.02 | 0.02 | 0.02 | 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 | 94.02 | 95.14 | 95.93 |
| **Other Professional Services** | | | | | | | | | |
| Vision Service Capitation | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.85 | 0.84 | 0.86 | 0.85 |
| 221 - Business Intelligence | 0.52 | 0.46 | 0.47 | 0.46 | 0.48 | 0.48 | 0.50 | 0.47 | 0.48 |
| 223 - Enterprise Configuration | 0.35 | 0.29 | 0.32 | 0.32 | 0.34 | 0.34 | 0.34 | 0.29 | 0.32 |
| 310 - Health Servcies - Utilization Management | 2.04 | 1.88 | 1.87 | 1.81 | 1.85 | 1.75 | 1.95 | 1.89 | 1.88 |
| 311 - Health Services - Quality Improvement | 0.76 | 0.54 | 0.54 | 0.59 | 0.61 | 0.60 | 0.56 | 0.54 | 0.59 |
| 312 - Health Services Education | 0.80 | 0.76 | 0.78 | 0.77 | 0.78 | 0.80 | 0.82 | 0.86 | 0.80 |
| 313 - Pharmacy | 0.35 | 0.28 | 0.28 | 0.28 | 0.31 | 0.30 | 0.28 | 0.30 | 0.30 |
| 314 - Enhanced Care Management | 1.02 | 0.86 | 0.92 | 0.98 | 0.97 | 0.97 | 1.01 | 0.97 | 0.96 |
| 316 - Population Health Management | 1.47 | 1.24 | 1.29 | 1.23 | 1.26 | 1.28 | 1.39 | 1.28 | 1.30 |
| 317 - In Lieu of Services | 0.33 | 0.30 | 0.31 | 0.31 | 0.33 | 0.33 | 0.33 | 0.34 | 0.32 |
| 321 - Homeless Management Information Services | 0.11 | 0.06 | 0.05 | 0.05 | 0.05 | 0.05 | 0.06 | 0.05 | 0.06 |
| 330 - Member Services | 2.67 | 2.54 | 2.50 | 2.51 | 2.64 | 2.53 | 2.62 | 2.57 | 2.57 |
| 331 - Member Outreach | 0.21 | 0.19 | 0.20 | 0.29 | 0.21 | 0.21 | 0.21 | 0.20 | 0.22 |
| 410 - Member Engagement | 0.15 | 0.13 | 0.14 | 0.14 | 0.15 | 0.14 | 0.14 | 0.14 | 0.14 |
| 601 - Behavioral Health | 0.42 | 0.36 | 0.35 | 0.36 | 0.40 | 0.37 | 0.39 | 0.33 | 0.37 |
| 602 - Quality & Health Equity | 0.20 | 0.19 | 0.19 | 0.20 | 0.19 | 0.18 | 0.21 | 0.18 | 0.19 |
| 605 - Quality Performance | 0.38 | 0.35 | 0.40 | 0.39 | 0.37 | 0.34 | 0.35 | 0.42 | 0.38 |
| Behavior Health Treatment | 7.87 | 8.27 | 6.15 | 9.35 | 7.18 | 9.67 | 8.83 | 12.05 | 8.67 |
| Mental Health Services | 2.41 | 1.25 | 0.74 | 1.36 | 1.51 | 1.37 | 1.73 | 1.72 | 1.51 |
| Other Professional Services | 5.39 | 3.87 | 5.25 | 5.54 | 5.99 | 5.89 | 4.83 | 6.26 | 5.37 |
| Total Other Professional Services | 28.30 | 24.67 | 23.61 | 27.79 | 26.48 | 28.47 | 27.40 | 31.73 | 27.30 |
| Emergency Room | 18.02 | 16.05 | 15.36 | 15.64 | 17.52 | 17.30 | 16.22 | 15.69 | 16.48 |
| Inpatient Hospital | 83.72 | 77.44 | 81.97 | 83.27 | 97.37 | 97.65 | 84.71 | 84.68 | 86.35 |
| Reinsurance Expense Premium | 0.67 | 0.66 | 0.67 | 0.59 | 0.67 | 0.63 | 0.64 | 0.65 | 0.65 |
| Outpatient Hospital | 39.61 | 38.71 | 35.75 | 41.40 | 35.55 | 37.99 | 38.34 | 37.85 | 38.15 |
| **Other Medical** | | | | | | | | | |
| Ambulance and NEMT | 14.75 | 17.48 | 16.60 | 14.39 | 15.84 | 16.15 | 14.32 | 13.80 | 15.42 |
| Home Health Services & CBAS | 4.05 | 3.78 | 2.93 | 3.45 | 2.80 | 4.07 | 4.16 | 4.69 | 3.74 |
| Utilization and Quality Review Expenses | 2.31 | 2.29 | 4.11 | 1.91 | 3.58 | 2.40 | 3.12 | 4.20 | 2.99 |
| Long Term/SNF/Hospice | 26.02 | 26.69 | 23.35 | 26.39 | 25.17 | 27.57 | 26.53 | 31.24 | 26.61 |
| Provider Enhancement Expense - Prop. 56 | 4.45 | 4.45 | 4.46 | 4.47 | 4.49 | 4.46 | 4.46 | 4.47 | 4.46 |
| Provider Enhancement Expense - GEMT | 1.36 | 1.28 | 1.32 | 1.32 | 1.32 | 1.33 | 1.32 | 1.38 | 1.33 |
| Enhanced Care Management | 12.69 | 13.62 | 13.16 | 13.16 | 13.20 | 13.22 | 16.24 | 12.48 | 13.47 |
| Community Support Services | 1.46 | 9.43 | 11.51 | 15.17 | 13.12 | 16.08 | 12.12 | 6.97 | 10.74 |
| Major Organ Transplant | 1.34 | 1.42 | 1.32 | 1.33 | 1.34 | 1.32 | 1.80 | 0.86 | 1.34 |
| Cal AIM Incentive Programs | 0.68 | 0.46 | 0.96 | 0.31 | 0.22 | - | 1.07 | - | 0.46 |
| Housing and Homelessness Incentive | - | - | - | - | - | 0.49 | 2.77 | - | 0.41 |
| Distinct Part Nursing Facility Expense | 0.00 | 0.00 | 0.00 | 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 | 6.14 | 6.22 | 5.60 |
| Total Other Medical | 74.91 | 85.73 | 84.62 | 87.65 | 86.37 | 93.00 | 94.06 | 86.32 | 86.59 |
| Pay for Performance Quality Incentive | 1.50 | 1.50 | 1.50 | 1.50 | 1.50 | 1.75 | 1.50 | 1.50 | 1.53 |
| Hospital Directed Payments | 147.94 | 143.13 | 145.47 | 145.46 | 145.81 | 145.94 | 145.54 | 145.41 | 145.59 |
| Hospital Directed Payment Adjustment | 255.01 | 4.82 | 0.04 | 0.28 | 2.72 | (0.09) | 10.51 | (132.24) | 17.73 |
| Non-Claims Expense Adjustment | (0.87) | (6.79) | (8.35) | (0.00) | (25.41) | (0.00) | 0.25 | 0.02 | (5.14) |
| IBNR, Incentive, Paid Claims Adjustment | 0.96 | 0.61 | 0.05 | (6.59) | (0.09) | (2.04) | 2.03 | 3.34 | (0.22) |
| Total Medical Costs | 739.10 | 481.99 | 476.19 | 493.35 | 486.08 | 524.62 | 515.22 | 370.08 | 510.92 |

KERN HEALTH SYSTEMS

**MEDI-CAL**
**SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT**
**FOR THE MONTH ENDED AUGUST 31, 2025**

| | August | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| 110 - Executive | 586,896 | 650,390 | 63,494 | 4,940,629 | 5,203,122 | 262,493 |
| 112 - Government Relations | 55,517 | 62,942 | 7,425 | 434,824 | 503,535 | 68,711 |
| 210 - Accounting | 342,404 | 370,068 | 27,663 | 2,790,998 | 2,960,540 | 169,542 |
| 220 - Management Information Systems (MIS) | 291,676 | 508,775 | 217,098 | 2,536,727 | 4,070,196 | 1,533,469 |
| 221 - Business Intelligence | 516,199 | 246,484 | (269,714) | 3,343,189 | 1,971,873 | (1,371,316) |
| 222 - MIS Development | 562,724 | 515,722 | (47,001) | 4,352,196 | 4,125,780 | (226,416) |
| 223 - Enterprise Configuration | 268,167 | 322,452 | 54,284 | 1,962,622 | 2,579,613 | 616,991 |
| 224 - Cyber Security | 76,238 | 43,744 | (32,494) | 412,732 | 349,949 | (62,783) |
| 225 - Infrastructure | 641,138 | 1,140,153 | 499,015 | 6,336,063 | 9,121,223 | 2,785,160 |
| 226 - Technical Administrative Services | 96,432 | 94,102 | (2,329) | 604,103 | 752,819 | 148,716 |
| 230 - Claims | 793,646 | 823,338 | 29,692 | 7,953,243 | 6,586,698 | (1,366,545) |
| 240 - Project Development | (187,245) | 216,007 | 403,252 | 1,599,301 | 1,728,055 | 128,755 |
| 310 - Health Services - Utilization Management | 55,256 | 50,148 | (5,108) | 409,615 | 401,181 | (8,434) |
| 311 - Health Services - Quality Improvement | 6,911 | 11,596 | 4,685 | 62,764 | 92,764 | 30,001 |
| 312 - Health Services - Education | 169 | 648 | 479 | 415 | 5,187 | 4,772 |
| 313 - Pharmacy | 0 | 11,450 | 11,450 | 32,219 | 91,600 | 59,381 |
| 314 - Enhanced Care Management | 22,214 | 22,583 | 368 | 199,638 | 180,661 | (18,977) |
| 316 - Population Health Management | 186 | 2,454 | 2,268 | 1,372 | 19,633 | 18,262 |
| 317 - Community Support Services | 25,688 | 3,150 | (22,538) | 27,881 | 25,203 | (2,678) |
| 320 - Provider Network Management | 188,330 | 326,776 | 138,446 | 2,218,529 | 2,614,211 | 395,681 |
| 321 - Homeless Management Information Serv | - | 1,854 | 1,854 | 1,190 | 14,833 | 13,644 |
| 322 - Delegation & Oversight | 31,710 | 30,422 | (1,288) | 233,390 | 243,374 | 9,984 |
| 330 - Member Services | 202,243 | 229,310 | 27,067 | 1,432,741 | 1,834,480 | 401,739 |
| 340 - Corporate Services | 906,946 | 1,128,044 | 221,098 | 7,106,290 | 9,024,356 | 1,918,065 |
| 360 - Audit & Investigative Services | 258,896 | 306,189 | 47,293 | 2,356,538 | 2,449,512 | 92,974 |
| 410 - Member Engagement | 63,798 | 62,873 | (925) | 517,616 | 502,987 | (14,629) |
| 420 - Sales/Marketing/Public Relations | 136,181 | 329,532 | 193,351 | 2,157,407 | 2,636,253 | 478,846 |
| 510 - Human Resourses | 443,736 | 460,498 | 16,761 | 3,730,033 | 3,683,980 | (46,053) |
| 520 - Legal | 33,920 | 122,824 | 88,904 | 579,522 | 982,589 | 403,067 |
| 601 - Behavioral Health | - | 3,350 | 3,350 | 16,722 | 26,800 | 10,078 |
| 602 - Quality & Health Equity | 9,651 | 35,573 | 25,922 | 151,866 | 284,584 | 132,718 |
| 605 - Quality Performance | 211,038 | 116,048 | (94,990) | 1,526,134 | 928,386 | (597,749) |
| Administrative Expense Adjustment | - | 200,000 | 200,000 | 1,053,608 | 1,600,000 | 546,392 |
| Total Administrative Expenses | 6,640,664 | 8,449,497 | 1,808,833 | 61,082,111 | 67,595,973 | 6,513,863 |

**MEDI-CAL**
**SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT**
**FOR THE MONTH ENDED AUGUST 31, 2025**

KERN HEALTH SYSTEMS

| | January | February | March | April | May | June | July | August | YTD TOTALS |
|---|---|---|---|---|---|---|---|---|---|
| 110 - Executive | 682,639 | 453,118 | 564,215 | 590,083 | 706,155 | 707,525 | 649,999 | 586,896 | 4,940,629 |
| 112 - Government Relations | 64,745 | 54,023 | 53,593 | 52,753 | 52,122 | 50,607 | 51,463 | 55,517 | 434,824 |
| 210 - Accounting | 373,730 | 270,170 | 370,641 | 425,988 | 328,977 | 293,602 | 385,487 | 342,404 | 2,790,998 |
| 220 - Management Information Systems (MIS) | 354,906 | 282,955 | 322,843 | 190,927 | 363,642 | 398,515 | 331,263 | 291,676 | 2,536,727 |
| 221 - Business Intelligence | 288,258 | 333,566 | 445,959 | 820,670 | 390,607 | (16,886) | 564,816 | 516,199 | 3,343,189 |
| 222 - MIS Development | 390,138 | 339,566 | 481,800 | 492,554 | 674,896 | 841,641 | 568,876 | 562,724 | 4,352,196 |
| 223 - Enterprise Configuration | 233,790 | 188,775 | 205,405 | 192,961 | 272,681 | 361,934 | 238,908 | 268,167 | 1,962,622 |
| 224 - Cyber Security | 31,621 | 51,523 | 39,996 | 64,290 | 59,425 | 41,757 | 47,881 | 76,238 | 412,732 |
| 225 - Infrastructure | 767,910 | 644,388 | 845,020 | 1,162,292 | 828,314 | 698,614 | 748,388 | 641,138 | 6,336,063 |
| 226 - Technical Administrative Services | 70,628 | 64,258 | 67,549 | 47,750 | 79,438 | 79,715 | 98,333 | 96,432 | 604,103 |
| 230 - Claims | 885,033 | 986,246 | 941,807 | 907,411 | 964,739 | 875,316 | 1,599,045 | 793,646 | 7,953,243 |
| 240 - Project Development | 214,035 | 237,465 | 220,963 | 149,624 | 421,861 | 297,080 | 245,517 | (187,245) | 1,599,301 |
| 310 - Health Services - Utilization Managemen | 30,019 | 52,541 | 40,446 | 52,147 | 64,953 | 50,249 | 64,004 | 55,256 | 409,615 |
| 311 - Health Services - Quality Improvement | (15,100) | 31,947 | 7,052 | 8,308 | 8,591 | 7,744 | 7,312 | 6,911 | 62,764 |
| 312 - Health Services - Education | - | - | - | - | - | 246 | (0) | 169 | 415 |
| 313 - Pharmacy | 10,795 | 10,500 | 10,500 | 357 | (0) | 67 | (0) | 0 | 32,219 |
| 314 - Enhanced Care Management | 18,954 | 44,579 | 20,337 | 23,983 | 22,006 | 27,607 | 19,956 | 22,214 | 199,638 |
| 316 - Population Health Management | 103 | - | - | 1,030 | 48 | 5 | 0 | 186 | 1,372 |
| 317 - Community Support Services | - | - | 883 | - | 0 | 1,310 | (0) | 25,688 | 27,881 |
| 320 - Provider Network Management | 297,212 | 274,630 | 285,138 | 289,369 | 327,952 | 266,832 | 289,066 | 188,330 | 2,218,529 |
| 321 - Homeless Management Information Serv | 73 | - | 54 | 1,964 | - | (901) | (0) | - | 1,190 |
| 322 - Delegation & Oversight | 50,538 | 1,369 | 26,376 | 45,370 | 45,974 | 36,047 | (3,994) | 31,710 | 233,390 |
| 330 - Member Services | 174,446 | 228,649 | 118,453 | 159,275 | 190,289 | 178,853 | 180,533 | 202,243 | 1,432,741 |
| 340 - Corporate Services | 1,085,693 | 680,455 | 851,850 | 876,263 | 885,564 | 887,141 | 932,377 | 906,946 | 7,106,290 |
| 360 - Audit & Investigative Services | 286,424 | 338,436 | 269,614 | 283,804 | 324,297 | 279,420 | 315,648 | 258,896 | 2,356,538 |
| 410 - Member Engagement | 67,809 | 62,520 | 64,681 | 66,137 | 67,561 | 62,705 | 62,404 | 63,798 | 517,616 |
| 420 - Sales/Marketing/Public Relations | 139,774 | 226,357 | 228,233 | 118,236 | 308,542 | 369,105 | 630,980 | 136,181 | 2,157,407 |
| 510 - Human Resourses | 727,474 | 317,319 | 475,133 | 432,281 | 477,233 | 428,938 | 427,918 | 443,736 | 3,730,033 |
| 520 - Legal | 35,231 | 100,899 | 142,724 | 118,635 | 47,741 | 53,469 | 46,903 | 33,920 | 579,522 |
| 601 - Behavioral Health | 307 | 200 | (0) | 76 | 15,950 | (0) | 188 | - | 16,722 |
| 602 - Quality & Health Equity | 10,624 | 9,938 | 10,083 | 72,665 | 10,603 | 14,026 | 14,276 | 9,651 | 151,866 |
| 605 - Quality Performance | 212,721 | 179,458 | 198,076 | 193,987 | 183,516 | 171,252 | 176,086 | 211,038 | 1,526,134 |
| Administrative Expense Adjustment | 202,969 | 198,773 | 375,177 | 160,116 | 69,345 | 47,536 | (308) | - | 1,053,608 |
| Total Administrative Expenses | 7,693,499 | 6,664,623 | 7,684,602 | 8,001,306 | 8,193,021 | 7,511,070 | 8,693,325 | 6,640,664 | 61,082,111 |

**KHS - GROUP HEALTH PLAN**
**STATEMENT OF NET POSITION**
**AS OF AUGUST 31, 2025**

| ASSETS | August 2025 | July 2025 | Increase/ (Decrease) |
|---|---|---|---|
| Cash and Cash Equivalents | 1,274,847 | 1,274,847 | - |
| Interest Receivable | 9,000 | 4,500 | 4,500 |
| Other Receivable | 125 | 125 | - |
| Total Current Assets | 1,283,972 | 1,279,472 | 4,500 |
| **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 | 38,366 | 33,866 | 4,500 |
| Total Net Position | 1,283,972 | 1,279,472 | 4,500 |
| TOTAL LIABILITIES AND NET POSITION | 1,283,972 | 1,279,472 | 4,500 |

**KHS - GROUP HEALTH PLAN**
**STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION**
**FOR THE MONTH ENDED AUGUST 31, 2025**

| | August | Budget | Variance | Year to Date | Budget | Variance |
|---|---|---|---|---|---|---|
| **REVENUES** | | | | | | |
| Premium | - | - | - | - | - | - |
| Interest | 4,500 | - | 4,500 | 36,415 | - | 36,415 |
| Other Investment Income | - | - | - | 1,950 | - | 1,950 |
| Total Revenues | 4,500 | - | 4,500 | 38,366 | - | 38,366 |
| **EXPENSES** | | | | | | |
| **MEDICAL COSTS** | | | | | | |
| IBNR and Paid Claims Adjustment | - | - | - | - | - | - |
| Total Medical Costs | - | - | - | - | - | - |
| GROSS MARGIN | 4,500 | - | 4,500 | 38,366 | - | 38,366 |
| **ADMINISTRATIVE COSTS** | | | | | | |
| Management Fee Expense and Other Admin Exp | - | - | - | - | - | - |
| Total Administrative Expenses | - | - | - | - | - | - |
| TOTAL EXPENSES | - | - | - | - | - | - |
| OPERATING INCOME (LOSS) BEFORE TAX | 4,500 | - | 4,500 | 38,366 | - | 38,366 |
| **NON-OPERATING REVENUE (EXPENSE)** | | | | | | |
| Total Non-Operating Revenue (Expense) | - | - | - | - | - | - |
| NET INCREASE (DECREASE) IN NET POSITION | 4,500 | - | 4,500 | 38,366 | - | 38,366 |
| 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) | **594,578** | 74,604 | 74,605 | 74,309 | 74,397 | 74,422 | 74,237 | 74,479 | 73,525 | 0 | 0 | 0 | 0 |
| CHILD | **1,335,505** | 167,252 | 167,669 | 167,854 | 167,367 | 165,950 | 166,463 | 166,724 | 166,226 | 0 | 0 | 0 | 0 |
| **SUB-TOTAL ADULT & FAMILY** | **1,930,083** | **241,856** | **242,274** | **242,163** | **241,764** | **240,372** | **240,700** | **241,203** | **239,751** | **0** | **0** | **0** | **0** |
| **OTHER MEMBERS** | | | | | | | | | | | | | |
| FULL DUALS - FAMILY | **4,249** | 566 | 526 | 545 | 541 | 533 | 534 | 510 | 494 | 0 | 0 | 0 | 0 |
| FULL DUALS - CHILD | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **SUBTOTAL OTHER MEMBERS** | **4,249** | **566** | **526** | **545** | **541** | **533** | **534** | **510** | **494** | **0** | **0** | **0** | **0** |
| **TOTAL FAMILY** | **1,934,332** | **242,422** | **242,800** | **242,708** | **242,305** | **240,905** | **241,234** | **241,713** | **240,245** | **0** | **0** | **0** | **0** |
| **SPD MEMBERS** | | | | | | | | | | | | | |
| **SPD (AGED AND DISABLED)** | **166,993** | 23,226 | 18,391 | 20,998 | 21,034 | 20,905 | 20,961 | 20,698 | 20,780 | 0 | 0 | 0 | 0 |
| **OTHER MEMBERS** | | | | | | | | | | | | | |
| BCCTP - TABACCO SETTLEMENT | **56** | 0 | 0 | 0 | 12 | 9 | 13 | 11 | 11 | 0 | 0 | 0 | 0 |
| FULL DUALS - BCCTP | **15** | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 0 | 0 | 0 | 0 |
| SPD FULL DUALS | **204,437** | 23,272 | 27,695 | 25,425 | 25,375 | 25,671 | 25,597 | 25,812 | 25,590 | 0 | 0 | 0 | 0 |
| EXPANDION FULL DUALS | **2,661** | 366 | 333 | 322 | 326 | 293 | 357 | 297 | 367 | 0 | 0 | 0 | 0 |
| **LONG TERM CARE (LTC)** | | | | | | | | | | | | | |
| LTC | **404** | 48 | 52 | 54 | 52 | 52 | 46 | 49 | 51 | 0 | 0 | 0 | 0 |
| LTC DUALS | **3,601** | 465 | 467 | 462 | 451 | 453 | 443 | 431 | 429 | 0 | 0 | 0 | 0 |
| **TOTAL LTC** | **4,005** | **513** | **519** | **516** | **503** | **505** | **489** | **480** | **480** | **0** | **0** | **0** | **0** |
| **TOTAL SPD** | **378,167** | **47,379** | **46,939** | **47,263** | **47,252** | **47,385** | **47,419** | **47,300** | **47,230** | **0** | **0** | **0** | **0** |
| **ACA OE - MEDI-CAL OPTIONAL EXPANSION** | | | | | | | | | | | | | |
| ACA Expansion Adult-Citizen | **923,975** | 114,640 | 115,806 | 115,229 | 115,342 | 115,600 | 116,146 | 116,616 | 114,596 | 0 | 0 | 0 | 0 |
| **TOTAL EXPANSION** | **923,975** | **114,640** | **115,806** | **115,229** | **115,342** | **115,600** | **116,146** | **116,616** | **114,596** | **0** | **0** | **0** | **0** |
| **TOTAL CLASSIC MEMBERS** | **3,236,474** | **404,441** | **405,545** | **405,200** | **404,899** | **403,890** | **404,799** | **405,629** | **402,071** | **0** | **0** | **0** | **0** |
| **GRAND TOTAL** | **3,236,474** | **404,441** | **405,545** | **405,200** | **404,899** | **403,890** | **404,799** | **405,629** | **402,071** | **0** | **0** | **0** | **0** |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Robert Landis, Chief Financial Officer

**SUBJECT:** Reports on Accounts Payable, Administrative Contracts and IT Technology Consulting Resources

**DATE:** October 23, 2025

Attached for your review are the following items:

1) Accounts Payable Vendor Report listing of payments over $20,000 for the months of July and August 2025.

2) Administrative Contract Report listing contracts between $50,000 and $200,000 through August 2025.

3) IT Technology Consulting Resources Report for the period ending July 31, 2025.

**Requested Action**

Receive and file.

KERN·HEALTH SYSTEMS

**July AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| WT/ACH | BCI HOLDINGS | 983,958.81 | 5,753,894.48 | JUL. 2025 EMPLOYEE HMO HEALTH BENEFITS & RX CLAIMS PREMIUM | VARIOUS |
| T3130 | OPTUMINSIGHT, INC **** | 627,081.30 | 1,482,371.30 | YEAR 2 EASYGROUP LICENSE | MIS INFRASTRUCTURE |
| T1845 | DEPARTMENT OF MANAGED HEALTH CARE **** | 620,930.59 | 620,930.59 | 1ST INSTALLMENT ANNUAL ASSESMENT 2025-2026 | ADMINISTRATION |
| WT/ACH | BLACKHAWK NETWORK INC **** | 511,258.28 | 2,778,258.28 | PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM | HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI |
| T4350 | COMPUTER ENTERPRISE | 506,293.74 | 3,403,890.55 | JUN. 2025 PROFESSIONAL SERVICES/CONSULTING SERVICES | VARIOUS |
| T1180 | LANGUAGE LINE SERVICES INC. **** | 354,307.77 | 1,801,819.28 | MAY & JUN. 2025 INTERPRETATION SERVICES | HEALTH SERVICES - WELLNESS & PREVENTION |
| T4737 | TEKSYSTEMS, INC | 226,665.78 | 1,629,066.28 | JUN. 2025 PROFESSIONAL SERVICES/CONSULTING SERVICES | VARIOUS |
| T2686 | ALLIANT INSURANCE SERVICES INC. **** | 225,359.03 | 228,158.14 | 2025-2026 INSURANCE PREMIUMS-WPV, FIDUCIARY, EXCESS CRIME,COMMERCIAL,AMVP, COMMERCIAL CRIME | ADMINISTRATION |
| T5738 | INSURICA - WALTER MORTENSEN INSURANCE **** | 199,685.00 | 228,158.14 | WORKERS COMP PREMIUM 2025-2026 | ADMINISTRATION |
| T5684 | REBELLIS GROUP LLC | 159,512.50 | 902,181.94 | MAY 2025 PROFESSIONAL SERVICES | MEDICARE |
| T6054 | WEBMD IGNITE **** | 147,249.33 | 207,239.75 | HEALTHWISE LICENSE FEES 2025 | HEALTH SERVICES - WELLNESS & PREVENTION |
| T5292 | ALL'S WELL HEALTH CARE SERVICES **** | 130,905.13 | 998,229.58 | MAY & JUN. 2025 TEMPORARY HELP | VARIOUS |
| T1183 | MILLIMAN USA | 124,130.25 | 380,889.00 | ACTUARIAL CONSULTING FEES | VARIOUS |
| T5426 | UNIVERSAL HEALTHCARE SERVICES, INC **** | 100,000.00 | 100,000.00 | INITIAL 50% COMPREHENSIVE OBESITY MANAGEMENT PROGRAM | HEALTH SERVICES - UM |
| T6276 | KFORCE INC | 98,624.84 | 176,976.66 | JUN. 2025 PROFESSIONAL SERVICES | VARIOUS |

KERN·HEALTH SYSTEMS

**July AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| T2961 | SOLUTION BENCH, LLC **** | 95,000.00 | 110,624.00 | M-FILES ANNUAL RENEWAL FEES 2025-2026 | MIS INFRASTRUCTURE |
| T4733 | UNITED STAFFING ASSOCIATES | 78,985.03 | 343,271.46 | MAY & JUN. 2025 TEMPORARY HELP -(9) MS: (3) ME | VARIOUS |
| T2413 | TREK IMAGING INC **** | 74,970.65 | 252,607.33 | MARKETING PROMOTIONAL SUPPLIES, EMPLOYEE EVENTS, NEW HIRE SHIRTS | VARIOUS |
| T5930 | DAYFORCE US, INC | 67,470.70 | 270,735.07 | 2025 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/DAYFORCE HUMAN CAPITAL MANAGEMENT | HUMAN RESOURCES |
| T4237 | CITIUS HEALTHCARE CONSULTING, LLC **** | 66,967.50 | 233,235.00 | FEB. & JUN. 2025 PROFESSIONAL SERVICES | PROJECT MANAGEMENT/ENTERPRISE CONFIGURATION |
| T5658 | THE PRUDENTIAL INSURANCE COMPANY OF AMERICA | 61,076.91 | 448,198.29 | JUL. 2025 VOLUNTARY LIFE, AD&D INSURANCE PREMIUM | VARIOUS |
| T6272 | KEY STAFFING INC. | 57,614.37 | 135,431.90 | JUN. 2025 TEMPORARY HELP (1) FIN, (1) CLAIMS, (1)HE, (1)AIS, (3) MS | VARIOUS |
| T4657 | DAPONDE SIMPSON ROWE PC **** | 57,273.50 | 111,795.00 | MAR. & APR. 2025 LEGAL SERVICES | LEGAL |
| T4722 | COGNIZANT TRIZETTO SOFTWARE GROUP, INC | 56,082.85 | 541,948.18 | JUN. & JUL. 2025 PROFESSIONAL SERVICES & JUN. 2025 EDI CLAIMS | MIS INFRASTRUCTURE/CLAIMS |
| T5520 | BG HEALTHCARE CONSULTING, INC | 55,475.00 | 336,875.00 | JUN. 2025 CONSULTING SERVICES | HEALTH SERVICES - QI |
| T5890 | DELTA DENTAL OF CALIFORNIA | 50,657.66 | 356,642.56 | JUL. 2025 EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM | VARIOUS |
| T3011 | OFFICE ALLY, INC | 40,983.18 | 436,931.46 | JUN. 2025 EDI CLAIMS | CLAIMS |
| T4460 | PAYSPAN, INC | 38,763.28 | 386,568.59 | JUN. 2025 ELECTRONIC CLAIMS/PAYMENTS | FINANCE |
| T5076 | MERIDIAN HEALTH SYSTEMS, P.C. | 37,650.00 | 162,675.00 | JUN. 2025 PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| T5337 | CAZADOR CONSULTING GROUP INC | 36,775.57 | 596,343.12 | MAY 2025 TEMPORARY HELP - (9) MS: (1) ME: (1) MKT: (1) UM | VARIOUS |

KERN·HEALTH SYSTEMS

**July AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| T5298 | TOTALMED, INC | 36,644.30 | 262,231.17 | MAY, JUN. & JUL. 2025 TEMPORARY HELP | HEALTH SERVICES - UM |
| WT/ACH | COLABS | 35,650.00 | 35,650.00 | INTEL AGREE SUBSCRIPTION YR 2 OF 3 | MIS INFRASTRUCTURE |
| T2509 | UNITED STATES POSTAL SERVICE **** | 33,969.39 | 78,365.44 | PERMIT 162 FALL 2025 POSTAGE | HEALTH SERVICES - UM |
| T2941 | KERN PRINT SERVICES INC. | 32,857.78 | 152,710.79 | ENVELOPES & LETTERHEAD | CORPORATE SERVICES |
| T6361 | NEMT SOLUTIONS LLC **** | 32,000.00 | 32,000.00 | JUL. & AUG. 2025 NMT TRANSPORTATION SERVICE | TECHNICAL ADMINISTRATIVE SERVICES |
| WT/ACH | PAYPRO | 31,862.98 | 284,174.52 | JUN. 2025 EMPLOYEE PREMIUM | PAYROLL DEDUCTION |
| T5564 | CLARISHEALTH, INC | 31,338.76 | 555,029.36 | JUN. 2025 CONSULTING SERVICES | CLAIMS |
| T4708 | HEALTH MANAGEMENT ASSOCIATES, INC. **** | 29,263.25 | 126,350.75 | MAR. & APR. 2025 PROFESSIONAL SERVICES | FINANCE/PROVIDER NETWORK MANAGEMENT |
| T5319 | CITIUSTECH INC. **** | 28,208.00 | 776,660.00 | FAST + MAINTENANCE & SUBSCRIPTION Q2 2025 | INFRASTRUCTURE |
| T4424 | GUROCK SOFTWARE GmbH **** | 27,611.00 | 27,611.00 | HOSTED SOFTWARE RENEWAL | PROJECT MANAGEMENT |
| T5882 | RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC | 26,290.00 | 211,095.00 | JUL. 2025 JANITORIAL SERVICES | CORPORATE SERVICES |
| T2869 | COMMUNITY ACTION PARTNERSHIP OF KERN **** | 26,200.00 | 35,200.00 | 2025 COMMUNITY GRANTS & AUG. RENT | MARKETING & PUBLIC AFFAIRS/CORPORATE SERVICES |
| T5877 | TGN CONSULTING LLC | 24,946.17 | 451,369.74 | LEADERSHIP DEVELOPMENT CONSULTING | HUMAN RESOURCES |
| T2458 | HEALTHCARE FINANCIAL, INC. | 24,334.87 | 266,198.51 | JUN. 2025 PROFESSIONAL SERVICES | ADMINISTRATION |
| T5022 | SVAM INTERNATIONAL INC **** | 23,560.00 | 95,204.00 | DEC. 2024 PROFESSIONAL SERVICES | PROJECT MANAGEMENT |

KERN·HEALTH SYSTEMS

**July AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| T5121 | TPx COMMUNICATIONS | 21,026.40 | 143,379.58 | JUN. 2025 LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES | MIS INFRASTRUCTURE |
| T5962 | GeBBS SOFTWARE INTERNATIONAL, INC | 21,000.00 | 54,000.00 | JUN. 2025 PROFESSIONAL SERVICES | BUSINESS INTELLIGENCE |
| T1022 | UNUM LIFE INSURANCE CO. | 20,191.80 | 133,713.66 | JUL. 2025 EMPLOYEE PREMIUM | VARIOUS |
| T4501 | ALLIED UNIVERSAL SECURITY SERVICES | 20,072.03 | 147,680.00 | JUN. & JUL. 2025 SECURITY SERVICES | CORPORATE SERVICES |
| T6362 | ARRIVE TRANSPORT SOLUTIONS LLC **** | 20,000.00 | 20,000.00 | JUL. 2025 NMT TRANSPORTATION SERVICE | TECHNICAL ADMINISTRATIVE SERVICES |
| | | **6,438,735.28** | | | |
| | TOTAL VENDORS OVER $20,000 | 6,438,735.28 | | | |
| | TOTAL VENDORS UNDER $20,000 | 997,604.24 | | | |
| | TOTAL VENDOR EXPENSES- JULY | $ **7,436,339.52** | | | |

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

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 | 5,753,894.48 | 2025 EMPLOYEE HMO HEALTH BENEFITS & RX CLAIMS PREMIUM | VARIOUS |
| T4350 | COMPUTER ENTERPRISE | 3,403,890.55 | PROFESSIONAL SERVICES/CONSULTING SERVICES | VARIOUS |
| WT/ACH | BLACKHAWK ENGAGEMENT SOLUTIONS, INC | 2,778,258.28 | PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM | HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI |
| T1408 | DELL MARKETING LP. | 1,868,605.97 | VLA ENTERPRISE LICENSE, EA RENEWAL & COMPUTER EQUIPMENT | MIS INFRASTRUCTURE |
| T1180 | LANGUAGE LINE SERVICES INC. | 1,801,819.28 | INTERPRETATION SERVICES | HEALTH SERVICES - WELLNESS & PREVENTION |
| T4737 | TEKSYSTEMS, INC. | 1,629,066.28 | PROFESSIONAL SERVICES | MIS INFRASTRUCTURE |
| T3130 | OPTUMINSIGHT, INC. | 1,482,371.30 | CLAIMS EDIT SOFTWARE LICENSE YR 3/5 | MIS INFRASTRUCTURE |
| T5292 | ALL'S WELL HEALTH CARE SERVICES | 998,229.58 | TEMPORARY HELP | VARIOUS |
| T5684 | REBELLIS GROUP LLC | 902,181.94 | PROFESSIONAL SERVICES | MEDICARE |
| T1845 | DEPARTMENT OF MANAGED HEALTH CARE **** | 620,930.59 | 1ST INSTALLMENT ANNUAL ASSESMENT 2025-2026 | ADMINISTRATION |
| T5337 | CAZADOR CONSULTING GROUP INC | 596,343.12 | TEMPORARY HELP | VARIOUS |
| T5111 | ENTISYS 360, E360 | 563,266.13 | VMWARE VSPHERE ENTERPRISE PLUS 2025 | TECHNICAL ADMINISTRATIVE SERVICES |
| T5564 | CLARISHEALTH, INC | 555,029.36 | CONSULTING SERVICES | CLAIMS |
| T4722 | COGNIZANT TRIZETTO SOFTWARE GROUP, INC | 541,948.18 | PROFESSIONAL SERVICES & EDI CLAIMS | MIS INFRASTRUCTURE/CLAIMS |
| T5877 | TGN CONSULTING LLC | 451,369.74 | LEADERSHIP DEVELOPMENT CONSULTING | HUMAN RESOURCES |
| T5658 | THE PRUDENTIAL INSURANCE COMPANY OF AMERICA | 448,198.29 | VOLUNTARY LIFE, AD&D INSURANCE PREMIUM | VARIOUS |
| T3011 | OFFICE ALLY, INC | 436,931.46 | EDI CLAIMS | CLAIMS |
| T4460 | PAYSPAN, INC | 386,568.59 | ELECTRONIC CLAIMS/PAYMENTS | FINANCE |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5340 | GARTNER INC | 386,099.99 | EXECUTIVE PROGRAM LICENSE & 2025 ON SITE TRAINING | TECHNICAL ADMINISTRATIVE SERVICES/HUMAN RESOURCES |
| T1183 | MILLIMAN USA | 380,889.00 | ACTUARIAL CONSULTING FEES | VARIOUS |
| T5890 | DELTA DENTAL OF CALIFORNIA | 356,642.56 | EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM | VARIOUS |
| T4733 | UNITED STAFFING ASSOCIATES | 343,271.46 | TEMPORARY HELP | VARIOUS |
| T5520 | BG HEALTHCARE CONSULTING, INC | 336,875.00 | CONSULTING SERVICES | HEALTH SERVICES - QI |
| T5886 | US POSTAL SERVICE | 300,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| WT/ACH | PAYPRO | 284,174.52 | EMPLOYEE PREMIUM | PAYROLL DEDUCTION |
| T3449 | CDW GOVERNMENT | 274,598.69 | NUTANIX CODES, ADOBE LICENSE RENEWAL & NESSUS VULNERABILITY SCANNER TOOL | MIS INFRASTRUCTURE |
| T5930 | DAYFORCE US, INC | 270,735.07 | 2025 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/DAYFORCE HUMAN CAPITAL MANAGEMENT | HUMAN RESOURCES |
| T2458 | HEALTHCARE FINANCIAL, INC. | 266,198.51 | CONSULTING | ADMINISTRATION |
| T5298 | TOTALMED, INC | 262,231.17 | TEMPORARY HELP | VARIOUS |
| T2413 | TREK IMAGING INC | 252,607.33 | MARKETING PROMOTIONAL SUPPLIES, EMPLOYEE EVENTS, NEW HIRE SHIRTS | VARIOUS |
| T5467 | MOSS ADAMS LLP | 251,157.13 | AUDIT SERVICES | FINANCE |
| T6246 | UNIVERSAL HEALTHCARE MSO, LLC | 235,500.00 | D-SNP PSA IMPLEMENTATION FEES | CAPITAL PROJECT |
| T4237 | CITIUS HEALTHCARE CONSULTING, LLC | 233,235.00 | PROFESSIONAL SERVICES | PROJECT MANAGEMENT/ENTERPRISE CONFIGURATION |
| T2686 | ALLIANT INSURANCE SERVICES INC. **** | 228,158.14 | 2025-2026 INSURANCE PREMIUMS | ADMINISTRATION |
| T5738 | INSURICA - WALTER MORTENSEN INSURANCE | 228,091.00 | WORKERS COMPENSATION AUDIT | ADMINISTRATION |
| T2469 | DST HEALTH SOLUTIONS, LLC | 218,725.00 | 2025 ACG LICENSE FEE & SUPPORT | BUSINESS INTELLIGENCE |
| T5882 | RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC | 211,095.00 | JANITORIAL SERVICES | CORPORATE SERVICES |
| T6054 | WEBMD IGNITE | 207,239.75 | 2025 LICENSE FEES | HEALTH SERVICES - WELLNESS & PREVENTION |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T6127 | MANIFEST MEDEX | 202,410.00 | 2025 QTR. 1 - HIE SUBSCRIPTION FEE | MIS INFRASTRUCTURE |
| T2584 | UNITED STATES POSTAL SVC. - HASLER | 200,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| T1128 | HALL LETTER SHOP, INC | 194,473.79 | M-CAL RENEWALS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS & ENVELOPES | VARIOUS |
| T6276 | KFORCE INC | 176,976.66 | PROFESSIONAL SERVICES | VARIOUS |
| T1272 | COFFEY COMMUNICATIONS INC. | 167,214.34 | WINTER ISSUE OF FAMILY HEALTH & WEBSITE ASSIST. MODULES | HEALTH SERVICES - WELLNESS & PREVENTION |
| T5076 | MERIDIAN HEALTH SYSTEMS, PC. | 162,675.00 | PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| T1097 | NCQA (NATIONAL COMMITTEE FOR QUALITY ASSURANCE) | 157,556.00 | POPULATION HEALTH PROGRAM ACCREDIATION | HEALTH SERVICES - QI |
| T2941 | KERN PRINT SERVICES INC. | 152,710.79 | OFFICE SUPPLIES | CORPORATE SERVICES |
| T5509 | NGUYEN CAO LUU-TRONG | 148,800.00 | CONSULTING SERVICES | HEALTH SERVICES - UM |
| T4501 | ALLIED UNIVERSAL SECURITY SERVICES | 147,680.00 | DEC. 2024-JAN. 2025 ONSITE SECURITY | CORPORATE SERVICES |
| T5121 | TPX COMMUNICATIONS | 143,379.58 | LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES | MIS INFRASTRUCTURE |
| T4963 | LINKEDIN CORPORATION | 142,532.00 | 2025 LEARNING HUB YR 1/2, RECRUITMENT JOB SLOTS YR 1/3 | HUMAN RESOURCES |
| T1231 | COUNTY OF KERN | 139,145.59 | M-CAL ELIGIBILITY STAFF SERVICES | MEMBER OUTREACH |
| T4514 | A.J. KLEIN, INC T. DENATALE, B. GOLDNER | 137,486.53 | LEGAL FEES | LEGAL |
| T6272 | KEY STAFFING INC | 135,431.90 | TEMPORARY HELP | VARIOUS |
| T6020 | ALLMED HEALTHCARE MANAGEMENT, LLC | 135,190.00 | 2025 SECURITY SERVICES | CORPORATE SERVICES |
| T4484 | JACOBSON SOLUTIONS | 134,622.64 | TEMPORARY HELP | CLAIMS |
| T1022 | UNUM LIFE INSURANCE CO. | 133,713.66 | EMPLOYEE PREMIUM | VARIOUS |
| T4165 | SHI INTERNATIONAL CO. | 130,306.49 | APC SMART-UPS BATTERIES SERVICE , FLEX LICENSE & SUPPORT, ENTW ON-PREMISES CALLING MAINTENANCE | MIS INFRASTRUCTURE |
| T6261 | RUSSELL REYNOLDS ASSOCIATES, INC | 129,888.00 | RECRUITMENT SERVICE FEE & ADMIN CHARGE FOR CIO ROLE | HUMAN RESOURCES |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T4708 | HEALTH MANAGEMENT ASSOCIATES, INC. / WAKELY CONSULTING GROUP, LLC | 126,350.75 | PROFESSIONAL SERVICES | FINANCE |
| T4785 | COMMGAP | 122,566.25 | INTERPRETATION SERVICES | HEALTH SERVICES - WELLNESS & PREVENTION |
| 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 |
| T5865 | HARTE-HANKS RESPONSE MANAGEMENT/AUSTIN, INC | 119,770.02 | PROFESSIONAL SERVICES | MEMBER SERVICES |
| T4353 | TWE SOLUTIONS, INC. | 115,674.58 | CRITICAL START MDR SERVICES SECURITY MONITORING | CYBER SECURITY |
| T5329 | RELAY NETWORK, LLC | 114,285.23 | TEXT MESSAGING SUBSCRIPTION | CAPITAL PROJECT |
| T4657 | DAPONDE SIMPSON ROWE PC | 111,795.00 | 2025 LEGAL SERVICES | LEGAL |
| T2961 | SOLUTION BENCH, LLC **** | 110,624.00 | SCANFINITY ANNUAL RENEWAL 2025-2026 & M-FILES ANNUAL RENEWAL FEES 2025-2026 | MIS INFRASTRUCTURE |
| T4054 | ASSOCIATION FOR COMMUNITY AFFILIATED PLANS | 105,000.00 | 2025 MEMBER DUES | ADMINISTRATION |
| T2918 | STINSON'S | 102,832.57 | OFFICE SUPPLIES | VARIOUS |
| T5967 | SAI360 INC | 102,265.00 | PROFESSIONAL SERVICES & 2 YR POLICY MANAGEMENT SYSTEM | AUDIT & INVESTIGATIVE SERVICES |
| T2167 | PG&E | 100,526.23 | UTILITIES | CORPORATE SERVICES |
| T5426 | UNIVERSAL HEALTHCARE SERVICES, INC **** | 100,000.00 | INITIAL 50% COMPREHENSIVE OBESITY MANAGEMENT PROGRAM | HEALTH SERVICES - UM |
| T5757 | BITFOCUS, INC | 98,471.34 | HMIS LICENSES & HEALTH CHECK TRAINING | HOMELESS MANAGEMENT INFORMATION SERVICES |
| T5480 | PRESS GANEY ASSOCIATES LLC | 95,512.25 | INITIAL 75% 2025 ECM SURVEY | ENHANCED CARE MANAGEMENT |
| T5022 | SVAM INTERNATIONAL INC | 95,204.00 | PROFESSIONAL SERVICES | VARIOUS |
| T1005 | COLONIAL LIFE & ACCIDENT | 88,602.20 | LIFE INSURANCE PREMIUM | VARIOUS |
| T4503 | VISION SERVICE PLAN | 83,583.84 | EMPLOYEE HEALTH BENEFITS | VARIOUS |
| T5963 | ANTAGE INCORPORATED | 81,550.00 | PROFESSIONAL SERVICES | ENTERPRISE DEVELOPMENT |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5571 | GHA TECHNOLOGIES INC | 80,374.17 | FORTINET SECURITY | MIS INFRASTRUCTURE |
| T2509 | UNITED STATES POSTAL SERVICE | 78,365.44 | PERMIT 162 SUMMER 2025 ISSUE OF FAMILY HEALTH | HEALTH SERVICES - WELLNESS & PREVENTION |
| T6022 | BAKERSFIELD AMERICAN INDIAN HEALTH PROJECT | 78,012.48 | CONTRACTOR SERVICES | HEALTH SERVICES - UM |
| T6218 | CLOUDERA, INC. | 77,940.10 | ANNUAL RENEWAL - METADATA PLATFORM | BUSINESS INTELLIGENCE |
| T5319 | CITIUSTECH INC. | 77,666.00 | FAST + MAINTENANCE & SUBSCRIPTION Q3 2024 | INFRASTRUCTURE |
| T5064 | QUEST DIAGNOSTICS CLINICAL LABORATORIES, INC. | 72,019.33 | PROFESSIONAL SERVICES | MIS INFRASTRUCTURE |
| T6274 | PANDANAI, INC | 72,000.00 | 2025/2026 AI SOFTWARE SUBSCRIPTION | COMPLIANCE |
| T5583 | THE MILHALIK GROUP, LLC | 71,930.00 | CONSULTING SERVICES | HEALTH SERVICES - QI |
| 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 |
| T6215 | BPO USA, P.C. | 67,357.27 | PROFESSIONAL SERVICES | BUSINESS INTELLIGENCE |
| T2446 | AT&T MOBILITY | 65,937.96 | CELLULAR PHONE/INTERNET USAGE | MIS INFRASTRUCTURE |
| T5863 | MANNA HAGOS | 61,318.50 | PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| WT/ACH | USPS | 60,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| T6285 | MERSMAN ENTERPRISES (MEI) | 59,750.00 | TGI TRAINING DEVELOPMENT CONSULTING | HEALTH EQUITY |
| T1404 | CALIFORNIA ASSOCIATION OF HEALTH PLANS | 59,506.00 | 2025 ANNUAL DUES ASSESSMENT | ADMINISTRATION |
| T5931 | SPROUT SOCIAL, INC | 54,000.00 | 2025-2026 SOCIAL MEDIA VIGILANCE MANAGEMENT | MIS INFRASTRUCTURE |
| T5962 | GeBBS SOFTWARE INTERNATIONAL, INC. | 54,000.00 | CONSULTING SERVICES | BUSINESS INTELLIGENCE |
| T2969 | AMERICAN BUSINESS MACHINES INC | 52,794.86 | HARDWARE AND MAINTENANCE | MIS INFRASTRUCTURE |
| T6192 | LANG SPECIALTY TRAILERS | 51,676.95 | MOBILE LAUNDRY TRAILER | MEMBER ENGAGEMENT |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5400 | CENTRO DE UNIDAD POPULAR BENITO JUAREZ, INC. | 49,250.55 | COMMUNITY HEALTH GRANT | GRANTS |
| T5742 | MICHAEL NGUYEN | 47,500.00 | PROFESSIONAL SERVICES | QUALITY & HEALTH EQUITY |
| T5275 | CREATIVE FINANCIAL STAFFING, LLC | 47,092.21 | TEMPORARY HELP | VARIOUS |
| T5435 | TEGRIA SERVICES GROUP - US, INC. | 42,875.00 | PROFESSIONAL SERVICES | BUSINESS INTELLIGENCE |
| T5550 | CHARTER COMMUNICATIONS OPERATING, LLC | 42,737.69 | INTERNET SERVICES | MIS INFRASTRUCTURE |
| T4228 | THE SSI GROUP, LLC | 42,640.00 | 2025 EDI CLAIMS | CLAIMS |
| T4960 | ZELIS CLAIMS INTEGRITY, LLC | 42,528.64 | 2025 CLAIMS EVALUATION SERVICES | CLAIMS |
| T2726 | DST PHARMACY SOLUTIONS, INC. | 42,000.00 | PHARMACY CLAIMS | PHARMACY |
| T6142 | GREAT PLACE TO WORK INSTITUTE, INC | 41,995.00 | EMPLOYEE ENGAGEMENT SURVEY ACCELERATE PACKAGE | HUMAN RESOURCES |
| T2933 | SIERRA PRINTERS, INC. | 40,656.21 | MEMBER HANDBOOKS & FLYERS | MEMBER SERVICES/COMMUNITY SUPPORT SERVICES |
| T5012 | KERN MEDICAL CENTER FOUNDATION | 40,000.00 | PHYSICIAN'S MIXER CME SPONSORSHIP | ADMINISTRATION |
| T1918 | PUBLIC RISK, INNOVATION, SOLUTIONS AND MANAGEMENT | 39,154.00 | MR OCIP DEDUCTIBLE LOSS FUND CONTRIBUTION | ADMINISTRATION |
| T4607 | AGILITY RECOVERY SOLUTIONS INC. | 37,996.32 | PROFESSIONAL SERVICES | CORPORATE SERVICES |
| T4331 | COTIVITI, INC | 37,565.44 | MEDICAL RECORD RETRIEVAL/ HANDLING | QUALITY PERFORMANCE |
| T6202 | KRAMER WORKPLACE INVESTIGATIONS | 36,884.00 | CONSULTING FEES | HUMAN RESOURCES |
| T2787 | SAGE SOFTWARE, INC. | 35,968.95 | SAGE 300 PREMIUM LICENSE RENEWAL | FINANCE |
| T5109 | RAND EMPLOYMENT SOLUTIONS | 35,701.85 | TEMPORARY HELP | VARIOUS |
| WT/ACH | COLABS | 35,650.00 | INTEL AGREE SUBSCRIPTION YR 2 OF 3 | MIS INFRASTRUCTURE |
| T6100 | SYMPLR | 35,515.73 | SOFTWARE LICENSE 2025/2026 | HEALTH SERVICES - UM |
| T2869 | COMMUNITY ACTION PARTNERSHIP OF KERN **** | 35,200.00 | 2025 COMMUNITY GRANTS & RENT FOR MOJAVE & RIDGECREST OFFICES | MARKETING & PUBLIC AFFAIRS/CORPORATE SERVICES |
| T2441 | LAURA J. BREZINSKI | 35,000.00 | MARKETING MATERIALS | MARKETING & PUBLIC AFFAIRS |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5977 | IMAGENET, LLC | 35,000.00 | KIOSK SERVICES | CORPORATE SERVICES |
| T3118 | AMERICAN ACADEMY HOLDINGS LLC dba AAPC | 34,440.17 | 2025 CPC TRAINING PACKAGE & AAPC MEMBERS | CLAIMS |
| T5321 | TYK TECHNOLOGIES LTD | 34,000.00 | SELF MANAGED ARCHITECTURE PLAN 2024/2025 | MIS INFRASTRUCTURE |
| T6116 | SIERRA SANDS UNIFIED SCHOOL DISTRICT | 34,000.00 | 2025-2026 ELEMENTARY SCHOOL GRANT | HEALTH SERVICES - WELLNESS & PREVENTION |
| T4182 | THE LAMAR COMPANIES | 33,073.97 | OUTDOOR ADVERISEMENT - BILLBOARDS | MARKETING & PUBLIC AFFAIRS |
| T5627 | DOCUSIGN, INC. | 32,379.42 | eSIGNATURE SUPPORT & (20) IAM ENTERPRISE LICENSES | MIS INFRASTRUCTURE/HUMAN RESOURCES |
| T2580 | GOLDEN EMPIRE TRANSIT DISTRICT | 32,000.00 | MARKETING - BUS ADVERTISING | MARKETING & PUBLIC AFFAIRS |
| T6361 | NEMT SOLUTIONS LLC **** | 32,000.00 | JUL. & AUG. 2025 NMT TRANSPORTATION SERVICE | TECHNICAL ADMINISTRATIVE SERVICES |
| T5398 | GOLDEN EMPIRE GLEANERS | 31,553.23 | FOOD BASKETS FOR MEMBERS | ENHANCED CARE MANAGEMENT |
| T3088 | GLEN BROWN CONSULTING | 31,387.50 | CONSULTING SERVICES | CAPITAL PROJECT |
| T5201 | JAC SERVICES, INC. | 31,172.50 | AC PREVENTATIVE MAINTENANCE & REPAIRS | CORPORATE SERVICES |
| T5936 | AXIOS HQ INC | 30,240.00 | 2024/2026 COMMUNICATIONS SOFTWARE | MIS INFRASTRUCTURE |
| T5988 | WASCO UNION HIGH SCHOOL DISTRICT | 30,200.00 | SCHOOL WELLNESS GRANT 2025-2026 | HEALTH SERVICES - WELLNESS & PREVENTION |
| T4993 | LEGALSHIELD | 30,179.00 | EMPLOYEE PREMIUM | VARIOUS |
| T4652 | BAKERSFIELD SYMPHONY ORCHESTRA | 30,000.00 | 2025 SPONSORSHIP | MARKETING & PUBLIC AFFAIRS |
| T5592 | BRAND CO MARKETING **** | 28,937.11 | THE RACK WEB HOSTING FEE & STORE MERCHANDISE | HUMAN RESOURCES |
| T4934 | APPLE INC. | 28,795.54 | COMPUTER EQUIPMENT | CAPITAL PROJECT |
| T5851 | ABSORB SOFTWARE NORTH AMERICA, LLC | 28,762.88 | DAYFORCE LEARNING LICENSE | MIS INFRASTRUCTURE |
| T4424 | GUROCK SOFTWARE GmbH **** | 27,611.00 | HOSTED SOFTWARE RENEWAL | PROJECT MANAGEMENT |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T3081 | ST. VINCENT DE PAUL STORE, INC. | 27,609.64 | COMMUNITY HEALTH PARTNERSHIP | COMMUNITY GRANTS |
| T2641 | MARANATHA GARDENING & LANDSCAPING, INC **** | 27,000.00 | 2025 GARDENING & LANDSCAPE REPAIRS | CORPORATE SERVICES |
| T6062 | PTO EXCHANGE | 26,719.33 | IMPLEMENTATION/TRANSACTION FEES | VARIOUS |
| T2938 | SAP AMERICA, INC | 26,584.72 | 2025/2026 ENTERPRISE SUPPORT & MAINTENANCE | MIS INFRASTRUCTURE |
| T5420 | PAYPRO ADMINISTRATORS | 24,185.20 | PROFESSIONAL SERVICES | HUMAN RESOURCES |
| T4766 | RICHLAND SCHOOL DISTRICT **** | 24,000.00 | SCHOOL WELLNESS GRANT 2025-2026 & COMMUNITY SPONSORSHIPS | HEALTH EDUCATION/ MARKETING & PUBLIC AFFAIRS |
| T5159 | AT&T CORP **** | 23,734.88 | INTERNET SERVICES | MIS INFRASTRUCTURE |
| T6311 | JMP OFFICE TECHNOLOGIES | 23,631.22 | POSTAGE METER MAINTENANCE & SUPPORT | CORPORATE SERVICES |
| T5536 | CALIFORNIA STATE UNIVERSITY BAKERSFIELD FOUNDATION | 23,300.00 | COMMUNITY SCHOLARSHIPS | MARKETING & PUBLIC AFFAIRS |
| T2955 | DELTA ELECTRIC INC. | 23,091.77 | ELECTICAL REPAIR | CORPORATE SERVICES |
| T2578 | AMERICAN STROKE ASSOC/AMERICAN HEART ASSOC WESTERN STATES | 23,000.00 | GO RED FOR WOMEN & HEART WALK SPONSORSHIP | MARKETING & PUBLIC AFFAIRS |
| T4024 | QUADIENT INC. | 22,799.64 | POSTAGE METER RENTAL & SUPPORT | CORPORATE SERVICES |
| T4731 | GO TO TECHNOLOGIES, INC | 22,737.00 | LOGMEIN SUBSCRIPTION RENEWAL | INFRASTRUCTURE |
| T5500 | MAGDALENE HOPE INC **** | 21,500.00 | COMMUNITY GRANTS | MARKETING & PUBLIC AFFAIRS |
| T1347 | ADVANCED DATA STORAGE **** | 21,384.05 | STORAGE AND SHREDDING SERVICES | CORPORATE SERVICES |
| T5436 | THE BEACON STUDIOS, LLC | 21,372.62 | MARKETING -VIDEO SERVICES | MARKETING & PUBLIC AFFAIRS |
| T5887 | PREPARIS INC **** | 21,289.58 | DISASTER RECOVERY | CORPORATE SERVICES |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5318 | CANONICAL GROUP LIMITED | 20,720.00 | UBUNTU PRO LICENSE & SUPPORT | INFRASTRUCTURE |
| T4544 | BARNES WEALTH MANAGEMENT GROUP **** | 20,280.00 | RETIREMENT PLAN CONSULTANTS | ADMINISTRATION |
| T6121 | JACKSON UTILIZATION MANAGEMENT CONSULTING **** | 20,020.00 | PROFESSIONAL SERVICES | HEALTH SERVICES - UTIL REVIEW |
| T2135 | BAKERSFIELD CITY SCHOOL DISTRICT | 20,000.00 | 2025-2026 ELEMENTARY SCHOOL WELLNESS GRANT | HEALTH SERVICES - WELLNESS & PREVENTION |
| T5511 | BARTZ-ALTADONNA COMMUNITY HEALTH CENTER | 20,000.00 | COMMUNITY HEALTH PARTNERSHIP | COMMUNITY GRANTS |
| T5535 | PANAMA-BUENA VISTA UNION SCHOOL DISTRICT | 20,000.00 | SCHOOL WELLNESS GRANT 2025-2026 | HEALTH EDUCATION |
| T6223 | WASCO UNION ELEMENTARY SCHOOL DISTRICT | 20,000.00 | SCHOOL WELLNESS GRANT 2025-2026 | HEALTH SERVICES - WELLNESS & PREVENTION |
| T6362 | ARRIVE TRANSPORT SOLUTIONS LLC **** | 20,000.00 | NON MEDICAL TRANSPORT | TECHNICAL ADMINISTRATIVE SERVICES |
| | | **39,273,860.92** | | |
| | TOTAL VENDORS OVER $20,000 | 39,273,860.92 | | |
| | TOTAL VENDORS UNDER $20,000 | 2,315,889.05 | | |
| | TOTAL VENDOR EXPENSES- JULY | **41,589,749.97** | | |

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

KERN·HEALTH SYSTEMS

**August AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| T2704 | MCG HEALTH LLC **** | 1,672,318.17 | 1,672,813.17 | ANNUAL HEALTH CARE MANAGEMENT & SOFTWARE LICENSE | UTILIZATION MANAGEMENT |
| WT/ACH | BCI HOLDINGS | 1,195,263.67 | 6,949,158.15 | AUG. 2025 EMPLOYEE HMO HEALTH BENEFITS & RX CLAIMS PREMIUM | VARIOUS |
| T2686 | ALLIANT INSURANCE SERVICES INC. | 721,588.20 | 949,746.34 | 2025-2026 INSURANCE PREMIUMS -COMMERCIAL CYBER & EXCESS CYBER. | ADMINISTRATION |
| T4350 | COMPUTER ENTERPRISE | 515,437.90 | 3,919,328.45 | JUL. 2025 PROFESSIONAL SERVICES/CONSULTING SERVICES | VARIOUS |
| WT/ACH | BLACKHAWK NETWORK INC | 469,560.28 | 3,247,818.56 | PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM | HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI |
| WT/ACH | INCOMM HEALTHCARE & AFFINITY, INC. **** | 450,000.00 | 450,000.00 | PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM | HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI |
| T4737 | TEKSYSTEMS, INC | 296,824.00 | 1,925,890.28 | JUL. 2025 PROFESSIONAL SERVICES/CONSULTING SERVICES | VARIOUS |
| T1960 | LOCAL HEALTH PLANS OF CALIFORNIA **** | 186,431.10 | 186,482.09 | 2025-2026 PMPY DUES | ADMINISTRATION |
| T1180 | LANGUAGE LINE SERVICES INC. | 180,953.44 | 1,982,772.72 | JUL. 2025 INTERPRETATION SERVICES | HEALTH SERVICES - WELLNESS & PREVENTION |
| T2458 | HEALTHCARE FINANCIAL, INC. | 153,556.68 | 419,755.19 | MAY & JUL. 2025 PROFESSIONAL SERVICES | ADMINISTRATION |
| T4237 | CITIUS HEALTHCARE CONSULTING, LLC | 133,329.00 | 366,564.00 | JUL. 2025 PROFESSIONAL SERVICES | PROJECT MANAGEMENT/ENTERPRISE CONFIGURATION |
| T5684 | REBELLIS GROUP LLC | 121,925.00 | 1,024,106.94 | JUN. 2025 PROFESSIONAL SERVICES | MEDICARE |
| T6127 | MANIFEST MEDEX **** | 101,199.75 | 303,609.75 | QTR 3 2025 HIE SUBSCRIPTION FEE | MIS INFRASTRUCTURE |

KERN·HEALTH SYSTEMS

**August AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| WT/ACH | HELPCARE AI **** | 100,000.80 | 100,000.80 | 2025- 2026 CLOUD BASED AI PLATFORM | MIS INFRASTRUCTURE |
| T4217 | CONTEXT 4 HEALTHCARE, INC **** | 99,598.24 | 99,598.24 | ANNUAL RENEWAL AMA FEES | MIS INFRASTRUCTURE |
| T5337 | CAZADOR CONSULTING GROUP INC | 92,728.14 | 689,071.26 | JUN. & JUL. 2025 TEMPORARY HELP - (9) MS: (1) ME: (1) MKT: (1) UM | VARIOUS |
| T5292 | ALL'S WELL HEALTH CARE SERVICES | 73,686.10 | 1,071,915.68 | JUL. & AUG. 2025 TEMPORARY HELP | VARIOUS |
| T6100 | SYMPLR **** | 72,508.40 | 108,024.13 | 2025-2026 HAYES KNOWLEDGE CENTER SUBSCRIPTION | UTILIZATION MANAGEMENT |
| T4902 | CHANGE HEALTHCARE TECHNOLOGIES, LLC **** | 67,151.88 | 78,910.22 | MAR. - JUN. 2025 EDI CLAIMS | CLAIMS |
| T4722 | COGNIZANT TRIZETTO SOFTWARE GROUP, INC. | 65,524.76 | 607,472.94 | JUL. & AUG. 2025 PROFESSIONAL SERVICES & JUL. 2025 EDI CLAIMS | MIS INFRASTRUCTURE/CLAIMS |
| T5520 | BG HEALTHCARE CONSULTING, INC | 63,087.50 | 399,962.50 | JUL. 2025 CONSULTING SERVICES | HEALTH SERVICES - QI |
| T6246 | UNIVERSAL HEALTHCARE MSO, LLC **** | 61,250.00 | 296,750.00 | D-SNP ADMINISTRATIVE SERVICES IMPLEMENTATION FEES | CAPITAL PROJECT |
| T1128 | HALL LETTER SHOP, INC **** | 60,721.05 | 255,194.84 | JUL. - SEPT. 2025 MEMBER MAILINGS | MEMBER SERVICES |
| T5886 | US POSTAL SERVICE **** | 60,000.00 | 360,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| T6276 | KFORCE INC | 54,287.56 | 231,264.22 | JUN. 2025 TEMPORARY HELP (1) FIN, (1) CLAIMS, (1)HE, (1)AIS, (3) MS | VARIOUS |
| T5890 | DELTA DENTAL OF CALIFORNIA | 50,534.01 | 407,176.57 | AUG. 2025 EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM | VARIOUS |
| T3011 | OFFICE ALLY, INC | 42,501.06 | 479,432.52 | JUL. 2025 EDI CLAIMS | CLAIMS |

KERN·HEALTH SYSTEMS

**August AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| T4733 | UNITED STAFFING ASSOCIATES | 41,735.01 | 385,006.47 | JUN., JUL. & AUG. 2025 TEMPORARY HELP -(9) MS: (3) ME | VARIOUS |
| T4657 | DAPONDE SIMPSON ROWE PC | 40,746.00 | 152,541.00 | MAY 2025 LEGAL SERVICES | LEGAL |
| T5865 | HARTE-HANKS RESPONSE MANAGEMENT/AUSTIN, INC **** | 40,412.26 | 160,182.28 | JUN & JUL. 2025 PROFESSIONAL SERVICES | MEMBER SERVICES |
| WT/ACH | USPS | 40,000.00 | 100,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| T5930 | DAYFORCE US, INC | 38,333.75 | 309,068.82 | 2025 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/DAYFORCE HUMAN CAPITAL MANAGEMENT | HUMAN RESOURCES |
| T4460 | PAYSPAN, INC | 37,407.74 | 423,976.33 | JUL. 2025 ELECTRONIC CLAIMS/PAYMENTS | FINANCE |
| T5863 | MANNA HAGOS **** | 33,349.50 | 94,668.00 | JUL. 2025 PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| WT/ACH | PAYPRO | 50,747.73 | 326,452.25 | JUN. & JUL. 2025 EMPLOYEE PREMIUM | PAYROLL DEDUCTION |
| T5064 | QUEST DIAGNOSTICS CLINICAL LABORATORIES, INC. **** | 31,779.00 | 103,798.33 | MAY - JUL. 2025 REPORTING SERVICES | MIS INFRASTRUCTURE |
| T5757 | BITFOCUS, INC. **** | 30,821.26 | 129,292.60 | JUL. & AUG. 2025 HMIS LICENSES | HMIS |
| T4331 | COTIVITI, INC **** | 27,021.50 | 64,586.94 | HEDIS 2025 TRUE-UP MEDICAL RETRIEVAL | QUALITY PERFORMANCE |
| T5882 | RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC | 26,290.00 | 237,385.00 | AUG. 2025 JANITORIAL SERVICES | CORPORATE SERVICES |
| T6202 | KRAMER WORKPLACE INVESTIGATIONS **** | 26,186.00 | 63,070.00 | MAY - JUN. 2025 CONSULTING SERVICES | HUMAN RESOURCES |
| T5962 | GeBBS SOFTWARE INTERNATIONAL, INC | 26,000.00 | 80,000.00 | JUL. 2025 PROFESSIONAL SERVICES | BUSINESS INTELLIGENCE |

KERN·HEALTH SYSTEMS

**August AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Current Month | Year-to-Date | Description | Department |
|---|---|---|---|---|---|
| T6358 | KENNADAY LEAVITT PC **** | 25,472.50 | 25,472.50 | JUL. 2025 LEGAL SERVICES | LEGAL |
| T5480 | PRESS GANEY ASSOCIATES LLC **** | 24,930.00 | 120,442.25 | CAHPS SURVEY INITIAL 75%, PROVIDER SATIFACTION SURVEY INITIAL 25% | MEMBER SERVICES/PROVIDER NETWORK MANAGEMENT |
| T4514 | AJ KLEIN, INC T. DENATALE, B. GOLDNER **** | 23,159.55 | 160,646.08 | JUL. 2025 LEGAL SERVICES | LEGAL |
| T2413 | TREK IMAGING INC | 22,452.59 | 275,059.92 | MARKETING PROMOTIONAL SUPPLIES, EMPLOYEE EVENTS, NEW HIRE SHIRTS | VARIOUS |
| T5076 | MERIDIAN HEALTH SYSTEMS, P.C. | 21,150.00 | 183,825.00 | JUL. 2025 PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| T5121 | TPx COMMUNICATIONS | 20,925.14 | 164,304.72 | JUL. 2025 LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES | MIS INFRASTRUCTURE |
| | | **7,790,886.22** | | | |
| | TOTAL VENDORS OVER $20,000 | 7,790,886.22 | | | |
| | TOTAL VENDORS UNDER $20,000 | 601,049.74 | | | |
| | TOTAL VENDOR EXPENSES- AUGUST | **$ 8,391,935.96** | | | |

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

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 | 6,949,158.15 | 2025 EMPLOYEE HMO HEALTH BENEFITS & RX CLAIMS PREMIUM | VARIOUS |
| T4350 | COMPUTER ENTERPRISE | 3,919,328.45 | 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 |
| T1180 | LANGUAGE LINE SERVICES INC. | 1,982,772.72 | INTERPRETATION SERVICES | HEALTH SERVICES - WELLNESS & PREVENTION |
| T4737 | TEKSYSTEMS, INC. | 1,925,890.28 | PROFESSIONAL SERVICES | MIS INFRASTRUCTURE |
| T1408 | DELL MARKETING LP. | 1,880,339.78 | VLA ENTERPRISE LICENSE, EA RENEWAL & COMPUTER EQUIPMENT | MIS INFRASTRUCTURE |
| 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 YR 3/5 | MIS INFRASTRUCTURE |
| T5292 | ALL'S WELL HEALTH CARE SERVICES | 1,071,915.68 | TEMPORARY HELP | VARIOUS |
| T5684 | REBELLIS GROUP LLC | 1,024,106.94 | PROFESSIONAL SERVICES | MEDICARE |
| T2686 | ALLIANT INSURANCE SERVICES INC. | 949,746.34 | 2025-2026 INSURANCE PREMIUMS | ADMINISTRATION |
| T5337 | CAZADOR CONSULTING GROUP INC | 689,071.26 | TEMPORARY HELP | VARIOUS |
| T1845 | DEPARTMENT OF MANAGED HEALTH CARE | 620,930.59 | 1ST INSTALLMENT ANNUAL ASSESMENT 2025-2026 | ADMINISTRATION |
| T4722 | COGNIZANT TRIZETTO SOFTWARE GROUP, INC | 607,472.94 | PROFESSIONAL SERVICES & EDI CLAIMS | MIS INFRASTRUCTURE/CLAIMS |
| T5111 | ENTISYS 360, E360 | 563,266.13 | VMWARE VSPHERE ENTERPRISE PLUS 2025 | TECHNICAL ADMINISTRATIVE SERVICES |
| T5564 | CLARISHEALTH, INC | 555,029.36 | CONSULTING SERVICES | CLAIMS |
| T3011 | OFFICE ALLY, INC | 479,432.52 | EDI CLAIMS | CLAIMS |
| T5877 | TGN CONSULTING LLC | 451,369.74 | LEADERSHIP DEVELOPMENT CONSULTING | HUMAN RESOURCES |
| WT/ACH | INCOMM HEALTHCARE****** | 450,000.00 | PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM | HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5658 | THE PRUDENTIAL INSURANCE COMPANY OF AMERICA | 448,198.29 | VOLUNTARY LIFE, AD&D INSURANCE PREMIUM | VARIOUS |
| T4460 | PAYSPAN, INC | 423,976.33 | ELECTRONIC CLAIMS/PAYMENTS | FINANCE |
| T2458 | HEALTHCARE FINANCIAL, INC. | 419,755.19 | CONSULTING | ADMINISTRATION |
| T5890 | DELTA DENTAL OF CALIFORNIA | 407,176.57 | EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM | VARIOUS |
| T5520 | BG HEALTHCARE CONSULTING, INC | 399,962.50 | CONSULTING SERVICES | HEALTH SERVICES - QI |
| T1183 | MILLIMAN USA | 390,945.64 | ACTUARIAL CONSULTING FEES | VARIOUS |
| T5340 | GARTNER INC | 386,099.99 | EXECUTIVE PROGRAM LICENSE & 2025 ON SITE TRAINING | TECHNICAL ADMINISTRATIVE SERVICES/HUMAN RESOURCES |
| T4733 | UNITED STAFFING ASSOCIATES | 385,006.47 | TEMPORARY HELP | VARIOUS |
| T4237 | CITIUS HEALTHCARE CONSULTING, LLC | 366,564.00 | PROFESSIONAL SERVICES | PROJECT MANAGEMENT/ENTERPRISE CONFIGURATION |
| T5886 | US POSTAL SERVICE | 360,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| WT/ACH | PAYPRO | 326,452.25 | EMPLOYEE PREMIUM | PAYROLL DEDUCTION |
| T5930 | DAYFORCE US, INC | 309,068.82 | 2025 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/DAYFORCE HUMAN CAPITAL MANAGEMENT | HUMAN RESOURCES |
| T6127 | MANIFEST MEDEX | 303,609.75 | 2025 QTR. 1 - 3 HIE SUBSCRIPTION FEE | MIS INFRASTRUCTURE |
| T6246 | UNIVERSAL HEALTHCARE MSO, LLC | 296,750.00 | D-SNP ADMINISTRATIVE SERVICES IMPLEMENTATION FEES | CAPITAL PROJECT |
| T2413 | TREK IMAGING INC | 275,059.92 | MARKETING PROMOTIONAL SUPPLIES, EMPLOYEE EVENTS, NEW HIRE SHIRTS | VARIOUS |
| T3449 | CDW GOVERNMENT | 274,698.06 | NUTANIX CODES, ADOBE LICENSE RENEWAL & NESSUS VULNERABILITY SCANNER TOOL | MIS INFRASTRUCTURE |
| T5298 | TOTALMED, INC | 265,354.25 | TEMPORARY HELP | VARIOUS |
| T1128 | HALL LETTER SHOP, INC | 255,194.84 | M-CAL RENEWALS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS & ENVELOPES | VARIOUS |
| T5467 | MOSS ADAMS LLP | 251,157.13 | AUDIT SERVICES | FINANCE |
| T5882 | RELIABLE JANITORIAL SERVICES AND CARPET CLEANING INC | 237,385.00 | JANITORIAL SERVICES | CORPORATE SERVICES |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T6276 | KFORCE INC | 231,264.22 | PROFESSIONAL SERVICES | VARIOUS |
| T5738 | INSURICA - WALTER MORTENSEN INSURANCE | 228,091.00 | WORKERS COMPENSATION AUDIT | ADMINISTRATION |
| 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 |
| T2584 | UNITED STATES POSTAL SVC. - HASLER | 200,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| T1960 | LOCAL HEALTH PLANS OF CALIFORNIA **** | 186,482.09 | 2025-2026 PMPY DUES | ADMINISTRATION |
| T5076 | MERIDIAN HEALTH SYSTEMS, PC. | 183,825.00 | PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| T1272 | COFFEY COMMUNICATIONS INC. | 172,103.15 | WINTER ISSUE OF FAMILY HEALTH & WEBSITE ASSIST. MODULES | HEALTH SERVICES - WELLNESS & PREVENTION |
| T2941 | KERN PRINT SERVICES INC. | 164,770.60 | OFFICE SUPPLIES | CORPORATE SERVICES |
| T5121 | TPX COMMUNICATIONS | 164,304.72 | LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES | MIS INFRASTRUCTURE |
| T4514 | A.J. KLEIN, INC T. DENATALE, B. GOLDNER | 160,646.08 | LEGAL FEES | LEGAL |
| T5865 | HARTE-HANKS RESPONSE MANAGEMENT/AUSTIN, INC | 160,182.28 | PROFESSIONAL SERVICES | MEMBER SERVICES |
| T1097 | NCQA (NATIONAL COMMITTEE FOR QUALITY ASSURANCE) | 158,566.00 | POPULATION HEALTH PROGRAM ACCREDIATION | HEALTH SERVICES - QI |
| T4501 | ALLIED UNIVERSAL SECURITY SERVICES | 155,719.01 | DEC. 2024-JUL. 2025 ONSITE SECURITY | CORPORATE SERVICES |
| T4657 | DAPONDE SIMPSON ROWE PC | 152,541.00 | 2025 LEGAL SERVICES | LEGAL |
| T6272 | KEY STAFFING INC | 149,493.69 | TEMPORARY HELP | VARIOUS |
| T6020 | ALLMED HEALTHCARE MANAGEMENT, LLC | 149,272.50 | PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| T5509 | NGUYEN CAO LUU-TRONG | 148,800.00 | CONSULTING SERVICES | HEALTH SERVICES - UM |
| T4165 | SHI INTERNATIONAL CO. | 143,666.49 | APC SMART-UPS BATTERIES SERVICE , FLEX LICENSE & SUPPORT, ENTW ON-PREMISES CALLING MAINTENANCE | MIS INFRASTRUCTURE |
| T4963 | LINKEDIN CORPORATION | 142,532.00 | 2025 LEARNING HUB YR 1/2, RECRUITMENT JOB SLOTS YR 1/3 | HUMAN RESOURCES |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T4484 | JACOBSON SOLUTIONS | 140,850.97 | TEMPORARY HELP | CLAIMS |
| T1231 | COUNTY OF KERN | 139,145.59 | M-CAL ELIGIBILITY STAFF SERVICES | MEMBER OUTREACH |
| T4785 | COMMGAP | 135,116.25 | INTERPRETATION SERVICES | HEALTH SERVICES - WELLNESS & PREVENTION |
| T1022 | UNUM LIFE INSURANCE CO. | 133,713.66 | EMPLOYEE PREMIUM | VARIOUS |
| T6261 | RUSSELL REYNOLDS ASSOCIATES, INC | 129,888.00 | RECRUITMENT SERVICE FEE & ADMIN CHARGE FOR CIO ROLE | HUMAN RESOURCES |
| T5757 | BITFOCUS, INC | 129,292.60 | HMIS LICENSES & HEALTH CHECK TRAINING | HOMELESS MANAGEMENT INFORMATION SERVICES |
| T5329 | RELAY NETWORK, LLC | 128,570.94 | TEXT MESSAGING SUBSCRIPTION | CAPITAL PROJECT |
| T4708 | HEALTH MANAGEMENT ASSOCIATES, INC. / WAKELY CONSULTING GROUP, LLC | 126,350.75 | PROFESSIONAL SERVICES | FINANCE |
| T6179 | BPM LLP | 121,734.63 | CONSULTING SERVICES - ERP SOFTWARE ADVISORY | CAPITAL PROJECT |
| T5480 | PRESS GANEY ASSOCIATES LLC | 120,442.25 | 2025 ECM SURVEY, MEMBER SATISFACTION SURVEY, PROVIDER SATISFACTION SURVEY, CAHPS SURVEY | VARIOUS |
| T5452 | BLACKHAWK ENGAGEMENT SOLUTIONS, INC | 120,000.00 | PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM | HEALTH SERVICES - WELLNESS & PREVENTION & HEALTH SERVICES -QI |
| T2918 | STINSON'S | 117,071.52 | OFFICE SUPPLIES | VARIOUS |
| T4353 | TWE SOLUTIONS, INC. | 115,674.58 | CRITICAL START MDR SERVICES SECURITY MONITORING | CYBER SECURITY |
| T2167 | PG&E | 114,714.19 | UTILITIES | CORPORATE SERVICES |
| T2961 | SOLUTION BENCH, LLC | 110,624.00 | SCANFINITY ANNUAL RENEWAL 2025-2026 & M-FILES ANNUAL RENEWAL FEES 2025-2026 | MIS INFRASTRUCTURE |
| T6100 | SYMPLR | 108,024.13 | SOFTWARE LICENSE 2025/2026 | HEALTH SERVICES - UM |
| T4054 | ASSOCIATION FOR COMMUNITY AFFILIATED PLANS | 105,000.00 | 2025 MEMBER DUES | ADMINISTRATION |
| T5064 | QUEST DIAGNOSTICS CLINICAL LABORATORIES, INC. | 103,798.33 | PROFESSIONAL SERVICES | MIS INFRASTRUCTURE |
| T5967 | SAI360 INC | 102,265.00 | PROFESSIONAL SERVICES & 2 YR POLICY MANAGEMENT SYSTEM | AUDIT & INVESTIGATIVE SERVICES |
| T1005 | COLONIAL LIFE & ACCIDENT | 101,280.68 | LIFE INSURANCE PREMIUM | VARIOUS |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5426 | UNIVERSAL HEALTHCARE SERVICES, INC | 100,000.00 | INITIAL 50% COMPREHENSIVE OBESITY MANAGEMENT PROGRAM | HEALTH SERVICES - UM |
| WT/ACH | USPS | 100,000.00 | POSTAGE (METER) FUND | CORPORATE SERVICES |
| WT/ACH | HELPCARE AI **** | 100,000.80 | 2025- 2026 CLOUD BASED AI PLATFORM | MIS INFRASTRUCTURE |
| T4217 | CONTEXT 4 HEALTHCARE, INC **** | 99,598.24 | ANNUAL RENEWAL AMA FEES | MIS INFRASTRUCTURE |
| T4503 | VISION SERVICE PLAN | 95,515.51 | EMPLOYEE HEALTH BENEFITS | VARIOUS |
| T5022 | SVAM INTERNATIONAL INC | 95,204.00 | PROFESSIONAL SERVICES | VARIOUS |
| T5863 | MANNA HAGOS | 94,668.00 | PROFESSIONAL SERVICES | HEALTH SERVICES - UM |
| T5963 | ANTAGE INCORPORATED | 93,200.00 | PROFESSIONAL SERVICES | ENTERPRISE DEVELOPMENT |
| T5571 | GHA TECHNOLOGIES INC | 80,374.17 | FORTINET SECURITY | MIS INFRASTRUCTURE |
| T5962 | GeBBS SOFTWARE INTERNATIONAL, INC. | 80,000.00 | CONSULTING SERVICES | BUSINESS INTELLIGENCE |
| T4902 | CHANGE HEALTHCARE TECHNOLOGIES, LLC **** | 78,910.22 | 2025 EDI CLAIMS | CLAIMS |
| T2509 | UNITED STATES POSTAL SERVICE | 78,365.44 | PERMIT 162 SUMMER & FALL 2025 ISSUE OF FAMILY HEALTH | HEALTH SERVICES - WELLNESS & PREVENTION |
| T6022 | BAKERSFIELD AMERICAN INDIAN HEALTH PROJECT | 78,012.48 | CONTRACTOR SERVICES | HEALTH SERVICES - UM |
| T6218 | CLOUDERA, INC. | 77,940.10 | ANNUAL RENEWAL - METADATA PLATFORM | BUSINESS INTELLIGENCE |
| T5319 | CITIUSTECH INC. | 77,666.00 | FAST + MAINTENANCE & SUBSCRIPTION Q3 2024 | INFRASTRUCTURE |
| T2446 | AT&T MOBILITY | 75,938.38 | CELLULAR PHONE/INTERNET USAGE | MIS INFRASTRUCTURE |
| T6274 | PANDANAI, INC | 72,000.00 | 2025/2026 AI SOFTWARE SUBSCRIPTION | COMPLIANCE |
| T5583 | THE MILHALIK GROUP, LLC | 71,930.00 | CONSULTING SERVICES | HEALTH SERVICES - QI |
| 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 |
| T2969 | AMERICAN BUSINESS MACHINES INC | 69,135.55 | HARDWARE AND MAINTENANCE | MIS INFRASTRUCTURE |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| 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 |
| T4331 | COTIVITI, INC | 64,586.94 | MEDICAL RECORD RETRIEVAL/ HANDLING | QUALITY PERFORMANCE |
| T6202 | KRAMER WORKPLACE INVESTIGATIONS | 63,070.00 | CONSULTING FEES | HUMAN RESOURCES |
| T6285 | MERSMAN ENTERPRISES (MEI) | 59,750.00 | TGI TRAINING DEVELOPMENT CONSULTING | HEALTH EQUITY |
| T1404 | CALIFORNIA ASSOCIATION OF HEALTH PLANS | 59,506.00 | 2025 ANNUAL DUES ASSESSMENT | ADMINISTRATION |
| T5275 | CREATIVE FINANCIAL STAFFING, LLC | 56,140.96 | TEMPORARY HELP | VARIOUS |
| T5931 | SPROUT SOCIAL, INC | 54,000.00 | 2025-2026 SOCIAL MEDIA VIGILANCE MANAGEMENT | MIS INFRASTRUCTURE |
| T6192 | LANG SPECIALTY TRAILERS | 51,676.95 | MOBILE LAUNDRY TRAILER | MEMBER ENGAGEMENT |
| T4228 | THE SSI GROUP, LLC | 47,976.40 | 2025 EDI CLAIMS | CLAIMS |
| T5550 | CHARTER COMMUNICATIONS OPERATING, LLC | 47,931.89 | INTERNET SERVICES | MIS INFRASTRUCTURE |
| T5742 | MICHAEL NGUYEN | 47,500.00 | PROFESSIONAL SERVICES | QUALITY & HEALTH EQUITY |
| T5988 | WASCO UNION HIGH SCHOOL DISTRICT | 45,300.00 | SCHOOL WELLNESS GRANT 2025-2026 | HEALTH SERVICES - WELLNESS & PREVENTION |
| T5109 | RAND EMPLOYMENT SOLUTIONS | 42,914.19 | TEMPORARY HELP | VARIOUS |
| T5435 | TEGRIA SERVICES GROUP - US, INC. | 42,875.00 | PROFESSIONAL SERVICES | BUSINESS INTELLIGENCE |
| T4607 | AGILITY RECOVERY SOLUTIONS INC. | 42,745.86 | PROFESSIONAL SERVICES | CORPORATE SERVICES |
| T2933 | SIERRA PRINTERS, INC. | 42,660.66 | MEMBER HANDBOOKS & FLYERS | MEMBER SERVICES/COMMUNITY SUPPORT SERVICES |
| T4960 | ZELIS CLAIMS INTEGRITY, LLC | 42,528.64 | 2025 CLAIMS EVALUATION SERVICES | CLAIMS |
| 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 |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T2441 | LAURA J. BREZINSKI | 40,000.00 | MARKETING MATERIALS | MARKETING & PUBLIC AFFAIRS |
| T5977 | IMAGENET, LLC | 40,000.00 | KIOSK SERVICES | CORPORATE SERVICES |
| T1918 | PUBLIC RISK, INNOVATION, SOLUTIONS AND MANAGEMENT | 39,154.00 | MR OCIP DEDUCTIBLE LOSS FUND CONTRIBUTION | ADMINISTRATION |
| T2869 | COMMUNITY ACTION PARTNERSHIP OF KERN | 36,400.00 | 2025 COMMUNITY GRANTS & RENT FOR MOJAVE & RIDGECREST OFFICES | MARKETING & PUBLIC AFFAIRS/CORPORATE SERVICES |
| T4182 | THE LAMAR COMPANIES | 36,212.28 | OUTDOOR ADVERISEMENT - BILLBOARDS | MARKETING & PUBLIC AFFAIRS |
| T2787 | SAGE SOFTWARE, INC. | 35,968.95 | SAGE 300 PREMIUM LICENSE RENEWAL | FINANCE |
| WT/ACH | COLABS HOLDING | 35,650.00 | INTEL AGREE YR 3 | MIS INFRASTRUCTURE |
| T3118 | AMERICAN ACADEMY HOLDINGS LLC dba AAPC | 34,440.17 | 2025 CPC TRAINING PACKAGE & AAPC MEMBERS | CLAIMS |
| T5321 | TYK TECHNOLOGIES LTD | 34,000.00 | SELF MANAGED ARCHITECTURE PLAN 2024/2025 | MIS INFRASTRUCTURE |
| T6116 | SIERRA SANDS UNIFIED SCHOOL DISTRICT | 34,000.00 | 2025-2026 ELEMENTARY SCHOOL GRANT | HEALTH SERVICES - WELLNESS & PREVENTION |
| T5398 | GOLDEN EMPIRE GLEANERS | 33,575.40 | FOOD BASKETS FOR MEMBERS | ENHANCED CARE MANAGEMENT |
| T4766 | RICHLAND SCHOOL DISTRICT | 33,000.00 | SCHOOL WELLNESS GRANT 2025-2026 & COMMUNITY SPONSORSHIPS | HEALTH EDUCATION/ MARKETING & PUBLIC AFFAIRS |
| T5627 | DOCUSIGN, INC. | 32,379.42 | eSIGNATURE SUPPORT & (20) IAM ENTERPRISE LICENSES | MIS INFRASTRUCTURE/HUMAN RESOURCES |
| T5851 | ABSORB SOFTWARE NORTH AMERICA, LLC | 32,358.24 | DAYFORCE LEARNING LICENSE | MIS INFRASTRUCTURE |
| T2580 | GOLDEN EMPIRE TRANSIT DISTRICT | 32,000.00 | MARKETING - BUS ADVERTISING | MARKETING & PUBLIC AFFAIRS |
| T6361 | NEMT SOLUTIONS LLC | 32,000.00 | JUL. & AUG. 2025 NMT TRANSPORTATION SERVICE | TECHNICAL ADMINISTRATIVE SERVICES |
| T3088 | GLEN BROWN CONSULTING | 31,387.50 | CONSULTING SERVICES | CAPITAL PROJECT |
| T5201 | JAC SERVICES, INC. | 31,172.50 | AC PREVENTATIVE MAINTENANCE & REPAIRS | CORPORATE SERVICES |
| T5936 | AXIOS HQ INC | 30,240.00 | 2024/2026 COMMUNICATIONS SOFTWARE | MIS INFRASTRUCTURE |
| T4993 | LEGALSHIELD | 30,179.00 | EMPLOYEE PREMIUM | VARIOUS |
| T4652 | BAKERSFIELD SYMPHONY ORCHESTRA | 30,000.00 | 2025 SPONSORSHIP | MARKETING & PUBLIC AFFAIRS |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T6223 | WASCO UNION ELEMENTARY SCHOOL DISTRICT | 30,000.00 | SCHOOL WELLNESS GRANT 2025-2026 | HEALTH SERVICES - WELLNESS & PREVENTION |
| T5592 | BRAND CO MARKETING | 28,937.11 | THE RACK WEB HOSTING FEE & STORE MERCHANDISE | HUMAN RESOURCES |
| T4934 | APPLE INC. | 28,795.54 | COMPUTER EQUIPMENT | CAPITAL PROJECT |
| T5159 | AT&T CORP | 28,214.11 | INTERNET SERVICES | MIS INFRASTRUCTURE |
| T4424 | GUROCK SOFTWARE GmbH | 27,611.00 | HOSTED SOFTWARE RENEWAL | PROJECT MANAGEMENT |
| T3081 | ST. VINCENT DE PAUL STORE, INC. | 27,609.64 | COMMUNITY HEALTH PARTNERSHIP | COMMUNITY GRANTS |
| T2641 | MARANATHA GARDENING & LANDSCAPING, INC | 27,505.00 | 2025 GARDENING & LANDSCAPE REPAIRS | CORPORATE SERVICES |
| T6062 | PTO EXCHANGE | 26,719.33 | IMPLEMENTATION/TRANSACTION FEES | VARIOUS |
| T2938 | SAP AMERICA, INC | 26,584.72 | 2025/2026 ENTERPRISE SUPPORT & MAINTENANCE | MIS INFRASTRUCTURE |
| T1189 | APPLE ONE EMPLOYMENT SERVICES **** | 26,378.86 | TEMPORARY HELP | VARIOUS |
| T6313 | mPULSE MOBILE, INC **** | 26,153.60 | H30 PORTAL IMPLEMENTATION | CAPITAL PROJECT |
| T6358 | KENNADAY LEAVITT PC **** | 25,472.50 | 2025 LEGAL FEES | LEGAL |
| T1347 | ADVANCED DATA STORAGE | 24,732.48 | STORAGE AND SHREDDING SERVICES | CORPORATE SERVICES |
| T5887 | PREPARIS INC | 24,293.52 | DISASTER RECOVERY | CORPORATE SERVICES |
| T5420 | PAYPRO ADMINISTRATORS | 24,185.20 | PROFESSIONAL SERVICES | HUMAN RESOURCES |
| T6311 | JMP OFFICE TECHNOLOGIES | 24,106.22 | POSTAGE METER MAINTENANCE & SUPPORT | CORPORATE SERVICES |
| T4024 | QUADIENT INC. | 23,942.04 | POSTAGE METER RENTAL & SUPPORT | CORPORATE SERVICES |
| T5536 | CALIFORNIA STATE UNIVERSITY BAKERSFIELD FOUNDATION | 23,300.00 | COMMUNITY SCHOLARSHIPS | MARKETING & PUBLIC AFFAIRS |
| T2955 | DELTA ELECTRIC INC. | 23,091.77 | BUILDING MAINTENANCE | CORPORATE SERVICES |
| T2578 | AMERICAN STROKE ASSOC/AMERICAN HEART ASSOC WESTERN STATES | 23,000.00 | GO RED FOR WOMEN & HEART WALK SPONSORSHIP | MARKETING & PUBLIC AFFAIRS |
| T4731 | GO TO TECHNOLOGIES, INC | 22,737.00 | LOGMEIN SUBSCRIPTION RENEWAL | INFRASTRUCTURE |

KERN·HEALTH SYSTEMS

**Year to Date AP Vendor Report**
**Amounts over $20,000.00**

| Vendor No. | Vendor Name | Year-to-Date | Description | Department |
|---|---|---|---|---|
| T5500 | MAGDALENE HOPE INC | 21,500.00 | COMMUNITY GRANTS | MARKETING & PUBLIC AFFAIRS |
| T5436 | THE BEACON STUDIOS, LLC | 21,372.62 | MARKETING -VIDEO SERVICES | MARKETING & PUBLIC AFFAIRS |
| T5318 | CANONICAL GROUP LIMITED | 20,720.00 | UBUNTU PRO LICENSE & SUPPORT | INFRASTRUCTURE |
| T4544 | BARNES WEALTH MANAGEMENT GROUP | 20,280.00 | RETIREMENT PLAN CONSULTANTS | ADMINISTRATION |
| T6121 | JACKSON UTILIZATION MANAGEMENT CONSULTING | 20,020.00 | PROFESSIONAL SERVICES | HEALTH SERVICES - UTIL REVIEW |
| T2135 | BAKERSFIELD CITY SCHOOL DISTRICT | 20,000.00 | 2025-2026 ELEMENTARY SCHOOL WELLNESS GRANT | HEALTH SERVICES - WELLNESS & PREVENTION |
| T5511 | BARTZ-ALTADONNA COMMUNITY HEALTH CENTER | 20,000.00 | COMMUNITY HEALTH PARTNERSHIP | COMMUNITY GRANTS |
| T5535 | PANAMA-BUENA VISTA UNION SCHOOL DISTRICT | 20,000.00 | SCHOOL WELLNESS GRANT 2025-2026 | HEALTH EDUCATION |
| T6362 | ARRIVE TRANSPORT SOLUTIONS LLC | 20,000.00 | NON MEDICAL TRANSPORT | TECHNICAL ADMINISTRATIVE SERVICES |
| | | **47,457,526.48** | | |
| | TOTAL VENDORS OVER $20,000 | 47,457,526.48 | | |
| | TOTAL VENDORS UNDER $20,000 | 2,487,314.28 | | |
| | TOTAL VENDOR EXPENSES- AUGUST | **49,944,840.76** | | |

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

| 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 |
| Symplr | $72,508.40 | Yes | UM | Christine Pence | Hayes Knowledge Center (Year 2) | 8/1/2025 | 7/31/2026 |

| 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 | $ 22,150 | $ 27,485 | $ 14,962 | $ 19,978 | $ 27,358 | $ 17,370 | $ 16,720 | $ - | $ - | $ - | $ - | $ - | $ 146,024 | $ 553,194 |
| 2 | Closed Loop Referral (CLR) Mgmnt | CAP | $ 1,000,267 | $ 1,937 | $ 2,404 | $ 17,638 | $ 17,668 | $ 18,546 | $ 14,447 | $ 15,569 | $ - | $ - | $ - | $ - | $ - | $ 88,210 | $ 912,058 |
| 3 | Medicare Advantage DSNP Software Modules | CAP | $ 4,122,638 | $ 26,909 | $ 24,241 | $ 25,250 | $ 48,603 | $ 49,079 | $ 66,807 | $ 74,917 | $ - | $ - | $ - | $ - | $ - | $ 315,806 | $ 3,806,831 |
| 4 | Accounting System Upgrade/Implementation | CAP | $ 401,757 | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 401,757 |
| 5 | Member & Provider Portal Implementation | CAP | $ 1,116,483 | $ - | $ - | $ 8,924 | $ 29,951 | $ 30,942 | $ 19,913 | $ 17,248 | $ - | $ - | $ - | $ - | $ - | $ 106,977 | $ 1,009,506 |
| 6 | Member Engagement | CAP | $ 713,511 | $ 35,170 | $ 40,554 | $ 56,021 | $ 52,079 | $ 33,257 | $ 27,791 | $ 40,058 | $ - | $ - | $ - | $ - | $ - | $ 284,929 | $ 428,582 |
| 7 | Text Messaging - Automate and Customize | CAP | $ 415,138 | $ 168 | $ 209 | $ 5,804 | $ 2,234 | $ 5,998 | $ 2,746 | $ 3,237 | $ - | $ - | $ - | $ - | $ - | $ 20,396 | $ 394,743 |
| 8 | Webex Calling Migration | CAP | $ 644,373 | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ 644,373 |
| | ***Capital Totals*** | | ***$ 9,113,386*** | ***$ 86,335*** | ***$ 94,893*** | ***$ 128,598*** | ***$ 170,512*** | ***$ 165,181*** | ***$ 149,074*** | ***$ 167,749*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ 962,342*** | ***$ 8,151,044*** |
| 9 | IT Staff Augmentation | EXP | $ 7,530,807 | $ 450,288 | $ 379,088 | $ 463,064 | $ 645,681 | $ 630,011 | $ 638,262 | $ 610,157 | $ - | $ - | $ - | $ - | $ - | $ 3,816,550 | $ 3,714,257 |
| 10 | PM Staff Augmentation | EXP | $ 277,624 | $ 114,683 | $ 68,603 | $ 107,342 | $ 97,321 | $ 71,598 | $ 80,766 | $ 74,765 | $ - | $ - | $ - | $ - | $ - | $ 615,077 | $ (337,453) |
| 11 | NCQA (The Mihalik Group) | EXP | $ 350,000 | $ 17,800 | $ 22,823 | $ 32,990 | $ 14,250 | $ 23,215 | $ 2,400 | $ - | $ - | $ - | $ - | $ - | $ - | $ 113,478 | $ 236,523 |
| 12 | DSNP (Rebellis) | EXP | $ 3,000,000 | $ 163,994 | $ 73,994 | $ 100,875 | $ 151,681 | $ 159,513 | $ 121,925 | $ 56,063 | $ - | $ - | $ - | $ - | $ - | $ 828,044 | $ 2,171,956 |
| | ***Operating Expense Totals*** | | ***$ 11,158,431*** | ***$ 746,765*** | ***$ 544,507*** | ***$ 704,270*** | ***$ 908,933*** | ***$ 884,336*** | ***$ 843,353*** | ***$ 740,984*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ -*** | ***$ 5,373,149*** | ***$ 5,785,282*** |

**KERN HEALTH SYSTEMS**
**BOARD OF DIRECTORS**
**NEW VENDOR CONTRACTS**
**October 23, 2025**

| Legal Name<br>DBA | Specialty | Address | Comments | Contract Effective Date |
|---|---|---|---|---|
| PAC 09/10/2025 (14) | | | | |
| Antelope Valley SNF Healthcare LLC<br>dba: Antelope Valley Care Center | SNF | 44567 North 15th St. West<br>Lancaster CA | | **10/1/2025** |
| Alissa Avila-Hansen<br>dba: The Doulove Way | Doula | 122 East Blvd Ste D<br>Tehachapi CA | | **10/1/2025** |
| Flood Bakersfield Ministries, Inc. | ECM | 1830 Truxtun Ave Ste 210<br>Bakersfield CA | | **10/1/2025** |
| Horizon Multicare Group Inc | Hospitalist | 19197 Golden Valley Road Ste. 935<br>Santa Clarita CA | Hospitalist Grp @ AV Medical Center in Lancaster CA | **10/1/2025** |
| California Rheumatology Institute Inc<br>dba: California Rheumatology Institute | Rheumatology | 3543 San Dimas St<br>Bakersfield CA | | **10/1/2025** |
| Ventura Institute of Ophthalmology Inc | Ophthalmology | 1739 W Ave J<br>Lancaster CA | | **10/1/2025** |
| Universal Healthcare MSO LLC<br>dba: Sunrise Wellness Care CHW | CHW Services | 5500 Ming Avenue Ste. 155<br>Bakersfield CA | CHW Applicants were processed for 9/1/2025 eff date since this is an existing provider w/new service contract. | **Retro-Eff 9/1/2025** |
| Marin Wellness Pharmacy LLC<br>dba: Apex Infusion Pharmacy | Pharmacy/Infusion Clinic | 3543 San Dimas St<br>Bakersfield CA<br>3299 E Hill Street Ste 301<br>Signal Hills CA | | **10/1/2025** |
| Fast Aid Urgent Care Inc | Urgent Care | 2611 S H Ste. C<br>Bakersfield, CA 93304 | Existing Providers & New Providers | **10/1/2025** |
| Cajon Medical Group PC | PCP | 8100 California City Blvd<br>California City, CA | | **10/1/2025** |
| Robert Marriott Medical Corp<br>dba: Advantage Wound Care | Podiatry | 3121 19th St<br>Bakersfield, CA | | **10/1/2025** |
| Waimea Bay Holdings, LLC<br>dba: Meadow Creek Post-Acute | SNF (LTC) | 7039 Alondra Blvd<br>Paramount CA | | **10/1/2025** |

**KERN HEALTH SYSTEMS**
**BOARD OF DIRECTORS**
**NEW VENDOR CONTRACTS**
**October 23, 2025**

| Legal Name<br>DBA | Specialty | Address | Comments | Contract Effective Date |
|---|---|---|---|---|
| Venice Beach Holdings LLC<br>dba: The Springs Post-Acute | SNF (LTC) | 10625 Leffingwell Rd<br>Norwalk CA | | **10/1/2025** |
| 22125 Roscoe Corp<br>dba: Topanga Terrace Rehabilitation and Subacute | SNF | 22125 Roscoe Blvd<br>Canoga Park CA | | **10/1/2025** |
| Skye's the Limit Production, LLC<br>dba: Play Thru It | CHW Services | 12 17th Street<br>Bakersfield CA | | **10/1/2025** |
| **PAC 10/01/2025 (9)** | | | | |
| Natasha Valdez LMFT A Marriage and Family Therapy Prof Corp<br>dba: Rooted Shifts to Healing | Mental Health | 330 H Street Ste. 1<br>Bakersfield CA | | **Retro-Eff 10/1/2025** |
| Healing Solutions Family Therapy Center, Inc.<br>dba: Healing Solutions Family Therapy Center | Mental Health | 104 South Robinson St<br>Tehachapi CA<br>815 West Lancaster Blvd<br>Lancaster CA | | **Retro-Eff 10/1/2025** |
| Makan Dental Corporation<br>dba: Advanced Oral Surgery | Oral & Maxillofacial Surgery | 5555 Truxtun Ave Ste 200<br>Bakersfield CA | | **11/1/2025** |
| Lakeview Surgery Center LLC | Ambulatory Surgery Center | 6501 Truxtun Ave Ste 180<br>Bakersfield CA | | **11/1/2025** |
| Raven Thomas<br>dba: Raven's Healing Birth Services | Doula | 8313 Brimhall Rd Bldg 2000<br>Bakersfield CA | | **11/1/2025** |
| Jurupa Valley Doulas LLC<br>dba: Jurupa Valley Doulas | Doula | 8082 Limonite Ave Suite 33006<br>Jurupa CA | | **11/1/2025** |
| United Home Health Care LLC | Home Health | 1717 30th Street<br>Bakersfield CA | | **11/1/2025** |
| Kevin Hamilton<br>dba: Med Express Non Emergency Medical Transportation LLC | Transportation: NEMT and NMT | 14352 Searspoint Ave<br>Bakersfield CA | | **11/1/2025** |
| SG Homecare Inc<br>dba: Stance Health Solutions | DME (Home Med Equip / O2 & REspirtory) | 23412 Cepheus Ct<br>Bakersfield CA | | **11/1/2025** |

**KERN HEALTH SYSTEMS**
**BOARD OF DIRECTORS**
**TERMED CONTRACTS**
**October 23, 2025**

| Legal Name<br>DBA | Specialty | Address | Comments | Contract Term Date |
|---|---|---|---|---|
| Thrifty Payless, Inc. | Pharmacy | Rite Aid Locations *ALL | Stores Closed | 8/1/2025 |
| Matthew M Malerich MD Inc | Orthopedic Surgeon | 300 Old River Road Ste. 200<br>Bakersfield CA | Retired | 8/12/2025 |
| Advanced Endoscopy and Pain Center LLC | Ambulatory Surgery Center | 1753 West Avenue J Ste. A<br>Lancaster CA | Voluntary Termination | 8/15/2025 |
| Antelope Valley Supportive Care & Hospice | Hospice | 1505 West Avenue J Ste. 303<br>Lancaster CA | Voluntary Termination | 8/15/2025 |
| Valley Imaging Medical Group | Radiology | 1311 Jefferson Street<br>Delano CA | Closed Location | 8/15/2025 |
| F&T 900 Inc<br>dba: E Ride | Transportation | 5300 California Ave Ste. 400A<br>Bakersfield CA | KHS Term due to no Professional Liability | 9/8/2025 |
| Geri-Care IV, LLC<br>dba: Antelope Valley Care Center | SNF | 44567 North 15th St West<br>Lancaster CA | New Tax ID Number | 9/30/2025 |
| Jessica Ann Acevedo | ABA Provider | 5308 Aurora Way<br>Bakersfield CA | Closed Individual Practice | 9/8/2025 |

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Martha Tasinga, Chief Medical Officer

**SUBJECT:** REVISED POLICY AND PROCEDURE – QP 23.06-P, 23.10-P, 23.23-P, 23.09-P, 23.14-P, 23.22-I, New P&P Monitoring Provider Exclusions (Medicare) and Quality Improvement 2.70-I Potential Quality Issue

**DATE:** October 23, 2025

**Background**

On 9/10/2024, the KHS Physician Advisory Committee (PAC) approved the red-lined revisions to Quality Performance Policy and Procedures:

- **23.06-P_Non-Physician Medical Practitioner & Attachment A Supervising Physician Agreement**
  - Annual review and revisions to bring up-to-date information with current practice
- **23.10-P_Delegated Credentialing & Attachment A-Delegated Credentialing Agreement**
  - Annual review and revisions to comply with 2025 NCQA Credentialing Standards
- **23.23-I_Credentialing Information Integrity**
  - Replacing P&P 23.19 Credentialing System Controls as NCQA came out with new 2025 Standards retitled Credentialing Information Integrity

On 10/2/2024, PAC approved red-lined revisions to Quality Performance Policy and Procedures and Quality Improvement Policy and Procedures:

- **23.09-P_Urgent Care Center**
  - Annual review and revisions to bring up-to-date information with current practice
- **23.14-P_CLIA Certification Requirements**
  - Annual review and revisions to bring up-to-date information with current practice
- **23.22-I_Ongoing Monitoring and Interventions**
  - Annual review and revisions to comply with 2025 NCQA Credentialing Standards
- **New-I_Monitoring Provider Exclusions (Medicare Required Policy)**
  - New Policy Language required by Medicare
- **2.70-I_QI Potential Quality Issue**
  - Annual review and revisions to bring up-to-date information with current practice

**Summary of revisions outlined below:**

| Policy Section | Policy Changes |
|---|---|
| **P&P QP_23.06-P_Non-Physician Medical Practitioner & Attachment A Supervising Physician Agreement** | Revision include:<br>• Revised physician to mid-level ratio to allow additional mid-levels for coverage based on LPHC Communication with DHCS dated 12/12/2024.<br>• Added new language specific to Nurse Practitioners with license designation 103 and 104 who no longer are required to have supervising agreement with a physician. |
| **P&P QP_23.10-P_Delegated Credentialing & Attachment A-Delegated Credentialing Agreement** | • Revised policy to include new NCQA Standards that became effective 7/1/2025 pertaining to Delegates credentialing policies, verifications, ongoing monitoring, new credentialing information integrity (standards, audit, training and analysis) and delegation of credentialing.<br>• Procedure A-#6 revised audit methodology<br>• Removed Credentialing System Controls and replaced with new standards for Credentialing Information Integrity requirements.<br>• Frequency of Reporting added to whom and how activities are to be reported to KHS.<br>• Added ongoing monitoring new standard requirements<br>• Added practitioner race, ethnicity and languages to be requested (voluntarily/optional). |
| **P&P QP_23.19-I_Credentialing Information Integrity**<br>**Attachment A: CII Audit and Analysis Summary Tool**<br>**Attachment B: Annual Confidentiality Agreement Cred Staff**<br>**Attachment C: Annual Credentialing Info Integrity Agreement Symplr Users** | • Changed name from Credentialing System Controls to new NCQA Credentialing Information Integrity.<br>• NCQA retired Credentialing System Control Standards and replaced with new Credentialing Information Integrity Standards effective 7/1/2025. Due to the extensive changes in the standards, the policy language was completely rewritten rather than red-lined in order to meet the intent and current practice of this standard. |
| **P&P QP_23.09-P_Urgent Care Center Revised** | Annual Review with revisions including:<br>• Reformatted to KHS New Policy Template.<br>• Minor revisions to bring up-to-date with current practice and credentialing requirements. |
| **P&P QP_23.14-P_CLIA Certification Requirements Revised** | Annual Review with revisions including:<br>• Reformatted to KHS New Policy Template.<br>• Minor revision to include Medicare approved laboratory accreditation sources. |

KERN HEALTH SYSTEMS

| Policy Section | Policy Changes |
|---|---|
| **P&P QP_23.06-P_Non-Physician Medical Practitioner & Attachment A Supervising Physician Agreement** | Revision include:<br>• Revised physician to mid-level ratio to allow additional mid-levels for coverage based on LPHC Communication with DHCS dated 12/12/2024.<br>• Added new language specific to Nurse Practitioners with license designation 103 and 104 who no longer are required to have supervising agreement with a physician. |
| | • Added verification source website to be used during primary source validation of CLIA Certificates |
| **P&P QP_23.22-I_Ongoing Monitoring and Interventions Revised** | Annual Review with revisions including:<br>• Reformatted to KHS New Policy Template.<br>• Added new NCQA Standards CR5 related to Medicare and Medi-Cal Sanctions and Exclusions.<br>• Changed monitoring from every 6-months to monthly<br>• Added new Licensing monitoring of expirations dates monthly<br>• Added appropriate interventions and evidence of review in PAC Meeting minutes. |
| **NEW P&P Monitoring Provider Exclusions (Medicare Policy)** | New Policy for Medicare LOB<br>• Policy outlines the process used to ensure all providers who submit a contract to the plan as well as all providers to whom a claims payment is made will be monitored against federal and state exclusion lists<br>• Describes if any contracted provider is found to be subsequently included on any of the identified lists that provider will be promptly terminated from the applicable network |
| **2.70-I_QI Potential Quality Issue**<br>**A-MR Request Form**<br>**B-Med Director Referral Form**<br>**C-Grievance Disposition Form**<br>**D-CAP Form**<br>**E-Tracking Categories**<br>**F-Threshold Methodology & Selection** | • Revision to bring up-to-date with current practice and attachments.<br>• Processing PQI – Level 2 sent to PAC to determine appropriate action to track and trend, initiate corrective action or referral for external review.<br>• Added - PQI Dept to maintain logs to track the timeliness of case reviews with targeted completion of 120-day time frame.<br>• Revised PQI Levels, Descriptions and Follow-up Action Table<br>• Revised Corrective Action Process |

**Requested Action**

- Approve new policy and procedure: QP New Monitoring Provider Exclusions for Medicare
- Approve revisions to existing policy and procedures:
    - 23.06-P Non-Physician Medical Practitioners
    - 23.10-P Delegated Credentialing
    - 23.23-I Credentialing Information Integrity
    - 23.09-P Urgent Care Center-Revised
    - 23.14-P CLIA Certification-Revised
    - 23.22-P Ongoing Monitoring-Revised
    - 2.70-I Potential Quality Issue Revised

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Non-Physician Medical Practitioners - Supervision by Physicians | **Policy #** | 23.06-P |
| **Policy Owner** | Quality Performance/Contracting | **Original Effective Date** | 08/1997 |
| **Revision Effective Date** | ~~10/1/2024~~9/2/2025 | **Approval Date** | 10/29/2024 |
| **Line of Business** | ☒ Medi-Cal ☒~~☐~~ Medicare ☐ Corporate | | |

## I. PURPOSE

Physician ~~offices~~ supervision of non-physician practitioners (NPPs) in California is state-regulated and depends on the NPPs role, with specific requirements for Nurse Practitioners (NPs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs). ~~will have standardized~~ Standardized procedures, if required, will ~~that~~ clearly define the scope of services and supervision of all non-physician medical providers (NPMP) in accordance with applicable California Code of Regulations, Business and Professions Code (BPC) and/or California Licensing Agency.

## II. POLICY

Kern Health Systems (KHS) ~~will encourage the~~ permits the use of non-physician medical practitioners (NPMP), also referred to as mid-level providers, with the intent of increasing member access to medical care and thereby improving patient outcome. While some NPs an practice independently without supervision, others require general or direct physician supervision. Physicians are responsible for the quality of care provided by the NPPs they supervise and specific limits on the number of NPPs a physician can supervise simultaneously ~~All NPMPs must have an established supervisory relationship with a contracted physician provider, when required, and the supervising requirements~~ must follow the standards and guidelines set forth in the applicable California Code of Regulations, Business and Professions Code (BPC), and/or California Licensing Agencies as follows:

A. Certified Nurse Midwife (CNM): Physician supervision is not required for any CNM practicing pursuant to Business and Professions Code, Section 2746.5.

B. Licensed Midwives (LM): LMs ~~can~~ may bill for services pursuant to their scope of practice as licensed practitioners with ~~established protocols, procedures and treatments authorized~~ no supervision by a physician or surgeon pursuant to Business and Professions Code 2505-2521

(Amendments AB1308 Bonilla Chapter 665, Statutes of 2013 Changes became effective 1/1/2014).

C. Nurse Practitioner (NP): Physician Supervision is required for services rendered pursuant to Business and Professions Code, (BPC) Section 2725, 2836.1(e) (furnishing numbers).

D. Physician Assistant (PA) ~~–~~ A PA cannot practice independently and must be supervised by a licensed physician (either MD or DO) and an agreement must be completed and signed by the PA and one or more physicians before the PA is permitted to practice pursuant to Business and Professions Code, Sections 3502, 3502.1, 3516 and 3516.5, Welfare and Institutions Code (W&I Code), Section 14132.966 and California Code of Regulations, Title 16, Section 1399.540.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| **Non-Physician Medical Practitioner** | A healthcare practitioner, other than a physician, licensed by the state in which they practice to assist or act in the place of a physician, who may bill directly under applicable state law. For the purposes of this policy, an Advanced Practice Health Care Provider includes, without limitation, Physician Assistants (PA), Nurse Practitioners (NP) and Clinical Nurse Specialists (CNS). |
| **Supervising Health Care Provider Professional** | ~~Professional~~ A licensed physician (either MD or DO) ~~or Advanced Practice Health Care Provider, who has their own NPI number, when~~ who is responsible for the quality of care provided by the NPPs they supervis~~ing services rendered by an Advanced Practice Health Care or Nonphysician Provider~~. |
| **Delegation of Services Agreement or Practice Agreement** | ~~The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician.~~ A formal agreement outlining specific services and protocols as required. A delegation of services or practice agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement. |

## IV. PROCEDURES

### A. TYPES OF NON-PHYSICIAN MEDICAL PRACTITIONERS (NPMP)

The terms non-physician medical practitioner and mid-level practitioner refers to the following categories of licensed medical providers:

1. Nurse Practitioners licensed by the Board of Registered Nursing (BRN)

2. Certified Nurse Midwife licensed by BRN
3. Licensed Midwives licensed by the Medical Board of California
4. Physician Assistant licensed by the Physician Assistant Board of California.

## B. SCOPE OF NON-PHYSICIAN MEDICAL PRACTITIONERS

KHS Plan members either select or are randomly assigned to a contracted primary care provider (PCP). The PCP may choose to arrange with a NPMP to provide primary care to assigned members but must provide active supervision, when applicable, of the care delivered. A Supervising Physician does not need to be present, and at a minimum, be available by telephone or other electronic communication~~; however, if the NPMP is performing a complete procedure that requires informed consent, the Supervising Physician must be immediately available to deal with any emergency complication that may occur~~. The NPMP shall consult with a physician regarding any task, procedure or diagnostic problem which the NPMP determines exceeds their level of competence or shall refer such cases to a physician.

A current specialty provider may employ a NPMP and may permit this provider to participate in the specialty care delivered to members in accordance with the Standardized Procedures, Protocols ~~Guidelines,~~or Delegation of Medical Services Agreement~~, and KHS~~. NPMPs will be credentialed in the specific specialty in which they will be working. The credentialing will be dependent on their training and experience in the field in which the NPMP is requesting to be credentialed. NPMPs practicing in a specialty setting may perform an initial evaluation of the patient as long as there are no significant clinical decisions or recommendations (i.e. surgery, admission, etc.). In cases of emergencies, as defined in California Code Regulations, Title 22, Section 51056 “Emergency Services”, the NPMP, to the extent permitted by the laws relating to license or certificate involved, may render emergency services to a patient pending establishment of contact with the physician. In all cases, the NPMP shall be responsible to maintain reasonable communication with the physician to keep the physician informed, to follow instructions and, in case of doubt, to seek assistance or additional instructions.

## C. KHS APPROVAL OF NON PHYSICIAN MEDICAL PRACTITIONERS

1. All NPMPs must meet the credentialing standards set forth in the KHS credentialing policy and procedure, KHS P&P 23.05-P Credentialing Program.

2. Additionally, all NPMPs, with the exception of CNMs, and their supervising physician must submit to KHS for review. as part of their credentialing packet, the following:

    a. When required, a Supervising Physician Agreement, Delegation Agreement or Practice Agreement at initial credentialing, and when there ~~are any~~is a change~~s~~ in their supervising physician (See Attachment A). The supervising physician may submit the existing delegation of service agreement on file in lieu of submitting the KHS Supervising Physician Agreement Form.

b. NPMP Training is variable. There are differences between Nurse Practitioners and Physician Assistants. KHS recognizes some NPMPs will receive formal "specialty" training in areas such as OB/GYN, Women's Health, Pediatrics, Surgery, Orthopedics, Oncology, etc. KHS requires six (6) months formal training in an official training program including nursing specialty certification or one (1) year of full-time work experience in the designated sub-specialty field being requested.

3. Physician Supervisor to Non-Physician Medical Practitioner Ratios

a. The supervising physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following:

~~a.~~b. Four (4) Nurse Practitioners

~~b.~~c. Four (4) Physician Assistants

d. A Physician supervisor may not supervise more than four (4) non-physician medical practitioners in any combination.

~~c.~~e. DHCS believes plans may credential more than four NPMP per one FTE physician, so long as the physician is not supervising more than four such practitioners during a given shift. (LHPC 12/12/2024)

The number of non-physician medical practitioners who may be supervised by a single sub-specialty care physician is limited, pursuant to BPC, Section 2836.1(e), and BPC Section 3502.5, and permitted to supervise:

a. Four (4) Physician Assistants
b. There is no limit to Nurse Practitioners (NP) unless the NP has a Furnishing License, the maximum supervision by a physician is 4-Nurse Practitioners with a Furnishing License.
c. A total of eight (8) equaling 4-NPs with furnishing licenses and 4-PAs at one time.
d. ~~Certified Nurse Midwives and Licensed Midwives~~ Physician Supervision is not required for these NPMP Types:~~.~~
    i. Certified Nurse Midwives
    ii. Licensed Midwives
    iii. Nurse Practitioners with New License Designations:
        1. 103-NP: Works under the provisions outlined in B&P Code 2837.103. This NP must work in a group setting with at least one physician and surgeon and has the 103-NP displayed on their license.
        2. 104-NP: Works under the provisions outlined in B&P Code 2837.104. This NP may work independently within the population focus of their National Certification and has the 104-NP displayed on their license.

3. If the National Certification expires, the 103-NP or 104-NP must immediately begin practicing under physician supervision and standardized procedures until they have regained their national board certification.
~~d.~~

On a quarterly basis the Plan will utilize network and enrollee data to review non-physician medical practitioners' caseloads and physician supervisor to non-physician medical practitioner ratios to ensure they do not exceed standards outlined in this policy.

4. Physician – Practitioner Interface

It is the responsibility of the supervising physician~~.~~ to comply with all applicable state and federal laws, regulations, standards that govern supervision of any and all activities related to non-physician medical practitioners; attest to having provided the legally required collaboration, consultation, and supervision consistent their physician licensure; and agree to be available to the non-physician medical practitioner in person, or through electronic means to provide supervision to the extent required by California professional licensing laws, necessary instruction in patient management, consultation and referral to appropriate care/services by specialist physicians or other licensed health care professionals, as may be required. The practice agreement document must be kept on file at the physician's or medical group's office, and readily available for review by the Department of Health Care Services (DHCS), upon request.

## D. NOTIFICATION OF CHANGES/ADDITIONS IN MID-LEVEL STAFF

KHS requires physicians or groups to report and submit required information to KHS on all non-physician practitioners as part of the initial or on-going recredentialing process. It is the responsibility of the contracting physician or medical group to notify KHS of changes or additions to their non-physician medical practitioners.

## E. IDENTIFICATION OF NONPHYSICIAN MEDICAL PRACTITIONERS

A health care practitioner shall disclose his or her name and practitioner's license status, as granted by the State of California, on a nametag with at least 18-point type. A health care practitioner in a practice or office, whose license is prominently displayed may opt not to wear a nametag and must ensure each patient is initially informed that he/she may be treated by an NPMP.

## F. NON-COMPLIANCE WITH STANDARDS AND REGULATIONS

KHS contracting physicians, who are identified as non-compliant with KHS standards or state guidelines, receive notification from the KHS Chief Medical Officer regarding clinical issues or from KHS Provider Relations regarding NPMP practitioner ratios or caseloads. Non-compliant physicians are subject to KHS Policy and Procedure #23.15 - Provider Disciplinary Action.

## V. ATTACHMENTS

| | |
|---|---|
| Attachment A: | Supervising Physician Agreement |

## VI. REFERENCES

| Reference Type | Specific Reference |
|---|---|
| Regulatory | Business and Professions Code (BPC), Sections 2505-2521, 2725, 2746.5, 2386.1 (e), 3502, 3502.1-5, 3516 and 3516.5, and Welfare and Institutions Code (W&I Code), Section 14132.966. California Code of Regulations, Title 16, Section 1399.540. Business and Professions Code (BPC) 2837.103 and 2837.104 |
| DHCS Contract (Specify Section) | DHCS Contact Section 5.2.4 Network Ratios (C) 274 Medical Managed Care (MMC) Companion Guide (CG) Version 3.0 with an effective date of August 1, 2025 adding a new Licensure Type to report Independent Nurse Practitioners as Licensure Type |
| Regulatory | DHCS Provider Manual Non-Physicians Medical Practitioners (NMP) March 2024 California Code Regulation Title 22, Section 51241 Physician Relationship to Nonphysician Medical Practitioners |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| **Revised** | **08/2025** | **Revised physician to NPMP ratio to allow additional NPMPs for coverage from LPHC Communication Dated: 12/12/2024. Added new language specific to non-supervision of Nurse Practitioners with license designation 103 and 104.** | **Y.Herrera QP Credentialing** |
| Revised | 10/2024 | Policy revised to bring language current with regulatory requirements CCR, B&PC, CA Licensing Agencies. Renumbered from 4.04-P to 23.06-P. | Y.H. QP/Contracting |
| Revised | 3/2018 | Policy revised to bring language current with DHCS Contract requirements. | PNM |
| Revised | 10/2017 | Revised policy to be in compliance with CCR Title 22 51240 NP/CNM, Title 16, 1399 for PAs. Remove requirements for Supervising Physician 30-mile radius, Mid-levels in a hospital setting, Updated site review criteria referencing policy 2.22 and QI's current process. Annual receipt of provider information letter and only require at initial, recredentialing or when changes are made. Remove requirement of monitoring physician interface and replace with supervising physician attestation on the | PMN |

| | | | |
|---|---|---|---|
| | | revised Attachment A-Provider Information Letter. | |
| Revised | 12/2016 | Reviewed by Provider Relations Manager. Removed section 3.2 as no longer applicable. | PNM |
| Revised | 12/2010 | Added language to allow mid-levels perform initial consults in a specialty setting. | PNM |
| Revised | 03/2011 | Mid-Levels will be credentialed in the specialty they will be working and dependent on their training and experience in that field. Specific language added for orthopedics. | PNM |
| Revised | 11/2009 | Revisions provided by Director of Claims and Provider Relations. | PNM/Claims |
| Revised | 09/2005 | Revised per DHS Comment 7/12/05 for Workplan Item 6c. | Claims |
| Revised | 08/2002 | Revised per DHS Comment (04/05/02). | PNM |
| Revised | 2002 | Revised per Medical Director request and DHS comment (10/31/01). | PNM |
| Revised | 02/2001 | Changes made as a result of DHS/DMHC Medical Review Audit (YE 08/31/00). | PNM |
| Revised | 10/2000 | Routine review. | PNM |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Physician Advisory Committee (PAC) | | 10/2/2024 |
| Board of Directors (BOD) | | 10/17/2024 |

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

| Chief Executive Leadership Approval * | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Chief Executive Officer | | |
| Chief Medical Officer | | |
| Chief Operating Officer | | |
| Choose an item. | | |
| *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:** 23.06-P Non-Physician Medical Practitioner

**Last approved version:** 4/2018

**Reason for revision:** Policy was revised to bring language current with regulatory requirements CCR, Business and Professions Code, CA Licensing Agencies.

| Director Approval | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Jake Hall Senior Director of Quality Performance & Contracting | | |
| | | |

Date posted to public drive: _____

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

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Delegated Credentialing | **Policy #** | 23.10-P |
| **Policy Owner** | Quality Performance/Contracting | **Original Effective Date** | 11/2010 |
| **Revision Effective Date** | ~~10/1/2024~~9/2025 | **Approval Date** | 10/29/2024 |
| **Line of Business** | ☒ Medi-Cal ☒~~☐~~ Medicare | | |

## I. PURPOSE

To outline the delegation guidelines and information for monitoring the credentialing and re-credentialing activities of practitioners and providers when authority to perform credentialing activities is delegated to another entity. To ensure the delegated credentialing/re-credentialing process meets Kern Health System (KHS) policies, and the standards set forth by applicable governing bodies including the Department of Health Services (DHCS), the Department of Managed Health Care (DMHC) and the National Committee for Quality Assurance (NCQA), and Centers for Medicare and Medicaid Services (CMS). To standardize Delegate's submission templates and format outline to be used for reporting required practitioner data and information.

## II. POLICY

Kern Health System (KHS) may delegate credentialing activities to qualified entities in accordance with the provisions of this policy. Each delegated entity shall sign a Delegated Credentialing Agreement (See Attachment A) which describes:

1. The responsibilities of KHS,
2. The responsibilities of the delegated entity,
3. The process for evaluation and oversight of the delegated entity's performance, and
4. Ensure the delegated entity has credentialing information integrity policies and procedures, audits credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues, and
4.~~.~~5. Other applicable criteria as outlined in "Attachment A, Delegation Agreement" including reporting requirement descriptions, format, frequency and how and to whom is reported.

The credentialing process will adhere to applicable state and federal law and the requirements of KHS' Medi-Cal contract with the State. A contracted practitioner must be credentialed to participate in KHS' health plan in order to treat KHS members. KHS will only delegate credentialing to Qualified Entities, as defined within this policy.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| CMS | Centers for Medicare and Medicaid Services |
| Delegation | The process whereby KHS gives another entity authority to perform certain functions on its behalf. While KHS may delegate the authority to perform a function, it cannot delegate the responsibility for assuring that the function is performed appropriately. |
| DHCS | Department of Health Care Services |
| Oversight | The monitoring and directing of a set of activities in order to assess performance. |
| Delegation Audit | An annual evaluation of a delegate's capacity to perform delegated credentialing activities using KHS' policies and NCQA and other legal and regulatory standards as applicable. |
| Delegated Entities | Hospital based physicians and/or physician groups (Group) that provide physician services, that KHS has determined have the capability of performing all required delegated credentialing processes. |
| Participating Practitioners | Clinicians requesting participation with KHS through Qualified Entities. Participating practitioners include, but are not limited to: Doctors of Medicine or Osteopathy (MDs/DOs), Podiatrists (DPMs), Chiropractors (DCs), Behavioral Health Practitioners, Mid-Levels, and any other licensed independent practitioner with whom the delegated entity contracts or who provides care to KHS members. |
| Credentials Committee | The qualified entity's designated committee which is responsible for making recommendations regarding decisions about practitioners' credentials. |

## IV. PROCEDURES

### A. DELEGATED CREDENTIALING PROCESS

Prior to entering into a Delegated Credentialing Agreement, KHS evaluates the capability of the Delegated Entity to perform the credentialing functions according to KHS standards, applicable state standards and those established by pertinent governing bodies including CMS, DHCS, DMHC and NCQA. The evaluation includes review of the following:

1. The Delegated Entity's credentialing criteria, policies, and procedures to assure they meet or exceed those of KHS' applicable state standards including those established by the National Committee for Quality Assurance (NCQA).

2. Minutes of the delegated entity's Credentials Committee meetings to verify critical review of the practitioners' credentials.

3. The pre-delegation assessment and evaluation may include a site visit, written review of the delegate's understanding of the standards and delegated tasks, staffing capacity, and performance records. The pre-delegation evaluation may be accomplished through a site visit, the exchange of documents and/or through pre-delegation meetings.

4. If the Delegated Entity is NCQA Accredited or the delegate possesses NCQA-Certification, KHS may use the accredited health plan audit results in its pre-delegation evaluation as an additional mechanism of ensuring the Delegated Entity's credentialing program and quality assurance program meets or exceeds KHS' applicable state, federal standards including those established by the National Committee for Quality Assurance (NCQA). NCQA Accreditation or Certification is not the sole method for determining if the GROUP is deemed capable to complete the specific delegation functions (i.e., credentialing and recredentialing),

5. KHS must evaluate any changes to the delegation agreement, responsibilities and/or activities made by the Delegated Entity prior to the implementation date. Prior written approval must be received from KHS prior to sub-delegating any activity. The delegate will oversee the work performed by the sub-delegate, as outlined in the Exhibit/Agreement. Failure on the part of the delegate to oversee any sub-delegated activity may result in termination of the delegation agreement with KHS.

~~6.~~ KHS will conduct, at a minimum, an annual due-diligence oversight review of delegates' credentialing and recredentialing activities to include policies, procedures, file review and minutes from credentialing committee. KHS has partnered with the Healthcare Industry Collaboration Effort ("HICE") and will accept audit results approved by HICE in lieu of conducting it's own review. KHS reserves the right to conduct their own review ~~During~~ during annual oversight ~~reviews~~, and if chosen, a file review may include one of the following methods:~~at least sixty (60) of a delegates credentialing files (30 Initial Files and 30 Recredentialing Files) will be audited to include initial and recredentialing, and/or using NCQA's 8/30 rule for sampling file review. The procedure involves an initial sampling of 8 files for initial and 8 files for recredentialing, the review of an additional sample of 22 files will be done only if the original 8 files fail a credentialing element.~~

- 5% or 50 of its files, whichever is less, to ensure that information is verified appropriately (sample should include at minimum 10 credentialing files and 10 recredentialing files; if fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
- NCQA 8/30 methodology

~~7.~~6. KHS will also include a review of the GROUP's credentialing policy and procedures including the policy for credentialing ~~system security controls~~ information integrity as

required by NCQA Credentialing Standards 2025 ~~CR1~~CR-8 Element A, ~~Element C, Factor 4~~. KHS will ensure the Group~~'s monitoring process and reporting of unauthorized modifications is conducted annually in accordance with the delegation agreement requirements or its own policies and procedures as required by NCQA CR.8, Element C, Factor 5~~ is compliant with CR-8 Element B pertaining to "Information Integrity Training", Element C pertaining to evidence of "Information Integrity Training" and Element D pertaining to "Information Integrity Improvement Action".

~~8.~~7. The annual evaluation may be conducted on-site, telephone consultation, virtual/remote review and/or desk-top documentation review.

~~9.~~8. Summary of the annual delegation review is recorded on the KHS Delegation Oversight Audit Summary Report which is presented to the KHS Physician Advisory Committee for review and approval.

## B. COMMITTEE AND BOARD REVIEW

The KHS Physician Advisory Committee (PAC) reviews the audit results. The recommendation of the Physician Advisory Committee is presented to the Board of Directors, and if delegated credentialing is approved, an agreement is executed between the parties outlining the responsibility of each and the specific activities that are delegated.

KHS may delegate to a separate entity all of the credentialing/recredentialing responsibilities or a portion of that process, such as primary source verification and maintenance of credentialing and recredentialing files.

KHS retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. The PAC bases the delegation decision on quality of services, experience, and availability of resources.

The credentialing delegate agrees that it will not sub-delegate delegated activities without prior written approval from KHS. Functions, which the delegate, directly or indirectly, delegates to a delegated third party, shall be in writing. The credentialing delegate acknowledges that the delegated third party will be limited to performing only those functions set forth and delegated in accordance with the agreement with such delegated third party, using standards approved by KHS and that are in compliance with applicable State, ~~and~~ Federal laws and NCQA Credentialing Standards.

## C. WRITTEN DELEGATION AGREEMENT

A mutually agree upon written document (Attachment A), signed by both parties, serves as the delegation agreement (Exhibit A) of the contracted entity. The agreement includes, but is not limited to, the following elements:

1. Describes the delegated activities and ~~Responsibilities~~ responsibilities of KHS and the Delegate Entity or Group

2. Includes detailed language of ~~Specific~~ specific credentialing activities being delegated which may include any or all of the following:

a. Maintenance of credentialing committee activities
b. Initial credentialing process for practitioners and/or providers
c. Primary source verification process
d. Ongoing monitoring of license and sanctions
e. Recredentialing process for practitioners and/or providers
f. Initial Site Visit Process, if required or delegated
g. Credentialing appeals process
h. Appropriate reporting to authorities
i. Decision making process
~~j. Credentialing System Controls process~~Credentialing Information Integrity

3. Frequency, ~~and~~ type of reporting, including semi-annual reporting describing:
a. Information reported/activities delegated
~~3.~~b.How and to whom information is reported

4. The process by which KHS evaluates the delegate's performance, including adherence to CMS regulations and quarterly reporting of the delegated entity to KHS.

5. KHS retained right, based on quality issues, to approve, suspend, and terminate individual practitioners, providers and sites in situations where it has delegated decision making.

~~5.~~

6. Statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement.

**D. DELEGATED ENTITY'S RESPONSIBILITIES**

Qualified entities shall conduct plan and practitioner reviews, including utilization review, quality assurance and peer review within the meaning of California Health and Safety Code Section 1370 *et seq*., and California Evidence Code Section 1157. Delegation requirements will include, but not be limited to, the following:

1. Delegate has a minimum of 50 providers that fall in the scope of credentialing. Less than 50 providers will be at the full discretion of KHS upon review and consideration of the pre-delegation audit.

2. Delegate has a credentialing program that has been in place for at least 12 consecutive months and determined to have the capacity to meet NCQA requirements before delegation begins.

3. Delegate has credentialed their entire network of providers.

4. Delegate has held a least three (3) credentialing committee meetings.

5. Verification of potential Delegated Entity's accreditation or certification by NCQA.

6. Non-NCQA accredited or certified potential Delegated Entities must have ability to meet KHS credentialing standards including but not limited to: Credentialing and Recredentialing Policies and procedures, credentialing and recredentialing application and attestations, Credentialing System Controls Policy and reports, and other relevant

credentialing and recredentialing documents or files, including those related to suspension and/or restrictions, fair hearing and appeals process, termination and notification to authorities, confidentiality, and non-discriminatory credentialing process.

7. Ensure the protected health information (PHI) of KHS members treated by participating practitioners remains protected. The delegated entity's credentialing policies and procedures must address the following:
    a. allowable uses of PHI
    b. safeguards to protect the information from inappropriate use or further disclosure
    c. requirements to ensure sub-delegates have similar safeguards
    d. how are individual practitioners are allowed access to their PHI
    e. KHS will be informed within one business day if inappropriate use of PHI occurs
    f. safeguards to ensure that PHI is returned, destroyed, or protected if the delegation agreement ends

8. Notify KHS of any changes to NCQA healthcare accreditation status within thirty (30) days of change notification.

9. Process for monitoring practitioner sanctions, complaints and the occurrence of adverse events at least monthly and in-between re-credentialing cycles. The delegated entity must conduct on-going monitoring of all practitioners who fall within the scope of credentialing. The delegated entity must be fully compliant with KHS, NCQA, and DHCS and use approved current sources of sanction information. Delegated entity's credentialing/peer review body minutes will include the sanction/complaints/adverse events that are reportable and were reviewed and actions or appropriate interventions taken.

10. Policies and procedures for on-going monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and takes appropriate action against practitioners when it identifies occurrence of poor quality. Delegated entity identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

11. Collect and evaluate, at least monthly (every 30-days) ongoing monitoring information (OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc.) and maintain current and accurate information about contracted participating practitioners using monitoring logs/spreadsheet for review for expiration and must include: Name of Board, date of query, date of report and signature/initials of staff reviewing report. Additionally, the delegated entity will include documentation of license expiration in the credentialing files and/or system and monitors licenses that will expire.

12. Conduct site visits and medical record reviews as applicable under NCQA healthcare accreditation organization standards.

## E. KERN HEALTH SYSTEMS' RESPONSIBILITIES

1. Prior to delegation and annually thereafter, conduct a review and audit of the credentialing and re-credentialing activities to ensure that the delegated entity is in accordance with KHS

approved policies and procedures, and established criteria. KHS will conduct an annual evaluation and audit of all delegates. The evaluation and audit will include a review of applicable credentialing & quality assurance policies and procedures related to the delegated function. If the delegate is NCQA accredited or possesses NCQA Certification, KHS may use the accredited health plan audit in its annual evaluation; however, the NCQA Accreditation or Certification is not the sole method for determining if the GROUP is deemed capable to complete the specific delegation functions (i.e., credentialing and recredentialing).

2. Results of KHS oversight audit shall be reported to the KHS PAC and BOD in writing including any corrective action plans, time period for correcting such deficiencies or re-audit if necessary. If any area of the credentialing/re-credentialing process is found to be out of compliance with NCQA guidelines and/or GROUP's credentialing policies and procedures approved by KHS, KHS may choose, in its sole discretion, to require a written corrective action plan (CAP) from GROUP and perform a follow-up review in sixty (60) days. If the GROUP does not implement corrective plan, or does not improve its performance, or its performance is deemed inadequate by KHS in its sole discretion, KHS may implement additional methods to improve performance such as joint meetings, on-site audits, regular conference calls until deficiencies are resolved. KHS, in its sole discretion, may impose additional actions to revoke, terminate or amend the delegation agreement as necessary.

3. Notify the delegated entity in writing of any changes to KHS's credentialing and re-credentialing policy and/or outside regulatory requirements that impact the delegated entity's responsibilities.

4. Retain the authority to approve and to suspend, limit, or terminate the participation of any practitioner, who does not meet KHS' participation requirements or fails to comply with KHS' operating procedures.

5. KHS shall maintain ultimate responsibility for all delegated credentialing and re-credentialing activities. Notwithstanding any other provision of this policy, KHS retains the right to:

    a. Approve a Practitioner or Practitioner location
    b. Terminate or suspend a Practitioner from the KHS network
    c. Overturn a Health Network Peer Review Body's credentialing or re-credentialing decision

**F. DELEGATED ACTIVITIES FOR INITIAL CREDENTIALING**

All practitioners must be qualified to participate in Medi-Cal in order to treat KHS members. Practitioners must not be excluded, suspended or ineligible from participation in the Medi-Cal or Medicare programs. Failure to meet Medi-Cal requirements may be cause for removal from KHS's network.

Credentialing activities must include collecting and verifying the following clinician credentials from "primary sources", as defined by NCQA and document and date this verification in writing according

to NCQA standards:

1. Current valid license to practice healthcare in California
2. Current privileges in good standing or coverage arrangements, as applicable
3. Current valid unrestricted DEA or CDS Certificate or appropriate waiver in California
4. Current board certification in the appropriate specialty, if applicable
5. Education and training in practicing specialty, if not board certified

~~5.~~

6. Five years of work history with documentation of gaps greater than six months
7. Current professional liability insurance within KHS approved limits
8. Review of Medicare/Medi-Cal Sanction Activities
9. Review of the Medicare Opt-Out Report
10. Site visit process, if applicable
11. Ongoing monitoring of sanction activities including Medicare/Medi-Cal, state licensure, Medicare Opt Out, as applicable. Reports must be reviewed ~~within a prescribed timeline of source publications or at least every six months when there is no regular publication~~ at least monthly (every 30-days).
12. State and/or Medi-Cal Requirements as applicable
13. Current, signed attestation statement by the practitioner confirming the correctness and completeness of their application and must address the following:

    a. Reasons for any inability to perform the essential functions of the position, with or without accommodation;
    b. Lack of present use of illegal drugs;
    c. History of loss or limitation of privileges or disciplinary action or negative license or privilege actions;
    d. History of loss of license and felony convictions;
    e. Current malpractice insurance coverage
    ~~d.~~f. Practitioner race, ethnicity and languages (voluntarily) and,
    ~~e. History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a practitioner has had privileges.~~
    g. Current and signed attestation confirming the correctness and completeness of the application.

## G. DELEGATED ACTIVITIES FOR RE-CREDENTIALING

The delegated entity must formally re-credential its practitioners at least every 36-months. The three-year period must be within 36 months of the last delegated entities last Credentialing Committee approval date. As part of the recredentialing process, all credentialing information must be reverified except for work history, education, and training.

1. Performance Monitoring of the following items:
    a. Member complaints and grievances
    b. Quality Improvement activities
    c. Utilization Management activities, if applicable
    ~~d. Member Satisfaction Survey Data~~

## H. REPORTING REQUIREMENTS

The delegated entity will notify KHS's Provider Relations Department of the following:

1. A monthly roster of newly approved practitioners. The roster must include at a minimum, the specific data elements outlined below or use the standardized ICE roster format:

    a. Last Name
    b. First Name
    c. Middle Name
    d. Degree/Title
    e. Gender
    f. Practitioner Practice Addresses
    g. Practitioner phone, fax, and email, if applicable
    h. Social Security Number and Tax ID Number
    i. Specialty and Sub-Specialty
    j. All valid and current Medical License Numbers and expiration dates
    k. Board Status and/or Certifications
    l. DEA/CDS Number and expiration date
    m. NPI Number
    ~~m.~~n. Practitioner race, ethnicity and languages
    ~~n. Languages Spoken~~
    o. Date of Credentialing Committee and/or Peer Review Approval (credentialing effective date)
    p. Modified credentialing terms, if applicable

2. Quarterly, Delegated entity will submit the Healthcare Industry Collaboration Effort (HICE) Quarterly Credentialing Submission Form and Roster of providers credentialed, recredentialed and terminated providers and credentialing activities, during the specified reporting period.

3. At least semi-annually, submission of a roster of contracted participating practitioners which includes at a minimum, the specific data elements outlined below or use the standardized ICE roster format:

a. Last Name
b. First Name
c. Middle Name
d. Degree/Title
e. All valid and current Medical License Numbers and expiration dates
f. Board Status and/or Certifications
g. Gender
h. Languages Spoken
i. Practitioner Practice Addresses
j. Practitioner phone, fax, and email, if applicable
k. NPI and Tax ID Numbers
l. Specialty and Sub-Specialty
m. Credentialing Committee dates (initial and re-credentialing dates)
n. Modified credentialing terms, if applicable

4. Changes to its credentialing and re-credentialing policies and procedures, processes, delegation or sub-delegation, and criteria within thirty (30) days of the change.

5. Submit thirty (30) days prior or upon notification any changes in the status of any of the delegated entity's participating practitioners, including, but not limited to terminations, resignations, or extended leave (more than 4 weeks), and changes in privileges.

6. Notify within ten (10) days of becoming aware of significant changes in an individual practitioners credentialing or re-credentialing status, including, but not limited to, loss of hospital privileges, loss of restriction of any state license, loss of limit of DEA permit, ineligibility or exclusion from any federal program, or disciplinary action taken against a practitioner.

7. Should the Delegated Entity file a Section 805 with the Medical Board of California and a report to the National Practitioner Data Bank (NPDB) within fifteen (15) business days after the effective date of any adverse action against a practitioner, the Delegated Entity will notify KHS within 15-days business days.

## I. CREDENTIALING DECISIONS

To ensure that a consistent and equitable process is used throughout the KHS network, the credentialing and re-credentialing policies of the delegated entity will adhere to at least the same qualification standard and participation terms and conditions set forth in KHS' Credentialing Policy and Procedure. The delegated entity's policy and procedures shall include the practitioner's right to appeal according to applicable laws. KHS will report all delegated credentialing and re-credentialing decisions to its Physician Advisory Committee, within **thirty (30) days** receipt of the delegated entity's decisions for final action. KHS retains the right to approve or reject each individual practitioner and/or practitioner sites, and to terminate, suspend, and/or limit participation by any individual practitioner.

## J. REPORTING TO REGULATORY AGENCIES

Each delegated entity must file a Section 805 with the Medical Board of California and a report to the National Practitioner Date Bank (NPDB) within three (3) business days after the effective date of the adverse action, if the action is reportable.

**K. REVOCATION AND RESUMPTION OF DELEGATED FUNCTIONS**:

1. KHS, in its sole discretion, reserves the right to revoke any or all of the Delegated Functions at any time if it is determined that Delegated Functions are not being performed in accordance with the terms of this Exhibit, the Agreement, the Delegation Grid, all Applicable Requirements, and NCQA standards.

2. Upon notice to GROUP that any or all Delegated Functions are revoked, KHS will work with GROUP to transition revoked Delegated Functions to KHS. The resumption of revoked Delegated Functions will be at the sole discretion of KHS and may require a new Delegation Grid mutually agreed to and executed by the parties.

3. In the event of revocation of Delegated Functions by KHS, or termination of this Delegation Agreement by either party, GROUP will use best efforts to facilitate KHS's resumption of Delegated Functions, including to the extent applicable, assisting with the transition of members' care.

4. Notwithstanding KHS's ability to revoke delegated functions, GROUP's failure to perform the Delegated Functions or respond to any corrective action plan shall be considered a material breach of this Delegation Agreement.

5. The resumption of revoked Delegated Functions will be at the sole discretion of KHS. If KHS determines GROUP may resume some or all Delegated Functions, a new Delegation Grid will be mutually agreed to and executed by the parties.

6. KHS retains the right to approve, suspend and terminate individual practitioners for which KHS has delegated decision-making or deny participation of any Group practitioner provider services to Members of KHS' Medi-Cal Managed Care Health Plan.

## V. ATTACHMENTS

| | |
|---|---|
| Attachment A: | Delegated Credentialing Agreement (Exhibit and Attachment Grid) |

## VI. REFERENCES

| Reference Type | Specific Reference |
|---|---|
| Other | NCQA Accreditation Credentialing Standards ~~CR.8 Delegated Credentialing 2023~~2025 |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| Revised | 09/2025 | Revised policy to include new NCQA Standards that became effective 7/1/2025 pertaining to Delegates credentialing policies, verifications, ongoing monitoring, new credentialing information integrity (standards, audit, training and analysis) and delegation of credentialing. | Yolanda Herrera |
| Revised | 09-2024 | Revised policy entirely to align with NCQA Delegated Credentialing Standards CR.8 and New Delegated Credentialing Agreement Exhibit with outlined responsibility grid. P&P Renumbered from 4.32-P to Quality Performance 23.10-P Exhibit/Attachment A-Delegation Agreement is a new template approved by KHS Compliance, DSR Health Law and TMG Consultants. | Yolanda Herrera |
| Revised | 08-2019 | Policy revised after review by DSR Health Law, minor revisions incorporated at the request of Alec Stone, Attorney | Yolanda Herrera |
| Revised | 03-2017 | Policy revised to incorporate requirements of adopted legislation SB 137. Policy submitted and approved by DMHC | Unknown |
| Revised | 11-2012 | Attachment A revised. Only formatting changes applied to policy, no substantial changes. | Unknown |
| Effective | 11-2010 | Policy created by Provider Relations | Yolanda Herrera |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Physician Advisory Committee (PAC) | | ~~10/2/2024~~9/10/2025 |
| Board of Directors (BOD) | | ~~10/17/2024~~10/23/2025 |
| Choose an item. | | |

| **Regulatory Agencies** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Department of Health Care Services (DHCS) | | |
| Department of Managed Health Care (DMHC) | Revision 2017-03 revised to incorporate requirements of adopted legislation SB 137. Policy submitted and approved by DMHC. | |

| | | |
|---|---|---|
| Choose an item. | | |

| Chief Executive Leadership Approval * | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Chief Executive Officer | | |
| Chief Medical Officer | | |
| Chief Operating Officer | | |
| Choose an item. | | |
| *Signatures are kept on file for reference but will not be on the published copy | | |

**Policy and Procedure Review**

**KHS Policy & Procedure:** 23.10-P, Delegated Credentialing

**Last approved version:** N/A

**Reason for revision:** The Quality Performance Department revised policy to align with NCQA requirements. In addition, the policy was renumbered from Provider Network Management (4.32-P) to Quality Performance (23.10-P).

| **Director Approval** | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Jake Hall Sr.<br><br>Director of Quality Performance and Contracting | | |
| | | |

Date posted to public drive: _____

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

**EXHIBIT (INSERT # or Letter)**
**DELEGATION CREDENTIALING AGREEMENT**

This Delegate Agreement is incorporated into the Agreement and is entered into between Kern Health System ("KHS") and [INSERT ~~GROUP~~DELEGATE NAME] ("~~GROUP~~DELEGATE") as of [INSERT DATE] ("Effective Date"). Any term not otherwise defined within this Exhibit shall have the meaning specified in the Agreement. In the event of any conflict or inconsistency between the terms of this Exhibit and the terms of the Agreement, the terms of the Agreement shall govern and prevail.

## RECITALS

**A.** KHS is licensed under the California Knox-Keene Health Care Service Plan Act of 1975 as a health care service plan.

**B.** ~~GROUP~~DELEGATE is a peer review body within the meaning of California Business and Professions Code Section 805 and conducts plan and practitioner reviews, including utilization review, quality assurance and peer review within the meaning of California Health and Safety Code Section 1370 *et seq*., and California Evidence Code Section 1157.

**C.** KHS acknowledges and agrees that the delegation of its credentialing and re-credentialing requirements to ~~GROUP~~DELEGATE does not relieve KHS of its responsibility to ensure that ~~GROUP~~DELEGATE's credentialing and re-credentialing are consistent with laws and regulations.

D. In its sole discretion, KHS reserves the right to terminate this Delegation Agreement upon written notice; ~~GROUP~~DELEGATE may terminate this Delegation Agreement upon ninety (90) days prior written notice to KHS

## Section 1: General Representations and Obligations of ~~GROUP~~DELEGATE:

1.1 ~~GROUP~~DELEGATE warrants and represents that all delegated functions will be performed in compliance with all ~~Applicable~~ applicable ~~Requirements~~requirements, including but not limited to State and Federal regulations, DHCS contractual requirements, including Medi-Cal requirements attached as an exhibit to this Delegation Agreement, and current National Committee for Quality Assurance ("NCQA") Credentialing standards. Delegated functions are set forth in the Delegation Grid attached herewith as Exhibit (X).

1.2 KHS will give notice to ~~GROUP~~DELEGATE of any changes in State and Federal regulations and NCQA Credentialing standards. ~~GROUP~~DELEGATE agrees to promptly comply with any such required changes. ~~Group~~DELEGATE shall maintain any and all license, certificates, registrations, or permits required to perform credentialing and recredentialing.

1.3 ~~GROUP~~DELEGATE shall initially credential, and every thirty-six (36)-months thereafter, re-credential all ~~GROUP~~DELEGATE practitioners, in accordance with credentialing and re-credentialing policies and procedures, approved by KHS and which meet accreditation standards and requirements including, but not limited to NCQA credentialing requirements.

1.4 If KHS determines a corrective action plan is needed, ~~GROUP~~DELEGATE warrants that ~~GROUP~~DELEGATE will create and implement a corrective action plan approved by KHS.

1.5 If ~~GROUP~~DELEGATE does not meet the timeline to implement the corrective action plan agreed to by ~~GROUP~~DELEGATE and KHS, ~~GROUP~~DELEGATE agrees that KHS has the right to exercise any and all remedies available to KHS under the Agreement, including the issuance of sanctions and penalties.

1.6 ~~GROUP~~DELEGATE shall not further sub-delegate the performance of any Delegated Function, as defined below, to another organization or entity without the express written consent of KHS. Should ~~GROUP~~DELEGATE receive KHS's express written consent to sub-delegate the performance of any Delegated Function, the ~~GROUP~~DELEGATE's subcontractor must comply with the terms and conditions set forth in this Exhibit, the Agreement, the Delegation Grid, and all Applicable Requirements. In the event ~~GROUP~~DELEGATE sub-delegates, ~~GROUP~~DELEGATE agrees to monitor and oversee its subcontractor's performance of sub-delegated functions by conducting continuous monitoring and an annual oversight audit based on best practice and industry standards.

1.7 ~~GROUP~~DELEGATE will notify KHS of any changes to its NCQA healthcare accreditation status within thirty (30) days of change notification.

**Section 2: Delegated Functions:**

2.1 ~~GROUP~~DELEGATE shall be responsible for the performance of the credentialing functions, collectively referred to as "Delegated Functions."

2.2 The Delegation Grid, Attachment 1 to this Exhibit, is hereby incorporated by reference. The Delegation Grid identifies the Delegated Functions and ~~GROUP~~DELEGATE's responsibilities related to the Delegated Functions.

2.3 The Reporting/Oversight Requirements, Attachment 1 to this Exhibit, is hereby incorporated by reference.

2.4 Delegated Functions shall be performed in a manner consistent with the terms set forth in this Attachment 1 Exhibit, the Delegation Grid/Reporting Oversight Requirements, the terms and conditions of the Agreement, and all Applicable Requirements.

**Section 3: KHS Oversight:**

3.1 KHS shall maintain ultimate responsibility for adhering to and otherwise fully comply with the terms and conditions of KHS's agreements with Government Agencies and State and Federal law.

3.2 As part of ~~GROUP~~DELEGATE's acceptance of the Delegated Functions, ~~GROUP~~DELEGATE agrees to cooperate, participate and comply with KHS's monitoring and oversight activities. Such audits and assessments shall be performed in accordance with State requirements, NCQA standards, and KHS's delegation oversight policies and procedures.

3.3 KHS shall monitor and oversee ~~GROUP~~DELEGATE's performance of Delegated Functions by conducting continuous monitoring through quarterly reports and conducts an annual oversight audit of the credentialing files, documents and reports set forth in the Delegation Grid and Reporting Deliverable Index based on KHS's delegation oversight procedures.

i. Continuous monitoring will include but is not limited to the following:
   a. Review of credentialing files, documents and reports as described in the Delegation Grid and the Reporting Oversight;
   b. Review of delegates credentialing system controls policies and procedures, and audits. *(New agreements on or after 07/01/2025, must include credentialing information integrity information (CII). Prior to 07/01/2025, if credentialing system controls information is included in the delegated agreement, an update is not required. If the information was not included, then the agreement must include CII language prior to 07/01/2025).*

ii. KHS and ~~GROUP~~DELEGATE shall collaboratively develop the annual audit schedule for Delegated Functions.

iii. Location of the audit shall be on site at ~~GROUP~~DELEGATE's business office(s), and/or desk audit will be conducted at KHS's business office.

iv. The annual audit will include but is not limited to the review of credentialing files, documents and reports, including the delegates credentialing system controls as described in the Delegation Grid and the Reporting Oversight at least annually.

~~v.~~ KHS will also include a review of the ~~GROUP~~DELEGATE's credentialing policy and procedures including the policy for credentialing ~~system security controls~~ information integrity (CII) as required by NCQA Credentialing Standards ~~CR1~~CR8, Element A, Credentialing Information Integrity, Element B-Information Integrity Training, Element C-Information Integrity Training and Element D-Information Integrity Improvement Action.~~Element C, Factor 4. KHS will ensure the Group's monitoring process and reporting of unauthorized modifications is conducted annually in accordance with the delegation agreement requirements or its own policies and procedures as required by NCQA CR.8, Element C, Factor 5.~~

v. Upon reasonable advanced notice from KHS with mutually agreed date and time by both Parties, ~~GROUP~~DELEGATE will cooperate in the annual onsite review to be performed by KHS. Such review may include interviews of appropriate representatives of ~~GROUP~~DELEGATE, review of credentialing policies and procedures and review of files relating to practitioners or a request for copies of required documentation. KHS may, at its sole discretion, choose to use the results of the annual Healthcare Industry Collaborative Effort (HICE) audit or NCQA healthcare accreditation audit in lieu of conducting its own if the ~~GROUP~~DELEGATE is deemed capable to complete the specific delegation functions.

3.4 If KHS determines a corrective action plan is needed, ~~GROUP~~DELEGATE will create and, upon approval of the plan by KHS, implement such corrective action plan.

3.5 KHS shall monitor ~~GROUP~~DELEGATE's ongoing performance to ensure corrective actions take place in a timely manner.

3.6 KHS shall perform additional follow up audits, as necessary, to verify the completion of corrective action plan(s).

3.7 KHS, in its sole discretion, has the right to exercise any and all remedies available to KHS under the Agreement, including the issuance of sanctions and penalties.

3.8 KHS reserves the right to directly monitor and oversee ~~GROUP~~DELEGATE's subcontractor's performance of sub-delegated functions by conducting continuous monitoring and an annual oversight audit as necessary.

3.9 In the event KHS amends its KHS 23.10-P Delegated Credentialing policy, including Section 8.0 Reporting Requirements, it shall provide ~~GROUP~~DELEGATE notice of such amendments at least sixty (60) days before the effective date of any change(s) to the KHS policy referenced herein.

**Section 4: Revocation and Resumption of Delegated Functions:**

4.1 KHS, in its sole discretion, reserves the right to revoke any or all of the Delegated Functions at any time if it is determined that Delegated Functions are not being performed in accordance with the terms of this Exhibit, the Agreement, the Delegation Grid, all Applicable Requirements, and NCQA standards.

4.2 Upon notice to ~~GROUP~~DELEGATE that any or all Delegated Functions are revoked, KHS will work with ~~GROUP~~DELEGATE to transition revoked Delegated Functions to KHS. The resumption of revoked Delegated Functions will be at the sole discretion of KHS and may require a new Delegation Grid mutually agreed to and executed by the parties.

4.3 In the event of revocation of Delegated Functions by KHS, or termination of this Delegation Agreement by either party, ~~GROUP~~DELEGATE will use best efforts to facilitate KHS's resumption of Delegated Functions, including to the extent applicable, assisting with the transition of members' care.

4.4 Notwithstanding KHS's ability to revoke delegated functions, ~~GROUP~~DELEGATE's failure to perform the Delegated Functions or respond to any corrective action plan shall be considered a material breach of this Delegation Agreement.

4.5 ~~The resumption of revoked Delegated Functions will be at the sole discretion of KHS. If KHS determines GROUP may resume some or all Delegated Functions, a new Delegation Grid will be mutually agreed to and executed by the parties.~~

**Commented [YH1]:** Addressed in 4.2 - This is duplicated

4.6 KHS retains the right to approve, suspend and terminate individual practitioners for which KHS has delegated decision-making or deny participation of any ~~Group~~DELEGATE practitioner ~~provider~~ providing services to Members of KHS' Medi-Cal Managed Care Health Plan.

**Section 5: Deliverables:**

5.1 Deliverables must be made in the manner and time described in the Delegation Grid attached to this Agreement or as mutually agreed upon by parties.

**Section 6: Entire Delegation Agreement:**

6.1. This Delegation Agreement constitutes the entire understanding of the parties on this subject matter and supersedes any prior delegation agreements.

**Section 7: Termination of Delegation Agreement**

A. KHS has the right to terminate this Delegation Agreement, in its sole discretion, with or without cause. The term of this Delegation Agreement begins on the Effective Date and ends upon a written notice of termination by either party pursuant to the terms of this Section. KHS may terminate this Agreement with or without cause immediately upon written notice to ~~GROUP~~DELEGATE. ~~GROUP~~DELEGATE may terminate this Delegation Agreement with or without cause by providing ninety (90) days' written notice to KHS. In the event this Delegation Agreement is terminated, ~~GROUP~~DELEGATE agrees to assist, to the extent applicable, with the transition of members' care.

**IN WITNESS WHEREOF,** the parties signify their acceptance of the terms and conditions of this Delegation Agreement by their signatures below.

| | |
|---|---|
| **Kern Health System**<br>Executed by | Executed By: [INSERT NAME] |
| Name: | Name: |
| Title: | Title: |
| Signature: | Signature: |
| Date: | Date: |

**Remainder of page is left blank intentionally.**

**EXHIBIT X: Attachment #1**
**Delegation Grid**
**Effective (INSERT DATE)**

The purpose of this grid is to specify the activities delegated by KHS to ~~GROUP~~DELEGATE. All Delegated Functions are to be performed in accordance with NCQA credentialing accreditation standards and State and Federal regulatory requirements as modified from time to time. ~~GROUP~~DELEGATE agrees to be accountable for all responsibilities delegated by KHS and will not further delegate (sub-delegate) any such responsibilities without prior written authorization by KHS. ~~GROUP may collect the data necessary to assess member experience and clinical performance (e.g. Complaints, CAHPS results or other member experience data, HEDIS results, claims or other clinical data, etc.). This data is also available from KHS upon request by emailing (INSERT CONTACT). GROUP must provide periodic reports as required by KHS. Required reports and documents must be sent to KHS's Audits and Oversight Unit via secure FTP site or emailed at (INSERT CONTACT). DHCS and DMHC requirements as well as NCQA standards not identified in this Delegation Grid remain the responsibility of KHS.~~

## Credentialing

The Health Plan reviews Delegate's Credentialing activities in-order to ensure service levels, quality, and compliance with regulatory requirements. The Plan adheres to the most current Federal and State regulations and NCQA standards to comply with these requirements. The Plan retains the right to approve, suspend and terminate individual practitioners, providers and sites in situations where it has delegated decision making. The Plan retains overall responsibility for the following procedural or structural components.

| Requirement | Delegated Yes / No |
|---|---|
| **NCQA CR 1: Credentialing Policies**<br>**Developing and implementing policies which describe the process for credentialing and recredentialing health care practitioners. At a minimum, such policies shall specify the following:** | |
| Element A: Practitioner Credentialing Guidelines<br>1. The types of practitioners it credentials and recredentials.<br>2. The verification sources it uses.<br>3. The criteria for credentialing and recredentialing. Credentialing criteria is reviewed and approved by the Credentialing Committee, medical director or other designated peer review body.<br>4. The process for making credentialing and recredentialing decisions.<br>5. The process for managing credentialing files that meet Organization's established criteria (i.e. clean files) and those files that do not meet criteria.<br>~~5.~~6. The criteria for practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the Credentialing Committee or other designated peer-review body.<br>~~6.~~7. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner.<br>~~7.~~8. The process for notifying practitioners if information obtained during credentialing process varies substantially from the information they provided to Organization.<br>~~8.~~9. The process for notifying practitioners of the credentialing and recredentialing decision within ~~60~~ **30** calendar days of the credentialing committee's decision.<br>~~9.~~10. The medical director or other designated physician's direct responsibility and participation in the credentialing program.<br>~~10.~~11. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.<br>12. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty. | **Yes / No**<br><br>**Frequency: Annually, at minimum**<br><br>**Process: Annual Audit of Delegate's Policy and Procedures** |

| Requirement | Delegated Yes / No |
|---|---|
| ~~11.~~13. The process for documenting information and activities in credentialing files for maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates | |
| NCQA CR 1, **Element B:** Practitioner Rights<br>The Delegate notifies practitioners about their right to:<br>1. Review information submitted to support their credentialing application.<br>2. Correct erroneous information.<br>3. Receive the status of their credentialing or recredentialing application, upon request. | **Yes** / No<br><br>**Frequency: Annually, at minimum**<br><br>**Process: Annual Audit of Delegate's Policy and Procedures** |
| ~~**Element C:** Credentialing System Controls~~<br>~~The Delegate's credentialing process describes:~~<br>~~1. How primary source verification information is received, dated and stored.~~<br>~~2. How modified information is tracked and dated from its initial verification.~~<br>~~3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate.~~<br>~~4. The security controls in place to protect the information from unauthorized modification.~~<br>~~5.~~1. ~~How Organization monitors its compliance with the policies and procedures in factors 1–4 at least annually and takes appropriate action when applicable.~~ | ~~Yes~~ |
| ~~**Element D:** Credentialing System Controls Oversight~~<br>~~At least annually, the delegate demonstrates that it monitors compliance with its credentialing controls, as described in Element C, factor 5, by:~~<br>~~1. Identifying all modifications to credentialing and recredentialing information that did not meet Organization's policies and procedures for modifications.~~<br>~~2. Analyzing all instances of modifications that did not meet Organization's policies and procedures for modifications.~~<br>~~3.~~1. ~~Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.~~ | ~~Yes~~ |
| **NCQA CR 2: Credentialing Committee**<br>**The Delegate designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.** | |
| **Element A:** Credentialing Committee:<br>The Delegate's Credentialing Committee:<br>1. Uses participating practitioners to provide meaningful advice and expertise when it makes credentialing decisions.<br>2. Reviews credentials for practitioners who do not meet established thresholds.<br>3. Ensures that files that meet established criteria are reviewed and approved by a medical director, designated physician or the Credentialing Committee. | **Yes** / No<br><br>**Frequency: Annually, at minimum**<br><br>**Process: Annual Audit of Delegate's Policy and Procedures and Credentialing Minutes** |
| **NCQA CR 3: Credentialing Verification**<br>The Delegate **verifies and reverifies credentialing information through primary sources in accordance with applicable federal and/or state law, NCQA Standards, unless otherwise indicated.** | |
| NCQA CR 3, **Element A**: Verification of Credentials<br>The Delegate verifies that the following are within the prescribed time limits:<br>1. A current and valid license to practice.<br>2. A valid DEA or CDS certificate, if applicable.<br>3. Education and training as specified in the explanation. *<br>4. Board certification status, if applicable.<br>5. Work history. *<br>6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.<br>7. National Practitioner Identifier (NPI) Number | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's credentialing files and recredentialing files during the look-back period~~Yes~~ |

**Commented [YH2]:** Moved to CR8 - New Standard Credentialing Information Integrity

| Requirement | Delegated Yes / No |
|---|---|
| 8. Clinical privileges in good standing, if applicable (CMS/DMHC/DHCS)<br>***Initial credentialing only***<br>~~8.~~ | |
| **NCQA CR 3, Element B:** Sanction Information *Regardless of product participation<br>The Delegate verifies the following sanction information for credentialing<br>1. State sanctions, restrictions on licensure and limitations on scope of practice.<br>2. Medicare and Medicaid sanctions<br>i. Verification source: NPDB, AMA, SAM or FSMB<br>3. Medicare and Medicaid Sanctions and Exclusions<br>i. Verification source: California DHCS Medi-Cal Suspended and Ineligible Provider List<br>4. Medicare Exclusions:<br>i. Verification source: OIG or Medicare Exclusion Database (MED)<br>~~2.~~ **Example**: State Medicaid Agency **AND** OIG or NPDB **AND** one of following: AMA, FSMB, NPDB, SAM~~Medicare and Medicaid sanctions/exclusions/preclusions. Providers terminated from either Medicare or Medicaid, or on either the Office of Inspector General (OIG), the Medi-Cal Suspended and Ineligible Provider List (DHCS) or the EPLS/EEDP/SAM Database (CMS) may not participate in Health Plan's network; including Medicare Debarment and opt-out. (CMS/DHCS)~~ | **Yes / No**<br>**Frequency**: Annually, at minimum<br>**Process**: Annual Audit of Delegate's credentialing files and recredentialing files during the look-back period~~Yes~~ |
| **NCQA CR 3, Element C:** Credentialing Application<br>Applications for credentialing include the following:<br>1. Reasons for inability to perform the essential functions of the position.<br>2. Lack of present illegal drug use.<br>3. History of loss of license and felony convictions.<br>4. History of loss or limitation of privileges or disciplinary actions.<br>5. Current malpractice insurance coverage.<br>~~5.~~6. Practitioner race, ethnicity and language.<br>~~6.~~7. Current and signed attestation confirming the correctness and completeness of the application. | **Yes / No**<br>**Frequency**: Annually, at minimum<br>**Process**: Annual Audit of Delegate's credentialing files and recredentialing files during the look-back period~~Yes~~ |
| **CMS/DHCS/DMHC Requirements for Opting Out of Medicare & Hospital Privileges**<br>**The Delegate has policies and procedures:**<br>• **To ensure providers have not opted out of Medicare (Medicare MC-Manual Chapter 6, § 60.2)**<br>• Prohibits employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Report) (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract<br>• Verifies the practitioner has privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. ((Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract) | **Yes / No**<br>**Frequency**: Annually, at minimum<br>**Process**: Annual Audit of Delegate's credentialing files and recredentialing files during the look-back period. |
| **NCQA CR 4: Recredentialing Cycle Length**<br>**The Delegate ~~formally~~ conducts timely ~~recredentials~~ recredentialing of its practitioners at least every 36 months.** | |
| **NCQA CR 4, Element A:** Recredentialing Cycle Length<br>The Delegate conducts timely recredentialing.<br>The 36-month recredentialing cycle begins on the date of the previous credentialing decision. (NCQA counts the 36-month cycle to the month, not the day)<br>Each file contains the Credentialing Committee decision date.<br>~~**Element A:** Recredentialing Cycle Length~~<br>~~The length of the recredentialing cycle is within the required 36-month time frame.~~ | **Yes / No**<br>**Frequency**: Annually, at minimum<br>**Process**: Annual Audit of Delegate's credentialing |

| Requirement | Delegated Yes / No |
|---|---|
| | files and recredentialing files during the look-back period.~~Yes~~ |
| ~~This applies to practitioners in the scope of credentialing as defined in CR1, Element A, B and APL 22-013 Screening and Enrollment as applicable. (requirements indicated with * are not required at recredentialing)~~ | ~~Yes~~ |
| **CMS/DHCS (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter APL 19-004) – Review of Performance**<br>Recredentialing policies and procedures requires information from quality improvement activities and member complaints in recredenti~~a~~ling decision-making process (CMS/DHCS) | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's credentialing files and recredentialing files during the look-back period. |
| ~~Each file contains the Credentialing Committee decision date.~~<br>~~The 36-month recredentialing cycle begins on the date of the previous credentialing decision. (NCQA counts the 36-month cycle to the month, not the day)~~ | ~~Yes~~ |
| **NCQA CR 5: Ongoing Monitoring and Interventions**<br>The Delegate **develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.** | |
| **Element A:** Ongoing Monitoring and Interventions *Regardless of product participation<br><br>The Delegate implements ongoing monitoring and makes appropriate interventions by:<br>1. Collecting and reviewing Medicare and Medicaid sanctions.<br>2. Collecting and reviewing sanctions and limitations on licensure.<br>3. Collecting and reviewing complaints.<br>4. Collecting and reviewing information from identified adverse events.<br>5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1–4. | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures, monitoring reports and documentation of interventions |
| **NCQA CR 5, Element B:** Appropriate Interventions<br>The Delegate reports the findings from CR-5, Element A 1-5 (as per their policies and procedures) to the Credentialing Committee, or other designated peer-review body, and implements interventions as needed. The report includes: affected practitioner, incident date, quality issue, date reported to committee and action take.<br><br>Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan's Credentialing Manager @ Yolanda.Herrera@khs-net.com, with the delegate's plan of action for the identified provider and date it was reviewed by their Credentialing/Peer Review Committee. | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures, monitoring reports and documentation of interventions |
| **CMS – Contracts Opt-Out Provisions (Medicare Managed Care Manual Chapter 6 §60.2)**<br>The Delegate maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare Program. | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures, monitoring reports, documentation of interventions and immediate notification of |

| Requirement | Delegated Yes / No |
|---|---|
| | identified providers to the health plan. |
| **DHCS - Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS All Plan Letter APL 19-004)**<br>The Delegate verifies that their contracted providers have not been terminated as a Medi-Cal provider or have not been placed on the Suspended and Ineligible Provider List. | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures, monitoring reports, documentation of interventions and immediate notification of identified providers to the health plan. |
| **CMS Monitoring Preclusions List**<br>The Delegate maintains a documented process for monitoring 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.<br>Delegates are responsible for reviewing these reports within thirty (30) days of its release and notify IEHP of any providers identified, to include the delegate's plan of action. | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures, monitoring reports, documentation of interventions and immediate notification of identified providers to the health plan. |
| **NCQA CR 6: Notification to Authorities and Practitioner Appeal Rights**<br>The Delegate **that has taken action against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process.** | |
| NCQA CR 6, **Element A:** Actions Against Practitioners<br>The Delegate has policies and procedures for:<br>1. Identifying the range of options available for taking actions against practitioners.<br>2. Making the appeal process known to practitioners.<br>3. Policy states that the delegate cannot have an attorney, if the practitioner does not have attorney representation [CA Bus. & Prof. Code 809.3(c)]<br>~~2.~~4. Ensure that the majority of hearing panel members are peers of the affected practitioner (a hearing officer does not meet intent) [CMS Chapter 6 § 60.4] | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures |
| **NCQA CR 7: Assessment of Organizational Providers**<br>The Delegate **has written policies and procedures for the initial and ongoing assessment of providers with which it contracts.** | |
| NCQA CR 7, **Element A:** Review and Approval of Provider<br>The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:<br>1. Confirms that the provider is in good standing with state and federal regulatory bodies.<br>2. Confirms that the provider has been reviewed and approved by an accrediting body.<br>3. Conducts an onsite quality assessment if the provider is not accredited. | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures |
| NCQA CR 7, **Element B:** Medical Providers<br>The Delegate includes at least the following medical providers in its assessment:<br>1. Hospitals<br>2. Home Health Agencies | Yes / No<br><br>**Frequency**: Annually, at minimum |

| Requirement | Delegated Yes / No |
|---|---|
| 3. Skilled Nursing Facilities<br>4. Free-Standing Surgical Centers * (CA H&S 1248.1 requires accreditation) | **Process**: Annual Audit of Delegate's policies and procedures |
| **CMS Required Provider Types: [CMS CHAPTER 6 § 70]**<br>If the Health Plan includes (Medicare), the Delegate includes the additional provider types in its assessment:<br>5. Hospices<br>6. Clinical Laboratories<br>7. Comprehensive Outpatient Rehabilitation Facilities (CORF)<br>8. Outpatient Physical Therapy Providers<br>9. Speech Pathology Providers<br>10. Outpatient Diabetes Self-Management Training Providers<br>11. Portable X-Ray Suppliers<br>12. Rural Health Clinics (RHC)<br>13. Federally Qualified Health Centers (FQHC) | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures |
| **NCQA CR 7, Element C:** Behavioral Healthcare Providers<br>The Delegate includes behavioral health care facilities providing mental health or substance abuse services in the following settings: 1. Inpatient, 2. Residential, 3. Ambulatory | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures |
| **NCQA CR 7, Element D**<br>**The Delegate assesses contracted medical health care providers against the requirements and within the time frame in Element A.**<br><br>The Delegate maintains a checklist, spreadsheet, or other record that it assessed providers against the requirements.~~Assessing Behavioral Healthcare Providers~~<br>~~The Delegate assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A.~~ | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's evidence the organizational providers were assessed per NCQA CR-7, Element A |
| **NCQA CR 7, Element E**<br>Assessing Behavioral Healthcare Providers<br>The Delegate assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A. | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's evidence the organizational providers were assessed per NCQA CR-7, Element A |
| **NCQA CR 8: Credentialing Information Integrity:**<br>**The Delegate has credentialing information integrity policies and procedures.** | |
| **NCQA CR 8, Element A:**<br>1. The Delegate has credentialing information integrity policies and procedures that specify the scope of credentialing information and the protection of each of the following types of credentialing information:<br>a) The practitioner application and attestation.<br>b) Credentialing documents received from the source or agent.<br>c) Documentation of credentialing activities: | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and |

| Requirement | Delegated Yes / No |
|---|---|
| - Verification dates.<br>- Report dates (e.g., sanctions, complaints, identified adverse events).<br>- Credentialing decisions.<br>- Credentialing decision dates.<br>- Signature or initials of the verifier or reviewer.<br>d) Credentialing Committee minutes.<br>e) Documentation of clean file approval, if applicable.<br>f) Credentialing checklist, if used.<br>2. The staff responsible for performing credentialing activities and specify the titles of staff who are:<br>a. Responsible for documenting credentialing activities.<br>b. Authorized to modify (edit, update, delete) credentialing information.<br>- Policies and procedures state if no staff are authorized to modify credentialing information under any circumstance, policies must include statement.<br>c. Responsible for oversight of credentialing information integrity functions, including auditing.<br>3. The process for documenting updates to credentialing information. The policies and procedures:<br>a. Specify when updates to existing credentialing information is appropriate (e.g., to update expiring credentials).<br>b. Describe the delegate's process for documenting the following when updates are made to credentialing information:<br>- When (date and time) the information was updated.<br>- What information was updated.<br>- Why the information was updated.<br>- Staff who updated the information.<br>4. Inappropriate documentation and updates. The delegate's policies and procedures specify that the following documentation and updates to credentialing information are inappropriate:<br>a) Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).<br>b) Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as a new credential)<br>c) Fraudulently altering existing documents (e.g., credentialing minutes, clean file reports, ongoing monitoring reports).<br>d) Attributing verification or review to an individual who did not perform the activity.<br>e) Updates to information by unauthorized individuals<br>5. Auditing, documenting and reporting identified information integrity issues.<br>a) The delegate's policies and procedures specify the delegate audits credentialing staff documentation and updates.<br>- The organization does not have to include the audit methodology, but must indicate that an annual audit is performed.<br>b) Describe the process for documenting and reporting inappropriate documentation and updates to: designated individual(s) when it identifies fraud and misconduct.<br>c) Specify consequences for inappropriate documentation and updates. | procedures and annual audit report. |
| **NCQA CR 8, Element B: Information Integrity Training**<br>The Delegate annually trains credentialing staff on:<br>1. Inappropriate documentation and updates as defined in NCQA CR 8, Element A, Factor 4.<br>2. Audits of staff, documenting and reporting information integrity issues. Training | **Yes / No**<br><br>**Frequency**: Annually, at minimum |

| Requirement | Delegated Yes / No |
|---|---|
| includes items outlined in NCQA CR 8, Element A, Factor 5.<br>a) The process for documenting and reporting inappropriate documentation and updates to: designated individual(s) when identified.<br>b) The consequences for inappropriate documentation and updates. | **Process**: Annual Audit of Delegate's policies and procedures including training material outlined by NCQA |
| **NCQA CR 8, Element C: Information Integrity Auditing and Analysis**<br>The Delegate annually:<br>i. Audits for inappropriate documentation and updates to credentialing information. Conducts qualitative analysis of inappropriate documentation and updates. | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures including CII Audit Tool and Analysis Report |
| **NCQA CR 8, Element D: Information Integrity Improvement Actions**<br>The Delegate annually:<br>1. Implements corrective actions to address all inappropriate documentation and updates found in Element C.<br>2. Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element C. | **Yes / No**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of documentation of CII Audit Tool and Analysis Report and Improvement actions, if applicable |
| **NCQA CR ~~89~~: Delegation of CR**<br>**If the Health Plan delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.**<br><br>**~~CR8~~ CR9 / Factor 3 – Reporting Requirements: ~~outlined below~~See Reporting Grid Exhibit** | Organization shall not sub-delegate the performance of CR functions to another organization or entity without the express written consent of the Plan. |
| **NCQA CR 9, Element A: Written Delegation Agreement**<br>The Delegate remains responsible for credentialing and recredentialing its practitioners, even if its delegates all or part of these activities.<br><br>The written delegation agreement:<br>1. Is mutually agreed upon.<br>2. Describes the delegated activities and the responsibilities of KHS and the Delegate.<br>3. Requires at least semiannual reporting of the delegate to KHS Credentialing Manager. *See attached<br>4. Describes the process by KHS evaluates the Delegate's performance, including Credentialing Information Integrity.<br>5. Specifies that KHS retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if KHS delegates decision making<br>6.Describes the remedies available to KHS if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. | **KHS Oversight**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of four randomly selected sub-delegates (or all sub-delegates if the Delegate has fewer than four sub-delegates) |
| **NCQA CR 9, Written Delegation Agreement CMS/DHCS Requirements**<br>i. All Delegation agreements include a statement that Delegate's must adhere to MA requirements. [Source: Medicare Managed Care Manual, Chapter 11 § 110.2]<br>ii. The written delegation agreement must require at least quarterly reporting of the delegated entity to KHS [Medi-Cal Contract Exh. 4-QI Activities]<br>iii. Evidence: Review of at least quarterly reporting of the delegated entity to KHS. [Medi-Cal Contract Exh. 4-QI Activities] | **KHS Oversight**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of four randomly selected sub-delegates (or all sub- |

| Requirement | Delegated Yes / No |
|---|---|
| | delegates if the Delegate has fewer than four sub-delegates) |
| **NCQA CR 9, Element C: Review of Credentialing Activities**<br>For delegation agreements in effect for 12 months or longer, KHS:<br>1. Annually reviews the Delegate's credentialing policies and procedures.<br>2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.<br>3. Annually evaluates the Delegate's performance against NCQA standards for delegated activities.<br>4. Semi-annually evaluates regular reports as specified in Element A.<br>5. Annually monitors the Delegate's credentialing information integrity to ensure that the IPA monitors its compliance with the delegation agreement or with the IPA's policies and procedures.<br>6. Annually acts on all findings from factor 5 and implements a quarterly monitoring process until the Delegate demonstrates improvement for one finding over three (3) consecutive quarters. | **KHS Oversight**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of four randomly selected sub-delegates (or all sub-delegates if the Delegate has fewer than four sub-delegates) |
| **NCQA CR 9, Element D: Opportunities for Improvement**<br>For delegation agreements in effect for 12 months or longer, KHS Conducts an audit of the effectiveness of corrective actions (Factor 6) on the findings for each delegate 3-6 months after completion of the annual audit. | **KHS Oversight**<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: KHS reviews reports for opportunities for improvement if applicable and appropriate actions to resolve issues from up to or four randomly selected delegates (or all sub-delegates if the Delegate has fewer than four sub-delegates) |
| **~~CR9~~CA H&S Code: Identification of HIV/AIDS Specialist**<br>**The Delegate documents and implements a method for identifying HIV/AIDS Specialist to who appropriate members may be given a standing or extended referral per criteria CA H&SC 1374.16, DMHC Tag (QM-004), DHCS MMCD All Plan Letter)** | |
| 1. There is written policy and procedure describing the process that the delegate identifies or reconfirms the appropriately qualified physician who meets the definition of an HIV/AIDS Specialist according to California State regulation on an annual basis.<br>2. On an annual basis, the delegate identifies or reconfirms the appropriate qualified physician who meets the definition of an HIV/AIDS Specialist according to California State regulation.<br>3. The list of identified qualifying physician is provided to the delegates department responsible for authorizing standing referrals. | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and procedures & evidence of identified/reconfirmed physicians and distribution of findings |
| **CA AB2581: Behavioral Health Only**<br>**The Delegate has written policy and procedures describing the credentialing turnaround time for behavioral health providers.** | |
| 1. The initial credentialing decision is to be completed within 60-days after receiving a completed credentialing application.<br>2. Written policy and procedures includes notifying the applicant within 7-business days to verify receipt and inform the applicant whether the application is complete. | Yes / No<br><br>**Frequency**: Annually, at minimum<br><br>**Process**: Annual Audit of Delegate's policies and |

23.10-P Attachment A, Delegated Credentialing Agreement Exhibit

| Requirement | Delegated Yes / No |
| --- | --- |
| | procedures & evidence initial credentialing file review |

## DHCS Provider Screening and Enrollment

| Requirement | Delegated Yes / No |
|---|---|
| **APL 22-013 Provider Screening and Enrollment (DHCS Credentialing Verification & Recredentialing)**<br>**Title 42 CFR, Section 438.602(b) requires the Medi-Cal Program to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers as well as prospective network providers.** | |
| ~~The Delegate ensures the following practitioners and providers meet DHCS enrollment and screening requirements:~~<br>~~1. Limited Risk: physician or non-physician practitioners and medical groups or clinics:~~<br>~~• Ambulatory Surgical Centers (ASCs)~~<br>~~• End-Stage Renal Disease (ESRD) facilities~~<br>~~• Federally Qualified Health Centers (FQHCs)~~<br>~~• Histocompatibility laboratories~~<br>~~• Hospitals, including Critical Access Hospitals (CAHs)~~<br>~~• Indian Health Service (IHS) facilities~~<br>~~• Mammography screening centers~~<br>~~• Mass immunization roster billers~~<br>~~• Organ Procurement Organizations (OPOs)~~<br>~~• Portable x-ray suppliers~~<br>~~• Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or the NASDAQ • Public or Government-Owned Ambulance Services Suppliers~~<br>~~• Religious Nonmedical Health Care Institutions (RNHCIs)~~<br>~~• Rural Health Clinics (RHCs)~~<br>~~• Radiation therapy centers~~<br>~~• Skilled Nursing Facilities (SNFs)~~<br>~~2. Moderate Risk:~~<br>~~• Community mental health centers~~<br>~~• Comprehensive outpatient rehabilitation facilities~~<br>~~• Currently enrolled (re-validating) home health agencies~~<br>~~Exception: Any such provider that is publicly traded on the NYSE or the NASDAQ is considered "limited" risk~~<br>~~• Currently enrolled (re-validating) suppliers of Durable Medical Equipment,~~<br>~~• Prosthetics, Orthotics, or Supplies (DMEPOS)~~<br>~~Exception: Any such supplier that is publicly traded on the NYSE or~~<br>~~• NASDAQ is considered "limited" risk~~<br>~~• Hospice organizations~~<br>~~• Independent clinical laboratories~~<br>~~• Independent diagnostic testing facilities~~<br>~~• Non-public, non-government owned or affiliated ambulance services suppliers~~<br>~~3. High Risk:~~<br>~~• Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS~~<br>~~• Providers prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months~~<br>~~• Diabetes Prevention Program (DPP) providers~~ | ~~Yes~~ |
| The Delegate ensures practitioners and providers meet DHCS enrollment and screening requirements (distinct and separate from credentialing requireements) where a DHCS state-level enrollment pathway exists pursuant to APL 22-013. | **Yes**<br><br>**Frequency**: At initial credentialing, recredentialing & monthly |

| Requirement | Delegated Yes / No |
|---|---|
| The Delegate verifies enrollment in Medi-Cal through the DHCS Provider Enrollment Portal to confirm the practitioner or provider meets enrollment and place-of-business requirements appropriate and adequate for the services billed or claimed to the Medi-Cal Program as relevant to scope of practice or type of business. | monitoring<br><br>**Process**: Annual Audit of Delegate's policies and procedures, monitoring reports, source verification in initial credentialing, recredentialing, and immediate notification to the health plan of identified providers who no longer appear enrolled. |
| The Delegate ensures that practitioners and providers meet the Medi-Cal Program screening and enrollment requirements described in DHCS APL 22-013. | Yes |
| The Delegate monitors practitioners and providers are in good standing with the Medi-Cal Program at least monthly. | Yes |

## REPORTING / OVERSIGHT REQUIREMENTS

| Requirement | Delegated Yes / No |
|---|---|
| **NCQA CR 8 / Factor 3: Delegation of CR - Reporting**<br>**The organization must receive regular reports from all delegates, even NCQA-Accredited delegates.** | |
| **1.1 REPORT: ROSTER OF NEWLY APPROVED PRACTITIONERS**<br>**1.2 FREQUENCY:** MONTHLY (Received no later than the 15th of each month)<br>**1.3 RECIPIENT:** KHS MANAGER (Yolanda Herrera at Yolanda.herrera@khs-net.com or Credentialing@khs-net.com)<br><br>The roster must include at a minimum, the specific data elements outlined below or use the standardized HICE roster format:<br>a. Last Name<br>b. First Name<br>c. Middle Name<br>d. Degree/Title<br>e. Gender<br>f. Practitioner Practice Addresses<br>g. Practitioner phone, fax, and email, if applicable<br>h. Social Security Number and Tax ID Number<br>i. Specialty and Sub-Specialty<br>j. All valid and current Medical License Numbers and expiration dates<br>k. Board Status and/or Certifications<br>l. DEA/CDS Number and expiration date<br>m. NPI Number<br>~~m.~~n. Practitioner race, ethnicity and languages<br>~~n.~~o. Languages Spoken<br>~~o.~~p. Date of Credentialing Committee and/or Peer Review Approval (credentialing effective date)<br>~~p.~~q. Modified credentialing terms, if applicable | Yes |
| **2.1 REPORT: QUARTERLY CREDENTIALING SUBMISSION FORM & ROSTER**<br>**2.2 FREQUENCY:** QUARTERLY (Due Dates: 1st Qtr: May 15th, 2nd Qtr: August 15th, 3rd Qtr: | Yes |

| Requirement | Delegated Yes / No |
|---|---|
| November 15th and 4th Qtr: February 15)<br>**2.3 RECIPIENT:** KHS MANAGER (Yolanda Herrera at Yolanda.herrera@khs-net.com or Credentialing@khs-net.com)<br><br>Delegated entity will submit the Healthcare Industry Collaboration Effort (HICE) Quarterly Credentialing Submission Form and Roster of providers credentialed, recredentialed and terminated providers and credentialing activities, during the specified reporting period. | |
| **3.1 REPORT: SEMI-ANNUAL ROSTER**<br>**3.2 FREQUENCY:** Due Dates: 1st Report: August 15th Covers Jan 1st – June 30th) and 2nd Report: February 15th Covers July 1st – December 31st)<br>**3.3 RECIPIENT:** KHS MANAGER (Yolanda Herrera at Yolanda.herrera@khs-net.com or Credentialing@khs-net.com)<br><br>Roster of contracted participating practitioners which includes at a minimum, the specific data elements outlined below or use the standardized HICE Roster format:<br>a. Last Name<br>b. First Name<br>c. Middle Name<br>d. Degree/Title<br>e. All valid and current Medical License Numbers and expiration dates<br>f. Board Status and/or Certifications<br>g. Gender<br>h. Languages Spoken<br>i. Practitioner Practice Addresses<br>j. Practitioner phone, fax, and email, if applicable<br>k. NPI and Tax ID Numbers<br>l. Specialty and Sub-Specialty<br>m. Credentialing Committee dates (initial and re-credentialing dates)<br>n. Modified credentialing terms, if applicable | Yes |
| **4.1 REPORT: ADDITIONAL NOTIFICATIONS**<br>**4.2 FREQUENCY:** Annual / Within 30 days of change / 30 days prior or upon notification of change / Within 10 business days / Within 15 business days of effective date of adverse decision **as indicated below.**<br>**4.3 RECIPIENT:** KHS MANAGER (Yolanda Herrera at Yolanda.herrera@khs-net.com or Credentialing@khs-net.com)<br><br>**Additional Notifications:**<br>a. Annually, or as part of annual oversight audit, ~~GROUP~~DELEGATE shall provide a copy of its credentialing and re-credentialing policies and procedures and a copy of its annual credentialing system controls oversight report, including any corrective actions.<br>b. Any revisions to the NCQA standards shall be deemed to be a mandated amendment to this Delegation Agreement.<br>c. Changes to its credentialing and re-credentialing policies and procedures, processes, delegation or sub-delegation, and criteria within thirty (30) days of the change.<br>d. Submit thirty (30) days prior or upon notification any changes in the status of any of the delegated entity's participating practitioners, including, but not limited to terminations, resignations, or extended leave (more than 4 weeks), and changes in privileges.<br>e. Notify within ten (10) business days, excluding holidays and weekends, of becoming aware of significant changes in an individual practitioners credentialing or re-credentialing status, including, but not limited to, loss of hospital privileges, loss of restriction of any state license, loss of limit of DEA permit, ineligibility or exclusion from any federal program, or disciplinary action taken against a practitioner.<br>f. ~~GROUP~~DELEGATE shall file a Section 805 with the Medical Board of California and a | Yes |

| Requirement | Delegated Yes / No |
|---|---|
| report to the National Practitioner Data Bank (NPDB) within fifteen (15) business days after the effective date of any adverse action against a practitioner if the action is reportable | |

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Credentialing Information Integrity | **Policy #** | 23.23-I |
| **Policy Owner** | Contracting/Quality Performance | **Original Effective Date** | 9/10/2025 |
| **Revision Effective Date** | 09/2025 | **Approval Date** | 9/10/2025 |
| **Line of Business** | ☒ Medi-Cal ☒ Medicare ☐ Corporate | | |

## I. PURPOSE

The purpose of this policy is to demonstrate Kern Health Systems (KHS) commitment to protecting the integrity of credentialing information used in the credentialing process by maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates in compliance with the National Committee for Quality Assurance (NCQA) standards related to CR8, Credentialing Information Integrity.

## II. POLICY

Ensuring all credentialing activities related to receiving, verifying, and processing an application for initial and/or recredentialing to Kern Health Systems (KHS) provider network are protected against inappropriate documentation or updates, are confidential under quality improvement and peer review protected regulations. This process also includes implementing training and auditing procedures including corrective actions as appropriate

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| CII | Credentialing Information Integrity (NCQA Standards) |
| NCQA | National Committee for Quality Assurance |
| PAC | Physician Advisory Committee (Credentialing Committee) |

## IV. PROCEDURES

### A. SCOPE OF CREDENTIALING INFORMATION (CR8.A-1)

1. KHS maintains and safeguards the information used in the credentialing and recredentialing process against inappropriate documentation and updates. Credentialing information protected under this integrity policy will include:
   - The practitioner application and attestation.
   - Credentialing documents received from the source or agent.
   - Documentation of credentialing activities:
     - Verification dates.
     - Report dates (e.g., sanctions, complaints, identified adverse events)
     - Credentialing decisions.
     - Credentialing decision dates.
     - Signature or initials of the verifier or reviewer.
   - Credentialing Committee minutes.
   - Documentation of clean file approval, if applicable.
   - Credentialing checklist, if used

### B. STAFF RESPONSIBLE FOR PERFORMING CREDENTIALING ACTIVITES (CR8.A-2)

1. The titles of staff responsible for documenting credentialing activities include the following:
   - Credentialing Coordinators
   - Credentialing Leads
   - Credentialing Supervisor
   - Credentialing Manager

2. Credentialing Staff are assigned user roles based on areas of responsibility as defined by their job description. User roles are assigned specific read/write system access as necessary to perform their duties which may include editing or updating the credentialing information;

| STAFF ROLE | AUTHORIZED TO MODIFY: |
|---|---|
| Medical Director | Update (Notes or dates of approval/denial, only) |
| Credentialing Manager | Edit, Update, Delete |
| Credentialing Leads | Edit, Update, Delete |
| Credentialing Coordinator | Edit, Update, Delete* (*with manager review/approval) |
| Credentialing Committee Chair | Update (limited to notes or dates of approval/denial, only) |

3. Primary source verifications may not be modified (edited/updated) when verification information changes, rather a new primary source verification will be completed.

4. Other credentialing activities and documents may be updated if the policy identifies that credentialing information changes and/or updates are appropriate.

5. The Credentialing Manager is responsible for the oversight of credentialing information integrity functions, including the audit monitoring process and corrective actions.

**C. PROCESS FOR DOCUMENTING UPDATES TO CREDENTIALING INFORMATION (CR8.A-3)**

Updates to existing credentialing information is appropriate if credentialing information changes:

1. When an update needs to be made to credentialing information, the Credentialing system's audit log functionality will document the date and time the update was made and who made the update.

2. When a new verification is required, the verification or system will include all appropriate documentation requirements to include the credentialing staff identifier (initials or staff identifier), date of the verification and stored in the applicant's credentialing electronic file and/or credentialing system.

3. When updates to the credentialing information are made, the date/time (when) will be captured electronically in the credentialing system and/or documented within the provider's electronic file.

4. When data requires an update, such as when the element expires prior to committee and requires a new verification, it does not alter a previously primary source verified record, rather a new verification (based on current data) will be completed. The original verification documentation is retained in the provider's electronic file and/or credentialing system.

    a. Credentialing Staff will include relevant explanations and reasons regarding what information was updated on the credentialing application checklist.

    b. The documentation will include the credentialing information that was updated (what), the reason for the update (why), and the staff identifier (who) that made the update in the credentialing system or credentialing electronic file.

    c. For updates to primary source verified data, the Credentialing Staff documents the data verifications on the application processing checklist and will make notation as to the change (why), contact method and/or name (staff), and will also update the credentialing system *(Symplr/Cactus)* to track the updates to include who made the update and the date and time it was made (when).

    d. The Credentialing Staff enters information regarding the update into the appropriate field (described above).
    **Type of updates to existing credentialing that are appropriate:**
        - *Updates to expired credentials (License, Certifications or other credentials)*
        - *Changes to provider data information*
        - *Error/Omission identified such as typographical errors*
        - *New information is available and needs to be added*
        - *Documents appended to incorrect provider profile*

5. **Inappropriate Documentation and Updates: The following documentation and updates to credentialing information are considered inappropriate: (CR8.A-4)**
    - Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verification date, attestation date, ongoing monitoring dates)
    - Creating documents without performing the activity (e.g., photocopying a prior credential and updating information as a new credential.)
    - Fraudulently altering existing documents (e.g., committee minutes, clean-file reports, ongoing monitoring logs)
    - Attributing verification or review to an individual who did not perform the activity.
    - Updates to information by unauthorized individuals.

6. KHS Credentialing Staff, whenever possible, should not delete a provider record from the credentialing system, without the approval of the Credentialing Manager. In the event of a duplicate provider record or the provider has withdrawn their application, the following steps will be followed:

    a. All relevant data must be migrated to the correct provider record and the duplicate record is identified as "DUP" at the end of the last name of the duplicate record. **Example**: Smith DUP The credentialing/verification status shall be entered as "Orphaned" to indicated abandonment of the record.
    b. Providers who have "**withdrawn**" application will be closed out according to the credentialing internal procedure - Reference Document "Withdrawn Application Instructions." The credentialing/verification status shall be updated as "Withdrawn" to indicated abandonment of the application process and Credentialing Staff will enter notes to include the date and person submitting the request authorizing the application to be withdrawn.

**D. AUDITING, DOCUMENTING AND REPORTING INFORMATION INTEGRITY ISSUES (CR8.A-5)**

KHS completes an annual credentialing information integrity audit of the credentialing staff's documentation and updates the credentialing information.

1. The credentialing information integrity audit will be completed using the CII Audit and Analysis tool (Attachment A).

2. Inappropriate documentation or updates identified will be tracked on the CII Audit and Analysis tool and the findings will be reported to the *Physician Advisory Committee* for review and determination of actions as appropriate.

3. If KHS identifies fraud and misconduct, it must be reported to NCQA's Reportable Events Reporting Hotline by the Credentialing Manager.

4. If inappropriate documentation and updates are identified during the credentialing information integrity audit, consequences will be determined based on the severity of the issue. These may include, but are not limited to:
    - Education and additional training with reaudit within 3-6 months

- Implementation of a Performance Improvement Plan if continued non-compliance
- Corrective action including but not limited to: verbal or written warning documented in the employee's personnel file and termination of employment.

## E. INFORMATION INTEGRITY TRAINING (CR8.B-1)

1. KHS trains credentialing staff on inappropriate documentation and updates to the credentialing activities.

   **Training materials specify that the following actions related to credentialing documentation and updates are considered inappropriate:**
   - Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verification date, attestation date, ongoing monitoring dates)
   - Creating documents without performing the activity (e.g., photocopying a prior credential and updating information as a new credential.)
   - Fraudulently altering existing documents (e.g., committee minutes, clean-file reports, ongoing monitoring logs)
   - Attributing verification or review to an individual who did not perform the activity.
   - Updates to information by unauthorized individuals.

   **Credentialing information includes:**
   - The practitioner application and attestation.
   - Credentialing documents received from the source or agent.
   - Documentation of credentialing activities
     - Verification dates.
     - Report dates.
     - Credentialing decisions.
     - Credentialing decision dates.
     - Signature or initials of the verifier or reviewer.
   - Credentialing Committee minutes.
   - Documentation of clean file approval, if applicable.
   - Credentialing checklist, if used

2. **Auditing (CR8.B-2)**: KHS completes an annual credentialing information integrity audit of the credentialing staff's documentation and updates to the credentialing information. The credentialing information integrity audit will be completed using the CII Audit and Analysis tool. Inappropriate documentation or updates identified will be tracked on the CII audit and analysis tool and the findings will be reported to the *Credentialing Manager* for review and determination of actions as appropriate.

3. If inappropriate documentation and updates are identified during the credentialing information integrity audit, consequences will be determined based on the severity of the issue. These may include, but are not limited to:
   a. Education and additional training with reaudit within 3-6 months
   b. Implementation of a Performance Improvement Plan if continued non-compliance

c. Corrective action including but not limited to: verbal or written warning documented in the employee's personnel file and termination of employment.

**F. AUDIT, ANALYSIS AND IMPROVEMENT ACTIONS (CR8.C-D)**

1. KHS annually audits credentialing information used in the credentialing process for the following inappropriate documentation and updates:
   - Falsifying credentialing dates (e.g., staff verification date, attestation date, credentialing decision date, etc.
   - Creating documents without performing the activity (e.g., photocopying a prior credential and updating information as a new credential.
   - Fraudulently altering existing documents (e.g., committee minutes, clean-file reports, ongoing monitoring logs, etc.)
   - Attributing verification or review to an individual who did not perform the activity.
   - Updates to information by unauthorized individuals.

2. The audit universe includes practitioner files for all initial credentialing decisions and all recredentialing decisions made during the look-back period (previous 12 months). A random sample of practitioner files from the audit universe will be selected using 5% or 50 files, whichever is less.

3. The random sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed within the look-back period, the organization audits all files.

4. The CII audit and analysis report includes the following information:
   - The report date.
   - The title of individuals who conducted the audit.
   - The 5% or 50 files auditing methodology.
     - Auditing period.
     - File audit universe size
     - Audit sample size.
   - The audit log:
     - File identifier.
     - Type of credentialing information audited.
   - Findings for each file.
     - A rationale for inappropriate documentation and updates, if applicable.
   - The number or percentage and total inappropriate documentation and updates by type of credentialing information.

5. The CII Audit and Analysis tool will be completed and maintained even if no inappropriate documentation and updates are found.

6. An annual qualitative analysis will be conducted for each instance of inappropriate documentation or update identified during the CII audit to determine the underlying cause.

7. If an instance of inappropriate documentation or update is identified, the CII Audit and Analysis tool will include the following:

- Titles of credentialing staff involved in conducting the qualitative analysis.
- The identified cause of each finding.

8. Documentation of the corrective actions planned or taken will be documented on the CII Audit and Analysis tool, including dates of actions, to address all inappropriate documentation and updates

9. The CII Audit and Analysis tool identifies staff (by title) who are responsible for implementing corrective actions.

10. A reaudit will be conducted and documented in the CII Audit and Analysis tool within 3–6 months following the annual audit to evaluate the effectiveness of corrective actions taken in response to identified findings.
    - The reaudit will include practitioner files for all credentialing decisions made, or due to be made, 3–6 months after the annual audit.
    - If noncompliance with integrity policies and procedures is identified during the reaudit, a qualitative analysis will also be included to assess the nature and cause of the noncompliance.

## V. ATTACHMENTS

| |
|---|
| Attachment A: CII_Audit-Analysis_Summary_Tool_HICE_2025.v2 |
| Attachment B: CII_Annual Confidentiality Agreement_Cred Staff_09.2025 |
| Attachment C: CII_Annual Cred_Info_Integrity_Agreement_Symplr Users_05.2025 |
| Attachment D: |

## VI. REFERENCES

| Reference Type | Specific Reference |
|---|---|
| Regulatory | NCQA Health Plan Credentialing Standards 2025, CR.8 Credentialing Information Integrity |
| Other | Health Industry Collaboration Effort, Inc (HICE) CA Credentialing Team Documents NCQA |
| Choose an item. | |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| **Revised** | **09/10/2025** | **NCQA retired Credentialing System** | **Y.Herrera** |

| | | | |
|---|---|---|---|
| | | **Controls Standards and replaced with new Credentialing Information Integrity Standards effective 7/1/2025. Due to the extensive changes in the standard policy language was completely rewritten rather than red-lined in order to meet the intent and current practice of this standard.** | |
| Revised | 08/01/2024 | Effective 8/2024, the policy was transferred to the QP Department. A QP policy number was assigned. | A.H Compliance |
| Effective | 03/06/2024 | Required by NCQA Credentialing Standards CR.1-C&D Ensuring all credentialing activities related to receiving, verifying, and processing an application for initial and/or recredentialing is received, dated, and stored; how modifications are tracked and by whom | PNM |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Physician Advisory Committee (PAC) | 9/10/2025 | 9/10/2025 |
| Board of Directors (BOD) | 10/23/2025 | 10/23/2025 |
| Choose an item. | | |
| Choose an item. | | |
| Choose an item. | | |
| Choose an item. | | |

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

| **Chief Executive Leadership Approval *** | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Chief Executive Officer | | |
| Chief Operating Officer | | |
| Chief Medical Officer | | |
| Choose an item. | | |
| *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:** 23.19-I Credentialing Information Integrity

**Last approved version:** 8/1/2024 Under Policy Name Credentialing System Controls

**Reason for revision: NCQA retired Credentialing System Controls Standards and replaced with new Credentialing Information Integrity Standards effective 7/1/2025. Due to the extensive changes in the standard language and policy requirements this policy was completely rewritten rather than red-lined.**

| **Director Approval** | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Jacob Hall<br><br>Senior Director of Quality Performance | | |
| | | |
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Date posted to public drive: _____

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

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Urgent Care Center (UCC) | **Policy #** | 23.09-P |
| **Policy Owner** | Quality Performance | **Original Effective Date** | 7/2000 |
| **Revision Effective Date** | 3/17/2023 | **Approval Date** | **10/1/2025** |
| **Line of Business** | ☒ Medi-Cal ☒ Medicare ☐ Corporate | | |

## I. PURPOSE

To define responsibilities of participating Urgent Care Centers that Kern Health Systems will contract ~~with a facility as an Urgent Care Center (UCC) only if~~ when the facility meets the requirements set forth in this policy.

~~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~~ non-life-threatening illnesses and injuries that need to be treated quickly but not so urgently that they require an ~~in an ambulatory medical facility outside of traditional hospital based or free standing~~ Emergency Department (ED).

## II. POLICY

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### 2.0 FACILITY CAPABILITIES

The minimum services available at an UCC must be:

A. Be independently owned and operated by a non-hospital organization
B. CLIA-Waived Lab, X-ray and Imaging on-site with 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
C. Location shall be open at a minimum of twelve (12) hours per day, 8:00 am to 8:00 pm
D. Location shall be open at a minimum of five (5) days per week to include Saturday and/or Sunday

E. Availability of a physician on-site during all days and hours of operation
F. Ability to cast closed, uncomplicated fractures
G. Availability of splints and crutches
H. Ability to suture lacerations not involving major structures or major nerves, arteries or tendons
I. 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
J. Ability and equipment to treat acute asthma attacks
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. Non-Physician 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.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| UCC | Urgent Care Center |
| ACLS | Advanced Cardiovascular Life Support |
| AHA | American Heart Association |
| BLS | Basic Life Support |

## IV. PROCEDURES

~~**2.0 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~~

~~3.0~~ **CREDENTIALING OF FACILITIES**

UCCs are credentialed and recredentialed based on the ~~criteria~~ capabilities listed in sections 2.0 of this policy and in ~~line~~ compliance with policy ~~4.01~~23.05-P *Credentialing Program, Section H, Item #3 Facility and Ancillary Providers/Assessment of Organizational Providers*.

Recredentialing and/or reassessment 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 with policy ~~4.43~~23.13-P *Medi-Cal Provider Enrollment Policy*.

## 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 |
|---|---|---|---|
| Revised | ~~MM-DD-YYYY~~10/2025 | Reformatted to KHS Template with minor changes to bring up-to-date with current practice. | Y. Herrera, Cred Manager |
| Revised | 08/2022 | 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 Manager |
| Effective | | | |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Physician Advisory Committee (PAC) | 10/01/2025 | 10/1/2025 |
| Board of Directors (BOD) | 10/23/2025 | 10/23/2025 |
| 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, Sr. Director of Contracting and Quality Performance | | |
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Date posted to public drive: _____

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

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Clinical Laboratory Improvements Amendments (CLIA) Certification Requirements | **Policy #** | 23.14-P |
| **Policy Owner** | QP-Quality Performance | **Original Effective Date** | 02/2002 |
| **Revision Effective Date** | 4/21/2023 | **Approval Date** | **10/01/2025** |
| **Line of Business** | ☒ Medi-Cal ☒ Medicare ☐ Corporate | | |

## I. PURPOSE

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.

## II. POLICY

**PROVIDERS REQUIRED TO BE CLIA CERTIFIED**

All contracted ~~providers~~ laboratories 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].

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| CLIA | Clinical Laboratory Improvement Amendments |
| | |

## IV. PROCEDURES

### 1. 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:

- Association for the Advancement of Blood & Biotherapies Accreditation Program (AABB)
- American Association for Laboratory Accreditation (A2LA)
- Accreditation Commission for Health Care Inc (ACHC)
- ~~Accreditation Association for Hospitals and Health Systems/Healthcare facilities Accreditation Program (AAHHS/HFAP)~~
- American Society for Histocompatibility and Immunogenetics (ASHI)
- Commission on Office Laboratory Accreditation, Inc (COLA)
- College of American Pathologists (CAP)
- The Joint Commission (TJC)

### 2. 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. 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.

**A. 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.

**B. 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 |
|---|---|

| | |
|---|---|
| Regulatory | 42 USC Section 263a-Clinical Laboratory Improvement Amendments |
| Regulatory | Chapter 3 of Division 2 of the California Business and Professions Code, which begins with Section 1200, is known as The Clinical Laboratory Act |
| Other | Centers for Medicare and Medicaid Services (CMS) for laboratories under the Clinical Laboratory Improvement Amendments (CLIA) |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| Revised | 10/2025 | Changed policy to new KHS Format, minor updates to formatting and revised CMS approved laboratory accreditations. | Y.Herrera Cred Manager |
| Revised | 01/2023 | 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 | Y.Herrera Cred Manager |
| Revised | 04/2017 | 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 | Y.Herrera Cred Manager |
| Effective | | | |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | Date Reviewed | Date Approved |
|---|---|---|
| Physician Advisory Committee (PAC) | 10/1/2025 | 10/1/2025 |
| Board of Directors (BOD) | 10/23/2025 | 10/23/2025 |
| 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, Sr. Director of Contracting and Quality Performance | | |
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Date posted to public drive: _____

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

[2] DHS Contract Section 3.25

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Ongoing Monitoring & ~~Sanction Activity Review~~Interventions | **Policy #** | 23.22-P |
| **Policy Owner** | Quality Performance/Contracting | **Original Effective Date** | 10/01/2024 |
| **Revision Effective Date** | 10/1/2025 | **Approval Date** | 10/29/2024 |
| **Line of Business** | ☒ Medi-Cal ☒~~☐~~ Medicare | | |

## I. PURPOSE

To ensure all contracted providers are absent from being identified as ineligible, suspended, sanctioned, debarred, excluded, restricted, or opted out of Federal and State Programs. Additionally, in accordance with Welfare and Institutions Code 14043.61, subdivision (a) a contracted provider shall be subject to suspension if claims for payment are submitted for services, goods, supplies, or merchandise provided, directly or indirectly to a Medi-Cal beneficiary, by an individual or entity that is suspended, excluded or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement form the Medi-Cal program and the individual or entity is listed on the Suspended and Ineligible Provider List, published by the department to identify suspended and otherwise ineligible providers, or on any list published by the Federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

## II. POLICY

A. Kern Health Systems (KHS) requires verification at initial, recredentialing and monthly thereafter, of practitioners and organizational providers ensuring a process for ongoing monitoring of practitioner sanctions, complaints and quality issues during intervals between formal credentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality and safety issues in a timely manner~~all contracted providers are absent from being identified as ineligible or suspended, sanctioned, debarred, excluded, restricted, or opted out of Federal and State Programs~~.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|

| | |
|---|---|
| Adverse Event | Adverse Event may include, but are not limited to, an injury that occurs while a member is receiving healthcare services from a provider; criminal indictments or convictions; media alerts; notification from other health plans; 805 Reports filed with the Medical Board of California; NPDB clinical privilege actions; pattern or trend of quality of care cases filed against practitioner. |
| Complaint | A complaint is the same as a Grievance. When KHS is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance. |
| DHCS | Department of Health Care Services (California) |
| Grievance | A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care of services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by KHS to make an authorization decision. |
| MBC | Medical Board of California |
| OIG | HHS Office of Inspector General |
| Opt Out Affidavits | CMS Opt Out Affidavits – A list of practitioners who are currently opted out of Medicare |
| RPD | DHCS Restricted Provider List |
| SAM | System for Award Management |

## IV. PROCEDURES

A. The following ongoing monitoring procedure will be followed ~~in reviewing the sanction reports~~:

1. ~~Primary source verification of Medicare and Medicaid sanction activity is obtained from~~KHS collects and reviews :
    a. Medicare and Medicaid Sanctions
    b. Medicare and Medicaid Exclusions
    c. Sanctions, limitations and expiration on licensure
    d. Internal Complaints/Grievances
    e. Information from identified adverse events
    ~~a. The Office of Inspector General (OIG)~~
    ~~b. The System for Award Management (SAM) formerly the Excluded Parties List System (EPLS)~~
    ~~c. DHCS Medi-Cal Provider Suspended and Ineligible List (S&I)~~
    ~~d. DHCS Restricted Provider List (RPD)~~
    ~~e. CMS Opt Out Affidavits (CMS Opt Out)~~
    ~~f. National Practitioner Data Bank (NPDB) Continuous Query upon receipt.~~

2. KHS identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the intervals between formal credentialing~~Primary source verification of California state licensure including licensure status, public actions, and 805 reports, as applicable, is obtained from the appropriate California licensing board at the time of initial, recredentialing and upon license expiration/renewal. During initial and recredentialing a record of review of the sanction reports and findings is maintained in the Provider's KHS electronic credentials~~

~~2.~~3. Collecting and reviewing Medicare and Medi-Cal Sanctions:~~.~~
   a. Primary source for Medi-Cal Sanctions is obtained from the California State Department of Healthcare Service Medi-Cal Suspended and Ineligible Report.
   b. Primary Source for Medicare Sanctions is obtained through SAM.Gov Portal as well as each practitioner is enrolled during the initial credentialing process with the National Practitioner Data Bank (NPDB) Continuous Query.

4. Collecting and reviewing Medicare and Medi-Cal Exclusions:
   a. KHS obtains exclusion information from each of the following sources:
      i. Medi-Cal Agency - California State Department of Healthcare Service Medi-Cal Suspended and Ineligible Report available over the internet;
      ii. List of Excluded Individuals and Entities from the Office of the Inspector General (OIG) available over the internet;
      iii. Medicare Exclusion Database from the CMS Preclusion List, accessible through CMS Enterprise Portal (Credentialing Manager Authorized Accessibility is downloaded monthly and made available to the Credentialing Staff).

5. Primary source verification of California state licensure including licensure status, public actions, and 805 reports, as applicable, is obtained from the appropriate California licensing board at the time of initial, recredentialing and upon license expiration/renewal. During initial and recredentialing a record of review of the sanction reports and findings is maintained in the Provider's KHS electronic credentials file.

~~3.~~6. Ongoing monitoring of providers in-between credentialing and recredentialing cycles is accomplished by reviewing the reports listed below relevant to the current provider types within the KHS Provider Network. The Credentialing Staff receives information when sanctions are filed against a provider and checks these providers against the KHS Network. Reports that must be downloaded due to size, are conducted through the KHS Business Intelligence "sweep" auto-report compared against all providers listed in the Symplr Credentialing database (Participating Providers) and providers in the QNXT database (Participating and Non-Participating) these auto-reports include OIG, SAM, and Medi-Cal Suspended & Ineligible List.

Reports are reviewed monthly or within thirty (30) calendar days of ~~release~~ a new alert or published report~~(published/posting date if available)~~, unless otherwise noted that there is no release date. Only those reports relevant to the current types of KHS Network Providers (MD, DO, etc) will be

monitored.~~If the reporting entity does not publish sanction information on a set schedule or published date, KHS Credentialing Staff will do one of the following:~~

~~a. Record the "date reviewed" on the document and indicate there is no release/published date.~~
~~b. Query the information at least every six (6) months if the reporting entity does not publish a sanctions report; or~~
~~c. KHS utilizes the sanction alert subscription service through the National Practitioner Data Banks Continuous Query for all credentialed licensed independent practitioners~~.

~~4. Ongoing Monitoring Reports for Current Provider Types~~

Expiration of Licensure – KHS documents the license expiration date in the credentialing files or system, and monitors all licenses that will expire on a monthly basis. The credentialing system has an automatic licensing module that records and updates the license directly from the licensing agency. The Credentialing Staff runs monthly reports and conducts primary source verification when the licensing module does not find an update from the licensing agency.

a. Medical Board of California (https://www.mbc.ca.gov/ ) – KHS subscribes to e-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBC. *

b. Osteopathic Medical Board of California (https://www.ombc.ca.gov/enforcement/enforcement_actions.shtml ) KHS subscribes to e-mail notifications and reviews the website monthly for published enforcement and disciplinary action reports. *

c. Podiatric Medical Board of California ( https://pmbc.ca.gov/consumers/dispsumm.shtml) KHS reviews the website monthly for published enforcement and disciplinary action reports for all doctors of Podiatric Medicine monthly. *

d. California Board of Psychology (https://www.psychology.ca.gov/) – KHS subscribes to e-mail notifications and reviews the website monthly for published enforcement and disciplinary action reports.

e. California Board of Registered Nursing (https://www.rn.ca.gov) – KHS reviews the website monthly for published enforcement and disciplinary action reports as well as utilizes the National Practitioner Data Bank (NPDB) Continuous Query process as a mechanism to receive disciplinary actions for Nurse Practitioners. *

f. Additional Boards and Bureaus included in monthly monitoring: Acupuncture Board of California, Behavioral Health Science Board of California, Chiropractic Examiners Board of California, California Board of Naturopathic Medicine, California Board of Optometry, Board of California Pharmacy, Dental Board of California, Physician Assistant Board of California, Board of California Psychology and Speech-Language Pathology and Audiology and Hearing Aid Dispenser Board of California. *

g. HHS Office of Inspector General (https://exclusions.oig.hhs.gov/?AspxAutoDetectCookieSupport=1) – KHS subscribes to

email notifications alerts when new sanction reports have been posted. OIG reports are downloaded from their website monthly for review. *

h. DHCS Medi-Cal Provider Suspended and Ineligible List (https://data.chhs.ca.gov/dataset/provider-suspended-and-ineligible-list-s-i-list~~/resource/48630a37-b5ba-4d3d-af54-e82b30e658a0~~) – KHS downloads the newest report from their website monthly for review. *

i. DHCS Restricted Provider List - KHS Credentialing Manager downloads the newest report from the~~ir website monthly for review. *~~DHCS EPortal Website.
   i. *No excluded, ineligible, sanctioned, debarred, or suspended providers qualify for Network membership or continued membership. (Source: Medicare Managed Care Manual, Chapter 6 § 60.2; DHCS All Plan Letter APL 19-004)

j. CMS Medicare Opt-Out Physicians, Northern and Southern California (https:data.cms.gov/Medicare- Enrollment/Opt-Out-Affidavits) – KHS downloads the newest report from their website monthly for review.*
   i. *No prospective or current KHS Provider shall qualify for Network membership or continued membership if provider has opted-out of the CMS Medicare Program. (Source: Medicare Managed Care Manual: Chapter 6 § 60.2)

k. CMS Preclusion List – KHS Credentialing Manager downloads the newest report monthly and is made available to the Credentialing Staff.

l. Alternate sources for licensure sanction, limitations, and expiration information from at least one of the following includes:
   i. NPDB
   ii. Federal Employees Health Benefit Plan (FEHB) Program department record, published by the Office of the Inspector General
   iii. FSMB

~~k.~~m. Complaints, Grievances and Adverse Events (related to quality of care) – At a minimum, information on complaints, grievances or adverse events will be reviewed at least once every six (6) months pursuant to Policy and Procedure #2.70-I Potential Quality ~~of Care~~ Issue (PQI)~~, Section IV. PQI Review Process, Section K. Tracking and Trending~~. Complaints, grievances, and adverse events (quality of care related) are reviewed with the Chief Medical Officer, or designee, for appropriate action and follow-up which may include corrective action plans, education or counseling of the provider and when applicable, referral to the Physician Advisory Committee (PAC).

~~l.~~n. Performance Monitoring for Recredentialing – Additionally, recredentialing for all providers shall include performance monitoring data from quality improvement activities, utilization management, member services complaints/grievances and compliance activities. The ~~Physician Advisory Committee~~PAC monitors the performance and outcomes of practitioners. (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)

B. Reporting ~~and Interventions~~

1. All sanctions, exclusions, disciplinary and adverse actions are reported immediately or within three (3) business days upon receipt to the KHS Chief Medical Office and/or KHS Chief Executive Officer. The KHS Chief Medical Office and/or KHS Chief Executive Officer ~~-~~shall determine if immediate action is warranted. All sanctions, exclusions, ~~and~~ disciplinary actions and/or adverse events will be reported monthly to the next regularly scheduled Physician Advisory Committee meeting for appropriate action and follow-up which may include, but not limited to the course of action pursuant to Policy and Procedure 4.48-P Disciplinary Action such as corrective action plans, education, or counseling of the provider and termination or no action, when warranted.~~-~~

2. If a Provider is identified on the Medicare Opt-Out listing or is actively excluded, ineligible, sanctioned, debarred or suspended on the OIG Report, Medi-Cal Suspended/Ineligible List, ~~or~~ DHCS Restricted Provider List, or CMS Preclusion List, the provider will be deactivated from the KHS Provider Network and notified immediately of their ineligibility for new or continued network participation and membership.

3. Record of verifications shall include the published report date or website date of verification (if there is no new report or a new published date) and initials of KHS Credentialing Staff who completed the verification. This information is saved in the providers electronic credential file and recorded on the file processing checklist for initial and recredentialing. Monthly monitoring reports, conducted by KHS Credentialing Staff, are kept electronically by month of review and reported to the KHS Compliance Department's Fraud Waste and Abuse Committee.

C. Interventions

The PAC is the designated credentialing/peer-review body responsible for implementing interventions as needed and recommending actions to address quality and safety issues.

The KHS Monthly Monitoring Report is presented monthly to the PAC at the next meeting after the identified occurrence and recommends appropriate interventions.

After determining which interventions are appropriate, the PAC acts to address the quality and safety issues and documents, in the PAC minutes, the following:

1. The affected practitioner (identified by the unique PRV Identification Number)
2. The Incident Date
3. Quality/Adverse Event or Issue
4. Date Reported to the PAC meeting
5. PAC Actions

Actions may include but are not limited to the following:

1. Formal Action: The PAC has the right to decide to terminate a practitioner if the practitioner:
    a. Has had his/her licensed revoked, suspended or otherwise limited
    b. Has been placed on probation, reprimanded, fined or has had his/her practice restricted by any state/federal agency.
    c. Has been censured, sanctioned or excluded from participation by Medicare/Medi-Cal.
2. Summary Action: Whenever a practitioner's conduct may result in imminent danger to the health

and safety of a KHS beneficiary member, the Chief Medical Officer, or designee Medical Director or Chief Executive Officer may immediately summarily restrict or suspend the practitioner's ability to provider health services to a KHS beneficiary member pursuant to Policy and Procedure 4.48-P Disciplinary Action, Reporting to Proper Authorities and Policy and Procedure 4.35-P Provider Hearings.

## V. ATTACHMENTS

| | |
|---|---|
| Attachment A: | HICE Ongoing Monitoring Review Tool ~~2024~~2025 |

## VI. REFERENCES

| Reference Type | Specific Reference |
|---|---|
| Other | National Committee of Quality Assurance Credentialing Standards CR.5 Ongoing Monitoring & Interventions ~~2023~~2025 |
| Regulatory | Medicare Managed Care Manual, Chapter 6 § 60.3; Medicare Managed Care Manual: Chapter 6 § 60.2 |
| All Plan Letter(s) (APL) | DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract. |
| Other KHS Policies | KHS Policy and Procedure #2.70-I Potential Quality ~~of Care~~ Issue (PQI) |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| **Revisions** | **9/16/25** | **NCQA Credentialing Standards CR5 new policy requirements related to Medicare & Medi-Cal Sanctions and Exclusions, required sources, change from monitoring every 6-months to monthly, new requirement for expiration of licensure, adverse events monitored monthly, appropriate interventions and new requirement for evidence in meeting minutes.** | **Y.Herrera QP Credentialing Manager** |
| Effective | 10/01/2024 | New policy created to outline additional details for existing monitoring/sanction | Y.H. QP/Contracting |

| | | | |
|---|---|---|---|
| | | reviews related to regulatory requirements. | |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Physician Advisory Committee (PAC) | Revisions 10/1/2025 | 9/4/2024 |
| Board of Directors (BOD) | Revisions 10/13/2025 | 10/17/2024 |

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

| **Chief Executive Leadership Approval *** | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Chief Executive Officer | | |
| Chief Medical Officer | | |
| Chief Operating Officer | | |
| Choose an item. | | |
| *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:** 23.22-P, Ongoing Monitoring and Sanction Activity Review

**Reason for revision:** N/A. New policy developed to meet monitoring and sanction activity requirements.

| **Director Approval** | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Jake Hall<br><br>Senior Director of Quality Performance and Contracting | | |

Date posted to public drive: _____

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

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Monitoring Provider Exclusions | **Policy #** | |
| **Policy Owner** | Quality Performance/Contracting | **Original Effective Date** | X/X/2025 |
| **Revision Effective Date** | X/X/2025 | **Approval Date** | X/X/2025 |
| **Line of Business** | ☒ Medi-Cal ☒ Medicare | | |

## I. PURPOSE

This policy outlines the process used to ensure all providers who submit a contract to the plan as well as all providers to whom a claims payment is made will be monitored against federal and state exclusion lists. The parties or entities on these lists are excluded from various activities, including rendering services to Medicare, Medi-Cal and other federal heath care program enrollees (unless in the case of an emergency, as stated in 42 CFR §1001.1901). Additionally, if any contracted provider is found to be subsequently included on any of the identified lists that provider will be promptly terminated from the applicable network.

## II. POLICY

The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) both require contractors, their subcontractors and other delegated entities to monitor federal and state exclusions lists. Kern Health System (KHS) will validated contracted providers are eligible to receive payment from CMS and DHCS programs through a review of the CMS Preclusion Provider List, the Office of the Inspector General (OIG-HHS) List of Excluded Individuals and Entities, the Medicare Opt-Out list, Medi-Cal Suspended and Ineligible Lists (SIPL), the Medi-Cal Restricted Provider Database (RPD) and the General Services Administration (GSA) Exclusions as referred through the Systems for Award Management (SAM) upon initial contracting/credentialing, recredentialing and monthly thereafter. Providers on any of these lists, except for the RPD, will be terminated from all lines of business including DSNP line of business. Providers on the RPD List will only be terminated from the Medi-Cal line of business only.

Additionally, KHS will complete a review of all providers being paid through the claims payment system to validate that none of the providers are included on these lists.

Should a provider be identified as subsequently being included on one of these lists, that provider will be terminated from the network and ineligible for any future payments under the applicable product line of business. Providers found on any of these lists are not eligible to file an appeal to KHS for reconsideration but instead must work with the appropriate regulatory entity for any corrections or updates to the list. Appropriate outreach will be provided to any impacted member according to required regulatory action. If there is no specific regulatory action for that specific list, then KHS will follow the provider termination member notification process.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| **The Centers for Medicare and Medicaid Services** | The Centers for Medicare and Medicaid Services, the Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations. |
| **Contracted provider** | A healthcare provider that has an agreement with a health plan to accept patients at an agreed-upon rate. |
| **Credentialing** | A regulated process of assessing the qualifications of specific licensed medical professional validating the medical professional's background and legitimacy. Credentialing, for providers that require it must be completed prior to contracting. |

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| **Delegated Provider Group** | Any contracted medical group or hospital physician organization where the group has been delegated for some functions managed by the plan such as provider credentialing, claims payment, new provider orientation or care management. |
| **Out of Area Provider** | Any contracted provider that does not have an office or business location within the health plan service level such as a mail order Durable Medical Equipment Company. |
| **Excluded Provider** | A provider is included on the List of Excluded Individuals and Entities (LEIE) file and is ineligible to receive payment from the Medicare or Medicaid programs or other federally funded programs. |
| **Medicare Opt-Out Provider** | A provider who has decided not to be included in the Medicare program and agrees not to bill Medicare for services. Medicare Opt-Out providers should not treat Medicare patients unless it is an emergency or unless they have an agreement with the Medicare patient for the member to pay out of pocket for the services and not bill Medicare. |
| **Non-contracted Provider** | A provider or supplier that does not contract with the Medicare Advantage plan to provide services covered by the MA plan. |

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| **Precluded Provider** | a provider that is included on the CMS Precluded Provider List. This list is comprised of providers who have engaged in behavior that CMS determines is detrimental to the best interests of the Medicare program. In general, providers on the Excluded Provider file are included on the Precluded Provider file, but not all Precluded Providers are on the Excluded Provider File. |

## IV. PROCEDURES

### 1.0 MONITORING PROVIDER EXCLUSIONS

1.1 Provider Types include, but are not limited to the following:

- 1.1.1 Physicians
- 1.1.2 Hospitals
- 1.1.3 Participating Physician Groups
- 1.1.4 Ancillary Providers

1.2 Monitoring for Excluded Parties

The names of parties that have been excluded from participation in federal health care programs are published in the Office of the Inspector General U.S. Department of Health and Human Services (OIG-HHS) List of Excluded Individuals and Entities (LEIE), CMS Preclusion List, Medi-Cal Suspended and Ineligible Provider List (SIPL), Medi-Cal Restricted Provider Database (RPD), and on the General Services Administration's (GSA) Exclusions Extract Data Package (EEDP) (or Excluded Parties List System (EPLS), which was replaced by the EEDP), as referenced through the System for Award Management (SAM).

***Providers on any of these lists, except for the RPD, will be terminated from all product lines of business including DSNP. Providers on the RPD will only be terminated from the Medi-Cal line of business***.

### 2.0 KHS and Provider Responsibilities

KHS is required to monitor federal and state sanction and exclusion lists to ensure that KHS is not contracting or paying excluded parties or entities for services rendered to enrollees in KHS health plans. KHS contracted providers and their downstream subcontractors or delegated entities must check the LEIE/OIG, CMS Preclusion List, SIPL, RDP, and EEDP/SAM exclusion lists prior to contracting with any new physician, hospital, ancillary provider, physician group, subcontractor, or other delegated entity for Medi-Cal or DSNP related health plan activities. KHS, its contracted providers, and their downstream subcontractors or delegated entities must frequently monitor these lists at least monthly to ensure parties or entities that were previously screened have not become excluded later.

**LEIE**

The OIG-HHS imposes exclusions under the authority of Sections 1128 and 1156 of the Social Security Act. A list of all exclusions and their statutory authority is available on the Exclusion



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Authority website at https://oig.hhs.gov/exclusions.
The current LEIE is available on the https://exclusions.oig.hhs.gov/.
Frequently asked questions (FAQs) and additional information about the LEIE is available at https://oig.hhs.gov/faqs/exclusions-faq/
***Providers on the OIG list will be terminated from all products including DSNP & Medi-Cal.***

**CMS Preclusion List**
The CMS Preclusion List is published by the Centers for Medicare & Medicaid Services to identify precluded providers. It is updated monthly and available with authorized user access approved by the KHS Compliance Office to access the CMS Enterprise Portal. The KHS Credentialing Manager is responsible and authorized to download the list from this portal.
***Providers on the CMS Preclusion List will be terminated from all products including DSNP & Medi-Cal.***

**SIPL**
The SIPL is published by DHCS to identify suspended and otherwise ineligible providers. It is updated monthly and available on the https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/sandi
Additional information about the list is located in the Medi-Cal Suspended and Ineligible Provider List introduction.
***Providers on the SIPL will be terminated from all products including DSNP & Medi-Cal.***

**EEDP/SAM**
The GSA's EEDP is a government-wide compilation of various federal agency exclusions and replaces the Excluded Parties List System (EPLS). Exclusions contained in the EEDP are governed by each agency's regulatory or legal authority. The EEDP also includes parties and entities from other federal exclusion databases. All parties or entities listed on the EEDP are subject to exclusion from Medicaid participation. The current EEDP is available on the https://sam.gov/search/?page=1&pageSize=25&sort=-modifiedDate&sfm%5BsimpleSearch%5D%5BkeywordRadio%5D=ALL&sfm%5Bstatus%5D%5Bis_active%5D=true
***Providers on the EEDP list will be terminated from all products including DSNP & Medi-Cal.***

**Restricted Provider Database (RPD)**
The RPD is published by DHCS to identify providers placed under a payment suspension while under investigation based upon a credible allegation of fraud (Title 42, Code of Federal Regulations (CFR) section 455.23 and Welfare and Institution Code (WIC) section 14107.11. The sanction action is specific to the individual rendering provider's National Provider Identifier and/or Tax Identification Number as listed on the database file. KHS contracted providers, subcontractors and delegated entities may continue contractual relationships with providers on the RPD that are listed under a "payment suspension only"; however, reimbursements for Medi-Cal covered services must be withheld. Contracts must be terminated with providers on the RPD that are not listed under a "payment suspension only." The RPD List is updated monthly and available with authorized user access approved by the KHS Compliance Office to access the DHCS E-Portal (https://eportal.dhcs.ca.gov/dhcs). Credentialing Manager is responsible and authorized to download the list from this portal.
***Providers on the RPD list will be terminated from the Medi-Cal line of business only.***

**Claims Payment For Excluded Parties**
KHS vendors, hospitals, and ancillary providers, subcontractors and delegated entities cannot pay participating and nonparticipating parties or entities included on these lists for any services using federal funds, except for emergency services provided by excluded providers under certain circumstances, see 42 CFR §1001.1901.

## V. ATTACHMENTS

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|---|
| Attachment A: HPMS Memo Dated December 14, 2018 - Preclusion List Requirements Frequently Asked Questions (FAQs) |
| Attachment B: HPMS Memo Date December 16, 2020 – Preclusion List Frequently Asked Questions |
| Attachment C: HPMS Preclusion List Part C and D Model Precluded Provider Letter (attachment A) |
| Attachment D: LEIE Exclusion List |
| Attachment E: Excluded Provider Frequently Asked Questions |
| Attachment F: Medicare Opt-Out List and FAQs |
| Attachment G: Medicare Opt-Out Website |

## VI. REFERENCES

| Reference Type | Specific Reference |
|---|---|
| Regulatory | *42 CFR § 417.478(e), § 422.224(b), § 460.86(b), and § 423.120(c)(6)(iv)(B)(1)* |
| Regulatory | Medicare Managed Care Manual Chapter 6, Relationship with Providers Section 60.2 |
| Choose an item. | |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| Effective | X/X/2025 | New Policy | |
| Revised | | | |
| Retired | | | |

## VIII. APPROVALS

| **Committees \| Board** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Choose an item. | | |
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| Choose an item. | | |
| Choose an item. | | |
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| **Regulatory Agencies** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| Choose an item. | | |
| Choose an item. | | |
| Choose an item. | | |

| **Leadership Approval *** | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| Chief Executive Officer | | |
| Chief Medical Officer | | |
| Jake Hall, Sr. Director of Contracting and Quality Performance | | |
| Director of | | |
| *Signatures are kept on file for reference but will not be on the published copy | | |

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KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br>POLICY AND PROCEDURES | | | |
|---|---|---|---|
| **Policy Title** | Potential Quality ~~of Care Issues~~Issue (PQI) | **Policy #** | 2.70-I |
| **Policy Owner** | Quality Improvement | **Original Effective Date** | 07-2020 |
| **Revision Effective Date** | 09-~~2023~~2025 | **Approval Date** | ~~10-31-2024~~ |
| **Line of Business** | ☒ Medi-Cal ☐☒ Medicare ☐ Corporate | | |

## I. PURPOSE

~~A.~~ ~~To provide~~This policy establishes a defined ~~method~~process for identifying and ~~processing~~ addressing a Potential Quality Issue (PQI ~~issues.~~) to ~~determine opportunities for improvement in~~ improve the delivery of health care to Kern Health ~~System~~Systems (KHS) members, ~~and to direct~~directing appropriate follow-up actions based ~~upon~~on investigative ~~outcomes~~findings, risk, and severity.

~~B. The policy also~~ It supports continuous ~~review of the quality~~evaluation of care ~~provided to members~~ to ensure ~~that a level of care, which meets~~services meet professionally recognized standards of practice, ~~is being delivered to all enrollees~~while identifying and ~~that~~correcting quality-of-care ~~problems are identified and corrected for~~issues across all provider entities. ~~This policy also ensures that Kern Health Systems (KHS²)~~Through this process, the KHS Quality Improvement System (QIS) effectively monitors, evaluates, and ~~takes~~implements corrective actions to ensure that providers in all care settings deliver safe, effective ~~action to address any needed improvements in the quality of~~, and high-quality care ~~delivered by Providers rendering services on behalf of KHS in any setting~~.

## II. POLICY

A. KHS Departments, Practitioners, Providers, and Healthcare Delivery Organizations (HDOs) ~~shall~~must refer ~~a~~all Potential Quality ~~Issue (PQI~~Issues (PQIs) to the Kern Health Systems (KHS) Quality Improvement (QI) Department for review and investigation.

B. The PQI process is overseen by the Kern Health Systems (KHS) Chief Medical Officer (CMO) ~~and supported by~~with support from the Quality Improvement Medical Director (QIMD).



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C. ~~Potential quality issues~~ PQIs are ~~consistently~~ identified~~, adequately~~ promptly and ~~timely~~thoroughly investigated by ~~appropriate~~qualified clinical staff, and followed by effective ~~action is taken~~actions to address any ~~need~~needed improvements in the quality of care.

D. The QI Department ~~shall conduct a review of~~reviews all PQIs ~~by~~through appropriately trained and qualified staff, including QI nurses and the QIMD.

E. The PQI process ~~will include~~includes provisions to ~~validate~~ensure consistency in ~~application of~~applying criteria and ~~decision~~ making ~~in~~decisions when screening PQIs~~ to determine if there is an existence of a PQI~~. To validate this consistency, the KHS QI Department ~~will conduct~~conducts inter-rater reliability audits ~~on~~of QI nurses at ~~a~~ minimum upon completion of training and annually thereafter. ~~Inter-rater reliability~~These assessments ~~will consist of assessing~~involve reviewing and scoring case files~~. Reviewers performing inter rater reliability monitoring will use~~ using standardized assessment tools to ensure accuracy and uniformity among reviewers.

F. PQI Levels are:
   ~~1.~~ _____Level 0 = No Quality-of-Care Concern
      ~~a. The PQI is then closed.~~
   ~~2.~~ _____Level 1 = Potential for Harm
      ~~a. Follow-up = Track and trend the area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider.~~
   ~~3.~~ _____Level 2 = Actual Harm
      ~~a. Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.~~
   ~~4.~~ _____Level 3 = Actual Morbidity or Mortality ~~Failure~~
      ~~a. Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.~~

~~G. Confidentiality~~

~~1.~~G. Information related to peer review is protected under California Evidence Code Section 1157 and will remain confidential. ~~Peer~~All peer review activities ~~will be carried out in a manner~~are conducted to preserve protection from discovery~~ or peer information.~~. Confidential and privileged peer review records ~~consist of the following:~~include peer review forms, correspondence ~~to and from the practitioner~~with practitioners regarding practice performance~~; determination~~, determinations of the Peer Review Committee, and any subsequent actions, including ~~all~~related letters sent to or received from the practitioner ~~regarding the review. Confidential Peer Review~~. These records ~~will be secured~~are securely maintained in the Credentialing ~~Department~~Department's confidential files.

H. ~~H.~~ This ~~Policy will comply~~policy complies with ~~CA~~California Peer Review 805 requirements by reporting ~~of specific~~specified information ~~regarding~~about licensees to the Medical Board as required.

~~I. Health Insurance and Accountability Act Requirements (HIPAA)~~

~~1.~~I. Only authorized personnel ~~can review~~may access member ~~protected health information~~Protected Health Information (PHI). Authorized ~~persons to view PHI as part of the peer review process~~individuals include Medical Directors, Peer Review staff ~~and~~, Quality staff, ~~or~~and delegated

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~~others.~~personnel involved in the peer review process. PHI includes, but is not limited to, a ~~member's~~member's name, address, telephone number, email address, ~~social security~~Social Security number, medical record number, and health plan beneficiary information.

## III. DEFINITIONS

| TERMS | DEFINITIONS |
|---|---|
| Complaint | A complaint is ~~the same~~defined as a Grievance. ~~When~~ If Kern Health Systems (KHS ~~is unable to~~) cannot clearly distinguish between a Grievance and an inquiry, ~~it shall~~the issue will be ~~considered~~treated as a Grievance. |
| Corrective Action Plan (CAP) | ~~This is a~~A plan approved by the Chief Medical Officer (CMO) to prevent recurrence of a quality issue ~~from occurring again in the future. A CAP is.~~ It serves as an agreement between the provider and Kern Health Systems (KHS) that ~~describes~~defines the problem and ~~appropriate~~outlines the measures required to achieve resolution. If the CAP ~~includes~~ involves patient reassignment ~~of patients~~, the CMO or ~~his/her~~ designee ~~notifies~~will notify the Chief Network Administration Officer to coordinate patient panel changes. |
| Grievance | ~~A Grievance is an~~An expression of dissatisfaction about any ~~matter~~issue other than an Adverse Benefit Determination. ~~Grievances may~~Examples include~~, but are not limited to,~~ concerns about the quality of care or services ~~provided, aspects of~~ issues with interpersonal ~~relationships~~interactions such as ~~rudeness of a~~ provider or ~~employee, and the~~ staff rudeness, or a beneficiary's ~~right~~objection to ~~dispute an~~a proposed extension of time ~~proposed~~ by Kern Health Systems (KHS ~~to make~~) for making an authorization decision. |
| Peer Review | ~~An activity that involves case~~ The evaluation of cases by an unbiased practitioner to assess, measure, ~~assess,~~ and improve professional practice and the quality of patient care. ~~The results of~~Results from peer review ~~activities~~ are used to identify opportunities ~~that include, but are not limited to: improving~~such as enhancing patient care, ~~improving~~strengthening clinical ~~judgement~~judgment and technical skills, ~~providing information related to~~informing determinations of clinical competency ~~determination~~ for reappointment, and ~~as necessary for~~ implementing corrective actions~~.~~ when necessary. |
| Peer | A ~~peer is a~~ practitioner ~~who has~~with expertise in the ~~appropriate~~relevant subject matter. ~~If the~~For questions ~~one~~ of general medical care, ~~then~~ any unbiased practitioner ~~can~~may serve as a peer reviewer. ~~If there are~~For specialty-specific clinical issues, ~~then~~ the peer reviewer must have sufficient clinical expertise and training to ~~provide an evaluation of~~evaluate the significant issues involved in ~~the review of~~ an individual case or ~~undesirable~~ pattern of care. |

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| External Peer Review | ~~An external peer review~~A consultant ~~will be utilized~~engaged to address specialty peer review issues ~~if a specific~~when the necessary clinical expertise is not available within the Kern Health Systems (KHS) practitioner network. |
| Peer Review Case | ~~A Peer review case is an~~An event that ~~corresponds to~~meets established criteria for peer review. ~~A case~~Cases may ~~be derived~~arise from medical staff indicators, sentinel events, third-party complaints, or other sources that ~~suggest~~indicate undesirable processes or outcomes of care. |
| Potential Inappropriate Care (PIC) | This is the term the Department of Health Care Services (DHCS) has identified for a Potential Quality of Care issue. They define it as a grievance related to the overuse, underuse, or misuse of health care ~~services I~~services. It is a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PICs require investigation to determine if an actual quality issue or opportunity for improvement exists. |
| Provider Preventable Condition (PPC) ~~And Hospital Acquired Condition (HAC)~~ | There are two types of ~~PPCs: health care-acquired conditions (HCAC~~Provider-Preventable Conditions (PPCs): Health Care-Acquired Conditions (HCACs), which ~~should~~must be reported ~~if these~~when they occur in an inpatient acute care hospital, and ~~other provider-preventable conditions (OPPC~~Other Provider-Preventable Conditions (OPPCs), which ~~should~~must be reported ~~if these~~when they occur in ~~any health care setting. Provider-preventable condition," "health care-acquired condition," and "other provider-preventable condition" are defined as set forth in Section 447.26(b) of Title 42 of the Code of Federal Regulations~~other health care settings. |
| Hospital Acquired Condition (HAC) | A health problem or injury a patient experiences during their hospital stay that was not present on admission and is not related to their underlying disease. |
| Potential Quality Issue (PQI) | ~~A Potential Quality Issue (PQI) is defined as a~~A possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues. |
| Quality of Care (QOC) ~~issue~~ | ~~Quality of Care means the~~The degree to which health services ~~for individuals and populations~~ increase the likelihood of desired health outcomes and ~~are consistent~~align with ~~current~~ professional ~~knowledge.~~ standards. |
| Screening Process | ~~This process includes a~~A complete review of the PQI referral. The QI Registered Nurse (RN) assigned to the episode will determine if further investigation is warranted based on the data gathered in the PQI ~~Referral.~~ |

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| | referral. |

## IV. PROCEDURES

### A. PQI ~~Submissions~~submission to the Quality ~~improvement~~Improvement Department

1. All PQI referrals are submitted to the QI Department and are initially screened and investigated by a QI RN to determine if a Quality ~~-~~ of ~~-~~ Care ~~Concern~~(QOC) issue exists. PQI sources for identification include, but are not limited to:
   a. ~~PQI Sources for Identification include, but are not limited to, the following sources:~~ Information gathered through Utilization Management~~.~~
   b. Referrals from any health plan staff~~.~~ or department
   c. Facility site reviews~~.~~
   d. Claims and encounter data~~.~~
   e. Pharmacy utilization data~~.~~
   f. Managed Care Accountability Set (MCAS) medical record abstraction process~~.~~
   g. Medical ~~Record Audits~~record audits
   h. Complaints/Grievances and Appeals from members~~.~~
   i. Provider Preventable Condition (PPC) ~~Reviews~~reviews
   j. Providers or other health care organizations
   ~~k. Pharmacy~~

2. PQI ~~Referrals~~referrals may be reported ~~by~~through any of the following~~:~~ channels:
   a. Any KHS staff member ~~via the~~may submit a Potential Quality of Care Issue (PQI) ~~Referral Form (Appendix A).~~through the Medical Management System.
   b. If a Provider Preventable Condition (PPC) is identified ~~via~~on the daily PPC report, a PQI episode will be created in KHS' medical management system for review. (Refer to Policy 2.72-I, Provider Preventable Condition Policy~~.~~).
   c. If a PPC is identified during the Utilization Management (UM) review process, a referral will be made to QI ~~indicating a PPC has been identified~~ for appropriate PPC reporting and PQI review. (Refer to Policy 2.72-I, Provider Preventable Condition Policy~~.~~).
   d. ~~Any~~ KHS ~~member, member of the~~members, community members, or ~~provider can call~~providers may report concerns by calling 661.632.1590 (Bakersfield~~) or),~~ 800.391.2000 (outside of Bakersfield), or 711 ~~for~~ (TTY/TDD~~, or they can complete~~). Reports may also be submitted via the Grievance form ~~located~~available on KHS' public website ~~and submit it via~~, either by mail or online.
   e. ~~For~~ Grievances related to potential ~~QOC~~ quality of care issues that are received ~~from~~through the Grievance ~~the QI Department~~ process shall be immediately ~~refer such Grievances~~referred by the QI Department to the Chief Medical Officer (CMO) or Quality Improvement Medical Director (QIMD) for review.

~~3. Cases are reviewed using professionally recognized, evidence-based standards of care to assess care provided.~~



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**B. Processing PQI ~~Referrals~~referrals**

1. The QI nurse assigned to review PQI referral cases will open ~~a~~the PQI referral episode and ~~requests~~request any additional medical records required for the PQI investigation~~. Medical Record Form (Appendix B).~~ (Attachment A).

2. The QI ~~Nurse~~nurse shall perform an initial clinical review upon receipt, to determine if the ~~Member~~member has any urgent clinical issues and provide care coordination interventions as needed.
3. Once the records have been received, they are uploaded into ~~KHS'~~KHS Medical Management System for review by the assigned QI nurse.
4. ~~After~~ Cases are reviewed using professionally recognized, evidence-based standards of care to assess the care provided.
4.5. Following completion of the investigation ~~by,~~ the QI ~~RN,~~nurse shall prepare a summary of the review ~~is created~~ using the SBAR format (Situation, Background, Assessment, and Recommendation) and ~~presented~~submit it to the CMO or ~~the~~ QIMD for ~~review~~evaluation and determination ~~for review and further determination~~ of whether a ~~QOC~~quality-of-care concern is present. Refer to the RN Referral - Medical Director Review Form (~~Appendix C~~)Attachment B).

5.6. ~~If it is not a quality-of-care issue but rather a service issue ,~~ after review of the medical records and the Provider's response ~~from the Provider~~, the matter is determined to be a service issue rather than a quality-of-care issue, the case will be closed~~, and~~. The PQI team will send a provider resolution letter ~~will be sent by the PQI team. And notifies~~to the Provider and notify Provider Relations~~. Please refer to (Appendix D)~~ of the outcome. Attachment C, which contains the listing of dispositions for Grievances and Appeals adopted from DHCS ~~that,~~ may serve as the ~~premise to initiate~~basis for initiating a PQI investigation of service issues ~~uniform~~in alignment with the KHS Grievance ~~Dept~~Department.

6.7. When the CMO or QIMD ~~determines~~determine the case to be:

a. Level 0 ~~=~~: No ~~Quality~~quality-of-~~Care Concern~~care concern due to insufficient evidence, documentation, or information to substantiate a PQI, the ~~PQI~~case is ~~then~~ closed~~:~~ with no further action required.
b. Level 1 ~~=~~: Potential for ~~Harm then it will require Follow-up = Track and trend the area of concern~~ harm substantiated PQI with documented evidence of possible member injury or harm and member is expected to recover fully without lasting limitations, the concern is tracked and trended for the specific provider~~, and the~~. The CMO, QIMD, or ~~QIMD~~PAC may ~~provide~~determine additional ~~actions that are~~ individualized ~~to the specific case or provider.~~actions.

~~7. The CMO QIMD documents follow up actions appropriate for the needed improvement and coordinates those items with the QI RN.~~

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c. ~~For PQIs determined to be a level 2 or greater~~ Level 2 or 3:

~~8.~~i. The CMO or QIMD will request any written information or clarification necessary from the provider regarding the issue in question.

~~9. PQIs Level 2 or greater~~The case will be forwarded ~~for further review as follows:~~

a. ~~If it is related to a Primary Care Provider (PCP), it will go~~ to the KHS Physician Advisory ~~Credentialing Peer Review~~ Committee (PAC ~~CRPR) for further review and action.~~

~~b.~~ii. ~~If it is related to a Specialty Care Provider (SCP) it will be forwarded to the physician)~~ for further evaluation. The PAC will determine appropriate actions, which may include tracking and trending, initiating a corrective action plan, and/or referring the case for review by an External Review Vendor (ERV).

~~c. The physician ERV will review and submit the findings and recommendations back to the KHS CMO QIMD. This will include all information reviewed by the external review entity and any guidance's made.~~

~~d. This information will then be forwarded to the PAC CRPR Committee.~~

| ~~LEVEL~~ | ~~DETERMINATION~~ | ~~ACTION~~ |
|---|---|---|
| ~~Level 0~~ | ~~No Quality of Care Concern~~ | ~~The PQI is then closed~~ |
| ~~Level 1~~ | ~~Potential for Harm Follow up~~ | ~~Track and trend the area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider.~~ |
| ~~Level 2~~ | ~~Actual Harm Follow up~~ | ~~Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.~~ |
| ~~Level 3~~ | ~~Actual Morbidity or Mortality Failure~~ | ~~Peer Review Due Process~~ |

~~8.~~ ~~For both PCP SCP PQIs submitted to the PAC CRPR Committee, all relevant documents and information will accompany the case and copies of all~~The CMO or QIMD document follow-up actions appropriate for the needed improvement and coordinate those items with the QI nurse.

~~10.~~9. All written correspondence and pertinent documents are filed in ~~KHS'~~KHS Medical Management system.

~~11.~~10. ~~The Physician Advisory Committee~~All PQIs are tracked for re-credentialing purposes. The PAC is responsible for making determinations for consideration in re-credentialing providers and ~~/~~/or recommending other actions.

~~12. All PQI QOC issues are tracked for re credentialing purposes.~~

~~13.~~ The QI Department ~~maintains a PQI log to track the timeliness of case reviews.~~

~~a. The targeted completion time frame for closing PQIs is 120 days.~~

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~~14.~~11. ~~The QI Dept designated staff~~ will support the PAC by ensuring all actions of the peer review body are carried out and monitored in compliance with de-identification, confidentiality, and peer review privileged requirements. Support functions include but are not limited to:

a. Drafting professional ~~letter(s)~~letters requesting responses to specific questions ~~to~~from providers or other medical entities.
b. Tracking ~~corrective action plans to assure~~ Corrective Action Plans (CAPs) to ensure timely completion.
c. Following up as ~~instructed~~directed by the ~~peer review body~~PAC to ~~assure~~confirm corrective actions have been ~~completed (i.e., follow up with Committee Members, Reviewers, CMO QIMD on additional coaching, training, CME, etc.).~~implemented.
d. ~~Tracking~~Submitting weekly tracking reports ~~are submitted weekly~~ to the CMO/or QIMD to ~~ensure timely follow-through of~~monitor progress on all open cases requiring CAPs, ~~Responses~~responses, and ~~when completed closing out cases~~closure.
e. ~~Non~~Monitoring and documenting instances of provider non-compliance with ~~provider~~ responses ~~and~~or corrective actions.
f. ~~All steps are documented~~Recording all actions and follow-up activities in the peer review database system.

12. The QI Department will maintain a PQI log to track the timeliness of case reviews with a targeted completion time frame of 120 days.

| PQI Level | Description | Follow-up Action |
|---|---|---|
| 0 – No Quality-of-Care Concern | Insufficient evidence, documentation, or information to substantiate a PQI. | Case is closed with no further action required. |
| 1 – Potential for Harm | Substantiated PQI with documented evidence of possible member injury or harm. Member is expected to recover fully without lasting limitations. | Concern is tracked and trended for the specific provider. The CMO, QIMD, or PAC may determine additional individualized actions. |
| 2 – Actual Harm | Substantiated PQI with documented evidence or suspicion of member injury or harm. Injury may be: (1) minor, with minimal adverse effects and recovery with minor limitations; or (2) major, with significant adverse effects or permanent residual effects and recovery with some limitations. | Referred to PAC for direction, which may include tracking and trending, initiating a corrective action plan, and/or referring the case for review by an External Review Vendor (ERV). |
| 3 – Actual Morbidity or Mortality | Substantiated PQI with documented evidence or suspicion of serious negative outcomes, including permanent | Referred to PAC for direction, which may include tracking and trending, initiating a corrective action plan, and/or referring the |



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| | disability or death. | case for review by an External Review Vendor (ERV). |

**C. Corrective Action Plans**

1. When ~~a determination by~~ the PAC ~~CRPR Committee is made~~ determines that a Corrective Action Plan (CAP ~~is needed. The provider's)~~ is required, the provider shall submit a response ~~to the CAP is expected~~ within 30 calendar days ~~of sending~~from the date the CAP requirement ~~to the provider~~is issued.

2. ~~The~~ The CMO or ~~their~~ designee ~~uses~~shall use the Corrective Action Plan Form ~~in (Appendix E~~(Attachment D) and ~~completes~~complete the following sections:
   ~~a.~~ (a) Date
   ~~b.~~, (b) Provider Name
   ~~c.~~, (c) Deficiency #
   ~~d.~~2.Number, and (d) Expected Outcomes.

3. The QI Department will send the CAP request via certified mail.

4. ~~The~~ If no provider response to a CAP has been received within two (2) weeks, the QI nurse ~~creates a~~shall create a follow-up task in the ~~medical management~~ Medical Management system ~~for follow-up with the provider if no response to the CAP issues has been received in 2 weeks and~~and implement the following steps ~~will be implemented~~:
   a. A second CAP request ~~will~~shall be sent to the provider via certified mail.
   b. The QIMD ~~will~~shall be notified to perform an outreach call to the provider.
   c. ~~QI will~~If the provider does not respond within three (3) business days of the QIMD's call, QI shall notify the Provider Network Management Department ~~if the provider does not respond to the QIMD's call. 3 business days~~.
   d. If the provider responds within seven (7 ~~days~~) days, the case shall proceed to standard CAP review.

5. CAP responses from providers ~~will~~shall be reviewed by the PAC ~~CRPR Committee~~.
   a. The ~~PAC CRPR committee will~~Committee shall address the "Plan" ~~portion~~section of the CAP ~~form (Appendix~~Form (Attachment D).
   b. A CAP may include, but is not limited to:
      i. Required attendance at continuing education programs ~~applicable~~relevant to the ~~issue~~ identified issue and approved by KHS.
      ii. Required training~~/~~, re-training ~~and/or~~, certification~~/~~, or re-certification for performance of ~~those~~ procedures that require specific training ~~and professional certification~~or credentials.
      iii. Track and trend analysis of ~~the~~ adverse quality issues identified in the ~~clinician's~~clinician's practice patterns ~~and~~.
      iv. In-service training for clinicians and/or their staff.
6. ~~Once~~ Upon completion of the PQI review process ~~is completed~~, a provider resolution letter ~~will~~shall be ~~sent to the Provider~~issued.
   a. If the case ~~was a~~is confidential ~~case, the Member~~, member information ~~will~~shall be blinded in the ~~Provider~~ resolution letter.

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b. If the ~~Provider~~provider disagrees with the determination, they may file a complaint ~~to be reviewed~~for reconsideration by the PAC ~~CRPR for further consideration~~.

c. If the PAC ~~CRPR~~ action ~~pertains to~~constitutes an adverse action as ~~required by~~defined under Section 805.01 ~~they have~~, the provider retains the right to ~~files~~request a Fair Hearing and Appeal ~~Process~~.

~~7. The QI Department shall generate trend reports of PQI cases and shall report to the Physician Advisory Committee (PAC) at least every six (6) months.~~

**D. Tracking and Trending**

1. Tracking and Trending is performed to ensure that an identified QOC has been resolved. This is also done to identify any continuing patterns of ~~concerns~~concern and opportunities for improvement. (Attachment E).

2. The standard period to track and trend is 6 months unless otherwise specified by the CMO, QIMD, or ~~QIMD.~~Physician Advisory Committee (PAC).

3. All cases ~~selected~~meeting the criteria for tracking and trending are logged by the QI Department into KHS' Medical Management System as well as tracked on a spreadsheet.

~~4. When~~Once a new PQI referral is received, the ~~assigned QI nurse reviews the Track and Trend log to see if the provider in the new referral is on active~~ track and ~~trending.~~

~~a. trend log will be reviewed.~~ If the provider is on the active list, the QI nurse notes ~~that~~ in their investigative review ~~and includes that information in the referral to the CMO or QIMD. l determination and instructions for any follow up actions.~~

~~b.~~4.. The PQI will undergo investigation and review in accordance with the process defined within this policy and procedure.

5. Providers with no further QOC occurrences during the duration of time they are actively tracked and trended are moved to the inactive Track and Trend log. Extension of active track and trend duration can result at the direction of the CMO, QIMD, or PAC.

~~a. Extension of active track and trending may result at the direction of the CMO or QIMD when a new QOC issues related to a provider on the tracking and trending list occurs.~~

6. The QI Department shall generate PQI trend reports and present them to the Physician Advisory Committee (PAC) at least every six (6) months.

~~6.~~7.Provider- specific trends will be reported to ~~Provider Network Management~~the PAC for inclusion ~~in~~into the re-credentialing process.

**E. Inter-Rater Reliability (IRR)**

1. ~~Each quarter, the~~Purpose

a. The IRR audit ensures QI nurses consistently apply criteria, demonstrate accurate

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clinical judgement, and maintain proper documentation in PQI screenings.

2. Frequency and Responsibility
   a. The QI Manager or designee will conduct an ~~audit of a~~Inter-Rater Reliability (IRR) audit for each QI nurse upon hire, annually thereafter, and more frequently as deemed necessary by QI leadership.
3. Audit Sample and Method

~~1.~~ A sample of ~~five (5) PQI~~four (4) QOC episodes ~~completed per QI nurse who processes PQIs to~~ will be selected for case studies and will evaluate ~~that they are meeting~~ consistency in ~~application of criteria and decision making in screening PQIs:~~
   ~~a. Complying~~compliance with this policy and procedure,
   ~~b. Employing~~ use of appropriate clinical assessment skills, and
   ~~c.~~a. ~~Documenting~~ proper documentation of the ~~PQI referral~~ process ~~properly.~~.

4. ~~The~~Review and Follow-Up
   ~~2.~~a. Completed reviews will be forwarded to the CMO ~~/~~and/or QIMD ~~to verify~~for verification of consistency ~~or if there are~~ and identification of any issues ~~identified in the audit.~~. Deficiencies will require follow-up action with the QI ~~RN and~~nurse, documented evidence ~~to support correction.~~supporting the corrective measures taken.

**F. Delegates**

1. KHS is responsible for ensuring ~~that their~~ delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. KHS will communicate ~~the~~ policy requirements to all delegated entities and subcontractors. KHS will ensure ~~that~~ all ~~their own~~ policies and procedures, as well as the policies, procedures, and practices of any delegates, sub plans, contracted providers, or subcontracted Independent Physician Associations or medical groups, comply with these requirements and those located in any applicable APL.

## V. ATTACHMENTS

| | |
|---|---|
| ~~Attachment A:~~ | ~~PQI Referral Form~~ |
| Attachment ~~B~~A: | Medical Requests Form |
| Attachment ~~C~~B: | Medical Director Referral Form |
| Attachment ~~D~~C: | Dispositions for Grievances |
| Attachment ~~E:~~D: | Corrective Action Plan Form |
| Attachment ~~F:~~E: | PQI Tracking Categories |

## VI. REFERENCES

| Reference Type | Specific Reference |
|---|---|



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|---|---|
| Other KHS Policies | Policy 4.40-P Corrective Action Plans |
| Other KHS Policies | Policy 4.48- P Provider Disciplinary Action |
| Regulatory | California Code, Business and Professions Code - BPC § 805 |
| Regulatory | California Evidence Code § 1157 |
| Regulatory | CA DHCS Quality Improvement Technical Guide -QM TAG 04-04-18 (ca.gov) |
| Regulatory | Welfare and Institutions Code 14131.11 |
| Regulatory | Title 42 of the Code of Federal Regulations, sections 447.26, 434 and 438 |
| ~~DHCS Contract (Specify Section)~~Regulatory | DHCS - Provider-Preventable Conditions (ca.gov) |
| ~~All Plan Letter(s) (APL)~~ | ~~All Plan Letter 17-00 May 23 2017 Reporting Requirements Related to Provider Preventable Conditions~~ |

## VII. REVISION HISTORY

| Action | Date | Brief Description of Updates | Author |
|---|---|---|---|
| Revised | 09-04-2025 | Annual review including updating PQI level table and the IRR procedure. | QI Director |
| Revised | 09-2023 | Revised to Specifically cover PQIs and Peer Review. Grievance Information was deleted and is defined in the grievance and Appeals policies and procedures. | |
| Revised | 10-2022 | On 10/26, The policy received minor edits recommended by the MS team. | |
| Revised | 04-2022 | Updates made to include PPC process and policy reference | |
| Revised | 03-2022 | Updates made per DHCS CAP | |
| Revised | 02-2022 | Changed the name of PIC to PQI to align with the term used in our contract with DHCS. Changed grievance review process so that all grievances received are reviewed by a QI nurse for evaluation of PQI presence, referral to medical director if a PQI may exist for final determination and further direction. Changed PQI process so that all PQI referrals go to the CMO or designated medical director for severity level determination and direction for follow up. Added verbiage to support assurance that PQI investigations and any CAPs issued are completed. Included | |



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| | | additional layer of quarterly auditing for nurses' PQI work. | |
| Revised | 05-2021 | Clarified time frames throughout the policy to distinguish calendar or business days. Reduced the amount of time response for 2nd request for medical information is due. Changed references to Medical Director to Chief Medical Officer or their designee. Modified who is notified when member re-assignment is planned from the CEO to the Chief Network Administration Officer. Added new Corrective Action Form | |
| Revised | 06-2020 | Policy revised to incorporate legal counsel's guidance. Jane Daughenbaugh, Director of Quality Improvement | J.D. Quality Improvement |
| ~~Created~~ Effective | 04-2020 | Policy created Jane Daughenbaugh, Director of Quality Improvement. | J.D. Quality Improvement |

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## VIII. APPROVALS

| **Committees \| Board** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| ~~Quality Improvement/Utilization Management (QI/UM)~~Board of Directors (BOD) | | ~~05-2022~~ |
| ~~Choose an item.~~Physician Advisory Committee (PAC) | | |
| ~~Choose an item.~~Quality Improvement Health Equity (QIHETC) | | |

| **Regulatory Agencies** (if applicable) | **Date Reviewed** | **Date Approved** |
|---|---|---|
| ~~Department of Managed Health Care (DMHC)~~Department of Health Care Services (DHCS) | | ~~10-14-2022~~ |
| ~~Department of Health Care Services (DHCS)~~Department of Managed Health Care (DMHC) | ~~File and Use~~ | ~~09-23-2022~~ |
| ~~Choose an item.~~Centers for Medicare & Medicaid Services (CMS) | | |

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| 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. | | |

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KERN HEALTH SYSTEMS

**Policy and Procedure Review**

**KHS Policy & Procedure:** ~~2.70 I Potential Quality of Care Issues (PQI)~~

**Last approved version:** ~~10 2022~~

~~**Reason for revision:** Revised to Specifically cover PQIs and Peer Review. Grievance Information was deleted and is defined in the grievance and Appeals policies and procedures.~~

**Reason for revision:**

| Director Approval | | |
|---|---|---|
| **Title** | **Signature** | **Date Approved** |
| ~~John Miller~~<br>~~Medical Director of Quality Improvement~~ | | |
| ~~Magdee Hugais~~<br>~~Director of Quality Improvement~~ | | |
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Date posted to website ("P" policies only) : _____

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**PLEASE ONLY SEND THE MEDICAL RECORDS REQUESTED**
**3 DAY NOTICE**

DATE:

TO: Medical Records STAT

COMPANY:

PHONE NO: FAX NO:

FROM: QI Coordinator
2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE: (661) 377-9495 FAX: (661) 473-7575

E-mail: QIMedicalRecords@khs-net.com

If sent via email, please send secure to protect the member's confidentiality.

**RE:**
**DOB:**
**MEM#:**

To Whom It May Concern:

Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information:

*** Please include the following information for the date range of () to present and forward as soon as possible***

**NURSES NOTES, VISIT NOTES, PROGRESS NOTES, HISTORY & PHYSICAL, PHYSICAN NOTES, OP REPORST, DIAGNOSIS, PHYSICIAN ORDERS, AND REFERRALS.**

This notice is to inform you that we have not received the Medical Records for the request submitted to you on **, 2025**, for the above-named member's complaint. As member grievances are time sensitive, it is imperative that we receive the requested information in a timely manner in order to complete the investigation of the members complaints and provide a response to the members. The initial request provided a seven (7) calendar day response time. This notice will allow you **three (3) more calendar days** to respond. If we do not receive your response by **, 2025**, ***we will consider this complaint to be resolved in favor of the member.***

**Mail to: Kern Family Health Care or**
**2900 Buck Owens Blvd**
**Bakersfield, CA 93308**
**Attn; Esmeralda Rodriguez**

**Fax to: Kern Family Health Care**
**(661) 473-7575**

**PLEASE ONLY SEND THE MEDICAL RECORDS REQUESTED.**

DATE:

TO: Medical Records

COMPANY:

PHONE NO: FAX NO:

FROM: QI Coordinator
2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE: (661) 377-9495 FAX: (661) 473-7575

E-mail: QIMedicalRecords@khs-net.com

If sent via EMAIL, please send secure to protect member's confidentiality.

**RE:**
**DOB:**
**MBR#:**

To Whom It May Concern:

Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information:

*** Please include the following information for the date range of () to present and forward as soon as possible***

**NURSES NOTES, VISIT NOTES, PROGRESS NOTES, HISTORY & PHYSICAL, PHYSICIAN NOTES,** OP REPORTS, DIAGNOSIS, PHYSICIANS ORDERS, AND REFERRALS.

Please return this letter (or copy) with requested information within **7 days**. Thank you for your prompt assistance in this matter.

**Mail to: Kern Family Health Care or**
**Buck Owens Blvd**
**93308**
**Attn: Esmeralda Rodriguez**

**Fax to: Kern Family Health Care 2900**
**(661) 473-7575 Bakersfield, CA**

KERN HEALTH SYSTEMS

Potential Quality of Care Review (QOC) – Grievance
**Medical Director Referral Form**

## Quality Improvement RN Review

| | |
|---|---|
| **Referral Date**: Click or tap to enter a date. | **Person Referring** Choose an item. |
| **Member Last Name**: | **Member First Name:** |
| **Member DOB**: Click or tap to enter a date. | **Member ID:** |
| **Work Item #:** | |

**Information reviewed by Grievance Nurse**:
☒ Original Grievance ☐ Medical Records ☐ UM/CM Records ☐ Claims
Other (Specify): Click or tap here to enter text.

**Grievance Statement**:

**Background:** Click or tap here to enter text.

**Assessment:** Click or tap here to enter text.

**Recommendation:** Close in favor of: Choose an item.

**Date Medical Records Requested:** Click or tap to enter a date.

**Grievance Nurse Reviewer**: Choose an item.

**Date Review Completed**: Click or tap to enter a date.

## QI Medical Director Review

KERN HEALTH SYSTEMS

Potential Quality of Care Review (QOC) – Grievance
**Medical Director Referral Form**

Information reviewed by QI Medical Director:

☐ Original Grievance ☐ UM/CM Records ☐ Claims
Other (Specify): Click or tap here to enter text.

**QI Medical Director Summary of Review**: Click or tap here to enter text.

**QI Medical Director Determination:**

☐ Potential QOC issue ☐ No QOC issue
Click or tap here to enter text.

☐ In Favor of the Provider/Plan ☐ In Favor of the Member

**Clinical Resolution Verbiage (Includes reasons for the decision):**
*INSERT CLINICAL RATIONALE FOR MEMBER HERE - if closed in favor of member, note that their case will be sent to the Quality Improvement (QI) Department for further review. Please note if further action was/was not needed and why.*

**Follow up Action:**

☐ PQI Referral to QI Department

☐ No further action needed

☐ Other (Describe): Click or tap here to enter text.

**QI Medical Director Reviewer**: Choose an item.

**Date Review Completed**: Click or tap to enter a date.

# Dispositions for Grievances

Listed below are the new dispositions for Grievances from DHCS. KHS will implement these in our workflow for grievances on 04/01/2020 going forward.

| | |
|---|---|
| Continuity Of Care Providers (COC-P) | Grievance related to continuity of care for continuing with a provider. Member's perception that their request for continuity of care is being rejected or not considered. |
| Geographic Access (GA) | Grievance related to geographic access to a state plan approved provider, pharmacy or hospital within the geographic requirements based on type of appointment and condition of member's health. |
| Language Access (LA) | Grievance related to the inability to access or concerns with linguistic and interpreter services at the providers office. |
| Out-of-Network (OON) | Grievance related to inability to obtain services from a non-contracted provider. |
| Physical Access (PA) | Grievance related to the inability to physically access a provider or health plan due to office closure, not having wheelchair access, inadequate ramp, elevators, inadequate parking, or other requirements under the American with Disabilities Act. |
| Provider Availability (PAV) | Grievance related to the inability to see providers during normal hours of operation or concerns with the providers' hours of operation. |
| Timely Access (TA) | Grievance related to timely access to a state plan approved provider within the time-frame requirements based on type of appointment and condition of member's health. |

| | |
|---|---|
| Driver Punctuality (DRP) | Grievance related to driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Driver showed up either early, late, or not at all. |
| Vehicle (VEH) | Grievance related to the transportation vehicle's cleanliness, not having wheelchair access or other requirements under the American with Disability Act, or issues related to the state of the vehicle that jeopardizes the member's safety. |
| Injury (INJ) | Grievance related to a member incurring a physical injury. |
| Scheduling (SCHD) | Grievance related to member experiencing difficulties in arranging, scheduling, or accessing transportation services |
| Discrimination (DIS) | Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, or sexual orientation. May also include complaints where the member is treated differently after filing a grievance. |
| Disability Discrimination (DDIS) | Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on disability. Include allegations of failure to provide auxiliary aids, or to make reasonable accommodations in policies and procedures, when necessary to ensure equal access for persons with disabilities. |
| Fraud / Waste / Abuse (FWA) | Grievance related to intentional or unintentional misuse of resources, fraudulent, non-compliant, dishonest or unethical |

| | |
|---|---|
| | conduct committed by a health network, plan, provider, vendor, consultant, and current or potential member. |
| PHI / Confidentiality / HIPAA (PCH) | Grievance related to the breach of Personal Health Information (PHI) or confidentiality. Privacy rules were not followed. For example, complaints regarding the provider inappropriately accessing, using or disclosing a member's PHI |
| Authorization (AUTH) | Grievance related to the timeliness of an authorization or communication regarding the result (approval, denial or modification) of the authorization |
| Eligibility (ELIG) | Grievance related to Medi-Cal plan member's eligibility or share of cost requirements. |
| Enrollment (ENR) | Grievance related to Medi-Cal plan enrollment information received, enrollment process, Medi-Cal plan member being dis-enrolled from plan, providers, or any of its health network, etc. |
| Referral (REF) | Grievance related to the MCP’s processing of referrals to covered services. |
| Assault / Harassment (AH) | Grievance related to the physical, emotional, or sexual misconduct by a medical professional. |
| Case Management / Care Coordination (CMCC) | Grievance related to case management or care coordination. |
| Inappropriate Care (IC) | Grievance related to the overuse, under-use, or misuse of Medi-Cal covered services. |
| Member Informing Materials | Grievance regarding written materials provided in alternative formats or translation in threshold languages. |

| | |
|---|---|
| (MIM) | |
| Provider / Staff Attitude (ATT) | Grievance related to interactions with the provider's staff/representatives (e.g., nonclinical staff such as provider offices or facilities), including but not limited to, inappropriate behavior, poor attitude, rudeness, mistreatment, or long wait times. |
| Technology / Telephone (TTAC) | Grievance related to on-line scheduling systems, health plan system's connectivity, user friendliness, excessive waits, accessibility, via plan's website; or a member's inability to reach a provider or health plan's staff via phone or waiting on the phone too long. |
| Quality of Care (QOC) | Grievances related to complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.<br>**Internal Notes: **Clinical services or Clinical condition or treatment. (Abbreviation-PQI)** |
| Abuse / Neglect / Exploitation (ANE) | Grievances related to cases involving potential or actual patient harm. |
| Timely Response To Auth / Appeal Request (TMAUTH) | Grievances related to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals). |
| Expedited Appeal Request Denied (EXD) | Grievances related to a plan denying a request for an expedited appeal. |
| Plan's Failure to Meet Timeframes for Resolution (FMT) | Grievances related to a plan not meeting the time-frames for resolution of grievances and appeals provided at 42 CFR §438.408(b)(1) and (2) |
| Barriers/ Impeded Access to Prenatal Doula Services | Grievances related to barriers and/or impeded access to prenatal doula services. |

| | |
|---|---|
| (PNDS) | |
| Barriers / Impeded Access to Labor and Delivery Doula Services (LDDS) | Grievances related to barriers and/or impeded access to labor and delivery doula services. |
| Barriers / Impeded Access to Postpartum Doula Services (PPDS) | Grievances related to barriers and/or impeded access to postpartum doula services. |
| Plan Customer Service (CS) | Grievance related to interactions with the plan's staff/representatives (e.g., member services, plan marketing agents), including but not limited to, inappropriate behavior, poor attitude, rudeness, mistreatment, or long wait times. |
| Provider Balance Billing (PBB) | A provider bills the insurance and then bills the member for the remaining balance, which is prohibited for Medi-Cal members. This often occurs when the provider's billing system is set up for commercial insurance payers, who allow for co-payments and co-insurance, which is prohibited for Medi-Cal. |
| Provider Direct Member Billing (PDMB) | A provider bypasses the insurance and bills the member for the full bill. This often occurs when the provider does not have the member's insurance on file or when the provider is non-contracted. |

Updated 03/10/2025

KERN HEALTH SYSTEMS

# Corrective Action Plan

**Date:** _____

| | |
|---|---|
| **Provider Name:** | **Provider Address:** |
| **Member Name:** | **Member DOB:** |
| **Member ID:** | |

**Deficiency #:** _____

**Deficiency Description (KHS Completes):**

**Expected Outcomes (KHS Completes):**

**Actions Taken (Completed by Provider):**

**Implementation Date (Completed by Provider):** _____

**Evidence of Completion/Supporting Documentation if Applicable (Completed by Provider):**

_____ _____

**Provider Signature** **Date**

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

KERN HEALTH SYSTEMS

**KHS Medical Director Name:** _____

☐ **Approved**

☐ **Rejected**

_____ _____

**Medical Director Signature** **Date**

**Comments:**

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

2.70-I Attachment F - PQI Tracking Categories

**DRAFT of PQI TRACKING CATEGORIES Example Only**

| ISSUE CODE | DESCRIPTION |
|---|---|
| **PQ-1** | DME/Supplies |
| **PQ-2** | Benefit Issue |
| **PQ-3** | Delay in Service |
| **PQ-4** | Denial of Service |
| **PQ-5** | Refusal of Care/Prescription by Provider |
| **PQ-6** | Refusal of Referral (Specialist or Ancillary Services) |
| **PQ-7** | Treatment/Diagnosis/Inappropriate Care |
| **PQ-8** | Delay in Authorization |
| **PQ-9** | Access to Care |
| **PQ-10** | Continuity and Coordination of Care |
| **PQ-11** | Communication/Conduct |
| **PQ-12** | Physical environment |
| **PQ-13** | Medical Record/Documentation |
| **PQ-14** | Non-Emergent Care Services Rendered by Non-Credentialed Provider |
| **PQ-15** | Systems Issue |

# PQI Threshold Methodology and Selection

**1. Introduction**

The purpose of this addendum is to provide a detailed justification for the selection of 0.99 PQI per 1000 interactions as the threshold for identifying underperforming providers in Potential Quality Issues (PQI) analysis. This addendum supports Policy 2.70-I by outlining the statistical methodology, rationale, and expected impact of this threshold on provider performance evaluation.

**2. Background and Methodology**

To establish a data-driven approach for identifying underperforming providers, a comprehensive analysis of PQI rates was conducted. This analysis aimed to determine:

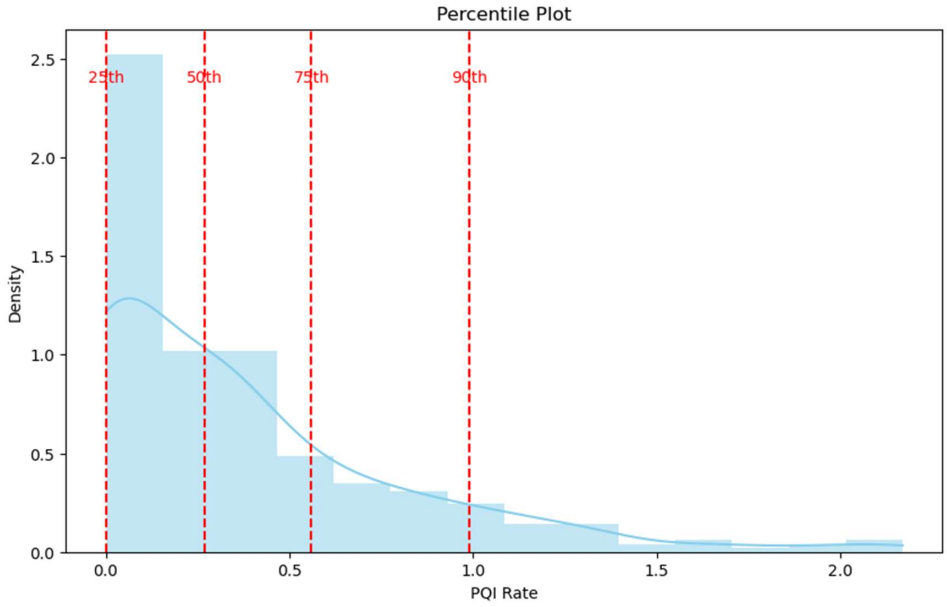
- The natural distribution of PQI rates across provider groups.
- The statistical outliers influencing PQI rate variation.
- The most appropriate threshold for defining significantly underperforming providers.

The methodology included:

A. **Data Cleaning and Outlier Removal:**
   - Provider types with extreme outliers (e.g., SNFs, Physicians, and Provider Groups) were examined.
   - Outliers with 1-2 interactions, which skewed rates, were removed.

B. **Percentile-Based Thresholding:**
   - The 75th percentile threshold was established at 0.56, indicating a point where provider rates became notably severe.
   - The 90th percentile threshold was calculated as 0.99, representing the most extreme cases of underperformance while maintaining statistical validity.

C. **Interquartile Range (IQR) Analysis:**
   - The middle 50% of provider PQI rates were analyzed to determine the range of standard performance.
   - The upper bound of the 90th percentile (0.99) was chosen to flag providers who consistently demonstrated a high deviation from the median PQI rate.




**3. Justification for the 0.99 Threshold**

The selection of 0.99 as the threshold for identifying significantly underperforming providers is justified based on the following factors:

**A. Statistical Significance**

- The 90th percentile captures the extreme upper outliers while allowing for normal performance variation.
- Providers exceeding 0.99 PQI rates demonstrate a deviation that is statistically rare and merits intervention.

**B. Clinical Relevance**

- A PQI rate above 0.99 indicates a higher frequency of quality concerns that may lead to adverse patient outcomes.
- The threshold ensures that only clinically significant deviations from expected provider performance trigger corrective action.

**4. Implementation and Monitoring**

To ensure effective application of the 0.99 threshold, the following steps will be integrated into PQI monitoring:

1. **Automated Flagging System:**
    - PQI reports will automatically flag providers with rates exceeding 0.99.

2. **Reassessment and Adjustment:**
    - The threshold will be re-evaluated annually based on emerging data trends.

**5. Conclusion**

The selection of 0.99 as the PQI threshold is grounded in statistical rigor and clinical relevance. It allows Kern Health Systems to effectively differentiate providers who require quality interventions while maintaining a data-driven approach to healthcare quality improvement.

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Traco Matthews, Chief Health Equity Officer

**SUBJECT:** Chief Health Equity Office Report

**DATE:** October 23, 2025

## BACKGROUND

Over the past two months, the health equity office has continued to strengthen its role as a driver of change, both within Kern Family Health Care and across the broader community. Each department has advanced major initiatives, showcasing the collective impact of our work.

Community engagement supported more than 700 navigator renewals in July and August while expanding outreach through farmworker cuadrillas and Medi-Cal renewal AI calls.
The team also fostered new volunteer partnerships and remained deeply connected to community health priorities. With leaders like Maritza and Emily chairing major initiatives such as Links for Life and Go Red, KFHC's influence in the community continues to grow.

The health equity team advanced critical work tied to NCQA accreditation, health disparity interventions and community partnerships. Highlights included development of pre- and postnatal care measures for Native communities, new interventions for chlamydia and cervical cancer, and the launch of the vendor diversity intake form. Faith-based engagement planning and cultural initiatives like Diwali and Hispanic Heritage Month reflect the breadth of their efforts.

Marketing and communications expanded KFHC's reach through more than 97,000 social media impressions, the launch of the smartwatch campaign and Medicare DSNP materials, and preparation of the 2025 community report for print. Internally, the approval of Workshop to replace Axios and the clearance of the new intranet vendor marked major infrastructure milestones.

Member engagement celebrated the launch of the InCOMM rewards program, progress on the member and provider portal and recognition from the Delano Chamber of Commerce as best insurance service. Expanded office presence in Wasco and McFarland and stronger school district partnerships also reinforced KFHC's local impact.

Together, these achievements highlight our steady progress in advancing equity, building systems and elevating community trust—key steps on our journey toward lasting impact.

## REQUESTED ACTION

Receive and file.

# HEALTH EQUITY DIVISION

## OCTOBER 2025 BOARD REPORT

Kern Family Health Care®

# COMMUNITY ENGAGEMENT

**233**
Board Hours

**138**
Volunteer Hours

**238**
Health Fair Hours

**91**
Sponsored Event Hours

## Praises and Progress

The community engagement team continued to strengthen member relationships and expand KFHC's presence across Kern County. Navigators completed nearly 800 renewals in July and August and provided ongoing assistance through Medi-Cal renewal AI calls. Their excellent service has been widely recognized by members returning for renewals, reinforcing KFHC's role as a trusted community partner.

Professional growth also remained a priority, with Maritza completing 52 hours of Medicare training and earning her Medicare sales license. Meanwhile, the team wrapped up three months of outreach with farmworkers, meeting individuals directly at their worksites to share Medi-Cal renewal and health benefit information. These face-to-face efforts built stronger connections with a population that often faces barriers to care.

Volunteerism and partnerships continued to grow, with new opportunities created through East Rotary and ongoing support for local health and resource events. The team's active involvement across community initiatives helps maintain KFHC's visibility and reinforces its commitment to health equity and access for all residents.

## Priorities

Looking ahead, the team will support several major health events, including Links for Life, led by Maritza, and the American Heart Association's Go Red campaign, chaired by Emily with Maritza serving on the committee. Planning is also underway for the 2026 Cervical Cancer Resource Fair, alongside the development of new community investment guidelines. September efforts will include Hispanic Heritage Month activities, expanded volunteer opportunities and continued collaboration with media partners to educate the public about Medi-Cal renewals.

Total membership renewals by CE navigators **788**

# HEALTH EQUITY

## Praises and Progress

The health equity team continued advancing accreditation, data improvement and community collaboration efforts throughout July and August. Following the NCQA Health Equity Accreditation submission, the division prepared targeted responses and began developing the workplan to maintain progress toward full accreditation.

Work also advanced on disparity programs aimed at reducing gaps in care, including pre- and postnatal health for Native communities and new interventions for chlamydia and cervical cancer screening. Action planning tied to the Health Disparity Report reinforced KFHC's long-term focus on addressing inequities through measurable outcomes.

Community partnerships remained a central focus. The team finalized the Kern Health Equity Partnership Community Conversations Report and began planning for the October launch of faith-based engagement activities. Collaborations with Greenfield Union School District and Memorial Hospital's doula training further demonstrated the team's reach and cross-sector impact. Additional progress included the completion of a vendor diversity intake form, contractor trainings to strengthen equity alignment and updates to SOGI data collection processes.

## Priorities

In September, the team will finalize the vendor diversity intake form, complete the NCQA workplan and continue enhancing data dashboards to strengthen accountability. Provider and member engagement will expand through new newsletter articles on intimate partner violence and doula services, as well as ECM provider trainings. Planning will also continue for upcoming cultural initiatives, including Hispanic Heritage Month and Diwali, while the team delivers Quality and Excellence Awards and advances the Community Reinvestment Plan to ensure resources align with community needs.

# MARKETING AND COMMUNICATIONS

## Praises and Progress

The marketing and communications team continued to expand KFHC's visibility and strengthen engagement across both internal and external audiences. In July and August, the team shared 109 social media posts that generated more than 97,000 impressions and 14,000 engagements—maintaining a strong 13 percent engagement rate. Campaign highlights included the smartwatch incentive encouraging well-child visits, the ongoing Medicare DSNP campaign and Hispanic Heritage Month preparations.

Major communications initiatives moved forward, including the completion and approval of the 2025 community report for print, continued production of internal newsletters and support for board presentations, memos and employee recognition communications. Content development remained active with Quality and Excellence Award video production, externship highlight reels, promotional pieces and the CSUB Expungement Clinic video. Creative work also advanced for Medicare DSNP materials, including billboards, flyers, postcards and web updates.

The team also made key progress on infrastructure, finalizing cybersecurity clearance for the new intranet vendor and approving the Workshop platform to replace Axios for newsletters—both significant steps in modernizing KFHC's communications systems.

## Priorities

In September, the team will continue driving strategic growth and branding efforts, including the Medicare DSNP brand launch and campaign rollout across TV, outdoor, radio and digital channels. Rebrand discussions have advanced to two finalist agencies, with a final selection to be made in partnership with executive leadership. Internal efforts include intranet contract kickoff, continued screensaver testing and the development of the 2026 internal communications plan. Externally, the team will support Hispanic Heritage Month, pain awareness and smartwatch campaigns while collaborating with government relations and legal on the crisis communications plan to ensure readiness and consistency in KFHC's messaging.

As of June
Choice Rate
73%

As of June
Market Share
86%

# MEMBER ENGAGEMENT

**98.5%**
Retention Rate

**5704** Member Interactions

**29**
Presentations

**558**
Disenrollments

## Praises and Progress

The member engagement division made strong progress on several major initiatives during July and August, with expansion and project completion rates exceeding 90 percent. The member materials library was finalized, the transportation feasibility study and text messaging program advanced significantly, and the new member rewards program went live in partnership with InCOMM after the approval of notice workarounds with NDN and LA taglines.

The team also continued improving systems that enhance access and communication. The member and provider portal project officially launched, revised HRAs for Medi-Cal and DSNP moved forward, and CCS transportation coverage advanced in collaboration with compliance. Completion of the DSNP summary of benefits, formulary and member handbook marked key milestones in strengthening member tools and information.

KFHC's visibility within the community continued to grow, with the furnishing and activation of Wasco and McFarland offices, the start of mobile washer and dryer unit use and new partnerships that directly benefit members. Collaboration with Welden School District also increased immunization compliance for children registering for school. The division celebrated additional recognition as KFHC was named Best Insurance Service by the Delano Chamber of Commerce and six team members earned Medicare licensing credentials.

## Priorities

In September, the team will focus on refining member tools and outreach, including the AI call script, HRA mailing list and Medi-Cal handbook. Work continues with mPulse to launch the new text messaging platform and with CS and Hall on revised DSNP HRAs. Efforts remain active on the in-house transportation pilot and member and provider portal, while the in-house feasibility study is on hold until October. Additional focus areas include the member satisfaction survey, ongoing Medicare sales training, Medicare website updates and continued coordination with compliance on CCS transportation benefits.

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

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

**SUBJECT:** 2nd and 3rd Quarter 2025 Operations Report

**DATE:** October 23, 2025

I am pleased to provide the following operational report highlighting activities and the performance metrics for both the 2nd and 3rd quarters of 2025. All Operational Departments continue to meet or exceed all regulatory requirements and performance metrics during both quarters.

## CLAIMS

We continue to receive an increasing number of claims each quarter with an overall 18% increase in claims in comparison to the third quarter of 2024. This increase can be directly attributed to the increase in new KHS membership throughout the year along with retention of existing members through the ongoing renewal redetermination process.

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. 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 the claims reached 89% during both quarters, 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 continues to receive a high volume of provider calls seeking clarification regarding claim payment and processing questions. During the 3rd Quarter the provider call volume was slightly higher than the previous quarter with over 9200 incoming calls, similar to the volume of the 3rd Quarter of 2024. We have received positive feedback from providers regarding this service.

## MEMBER SERVICES

The volume of calls into Member Services was similar to previous quarters. Key performance indicators (abandonment rate, average talk time) are all aligned with normal trends with the exception of average speed to answer. 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 make adjustments 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.

The need to make manual outreach calls was eliminated during the 3rd quarter with the implementation of Ai technology to make outbound calls for member Medi-Cal renewals. Implementing this new technology allowed management to reduce the number of temporary employees that were performing this task manually. We have received very positive reactions from members who have received these Ai generated calls. We have found the software to be extremely personable, with the ability to handle other languages and can respond to most questions and when it cannot, it transfers the call to a "live" member services agent. The Ai tool also includes a question asking the member if they would like to receive future text and automated calls from KHS. Obtaining these responses increases our ability to communicate with our members in the future via automation and text messaging.

Member walk-in visits have also increased by 24% during the 3rd quarter as a result of our implementation of Ai outreach for member redetermination. In addition to requesting assistance with their Medi-Cal renewal, visitors also visit the office for 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 2nd and 3rd quarters almost 8700 members created new online accounts. Currently over 102,000 (25%) of our members have online member portal accounts which allow 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 Department (PNM) monitors provider network growth, capacity, and accessibility.

The Primary Care Provider (PCP) network continued to grow slightly during the 2nd and 3rd quarters, with a net increase of 34 PCPs for a total of 551 PCP providers while the specialty provider network had a sizeable increase of 165 specialists during the same time period. Our complete contracted provider network consists of 4,768 providers at the close of the 3rd Quarter. It is noteworthy that our overall provider network continues to grow during the past twelve months. At the end of the 3rd Quarter 2024 our complete provider network consisted of 4,220 providers compared to the current network of 4,768 providers a 13% overall increase.

PNM monitors network capacity/adequacy via a Full-Time Equivalency (FTE) provider to member ratio, which is based on regulatory requirements. For PCPs, the regulatory standard is one FTE PCP for every 2,000 members. As of the 3rd Quarter of 2025, the Plan maintained a network of one FTE PCP for every 1,378 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 3rd Quarter, the Plan maintained a network of one FTE Physician for every 292 members, meeting the requirement. Even as our membership continues to grow, the Plan's network continues to meet all regulatory capacity/adequacy requirements. 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 3rd Quarter, the PCPs provided visits on average within 2.2 days. Non-urgent appointments with a specialist must be made available within 15 days. Our specialist appointment is currently at 9.2 days.

**GRIEVANCE REPORT**

Total Grievances for the 2nd and 3rd quarters rose slightly over previous quarters primarily in Access to Care, Medical Necessity, Quality of Service and Exempt Grievances. Medical Necessity growth was impacted by the changes made to the guidelines for several of the Community Support Services benefit, specifically medically tailored meals and personal homemaker services. Changes were also implemented to the medical transportation procedures which impacted Access to Care and Quality of Service. We anticipate this increase in grievances may continue into the 4th quarter while members become accustomed to the new plan procedures for both community support services and the transportation benefit. The volume of Exempt grievances, those grievances requiring less investigation and easily resolved, also increased due to both the community support service and transportation benefit changes.

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 78 grievances classified as discrimination during the 2nd Quarter and 61 in the 3rd 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 3rd Quarter of 2025. Following the review and investigation of the 535 Potential Inappropriate Care by the Quality Department, 450 of the decisions were upheld, 76 were overturned and ruled in favor of the members and 9 grievances were still under review by the Quality Department. The remaining 1,781 grievances were reviewed and managed by the Grievance Coordinators, 1,258 of the decisions were upheld by the Plan, 508 were overturned and ruled in favor of the member and 15 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 3rd Quarter of 2025, there was over 1.7 million medical encounters provided to our 400,000 members. In total, KHS received 2.47 grievances per 1,000 members per month, well within the range of the other LHPC Plan averages of 1.00 – 3.99 per month.

**REQUESTED ACTION**

Receive and file.

# 2nd and 3rd Quarter 2025 Operational Report

Alan Avery
Chief Operating Officer

# 3rd Quarter 2025 Claims Department Indicators

| Activity | Goal | 3rd Quarter 2025 | Status | 2nd Quarter 2025 | 1st Quarter 2025 | 4th Quarter 2024 | 3rd Quarter 2024 |
|---|---|---|---|---|---|---|---|
| Claims Received | | **1,747,043** | | 1,751,764 | 1,659,951 | 1,529,137 | 1,475,200 |
| Electronic | 95% | **99%** | | 99% | 99% | 99% | 99% |
| Paper | 5% | **1%** | | 1% | 1% | 1% | 1% |
| Claims Processed Within 30 days | 90% | **98%** | | 99% | 99% | 98% | 98% |
| Claims Processed within 45 days | 95% | **99%** | | 99% | 99% | 99% | 99% |
| Claims Processed within 90 days | 99% | **99%** | | 100% | 99% | 99% | 100% |
| Claims Inventory-Under 30 days | 96% | **98%** | | 99% | 99% | 99% | 99% |
| 31-45 days | <3% | **1%** | | <1% | <1% | <1% | <1% |
| Over 45 days | <1% | **1%** | | <1% | <1% | <1% | <1% |
| Auto Adjudication | 85% | **89%** | | 89% | 88% | 88% | 88% |
| Audited Claims with Errors | <3% | **2%** | | 2% | 2% | 2% | 1% |
| Claims Disputes | <5% | **<1%** | | <1% | <1% | <1% | <1% |
| Provider Calls | | **9,274** | | 8,921 | 8,736 | 8,060 | 10,260 |

KERN HEALTH SYSTEMS

# 3rd Quarter 2025 Member Service Indicators

| Activity | Goal | 3rd Quarter 2025 | Status | 2nd Quarter 2025 | 1st Quarter 2025 | 4th Quarter 2024 | 3rd Quarter 2024 |
|---|---|---|---|---|---|---|---|
| Incoming Calls | | 70,159 | | 76,764 | 77,449 | 68,844 | 74,004 |
| Abandonment Rate | <5% | 3% | | 2% | 1% | 2% | 1% |
| Avg. Answer Speed | <2:00 | :46 | | :20 | :11 | :18 | :13 |
| Average Talk Time | <9:00 | 8:28 | | 8:01 | 7:57 | 8:02 | 8:20 |
| Top Reasons for Member Calls | Trend | 1. New Member<br>2. Demographic changes<br>3. PCP Change<br>4. ID Card<br>5. Referrals | | 1. New Member<br>2. Demographic changes<br>3. PCP Change<br>4. ID Card<br>5. Referrals | 1. New Member<br>2. Demographic changes<br>3. PCP Change<br>4. ID Card<br>5. Referrals | 1. New Member<br>2. Demographic changes<br>3. PCP Change<br>4. ID Card<br>5. Referrals | 1. New Member<br>2. PCP Change<br>3. Demographic changes<br>4. ID Card<br>5. Referrals |
| Outbound Calls | Trend | 55,079 | | 69,300 | 69,357 | 61,622 | 67,046 |
| # of Walk Ins | Trend | 1887 | | 1524 | 1542 | 1343 | 1305 |
| Member Portal Accounts-Q/Total | 4% | 4500<br>102,847<br>(25.68%) | | 4194<br>98,269<br>(24.27%) | 4277<br>94,074<br>(23.25%) | 3677<br>89,798<br>(22.24%) | 4217<br>85,968<br>(21.44%) |

KERN HEALTH SYSTEMS

# 3rd Quarter 2025 Provider Network Indicators

| Activity | Goal | 3rd Quarter 2025 | Status | 2nd Quarter 2025 | 1st Quarter 2025 | 4th Quarter 2024 | 3rd Quarter 2024 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| # of PCP | | **551** | | 538 | 517 | 505 | 491 |
| % Growth | | **2.42%** | | 4.06% | 2.38% | 2.85 | 3.15% |
| # of Specialist | | **739** | | 682 | 574 | 559 | 548 |
| % Growth | | **8.36%** | | 18.8% | 2.68% | 2.01% | [1.97] |
| | | | | | | | |
| FTE PCP Ratio | 1:2000 | **1:1,378** | | 1:1,431 | 1:1,483 | 1:1,514 | 1:1544 |
| FTE Physician Ratio | 1:1200 | **1:292** | | 1:283 | 1:180 | 1:256 | 1:260 |
| | | | | | | | |
| PCP | < 10 days | **2.2 days** | | 2.5 days | 3.6 days | 1.3 days | 2.5 days |
| Specialty | < 15 days | **9.2 days** | | 6.7 days | 7.1 days | 3.5 days | 4.6 days |

KERN HEALTH SYSTEMS

# 3rd Quarter 2025 Grievance Report

| Category2 | Q3 2025 | Status | Issue | Q2 2025 | Q1 2025 | Q4 2024 | Q3 2024 |
|---|---|---|---|---|---|---|---|
| Access to Care | 800 | | Appointment Availability | 832 | 713 | 603 | 530 |
| Coverage Dispute | 0 | | Authorizations and Pharmacy | 0 | 0 | 0 | 0 |
| Medical Necessity | 299 | | Questioning denial of service | 220 | 192 | 241 | 275 |
| Other Issues | 172 | | Miscellaneous | 165 | 141 | 134 | 92 |
| Potential Inappropriate Care | 513 | | Questioning services provided. All PIC identified cases forwarded to Quality Dept. | 493 | 535 | 476 | 438 |
| Quality of Service | 687 | | Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department | 702 | 654 | 509 | 467 |
| Discrimination (New Category) | 61 | | Alleging discrimination based on the protected characteristics | 78 | 81 | 71 | 52 |
| Total Formal Grievances | 2532 | | | 2490 | 2316 | 2034 | 1854 |
| Exempt | 981 | | Exempt Grievances- | 985 | 683 | 644 | 774 |
| Total Grievances (Formal & Exempt) | 3513 | | | 3475 | 2999 | 2678 | 2628 |

**KHS Grievances per 1,000 members – 2.47**
**LHPC Average 1.0 – 3.99/month**

KERN HEALTH SYSTEMS

# Additional Insights-Formal Grievance Detail

| Issue | 2025 3rd Quarter Grievances | Upheld Plan Decision | Further Review by Quality | Overturned Ruled for Member | Still Under Review |
|---|---|---|---|---|---|
| Access to Care | 317 | 198 | 0 | 116 | 3 |
| Coverage Dispute | 0 | 0 | 0 | 0 | 0 |
| Specialist Access | 396 | 226 | 0 | 165 | 5 |
| Medical Necessity | 192 | 126 | 0 | 66 | 0 |
| Other Issues | 141 | 119 | 0 | 22 | 0 |
| Potential Inappropriate Care | 535 | 450 | 0 | 76 | 9 |
| Quality of Service | 654 | 510 | 0 | 137 | 7 |
| Discrimination | 81 | 79 | 0 | 2 | 0 |
| **Total** | **2316** | **1708** | **0** | **584** | **24** |

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:** Deborah Murr, Chief Compliance and Fraud Prevention Officer

**SUBJECT:** Chief Compliance and Fraud Prevention Officer Report

**DATE:** October 23, 2025

## BACKGROUND

Kern Health Systems (KHS) is required to implement an effective Compliance Program that meets the regulatory requirements set forth in both the Department of Health Care Services (DHCS) contract and the Department of Managed Health Care (DMHC) Knox-Keene license.

The principles outlined in the regulatory guidelines are applicable to all KHS relevant decisions, situations, communications, and developments that align with requirements defined by the Office of Inspector General (OIG). The Governing Board is required to exercise reasonable oversight with respect to the implementation and effectiveness of the Compliance program.

## DISCUSSION

Regulatory filings, e.g., reports, financial data, quality performance, and surveys are filed in response to new services, programs, and oversight requirements that are mandated under our contract and license. Currently, KHS is on track to meet or exceed the number of filings completed in 2024.

Privacy Protections and Fraud Prevention remain a key focus for KHS' Compliance department. Suspected violations are promptly investigated and reported to DHCS for probable violations of policies, regulations, statutes, or program requirements. Between August and September 2025, the Compliance Department investigated 73 allegations of privacy concerns, with seven (7) forwarded to DHCS for review in which all remain under review with DHCS.

In 2025, the Compliance department investigated 541 suspected fraud, waste, and abuse allegations, which represents a 35% increase for the same time period in 2024 (highest ever in a year to date). 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.

The Compliance Department conducts internal audits and monitoring activities to determine the organizational alignment to all regulatory and contractual obligations and conducts risk analysis to prioritize remediation plans if warranted. Internal resource constraints have impacted internal audits scheduled. To date in 2025, Compliance conducted internal audits of Exempt, Expedited, and Standard Grievances (previous audit findings), Utilization Management Notice of Action (NOA) letters, KHS website, and the Provider Manual.

Currently in review are the semi-annual review of all grievance types; Notice of Appeal Resolutions (NAR), and Post-Stabilization/Concurrent Inpatient Reviews (DMHC audit finding). Internal resource constraints have impacted fully internal audits scheduled.

**Department of Managed Health Care (DMHC)**

2023 DMHC Medical Audit / 2025 DMHC Follow Up Audit

- Follow Up Audit Period: 11/01/2024 – 06/30/2025
- Virtual interviews tentatively scheduled for 11/10/2025 (awaiting actual schedule)

2024 DMHC Audit of Fiscal and Administrative Affairs

- Received Final Report 08/14/2025
- Corrective Actions taken regarding the two findings were accepted with no follow up needed.
    - Claims processing error for retroactive update to one provider contract due to timing of TRI adjustments occurring at the same time
    - Key personnel filings not submitted timely

**Department of Health Care Services (DHCS)**

2023 Focused Audit (Behavioral Health & Transportation)

- Submitted updated corrective action plan (CAP) template in August per DHCS request
- Awaiting formal closure/acceptance of CAP

2025 Focused Audit (Information Systems Security)

- Audit period: 05/01/2024 – 04/30/2025
- Audit closing remarks scheduled for 10/13/2025, which will be followed by Preliminary Report

This report provides an overview of the July 2025 through September 2025 KHS Compliance Program activities with the corresponding updates.

**REQUESTED ACTION**

Receive and file.

**Compliance**
**Key Performance Indicators**
**October 2025**

KERN HEALTH SYSTEMS

## Compliance Communications

**Department of Managed Health Care (DMHC)**

- 2023 DMHC Medical Audit / 2025 DMHC Follow Up Audit
  - Follow Up Audit Period: 11/01/2024 – 06/30/2025
  - Submitted numerous pre-audit deliverables
  - File orientation sessions currently being scheduled
  - Virtual interviews tentatively scheduled for 11/10/2025 (awaiting actual schedule)
- 2024 DMHC Audit of Fiscal and Administrative Affairs
  - Received Final Report 08/14/2025
  - Corrective Actions taken regarding the two findings were accepted with no follow up needed.
    - Claims for retroactive update to one provider contract not processed accurately (due to timing of TRI adjustments occurring at the same time)
    - Key personnel filings not submitted timely

**Department of Health Care Services (DHCS)**

- 2023 Focused Audit (Behavioral Health & Transportation)
  - Submitted updated corrective action plan (CAP) template in August per DHCS request
  - Awaiting formal closure/acceptance of CAP
- 2025 Focused Audit (Information Systems Security)
  - Audit period: 05/01/2024 – 04/30/2025
  - Submitted numerous pre-audit deliverables
  - Participated in virtual interviews in August & submitted follow up documentation
  - Audit closing remarks scheduled for 10/13/2025, which will be followed by Preliminary Report.

**DSNP:**

- CMS contracting complete
- Member and Marketing materials submitted and approved
- Marketing as of 10/01/2025
- Annual Enrollment Period begins 10/15/2025
- Implementation activities ongoing

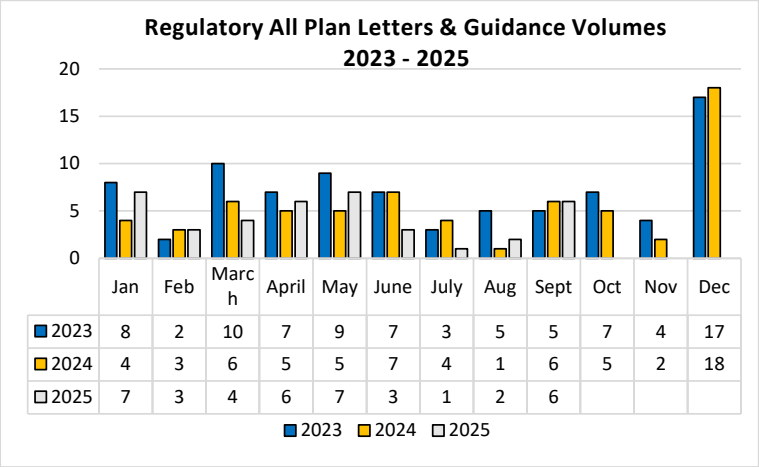
**Enterprise Risk Assessment Project:**

- Project ongoing
  - Enterprise Risk Management Training content nearing completion
  - Enterprise Risk Management Risk Register drafted and under review
  - Stakeholders identified for individual and small group sessions
- Project will continue throughout 2025 with gap analysis and remediation plan.

**Compliance Capsules:**

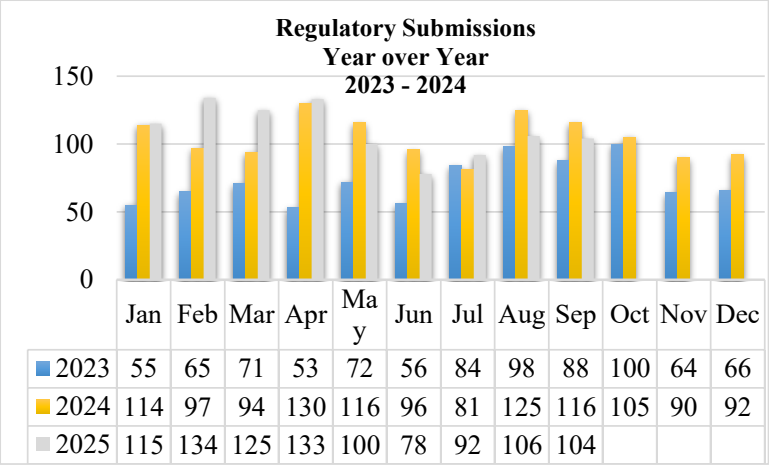
- August: Regulatory Submissions Guide
- September: DOJ, HHS & CMS

## All Plan Letter (APLs) & Guidance Letters

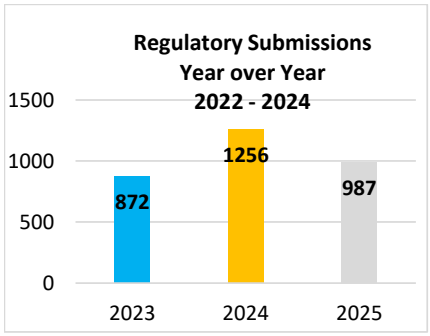



| All Plan Letters & Guidance Letters Received | | |
|---|---|---|
| 2023 | 2024 | 2025 |
| 83 | 66 | 39 |

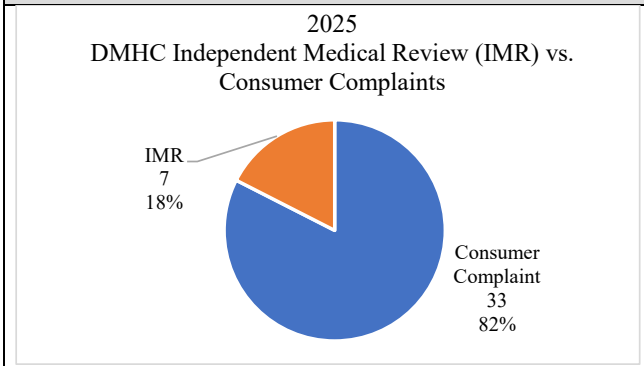
## Regulatory Reports & Filings




| Regulatory Submissions | | |
|---|---|---|
| Regulatory Agency | August 2025 | September 2025 |
| DHCS | 88 | 97 |
| DMHC | 18 | 7 |
| **Total** | **106** | **104** |




## DMHC Consumer Complaints & Independent Medical Reviews (IMR)



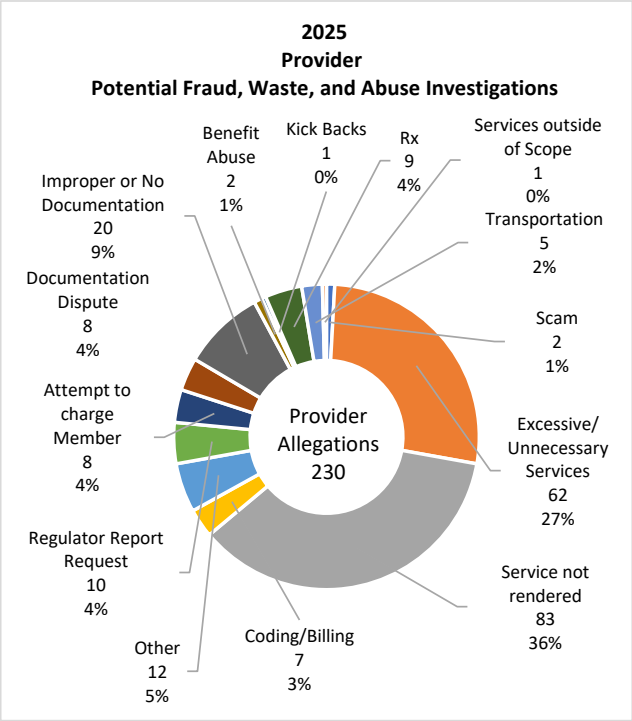

| Decision | KHS Response | DMHC Response |
|---|---|---|
| Upheld | 19 | 35 |
| Overturned | 8 | 2 |
| Return to Plan (Grievance Process not completed prior to DMHC complaint) | 6 | 0 |
| Duplicate | 1 | 0 |
| Misdirected | 3 | 1 |
| Services Never Denied | 3 | 0 |
| In Process | 0 | 2 |
| **Grand Total** | 40 | 40 |

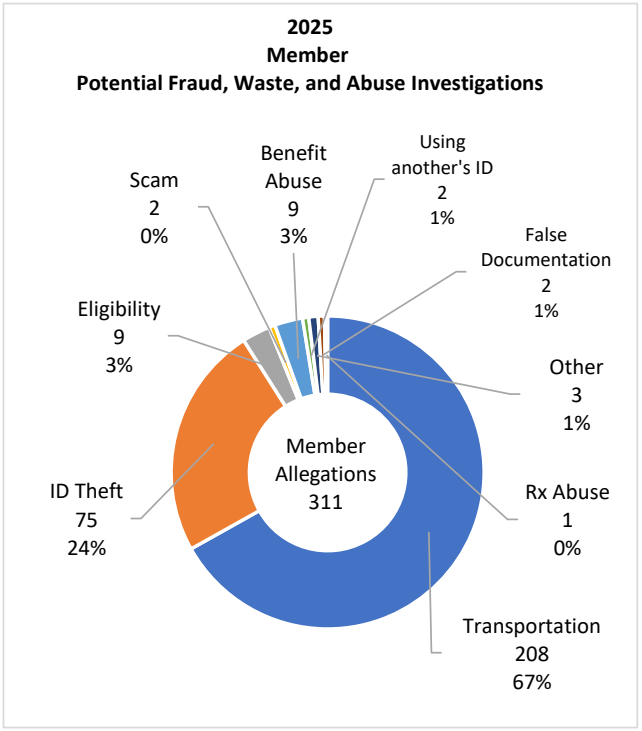
## HIPPA Breach Activity

**Summary of potential Protected Health Information (PHI) disclosures for August 1 through September 30, 2025:** The Plan is dedicated to ensuring the privacy and security of the PHI and personally identifiable information (PII) that may be created, received, maintained, transmitted, used, or disclosed in relation to the Plan's members. The Plan strictly complies with the standards and requirements of Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

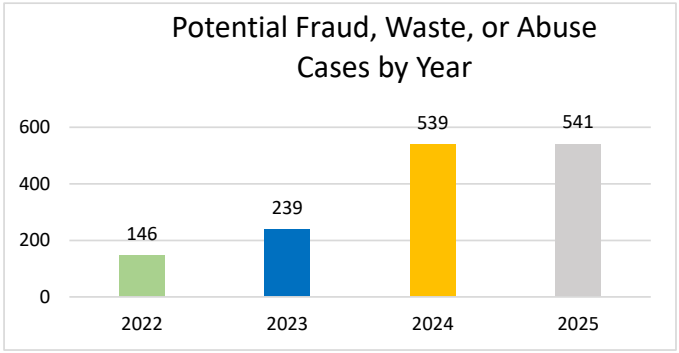
During the period from August 1st to September 30th, 2025, the Compliance Department investigated and reviewed seventy-three (73) allegations of privacy concerns and two (2) of the cases were sent to the State for their review. Currently, seven (7) of the cases reported, including the two (2) reported in this timeframe, are still under review by the State.

## Fraud, Waste, and Abuse (FWA)




2025 cases have surpassed the full year of 2024. Overall trending continues at a 35% increase in cases to date compared to same time period in 2024:



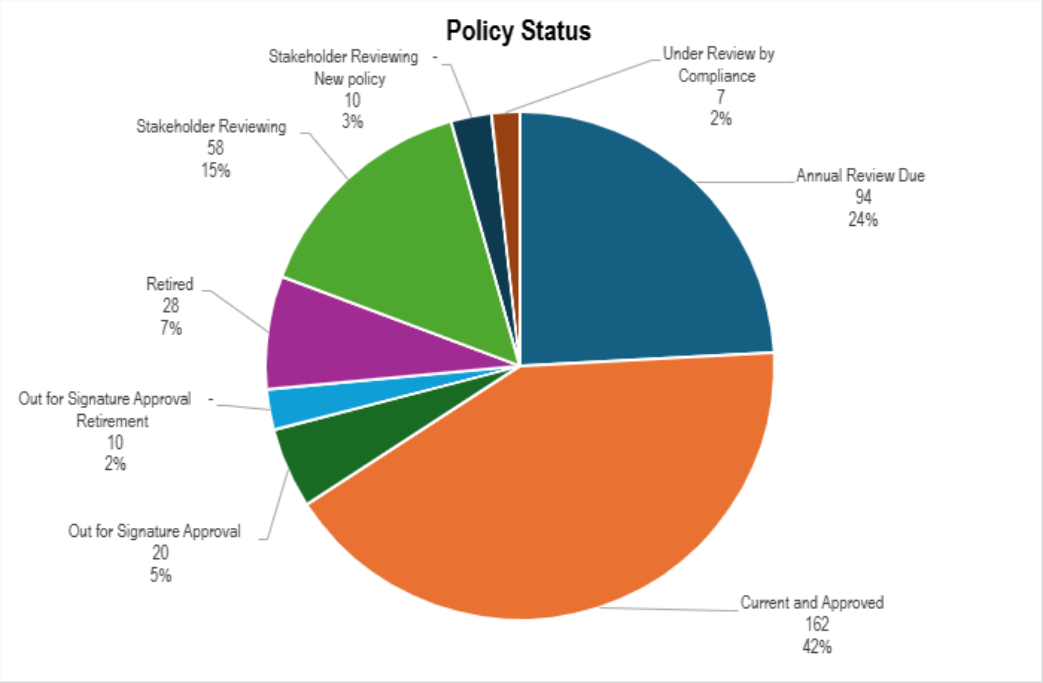
| All Plan Letters (APLs) & Guidance Letters<br>August – September 2025 | |
|---|---|
| **Department of Health Care Services (DHCS)** | |
| **APL 25-012**<br>Targeted Provider Rate Increases<br>(Issued 8/19/2025) | This APL provides guidance to KHS on eligible Network Provider payment requirements applicable to Medi-Cal Targeted Rate Increases, effective for dates of service on or after January 1, 2024. |
| **APL 25-013**<br>Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage<br>(Supersedes APL 22-012)<br>(Issued 9/18/2025) | This APL provides guidance to KHS on the oversight and administration of the Medi-Cal pharmacy benefit. |
| **APL 25-014**<br>Update to Provider Directory Requirements<br>(Issued 9/26/2025) | This APL provides guidance to KHS on updated Provider Directory requirements pursuant to the Consolidated Appropriations Act, 2023, State Health Official Letter (SHO) 24-003, Code of Federal Regulations (CFR) section 438.10. |
| **Department of Managed Health Care (DMHC)** | |
| **APL 25-013**<br>Amendments to Rules 1300.51, 1300.52, 1300.52.4, 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2026 and Continuing Thereafter<br>(Issued 9/4/2025) | This APL provides notice to KHS of new amendments to 28 CCR §§ 1300.51, 1300.52, 1300.52.4, 1300.67.2.2, and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2026 Annual Network Report submission and continuing thereafter. |
| **APL 25-014 (OPM)**<br>Provider Appointment Availability Survey Manual and Report Form Amendments Beginning RY 2027/MY 2026 and Continuing Thereafter.<br>(Issued 9/4/2025) | This APL provides notice to KHS of amendments to Rule 1300.67.2.2 and the following Timely Access Compliance Report documents: Provider Appointment Availability Survey Manual, Report Forms and the Timely Access Submission Instruction Manual. |
| **APL 25-015**<br>Assembly Bill 144 and Coverage of Preventive Care Services<br>(Issued 9/18/2025) | This APL outlines KHS's obligations to cover preventive care items and services prior to the enactment of AB 144 and summarizes AB 144's new requirements regarding coverage of preventive care items and services. The APL also highlights recent recommendations by CDPH regarding immunizations to protect against COVID-19, RSV, and influenza. |

**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. The following audits are underway: The 2nd semi-annual review of all grievance types; Notice of Appeal Resolutions (NAR), and Post-Stabilization/Concurrent Inpatient Reviews (DMHC audit finding). Due to staffing constraints, these audits have recently resumed.

**Policies**




| 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.<br><br>These submissions often reflect an amendment or material modification to the plan's license and, in some cases, are subject to Department approval prior to making the requested change to plan operations. |
| **Regulatory Submission Volume** | Regulatory submissions to both DHCS and DMHC continue to increase annually. As demonstrated in the graphs above, submissions to date continue to increase steadily year 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 August and September 2025, a total of ten (10) Consumer Complaints/IMRs were received, of which eight (8) were closed following KHS' response with no further action needed, and two (2) are pending DMHC review.

**Fraud, Waste, and Abuse (FWA)**

The Plan investigates and reports information and evidence of alleged fraud, waste, & abuse cases to appropriate state and federal officials. Information compiled during an investigation is forwarded to the appropriate state and federal agencies as required. For 2025, the volumes continue to trend up, with 35% more cases received through September when compared to the same time period in 2024. The 2025 cases to date through 09/30/2025 surpassed the total volume in 2024, with the highest ever number of referrals received in the month of September.

**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 remarks scheduled for 10/13/2025, after which time a Preliminary Audit Report should be received.

**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, which will be conducted in November 2025.

Four (4) findings are being referred to the Office of Enforcement:

- The Plan fails to consistently ensure its delegate complies with required utilization management notification standards.
- The Plan failed to consistently demonstrate that for concurrent review denials, care was not discontinued until the enrollee's treating provider had been notified and agreed to an appropriate care plan. Section 1367.01(h)(3).
- The Plan inappropriately denies post-stabilization care and is operating at variance with policies filed with the Department.
- The Plan improperly denied payment for emergency services and treatment. Section 1371.4(b) and (c).

    - Two (2) – not able to remediate as these were pharmacy-related and Pharmacy is now carved out

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 tentatively scheduled beginning 11/01/2025

3. **DMHC Audit of Fiscal and Administrative Affairs (Financial Audit) – 2024:**

- Received Preliminary Report 06/05/2025 with two findings:
    - Claims for retroactive update to one provider contract not processed accurately (due to timing of TRI adjustments occurring at the same time)
    - Key personnel filings not submitted timely
- Submitted KHS response, with corrective actions taken, on 07/18/2025
- Final Audit Report received on 08/14/2025, with corrective actions taken accepted and no additional follow up required.

KERN HEALTH SYSTEMS

# Compliance Capsule – August 2025

## Ready, Set, Submit: Guidelines Made Simple

Based on insights from the 2025 Compliance Survey, we have outlined key submission guidelines for documents routed through the Compliance Department for quality assurance and regulatory submission. The list below highlights common types of submissions:

| Type of Submission | Key Guidelines |
|---|---|
| **Event Letters of Agreement (LOA)**<br><br>Before participating in any marketing event, KHS must submit an agreement between KHS and the event organizer to DHCS. | ✓ Check spelling, formatting, and signatures.<br>✓ LOA must include the address and location of the event.<br>✓ Attach flyer with event: date, time, and location.<br>✓ Submit to heather.pruitt@khs-net.com at least 2 days prior (ideally 5 days for internal processing). |
| **Member Informing Material**<br><br>These materials help members understand Kern Family Health Care services and benefits.<br><br>**Examples:** Member Handbook, Provider Directory, Flyers, Brochures, Letters, Call Scripts, Surveys, etc. | ✓ Use the DHCS Review Tool Checklist – a guide to keep your content compliant. You can request the checklist from Compliance.<br>✓ Send to the Member Engagement Team for review to ensure the document maintains consistency across all member communications.<br>📌 DMHC submission may be required, Compliance will advise. |
| **Member Incentive (MI) Forms**<br><br>Incentives encourage participation in health education, focus groups, and surveys. DHCS approval is required unless exempt. | ✓ Submit to the Wellness & Prevention team for review.<br>✓ Check spelling and grammar.<br>✓ Ensure forms are complete prior to submission to Compliance.<br>✓ Attach original approval form with evaluations. |
| **New Policy & Procedure**<br><br>KHS must maintain clear, current policies to meet regulatory obligations and business standards. Current policies are located on the Compliance P drive. | ✓ Use the new policy template, this is required for SAI360 (policy management software).<br>✓ Proofread for grammar and structure.<br>✓ Include a brief purpose for the new policy.<br>✓ Policy numbers are assigned by the Policy Team.<br>📩 Questions? Emal: PolicyTeam@khs-net.com |
| **Regulatory Reporting (SFTP) via Secure File Transfer Protocol)**<br><br>Required reporting are listed on the Compliance Regulatory Calendar 2025 Regulatory Calendar.xlsx | ✓ Use correct naming conventions (see Excel instructions tab by report).<br>✓ SFTP submissions require a Data Exchange Request Form (DERF).<br>✓ **Compliance does not review data for accuracy.**<br>🗓️ Review the Compliance Regulatory Calendar – if updates are needed let Compliance know. |

**Did You Know?** Regulators have timelines for most of the submissions we send their way: **DMHC** responds within **30 days** and **DHCS** may take up to **60 days**. Understanding these timelines helps us plan ahead and set realistic expectations for feedback.

**Questions?** Compliance is here to help you secure regulatory approval. If you have questions reach out to Deborah Murr, Chief Compliance & Fraud Prevention Officer, or Jane MacAdam, Director of Compliance & Regulatory Affairs.

**Stay sharp. Stay compliant.**

KERN HEALTH SYSTEMS

# Compliance Capsule – September 2025

At KHS, our top priority is the service we provide our members. To provide for our members, KHS must meet or exceed requirements from local, state, & federal regulations. Here are three regulatory agencies you may or may not have heard of and their roles, focus, & responsibilities to healthcare compliance:

1. **CMS (Centers for Medicare & Medicaid Services)**:
    - **Role**: CMS administers the **Medicaid** and **Medicare** programs – including Dual Special Needs Plan (D-SNP), which KHS will be implementing in January 2026.
    - **Focus**: It oversees health care services for eligible individuals, including seniors, low-income families, and people with disabilities.
    - **Responsibilities**:
        - Manages billing, payments, and program integrity for Medicare and Medicaid.
        - Implements policies related to health care coverage, reimbursement, and quality improvement.
        - Ensures access to health care services for beneficiaries.
2. **DOJ (Department of Justice)**:
    - **Role**: DOJ is responsible for enforcing federal laws, including those related to health care fraud.
    - **Focus**: It investigates and prosecutes health care fraud cases.
    - **Responsibilities**:
        - Collaborates with other agencies to enforce laws such as the **False Claims Act**.
        - Handles criminal prosecutions and civil litigation against individuals and entities involved in fraudulent activities.
        - Works to recover funds obtained through fraudulent practices.
3. **HHS (Department of Health and Human Services)**:
    - **Role**: HHS oversees various health-related programs and services.
    - **Focus**: It aims to improve public health and well-being.
    - **Responsibilities**:
        - HHS-OIG (Office of Inspector General) within HHS focuses on detecting and preventing fraud, waste, and abuse.
        - Coordinates efforts with DOJ to combat health care fraud.
        - Administers the **Health Care Fraud and Abuse Control Program (HCFAC)**.
        - Ensures program integrity and protects beneficiaries.

In summary, CMS manages health care programs, DOJ prosecutes fraud cases, and HHS-OIG oversees program integrity. Their collaboration helps safeguard taxpayer dollars and ensures quality health care.

The Compliance Department promotes ethical conduct and commitment to ensuring compliance with all regulatory requirements and serves as a resource for employees and subcontractors; acts as the liaison between operational departments and regulators; conducts investigations, monitoring, and audits; and coordinates implementation of new or updated requirements, among others.

To learn more about these agencies, visit their websites at DOJ-OIG, HHS-OIG, and CMS . You can also reach out to the Compliance Department at compliance@khs-net.com or Deborah Murr, the Chief Compliance and Fraud Prevention Officer at 661.664.5141, or deborah.murr@khs-net.com with questions or comments.

# NON EMERGENCY MEDICAL TRANSPORTATION STRATEGIES

## GOVERNANCE AND COMPLIANCE COMMITTEE

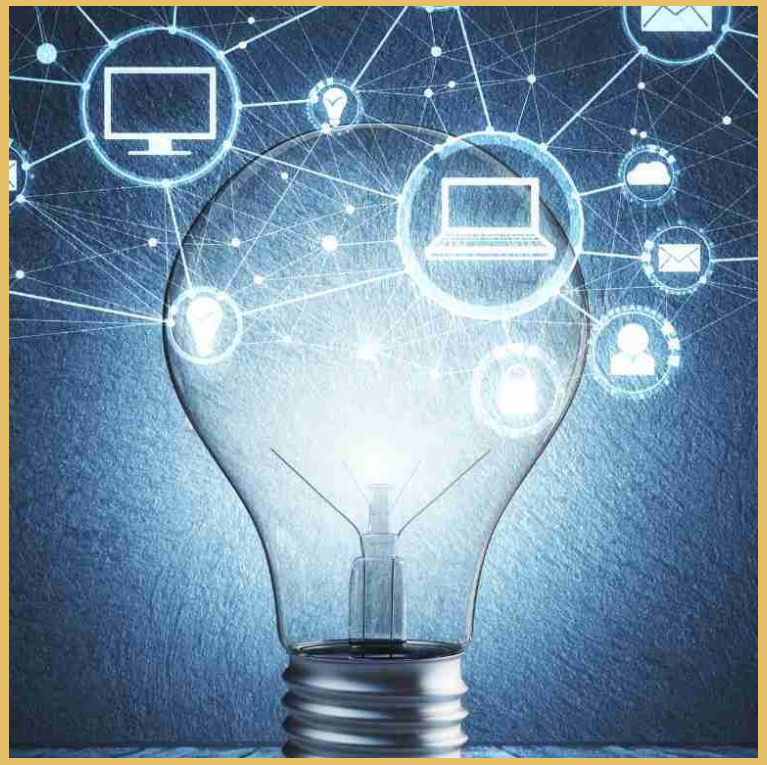
Deborah Murr, MHA, CHC, BS-HCM, RN
Chief Compliance and Fraud Prevention Officer
Kern Health Systems

# AGENDA

- Issues Identified
- Trending
- Innovative solutions
- Performance

# CHANGE PROMPTS

## Issues Identified



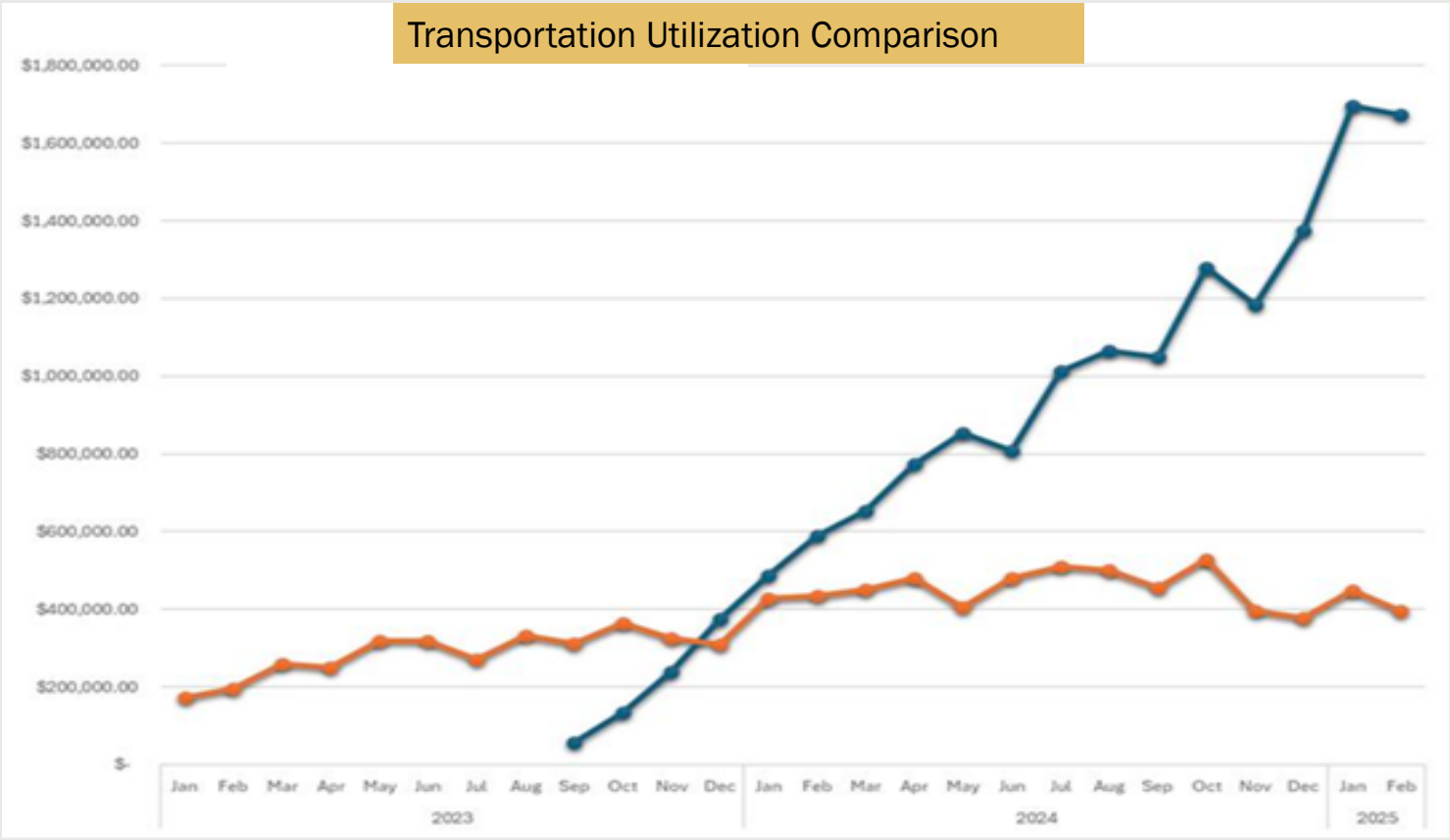
# IDENTIFIED ABERRANCIES

- **Regulatory Audit findings**
- Modification to service level outlined in the Physician Certification Statement (PCS) form.
- Door-to-door assistance
- Verification of no-show rates for NEMT and NMT providers
- **Investigation of FWA**
- Vendor
- Member
- **Financial findings**
- Data reveals a steady increase in costs and utilization

# TRENDING

Sustainability

# EARLY TRENDS



# INNOVATIVE SOLUTIONS

# GUARDRAILS

- Technology
- Administrative Enhancements
- Oversight and Reporting
- Operational efficiency

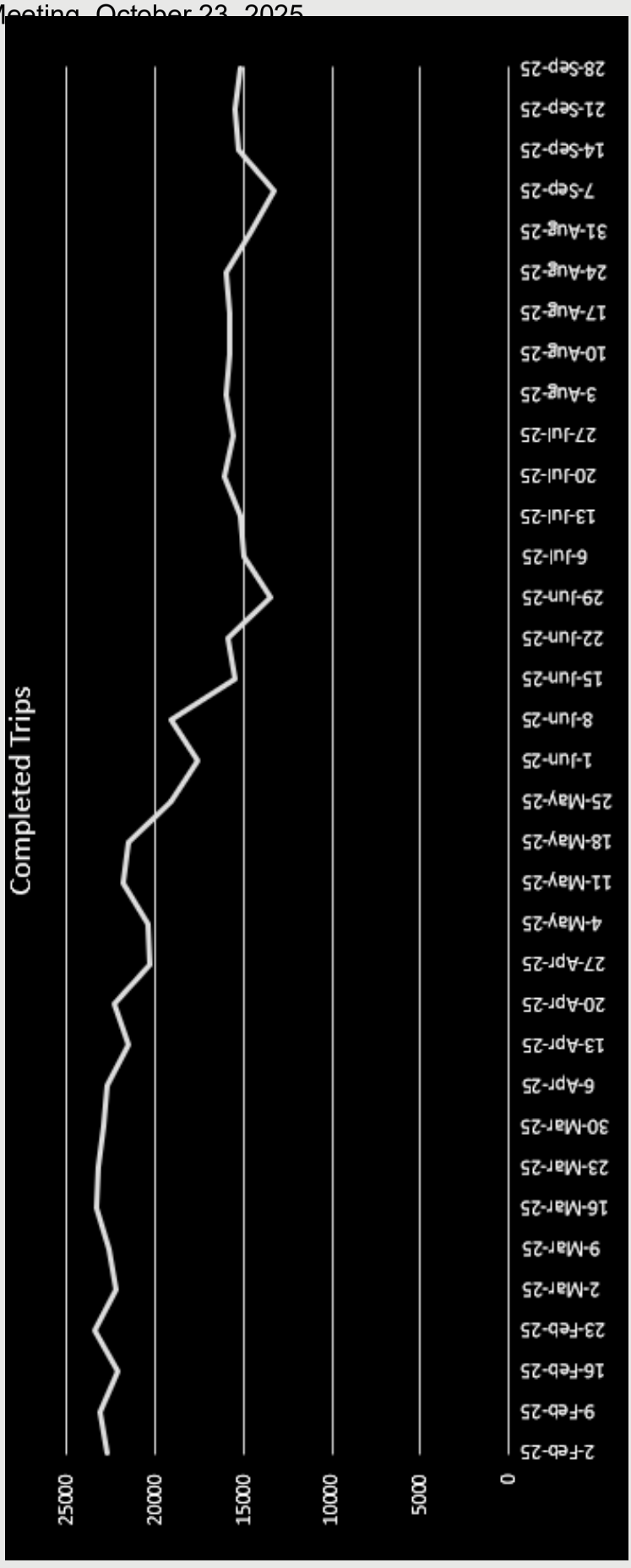
| CONTROL AREA | PRIORITY | SOLUTION | DATE |
|---|---|---|---|
| Mobile Application | Provider Attestation & Trip Verification | Provider training and adoption | 7/11/2025 |
| Advance Reservation | 48 Hours Notice w/ clinical exceptions | Member/Provider pairing Chemo/dialysis/ discharge | 6/16/2025 |
| Standing Order (STO) | 90-day expiration | Re-evaluation process | 6/15/2025 |
| Distance | 50 miles maximum w/ specialty exceptions | Closest facility vs member choice | 8/1/2025 |
| Member History | Legitimate Need Validation | Limit mode of transportation Restriction code to eligibility file | 6/4/2025 |
| Locations | Approved destination | Provider file flags | 5/15/2025; 8/15/2025 |

# PERFORMANCE OUTCOMES

# TRENDING

| Month | Avg. Weekday Volume | % Chance From Month Prior | % Change Since March |
|---|---|---|---|
| March | 4137 | | |
| April | 4007 | -3% | -3% |
| May | 3754 | -6% | -9% |
| June 16th | 2970 | -21% | -28% |
| July | 2730 | -8% | -34% |
| August | 2951 | 8% | -29% |
| September | 2769 | -6% | -33% |

# TRENDING


Completed Trips
25000
20000
15000
10000
5000
0
2-Feb-25
9-Feb-25
16-Feb-25
23-Feb-25
2-Mar-25
9-Mar-25
16-Mar-25
23-Mar-25
30-Mar-25
6-Apr-25
13-Apr-25
20-Apr-25
27-Apr-25
4-May-25
11-May-25
18-May-25
25-May-25
1-Jun-25
8-Jun-25
15-Jun-25
22-Jun-25
29-Jun-25
6-Jul-25
13-Jul-25
20-Jul-25
27-Jul-25
3-Aug-25
10-Aug-25
17-Aug-25
24-Aug-25
31-Aug-25
7-Sep-25
14-Sep-25
21-Sep-25
28-Sep-25

# THANK YOU

Deborah Murr
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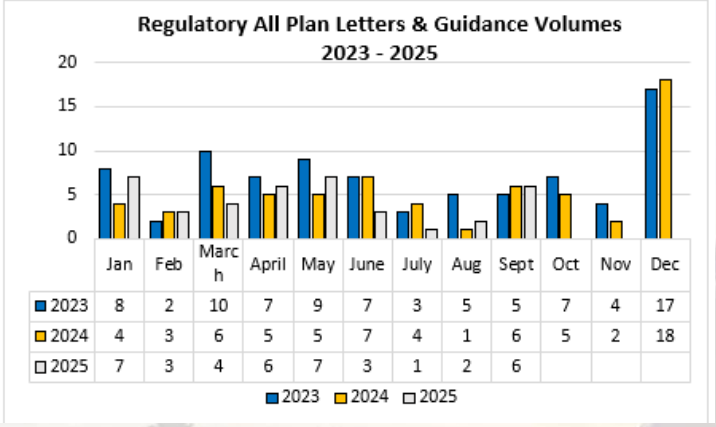
# Chief Compliance and Fraud Prevention Officer (CCFPO)Report

# Agenda

- CCFPO Key Performance Indicators (KPI)
- Enterprise Risk Management
- Non-Emergency Transportation Strategies
- Regulatory Audit Update

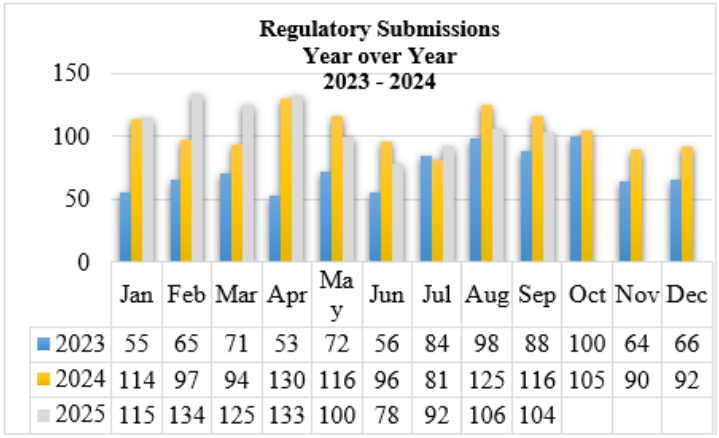
# Compliance Key Performance Indicators

## All Plan Letter (APLs) & Guidance Letters

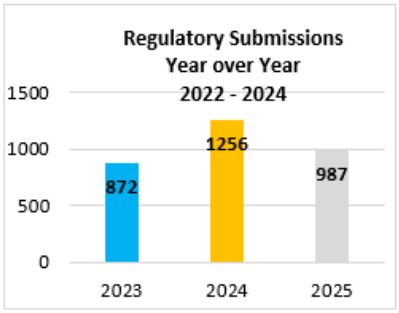



| All Plan Letters & Guidance Letters Received | | |
|---|---|---|
| 2023 | 2024 | 2025 |
| 83 | 66 | 39 |

## Regulatory Reports & Filings

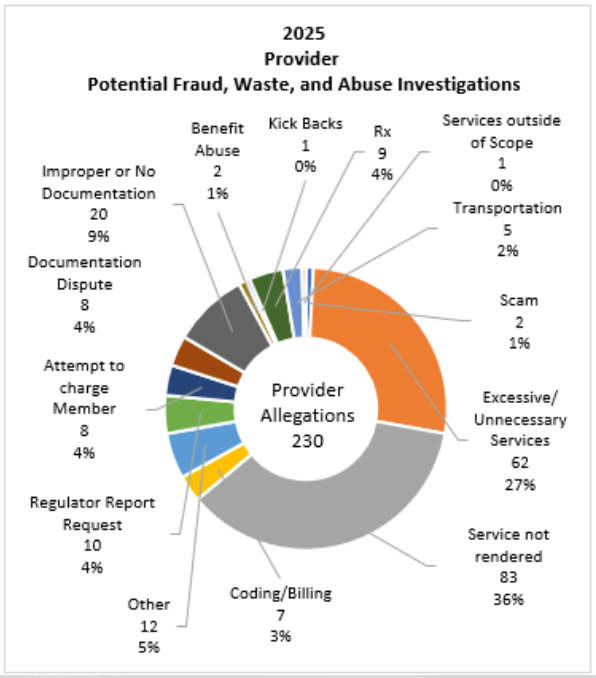


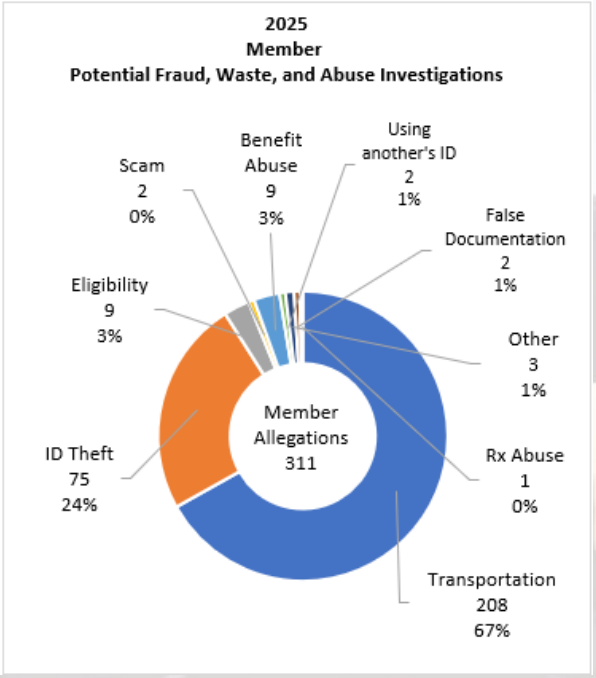

| Regulatory Submissions | | |
|---|---|---|
| Regulatory Agency | August 2025 | September 2025 |
| DHCS | 88 | 97 |
| DMHC | 18 | 7 |
| **Total** | **106** | **104** |

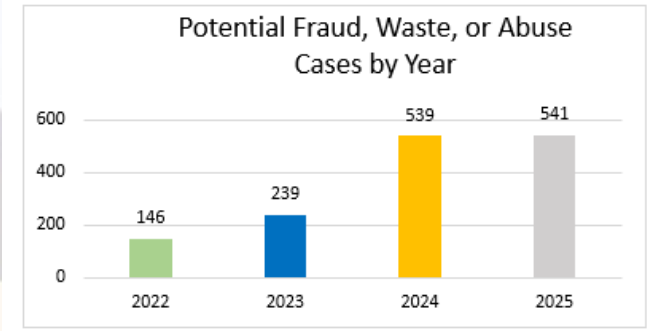


# Compliance Key Performance Indicators

## Fraud, Waste, and Abuse (FWA)

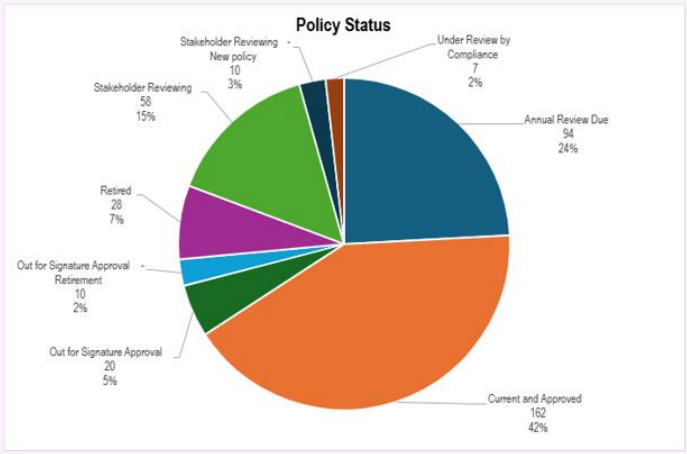


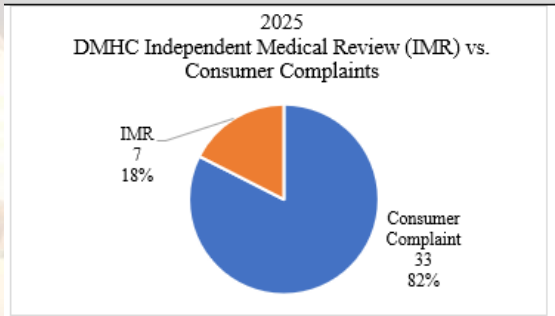



# Compliance Key Performance Indicators

**Policies**

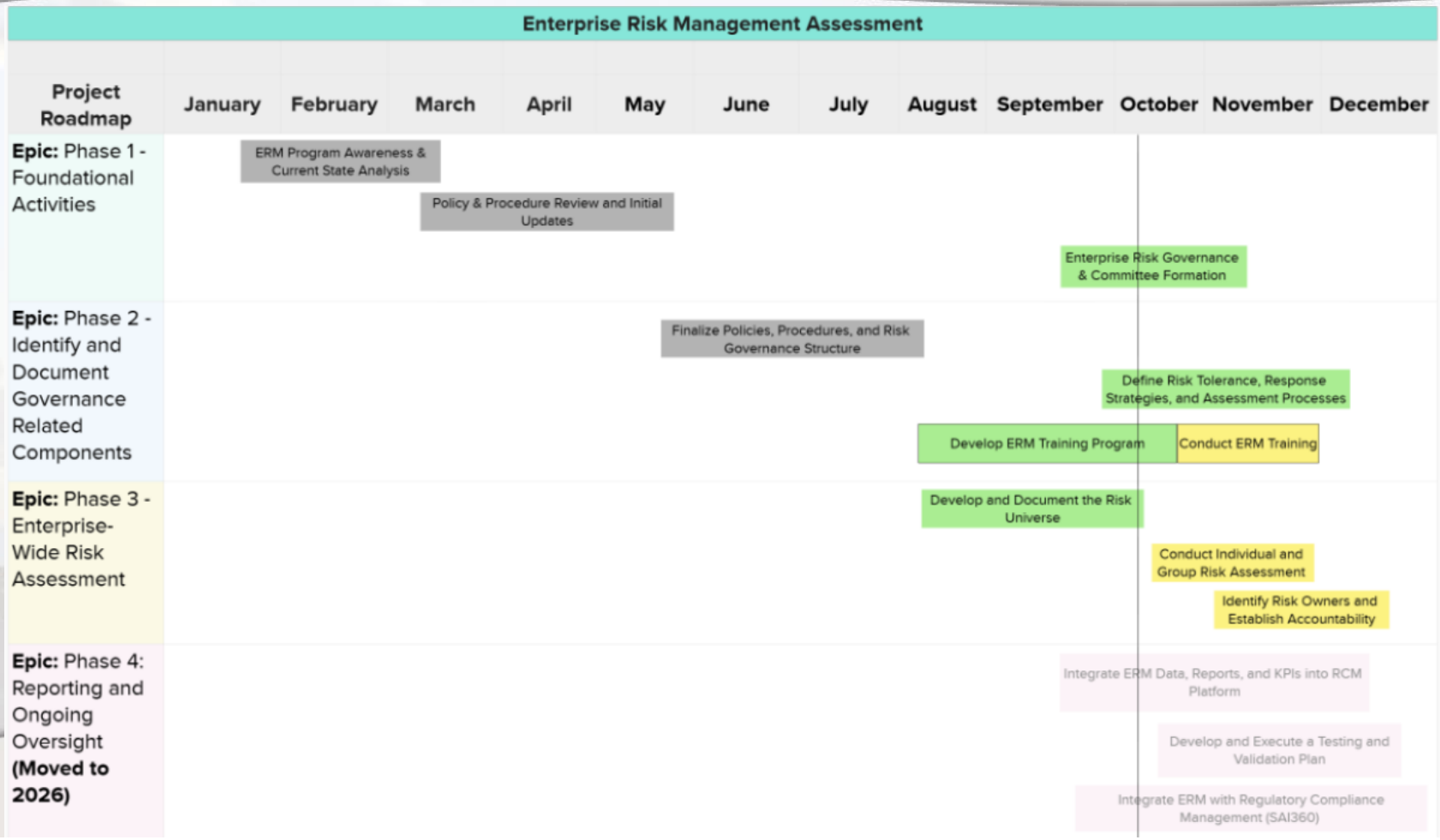



**DMHC Consumer Complaints & Independent Medical Reviews (IMR)**




| Decision | KHS Response | DMHC Response |
|---|---|---|
| Upheld | 19 | 35 |
| Overturned | 8 | 2 |
| Return to Plan (Grievance Process not completed prior to DMHC complaint) | 6 | 0 |
| Duplicate | 1 | 0 |
| Misdirected | 3 | 1 |
| Services Never Denied | 3 | 0 |
| In Process | 0 | 2 |
| **Grand Total** | 40 | 40 |

# Enterprise Risk Timeline



# Enterprise Risk Register

**Risk Universe**
Risk Domains
Clinical/Safety/Quality
Financial
Hazards
Human Capital
Legal/Regulatory
Operational
Strategic
Technology

**ECM Terminology**

**Staff Training & Board Materials**

**Staff Interviews**

**Risk Roadmap, Testing Plan, and Remediation**

**SAI360 Integration**

| 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 |

# Non-Emergency Transportation Strategies

Kern Health Systems (KHS) contracts with third party transportation brokers to arrange nonemergency transportation for beneficiaries unable to obtain transportation independently to medical appointments.

To curb fraudulent activity, KHS has implemented and strengthened several safeguards including:

- New technology
- Provider and vehicle screening, such as enrolling providers and monitoring driver and vehicle credentials
- Advance reservation
- Pre-trip approval, such as verifying eligibility prior to scheduling a trip
- Post-trip validation, such as validating that trips occurred through trip logs
- Distance limitations
- Internal alternative options

Any identified aberrancies for potentially fraudulent activities are submitted to the Compliance Special Investigation Unit (SIU) for further review and potential corrective actions if warranted

# Non-Emergency Transportation Strategies

## GUARDRAILS

- Technology
- Administrative Enhancements
- Oversight and Reporting
- Operational efficiency

| CONTROL AREA | PRIORITY | SOLUTION | DATE |
|---|---|---|---|
| Mobile Application | Provider Attestation & Trip Verification | Provider training and adoption | 7/11/2025 |
| Advance Reservation | 48 Hours Notice w/ clinical exceptions | Member/Provider pairing Chemo/dialysis/ discharge | 6/16/2025 |
| Standing Order (STO) | 90-day expiration | Re-evaluation process | 6/15/2025 |
| Distance | 50 miles maximum w/ specialty exceptions | Closest facility vs member choice | 8/1/2025 |
| Member History | Legitimate Need Validation | Limit mode of transportation Restriction code to eligibility file | 6/4/2025 |
| Locations | Approved destination | Provider file flags | 5/15/2025; 8/15/2025 |

## Average Weekday Trip Volume Analysis

| Month | Avg. Weekday Volume | % Chance From Month Prior | % Change Since March |
|---|---|---|---|
| March | 4137 | | |
| April | 4007 | -3% | -3% |
| May | 3754 | -6% | -9% |
| June 16th | 2970 | -21% | -28% |
| July | 2730 | -8% | -34% |
| August | 2951 | 8% | -29% |

# Regulatory Audits Update

**Department of Health Care Services (DHCS)**

2025 Information Technology Focused Audit

DHCS conducted a virtual audit from 08/12/2025 – 08/14/2025 of the Plan's internal controls to ensure the Plan follows HIPAA requirements for the audit period 05/01/2024 –04/30/2025.

Specific areas of focus for DHCS' audit will include, but are not limited to the following:

- Data protection and encryption
- Disaster Recovery
- Interoperability

KHS closure meeting held on 10/13/2025 and corrective actions will be based on any findings.

2024 Routine Medical Audit

The DHCS 2024 Medical Survey completed on 12/20/2024. The Plan received the Preliminary Audit Reports, reporting *no findings* for the audit period for both our main DHCS contract and the state supported services contract.

2023 Limited Scope Medical and Focused Transportation/Behavioral Health Audit

The DHCS 2023 Limited Scope Medical Audit and Focused Audit for Transportation/Behavioral Health closed six of the seven findings with a Corrective Action Plan (CAP) update submitted to DHCS on 5/2/2025. KHS is currently awaiting final closure of the *one remaining finding*.

# Regulatory Audits Update

## Department of Managed Health Care (DMHC)

2024 Routine Financial Audit

KHS received the final report from the 2024 Routine Examination of Fiscal and Administrative Affairs for the quarter ended 09/30/2024 from DMHC (Financial Audit) conducted on April 7, 2025 and concluded the Onsite (Virtual) financial audit in May 2025.

Areas of focus included:

- Financial Statements – *in compliance*
- Calculation of Tangible Net Equity - *in compliance* with the TNE requirements of Rule 1300.76 as of quarter ended September 30, 2024
- Claims for retroactive update to one provider contract not processed accurately (due to timing of TRI adjustments occurring at the same time)
- Key personnel filings not submitted within 5 days to DMHC

The Department determined the Plan's compliance efforts were responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

# Regulatory Audits Update

## Department of Managed Health Care (DMHC)-continued

2023 Routine Medical Audit

The final report for the 2023 DMHC Medical Audit was received in October 2024 for audit period 09/01/2020 through 08/31/2022. Department identified 20 deficiencies in several categories:

- Grievances and Appeals (8 findings)
- Access and Availability of Services (3 findings)
- Emergency Services and Care (2 findings)
- Utilization Management (7 findings)

DMHC is conducting a follow up survey scheduled November 10, 2025, for audit period 11/01/2024 – 06/30/2025 to validate corrective actions have been remediated.

Office of Enforcement

KHS received a subpoena, and interrogatories notice from the DMHC Office of Enforcement in June 2025 related to the Utilization Management processes that were in place during the follow up review period 1/1/2023 through 1/1/2024. KHS provided responses to the Office of Enforcement on September 10, 2025, and is waiting for further information from DMHC.

# You + Us = a better day!

## Questions

**Deborah Murr, Chief Compliance and Fraud Prevention Officer**
deborah.murr@khs-net.com
**(661)664-5141**

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

# MEMORANDUM

**TO:** Kern Health Systems Board of Directors

**FROM:** Martha Tasinga, Chief Medical Officer

**SUBJECT:** Chief Medical Officer Report

**DATE:** October 23, 2025

## BACKGROUND

The Chief Medical Officer's presentation highlights utilization trends and key clinical focus areas. Physician services, inpatient care, and outpatient services are experiencing sustained higher-than-projected utilization, largely driven by chronic and complex medical conditions.

In addition, the report provides a look at MCAS performance and Medical Loss Initiatives (MLR), including MLR Task Force, priorities, activities, and utilization.

Included is Attachments A – H with the detailed medical management performance dashboard.

## REQUESTED ACTION

Receive and File.

KERN HEALTH SYSTEMS

# MARTHA TASINGA MD.MPH.MBA

OCTOBER 23,2025

## CHIEF MEDICAL OFFICER REPORT

# AGENDA

**Physician Services Utilization**

- Outpatient
- Inpatient
- Outpatient Hospital
- Post Acute

**MCAS Update**

**Medical Loss Initiative**

# PHYSICIAN SERVICES

Utilization of physicians' outpatient services:

- Is higher than projected for all AIDE codes, worse for SPDs
  - SPD projected utilization 500 visits per 1000 member months and we are currently at 2000 to 2500 visits per 1000 member months
  - Projected cost per visit is has leveled off since April 2025.
- Drivers of increase in utilization and cost are:
  - Increase utilization for preventive service,
  - Diabetes,
  - Hypertension
  - Kidney disease

Refer to **Attachment A** for full Detail

# INPATIENT HOSPITAL UTILIZATION

- Admissions per 1000 for SPD is much high than projected but is leveling off
- Cost per bed day is higher than projected for all AIDE codes
- Admissions per 1000 member months and Cost per admission for all aide codes is at or lower than budget
- Top Inpatient diagnosis
  - Maternity
  - Complications of chronic conditions and social issues:
    - Sequalae of Cerebrovascular diseases,
    - Alzheimer disease,
    - Disorders of muscle wasting and metabolic encephalopathy
- Major care giving implications and higher rates of readmission (social admits")
- End of life issues
- Higher risk of readmissions
- Placement challenges (Mental Health, substance use diagnosis, homelessness)

Refer to **Attachment B & E** for full Detail

# INPATIENT HOSPITAL UTILIZATION

| | QUARTER 1, 2025 | Quarter3 2025 |
|---|---|---|
| Bed-days per 1000 | 164 | 149 |
| Admits per 1000 | 54 | 52 |
| SNF admits per 1000 | 2 | 2 |
| LTAC admits per1000 | 6 | 4 |

Refer to **Attachment B & E** for full Detail

# OUTPATIENT HOSPITAL

- Includes Observation level of care, outpatient elective surgeries
- Visits per member per month have been above projections for all Aide groups
- Cost per visit is also higher than projected
- Working with our Hospitalist teams to develop strategies for appropriate utilization of Hospital outpatient services

Refer to **Attachment C** for full Detail

# EMERGENCY ROOM UTILIZATION

- Stable
- The slight increase after covid has stabilized and utilization for all Aide codes remains lower than pre Covid.
- Most ER visits occurring at BMH

Refer to **Attachment D & F** for full Detail

# MCAS

## QUALITY PERFORMANCE

# MY2025 YTD Performance

- Meeting MPL for 6 measures
- 2 measures are within 5% of meeting MPL

*GSD is an inverse measure – not currently compliant based on administrative data

| AMR | BCSE | CBP | CCS | CDEV | CHL Adults and Peds |
|---|---|---|---|---|---|
| 75.09% | 51.65% | 54.32% | 54.50% | 25.33% | 49.88% |
| *HITS FOR MPL (196)* | *HITS FOR MPL 1,376* | *HITS FOR MPL 3,891* | *HITS FOR MPL (1,333)* | *HITS FOR MPL 1,345* | *HITS FOR MPL 793* |
| MPL: 63.66% | MPL: 55.87% | MPL: 67.88% | MPL: 52.32% | MPL: 35.70% | MPL: 56.30% |
| Over MPL by 11.43% | Under MPL by 4.22% | Under MPL by 13.56% | Over MPL by 2.18% | Under MPL by 10.37% | Under MPL by 6.42% |
| AMR is not held to MPL. | | | | | |

| CIS | FUA 30 Day Follow-up | FUM 30 Day Follow-up | GSD HBA1C >9% | IMA | LSC |
|---|---|---|---|---|---|
| 18.43% | 24.29% | 33.96% | 56.86% | 35.98% | 74.81% |
| *HITS FOR MPL 351* | *HITS FOR MPL 172* | *HITS FOR MPL 320* | *HITS FOR MPL 6,087* | *HITS FOR MPL (150)* | *HITS FOR MPL (314)* |
| MPL: 23.89% | MPL: 39.10% | MPL: 57.13% | MPL: 30.41% | MPL: 34.14% | MPL: 69.96% |
| Under MPL by 5.46% | Under MPL by 14.81% | Under MPL by 23.17% | Under MPL by 26.45% | Over MPL by 1.84% | Over MPL by 4.85% |
| | | | Inverted Measure | | |

| PPC Post | PPC Pre | TFLCH | W30 0 - 15 Months | W30 15 - 30 Months | WCV |
|---|---|---|---|---|---|
| 68.38% | 64.02% | 37.80% | 47.99% | 68.57% | 41.16% |
| *HITS FOR MPL 847* | *HITS FOR MPL 1,344* | *HITS FOR MPL (29,782)* | *HITS FOR MPL 645* | *HITS FOR MPL 274* | *HITS FOR MPL 20,636* |
| MPL: 82.48% | MPL: 86.37% | MPL: 19.00% | MPL: 63.38% | MPL: 72.32% | MPL: 55.41% |
| Under MPL by 14.10% | Under MPL by 22.35% | Over MPL by 18.80% | Under MPL by 15.39% | Under MPL by 3.75% | Under MPL by 14.25% |

KERN HEALTH SYSTEMS

Refer to **Attachment H** for full Detail

# MY2025 Trending Performance

KHS MCAS MY2024 vs. MY2025 Comparison

- 12 measures are trending higher than the previous year at the same point in time

*GSD is an inverse measure

KERN HEALTH SYSTEMS

# MY2025 vs. MY2024 Minimum Performance Levels

Each year, NCQA updates national benchmarks, which DHCS adopts as Minimum Performance Levels (MPLs) for the MCAS measures. While MPLs usually shift slightly, several measures saw increases of up to six percent this year.

| Measure Acronym | MY2024 MPL | MY2024 HPL | MY2025 MPL | MY2025 HPL | MPL DIFF |
|---|---|---|---|---|---|
| AMR | 66.24% | 76.65% | 63.66% | 76.25% | -2.58% |
| BCS-E | 52.68% | 63.48% | 55.87% | 66.31% | 3.19% |
| CCS | 57.18% | 67.46% | 52.32% | 64.21% | -4.86% |
| WCV | 51.81% | 64.74% | 55.41% | 67.63% | 3.60% |
| CIS-10 | 27.49% | 42.34% | 23.89% | 34.79% | -3.60% |
| CHL | 55.95% | 69.07% | 56.30% | 70.67% | 0.35% |
| CBP | 64.48% | 72.75% | 67.88% | 75.43% | 3.40% |
| DEV | 35.70% | N/A | | | |
| FUM | 53.82% | 73.12% | 57.13% | 74.67% | 3.31% |
| FUA | 36.18% | 49.40% | 39.10% | 53.27% | 2.92% |
| GSD | 33.33% | 27.01% | 30.41% | 23.60% | -2.92% |
| IMA-2 | 34.30% | 48.66% | 34.14% | 47.16% | -0.16% |
| LSC | 63.84% | 79.51% | 69.96% | 82.86% | 6.12% |
| PPC-PST | 80.23% | 86.62% | 82.48% | 88.32% | 2.25% |
| PPC-PRE | 84.55% | 91.85% | 86.37% | 91.97% | 1.82% |
| TFL-CH | 19.00% | N/A | | | |
| W30-6+ | 60.38% | 69.67% | 63.38% | 71.71% | 3.00% |
| W30-2+ | 69.43% | 79.94% | 72.32% | 82.12% | 2.89% |

*DEV and TFL-CH do not follow NCQA as the measure steward

# MEDICAL LOSS INITIATIVE

# **MLR** TASK FORCE

- Multidisciplinary team
- Executives, Medical Directors, Claims, Contracting, UM, Pharmacy, Population Health Management, IT
- Meet weekly
- Identify priorities and direction
- Monitor progress
- Discuss challenges

## MLR PRIORITIES

- MLR GOAL: 93%
- Identify and address potential overutilization
- Identify and implement programs to improve member outcomes
- Discuss new payment methodologies to promote efficient, quality care

# MLR ACTIVITIES

- New Special Programs
- Clarification of guidelines for Community Support Services
- Outlier monitoring
- Hospitalist Report card
- Daily rounds with KHS Nurses and Medical Directors
- Weekly rounds with hospital Nurses and Medical Directors
- Institute interdisciplinary care team for top 300-400 high utilizers/high-cost members
- Dashboard for monitoring progress

# TOP 308 HIGH UTILIZATION/HIGH-COST MEMBER

- Out of the total 308 members, 176 members (57%) receiving complex case management
- 46 members have declined Complex case management services
- Attempted home visits for 35 that were unable to reach by phone,11 members (31%) were not at the address we have
- 79 members are undergoing chemotherapy
- Majority of them on Keytruda at 30 to 50 K every 3 weeks)
- 20 members enrolled in the MOT Program. 11 were post-transplant
- Average 3.5 acute care admission per patient since 1/12025
- Out of the 308 members, 177 members were hospitalized within Kern County.
- A third of the hospitalizations were out of county for different reasons at 4 X the cost of in county admission

# **EXPIRED MEMBERS** (FROM THE TOP 308)

- Expired Members Details: 38 members
- Age range 23 to 88 years old (4 members 60+ years old)
  - All cost during the last 6 months of life
  - Young patients with old people medical issues
  - This makes end of life care decisions difficult for families
- The top five most common diagnoses at the time of death are:
  - Sepsis and septicemia
  - Cancer-related diagnoses
  - Heart-related conditions
  - Acute respiratory failure
  - Kidney failure: Kidney failure and complications.

# IMPLEMENTATION OF OUTLIERS REPORT MONITORING

- Identify members, providers and services that are above the average
- Evaluate utilization trends for services to identify potential concerns
- Implement processes manage identified outliers

# OUTLIERS IDENTIFIED

- Skin substitute for wound management
- High-volume codes, especially DNA testing and pathogen quantification,
- ABA services; intensity and frequency of services
- Some medications

# QUSTIONS?

**THANK YOU**

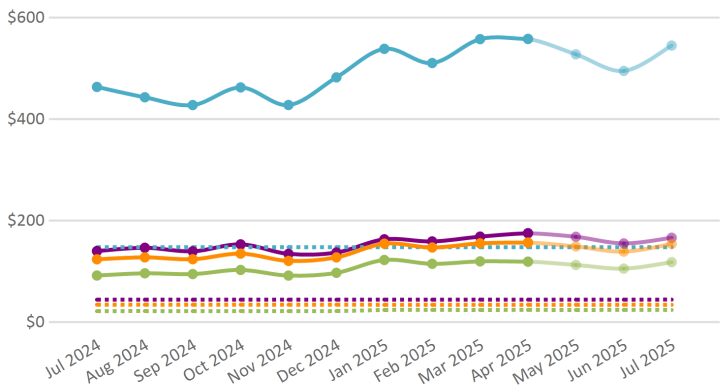
**Martha Tasinga, MD**
**Chief Medical Officer**

# Physician Services

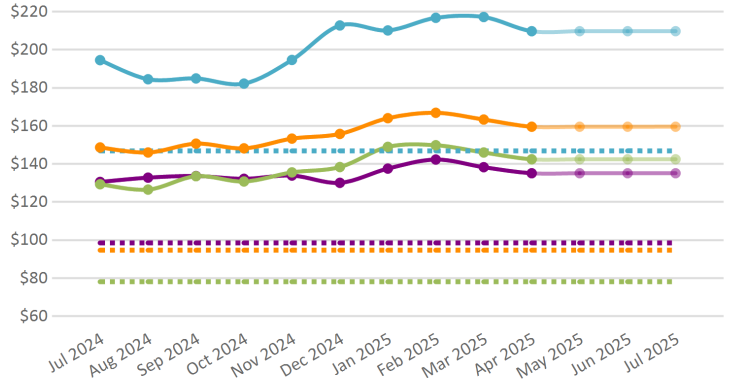
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

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

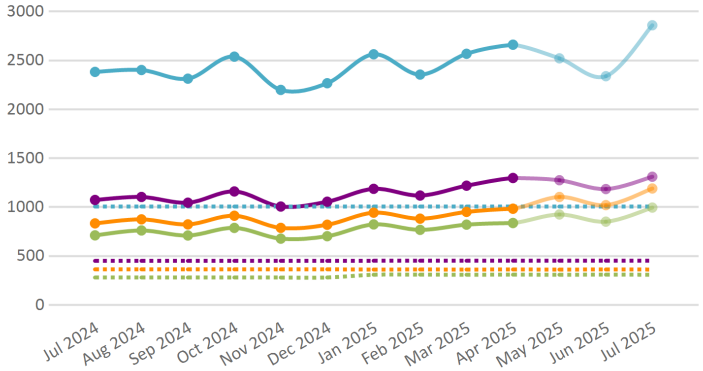
## Professional Services Incurred by Aid Group PMPM



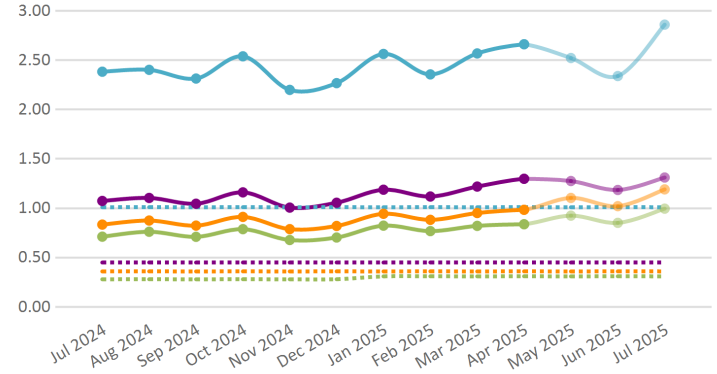

## Cost per Professional Service Visit by Aid Group




## Professional Service Visits per 1,000 per Month by Aid Group




## Professional Service Visits per Member per Month by Aid Group




Services provided through: 7/31/2025  Claims Paid through: 8/31/2025

Business Intelligence

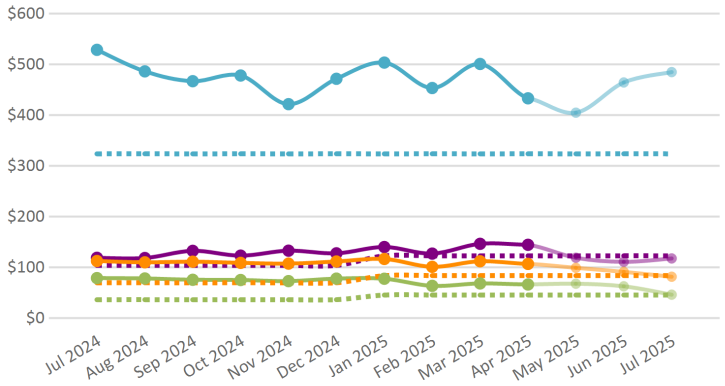
KERN HEALTH SYSTEMS

# Inpatient

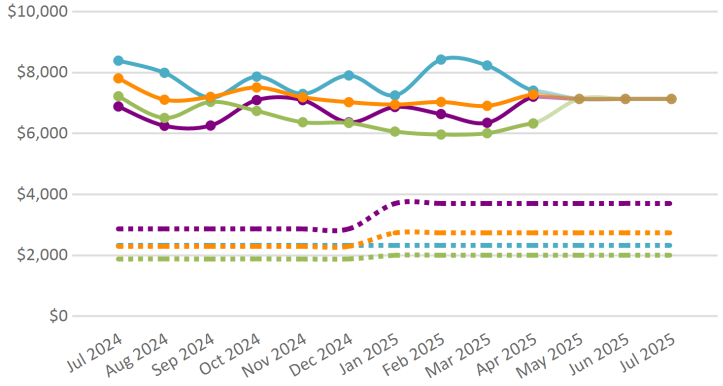
(Includes: Inpatient Hospital Claims)

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

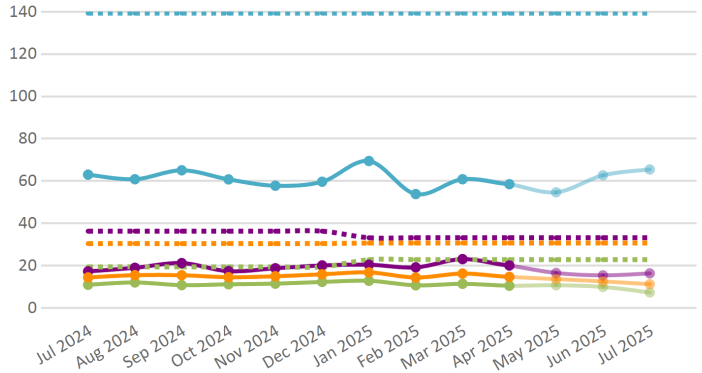
## Inpatient Services Incurred by Aid Group PMPM



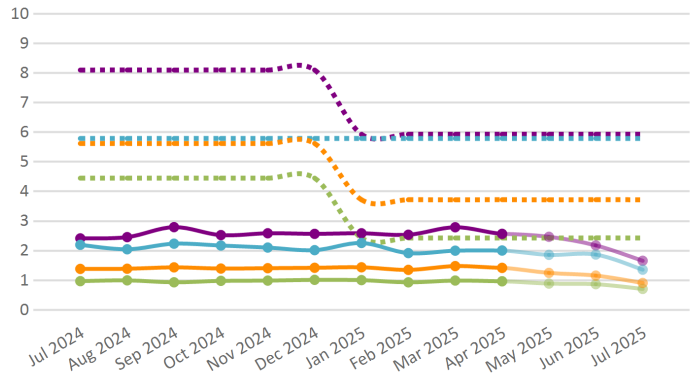

## Cost Per Bed Day by Aid Group




## Incurred Bed Days per 1,000 per Month by Aid Group




## Average Length of Stay in Days by Aid Group



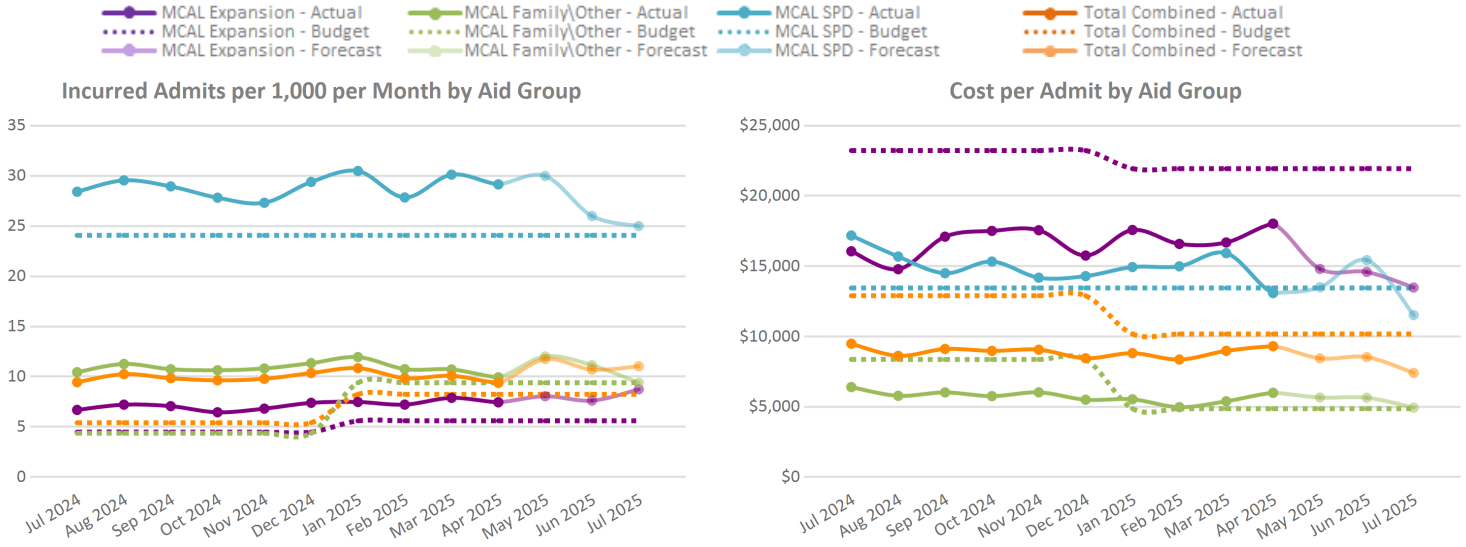

Services provided through: 7/31/2025  Claims Paid through: 8/31/2025

Business Intelligence

KERN HEALTH SYSTEMS

# Inpatient

(Includes: Inpatient Hospital Claims)




Services provided through: 7/31/2025 Claims Paid through: 8/31/2025

Business Intelligence

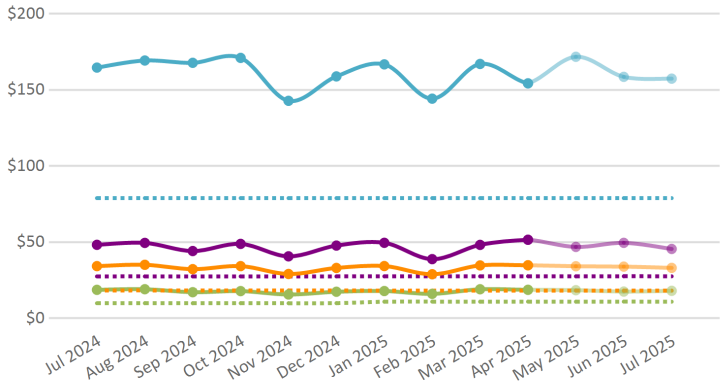
KERN HEALTH SYSTEMS

# Outpatient Hospital

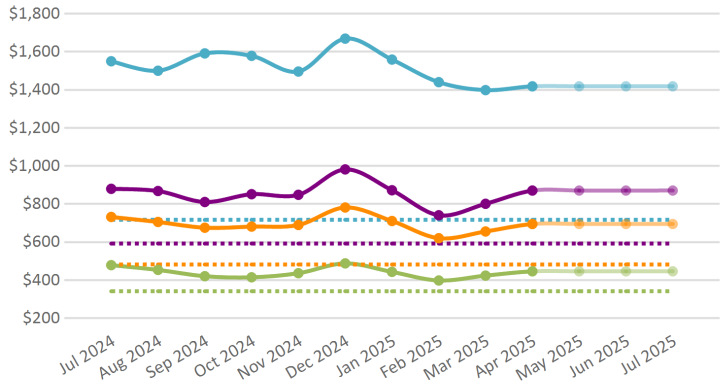
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

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

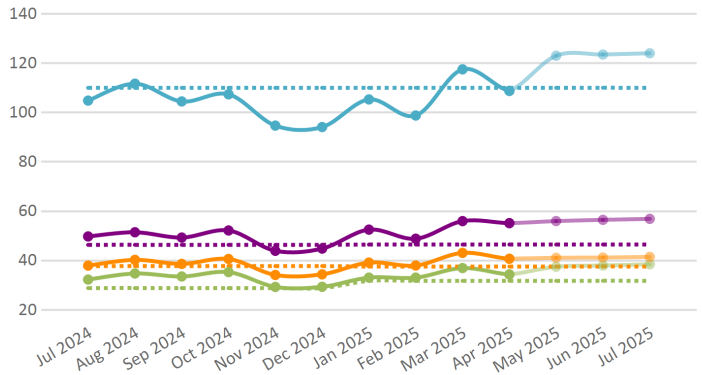
## Outpatient Services Incurred by Aid Group PMPM



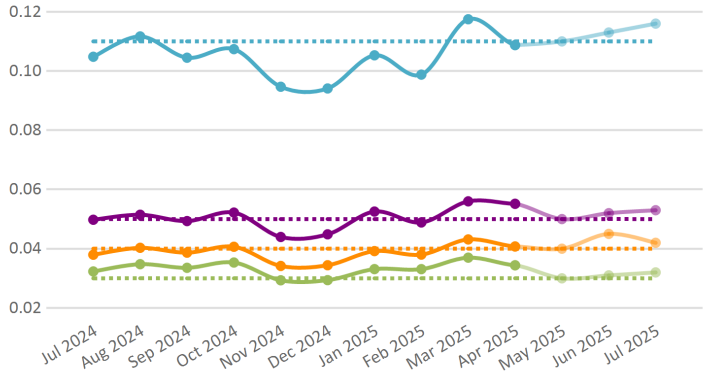

## Cost Per Outpatient Visit by Aid Group




## Outpatient Visits per 1,000 per Month by Aid Group

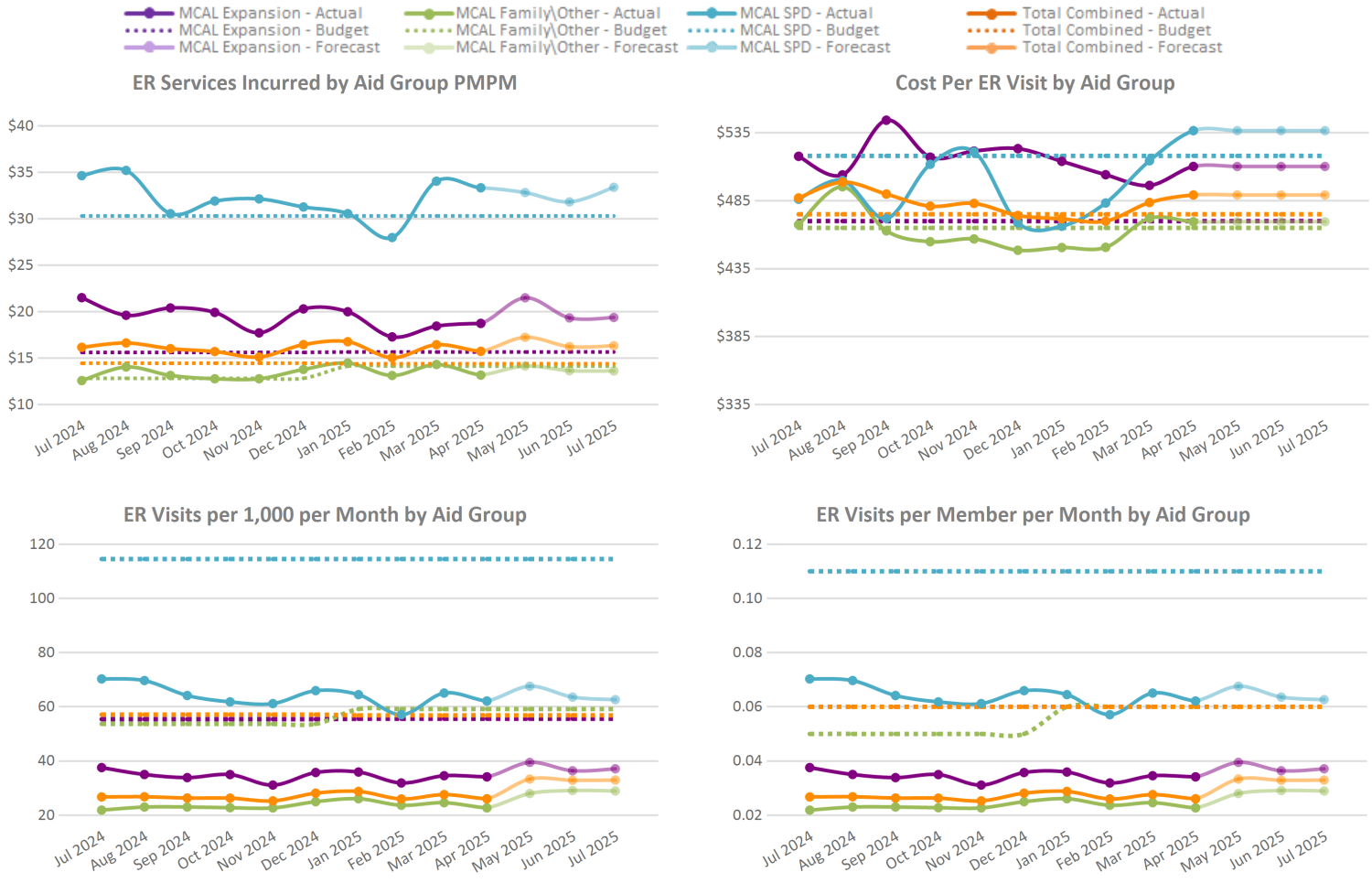



## Outpatient Visits per Member per Month by Aid Group



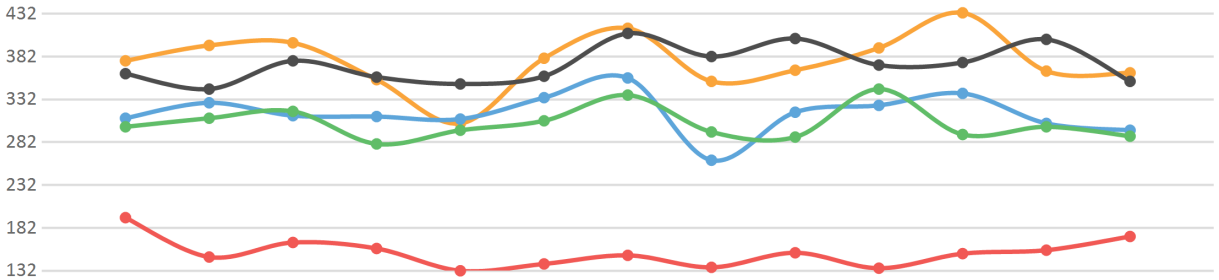

Services provided through: 7/31/2025  Claims Paid through: 8/31/2025

# Emergency Room

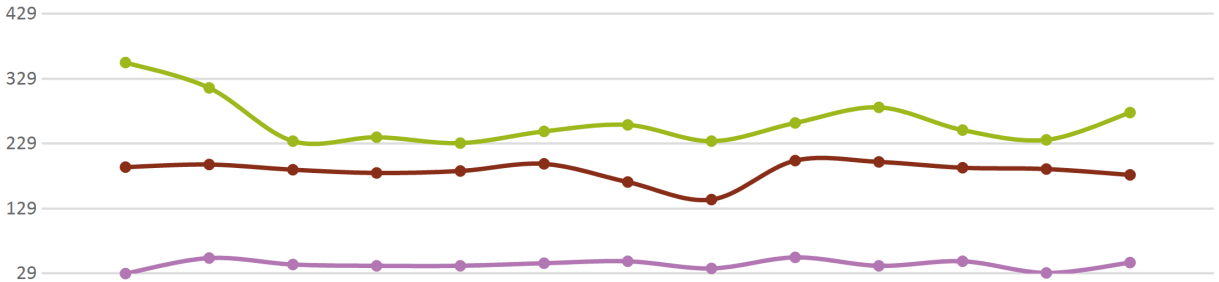



Services provided through: 7/31/2025  Claims Paid through: 8/31/2025

# Inpatient Admits by Hospital

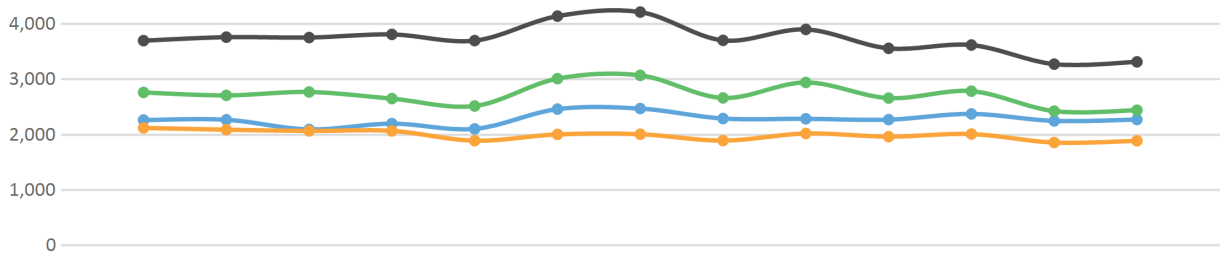



| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| KERN COUNTY HOSPITAL AUTHORITY | 377 | 395 | 398 | 355 | 304 | 380 | 415 | 353 | 366 | 392 | 433 | 365 | 363 |
| BAKERSFIELD MEMORIAL HOSPITAL | 362 | 344 | 377 | 358 | 350 | 359 | 409 | 382 | 403 | 372 | 375 | 402 | 353 |
| ADVENTIST HEALTH BAKERSFIELD | 310 | 328 | 313 | 312 | 309 | 334 | 357 | 261 | 317 | 325 | 339 | 304 | 296 |
| MERCY HOSPITAL | 300 | 310 | 318 | 280 | 296 | 307 | 337 | 294 | 288 | 344 | 291 | 300 | 289 |
| GOOD SAMARITAN HOSPITAL | 194 | 148 | 165 | 158 | 132 | 140 | 150 | 136 | 153 | 135 | 152 | 156 | 172 |

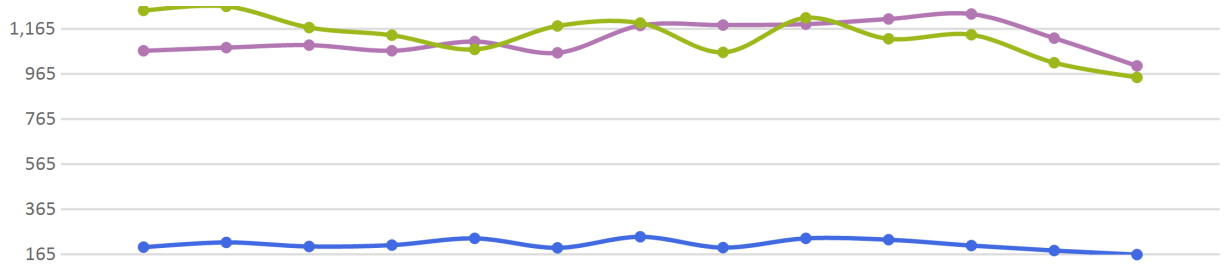



| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OUT OF AREA | 354 | 315 | 233 | 239 | 230 | 248 | 258 | 233 | 261 | 285 | 250 | 235 | 277 |
| OTHER LOCAL HOSPITALS | 193 | 197 | 189 | 184 | 187 | 198 | 170 | 143 | 203 | 201 | 192 | 190 | 181 |
| ADVENTIST HEALTH DELANO | 29 | 53 | 43 | 41 | 41 | 45 | 48 | 37 | 54 | 41 | 48 | 30 | 46 |

# Emergency Visits by Hospital

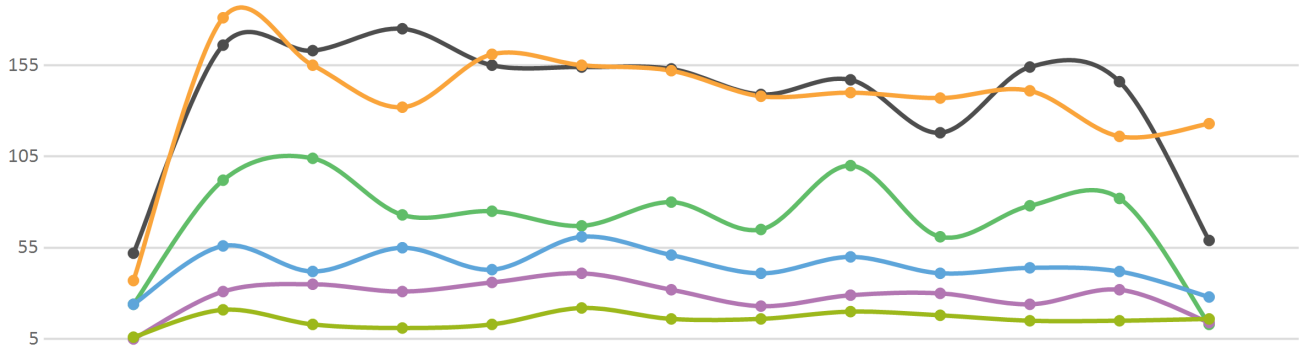



| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BAKERSFIELD MEMORIAL | 3,700 | 3,763 | 3,756 | 3,813 | 3,701 | 4,143 | 4,216 | 3,705 | 3,903 | 3,561 | 3,621 | 3,276 | 3,317 |
| MERCY HOSPITAL | 2,764 | 2,712 | 2,773 | 2,653 | 2,520 | 3,014 | 3,073 | 2,666 | 2,945 | 2,663 | 2,788 | 2,427 | 2,444 |
| ADVENTIST HEALTH | 2,266 | 2,271 | 2,097 | 2,202 | 2,107 | 2,464 | 2,474 | 2,294 | 2,289 | 2,274 | 2,377 | 2,251 | 2,275 |
| KERN MEDICAL | 2,124 | 2,092 | 2,070 | 2,070 | 1,893 | 2,007 | 2,010 | 1,895 | 2,023 | 1,967 | 2,013 | 1,860 | 1,891 |

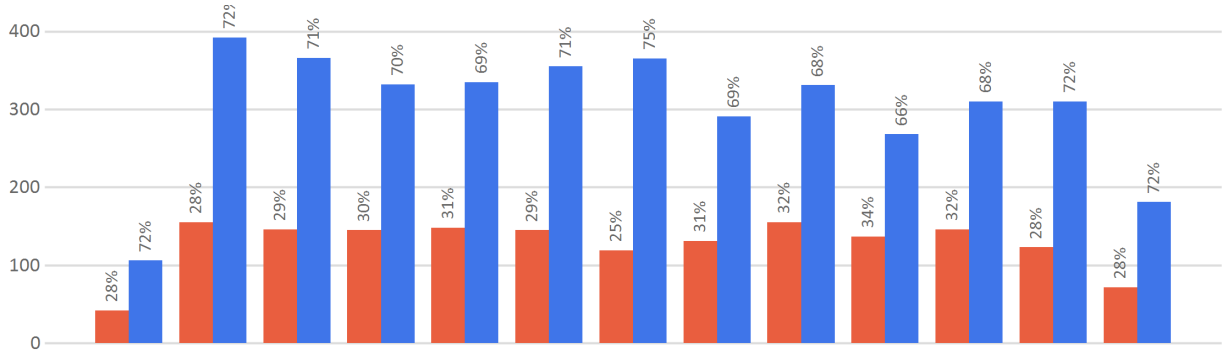



| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| OUT OF AREA | 1,248 | 1,266 | 1,172 | 1,138 | 1,075 | 1,179 | 1,192 | 1,062 | 1,215 | 1,122 | 1,140 | 1,016 | 951 |
| DELANO REGIONAL HOSPITAL | 1,069 | 1,083 | 1,094 | 1,069 | 1,110 | 1,060 | 1,181 | 1,183 | 1,187 | 1,210 | 1,232 | 1,125 | 1,002 |
| KERN VALLEY HEALTHCARE | 198 | 219 | 201 | 207 | 237 | 195 | 244 | 196 | 237 | 231 | 205 | 183 | 165 |

## Obstetrics Metrics




| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BAKERSFIELD MEMORIAL | 52 | 166 | 163 | 175 | 155 | 154 | 153 | 139 | 147 | 118 | 154 | 146 | 59 |
| KERN MEDICAL | 37 | 181 | 155 | 132 | 161 | 155 | 152 | 138 | 140 | 137 | 141 | 116 | 123 |
| MERCY HOSPITAL | 24 | 92 | 104 | 73 | 75 | 67 | 80 | 65 | 100 | 61 | 78 | 82 | 13 |
| ADVENTIST HEALTH | 24 | 56 | 42 | 55 | 43 | 61 | 51 | 41 | 50 | 41 | 44 | 42 | 28 |
| DELANO REGIONAL HOSPITAL | 5 | 31 | 35 | 31 | 36 | 41 | 32 | 23 | 29 | 30 | 24 | 32 | 14 |
| OTHER | 6 | 21 | 13 | 11 | 13 | 22 | 16 | 16 | 20 | 18 | 15 | 15 | 16 |




| | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| VAGINAL DELIVERY | 106 | 392 | 366 | 332 | 335 | 355 | 365 | 291 | 331 | 268 | 310 | 310 | 181 |
| C-SECTION DELIVERY | 42 | 155 | 146 | 145 | 148 | 145 | 119 | 131 | 155 | 137 | 146 | 123 | 72 |

**Attachment H**

# Asthma Medication Ratio

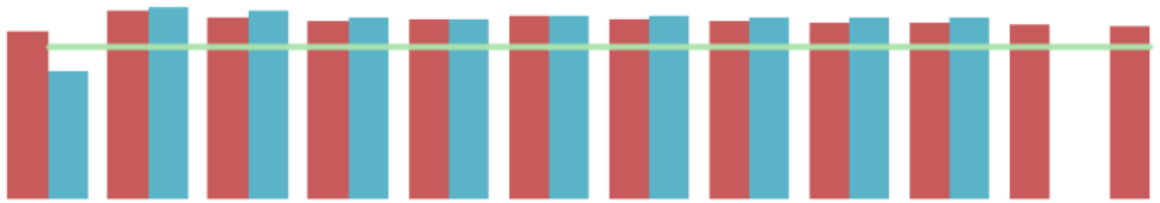
The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

AMR

**Hits needed for MPL**

**0**

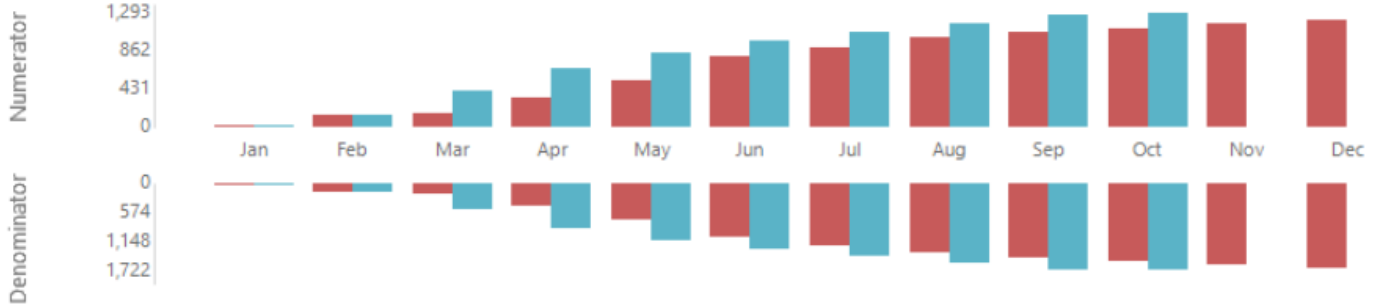
*Rate: 75.09%*
*Prior Year: 73.16%*
*+1.92% change*



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 70.00% | 77.96% | 75.70% | 74.17% | 75.00% | 76.02% | 74.53% | 73.80% | 73.41% | 73.16% | 72.32% | 71.66% |
| 2025 | 52.94% | 79.89% | 78.56% | 75.48% | 74.80% | 75.87% | 75.82% | 75.13% | 75.07% | 75.09% | | |
| 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% |

1,293

1,722



# 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

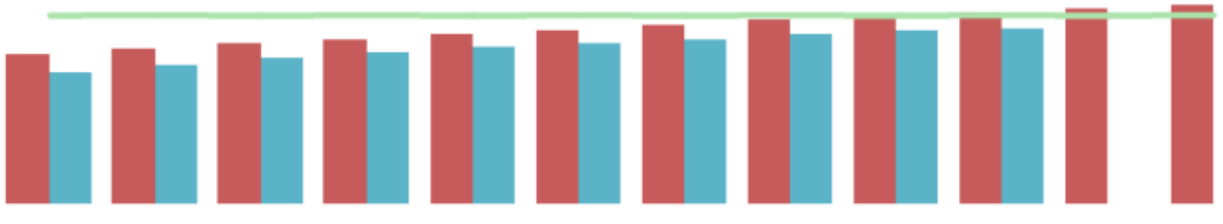
**Hits needed for MPL**

**1,376**

*Rate: 51.65%*

*MPL: 55.87%*

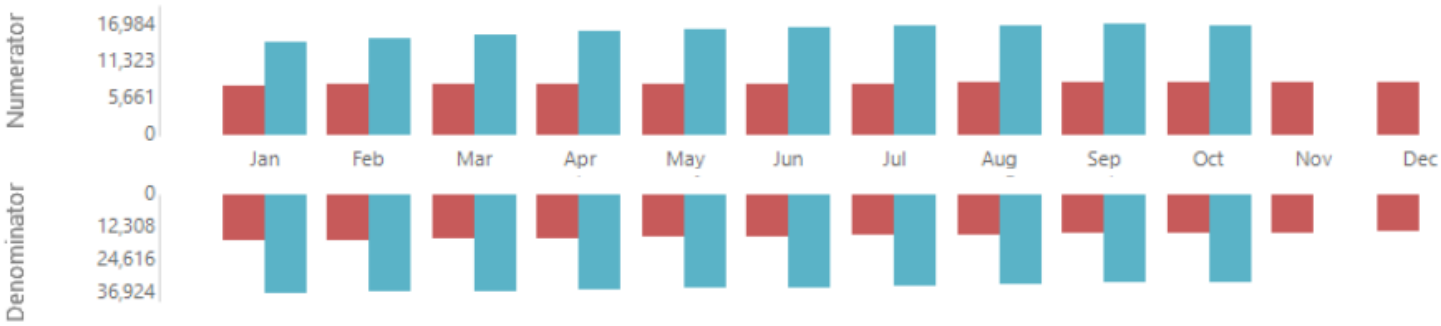





| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 44.23% | 45.63% | 47.44% | 48.73% | 50.08% | 51.42% | 52.66% | 54.29% | 55.56% | 56.51% | 57.69% | 58.61% |
| 2025 | 39.02% | 40.94% | 42.98% | 44.78% | 46.30% | 47.46% | 48.70% | 50.11% | 51.16% | 51.65% | | |
| 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% |

16,873

32,665



# 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**

**3,891**

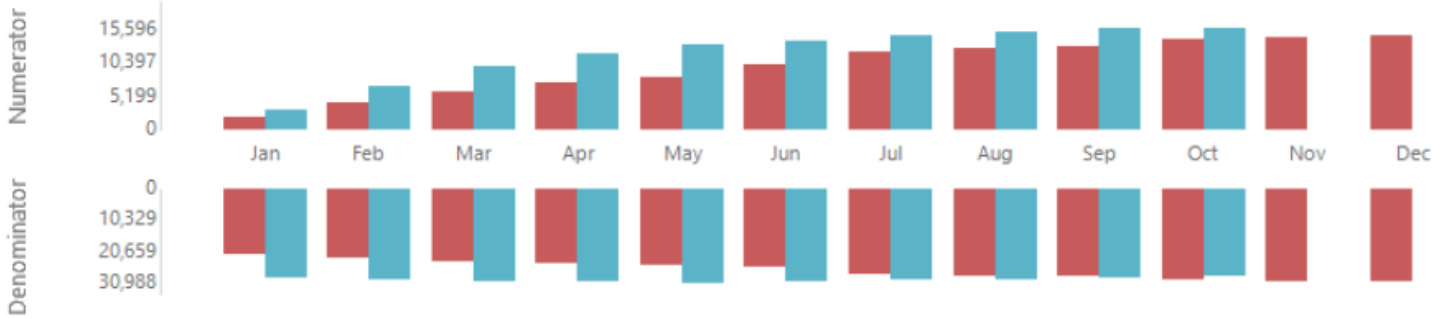
*Rate: 54.32%*

*MPL: 67.88%*

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 9.26% | 18.53% | 25.05% | 29.78% | 33.20% | 39.86% | 43.20% | 44.26% | 45.40% | 46.51% | 47.43% | 48.39% |
| 2025 | 10.99% | 22.56% | 32.06% | 38.27% | 42.30% | 45.56% | 48.48% | 51.22% | 53.43% | 54.32% | | |
| 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% |

15,591

28,701



# 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:

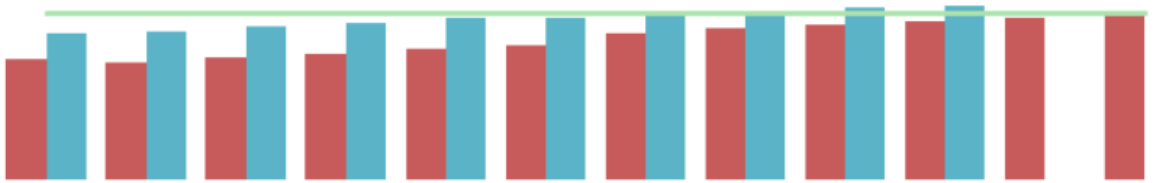
- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) test ing 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**

**0**

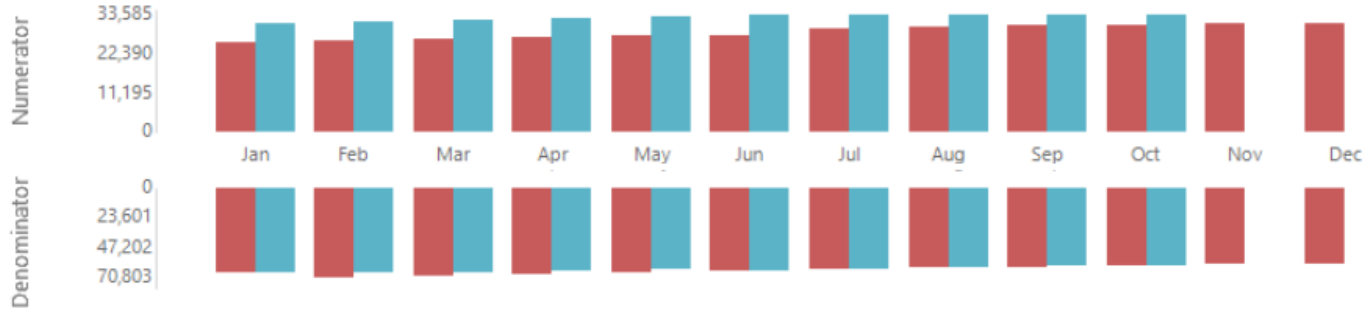
*Rate: 54.50%*
*Prior Year: 49.70%*
*+4.80% change*




| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 37.99% | 36.76% | 38.23% | 39.55% | 40.91% | 42.09% | 46.05% | 47.50% | 48.49% | 49.70% | 50.69% | 51.71% |
| 2025 | 45.81% | 46.30% | 47.70% | 48.96% | 50.43% | 50.80% | 51.80% | 52.94% | 53.94% | 54.50% | | |
| 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% |

33,346

61,186



# 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**

**1,345**

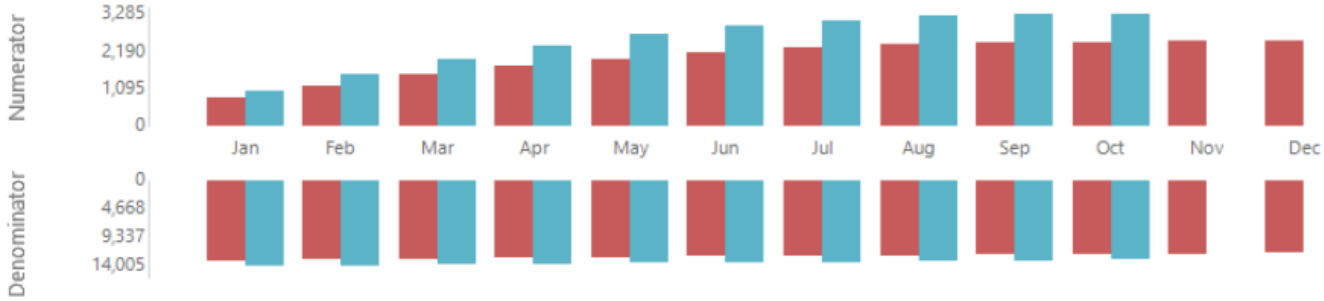
*Rate: 25.33%*

*MPL: 34.70%*

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 6.26% | 9.18% | 11.86% | 13.90% | 15.79% | 17.40% | 18.80% | 19.66% | 20.27% | 20.64% | 20.84% | 20.93% |
| 2025 | 7.42% | 10.97% | 14.21% | 17.12% | 20.09% | 21.79% | 23.26% | 24.43% | 25.08% | 25.33% | | |
| 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% |

3,285

12,971



# Chlamydia Screening in Women

The percentage of members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.

## CHL Adults and Peds

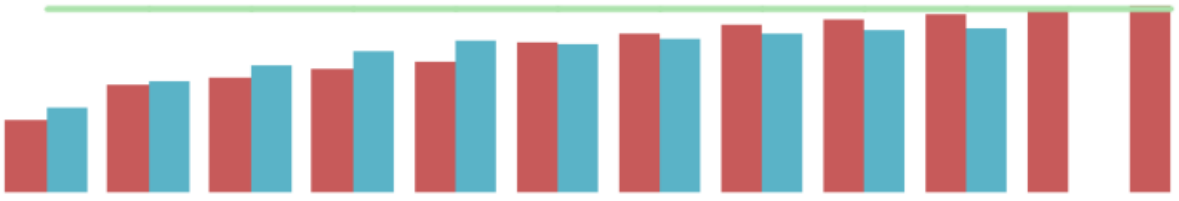
**Hits needed for MPL**

**793**

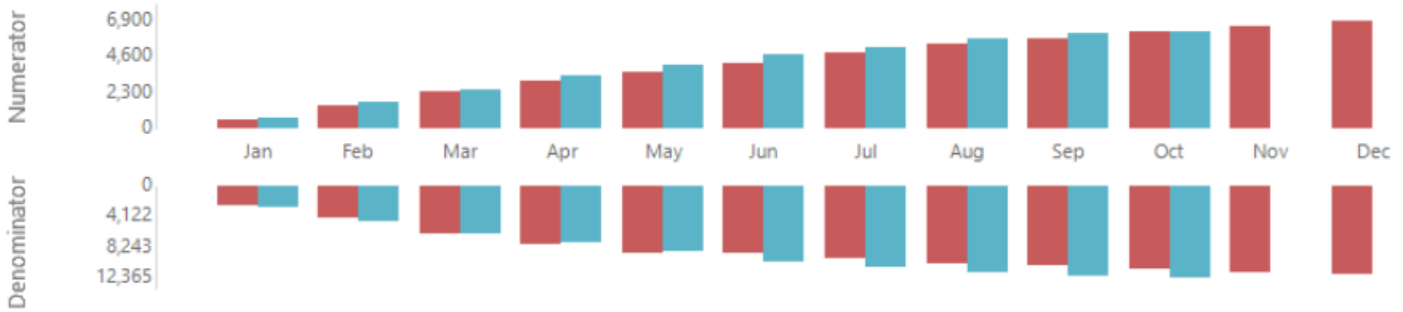
*Rate: 49.88%*
*Prior Year: 54.37%*
*-4.49% change*

6,168

12,365



| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 22.15% | 33.05% | 35.23% | 37.90% | 39.96% | 45.63% | 48.75% | 51.25% | 52.92% | 54.37% | 55.75% | 57.05% |
| 2025 | 25.79% | 34.17% | 38.95% | 43.18% | 46.56% | 45.43% | 46.65% | 48.42% | 49.52% | 49.88% | | |
| MPL | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% | 56.30% |



# 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**

**351**

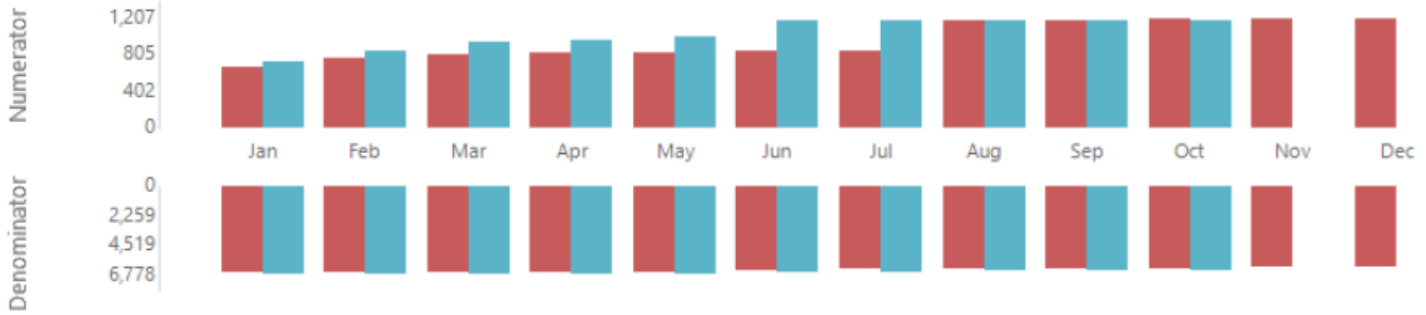
*Rate: 18.43%*

*MPL: 23.89%*

| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 10.01% | 11.62% | 12.17% | 12.53% | 12.42% | 13.04% | 13.14% | 18.61% | 18.77% | 19.03% | 19.33% | 19.45% |
| | 2025 | 10.61% | 12.47% | 13.82% | 14.27% | 15.05% | 17.93% | 18.05% | 18.15% | 18.31% | 18.43% | | |
| | 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% |

1,188

6,446



# 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**

**172**

*Rate: 24.29%*

*Prior Year: 23.16%*

*+1.14% change*

283

1,165

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 20.00% | 16.11% | 20.27% | 19.10% | 18.59% | 20.93% | 22.50% | 23.91% | 22.91% | 23.16% | 23.13% | 22.84% |
| 2025 | 16.25% | 16.43% | 19.51% | 21.14% | 21.36% | 21.65% | 23.75% | 23.90% | 24.28% | 24.29% | | |
| 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% |

# 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**

**320**

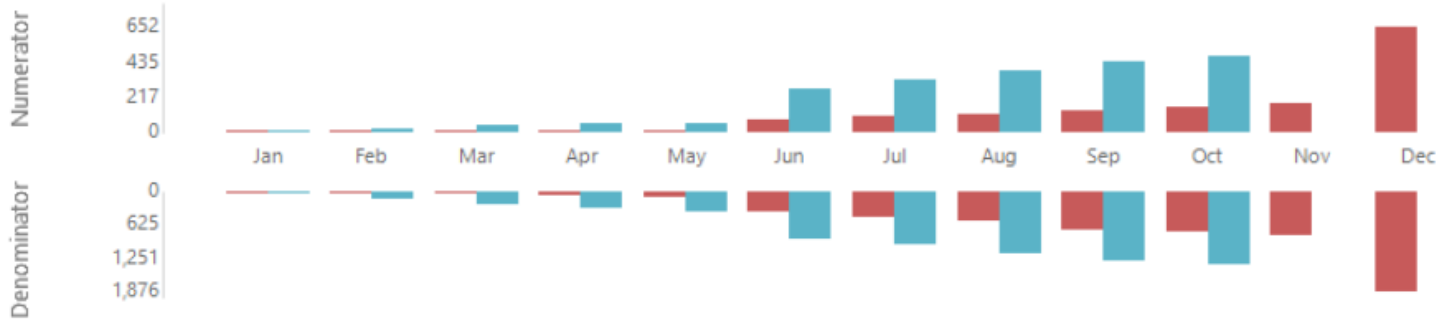
*Rate: 33.96%*

*MPL: 57.13%*

470

1,384

| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 9.09% | 25.00% | 21.88% | 17.86% | 15.91% | 19.74% | 20.82% | 20.25% | 19.50% | 20.53% | 21.45% | 34.75% |
| | 2025 | 9.80% | 13.91% | 17.83% | 17.03% | 17.26% | 30.56% | 32.83% | 33.39% | 33.46% | 33.96% | | |
| | 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% |



# 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%

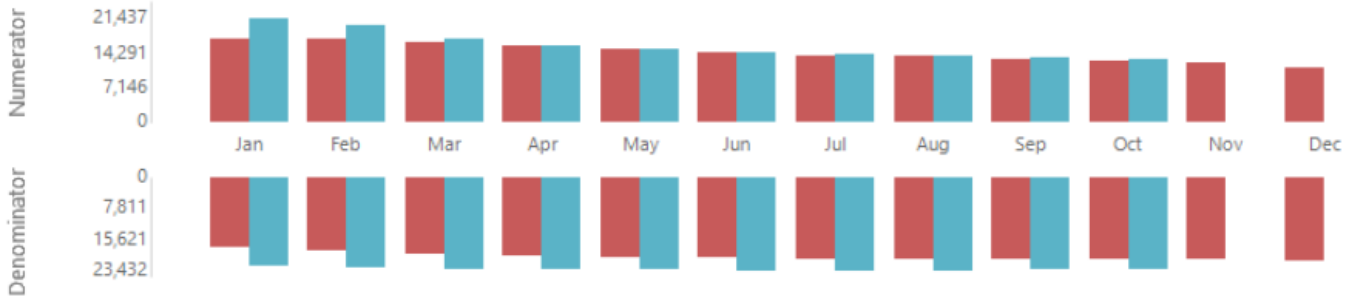
**Hits needed for MPL**

**6,087**

*Rate: 56.86%*
*Prior Year: 61.58%*
*+4.72% change*

13,085
23,012

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 98.79% | 92.48% | 85.96% | 80.56% | 75.65% | 71.23% | 67.63% | 66.71% | 62.92% | 61.58% | 59.61% | 54.41% |
| 2025 | 96.31% | 88.14% | 74.38% | 67.74% | 64.57% | 61.03% | 59.85% | 58.81% | 57.11% | 56.86% | | |
| 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% |




**GSD is an inverse measure – not currently compliant based on administrative dat*

# 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.

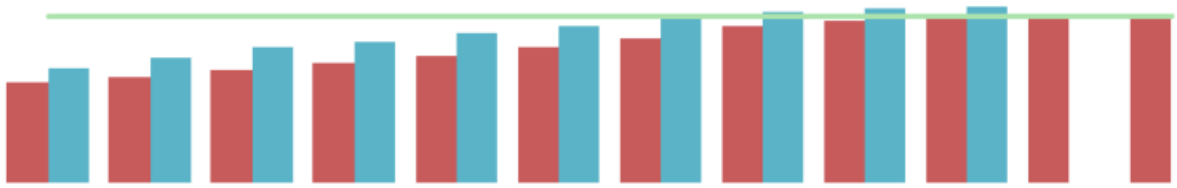
IMA

**Hits needed for MPL**

**0**

*Rate: 35.98%*

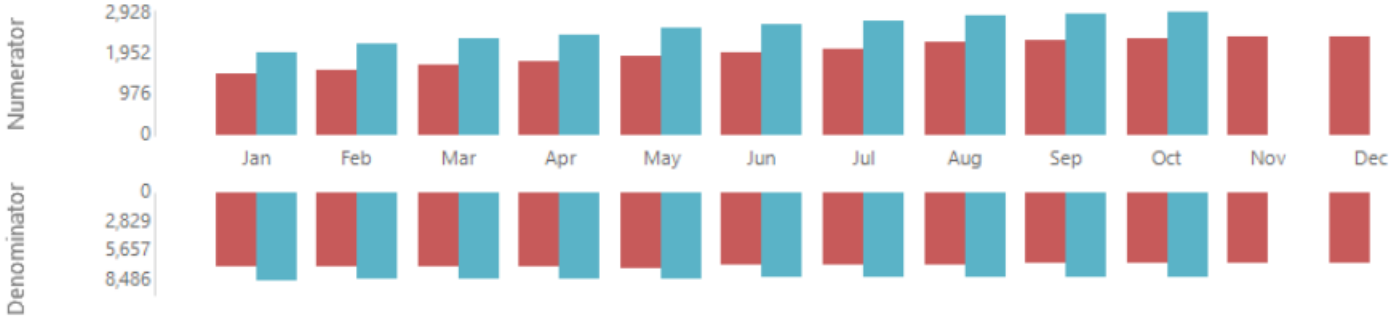
*MPL: 34.14%*



| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 20.41% | 21.78% | 23.08% | 24.49% | 25.82% | 27.71% | 29.52% | 32.00% | 32.88% | 33.54% | 34.05% | 34.25% |
| | 2025 | 23.52% | 25.63% | 27.62% | 28.83% | 30.65% | 32.07% | 33.33% | 34.84% | 35.59% | 35.98% | | |
| | 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% |

2,928

8,137



# Lead Screening in Children

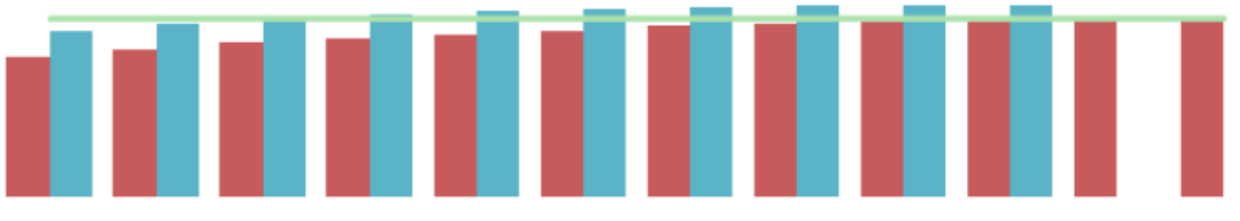
The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

LSC

**Hits needed for MPL**

**0**

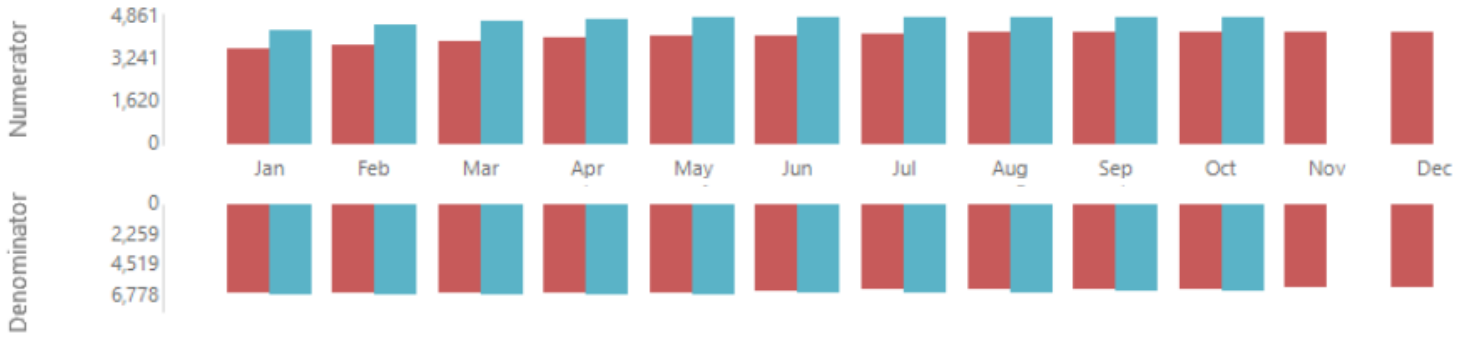
*Rate: 74.81%*
*Prior Year: 68.60%*
*+6.22% change*




| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 54.60% | 57.84% | 60.05% | 62.04% | 63.05% | 64.95% | 66.60% | 67.25% | 67.90% | 68.60% | 68.96% | 69.11% |
| | 2025 | 64.57% | 67.38% | 69.66% | 71.31% | 72.55% | 73.44% | 73.99% | 74.42% | 74.74% | 74.81% | | |
| | 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% |

4,842

6,472



# 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**

**1,344**

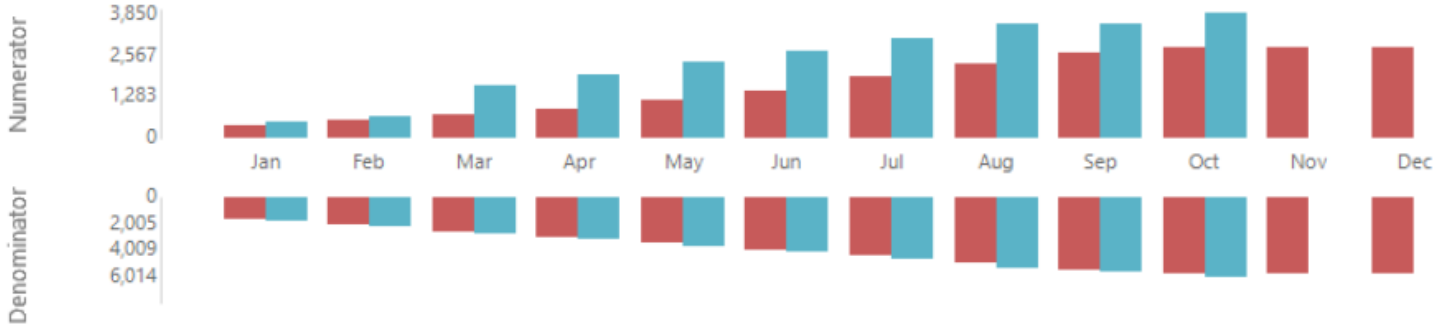
*Rate: 64.02%*

*MPL: 86.37%*

| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 25.10% | 26.84% | 28.68% | 30.70% | 33.22% | 37.55% | 43.83% | 46.35% | 48.18% | 49.63% | 49.44% | 49.27% |
| | 2025 | 27.34% | 30.00% | 60.25% | 61.72% | 63.46% | 64.71% | 65.78% | 66.53% | 63.55% | 64.02% | | |
| | 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% |

3,850

6,014



# 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.

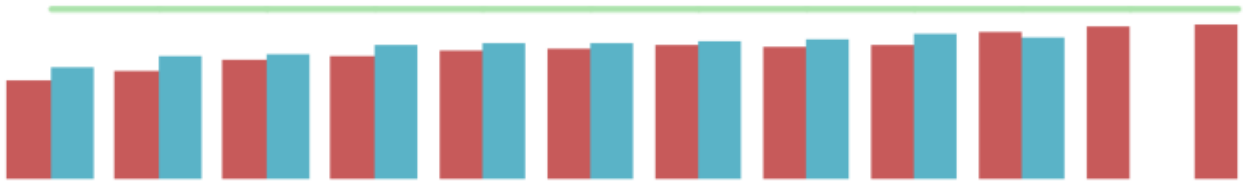
## PPC Post

**Hits needed for MPL**

**847**

*Rate: 68.38%*

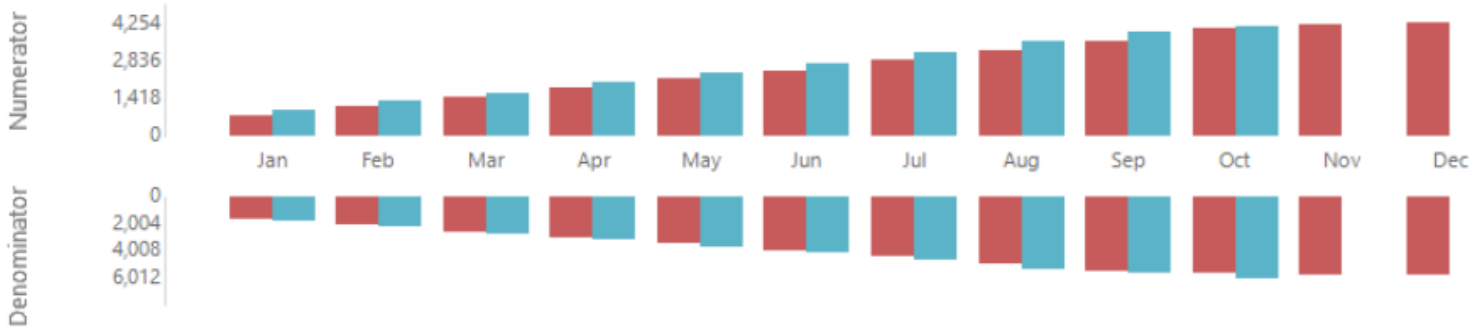
*MPL: 82.48%*




| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 47.47% | 52.40% | 57.47% | 59.74% | 61.76% | 63.15% | 64.75% | 64.29% | 64.65% | 71.15% | 74.06% | 74.66% |
| | 2025 | 53.97% | 59.25% | 60.25% | 64.83% | 65.32% | 65.48% | 66.72% | 67.60% | 70.48% | 68.38% | | |
| | 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% |

4,111

6,012



# Prevention: Topical Fluoride for Children

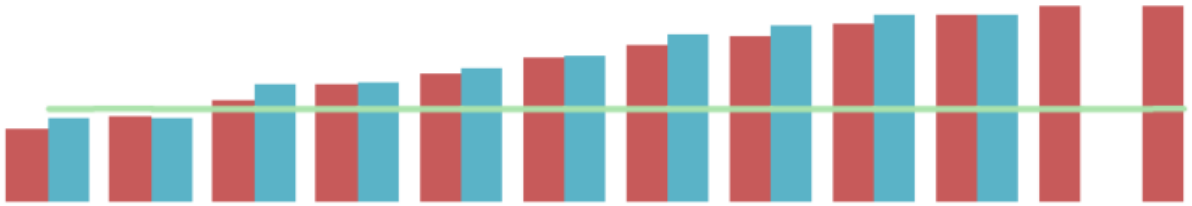
Percentage of children aged 1–21 years who received at least 2 topical fluoride applications as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year.

TFLCH

**Hits needed for MPL**

**0**

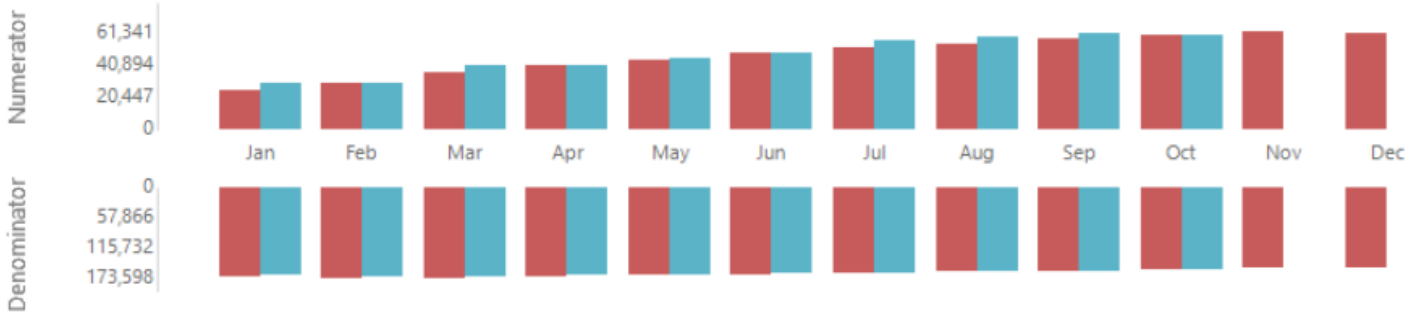
*Rate: 37.80%*
*Prior Year: 37.77%*
*+0.03% change*



| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 14.64% | 17.16% | 20.65% | 23.68% | 26.00% | 29.18% | 31.71% | 33.47% | 35.76% | 37.77% | 39.36% | 39.53% |
| | 2025 | 16.98% | 16.82% | 23.76% | 23.94% | 26.90% | 29.40% | 33.94% | 35.64% | 37.61% | 37.80% | | |
| | 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% |

59,887

158,446



# 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

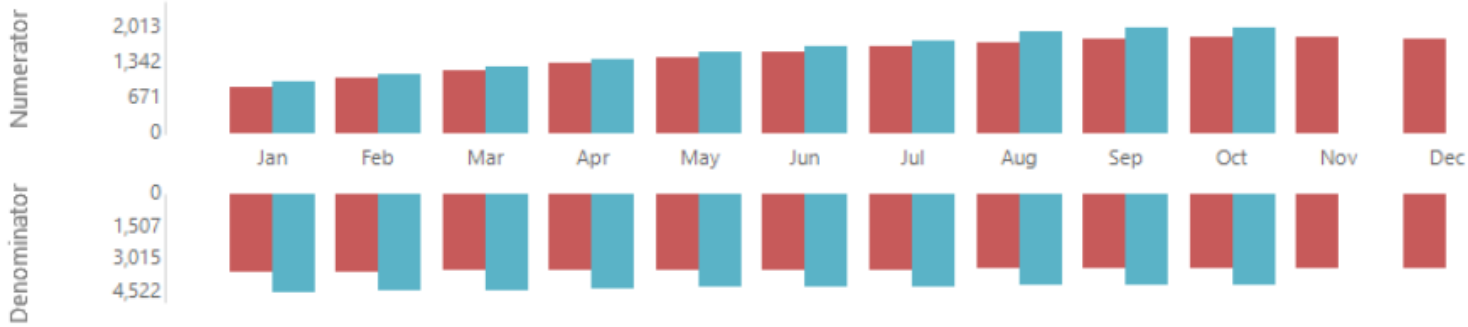
**Hits needed for MPL**

**645**

*Rate: 47.99%*
*Prior Year: 53.09%*
*-5.10% change*

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 24.72% | 29.30% | 34.04% | 37.92% | 41.33% | 44.51% | 47.26% | 49.52% | 51.70% | 53.09% | 53.62% | 52.20% |
| 2025 | 21.56% | 24.94% | 28.57% | 31.99% | 35.59% | 38.29% | 41.26% | 45.27% | 47.20% | 47.99% | | |
| 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% |

2,013
4,195



# 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**

**274**

*Rate: 68.57%*

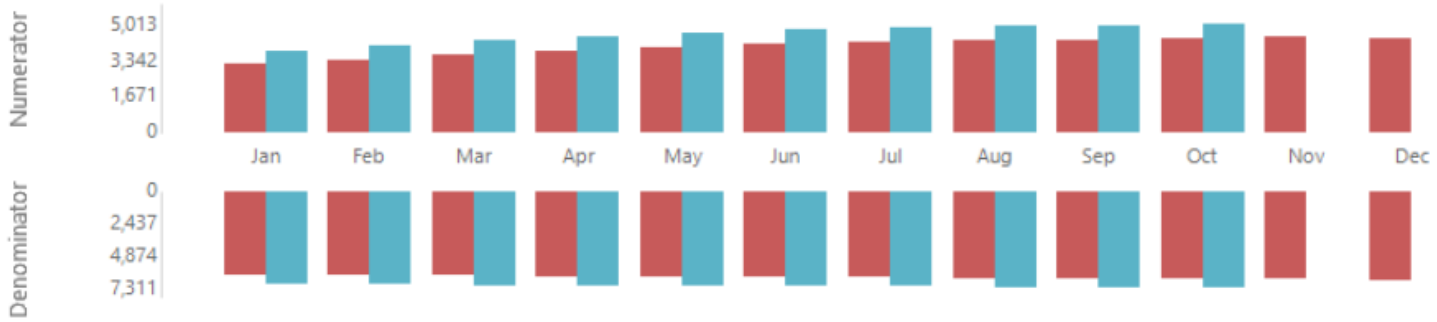
*Prior Year: 66.53%*

*+2.04% change*

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | 51.49% | 54.30% | 56.86% | 59.32% | 61.71% | 63.56% | 64.36% | 65.26% | 66.12% | 66.53% | 66.71% | 65.87% |
| 2025 | 53.86% | 57.50% | 60.60% | 63.14% | 65.28% | 66.60% | 67.69% | 68.33% | 68.61% | 68.57% | | |
| 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% |

5,013

7,311



# 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**

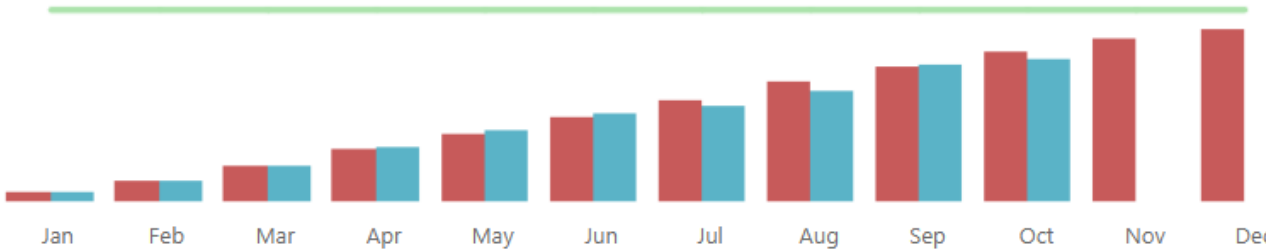
**20,636**

*Rate: 41.16%*

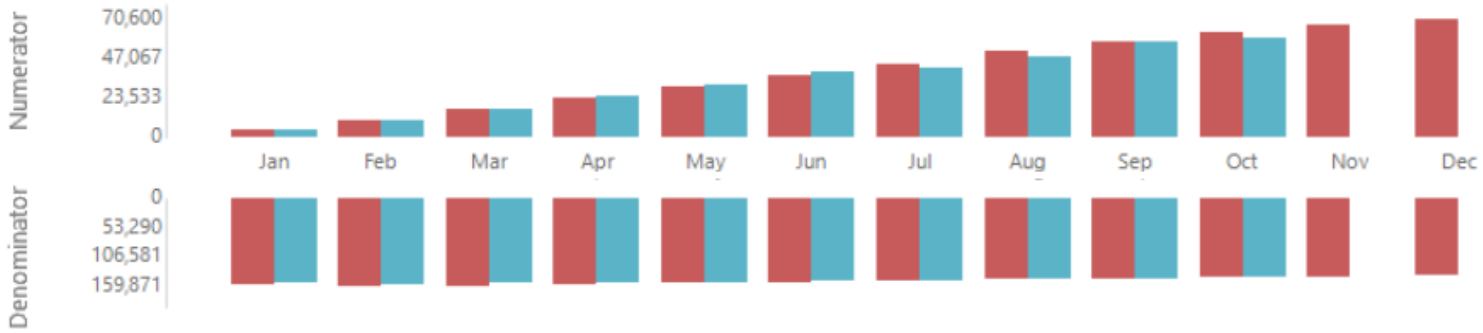
*MPL: 55.41%*

59,621

144,843



| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2024 | 2.80% | 6.13% | 10.59% | 15.01% | 19.77% | 24.31% | 29.14% | 34.53% | 38.73% | 43.19% | 46.72% | 49.77% |
| | 2025 | 2.75% | 6.25% | 10.67% | 15.71% | 20.67% | 25.71% | 27.55% | 32.14% | 39.29% | 41.16% | | |
| | 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% |



# KERN HEALTH SYSTEMS

**BOARD OF DIRECTOR'S MEETING**

2025

Chief Executive Officer's Report

**Emily Duran**

October 23, 2025

## KHS CORPORATE STRATEGIC PLAN

The Kern Health Systems (KHS) Strategic Plan outlines the organization's priority areas and serves as a roadmap for 2023–2025. KHS continues to make steady progress toward achieving its strategic goals, with notable accomplishments across all focus areas through the second quarter of 2025. Overall, the organization remains on track in meeting the objectives outlined in the Strategic Plan.

## LEGISLSTIVE SUMMARY

**Federal** – We are still actively monitoring the impacts of HR 1 by collaborating with our Federal and State Trade Associations to advocate for appropriate transition timelines regarding the proposed changes to provider taxes, eligibility, and work requirements. A key HR 1 provision that we are currently monitoring involves restrictions on payments to certain "prohibited entities" that provide abortions, effective for one year following enactment. The Department of Health Care Services (DHCS) has already issued an All-Plan Letter (APL) outlining these restrictions and their implications for providers.

We have identified two providers that are considered prohibited entities, and we are working closely with DHCS to ensure that they are informed about the current payment situation. The APL released by DHCS has undergone three revisions in recent months due to ongoing legal challenges. As of this week, prohibited entity providers are temporarily not permitted to submit claims while awaiting future court guidance. This ongoing situation presents challenges for our health plan and others throughout the state, as the evolving guidance complicates claims payment operations. We remain committed to working with our regulators and DHCS to ensure that our concerns are addressed in the development of policies related to HR 1.

In addition, our CEO, Emily Duran, attended the annual CEO conference hosted by the Association of Community Affiliated Plans (a Federal Trade Association), where she engaged in direct advocacy with our Congressional delegation from Kern County regarding HR 1 and other healthcare related issues.

**State –** The State Legislative Session concluded on September 13, 2025, marking the final day for each house to pass bills on the floor. The Governor has until October 12, 2025, to either sign or veto any bills. We continue to closely monitor the status of the Governor's signature and vetoes for 20 bills. The current list of bills that we are still tracking can be found in **Attachment A: Bill Tracking**. In total, we tracked 65 bills internally; of these, 20 passed the legislature, and 11 were signed by the Governor. We are still assessing the outcome of 9 bills that remain unsigned and have not been vetoed.

Below is a summary of some notable bills that have passed so far:

AB 543 (Gonzalez) – This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness who appear to be otherwise eligible for full-scope Medi-Cal coverage without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons.

SB 660 (Menjivar) – The bill would expand the entities that are specifically required to execute a data sharing agreement with the California Health and Human Services Data Exchange Framework and authorize the Department to determine other categories of entities required to execute a data sharing agreement, as specified. The bill would require the Department, no later than July 1, 2026, to establish a process to designate qualified health information organizations as data sharing intermediaries that have demonstrated their ability to meet requirements of the California Health and Human Services Data Exchange Framework. The bill would require the Department to annually report to the Legislature on the California Health and Human Services Data Exchange Framework, including compliance with data sharing agreements.

Please note that all bills will take effect on January 1, 2026, unless specified otherwise. Kern Family Health Care (KFHC) staff will work internally to evaluate and prepare for the internal operational implications of these bills, which include collaborating with our Trade Associations and regulators on the development of any regulatory guidance, and completing required deliverables.

Furthermore, the team recently hosted on-site tours of our operations for two County Supervisors. During these tours, Supervisors engaged with internal operational leadership to discuss their role within KFHC. The tours were an excellent opportunity to provide a general overview of the services KFHC provides to the community and address any questions the Supervisors had. These tours have been positively received, and the team plans to extend invitations to all three remaining Supervisors for future tours. All local, state, and federal elected officials and their staff are welcome to coordinate with the team in scheduling a tour.

**MEDICARE D-SNP**

**Background**

The CalAIM initiative focuses on transforming Medi-Cal to reduce health disparities, improve health outcomes, and enhance care delivery, particularly for the most vulnerable populations. Dual-eligible members, who qualify for both Medicare and Medi-Cal, often face complex healthcare needs and coordination challenges, which led to the creation of Dual Special Needs Plans (D-SNPs). These Medicare Advantage plans provide tailored care coordination and wrap-around services for this population. In alignment with CalAIM's January 1, 2026, timeline, KHS will implement a D-SNP line of business to integrate care across both programs, requiring significant regulatory compliance, new internal infrastructure, and process development.

**Update**

KHS received our executed contract from CMS in September. All member material has been approved by CMS and is ready for distribution and posting on the KHS website. The second provider education meeting was help in late September and was well attended.

The annual enrollment period starts 10/15/2025 and our sales team is trained and ready to go with sales events held in the KHS board room and in outlying areas.

Continued implementation with each selected supplemental benefit vendor including finalizing data sharing and member material. Regular implementation meetings with Universal Health Care MSO and MedImpact are occurring to implement the contractual delegated functions.

## GRANTS AND STRATEGIC INITIATIVES 2023 – 2025

**Quality Grant Highlight:**

The Quality Grant with Kern Medical has supported essential needs such as staffing, medical supplies, transportation, educational materials, and administrative costs for the current mobile unit. The two new mobile clinics represent a critical step toward long-term sustainability as the grant period nears its end. By bringing care directly into Kern County neighborhoods, they reduce barriers to access and ensure that families continue receiving needed services beyond the life of the grant. A total of 200 mobile clinic events are planned, partnering with schools, community centers, and local organizations to deliver health fairs, resources, and direct services. This model not only increases accessibility but also strengthens community partnerships that will carry forward.

**Healthcare Workforce Initiative Highlight:**

In the August 2025 Board Report, Dignity Health was highlighted for a future white coat ceremony that would be held for all new residents. Below is an update regarding this exciting ceremony. In addition to Dignity Health, KHS would also like to highlight CSU Bakersfield for the launch of the Doctor of Nursing Program for Fall 2025. These milestones for rural residency and nursing programs are vital steps toward addressing provider shortages in Kern County. Such programs are the most effective for building a sustainable healthcare workforce, as physicians and nurses often remain and practice in the communities where they train. Over time, the programs will help expand access to care, reduce gaps in specialty coverage, and provide consistent, high-quality medical services for local families.

**Dignity Health**

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

**California State University, Bakersfield (CSUB)**

CSUB officially launches its Doctor of Nursing Practice (DNP-NP) Program. This new program will prepare the next generation of doctoral-level nurse practitioners to meet the urgent need for primary care providers in our region while advancing the profession's educational and scholarly standards.

# KHS AUGUST 2025 ENROLLMENT:

## MEMBER DEMOGRAPHICS

| Member Age | |
|---|---|
| 0-5 | 12% |
| 18-Jun | 30% |
| 19-44 | 35% |
| 45-64 | 17% |
| 65+ | 6% |

| Ethnicity | |
|---|---|
| Hispanic | 64% |
| Caucasian | 15% |
| Unknown | 12% |
| 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 |
| 2025-09 | 73,867 | 166,791 | 25,920 | 20,459 | 115,007 | 521 | 402,565 |
| 2025-10 | 73,026 | 166,085 | 25,800 | 20,288 | 114,241 | 563 | 400,003 |
| % Change | -1.1% | -0.4% | -0.5% | -0.8% | -0.7% | 8.1% | -0.6% |

**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 OCTOBER AND NOVEMBER:**

| Organization Name | Event Name | Purpose | Donated Amount |
|---|---|---|---|
| Bakersfield Ronald McDonald House | A Galactic Gala Under the Galaxy | The gala aims to raise funds for the Ronald McDonald House programs and initiatives, providing essential support to families facing extended hospitalizations. | $3,000 |
| Links for Life, Inc | Lace'n It Up - 5K Fun Run & Celebration Walk | Proceeds benefit Kern County community with breast cancer services. The organization supports local survivors and educates the community about breast cancer throughout the year, especially during October, which is Breast Cancer Awareness Month. Over 100 KFHC employees and family members participated in the walk and raised funds to cover team t-shirts. | $5,000 |
| Adventist Health Bakersfield Foundation | VIPink Memories & Milestones | Support essential breast health programs, expand access to cutting-edge equipment and offer direct assistance to patients navigating their fight against breast cancer. | $2,500 |
| Boys & Girls Clubs of Kern County | 2025 Artfest | To enable all young people, especially those in need, to reach their full potential as productive, caring, responsible citizens. | $2,500 |

| Organization Name | Event Name | Purpose | Donated Amount |
|---|---|---|---|
| H.E.A.R.T.S. Connection | Hero's 4 HEARTS Walk | HEARTS Connections enhances the quality of life for people with special needs through a family resource center. | $1,500 |
| No Sister Left Behind Nonprofit Organization | Total Well-Being Women's Conference 2025 | The goal is to provide a much-needed service to women who need economic empowerment but are under-educated, and thus, underprepared and unqualified for jobs that would afford them a better life. NSLB will provide several scholarships for individuals who cannot afford the registration fee. | $750 |
| Kern County Cancer Foundation | North Kern Cancer Run/Walk Festival 2025 | A dual purpose: to raise funds and awareness for local kids who are bravely battling cancer, all while creating a fun and supportive community event. | $1,000 |
| Apple Core Project, Inc. | Annual Party in the Garden | Provide education, monthly food distributions, and a nurture space within their community garden. | $3,000 |
| Clinica Sierra Vista | Spooktacular Fall Well Child Event | A free seasonal gathering designed to offer families a joyful and enriching Halloween experience and simultaneously provide Well Child Exams. This event is a critical opportunity to improve the health of children through comprehensive Well Child Visits, while also supporting the broader community by offering educational resources, health information, and access to services. | $1,000 |
| Friends of Mercy Foundation | Healthful Harvest/La Cosecha Saludable 2025 | The goal is to create awareness, provide education and services, and connect Arvin residents to health and local community resources. Food, entertainment, and incentives will also be provided. | $5,000 |
| Kern Down Syndrome Network | Walk for A Million Dreams | Fundraising efforts will support local programs and services that benefit all individuals with down syndrome. | $1,000 |
| Golden Empire Gleaners | Rhythm & Roots | To help alleviate hunger and provide food for those in need in Kern County. | $2,500 |
| California Living Museum Foundation | Holiday Lights at CALM | CALM works hand in hand with the Kern County Superintendent of Schools to educate students and adults alike to the betterment of our planet; currently hosting over 20,000 students annually through our doors on school field trips. | $2,500 |
| Safe Haven Kid's League of California City | A Giving Resource Spectacular | Donations will provide free food boxes, educational items, and hygiene kits to families in need. | $1,000 |
| The Wildlands Conservancy | 3rd Annual Howl-O-Ween | Encourage kids and adults to celebrate fall outdoors and learn more about the strange and chilling creatures that live in their backyards. | $500 |

| Organization Name | Event Name | Purpose | Donated Amount |
|---|---|---|---|
| The Blessing Corner | Holiday Support (Thanksgiving & Christmas) | Thanksgiving: A community distribution event for thanksgiving turkey meal-in-a-box for up to 300 families that have a place to cook and prepare their family's meal, including seniors and veterans. Host the annual Thanksgiving Day sit-down meals at the Blessing Corner for up to 300 individuals. Christmas: A community holiday meal-in-a-box giveaway for up to 200 families having a place to cook their meals. Host the annual Christmas Day Extravaganza which includes a sit-down meal, toys and gift items for up to 500 that will include the unsheltered and individual families with children. | $3,000 |
| Delano First Assembly of God | Annual Thanksgiving Food Boxes | All donations will go to the Delano First Assembly of God Soup Kitchen Ministry to build Thanksgiving food baskets. Food baskets will be distributed locally with the community. | $1,500 |
| West Side Family Health Care | Tug of War Tournament - Mud Mayhem during Taft Oildorado Days | Support a fun, family-friendly community event. Strengthen community presence while making a difference. | $1,500 |
| West Side Recreation & Park District | Community Garden Fest during Taft Oildorado Days | Support a space where families can grow fruits, vegetables, flowers, and more — inspiring creativity alongside healthy living. | $1,000 |
| Kern Partnership for Children and Families | 38th Annual Holiday Cottage | Fill specific holiday wishes for children in Kern County's foster care system, making their holiday season brighter by providing them with gifts they might not otherwise receive. The program relies on the community to fulfill these wishes, with individuals and organizations donating gifts or money to support the foster youth and ensure they experience the magic of the holidays. | $10,000 |
| JJ's Legacy | 10th Annual Grillin' & Brewin' | The event promotes organ donation awareness and registration. Proceeds from the event benefit the Got the Dot program, which encourages high school students to register as organ donors and helps spread awareness about organ donation in the community. | $1,250 |

**KHS WILL ALSO PARTICIPATE IN THE FOLLOWING EVENTS IN AUGUST AND SEPTEMBER:**

| Organization Name | Event Name | Location | Date | Time |
|---|---|---|---|---|
| Family Health Care Network | Delano Adult School Health Fair | 1811 Princeton Street, Delano 93215 | 10/3/2025 | 4:00pm-6:00pm |
| Arvin Police Department | National Night Out 2024 | 200 Campus Dr., Arvin 93203 | 10/3/2025 | 5:30pm-8:00pm |
| American Cancer Society | Relay for Life | Ker McGee Center 100 W. California Ave., Ridgecrest 93555 | 10/4/2025 | 10:00am-5:00pm |
| Delano Police Department | 2025 National Night Out | 502 Jefferson St., Delano 93215 | 10/7/2025 | 5:00pm-7:00pm |

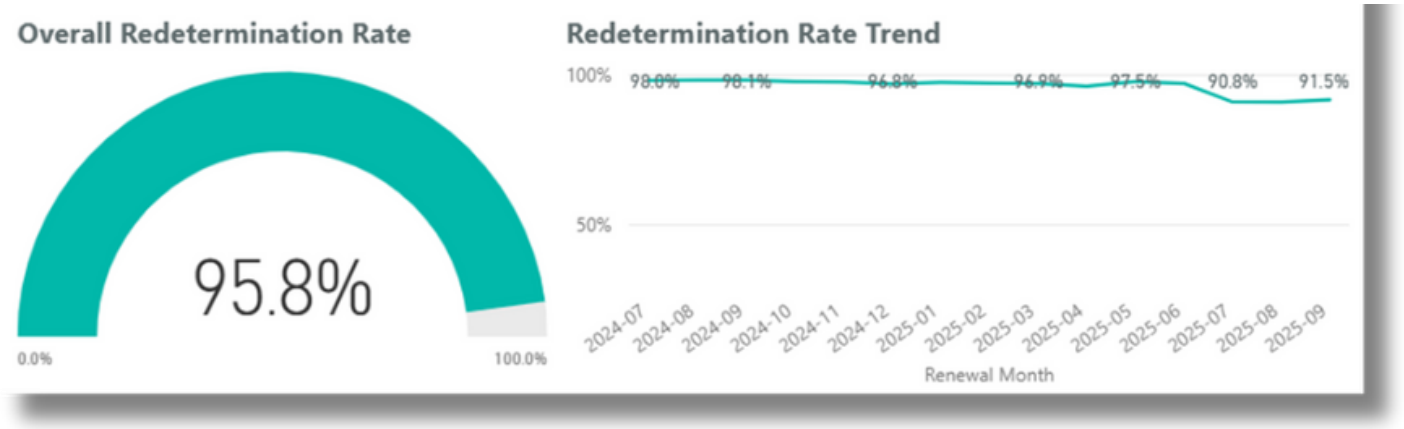
**KHS WILL ALSO PARTICIPATE IN THE FOLLOWING EVENTS IN AUGUST AND SEPTEMBER:**

| Organization Name | Event Name | Location | Date | Time |
|---|---|---|---|---|
| California Department of Corrections and Rehabilitation | Adult Re-Entry Resource Fair | 3201 F St., Bakersfield 93301 | 10/8/2025 | 10:00am-12:00pm |
| CAPK Veterans Supportive Services | Kern County Veterans Stand Down & Resource Day | 3805 Chester Ave., Bakersfield 93305 | 10/9/2025 | 8:00am-3:00pm |
| Love from Above Community | 3rd Annual Hunger & Homelessness March | Mill Creek Park, Bakersfield | 10/11/2025 | 11:00am-3:00pm |
| Wasco Police Department | National Night Out | 830 7th St., Wasco 93280 | 10/10/2025 | 4:00pm-9:00pm |
| Vision y Compromiso | Jamaica 2025 Resource Fair | 1305 Water St., Bakersfield 93305 | 10/12/2025 | 12:00:00pm-7:00pm |
| Greenfield Family Resource Center | Community Resource Fair Open House | 5400 Monitor St., Bakersfield 93307 | 10/14/2025 | 3:30pm-6:30pm |
| The City of Shafter | 2025 National Night Out | 701 S. Schnaidt St., Shafter 93263 | 10/16/2025 | 5:00pm-8:00pm |
| Children First | Fall Festival Resource Fair | 1511 Niles St., Bakersfield 93305 | 10/17/2025 | 4:00pm-6:00pm |
| Kern County Sheriff's Office | National Night Out - Trick or Treat | Stramler Park - 4003 Chester Ave., Bakersfield 93301 | 10/21/2025 | 5:00pm-8:00pm |
| Casa Loma Elementary | Trunk or Treat | 525 E. Casa Loma Dr., Bakersfield, 93307 | 10/24/2025 | 5:00pm-6:30pm |
| City of Ridgecrest | Trunk or Treat | Kerr Mc Gee 100 W. California Ave., Ridgecrest 93555 | 10/24/2025 | 4:30pm-7:30pm |
| Vineland School District | Halloween Trunk or Treat | 8301 Sunset Blvd., Bakersfield 93307 | 10/24/2025 | 5:30pm-8:30pm |
| Golden Hills Community Services District | Ghoulden Hills Trick or Treat | 21750 Westwood Blvd., Tehachapi 93561 | 10/25/2025 | 4:00pm-7:30pm |
| Lamont - Weedpatch LESD | Fall Harvest Festival | 10301 San Diego St., Lamont 93241 | 10/30/2025 | 4:30pm-7:00pm |
| Oildale Community Action Team | Oildale Trunk or Treat | N Chester Ave. - Frontage Rd. - North of Norris Rd., Bakersfield 93308 | 10/30/2025 | 5:30pm-7:30pm |

**Medi-Cal Renewal Updates**

As anticipated, in July we experienced a substantial increase in the number of members who need to renew their Medi-Cal. This workload will continue each month. We continue to 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 to 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 and community-based organizations to support Medi-Cal renewal efforts. KCHS is now providing 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. Finally, KCHS is working with CalSAWS to install a kiosk that allows members to scan their documents directly to their case file at the KFHC office and to allow KFHC members with Medi-Cal questions who call KCHS to be transferred to the KFHC call center for assistance.

*Below are KFHC Medi-Cal Redetermination Trending Rates.*




**KFHC Media Clips**

We compiled local media coverage that KFHC received in August 2025 – September 2025. Please see **Attachment B: Public Relations and Publicity Media Clips.**

# KHS MEMBER ENGAGEMENT | COMMUNITY HIGHLIGHTS

## SUPPORTING KERN COUNTY VETERANS THROUGH PERMANENT HOUSING

Kern Family Health Care joined thousands of local families at the 16th Annual Ready-Set Back 2 School Health and Wellness Fair at the Kern County Museum, hosted by Kern County Child Support Services. The event distributed more than 4,000 backpacks filled with school supplies to students across Kern County, helping families prepare for a successful start to the school year.

Our Community Engagement Team was on site providing information about Medi-Cal renewals, sharing member resources, and connecting families to important health services before coverage lapses. Isenia Calderon, MCAS Coordinator, also represented our Quality Performance Team, educating attendees about KFHC's Member Rewards Program (MERP), which encourages preventive care through member incentives.

This outreach exemplifies KFHC's commitment to community connection, health education, and proactive member engagement—ensuring families are equipped not only for school, but for better health outcomes year-round.

## KFHC TEAM RUNS STRONG FOR BREAST CANCER AWARENESS

Kern Family Health Care team proudly participated in the Links for Life "Lace'n It Up" 5K & 1K Celebration Walk, joining hundreds of community members to raise awareness and funds for breast cancer education, prevention, and survivor support.

With more than 100 KFHC employees and family members taking part, our team earned the trophy for largest group participation, along with several individual race wins. All proceeds from the event directly support Links for Life's work providing mammograms, diagnostic services, and resources for women and families across Kern County.

This strong turnout exemplifies KFHC's commitment to community health, local partnerships, and employee engagement in causes that align with our mission to promote wellness for all.

# KHS PROVIDER HIGHLIGHTS

## 2025 PROVIDER AWARDS

As part of our continued commitment to quality improvement and health equity, Kern Family Health Care proudly recognized seven outstanding partners through our 2025 Quality and Excellence Awards. These awardees exemplify innovation, collaboration, and impact in service to our members and communities. While budget reductions prevented us from hosting our traditional awards dinner this year, our leadership team personally recognized each awardee in individual visits to celebrate their achievements and express our continued gratitude.

**Award Recipients**

*Quality Excellence Award* | *Coastal Kids*, *A Professional Medical Corporation* Recognized for delivering consistently high-quality, patient-centered care. Coastal Kids demonstrated strong staff engagement, process improvement, and extended access through after-hours clinics—all while maintaining top performance standards.

*Quality Progress Award* | *Universal Healthcare Services*, *Inc.* Awarded for measurable year-over-year improvement in key clinical metrics, innovative strategies to improve access, and deep engagement in health equity initiatives such as the EPT program and the IHI-DHCS Child Health Equity Collaborative.

*Quality Innovation Award* | *Kern Medical* Honored for its agile and responsive approach to mobile care delivery across Kern County. Kern Medical continues to be a reliable partner, implementing mobile units and training staff on MCAS measures to expand preventive care access.

*Community Collaboration Award* | *Safe Haven Kids League* Celebrated for its trusted partnership in expanding services to California City, including food distribution, mobile health fairs, and outreach support. Their efforts led to the establishment of recurring mobile services in this rural community.

*Educational Partnership Award* | *California State University, Bakersfield* Acknowledged for its leadership in hosting legal expungement clinics, removing critical barriers to employment and housing. This work directly supports CalAIM goals and reinforces the link between justice and health equity.

*Community Impact Award* | *The Open Door Network* Recognized for seamlessly integrating Enhanced Care Management (ECM) into their longstanding services for victims of violence, homelessness, and exploitation—delivering consistent quality and expanding wraparound care for vulnerable members.

*Health Equity Champion Award* | *Polyclinic Medical Center, Inc.* Honored for expanding access through weekend clinics, investing in infrastructure improvements, and actively participating in the EPT program. Their work supports digital equity and care accessibility while achieving strong MCAS performance.

While we were unable to host an in-person celebration this year, each awardee received a physical award and was featured in a special video tribute. We are grateful for their partnership and the vital role they play in advancing our mission.

# KHS ORGANIZATIONAL HIGHLIGHTS

## 28TH ANNUAL KCSHRM CONFERENCE - HUMAN RESOURCES TEAM

Our Human Resources team recently represented Kern Family Health Care at the 28th Annual Kern County SHRM Conference—Kern County's premier event for HR professionals and business leaders shaping the future of work. The conference drew over 400 participants and focused on "People-Centered, Future-Ready" leadership.

I'm proud to share that our own Devin Brown, Chief Human Resources Officer, served as a featured panelist, sharing thought leadership on workforce development and HR innovation. Lupita Cervantes, Talent Acquisition Specialist, was recognized with a SHRM Foundation Scholarship to advance her professional certification goals, and Elizabeth Maldonado, Employee Relations Advisor and KCSHRM Board Director, played a key role in organizing this year's largest regional HR event.

Their active participation reflects KFHC's ongoing commitment to cultivating professional excellence, investing in our people, and shaping the future of our workforce—both within our organization and across Kern County.

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BETTER WORKPLACES
BETTER WORLD™

## CELEBRATING OUR EMPLOYEES AT THE ANNUAL AWARDS LUNCHEON

KHS hosted its Annual Employee Awards Luncheon, celebrating the heart of our organization—our people. The event recognized employees for their years of dedicated service, commitment to our mission, and daily embodiment of KFHC's Core Values: Collaboration, Compassion, Equity, Excellence, Innovation, and Integrity.

We were especially proud to honor Alex Soto, Mailroom Operations Coordinator, as Employee of the Year, recognizing his outstanding contributions and teamwork across departments.

Events like this reaffirm our deep appreciation for the employees who make KFHC a Great Place to Work®, and whose passion and excellence continue to drive our service to members and the Kern County community.

## *Bill Tracking:*

| Title | Description | Status |
|---|---|---|
| **AB 45 (Bauer-Kahan)** | This bill would prohibit the collection, use, disclosure, sale, sharing, or retention of the personal information of a natural person who is physically located at, or within a precise geolocation of, a family planning center, except collection or use as necessary to perform the services or provide the goods requested. The bill would authorize an aggrieved person to institute and prosecute a civil action against a natural person, association, proprietorship, corporation, trust, foundation, partnership, or any other organization or group of people acting in concert for a violation of these provisions.<br><br>This bill would, subject to specified exceptions, prohibit geofencing, or selling or sharing personal information with a third party to geofence, as defined, an entity that provides in-person health care services in California for specified purposes, and would prohibit the use of personal information obtained in violation of this provision. The bill would provide that violators are subject to an injunction and liable for a civil penalty assessed and recovered in a civil action brought by the Attorney General, and deposited in the California Reproductive Justice and Freedom Fund. The bill would also provide that a statement signed under penalty of perjury, as specified, that the personal information will not be used for selling or sharing personal information in violation of these geofencing provisions is prima facie evidence that the personal information was not sold or shared in violation of these geofencing provisions.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB45 | 09/26/25 - Chaptered by Secretary of State - Chapter 134, Statutes of 2025. |
| **AB 50 (Bonta)** | Exiting law requires a pharmacist, when furnishing self-administered hormonal contraceptives, to follow specified standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. Existing law requires those standardized procedures or protocols to require that the patient use a self-screening tool that will identify related patient risk factors and that require the pharmacist to refer the patient for appropriate follow-up care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical follow-up, and other appropriate information. Existing law authorizes a pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive pursuant to the above-described protocols to furnish, at the patient's request, up to a 12-month supply at one time.<br><br>This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would additionally authorize a pharmacist to furnish up to a 12-month supply at one time of over-the-counter contraceptives at the patient's request. The bill would make related conforming changes.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB50 | 09/26/25 - Chaptered by Secretary of State - Chapter 135, Statutes of 2025. |

| | | |
|---|---|---|
| **AB 55 (Bonta)** | Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth certain criteria for Medi-Cal reimbursement to alternative birth centers for facility-related delivery costs.<br><br>Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement provisions described above, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions.<br><br>This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. The bill would require the facility to provide pregnancy and postpartum services, consistent with certain standards. The bill would remove the above-described proximity requirement and would instead require a written plan policy for hospital transfer. The bill would require the plan policy to include certain requirements with regard to providing the hospital with specified medical records, speaking with the receiving provider, and providing the patient patients and clients with the estimated transfer time. time, including a clear explanation of the facility's overall emergency transfer plan, as specified.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB55 | 09/16/25 - Enrolled and presented to the Governor at 2 p.m. |
| **AB 144** | 2025 Health Budget Bill.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB144 | 09/17/25 - Chaptered by Secretary of State - Chapter 105, Statutes of 2025. |
| **AB 260 (Aguiar-Curry)** | This bill would authorize the State Department of Public Health to adopt regulations to include or exclude mifepristone and other medication abortion drugs from the requirements of the Sherman Food, Drug, and Cosmetic Law, but would exclude the drugs from those requirements if the drugs are no longer approved by the United States Food and Drug Administration (FDA). The bill would authorize a pharmacist to dispense mifepristone or other drug used for medication abortion without the name of the patient, the name of the prescriber, or the name and address of the pharmacy, subject to specified requirements. The bill would require the pharmacist to maintain a log, as specified, that is not open to inspection by law enforcement without a subpoena, and would prohibit the disclosure of the information to an individual or entity from another state. The bill would prohibit criminal, civil, professional discipline, or licensing action against a pharmacist for manufacturing, transporting, or engaging in specified other acts relating to mifepristone or other medication abortion drugs, and would prohibit the California State Board of Pharmacy from denying an application for licensure or taking disciplinary action against an applicant or licensee for engaging in certain acts relating to mifepristone or other medical abortion drugs.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB260 | 09/26/25 - Chaptered by Secretary of State - Chapter 136, Statutes of 2025. |

| | | |
|---|---|---|
| **AB 489 (Bonta)** | Existing law establishes various healing arts boards within the Department of Consumer Affairs that license and regulate various healing arts licensees. Existing laws, including, among others, the Medical Practice Act and the Dental Practice Act, make it a crime for a person who is not licensed as a specified health care professional to use certain words, letters, and phrases or any other terms that imply that they are authorized to practice that profession.<br><br>This bill would make provisions of law that prohibit the use of specified terms, letters, or phrases to falsely indicate or imply possession of a license or certificate to practice a health care profession, as defined, enforceable against an entity who develops or deploys artificial intelligence (AI) or generative artificial intelligence (GenAI) technology that uses one or more of those terms, letters, or phrases in its advertising or functionality. The bill would prohibit the use by AI or GenAI technology of certain terms, letters, or phrases that indicate or imply that the advice, care, reports, or assessments being provided through AI or GenAI is being provided by a natural person with the appropriated health care license or certificate.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB489 | 09/15/25 - Enrolled and presented to the Governor at 4:30 p.m. |
| **AB 543 (Mark Gonzalez)** | This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports.<br><br>The bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness who appear to be otherwise eligible for full-scope Medi-Cal coverage without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons.<br><br>The bill would authorize a managed care plan to establish reasonable requirements governing participation in the plan network, if protocols and network participation requirements are consistent with the goal of authorizing services to Medi-Cal beneficiaries who are experiencing homelessness. The bill would require a managed care plan to have appropriate mechanisms, procedures, or protocols to ensure timely communication between the contracted street medicine provider, the Medi-Cal beneficiary's plan or independent practice association, and the beneficiary's primary care provider for purposes of care coordination.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB543 | 10/06/25 - Chaptered by Secretary of State - Chapter 374, Statutes of 2025. |

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|---|---|---|
| **AB 688 (Mark Gonzalez)** | This bill, the Telehealth for All Act of 2025, would require the department, commencing in 2028 and every 2 years thereafter, to use Medi-Cal data and other data sources available to the department to produce analyses in a publicly available Medi-Cal telehealth utilization report. The bill would authorize the department to include those analyses in each of the department's Biennial Telehealth Utilization Reports, as specified.<br><br>The bill would require the analyses to address telehealth access and utilization data, including various metrics on telehealth visits and claims, disaggregated by geographic, demographic, and social determinants of health categories to identify disparities. The bill would require the department to identify additional data elements for inclusion in future reports to help to identify and address access-to-care issues or provide greater insight into utilization of telehealth modalities.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB688 | 09/04/25 - Enrolled and presented to the Governor at 4 p.m. |
| **SB 7 (McNerney)** | This bill would require an employer to provide a written notice that an automated decision system (ADS), for the purpose of making employment-related decisions, not including hiring, is in use at the workplace to all workers that will foreseeably be directly affected by the ADS, as specified. The bill would require the employer to maintain an updated list of all ADS currently in use. The bill would require an employer to notify, as provided, a job applicant that the employer utilizes an ADS in hiring decisions, if the employer will use the ADS in making decisions for that position. The bill would prohibit an employer from using an ADS that does certain functions and would limit the purposes and manner in which an ADS may be used to make decisions. The bill would require an employer to allow a worker to access their data collected or used by an ADS and to correct errors in data, as specified.<br><br>This bill would require an employer to provide a written notice to a worker that has been affected by a discipline decision made by an ADS, and grant the worker who was subject to that decision the right to appeal the decision within 30 days of the notification. The bill would require an employer to provide an explanation for the decision within 14 business days of receiving an appeal, designate a human reviewer who meets specified criteria to objectively evaluate all evidence, and rectify the decision, as provided, within 21 business days if the human reviewer determines that the employment-related decision should be overturned.<br><br>This bill would prohibit an employer from discharging, threatening to discharge, demoting, suspending, or in any manner discriminating or retaliating against any worker for taking certain actions asserting their rights under the bill. The bill would require the Labor Commissioner to enforce the bill's provisions, as specified, and would authorize a public prosecutor or any worker who has suffered a violation or their representative to bring a civil action. The bill would set forth specified types of relief that a plaintiff may seek and that an employer that violates these provisions is subject to, including a $500 civil penalty per violation.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB7 | 09/10/25 - Enrolled and presented to the Governor at 2 p.m. |

| | | |
|---|---|---|
| **SB 246 (Grove)** | This bill would require the department, subject to any necessary federal approvals and the availability of federal financial participation, to make additional Medi-Cal payments to district and municipal public hospitals (DMPHs), defined as nondesignated public hospitals, and to their affiliated government entities, in recognition of the Medi-Cal managed care share of GME costs. Under the bill, these payments would be made in a manner consistent with the methodology for GME payments to DPHs and their affiliated government entities and would consist of the above-described direct and indirect GME payment components. The bill would authorize the department to seek federal approval for other forms of GME payments to DMPHs and their affiliated government entities, as specified.<br><br>Under the bill, the nonfederal share of payments under these provisions would consist of voluntary IGTs of funds provided by DMPHs or their affiliated government entities, or other eligible public entities, to the extent permitted under certain federal regulations and other applicable federal Medicaid laws, and with no state General Fund moneys being used to fund the nonfederal share of payments. The bill would establish the DMPH GME Special Fund, with moneys deposited being continuously appropriated to the department for purposes of these provisions.<br><br>The bill would require the department to seek any necessary federal approvals for GME payments, effective no sooner than January 1, 2026. The bill would authorize the Director of Health Care Services to modify the requirements set forth in these provisions to the extent necessary to meet federal requirements or to maximize federal financial participation, as specified.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB246 | 10/03/25 - Chaptered by Secretary of State. Chapter 308, Statutes of 2025. |
| **SB 250 (Ochoa Bogh)** | Existing federal Medicaid law requires the state to publish an online directory of physicians and, at state option, other providers, as specified. Existing state law sets forth Medi-Cal managed care provisions relating to a Medi-Cal applicant or beneficiary being informed of the health care options available regarding methods of receiving Medi-Cal benefits, including through certain provider directories. The department has administratively created an online provider directory through an internet website known as Medi-Cal Managed Care Health Care Options.<br><br>This bill would require, as part of the health care options information posted by the department, in the provider directory that lists accepted Medi-Cal managed care plans, through the Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, that the directory include skilled nursing facilities as one of the available searchable provider types. The bill would require that this provision be implemented in conjunction with implementation of the above-described provisions. The bill would require the department to annually update that provider directory to ensure that information is accurate and readily accessible to the public.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB250 | 10/03/25 - Chaptered by Secretary of State. Chapter 309, Statutes of 2025. |

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| **SB 278 (Cabaldon)** | Existing law generally imposes penalties on a person who negligently, willfully, or maliciously discloses the results of a human immunodeficiency virus (HIV) test to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, as specified. Existing law, notwithstanding the above-described restrictions, authorizes the recording of the HIV test results by the physician who ordered the test in the test subject's medical record and authorizes other disclosure of the results without written authorization of the test subject, or the subject's representative, to the test subject's providers of health care, excluding a regulated health care service plan, for purposes of diagnosis, care, or treatment of the patient.<br><br>This bill would authorize the disclosure of results of an HIV test that identifies or provides identifying characteristics of a Medi-Cal beneficiary without written authorization of the test subject, or the subject's representative, to the Medi-Cal managed care plan to which the beneficiary is assigned, if applicable, for the purpose of administering quality improvement programs, including, but not limited to, value-based payment programs and healthy behavior incentive programs, designed to improve HIV care for Medi-Cal beneficiaries. The bill would make an exception for Medi-Cal beneficiaries who have opted out through a mechanism that the department would be required to develop by December 31, 2026, as specified.<br><br>Under the bill, HIV test results that do not identify or provide identifying characteristics of the test subjects would be authorized for disclosure without written authorization by the Medi-Cal managed care plan to departmental staff for the above-described purpose.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB278 | 09/16/25 - Enrolled and presented to the Governor at 3 p.m. |
| **SB 338 (Becker)** | This bill would establish the Virtual Health Hub for Rural Communities Pilot Program, and would require the State Department of Public Health to administer the program to expand access to health services for farmworkers in rural communities. The bill would require the department to distribute grants to partnerships of 2 separate community-based organizations, except as specified, to establish and deploy virtual health hubs, as defined, and to administer the program and to provide technical assistance to the grant recipients for any licensing or reporting requirements necessary to fulfill the program obligations. The bill would outline criteria for the grants and require the department to give priority to community-based organizations that meet specified criteria, including, but not limited to, a history of serving medically underserved communities. The bill would require the grant recipients, among other things, to deploy virtual health hubs, as defined, in 2 rural communities based on farmworker population and access to health care and to submit specified information on the program to the department. Under the bill, the virtual health hubs would include, at a minimum, computers, Wi-Fi, cubicles for virtual visits, and exam rooms for telemedicine. The bill would create the Virtual Health Hub Fund and would condition implementation of these provisions on no General Fund moneys being used, there being a minimum of $2,000,000 in the fund, and the department posting a notice on its internet website.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB338 | 10/03/25 - Chaptered by Secretary of State. Chapter 311, Statutes of 2025. |

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| **SB 402 (Valladares)** | Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism and defines "behavioral health treatment" to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional. Existing law defines "qualified autism service provider," "qualified autism service professional," and "qualified autism service paraprofessional" for those purposes. Those definitions are contained in the Health and Safety Code and the Insurance Code.<br><br>This bill would move those definitions to the Business and Professions Code. The bill would also make technical and conforming changes.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB402 | 10/06/25 - Chaptered by Secretary of State. Chapter 413, Statutes of 2025. |
| **SB 418 (Menjivar)** | Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex.<br><br>This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after the bill's operative date to cover up to a 12-month supply of a United States Food and Drug Administration (FDA)-approved prescription hormone therapy, and the necessary supplies for self-administration, that is prescribed by a network provider within their scope of practice and dispensed at one time, as specified. The bill would make the same prescription hormone therapy a covered benefit under the Medi-Cal program, as specified. The bill would prohibit a plan, an insurer, or the Medi-Cal program from imposing utilization controls or other forms of medical management limiting the supply of this hormone therapy to an amount that is less than a 12-month supply, but would not prohibit a contract, a policy, or the Medi-Cal program from limiting refills that may be obtained in the last quarter of the plan, policy, or coverage year if a 12-month supply of the prescription hormone therapy has already been dispensed during that year. The bill would repeal these provisions on January 1, 2035.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB418 | 09/22/25 - Enrolled and presented to the Governor at 2 p.m. |

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| **SB 439 (Weber Pierson)** | Existing law establishes the Health Care Benefits Fund to support the University of California's implementation of the California Health Benefit Review Program. Under the program, the University of California assesses legislation proposing to repeal or mandate a benefit or service requirement on health care insurance plans or health insurers. Under the program, the University of California provides a written analysis that includes, among other data, financial impacts of legislation on publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program. Existing law imposes an annual charge on health care service plans and health insurers for the 2022–23 to 2026–27 fiscal years, inclusive, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment on health care service plans and health insurers from exceeding $2,200,000. Under existing law, the fund and the program become inoperative on July 1, 2027, and are repealed as of January 1, 2028.<br><br>This bill would extend the operation of the California Health Benefit Review Program and the Health Care Benefits Fund through July 1, 2033, and would authorize the continued assessment of the annual charge on health care service plans and health insurers for that purpose for the 2026–27 to 2032–33 fiscal years, inclusive. The bill would increase the allowable total annual assessment on health care service plans and health insurers to $3,200,000. The bill would remove the Healthy Families Program as an example of the publicly funded state health insurance programs within an analysis of financial impacts of legislation.<br><br>This bill would make these provisions inoperative on July 1, 2032, and would repeal it as of January 1, 2033.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB439 | 10/03/25 - Chaptered by Secretary of State. Chapter 318, Statutes of 2025. |
| **SB 497 (Wiener)** | This bill would additionally prohibit a provider of health care, a health care service plan, or a contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or gender-affirming mental health care in response to a criminal or civil action, including a foreign subpoena, based on another state's law that interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care. The bill would also prohibit a provider of health care, health care service plan, contractor, or employer from cooperating with or providing medical information to an individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care, as specified. The bill would prohibit these entities from releasing medical information related to sensitive services, as defined, in response to a foreign subpoena that is based on a violation of another state's laws authorizing a criminal action against a person or entity for provision or receipt of legally protected health care activity, as defined. The bill would also generally prohibit the issuance of a subpoena based on a violation of another state's law that interferes with a person's right to seek or obtain gender-affirming health care or gender-affirming mental health care, as specified.<br><br>This bill would prohibit a state or local agency or employee, appointee, officer, contractor, or official or any other person acting on behalf of a public agency from providing any CURES data or expend any resources in furtherance of any interstate investigation or proceeding seeking to impose civil, criminal, or disciplinary liability upon the provision or | 09/22/25 - Enrolled and presented to the Governor at 11 a.m. |

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| | receipt of legally protected health care activity, as defined. The bill would prohibit out-of-state law enforcement from having access to CURES data through the interstate data sharing hub and would require a warrant, subpoena, or court order for a law enforcement agency to obtain information from CURES as part of a criminal investigation.<br><br>This bill would make it a misdemeanor for a person to access the CURES database when not authorized by law, and would make it a misdemeanor for a person who is authorized to access the database to knowingly furnish information from the CURES database to a person who is not authorized by law to receive that information. By creating new crimes, the bill would impose a state-mandated local program.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260SB497 | |
| **SB 660 (Menjivar)** | This bill would require the Department of Health Care Access and Information, on or before January 1, 2026, and subject to an appropriation in the annual Budget Act, to take over the establishment, implementation, and all of the functions related to the California Health and Human Services Data Exchange Framework, including the data sharing agreement and policies and procedures, from the agency.<br><br>The bill would expand the entities that are specifically required to execute a data sharing agreement with the California Health and Human Services Data Exchange Framework and authorize the Department to determine other categories of entities required to execute a data sharing agreement, as specified. The bill would require the Department, no later than July 1, 2026, to establish a process to designate qualified health information organizations as data sharing intermediaries that have demonstrated their ability to meet requirements of the California Health and Human Services Data Exchange Framework. The bill would require the Department to annually report to the Legislature on the California Health and Human Services Data Exchange Framework, including compliance with data sharing agreements.<br><br>The bill would expand the membership of the stakeholder advisory group and also establish the CalHHS Data Exchange Board as a separate entity from the stakeholder advisory group. The board would be composed of 14 members who are appointed or serve ex officio. The board, among other things, would be required to review, modify, and approve modifications to the California Health and Human Services Data Exchange Framework data sharing agreement and any new policies and procedures developed by the center.<br><br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260SB660 | 10/03/25 - Chaptered by Secretary of State. Chapter 325, Statutes of 2025. |

Kern Family Health Care

# Public Relations and Publicity

## Media Clips Report

August 2025-September 2025

## Features

### Kern Leaders Academy Proudly Announces the Class of 2025

**Featured On: Kern County Family Magazine** | August 14, 2025

"Kern Leaders Academy proudly announces the selection of its 2025 class! This cohort represents a diverse group of outstanding individuals from across Kern County who have demonstrated exceptional potential and commitment to leadership, service, and community improvement. Graduates don't just serve; they lead with purpose, becoming the changemakers Kern County needs to tackle tomorrow's toughest challenges. Class fellows include...Cesar Delgado, Chief Information Officer, **Kern Family Health Care (KFHC)**..." **Click here to read more.**

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### Curae Announces Series of New Health System Partnerships to Bring Financial Access Technologies to Patients and Providers

**Featured On: Global FinTech Series** | August 20, 2025

"Curae Finance, LLC ("Curae"), a leading healthcare-focused financial technology company, announced new partnerships with multiple health systems across the United States. Curae will provide their new clients with a tailored selection of patient financial access solutions, depending on each organization's operational, financial, and clinical challenges and goals. Curae's new partnerships...Kern Family Health Care (KFHC) (Kern County, California)" **Click here to read more.**

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### Transforming Patient Payment Collection: How AI Legalese Decoder Enhances Partnerships in Health Systems

**Featured On: Legalese Decoder** | August 20, 2025

"Curae Finance has partnered with four new health systems dedicated to patient payment solutions. These newly partnered institutions include...**Kern Family Health Care** situated in California. These organizations will join existing clients such as UF Health in Florida, Piedmont Healthcare, and Banner Health. This expansion is pivotal in providing much-needed support to healthcare providers navigating the complexities of patient payments." **Click here to read more.**

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### CSU Bakersfield unveils cutting-edge simulation lab for nursing students

**Featured On: BakersfieldNow** | August 29, 2025

"California State University, Bakersfield, has unveiled a state-of-the-art simulation lab designed to enhance the education of students in its highly regarded nursing and family nurse practitioner programs. The new facility aims to prepare students better to address the severe shortage of healthcare providers in the community. The announcement took place Friday morning at the Paul F. Romberg Nursing Education Center, with support from partners including **Kern Family Health Care** and the Varansi family." **Click here to read more.**

# Features (cont...)

## Citing changing trends, CSUB launches doctorate in nursing program

**Featured On: The Bakersfield Californian** | August 29, 2025

"The need is great: Kern County is a federally designated health professional shortage area, said Emily Duran, CEO of **Kern Health Systems**, which helped develop the program with a $1 million grant. "We don't have enough specialists, we don't have enough physicians, we don't have enough nurses, we don't have a lot of staff that will really take care of the growing population that we have in this community," Duran said. But the school's new DNP program will help alleviate that problem, Duran said at the event, which is why Kern Health System's board started developing the program several years ago." **Click here to read more.**

## Local healthcare executive to lead 2026 Kern County Go Red for Women® movement

**Featured On: AHA Newsroom** | September 04, 2025

"The American Heart Association, the world's leading nonprofit organization devoted to a world of healthier lives for all, announces Emily Duran, chief executive officer at **Kern Family Health Care**, as the community volunteer chairperson of the 2026 Kern County Go Red for Women movement. " **Click here to read more.**

## STEM Lab sparks curiosity and confidence in local youth

**Featured On: 23abc** | September 04, 2025

"Charmed & Chosen Inc. is working alongside Leadership Bakersfield Team 3 and a **Kern Health Systems** Community Grant to create the lab — packed with high-tech tools including laptops, microscopes, solar-powered robot kits, and even a 3D printer. " **Click here to read more.**

# Mentions

## Kern County residents sound alarm as Public Health services face cuts

**Mentioned On: Kern Sol News** | August 1, 2025

"Carrigan explained that **Kern Health Systems** and Kern Medical had agreed to expand mobile clinic coverage in those areas, though she acknowledged that losing the county's routine mobile services would still create service gaps." **Click here to read more.**

## 4th CAPK baby shower gives necessary supplies to expecting moms

**Mentioned On: The Daily Independent** | August 4, 2025

"Twenty-five expecting mothers celebrated a communal baby shower with essential supplies for their new babies. Donors First 5 Kern, Kern Family Health Care, and the Mercy Foundation provided Oasis with..." **Click here to read more.**

*COMMITTEE:* ***Fraud, Waste, and Abuse (FWA) Committee***
*DATE OF MEETING:* ***August 4, 2025***
*CALL TO ORDER:* ***3:00 pm by Jane MacAdam – Director of Compliance and Regulatory Affairs***

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|---|---|---|
| **Members Present On-Site:** | N/A | |
| **Members Virtual Remote:** | N/A | |
| **Members Excused=E Absent=A** | N/A | |
| **Staff Present:** | Cynthia Cardona, Cultural and Linguistic Services Manager<br>Sandeep Dhaliwal, Compliance Manager, Audits and Investigations<br>Russell Hasting, PHM Manager of Case Management<br>Yolanda Herrera, Credentialing Manager<br>Magdee Hugais, Director of Quality Improvement<br>Jane MacAdam, Director of Compliance and Regulatory Affairs<br>Robin Dow-Morales, Senior Director of Claims<br>Veronica Barker, Controller<br>Michelle Church, Pharmacist<br>Amy Sanders, Executive Health Services Coordinator<br>Melissa McGuire, Senior Director of Delegation Oversight<br>Cassandra Rangel, Compliance Specialist<br>Amisha Pannu, Senior Director of Provider Network<br>Bruce Wearda, Director of Pharmacy<br>Elizabeth Johns, Compliance Analyst<br>Loni Hill-Pirtle, Director of Enhanced Care Management<br>Dr. Khalsa, Medical Director -Utilization Management<br>Dr. Martha Tasinga, Chief Medical Officer - Utilization Management<br>Dr. Sukhpreet Sidhu, Population Health Medical Director | Deborah Murr, Chief Compliance and Fraud Prevention Officer<br>Alan Avery, Chief Operations Officer<br>Heather Pruitt, Compliance Analyst<br>Martha Quiroz, Member Services Manager<br>Paoloa Reyes, Compliance Analyst<br>Maria Parra, Member Services Manager<br>Cesar Delgado, Chief Information Officer<br>Karen Beale, Compliance Analyst<br>Robert Landis, Chief Financial Officer<br>Christina Kelly, Pharmacy Administrative and Support Supervisor<br>Christine Pence, Senior Director of Health Services<br>Nate Scott, Senior Director of Member Services<br>Kailey Collier, Director of Quality Performance<br>Adriana Salinas, Director of Community and Social Services<br>Greg Panero, Provider Network Analytics Program Manager<br>Jeff Pollock, Regulatory and Government Program Manager<br>Michelle Curioso, Director of Population Health |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| Action Items from 05/25/2025 | A. Telehealth Bulletin<br><br>B. CBAS – follow up on CBAS discussion from 02/25/2025 meeting | A. The guidelines and bulletin did go out on July 2nd, and its purpose is to re-educate our providers on the requirements surrounding telehealth. There are some frequency restrictions, and we are paying way more than Medi-Cal billing guidelines indicate on telehealth. Educating is the first step, and we are not stopping claim payment at this time but trying to reinforce what the requirements are. We will monitor the telehealth claims after October and see whether or not the bulletin made a difference.<br><br>B. Jane will be scheduling a meeting to discuss the next steps as they relate to the way CBAS providers are filling out forms and the way KHS is processing authorizations. The goal will be to come up with recommendations on how to address the ongoing challenges. More to come at the next meeting. | A. Completed 07/02/2025<br><br>B. To be scheduled |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| Corrective Action Plans (CAP) | A. Status of open CAPs:<br>• B2024.107<br>• B2024.113<br>• B2023.19<br>• B2022.61<br>• B2023.64<br><br>B. Ongoing high priority cases:<br>• B2024.98<br>• B2025.09<br>• B2025.61<br>• B2025.99<br>• B2025.129 | Jane provided a brief update on the status of each of the cases and the Committee discussed. No specific concerns were raised or additional action items identified.<br><br>A. These cases are all formal corrective action plans.<br><br>B. These cases have not made it to the level of a formal corrective action plan and are currently under further investigation. | *N/A* |
| Transportation | Transportation Provider Contracts<br>• Empty Van Miles<br>• Multiple members in same vehicle | We've noticed a significant amount of billing for empty van miles, with vendors charging for multiple patients despite using only one vehicle. Since the contract language references the vehicle rather than individual members, we may need to consider revising the contract or issuing a clarification to our transportation vendors. Jane will follow up with the contracting team on next steps. | *N/A* |
| Hospice | Hospice - Medicare Crossover Claims (B2025.128) | A question was raised regarding Medicare crossover claims—specifically, whether KHS has the authority to deny a crossover claim if Medicare has paid it but we suspect it may not be legitimate. KHS will continue to closely review these cases and | *N/A* |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | | plans to have a follow-up discussion to address the issue further. | |
| CPT 81479 | Removed from PA List<br>Claims Process | This code was previously included on the PA list but had been removed. We recently received an inquiry from the state regarding a specific provider who appears to be misusing it.<br>Karen Beale noted that the code wasn't being denied due to lack of authorization, but rather because it's an unlisted code that requires supporting documentation. There was some uncertainty about whether UM had re-added it to the PA list. It has now been confirmed that the code is back on the PA list | *N/A* |
| Report | A. Member Services – Martha - Frequent Rider Report for February through June 2025<br>1. Members Researched in February 2025 - 133<br>a. Members with no or less than 3 FWA occurrences - 67<br>b. Members on Restriction – 27<br>c. Members Outreached – 39<br>d. Members Issued a Warning – 24<br>e. Members Restricted Pending Follow Up – 16<br>f. Members Restricted to Bus Passes – 5<br>2. Members Researched in March 2025 – 109<br>a. Members with no or less than 3 FWA occurrences – 58 | N/A | *N/A* |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | b. Members on Restriction – 27<br>c. Members Outreached – 24<br>d. Members Issued a Warning – 9<br>e. Members Restricted Pending Follow Up – 15<br>f. Members Restricted to Bus Passes – 10<br><br>3. Members Researched in April 2025 - 99<br>a. Members with no or less than 3 FWA occurrences - 50<br>b. Members on Restriction – 19<br>c. Members Outreached – 30<br>d. Members Issued a Warning – 16<br>e. Members Restricted Pending Follow Up – 14<br>f. Members Restricted to Bus Passes – 4<br><br>4. Members Researched in May 2025 – 60<br>a. Members with no or less than 3 FWA occurrences - 43<br>b. Members on Restriction – 10<br>c. Members Outreached – 7<br>d. Members Issued a Warning – 3 | | |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | e. Members Restricted Pending Follow Up – 4<br>f. Members Restricted to Bus Passes – 6<br><br>5. Members Researched in June 2025 – 60<br>a. Members with no or less than 3 FWA occurrences - 43<br>b. Members on Restriction – 8<br>c. Members Outreached – 9<br>d. Members Issued a Warning – 1<br>e. Members Restricted Pending Follow Up – 4<br>f. Members Restricted to Bus Passes – 4 | | |
| | B. Credentialing - Provider Monitoring Reports - Yolanda<br>There were two providers found during the second quarter, but their findings were not related to fraud, waste and abuse, and those were reported to our physician advisory committee. They get put on monthly monitoring. One was actually dismissed. We will be adding the CMS Medicare preclusion list in this hopefully by the end of the year, but it's with business intelligence to create a suite through the process, but we'll be incorporating that as well | N/A | *N/A* |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | C. Compliance – Jane<br>1. Verification of Services<br>We send between 400-500 texts a month. The majority of people do not respond at all, but the increase in the response rate compared to our previous response rate when we sent manual letters has been great. Our previous response rate was less than .001% and now it has increased to 20%. Our obligation with DHCS is that we have a process in place to verify services rendered have been received. So, this is one of the ways in which we support that.<br>April - 485 texts sent, 90 responses – 19%<br>May - 492 texts sent, 107 responses – 22%<br>June - 494 texts sent, 95 responses – 19%<br>2. FWA Investigations<br>Cases for 2025 will surpass the number of cases worked in 2024.<br>a. Cases so far for 2025 – 390<br>b. Cases submitted to DHCS: 197 – 50%<br>i. 197 submitted timely – 99%<br>ii. 1 submitted late – 1%<br>Late submissions continue to be addressed with the submitter upon receipt for retraining as needed. | N/A | *N/A* |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | c. Cases not submitted to DHCS: 179 – 46%<br><br>3. Calendar year 2025 FWA Allegations Member vs Provider<br>a. Provider – 156 (40%) cases<br>i. #1 FWA allegation – 56 Cases for services not rendered.<br>ii. #2 FWA allegation – 44 cases for excessive/unnecessary services<br>b. Member- 234 (60%) cases<br>i. #1 FWA allegation - 145 cases for Transportation<br>ii. #2 FWA allegation – 67 cases for ID theft | | |
| **OPEN FORUM** | Open Forum or other Summary/Discussion made. | N/A | *N/A* |
| **NEXT MEETING** | Next meeting will be held Monday, November 3rd, 2025. | N/A | *N/A* |
| **ADJOURNMENT** | The Committee adjourned at 4:02 pm. | N/A | *N/A* |



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KERN HEALTH SYSTEMS

*COMMITTEE:* ***PHYSICIAN ADVISORY COMMITTEE***
*DATE OF MEETING:* ***AUGUST 6, 2025***
*CALL TO ORDER:* ***7:04 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

| | | | |
|---|---|---|---|
| **Members Present On-Site:** | Martha Tasinga, MD – KHS Chief Medical Officer<br>Hasmukh Amin, MD – Network Provider, Pediatrics | Gohar Gevorgyan, MD – Network Provider, FP<br>Miguel Lascano – Network Provider, OB/GYN | Ashok Parmar, MD– Network Provider, Pain Medicine |
| **Members Virtual Remote:** | Atul Aggarwal, MD – Network Provider, Cardiology<br>David Hair, MD - Network Provider, Ophthalmology<br>Abdolreza Sandabadi, MD, PhyD | | |
| **Members Excused=E Absent=A** | Raju Patel, MD - Network Provider, Internal Medicine (A) | | |
| **Staff Present:** | Amy Daniel, Executive Health Services Coordinator<br>Michelle Curioso, Director of PHM<br>Yolanda Herrera, Credentialing Manager | Magdee Hugais, Director of Quality Improvement<br>John Miller MD, QI Medical Director<br>Yesenia Sanchez, Credentialing Coordinator | Sukhpreet Sidhu MD, PHM Medical Director<br>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 7:04 AM. | | N/A |
| Public Presentation | There were no requests for public presentation | | |
| Committee Minutes | **Approval of Minutes**<br>Dr. Tasinga presented the meeting minutes of June 4, 2025 for review and approval. | ☑ **ACTION**: Dr. Amin moved to approve minutes of June 4, 2025, seconded by Dr. Parmar. Motion carried. | 8/6/25 |



PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
WELFARE AND INSTITUTIONS CODE SECTION 14087.38
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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| Past Public Presentation Follow-up | As requested, Dr. Tasinga provided follow-up regarding Dr. Kumar's request to open or expand the UM Criteria for vascular procedures for venous ablations to include additional provider types. Dr. Tasinga provided the committee with the past issues and history leading to implement vascular guidelines. After thorough analysis, and in light of current budget analysis being focused in other key areas, Dr. Tasinga provided the following information:<br>1. Review of current data does not reveal any access issues or delays in patients receiving treatment under the current guidelines.<br>2. Also, there are no member grievances that validate a need to expand the venous ablation network.<br>3. There is sufficient vascular surgeons who are able to provide treatment to our members. | ☑ **CLOSED**: Dr. Tasinga will notify Dr. Kumar that at this time KHS will continue with the current vascular guidelines limiting and redirecting referrals to vascular surgery trained providers. | 8/6/25 |
| Committee Announcements | There were no committee announcements | ☑ **CLOSED** – Informational Only | N/A |
| **PEER REVIEW REPORTS ACTIVITIES** | **Peer Review Reports**<br><br>**CREDENTIALING REPORT**<br>**Mental Health Pre-Approvals from Reports dated 06/25/2025 and 8/1/25:**<br>In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 06/25/2025 and 08/01/2025 Credentialing Reports, all files met clean file criteria, in compliance with the 60-day turnaround requirements. [redacted]<br><br>**INITIAL CREDENTIALING REPORT**<br>Initial Applicants List Dated **08/06/2025.** The clean files were accepted as presented with no additional discussion. The following | ☑ **ACTION**: Dr. Lascano moved to approve the Behavioral/Mental Health Credentialing Report dated 06/25/2025 & 08/01/2025, seconded by Dr. Parmar.<br>Motion carried.<br><br>☑ **ACTION**: Dr. Lascano moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 8/6/2025, seconded by Dr. Parmar.<br>Motion carried. | *8/6/25*<br><br>*8/6/25* |



PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
CALIFORNIA HEALTH & SAFETY CODE SECTIONS 1370-1371
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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | initial applications were presented for comprehensive review:<br>• [redacted]<br>• [redacted]<br>**RECREDENTIALING REPORT**<br>**Recredentialing Providers Lists Dated 8/6/2025.**<br>Recredentialing files meeting clean file review, report dated 8/6/2025, were accepted as presented with no additional questions or alternative actions.<br><br>**Member Grievances**: There was one provider presented with Member & Quality Grievances of .99 or higher; however, it was | ☑ **ACTION**: Dr. Lascano moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (1-year modified appointment), and [redacted] (3-yr appointment), seconded by Dr. Parmar.<br>Motion carried. | *8/6/25* |



PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | reported there were 579 interactions in 3-years with no QOC concerns identified (Recred #3).<br><br>The following recredentialing applications were presented for comprehensive review:<br>• [redacted]<br>• [redacted]<br>• [redacted]<br><br>**NEW VENDOR CONTRACTS**<br>New Vendor Contracts List Dated **August 6, 2025**, were accepted as presented with no additional questions or comments by the committee members. | ☑ **ACTION**: Dr. Lascano moved to approve recredentialing Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointment), seconded by Dr. Parmar.<br>Motion carried. | *8/6/25* |



PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:**<br>Yolanda Herrera, KHS Credentialing Manager reported on the June and July 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. Monthly monitoring includes state and federal websites including OIG, SAM, NPDB Continuous Query, DHCS Restricted Providers, DHCS Suspended & Ineligible resulted in two new/updated findings:<br>[redacted] | ☑ **ACTION**: Dr. Amin moved to approve acceptance of the Monthly Monitoring report, seconded by Dr. Aggarwal.<br>Motion carried.<br><br>☑ **ACTION**: Dr. Lascano [redacted] seconded by Dr. Amin.<br>Motion carried. | |


PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| OLD BUSINESS | | | |
| NEW BUSINESS | **Level 2 Potential Quality Issues (PQIs)**<br>Magdee Hugais, Director of Quality Improvement, presented the August Level 2 PQI Report.<br>[redacted] | [redacted] | [redacted] |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | [redacted] | | |
| | **QI Track and Trend July & August Report 2025**<br>Magdee Hugais, Director of Quality Improvement, presented the Potential Quality Issues (PQI) Track and Trend Report data for 6/1/2025-6/30/2025 and 7/1/2025-7/31/2025.<br><br>The report was accepted as presented with no further action requested or taken by the committee. | ☑ **ACTION**: Dr. Amin moved to approve the QI Track and Trend July and August 2025 Report as presented and reviewed, seconded by Dr. Gevorgyan. Motion carried | *8/6/25* |
| | **Medicare Part B Criteria (Pharmacy)**<br>Bruce Wearda, Director of Pharmacy presented information regarding Medicare requirement of each health plan to have criteria outlining the coverage of the drugs that fall under the Part B benefit. CMS also requires each plan's governing body to establish or adopt those criteria. Medicare has some National Coverage Determination (NCD) already established that all plans must use. Medicare has Local Coverage Determination (LCD) that must be used for that particular region. Any drug not listed on those lists can have criteria created by the plan. | ☑ **ACTION**: Dr. Gevorgyan moved to adopt the NCD and LCD Criteria as outlined in the KHS Part B Drug List dated 06/30/2025, seconded by Dr. Parmar.<br>Motion carried | *8/6/25* |
| **OPEN FORUM** | There was no open discussion. | ☑ **CLOSED** – Informational Only | *N/A* |
| **NEXT MEETING** | Next meeting will be held Wednesday, September 10, 2025 (2nd Wednesday of month due to Labor Day Holiday) | Informational only. | *N/A* |
| **ADJOURNMENT** | The Committee adjourned at 7:59 AM.<br><br>**Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator** | **N/A** | *N/A* |


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***For Signature Only – Physician Advisory Committee Minutes 08/06/2025:***

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name



**PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157**
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# SUMMARY

## FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
**2900 Buck Owens Boulevard**
Bakersfield, California 93308

**Friday, August 8, 2025**

**8:30 A.M.**

COMMITTEE RECONVENED

Members: Elliott, Bowers, McGlew, Turnipseed, Watson
ROLL CALL: 3 Present; 2 Absent – McGlew, Watson

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

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

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

FINANCIAL MATTERS

CA-3) Minutes for Kern Health Systems Finance Committee meeting on June 13, 2025 - APPROVED
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

4) Report on Kern Health Systems investment portfolio for the second quarter ending June 30, 2025 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

5) Proposed renewal and binding of insurance coverages for Primary and Excess General Liability from September 29, 2024 through September 29, 2026, Employed Lawyers Professional Liability Insurance from August 15, 2025 through August 15, 2026 and Earthquake Insurance from October 15, 2025 through October 15, 2026 (Fiscal Impact: $950,000 Estimated; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

6) Proposed Contract Extension and Retroactive Approval with the Periscope Group increasing the current Not-to Exceed amount by $569,910, which includes a retroactive amount of $99,000 and $470,910 for the two (2) year extension, from $304,650 to $874,560 to perform in-home functional mobility need assessments for KHS' members from September 5, 2025, through September 4, 2027 (Fiscal Impact $569,910 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

7) Proposed increase in the Not-to Exceed amount with Cognizant by $250,000 from $6,607,387 to $6,857,387 for processing claims and integrating authorization data using the Health Process Automation (HPA) tool from September 11, 2025, through September 10, 2026 (Fiscal Impact $250,000 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

8) Proposed increase in the Not-to Exceed amount with CommGap by $198,558 from $190,000 to $388,558 for in-person interpreting services from August 14, 2025, through July 5, 2026 (Fiscal Impact $198,558 over the term of the contract; Budgeted) – APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

9) Report on Kern Health Systems financial statements for May 2025 and June 2025 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

10) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for May 2025 and June 2025 and IT Technology Consulting Resources for the period ended May 31, 2025 (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
**Bowers-Turnipseed: 3 Ayes; 2 Absent – McGlew, Watson**

ADJOURN TO FRIDAY, OCTOBER 17, 2025 AT 8:30 A.M.

KERN HEALTH SYSTEMS

*COMMITTEE:* ***UTILIZATION MANAGEMENT COMMITTEE***
*DATE OF MEETING:* ***AUGUST 13, 2025***
*CALL TO ORDER:* ***12:03 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

| | | | |
|---|---|---|---|
| **Members Present On-Site:** | Ashok Parmar, MD –Specialist Pain Medicine | Parikshat Sharma, MD – Outpatient Specialist | Karan Srivastava, MD – Orthopedic Surgeon |
| **Members Virtual Remote:** | Maninder Khalsa, MD – KHS UM Medical Director | | |
| **Members Excused=E Absent=A** | Philipp Melendez, MD – OB/GYN (A) | | |
| **Staff Present:** | Linda Corbin, Health Services Consultant (Remote)<br>Amy Daniel, Executive Health Services Coordinator<br>Dan Diaz, CCM Manager, RN<br>Erin Endes, Health Services Manager (Remote) | Alma Garcia, NCQA Accreditation Specialist<br>Jiwan Gill-Sharma, UM Inpatient Clinical Supervisor<br>Loni Hill-Pirtle, Director of Enhanced Case Mgmt.<br>Kulwant Kaur, UM Outpatient Clinical Supervisor RN | Christine Pence, Senior Director of Health Services<br>Melinda Santiago, Director of Behavioral Health<br>Nate Scott, Director of Member Services<br>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 as 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**<br>The minutes of May 14, 2025 were presented for review and approval. | ☑ **ACTION**: Dr. Parmar moved to approve minutes of May 14, 2025, seconded by Dr. Srivastava. Motion carried. | 8/13/25 |
| **OLD BUSINESS** | There was no old business to present. | N/A | N/A |
| **NEW BUSINESS** | **Welcome & Introduction**<br>**Introductions:**<br>Dr. Khalsa welcomed the members of UM Committee. | ☑ **CLOSED**: Informational only. | N/A |

| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | **UM Report 2nd Quarter 2025**<br>Dr. Khalsa presented the 2nd Quarter 2025 UM Report. The following highlights were noted:<br>• UM Timeliness of Decisions – KHS remains consistent with Urgent compliance at 99.8% and Routine compliance timelines at 100%.<br>• UM Referral Notification is compliance increased to 100% for member notification and 100% provider notification and MD Signature.<br>• Outpatient Referrals – continues to increase in numbers to 103228 from last quarter which was 100842.<br>• Adult & Pediatric Referrals – remain consistent in comparison to past quarters.<br>• Denial Percentage – 1st Quarter denied referrals are 3.5% April, 2.9% May and 3.2% June.<br>• DSNP Policies have been completed and submitted for internal review. | ☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members. | *8/13/25* |
| | **UM/Internal Auditing Activities**<br>Christine Pence reported on the UM Auditing Activities that included the following items:<br>• HICE Q2 Summary for Inpatient Metrics reflects an appropriate % of change in comparison to 2024 with a downward trend.<br>• Internal Auditing for 2nd Quarter Non-Clinical Staff audits passed 100% and All Licensed Staff reviewers also passed the required IRR Testing with a passing score of 95% or higher.<br>• UM Systems Control Audits were reviewed, indicating 118,923 total files, 11 with non-compliant modifications. Action and interventions included additional training along with 1:1 process training with link to training guides. UM Director will continue to monitor each quarter until improvement of at least one finder over 3 consecutive quarters is demonstrated. | ☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members. | *8/13/25* |

| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| **OPEN FORUM** | **Open Forum** | ☑ **CLOSED**: Informational discussion only. | *N/A* |
| **NEXT MEETING** | Next meeting will be held Wednesday, November 7, 2025 at 12:00 PM | ☑ **CLOSED**: Informational only. | *N/A* |
| **ADJOURNMENT** | The Committee adjourned at 1:00 PM<br>***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator*** | **N/A** | *N/A* |

***For Signature Only – Utilization Management Committee Minutes 8/13/2025***

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **AUGUST 25, 2025**
CALL TO ORDER: **6:41 P.M. BY BRUCE WEARDA – ALTERNATE CHAIR**

| | | | |
|---|---|---|---|
| **Members Present On-Site:** | Alison Bell, PharmD – Network Provider, Geriatrics<br>Dilbaugh Gehlawat, MD – Network Provider,Pediatrician<br>Todd Farrer, MD – Network Provider, Geriatrics | Kimberly Hoffmann, Pharm D.,Pharmacist, Psych<br>Bruce Wearda, RPh – KHS Director of Pharmacy | |
| **Members Virtual Remote:** | James "Patrick" Person, RPh – Network Provider<br>Sarabjeet Singh, MD - Network Provider, Cardiology | | |
| **Members Excused=E Absent=A** | Vasanthi Srinivas, MD – Network Provider, OB/GYN - E<br>Joseph Tran, MD – Network Provider – A | Abdolreza Saadabadi, MD – Psych | |
| **Staff Present:** | Amy Daniel, KHS Executive Health Svcs Coordinator | John Miller, MD, KHS Medical Director<br>Sukhpreet Sidhu, MD, KHS Medical Director | |

| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| Quorum | Attendance / Roll Call | Committee quorum requirement met.<br>Introduced Dr. Todd Farrer to the committee.<br>Kim Hoffmann arrived late to the meeting. | *08/25/25* |
| **APPROVAL OF MINUTES** | The Committee's Alternate Chairperson, Bruce Wearda, presented the meeting minutes for approval. | ☑ **ACTION**: Dr. Gehlawat moved to approve minutes of May 19, 2025, seconded by Alison Bell. 6 approved, 0 nays. | *08/25/25* |
| **OLD BUSINESS** | None | | *N/A* |
| **NEW BUSINESS** | • Report on Plan Utilization Metrics<br>Bruce Wearda shared the metrics with the committee. Dr. Gehlawat asked if Gardasil costs for pediatrics are included. Bruce stated that it is carved out for pediatric children. This only pertains to the adult population. | | |

| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | • Educational Articles<br>Bruce Wearda the articles with the committee.<br>1. Pharmacists Furnishing Nicotine Replacement Therapy Products<br>2. Menopausal Hormone Therapy for Bothersome Vasomotor Symptoms<br>• DUR General Topics<br>1. Bruce shared an article regarding "Prescribing Cascades" can put Older Adults at Risk.<br>The committee agreed that it was a very appropriate article.<br>• D-SNP Update<br>2. Bruce shared that there are many rules that govern D-SNP plans. CMS has guidelines about what can be discussed due to open enrollment. He further explained that there will be co-pays and tiers with D-SNP as opposed to Medi-Cal. He also stated there are 6 protected classes of drugs that all or almost all drugs and their formulations must be covered.<br>He also conveyed that the formulary and MTM programs have been approved by CMS.<br>Bruce then explained that Health Plans must follow CMS guidelines regarding Medicare Part B coverage criteria. Plans must adhere to National Coverage Determination (NCD) and Local Coverage Determination (LCD). If no NCD or LCD exists, plans then may make their own criteria.<br>• NCQA<br>3. KHS has been approved for both Health Plan and Equity. | Recommended action – Bruce called for a vote to adopt KHS' policy will be to utilize NCD and LCD before applying their own criteria. Alison Bell moved to approve, and Dr. Gehlawat seconded. 6 approved, 0 nays. | |

| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | • DHCS/Executive Order N 01-19<br>1. The May Revise Update: Bruce presented the final budget elements. They included things like drugs for weight loss no longer being covered, elimination of covering OTC drugs, and introduction of premiums for individuals between 19-59 with unsatisfactory immigration status.<br>There was a discussion about weight-loss drugs within the committee. Alison Bell stated that Zepbound and Wegovy are listed on the Medi-Cal formulary. Phentermine is not listed.<br>Dr. Farrer questioned how GLP-1's are covered. Bruce said going forward those for diabetic conditions are covered, and weight-loss will not be. Dr. Farrer asked if there was any step-therapy. Bruce said not necessarily step-therapy but there are conditions outlined in the Medi-Cal formulary. | | |
| **OPEN FORUM** | There were no topics presented during open forum. | ☑ **ACTION**: N/A | *08/25/25* |
| **NEXT MEETING** | Next meeting will be held Monday, November 24, 2024 at 6:30 pm | ☑ **CLOSED**: Informational only. | *N/A* |
| **ADJOURNMENT** | The Committee adjourned 7:20 pm. | ☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. Alison Bell seconded it. 7 Ayes, 0 Nays. | *08/25/25* |

***Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator***

***For Signature Only – Drug Utilization Review Committee Minutes 09/30/24***

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

*COMMITTEE:* ***PHYSICIAN ADVISORY COMMITTEE***
*DATE OF MEETING:* ***SEPTEMBER 10, 2025***
*CALL TO ORDER:* ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

| | | | |
|---|---|---|---|
| **Members Present On-Site:** | Martha Tasinga, MD – KHS Chief Medical Officer<br>Hasmukh Amin, MD – Network Provider, Pediatrics | Gohar Gevorgyan, MD – Network Provider, FP | Raju Patel, MD - Network Provider, Internal Medicine |
| **Members Virtual Remote:** | David Hair, MD - Network Provider, Ophthalmology<br>Ashok Parmar, MD– Network Provider, Pain Medicine | | |
| **Members Excused=E Absent=A** | Atul Aggarwal, MD – Network Provider, Cardiology (E)<br>Miguel Lascano – Network Provider, OB/GYN (E) | Abdolreza Saadabadi, MD – Behavioral Health (E) | |
| **Staff Present:** | Amy Daniel, Executive Administrative<br>Jake Hall, Deputy Director of Contracting | Yolanda Herrera, Credentialing Manager<br>Magdee Hugais, Director of Quality Improvement<br>John Miller MD, QI Medical Director | Yesenia Sanchez, Credentialing Coordinator<br>Sukhpreet Sidhu MD, PHM Medical Director |

| 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 presentation | | |
| Committee Minutes | **Approval of Minutes**<br>Dr. Tasinga presented the meeting minutes of August 6, 2025 for review and approval. | ☑ **ACTION**: Dr. Amin moved to approve minutes of August 6, 2025, seconded by Dr. Hair. Motion carried. | 9/10/25 |


PEER REVIEW PROTECTED UNDER CALIFORNIA B&P CODE SECTION 1157
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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| Committee Announcements | There were no committee announcements | ☑ **CLOSED** – Informational Only | 9/10/25 |
| **PEER REVIEW REPORTS ACTIVITIES** | **Peer Review Reports**<br><br>**CREDENTIALING REPORT**<br>**Mental Health Pre-Approvals from Reports dated 09/02/2025:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 09/02/2025 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 regarding mental health & behavioral health providers were reviewed under the Initial Credentialing Report below.<br><br>**INITIAL CREDENTIALING REPORT**<br>Initial Applicants List Dated **09/10/2025** were presented:<br>• The clean files were accepted as presented with no additional discussion.<br>• There were no initial applications presented for comprehensive review.<br><br>**RECREDENTIALING REPORT**<br>Recredentialing Providers Lists Dated **8/6/2025** were presented:<br>• Recredentialing files meeting clean file review, report dated 9/10/2025, were accepted as presented with no additional questions or alternative actions.<br><br>**Member Grievances**: There was one provider presented with Member & Quality Grievances of .99 or higher; however, it was reported there were 579 interactions in 3-years with no QOC concerns identified (Recred #3).<br><br>The following recredentialing application was presented for comprehensive review: | ☑ **ACTION**: Dr. Amin moved to approve the Behavioral/Mental Health Credentialing Report dated 09/02/2025, seconded by Dr. Patel. Motion carried.<br><br>☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 9/10/2025, seconded by Dr. Patel.<br>Motion carried. | *9/10/25*<br><br>*9/10/25* |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| | • [redacted]<br><br>**NEW VENDOR CONTRACTS**<br>New Vendor Contracts List Dated **September 10, 2025**, were accepted as presented with no additional questions or comments by the committee members.<br><br>**MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:**<br>Yolanda Herrera, KHS Credentialing Manager reported on the August 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. 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. | ☑ **ACTION**: Dr. Lascano moved to approve Comprehensive Reviews as listed with approval recommendations for [redacted] (3-yr appointment), seconded by Dr. Parmar. Motion carried.<br><br>☑ **ACTION**: Dr. Amin moved to approve monthly monitoring report as presented with no new findings or updates, seconded by Dr. Patel. Motion carried. | *9/10/25*<br><br>*9/10/25* |
| **OLD BUSINESS** | **Level 2 Potential Quality Issues (PQIs)**<br>Magdee Hugais, Director of Quality Improvement, presented the August Level 2 PQI Report.<br><br>**Case #1** [redacted] | ☐ **Pending** – Table request for additional information<br>[redacted] | *Pending* |



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| | [redacted] | [redacted] | |
| **NEW BUSINESS** | **Level 2 Potential Quality Issues (PQIs)**<br>There were no new cases to present. | ☑ **CLOSED** – Informational Only | *N/A* |
| | **QI Track and Trend September Report 2025**<br>Magdee Hugais, Director of Quality Improvement, presented the Potential Quality Issues (PQI) Track and Trend Report data for 8/1/2025-8/31/2025.<br><br>The report was accepted as presented with no further action requested or taken by the committee. | ☑ **ACTION**: Dr. Amin moved to approve the QI Track and Trend July and August 2025 Report as presented and reviewed, seconded by Dr. Gevorygan. Motion carried. | *9/10/25* |
| | **Credentialing Revised Policy and Procedures**<br>Yolanda Herrera, Credentialing Manager presented the following P&P revisions:<br>• 23.06-P Non-physician Medical Practitioners<br>*Revised to be compliant with Nurse Practitioner 103 License designation that no longer requires supervision.*<br>• 23.10-P Delegated Credentialing<br>*Revised to become compliant with the new NCQA Standard related to reporting requirements, credentialing information integrity and ongoing monitoring*<br>• 23.19-I Credentialing Information Integrity<br>*Revised due to new standards replacing Credentialing System Controls and policy number will be changed to 23.23.* | ☑ **ACTION**: Dr. Amin moved to approve the revisions to QP-Credentialing P&Ps #23.06-P, 23.10-P and 23.23-I as presented, seconded by Dr. Patel. Motion carried | *9/10/25* |



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| **OPEN FORUM** | There was no open discussion. | ☑ **CLOSED** – Informational Only | *N/A* |
| **NEXT MEETING** | Next meeting will be held Wednesday, October 1, 2025 | Informational only. | *N/A* |
| **ADJOURNMENT** | The Committee adjourned at 7:40 AM.<br>**Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator** | **N/A** | *N/A* |


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***For Signature Only – Physician Advisory Committee Minutes 09/10/2025:***

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:* ***Compliance Committee***
*DATE OF MEETING:* ***September 19, 2025***
*CALL TO ORDER:* ***3:03 PM by Jane MacAdam- Director of Compliance and Regulatory Affairs***

| | | | |
|---|---|---|---|
| **Members Present On-Site:** | N/A | | |
| **Members Virtual Remote:** | N/A | | |
| **Members Excused=E Absent=A** | N/A | | |
| **Staff Present:** | Karen Beale, Compliance Analyst II<br>Elia Bercian, Compliance Program Specialist<br>Brandon Bowe, Compliance Analyst<br>Stephanie Camarena, Compliance Supervisor<br>Cynthia Cardona, Cultural and Linguistic Services Manager<br>Tiffany Chatman, HE Manager of Wellness & Prevention<br>Sandeep Dhaliwal, Compliance Manager, Audits and Investigations<br>Robin Dow-Morales, Senior Director of Claims | Andrea Hylton, Director of Administrative Services<br>Jane MacAdam, Director of Compliance & Regulatory Affairs<br>Melissa McGuire, Senior Director of Delegation Oversight<br>Deborah Murr, Chief Compliance and Fraud Prevention Officer<br>Kristie Onaindia, Provider Relations Manager<br>Greg Panero, Network Analytics Program Manager<br>Amisha Pannu, Senior Director of Provider Network<br>Kalpna Patel, QI Supervisor RN<br>Jeff Pollock, Compliance Manager | Paola Reyes, Compliance Analyst<br>Amy Sanders, Member Services Manager<br>Melinda Santiago, Director of Behavioral Health<br>Isabel Silva, HE Senior Director of Wellness and Prevention<br>Nate Scott, Senior Director of Member Services<br>Mindy Van Peursem, Compliance Analyst<br>Bruce Wearda, Director of Pharmacy<br>Amber Weaver, Compliance Senior Support Clerk |



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| | Flor Del Hoyo Galvan, Manager of Member Wellness & Prevention<br>Amanda Gonzalez, Director of Utilization Management<br>Jake Hall, Senior Director of Contracting and Quality Performance<br>Jared Harness, Compliance Analyst<br>Yolanda Herrera, QP Credentialing Manager<br>Loni Hill-Pirtle, Director Enhanced Care Management | Heather Pruitt, Compliance Analyst<br>Cassandra Rangel, Compliance Program Specialist<br>Paola Reyes, Compliance Analyst<br>Amy Sanders, Member Services Manager<br>Melinda Santiago, Director of Behavioral Health | |

| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| **1. Action Items: Jane MacAdam** (from 05/14/2025 Meeting; Minutes Attached) | A. Jiva Grievance Module update<br><br>1. The Jiva Grievance Module will go live 09/29/2025. There were issues with the API loader, and it is currently being worked on. Testing will be completed on 09/19/2025 or 09/22/2025 and team training next week, and go live on week of 09/29/2025. | ☑ ***Action Item***:<br>**1.** Amy will provide updates on the Jiva Grievance Module go-live timeline, including whether the implementation will remain on track. MS will have to engage all applicable departments to ensure all tasks assigned through JIVA are working correctly and are visible. | N/A |
| | B. Robin clarified that the Claims department has not yet begun using AI. An update will be provided once any AI-related initiatives are launched within Claims.<br><br>1. Deb inquired whether the Claims department will be utilizing AI for provider calls. Robin confirmed that AI will be implemented for this purpose. Deb noted that Claims will be contacted soon regarding this initiative. | ☑ ***Action Item***:<br>**2.** Robin will notify Jane before they initiate anything with AI. | N/A |



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| | C. Robin shared that the claims audit report she wants to begin sharing is almost ready and will be ready for the next meeting. | N/A | N/A |
| | D. 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. | N/A | N/A |
| **2. 05/14/2025 Meeting Minutes** | Included in packet | N/A | N/A |
| **3. Governance & Compliance Committee Meetings:**<br><br>**Deb Murr** | A. Governance & Compliance Committee Meetings<br><br>1. The Governance and Compliance Committee continues to meet every other month, typically convening prior to the Board meetings. This committee serves as a forum for reviewing matters related to Compliance and other organizational activities.<br>2. The committee consists of four board members, Deb, Emily, and Legal.<br>3. Jake provides an update for MCAS, the Board has a very heavily vested interest in the outcomes and the improvements made by the organization with the strike team and the efforts that have been put into place so far.<br>4. Discus audit findings, look at project updates, discuss legal issues.<br>5. Fraud, waste, and abuse items are presented for discussion and review. | N/A | N/A |



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| **4. Enterprise Risk Management (ERM):**<br>**Deb Murr, Jane MacAdam** | A. Enterprise Risk Management (ERM) Update<br>1. Engaged an outside entity Moss Adam/Baker Tilly in February 2025 to do an enterprise risk management assessment to deliver a management framework to review risk within the organization. We have been working through policies, developing charters for a risk committee and started working on risk management framework.<br>2. There are over one hundred risks that are being reviewed and ranked in prioritization. An ongoing process will be established to ensure this is conducted annually.<br>3. Forthcoming- interviews with each department leadership to go over risk register and identify things that have not been thought of as potential risk within each organizational department, more to come.<br>4. The goal is to have all risks identified, along with a defined process and roadmap, by early 2026.<br>5. Jane noted that some individuals may be contacted by Compliance regarding the project, as there are ongoing discussions about incorporating risk as a dedicated agenda item in select or potentially all committee meetings. Further updates will be provided as decisions are finalized. | N/A | N/A |



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| **5. Regulatory Audits**<br>**Jane MacAdam** | A. 2023 DHCS Focused Audit (Behavioral Health (BH/Transportation):<br>1. No updates to report regarding the 2023 DHCS focused audit.<br>2. The submission on the actual CAP was in May, and DHCS asked to translate information onto a different template, which has been completed. DHCS hasn't formally closed the CAP. | N/A | N/A |
| | B. 2023 DMHC Medical Audit:<br>1. There will be a 2025 DMHC follow up audit to the 2023 audit.<br>2. The focus on this audit will be the things DMHC determined were not satisfactorily corrected in order to validate that they have been corrected.<br>3. A notification was received in July. Additional requests have been received with tight turnaround times. They are reviewing and continuing to submit follow ups based on those documentations.<br>4. Interview sessions are set to begin on November 10, 2025; however, there is no formal schedule on who DHCS will request to interview. | N/A | N/A |
| | C. 2025 DHCS Focused Audit:<br>1. Notification was received on 07/11/2025. | N/A | N/A |



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| | 2. The focus of this audit is mainly IT, focused on information security controls, and interoperability.<br>3. Pre-Audit deliverables were submitted on 07/31/2025.<br>4. Interviews were held on the week of 08/11/2025 and 08/18/2025. There have been responses to additional requests that have been made throughout.<br>5. Closing remarks tentatively targeted for week of 09/29/2025. | | |
| | D. 2024 DMHC Audit of KHS Fiscal and Administrative Affairs<br>1. Preliminary Audit Report was received on 06/05/2025.<br>2. A response and corrective actions were submitted on 07/18/2025.<br>3. There were two (2) findings: Claims payments-retroactive contract rate change for a specific provider and Key Personnel timely submission. Findings were surrounding the timeliness of submissions.<br>4. CAP was submitted and was officially accepted and closed out. The final report is listed on page 6 in the packet. | N/A | N/A |



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| | E. 2024-2025 HSAG Encounter Data Validation Audit (EDV)<br><br>1. All requested records submitted timely (40% by 04/11/2025; 100% by 05/13/2025)<br>2. Follow up clarification was responded to on 07/24/2025.<br>3. Awaiting additional follow-up report from HSAG. | N/A | N/A |
| | F. HSAG Network Adequacy Data Validation Audit (NAV)<br><br>1. Documentation request packet received 05/28/2025.<br>2. Audit Kick-Off call 06/18/2025.<br>3. Pre-Audit deliverables submitted.<br>4. Follow up request submitted.<br>5. Virtual interviews session 08/19/2025.<br>6. Follow up request submitted 08/20/2025.<br>7. Awaiting report or additional follow-up. | N/A | N/A |
| **6. DSNP**<br>**Jane MacAdam** | A. DSNP<br><br>1. State Medicaid Agency Contract (SMAC) received from DHCS in June (also submitted to CMS and approved).<br>2. KHS approved for CMS contract and submitted | N/A | N/A |



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| | the required signature.<br>3. Counter-Signed CMS contract received 09/19/2025.<br>4. Required member materials (ID card, Summary of Benefits, Member Handbook, Provider/Pharmacy Directory, Formulary) approved by multiple regulators.<br>5. Many marketing materials have been approved (awaiting approval on a few)<br>6. All the focus is to be ready for 10/01/2025 and for 01/01/2026, which is when benefits will start.<br>a. Deb asked about the current status of policy development. Jane noted that several individuals have been actively working on policies, and Compliance is continuing efforts and will follow up as needed. Amy shared that she has discontinued work on the MS policies. | | |
| **7. Reports**<br>**Amy Sanders** | A. Member Services Quarterly Grievance Audits: Amy Sanders<br>1. The goal for 2025 Q2 is to audit thirty (30) case files per quarter with an average score of 90% or above.<br>2. Q2 monthly audit average is 97.33%.<br>a. April 98%<br>b. May 98.5%<br>c. June 95.5% | ☑ ***Action Item*:**<br>2. Amy will provide an update in response to Jane's question regarding whether the timeliness percentage has increased or decreased from the previously reported 25%. | N/A |



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| | 3. Trends identified:<br>a. Not sending the Resolution letter after the 30th even after the grievance was resolved timely after the thirty-day process.<br>b. Sending request for response to providers after the fifth (5th) day (not regulatory)<br>c. Documenting the incorrect closure date on the resolution letter. (not regulatory)<br>d. Not documenting QNXT/Call Log (not regulatory)<br><br>4. Q2 goal of 90% met.<br>a. Individual scores are shared with staff during their monthly one-on-ones.<br>b. Common deficiencies will be shared with staff during team meetings in an effort to reduce the number of errors.<br>i. Jane asked whether the percentage of reports being processed in a timely manner has increased from the previously reported 25%. | | |
| **Kalpna Patel** | B. Quality Improvement: Kalpna Patel<br><br>1. IHA Audits<br>a. Q2 findings: Audited forty-five (45) provider groups.<br>i. Twenty-two (22) scored 100%.<br>ii. Twelve (12) regions received between 90-99% overall score. | N/A | N/A |



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| | iii. Nine (9) regions received between 80-89% overall score.<br>iv. Two (2) regions received 79% or below overall score.<br><br>b. Common issues identified: lack of documentation regarding mental health history, preventative screening not documented, risks not documented, health education not provided, and IHA not being complete within 120 days.<br><br>2. Corrective Action Plan:<br><br>a. Provider educational letters sent to each PCP region.<br>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.<br>i. Jane asked whether there is a report tracking provider performance percentages from one quarter to the next. Kalpna confirmed that this information is being monitored using a tracking sheet.<br><br>3. Exempt Grievance Audits<br>a. Shared with MS/Grievance<br>b. 100% for Q2 | | |



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| | 4. NAR Audits<br>a. April: Two (2) findings<br>i. One (1) Spelling, grammar, verbiage, and format error<br>ii. One (1) Criteria error<br>b. May: Three (3) findings<br>iii. One (1) Sixth grade readability<br>iv. One (1) Criteria<br>v. One (1) Hierarchy error<br>c. June: Four (4) findings<br>vi. One (1) Spelling, grammar, verbiage, and format error<br>vii. Two (2) Criteria error<br>viii. One (1) Overall process<br>d. Issues identified: Missing uploaded criteria documentation, missing hierarchy, and readability language was above sixth grade.<br>ix. Deb inquired whether a trend is being monitored for repeat offenders. According to Kalpna, trends are being tracked for both nurses that complete appeals and MD's as well. | | |



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| | 5. Gold Card Audits<br>a. Aggregated findings<br>i. Centric Health: 67% met criteria for medical necessity.<br>ii. Comprehensive Cardiovascular Medical Group: 100% met criteria for medical necessity.<br>iii. Hao Bui MD Inc: 61% met criteria for medical necessity.<br>iv. Rheumatology Services Medical Group: 100%<br>v. Other providers: 100%<br>b. Corrective Action Plan: To be determined per Dr. Miller<br>c. Kristie inquired whether providers are being informed about the specific issues identified and whether the outreach is being conducted by PNM or QI. According to Kalpna, providers receive educational letters and are given the opportunity to engage in discussions with the team conducting the outreach.<br>6. CBCC Audits<br>a. 56% met criteria.<br>b. Corrective Action Plan (CAP): under Medical Director review | | |



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| | 7. Lead Screening Audits<br>a. Zero (0) PCP regions received a 100% overall score.<br>b. One (1) PCP region received a 90-99% overall score.<br>c. Two (3) PCP regions received an 80-89% overall score.<br>d. Eighteen (13) PCP regions received 79% and/or less.<br>e. CAPS pending<br>f. Provider educational letters sent to each PCP region.<br>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<br><br>8. Telehealth Audit<br>a. Two (2) PCP regions received 100% overall score.<br>b. Two (2) PCP regions received 90-99% overall score.<br>c. Ten (10) PCP regions received 80-89% overall score.<br>d. Three (3) PCP regions received 79% or below the overall score.<br>e. One (1) PCP regions received N/A score.<br>f. Provider educational letters sent to each provider region.<br>g. Provider 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. | | |



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| **Amanda Gonzalez** | C. UM Audits<br>1. Q2 2025 audit results compared to the average total of 2024.<br>a. 5.3% reduction in overall referrals processed compared to quarter one of 2025.<br>b. The percentage of modified and delayed referrals remained consistent with an increase in the percentage of denied referrals.<br>2. Q2 2025 improvements<br>a. The errors in mailing notification to members more than 2 days after the decision, errors in Notice of Action (NOA) reading level, and missing criteria improved.<br>b. The errors in processing the referral and missing signatures increased.<br>3. Corrective Action Plan – Log 5 (11/01/2024 – 06/30/2025)<br>a. The Utilization Management Department issued themselves a Corrective Action Plan (CAP) in response to self-identified error during the DMHC Log 5 reporting period of November 1, 2024, through June 20, 2025.<br>b. The CAP details the issues identified, root cause analysis, corrective actions taken, and | N/A | N/A |



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| | preventive measures that will be implemented to ensure ongoing compliance.<br>c. Issue Summary<br>i. The Plan identified errors related to missing member notification dates in both inpatient and outpatient records during the reporting period.<br>ii. Inpatient: eighteen cases where member notifications should have been issued but were not<br>iii. Outpatient: 228 service lines (97 unique referrals) where member notifications should have been issued but were not<br>iv. These errors were due to process gaps in ensuring required member notifications were issued and documented.<br>d. Root Cause Analysis<br>i. Gaps in staff awareness and understanding of notification requirements.<br>ii. Insufficient monitoring and auditing processes to detect missed notifications prior to Log 5 submission.<br>iii. Limited real-time verification to confirm that notifications were | | |



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| | generated and properly logged.<br>e. Corrective Actions<br>i. Identify all impacted cases from the July 2025 review.<br>ii. Conduct targeted retraining with UM staff and NCIC team on notification requirements.<br>iii. Conduct quarterly audits to monitor compliance with notification requirements and identify trends. | | |
| **Flor Del Hoyo Galvan** | 4. Health Education<br>1. Service Audit<br>a. Areas at 100%<br>i. Facilitator checklist/agenda<br>ii. Class supplies prepared.<br>iii. Class started on time.<br>iv. Participants signed in<br>v. Covered SMART goals.<br>vi. Checked for participant questions.<br>vii. Responded to participants' questions.<br>viii. Covered all the topics and information.<br>ix. Facilitator was in control at all times.<br>x. Explained the follow up calls for | N/A | N/A |



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| | member.<br>xi. Engaged participants in various way.<br>xii. Cameras on for virtual classes<br>xiii. Spoke loud and clear.<br>xiv. Class ended on time.<br>b. Areas below 50%<br>i. None<br>i. Invite a nurse to explain nicotine aids and using real testimonial videos highlighting the harms of smoking.<br>ii. A few participants suggested more activities or specific content adjustments.<br>iii. Increasing group participation and punctuality to minimize distractions<br>iv. Focusing more on reading food labels and sharing healthier foods and recipes<br>2. Class Effectiveness<br>a. Breathe Better Program, Q2 2025<br>i. 85% Pre-Test<br>ii. 88% Post-Test<br>b. Fresh Start, Q2 2025<br>i. 88% Pre-Test | | |



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| | ii. 100% Post-Test<br>c. Nutrition Education Q2 2025<br>i. 82% A+E Pre-Test<br>ii. 91% A+E Post-Test<br>iii. 71% EHBA Pre-Test<br>iv. 93% EHBA Post-Test<br>d. Diabetes Prevention Program Q2 2025<br>i. 69% Pre-Test<br>ii. 87% Post-Test<br>e. Deep, Q2 2025<br>i. 69% Pre-Test<br>ii. 84% Post-Test<br>f. Asthma Follow Up Call Results by Quarter<br>i. 91.5% Q2 2024<br>ii. 77.3% Q3 2024<br>iii. 84.1% Q4 2024<br>iv. 100% Q1 2025<br>v. 100% Q2 2025<br>g. Diabetes Management, Average Weight Comparison at Class 1 and Class 6 by Quarter<br>i. Class 1: 184 Q3 2024<br>ii. Class 6: 181.3 Q3 2024 | | |



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| | iii. Average weight loss trend: -1.47%<br>iv. Class 1: 219 Q4 2024<br>v. Class 6: 211.2 Q4 2024<br>vi. Average weight loss trend: -3.56%<br>vii. Class 1: 197 Class 1 Q1 2025<br>viii. Class 6: 195.1 Class 6 Q1 2025<br>ix. Average weight loss trend: -0.96%<br>x. Class 1: 187.5 Class 1 Q2 2025<br>xi. Class 6: 185.8 Class 6 Q2 2025<br>xii. Average weight loss trend: -0.91%<br>h. Diabetes Prevention Program (KHS), 2025 Q1-Q2 Weight Loss<br>i. Cohort 1: 75.7 lbs.<br>ii. Cohort 2: 53.5 lbs.<br>iii. Cohort 3: 65.2 lbs.<br>iv. Jane asked whether the cohort class sizes are consistent. Flor clarified that they are not, noting that class size fluctuates due to members withdrawing throughout the year. | | |
| **MOU Status**<br>**Jane MacAdam and Tiffany Chatman** | E. MOU Status<br>1. Five (5) MOUs have been executed.<br>a. KCPHD and Kern County MCPs (KHS, Anthem, & KP) executed a joint MOU | N/A | N/A |



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| | 1/30/2025.<br>b. Kern County MCPs (KHS, Anthem, & KP) and CAPK executed a joint MOU 1/7/2025.<br>c. Kern County MCPs (KHS, Anthem, & KP) and CSV executed a joint MOU 12/31/2024.<br>d. Probations Dept and Kern County MCPs (KHS, Anthem, & KP) executed a joint MOU 1/28/2025.<br>e. First 5 agency and Kern County MCPs (KHS, Anthem, & KP) executed a joint MOU 7/8/2025.<br>2. All MOUs that have been executed are listed on the Kern Family Healthcare website.<br>3. There will be additional MOUs that will be added next year and will be included in the 2026 project. | | |
| **Jane MacAdam** | F. Compliance: Jane MacAdam<br><br>1. Compliance Grievance Audits 4th Quarter, 2024<br>a. Expedited Grievance Audit Results Summary:<br>i. All four (4) cases were reviewed and validated that the nature of the grievance qualified to be expedited and correct regulatory language was used. | ☑ ***Action Item***:<br>3. Will collaborate with Member Services to bring down the reading level to sixth grade. | N/A |



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| | b. Exempt Grievance Audit Results Summary:<br><br>i. 97% accurate categorization – only one case did not meet exempt status. (29/30 = 97%)<br><br>c. Standard Grievance Audit Results Summary: Grievance Letters (30 Samples Reviewed):<br><br>i. 90% of acknowledgement letters were sent timely (27/30 = 90%)<br>ii. All thirty (30) final resolution letters were not found to be at the appropriate<br>iii. reading level. (0/30 = 100%)<br>iv. 100% of the final resolution letters used clear and concise language to address.<br>v. members complaint (30/30 = 100%)<br>vi. 53% of the final resolutions letters were sent beyond the thirty (30) days or the<br>vii. field was left blank on the log (16/30 = 53%)<br><br>d. Days to Acknowledgement Letter:<br><br>i. 23 have negative numbers (sent date occurred prior to received date) =.013%<br>ii. 246 were sent beyond the five-day | | |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | requirement (6+ days) = 14%<br>iii. 16 contained data entry errors on the date on the log (e.g. 10/018/2024,10/7/224 etc.)<br><br>e. Days to Final Response Letter:<br><br>i. 577 Fields left blank = 33%<br>ii. 838 letters were sent timely = 48%<br>iii. 329 letters sent beyond the required timeframe = 19%<br>iv. 6 fields list "#VALUE" which are the result of typographical errors = .003%<br><br>2. UM Call Audit: May 2025<br><br>a. For the month of May there were a total of twenty test calls made to the UM department. Of those twenty calls, all of them were appropriately responded to by UM staff (20/20=100%).<br><br>b. The staff members who answered the phone or returned messages responded appropriately to each call (offering to assist with the request and asking for name &DOB).<br><br>c. Follow-Ups/Next Steps:<br>i. None | | |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | 3. HIPAA "Walkabout"<br><br>a. The primary goal of a HIPAA walkabout is to identify potential vulnerabilities in the organization's HIPAA compliance program and ensure that staff are effectively implementing security safeguards and privacy protocols.<br><br>b. Key Areas of Focus:<br><br>i. PHI Handling: Check how staff handles PHI and other identifiable information, including whether it is stored securely, displayed appropriately, and disposed of properly.<br>ii. Confidentiality: Assess whether staff are maintaining confidentiality.<br>iii. Access Controls: Examine whether access to PHI is restricted and whether systems are properly secured.<br>iv. Security Safeguards: Ensure that technical and physical safeguards are in place. to protect PHI from unauthorized access, use, or disclosure.<br>c. Benefits:<br><br>i. Identify and correct vulnerabilities | | |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | in their HIPAA compliance program before.<br>They lead to a breach or violation.<br>ii. Ensure staff are properly trained and equipped to protect patient privacy and<br>security.<br>iii. Demonstrate a commitment to HIPAA compliance to patients and regulators.<br>iv. Avoid potential financial penalties and reputational damage associated with HIPAA violations.<br><br>d. Jane emphasized the importance of leadership reminding staff not to access member information for friends, relatives, or acquaintances. The appropriate protocol is to direct such individuals to Member Services for assistance.<br><br>4. All Plan Letters & Guidance Letters Received<br>a. Twenty-Eight (28) in 2025<br><br>5. Regulatory Reports & Filings<br>a. 777 in 2025 for DHCS and DMHC combined.<br><br>6. DMHC Consumer Complaints & Independent Medical Reviews (IMR) | | |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | a. IMR - Five (24%)<br>b. Consumer Complaint – Twenty-Five (76%)<br>i. Upheld – Fifteen (15) (KHS) Nineteen (19) (DMHC)<br>ii. Overturned – Six (6) (KHS) One (1) (DMHC)<br>iii. Return to Plan – Four (4) (KHS) Zero (0) (DMHC)<br>iv. Duplicate – One (1) (KHS) Zero (0) (DMHC)<br>v. Misdirected – Two (2) (KHS) One (1) (DMHC)<br>vi. In Process Two (2) (KHS) Nine (9) (DMHC)<br>vii. Grand Total: Thirty (30)<br><br>7. HIPPA Breach Activity<br>a. From June 1st to July 31st, 2025, the Compliance Department investigated and reviewed fifty-four (54) allegations of privacy concerns.<br>i. Six (6) cases sent to the State for review.<br>ii. The six (6) cases are still under review by the State. | | |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
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| | 8. Fraud, Waste, and Abuse (FWA)<br>a. There has been a 35% increase in cases to date in 2025 compared to the same time period in 2024.<br>b. Melinda asked how many of the investigations have resulted in confirmed cases of fraud. Jane responded that none have been definitively proven as fraud. However, suspected cases tend to fall under provider abuse and waste, particularly related to coding, billing practices, and overutilization of services.<br><br>9. Compliance Capsules<br>a. Sent to all staff via email and available on Dayforce Hub, included in the meeting packet for reference. | | |
| **OPEN FORUM** | A. N/A | N/A | |
| **NEXT MEETING** | Next meeting is scheduled for Wednesday,<br>November 12, 2025: 3:00 – 4:30 PM | N/A | N/A |
| **ADJOURNMENT** | Meeting Adjournment 4:30pm | N/A | N/A |



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KERN HEALTH SYSTEMS

*COMMITTEE: COMMUNITY ADVISORY COMMITTEE (CAC)*
*DATE OF MEETING: September 23, 2025*
*CALL TO ORDER: 11:05 AM by Rukiyah Polk - Chair*

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| **Members Present:** | *Ashton Chase*<br>*Beatriz Basulto*<br>*Evelin Torres*<br>*Jasmine Ochoa*<br>*Jennifer Slayton*<br>*Lourdes Bucher*<br>*Nalasia Jewel*<br>*Rukiyah Polk*<br>*Tammy Torres* | **Members Absent:** | Alyssa Olivera<br>*Rocio Castro*<br>*Jay Tamsi*<br>*Jessika Lopez*<br>*Mark McAlister*<br>*Michelle Bravo* | **Staff Present:** | *Amy Sanders, Member Services Manager*<br>*Anastasia Lester, Sr. Health Equity Analyst*<br>*Nate Scott, Sr. Director of Member Services*<br>*Carlos Bello, W&P Program Manager*<br>*Cynthia Cardon, C&L Services Manager*<br>*Stephanie Rico, Member Engagement Representative*<br>*Cynthia Jimenez, C&L Specialist*<br>*Lela Criswell, Member Engagement Manager*<br>*Moises Manzo, C&L Specialist*<br>*Vanessa Nevarez, Health Equity Coordinator* |

| Agenda Item | Discussion/Conclusion | Recommendations/Action | Date Resolved |
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| Quorum | 9 committee members present; Alyssa Olivera, Rocio Castro, Jay Tamsi, Jessika Lopez, Mark McAlister, and Michelle Bravo were absent. | Committee quorum requirements met. | N/A |
| Call to Order | Rukiyah Polk, Chair, called meeting to order at 11:05 am. | N/A | N/A |
| Public Presentation | There were no public presentations. | N/A | N/A |

KERN HEALTH SYSTEMS

| Agenda Item | Discussion/Conclusion | Recommendations/Action | Date Resolved |
|---|---|---|---|
| Committee Announcements | Rukiyah gave the opportunity for member updates.<br>• Nalasia J. announced that she will be stepping down as a member of the CAC; the December 2025 meeting will be her last.<br>• Jennifer S. requested a presentation at the next CAC meeting that provides an overview of HR1 and its potential impact on KFHC members.<br>• Anastasia L. reminded the CAC that there are still slots to fill in the CAC selection committee: a Delano member, LGBTQ+, and a foster youth or parent. Ashton C. added that the first CAC selection committee meeting went well and was very informative.<br>• Rukiyah P. shared that she attended the SAC/BH-SAC meeting which covered the following topics: Stakeholder Engagement, Measures Timeline, Phase 2 Measures, Theory of Change, Community Planning Alignment, New Requirements, Planning Timeline, and Investment Policies. | • Informational only.<br>• Informational only.<br>• Informational only.<br>• Informational only. | N/A<br>N/A<br>N/A<br>N/A |
| Committee Minutes | **<u>Approval of Minutes</u>**<br>CA-3) The Committee's Chairperson, Rukiyah Polk, presented the CAC Minutes for approval. | **Action:**<br>• Tammy T. first, Evelin T. second. All aye's. Motion carried. | 9/23/25 |

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| Old Business | There was no old business to present. | N/A | N/A |
| New Business | **Consent Agenda Items**<br><br>CA-4) August 2025 Medi-Cal Membership Enrollment Report | N/A | N/A |
| | 5) 2nd Quarter 2025 Operational Board Update<br><br>• Amy S. addressed Jennifer S's. recommendation for an HR1 presentation at the next CAC. Amy S. assured the committee that herself, Lela C. and Nate S., will prepare a presentation outlining the progress of their internal HR1 discussions which will explore ways to engage members and generate ideas to help them stay enrolled.<br>• Amy S. presented the 2025 Operational Board Report that covers Q2 data. The report shows that Medi-Cal renewals have increased by 78%. Amy S. added that renewal activity typically rises in Q1. The increase in transportation-related grievances is due to the new 48-hour advance scheduling requirement for appointments. Beatriz B. asked about the grievance review process then began to share a personal experience involving poor service at Verdugo Hospital. Beatriz B. expressed her frustration that her grievance response claimed, "everything was fine," which she disputes, noting she had no witnesses to | • Informational only.<br><br>• Nalasia J. first, Lourdes B. second. All aye's. Motion carried. | N/A<br><br>9/23/25 |

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| | support her account. She also emphasized her concern about repeated survey requests despite having already provided feedback. Amy S. agreed to review Beatrix B's. grievance and follow up. A motion to approve was requested.<br><br>6) 2nd Quarter 2025 Grievance Summar Report<br><br>• 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 3,475 were received during Q2 with Access to Care Grievances at 36.6%, Quality of Service Grievances at 34.9%, and Quality of Care Grievances at 14.2%. Standard Grievances were at 71.7% (resolved within 30 days) and Exempt Grievances were at 28.3% (resolved within one business day). Resolution Outcomes closed in favor of the enrollee were at 45.9%, closed in favor of the plan or provider at 51.4%, and remained open at time of reporting at 2.7%. A motion to approve was requested.<br><br>7) Population Needs Assessment (PNA) Presentation<br><br>• Carlos B. gave an overview of the Population Needs Assessment (PNA) which is 100 pages long and can be found on the KFHC website. It can be translated into other languages, as | • Tammy T. first, Ashton C. second. All aye's. Motion carried.<br><br>• Tammy T. first, Evelin T. second. All aye's. Motion carried. | 9/23/25<br><br>9/23/25 |

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| | needed. The PNA is an annual assessment of member characteristics, health, and social needs and KHS partners with local health departments to complete. The PNA covers the two previous years' data and is used to review and update activities, internal resources, and community resources to address member needs and health care disparities. Carlos B. shared that the social determinants of health claims have increased nearly 20%. KFHC has started collecting Sexual Orientation Gender Identity (SOGI) data in response to the increase in investigating disparities, as well as collaborating with community partners and other KFHC departments such as Behavioral Health and the Health Equity department's Regional Advisory Committee (RACs). Jennifer S. commented that she is surprised to see the data for children and adolescence being diagnosed with asthma so high because in Lamont they are diagnosed with asthma-like symptoms. Carlos B. responded that asthma is harder to diagnose in a child and asked Jennifer S. to send her data to Carlos B. for review. Ashton C. asked about the significant increase in the homeless population and if there were any resources available to educate her patients. Carlos B. responded that he would need to review and get back to her. A motion to approve was requested. | | |

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| | 8) Member Rewards Program Presentation<br><br>• Lela C. provided the committee with a Member Rewards Program update. The program has transitioned from Walmart gift cards to Visa cards, which can be used anywhere Visa is accepted. Members will first receive a notice followed by the card in the mail. If members earn additional rewards, the same card will be reloaded rather than issuing a new one. Lela C. shared that KHS will be able to track purchases to identify trends and added that certain purchases are restricted such as firearms and alcohol. Tammy T. asked if each member, such as children, will receive their own cards. Lela C. replied that yes, a child will receive a card with their name on it that can be used by the parents. Jasmine O. praised the branding and marketing of the new card design and asked how the card is restricted from certain purchases. Lela C. explained that the card is automatically blocked from restricted categories. A motion to approve was requested. | • Tammy T. first, Ashton C. second. All aye's. Motion carried. | 9/23/25 |
| Open Forum | There were no items to present. | N/A | N/A |
| Next Meeting | The next meeting will be held on Tuesday, December 9, 2025, at 11:00am. | N/A | N/A |

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| Adjournment | The Committee adjourned at 12:15pm.<br><br>***Respectfully submitted:***<br>***Vanessa Nevarez, Health Equity Project Coordinator*** | Lourdes B. first, Tammy T. second.<br>All aye's. Motion carried. | N/A |

KERN HEALTH SYSTEMS

*COMMITTEE:* ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
*DATE OF MEETING:* ***September 23, 2025***
*CALL TO ORDER:* ***7:15 AM BY TRACO MATTHEWS, CHAIR***

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| Members Present On-Site: | Cassandra Mulder - KC Public Health<br>Satya Arya, MD - ENT.<br>Danielle Colayco, PharmD – Komoto<br>Martha Tasinga, KHS Chief Medical Officer | Allen Kennedy – Quality Team DME<br>Chan Park, MD – Vanguard Family Medicine<br>Todd Jeffries – Bakersfield Community Healthcare | Rukiyah Polk - CAC Chair<br>Jasmine Ochoa – Asst. Director of Health Services<br>Traco Matthews – KHS Chief Health Equity Officer (Non-Voting) |
| **Members Virtual Remote:** | | | |
| **Members Excused=E Absent=A** | Debra Cox – Omni Family Health (A)<br>Philipp Melendez, MD – OB/GYN (A) | | |
| **Staff Present:** | Adriana Salinas – Director of Community & Social Services<br>Alma Garcia, NCQA Accreditation Specialist<br>Anastasia Lester - Sr. Health Equity Analyst<br>Ann StoryGarza - Assistant General Counsel<br>Amy Sanders - Member Services Manger | Maninder Khalsa - Medical Director<br>John Miller - Quality Improvement Medical Doctor<br>Vanessa Nevarez – Health Equity Coordinator<br>Russel Hasting – Manager of Case Management, Pop Health Management<br>Kailey Collier – Director of Quality Performance<br>Steve Pocasangre – NCQA Accreditation Specialist | Marilu Rodriguez – Sr. Health Equity Analyst<br>Melinda Santiago - Director of Behavioral Health<br>Magdee Hugais - Director of Quality Improvement<br>Christine Pence – Senior Director of Health Services<br>Greg Panero – Provider Network Program Manager<br>Pawan Gill - Health Equity Manager |

| Agenda Item | Discussion/Conclusion | Recommendations/Action | Date Resolved |
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| Quorum | 9 of 11 committee members present, Philipp Melendez and Debra Cox were absent. | Committee quorum requirements met. | N/A |
| Call to Order | Traco Matthews, Chair, called meeting to order at 7:15 am. | N/A | N/A |
| Public Presentation | There were no public presentations. | N/A | N/A |

| Agenda Item | Discussion/Conclusion | Recommendations/Action | Date Resolved |
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| Committee Announcements | Traco Matthews gave the opportunity for member updates.<br>• Danielle C. shared that her Community Health Worker (CHW) team has doubled in size, going from two to | • N/A | • N/A |


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| | four.<br>• Cassandra M. shared that Kern County Public Health (KCPH) will be having car seat events on October 4th and November 21st.<br>• Jasmine O. announced that she will be stepping down as a member of the EQIHEC and Maggie V. will be her replacement. | • N/A<br>• N/A | • N/A<br>• N/A |
| Committee Minutes | **Approval of Minutes**<br>• CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes from June 17, 2025, for approval. | **Action:**<br>• Satya A., Todd J. second. All aye's. Motion carried. | 9/23/25 |
| Old Business | There was no old business to present. | N/A | N/A |
| New Business | **Consent Agenda Items**<br>• CA-4) Health Equity Transformation Steering Committee (HETSC) Minutes from May 13, 2025.<br>• CA-5) Behavioral Health Advisory Committee (BHAC) Minutes from April 9, 2025.<br>• CA-6) Pharmacy Drug Utilization Review (DUR) Minutes from May 19, 2025.<br>• CA-7) Physician Advisory Committee (PAC) Redacted Minutes from April 2, 2025.<br>• CA-8) Physician Advisory Committee (PAC) Redacted Minutes from May 7, 2025.<br>• CA-9) Population Health Management Committee (PHMC) Minutes from June 4, 2025.<br>• CA-10) Utilization Management Committee (UMC) Minutes from May 14, 2025.<br>• CA-11) Quality Improvement Workgroup (QIW) Minutes from May 22, 2025.<br>• CA-12) Network Adequacy Committee (NAC) Minutes from May 9, 2025.<br>• CA-13a) Wellness & Prevention (W&P) Q2 2025 Activities Report.<br>• CA-13b) Cultural & Linguistics (C&L) Q2 2025 | **Action:** | |


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| | Activities Report.<br>• A motion to approve Consent Agenda Items was requested. | • Satya A. first, Todd J. second. All aye's. Motion carried. | 9/23/25 |
| | **14) Health Equity Transformation Steering Committee (HETSC)**<br>• Pawan G. shared the updated Health Equity Workplan which is organized by domains, with three new programs added under the Member Domain and an additional initiative under the Provider Domain. The Intimate Partner Violence (IPV) Community of Practice is conducted in collaboration with the Population Health Learning Center. The goal is to identify and address barriers faced by members experiencing IPV, understand related adverse health effects, and develop mitigation strategies. The second program, Cervical Cancer Screening – Asian Pacific Islander population, is in collaboration with Bakersfield Sikh Women's Association, Adventist Health, and other local organizations aimed to increase cervical cancer screening rates within the target population. The Chlamydia Screening Intervention – Hispanic Population focuses on rural and farming communities, aimed at developing and implementing culturally tailored interventions to improve screening compliance. Lastly, the Equity Practice Transformation (EPT) Program, which was previously discussed but now formally added to the workplan supports 12 participating clinics in meeting their November 2025 deliverables. A motion to approve was requested.<br>• Pawan G. provided Q2 2025 Regional Advisory Committee (RAC) updates. The Q2 RAC meetings were held across all 5 regions of Kern County (Central – Oildale, North – Lost Hills, East – Ridgecrest, West – Buttonwillow, South – Lamont) and the focus was Telehealth. Awareness and understanding of telehealth varied widely across regions: some areas were highly informed due to proactive provider engagement where others had limited knowledge. Many members were unaware that bilingual telehealth options existed. Traco | **Action:**<br>• Danielle C. first, Allen K. second. All aye's. Motion carried.<br>• Danielle C. first, Chan P. second. All aye's. Motion carried. | 9/23/25<br>9/23/25 |



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| | M. added that the Department of Healthcare Services (DHCS) encouraged all managed care plans to promote Telehealth awareness due to rising ICE-related concerns impacting members' comfort with in-person care. Traco M. expressed appreciation to the Health Equity department for their continued community engagement efforts. A motion to approve was requested.<br><br>**15) Quality Improvement Workgroup (QIW)**<br><br>• Magdee H. presented the QIW Q2 2025 Report which includes the QI Work Plan, quality of care, potential quality issues (PQIs), appeals, NCQA accreditation progress, Cultural & Linguistics, Member Wellness & Prevention, and ECM program updates. PQIs have decreased across the KHS network, indicating improved member safety and provider performance. The NCQA Accreditation results as a Health Plan are 99% and as Health Equity are 100%. These results reflect thousands of hours of cross-departmental collaboration and strong executive support. Traco M. extended appreciation to Magdee, the QI team and all KHS staff for exemplary performance in achieving dual NCQA accreditations. The next accreditation cycle is scheduled for 2028 where QIW will continue to conduct annual gap analyses to stay current with evolving NCQA standards. The 2025 ECM Program Description was reviewed and approved; minor updates were made to reflect the new year's initiatives. A motion to approve was requested.<br><br>**16) Quality Performance (QP)**<br><br>• Kailey C. acknowledged that the QP Q2 Report was presented at the previous EQIHEC and is included in the packet for reference to avoid repetition and maintain alignment with the EQIHEC cadence. She presented a year-to-date and year-over-year performance overview for 2025, comparing progress to 2024, sharing that 13 of 18 MCAS measures show | • Satya A. first, Allen K. second. All aye's. Motion carried.<br><br>• Todd J. first, Chan P. second. All aye's. Motion carried. | 9/23/25<br><br>9/23/25 |


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| | improvement compared to the same period last year. Several measures are hybrid, meaning they require medical record review during the annual audit, so the final rates may change. The 5 measures meeting Minimum Performance Levels (MPLs) are Asthma Medication Ratio (AMR), Cervical Cancer Screening (CCS), Immunization Status for Adolescents (IMA), Lead Screening in Children (LSC), and Topical Fluoride in Children. Kailey C. added that the strong performance gains are attributed to enhanced data integration with providers, ongoing outreach and health equity initiatives, and strong cross departmental collaboration. Traco M. asked if there are early projections for end-of-year performance since the measurement year is nearing completion. Kailey C. responded that it is too early for definitive results. The goal remains to exceed last year's outcomes of 12 measures meeting the MPL. A motion to approve was requested.<br><br>**17) Behavioral Health Advisory Committee (BHAC)**<br><br>• Melinda S. presented the Behavioral Health Q2 2025 Report which highlights the department's strategic goals and quarterly progress. The update focused on internal development, quality improvement initiatives, network growth, and coordination efforts with Kern Behavioral Health and Recovery Services (KBHRS). Melinda S. added that there is an upward trend in psychiatry access, driven largely by telehealth expansion. The continued challenge is member awareness of telehealth benefits and technology access barriers like limited Wi-Fi in rural areas. Recruitment and retention grants through PNM are being explored, particularly to boost psychology services for autism assessments and diagnostic evaluations. The BHAC continues to show strong progress in quality improvement, data infrastructure and collaborative partnerships. Next quarter will focus on expanding the local provider base and continuing to improve access and care coordination, particularly for SUD and youth | • Satya A. first, Rukiyah P. second. All aye's. Motion carried. | 9/23/25 |



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| | behavioral health initiatives. Jasmine O. asked how a successful home visit is defined regarding the Community Health Worker (CHW) metrics for 2024 and 2025. Melinda S. responded that a successful visit is currently defined as making contact with the individual. She added that engagement success does not always translate into improved outcomes and some individuals may require multiple attempts before trust is established and services are completed. Cassandra M. asked if KHS would join a Cohort for school linked programs. Melinda S. replied that KHS began collaborating last year with five LEAs in Cohort 2. She added that an interim MOU is under development and will be presented at the Board of Directors on October 23rd which if approved will allow monitoring of which schools and providers are actively participating. Despite slow progress, the state emphasized that the program will not be discontinued and MCPs are expected to "make it work". A motion to approve was requested.<br>• A motion to approve agenda item 17.b BHAC Department Updates – Receive and File was requested.<br><br>**<u>18) Population Health Management (PHM)</u>**<br><br>• Russel H. provided a Q2 2025 PHM update which highlighted the Complex Case Management (CCM) Program. CCM addresses complex medical, behavioral, and social needs of high-risk members. Each member receives a dedicated RN, comprehensive assessment, individualized care plan, and ongoing support to reduce avoidable doctor visits and hospitalizations by empowering members through education, advocacy, and culturally responsive care. Russel H. also shared that CCM underwent an intensive file review as part of the NCQA process and a compliance score of 100% was achieved. A motion to approve was requested.<br>• A motion to approve agenda items 18.b PHM Department Updates – Receive and File was requested.<br>• Allen K. left the meeting at 8:20am. | • Chan P. first, Danielle C. second. All aye's. Motion carried.<br><br>• Todd J. first, Danielle C. second. All aye's. Motion carried.<br><br>• Todd J. first, Danielle C. second. All aye's. Motion carried. | 9/23/25<br><br>9/23/25<br><br>9/23/25 |


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| | • Traco M. announced that there will be one agenda item per department going forward.<br><br>**19) Utilization Management (UM)**<br><br>• Dr. Khalsa presented the 2025 UM report which covered Q2 analytics, including timeliness of decisions, referral notifications, inpatient trends, and hospital utilization. Urgent requests continue to be processed quickly and within compliance timelines while routine requests experience occasional delays due to missing or delayed medical records from providers. Dr. Khalsa added that UM must notify both providers and members of decisions within regulatory timeframes and include clinical criteria for denials. Ongoing staff coaching and training are in place to maintain compliance with DHCS and NCQA requirements. Inpatient numbers remained consistent with Q1 trends, averaging 400-450 hospitalized members at any time. June data appears slightly lower, likely due to pending claims and hospitalizations include a mix of acute, trauma, surgical, and obstetric cases. Members requiring highly specialized services are referred to contracted centers of excellence including Keck/UCS Hospital, USC Norris Cancer Center, and UCLA Medical Center. Dr. Khalsa praised his team for maintaining high standards and responsiveness amid fluctuating referral volumes. Christine P. provided an overview of quality monitoring and compliance in the UM department which includes delays, modifications, and denials. She shared that a recent issue identified some member notification letters were sent to print but not physically mailed due to process gaps and new oversight measures are being implemented to detect and correct these issues promptly, before audits occur. Each finding in the quarterly report includes a Corrective Action Plan (CAP) to address root causes and prevent occurrence. A motion to approve was requested. | • Satya A. first, Chan P. second. All aye's. Motion carried.<br><br>. | 9/23/25 |



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| | **20) Network Adequacy Committee (NAC)**<br><br>• Greg P. presented the Q2 2025 NAC Report which reviewed network standards, compliance, access monitoring, grievances, and provider growth. The committee's goal remains to ensure timely, equitable access to care and to maintain compliance with DHCS and DMHC requirements. Greg P. added that out of 148 Primary Care Provider (PCP) offices surveyed, 147 met emergency voicemail standards and 145 met urgent access standards. Noncompliant offices were notified by letter and contacted by Provider Relations for corrective follow-up. The NAC found that the top access-related grievances categories are timely access and technology/telephone issues. Most grievances originated from Central Kern, reflecting its higher provider and member density and Eastern Kern continues to face access challenges due to geographic dispersion and provider shortages. Because of these challenges, ongoing provider recruitment and retention grants are focused on Eastern Kern. Full Time Equivalency (FTE) Ratios were shown with a PCP ratio of 1 per 2,000 which is consistently improving and a Physician ratio of 1 per 1,200 members which remains well below the threshold aided by tertiary partnerships such as UCLA, USC, and Valley Children's. Traco M. thanked Greg P. for the clarity and simplicity in his reporting and emphasized that the positive trend in PCP growth was a critical success for improving equitable access and quality care. A motion to approve was requested.<br><br>**21) Member Services**<br><br>• Amy S. presented the Operational Board Report that focuses on Q2 member grievances, trends, and areas of concern. The overall volume of grievances and appeals increased by 7% from Q1 to Q1 which is largely attributed to transportation-related grievances due to a change in the transportation scheduling process. The change requires members to schedule rides at least 48 | • Danielle C. first, Jasmine O. second. All aye's. Motion carried.<br><br>• Danielle C. first, Todd J. second. All aye's. Motion carried. | 9/23/25<br><br>9/23/25 |


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| | business hours in advance for non-urgent appointments. Exceptions are made for urgent appointments. Amy S. shared that the top grievance categories are access to care, quality of care, and quality of service. Although access metrics remain stable, member perception of access continues to generate grievances. A motion to approve was requested.<br>• 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 3,475 were received during Q2 with Access to Care Grievances at 36.6%, Quality of Service Grievances at 34.9%, and Quality of Care Grievances at 14.2%. Standard Grievances were at 71.7% (resolved within 30 days) and Exempt Grievances were at 28.3% (resolved within one business day). Resolution Outcomes closed in favor of the enrollee were at 45.9%, closed in favor of the plan or provider at 51.4%, and remained open at time of reporting at 2.7%. Dr. Martha T. clarified that many access to specialist grievances stem from the member perception rather than true provider shortages. An example is a member may request to see a specialist for minor conditions such as a sore throat when a primary care physician can appropriately manage the issue. Dr. Martha T. assured the committee that the network has sufficient specialists, but members' expectations and understanding of when specialty care is needed influence grievance volume. A motion to approve was requested. | • Danielle C. first, Chan P. second. All aye's. Motion carried. | 9/23/25 |

| Agenda Item | Discussion/Conclusion | Recommendations/Action | Date Resolved |
|---|---|---|---|
| Next Meeting | The next meeting will be held on Tuesday, December 16, 2025, at 7:15am. | Informational only. | N/A |
| Adjournment | The Committee adjourned at 9:06am.<br>***Respectfully Submitted:***<br>***Vanessa Nevarez, Health Equity Project Coordinator*** | • Danielle C. first, Jasmine O. second. All aye's. Motion carried. | N/A |


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*For Signature Only – EQIHEC Minutes 9/23/25*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name


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# SUMMARY

## GOVERNANCE AND COMPLIANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
**2900 Buck Owens Boulevard**
Bakersfield, California 93308

**Thursday, September 25, 2025**

**8:30 A.M.**

COMMITTEE RECONVENED

Members: Acharya, Hoffmann, Meave, Turnipseed
ROLL CALL: 2 Present – 2 Absent – Acharya, Meave

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

COMMITTEE MATTERS

3) Report on Kern Health Systems Enterprise Risk Management Project Update (Fiscal Impact: None) - RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS

4) Report on Non-Emergency Medical Transportation Strategies (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS

5) Report on Kern Health Systems Regulatory Audit Schedule (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS

6) Report on Kern Health Systems Managed Care Accountability Set (MCAS) Non-engaged membership strategies (Fiscal Impact: None) – RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS

ADJOURNED TO THURSDAY, NOVEMBER 20, 2025 AT 8:30 A.M.

KERN HEALTH SYSTEMS

*COMMITTEE:* ***2025 Delegated Entity Oversight Committee***
*DATE OF MEETING:* ***October 1, 2025***
*CALL TO ORDER:* ***1:05 pm by Jane MacAdam - Director of Compliance and Regulatory Affairs***

| | | | |
|---|---|---|---|
| **Members Present On-Site:** | N/A | | |
| **Members Virtual Remote:** | N/A | | |
| **Members Excused=E Absent=A** | N/A | | |
| **Staff Present:** | Stephanie Camarena, Compliance Supervisor<br>Michelle Church, Pharmacist<br>Sandeep Dhaliwal, Compliance Manager, Audits, and Investigations<br>Misty Dominguez, Director of Health Services Special Programs<br>Robin Dow-Morales Senior Director of Claims<br>Heather Fowler, Senior Regulatory and Government Program Manager<br>Yolanda Herrera, Credentialing Manager<br>Magdee Hugais, Director of Quality Improvement<br>Jane MacAdam, Director of Compliance and Regulatory Affairs<br>Traco Matthews, Chief Health Equity Officer<br>Melissa McGuire, Senior Director of | Greg Panero, Provider Network Analytics Program Manager<br>Maria Parra, Member Services Manager<br>Christine Pence, Senior Director for Health Services<br>Jeff Pollock, Regulatory and Government Program Manager<br>Martha Quiroz, Member Services Manager<br>Cassandra Rangel, Compliance Program Specialist<br>Lizbeth Rodriguez, Delegation Oversight Business Analyst<br>Amy Sanders, Member Services Manager<br>Nate Scott, Senior Director of Member Services<br>Isabel Silva, Senior Director of Wellness and Prevention<br>Ebeth Soliman, Member Services | |



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| | Delegation and Oversight<br>Daniel Miller, Member Services Supervisor<br>Deborah Murr, Chief Compliance and Fraud Prevention Officer | Supervisor<br>Katie Sykes, Delegation Oversight Manager<br>Bruce Wearda, Director of Pharmacy | |

| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| **A. Action Items** (From 07/01/2025 Meeting)<br><br>Jane MacAdam | 1. Sandeep will send a new Delegation Oversight Committee meeting invite by the end of day 7/1/2025.<br>a. Completed/Closed<br><br>2. AB 1455-Claims Timeliness: Add topic to VSP JOM meeting as an agenda item.<br>a. Completed/Closed-Katie aligned with Robin regarding the topic as it goes live January 2026 and are on track to align with VSP to close out. Robin requested a copy of their new Policy. Will keep the topic on the agenda to discuss in their JOM meeting.<br><br>3. Eye Exam Letter-KHS and VSP will coordinate to file with the State.<br>a. Pending.<br><br>4. Jane to send the Delegation Oversight/Pre Delegation Audit report findings out to Stakeholders and CareNet.<br>a. Pending<br><br>5. Katie will assist Ebeth in locating the lower modalities audio calls that were requested.<br>a. Completed/Closed<br>6. MS to filter Provider no shows for Q1 and Q2 for the next meeting.<br>a. Pending | ☑ **ACTION**<br>1. Robin requested a copy of VSP's new Policy.<br>2. Eye Exam Letter: Katie to follow up with C&L for an update on the submitted Work Item for the readability and about six (6) other revisions. Katie will continue to be the lead to coordinate with VSP to submit to the regulator.<br>3. DO/PD Audit: Jane to finalize the report and have an update in the interim and will share it with anyone involved with the audit and will share it in the next committee meeting.<br>4. MS No Show Filter: Jane to review the recording and will provide a follow up if there is an Action Item outside of the meeting.<br>5. AllMed: Jane to follow up with Magdee to see if there are any topics to share in the Committee.<br>6. Lower modality process: Jane will review the recording to follow up on the matter | *N/A* |


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| | 7. Jane will coordinate with Magdee on the updated AllMed Prior Authorizations and Appeal reports and send them out to the Committee.<br>a. Pending: Magdee confirmed they do have reports that may need to be shared with this committee.<br><br>8. Jane and Amy will meet to discuss the lower modality process.<br>a. MS team did submit questions for DHCS, but not sure if these answered all questions brought up in the previous meeting.<br>b. Jane will review the recording to follow up on the matter. | | |
| **B. VSP**<br><br>Jane MacAdam, Robin Dow-Morales, Katie Sykes | 1. AB 1455- Claims Timeliness:<br>a. No Concerns<br>b. The report is included in the packet<br><br>2. JOM Meeting Minutes:<br>a. VSP has an ETA for the member promise report by end of the year.<br>b. Topic will stay on the agenda and will have an update in Q4 meeting.<br>c. Talked through the eye exam letter revisions coordinating with DHCS/VSP.<br>d. Coordinated with VSP for APL regarding TGI training. VSP was exempt through DMHC bill that aligned and removed it.<br>i. Q-Yolanda H.: Did we not do an annual oversight for VSP this year?<br>A-Jane: we have not due to the delay we had in getting them the report last year, but it is on her radar and do need to do one. | ☑ **ACTION**:<br>7. Annual Oversight : Jane to follow up with Yolanda and others regarding the matter. | *N/A* |
| **C. CareNet** | 1. Delegation Oversight/Pre Delegation Audit:<br>a. Jane needs to send the Delegation Oversight/Pre | ☑ **ACTION**:<br>8. Jane to send the Delegation | *N/A* |



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| AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS/ ACTION | DATE RESOLVED |
|---|---|---|---|
| Jane MacAdam, Katie Sykes | Delegation Audit results out to Stakeholders and CareNet.<br><br>2. JOM Meeting Minutes:<br>a. The report is included in the packet on page 18.<br>b. CareNet staff were required to complete the TGI training for the call center in September and 90% completed the training. Everything else was closed out after Q2.<br>i. Q: Jane -Did CareNet use our TGI training, or did they use their own? A: Katie- Yes, they used our training.<br><br>3. RFP/New Contract for nurse hotline:<br>a. CareNet contract is expiring at the end of October 2025.<br>b. RFP finalist: CareNet or Optum to continue contracting with 24/7 nurse triage line.<br>c. The IT strategic initiative team will do a final presentation at their October Board meeting to support the final decision which will result in an extension with CareNet, possible renewal or vendor transition for the benefit. | Oversight/Pre Delegation Audit report findings out to Stakeholders and CareNet. | |
| **D. American Logistics**<br><br>Jane MacAdam, Katie Sykes, Daniel Miller, Amy Sanders | 1. DHCS Focused Audit:<br>a. Finding Lowering of Modality: Not adequately monitoring AL to ensure they are not lowering the Member modality without the Member requesting it.<br>i. MS reviewed thirty (30) calls a month,<br>ii. Q2 deficiency was 16%, they did not meet their SLA that is set at 95%.<br>iii. Performance increased from Q1 from 76% to 84% and are working closely with AL to improve. | ☑ **ACTION**:<br>9. Jane to send out an updated packet for this meeting as there is an updated item in the agenda.<br>10. Katie to update June's data in the packet from 0% to 85%.<br>11. Katie to review the process for improvements regarding the patterns of providers not offering door to door assistance<br>12. Delegation Oversight Audit: Jane to report back at the next meeting. | *N/A* |


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| | iv. Q2 findings were shared with their management team on September 19, 2025. Pending feedback and will discuss it in the next JOM meeting.<br>b. Finding -The Plan did not Adequately monitor and oversee AL Broker compliance with Door-to-Door assistance for Members receiving NEMT services.<br>i. Survey process conducted by MS to see if Members' received Door-to-Door assistance: Q2: 92%, lowered for June at 85%, Q1 was 98% and prior to that, they were at 99%.<br>ii. Follow ups/Next steps: MS will adjust the survey methodology as needed.<br>i. Concern:<br>a. Martha-any kind of pattern that they see with provider not offering door to door, MS does not have any processes in place to help improve those.<br>b. Katie-Can take that back and look at the providers that took the trips to identify if it is a trend with the same provider.<br>c. Finding The Plan did not Adequately monitor and oversee AL Broker compliance with verifying No-Show rates for NEMT and NMT Providers.<br>ii. Received a monthly report from AL to track who was at fault. No deficiencies to report for this process. | | |



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| | iii. Q2 report results indicated one repeat provider, ACE Medical Transport, only confirmed one (1) out of three (3) unique Members impacted by a no show were able to get their trip rescheduled and make it to their original appointment.<br><br>iv. AL implemented their Ride Café mobile app on June 2nd for greater visibility.<br><br>v. No no-shows reported for July or August. Looking at more Member no-shows now so this is on track for monthly monitoring.<br><br>Q: Jane- If someone calls AL and says the driver did not show up, and request another ride, are they documenting that?<br>A: Martha-they should be, they have the google sheet to fill out and has a question if the ride was rebooked.<br>Katie: the process has changed a couple of time and we did get a full log of their failed trips but there are lots of reasons why they are categorized as failed and not categorized just as no-show. Now they are going to get a monthly provider fall out report, but it is still in progress.<br><br>vi. Will be transferring the process from email delivery to SFTP for call recordings and FWA call recording request.<br><br>2. Delegation Oversight Audit:<br>a. Completed Q1 and need to get results out and will report back on next meeting. | | |


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| | 3. JOM Meeting Minutes: APL 25-005 Impact<br>a. AL member facing staff and temporary call center staff agency complete the TGI training and provided an attestation of completion.<br>b. Alternate Format Selection:<br>i. A new Data Share process for AL to use for Members that require mileage reimbursement forms.<br>ii. Data sharing was implemented with VSP to provide any written materials to Members who request alternate format selection. | | |
| **E. Transportation Committee**<br><br>Katie Sykes | 1. Overview/Updates:<br>a. MS is reporting monthly Grievance trends by category.<br>b. MS is reporting monthly LOA stats.<br>c. The focus is PCS form and lowering modality process.<br>d. New oversight areas-developed a transportation oversight grid. | **N/A** | *N/A* |
| **F. Language Line**<br><br>Katie Sykes | 1. JOM Meeting Minutes:<br>a. Staff were not required to complete the TGI training as their member facing staff arenot on the call with the Member alone, there is an intermediate KHS member representative on the call, and they already do Cultural Competency training.<br>b. They want to check with C&L, HEO, and MS team to ensure we have the proper support from Language Line.<br>c. Nothing pending. | **N/A** | *N/A* |



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| **G. LifeSigns**<br><br>Katie Sykes | 1. JOM Meeting Minutes-Katie:<br>a. They completed their own TGI training not KHS's training. We have their attestation on file.<br>b. Q2 report was trended and reviewed and are meeting their SLA.<br>c. Nothing to report. | **N/A** | *N/A* |
| **H. AllMed**<br>Magdee Hugias | 1. AllMed Prior Authorizations and Appeal:<br>a. Met in Q3 to discuss Q2. They did not meet most of their SLA's. They met one SLA and some were not applicable.<br>b. Their performance was presented at the JOM.<br>c. Implemented new Data Sharing with AllMed to get turn around time information on a monthly basis.<br>d. They went live with a new contract amendment to include ABA therapy cases in Q3.<br>e. They are on pause for prior auth but continue to do appeals for the plan. | **N/A** | |
| **I. DSNP**<br><br>Jane MacAdam<br>Katie Sykes | 1. Semi-go live first phase. Annual enrollments start October 15, 2025.<br>2. Universal Delegation Oversight:<br>a. Working on additional delegation oversight of Universal from a readiness and pre-delegation perspective.<br>b. Working on a readiness checklist and will receive the 2026 one from CMS soon.<br><br>3. MedImpact Delegation Oversight:<br>a. Will use what Rebellis completed as the pre delegation audit for MedImpact.<br>b. Once the new readiness checklist from CMS is | **N/A** | |


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| | received, we will continue to align pharmacy and MedImpact to make sure the checklist items are met for Part B.<br><br>4. Pre-Delegation Audit for Supplemental Vendors:<br>a. VSP, Delta Dental, & Nations Benefit.<br>b. 95% of the requests for the audits are in. doing phase review and reporting assessment on P&P and documents.<br>c. Katie is the point of contact.<br>d. No hard date deadline but estimate review to be completed by the beginning of November. | | |
| **J.** Monitoring /Auditing Results<br>Katie Sykes,<br>Isabel Silva,<br>Jane MacAdam | 1. Delegation oversight and Compliance Q2 SLAs:<br>a. AllMed:<br>i. SLA #1-Outpatient Episode Types/Referral turnaround times not met at 96.2%.<br>ii. SLA#2-NOA Letters not met at 97.0%<br>iii. SLA#3-Same Specialty Review of Appeal not met at 91.7%<br>iv. SLA#4- Appeal Episode Types/Processing turnaround times not met at 97.7%.<br>v. SLA#5-NAR not met at 82.6%<br>vi. SLA #6 Manual Tracking Log met at 100%.<br>vii. Will be added to CAP process.<br><br>b. American Logistics:<br>i. SLA #1-Average Speed of Answer (ASA) not met at 64.2%.<br>ii. SLA#2-Abandoned rate not met at 7.6%<br>iii. SLA#3-Excess Wait Time not met at 96.3%<br>iv. SLA#4- Failed Tripes Met at 100%<br>v. SLA#5-Ride Timeliness met at 99.5%<br>vi. SLA #6 Grievance handling met at 0.1% | 13. AllMed: Magdee to meet with Katie to begin CAP process.<br><br>14. Isabel to follow up with Cynthia to confirm if they review language changes in Member's accounts when Members report not receiving NOA/GTL Translation.<br><br>15. Jane will follow up with Yolanda to discuss the VSP survey for 2025. | |



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| | vii. SLA#7 Transit Pass Processing met at 93.4%<br>viii. SLA#8 Call monitoring/Lowering Modality not met at 84.3%<br>ix. SLA#9 Call Monitoring/Script Adherence not met at 48.3%<br><br>c. CareNet:<br>i. Meeting everything<br><br>d. Language Line:<br>i. Meeting Everything<br><br>e. VSP:<br>i. Meeting Everything<br><br>f. Harte Hanks: (terminated)<br>i. Meeting Everything<br><br>g. Life Signs:<br>i. Meeting Everything<br><br>h. Zelis:<br>i. Meeting Everything with the exception of Average speed of under 30 seconds, for the provider call center.<br><br>2. Cultural Linguistics:<br>a. Bilingual call audits<br>i. Thirty (30) Spanish Calls Audited<br>ii. 98% Did not have difficulty Communicating with Members in non-English language.<br><br>b. Post Survey Calls | | |


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| | i. 10,914 Spanish Post Call Surveys<br>ii. 94% of Members are Satisfied with the linguistic performance of bilingual staff.<br><br>c. Vendor bilingual:<br>i. One Hundred ninety-nine (199) Spanish Audio Calls Audited<br>ii. AL and VSP, CareNet, Harte Hanks<br>iii. 94% of Bilingual staff did not have difficulty communicating with Members in a non-English language.<br>d. Language Line:<br>i. Thirty (30) OPI Interpreter Service Calls<br>ii. 100% of audited calls "Met expectation"<br><br>e. Member Satisfactory survey and Staff Satisfactory Survey:<br>i. Member Onsite Interpreting<br>1) Thirty (30) Surveyed<br>2) 100% reported "Strongly Agreed" Satisfaction<br>ii. Member OPI/VRI Interpreting<br>3) Thirty (30) Surveyed<br>4) 100% reported "Strongly Agreed" Satisfaction<br>iii. Member Translations<br>5) Thirty-one (31) Surveyed<br>6) 99% reported "Very Satisfied" Satisfaction<br>7) Six (6) Members reported not receiving NOA/GTL Translation.<br>a) This has been sent to Amy & Christine.<br>b) Letters were remailed to | | |



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| | Members.<br>c) Q: Martha: Have we noticed if there has been any changes in their language or no longer reflects "Spanish" in their language?<br>A: Isabel- does not believe they are reviewing that information but will follow up with Cynthia.<br>Amy-Grievance does confirm if the letters are translated and mailed out timely.<br><br>iv. KHS Staff OPI Satisfaction<br>1) One hundred twenty-two(122) Surveyed<br>2) 100% reported "Strongly Agreed" Satisfaction<br><br>v. Press Ganey Satisfaction Survey:<br>1) 5,395 surveyed, two hundred seventy-five 275 responses (5.4%)<br>2) Over 97% "Very Satisfied"<br>3) 99% "Understood the information in the translated document"<br>4) 97% "Received the translated document in a timely manner".<br>vi. KFHC Member Newsletter: Summer 2025<br>1) Thirteen (13) responses overall "Very Satisfied" | | |


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| | 3. Transportation Provider Enrollment Monitoring:<br>a. No issues and the monitoring have been occurring monthly.<br><br>b. Q:Katie- Is this separate from the annual audit you were asking about for the Medi-Cal delegate. You said you would need to schedule your own, is this different from that effort?<br>A: Yolanda – That was for VSP not transportation. AL, we did December 2024 and would not come up until December 2025.<br><br>c. Q: Yolanda: we conducted a VSP survey in August 2024, should have had another in August 2025, would we be able to combine with Medicare pre delegation?<br>A: Katie- we were planning on defining the 2026 Audit schedule in Q4 but want to kick off audits until 2026 for CY 2025.<br>Jane-we cannot loop this in the D-SNP pre-delegation audit that's activity that under way. Will follow up to discuss. | | |
| **OPEN FORUM** | DO has scheduled all six (6) JOM meetings for October. Two are similarly structured and scheduled on the same day. The only new delegate to call out is MCOM-Member reward solution delegate went live in September and will begin trending their performance beginning September. | ☑ **ACTION** | *N/A* |



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| **NEXT MEETING** | TBD | 16. Need to reschedule the next Committee meeting as November 11 is a Holiday. | |
| **ADJOURNMENT** | The Committee adjourned at 4:19 p.m. | **N/A** | |


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