KERN HEALTH SYSTEMS

REGULAR MEETING OF THE BOARD OF DIRECTORS

Thursday, April 18, 2024
at
8:00 A.M.

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

The public is invited.

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

AGENDA

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, April 18, 2024

8:00 A.M.

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

PLEASE SILENT CELL PHONES AND OTHER ELECTRONIC DEVICES DURING THE MEETING

BOARD TO RECONVENE

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

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

2) CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION - (Government Code § 54956.9 (d) (1) and (g))
Name of case: Oxford, Michelle vs KHS

8:15 A.M.

BOARD TO RECONVENE

REPORT ON ACTIONS TAKEN IN CLOSED SESSION

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

BOARD MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-5) Minutes for Kern Health Systems Board of Directors regular meeting on February 15, 2024 (Fiscal Impact: None) –
APPROVE

6) Kern County Board of Supervisors appointment of Alex Alva, 2nd District Community Representative, for term expiring April 21, 2026 (Fiscal Impact: None) –
RECEIVE AND FILE

7) Report by Daniells Phillips Vaughan & Bock on the audited financial statements of Kern Health Systems for the year ending December 31, 2023 (Fiscal Impact: None) – APPROVE

CA-8) Report on Kern Health Systems 2023 Provider Satisfaction Survey (Fiscal Impact: None) –
RECEIVE AND FILE

CA-9) Report on Kern Health Systems 2023 Member Satisfaction Survey (Fiscal Impact: None) –
RECEIVE AND FILE

CA-10) Report on Kern Health Systems 2024 Utilization Management (UM) Program Evaluation and the 2024 UM Program Description (Fiscal Impact: None) –
APPROVE

CA-11) Report on Kern Health Systems Quality Improvement (QI) 2023 Program Evaluation, 2024 QI Program Description and the 2024 Quality Improvement Work Plan (Fiscal Impact: None) –
APPROVE

CA-12) Report on Kern Health Systems Code of Conduct (Fiscal Impact: None) –
RECEIVE AND FILE

CA-13) Report on Kern Health Systems Compliance Self-Study Employee Guide (Fiscal Impact: None) –
RECEIVE AND FILE

CA-14) Report on Kern Health Systems Annual Compliance Survey (Fiscal Impact: None) –
RECEIVE AND FILE

CA-15) Report on Kern Health Systems 2023 Department of Health Care Services Draft Audit Report Response (Fiscal Impact: None) –
RECEIVE AND FILE

CA-16) Report on Kern Health Systems 2023 Department of Managed Health Care Preliminary Audit Report (Fiscal Impact: None) –
RECEIVE AND FILE

CA-17) Report on Kern Health Systems 2024 Compliance Work Plan Q1 Update (Fiscal Impact: None) –
RECEIVE AND FILE

18) Proposed Agreement with AllMed Healthcare Management, LLC, to provide Clinical Augmentation Services, from July 1, 2024 through June 30, 2027 (Fiscal Impact: $19,076,145 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

CA-19) Proposed Agreement with OptumInsight, Inc., for the renewal of the Optum Prospective Payment contract from May 1, 2024 through April 30, 2029 (Fiscal Impact: $3,411,038 over the term of the contract; Budgeted) –
APPROVE; AUTHORIZE CHIEF EXECUTIVE OFFICER TO SIGN

20) Report on Kern Health Systems Financial Statements for December 2023 and January 2024 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-21) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for December 2023 and January 2024 and IT Technology Consulting Resources for the period ended December 31, 2023 (Fiscal Impact: None) –
RECEIVE AND FILE

CA-22) 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-23) Proposed revisions to Policy 4.01-P Credentialing Program and proposed new Policies 4.55-I Assessment of Organizational Providers and 4.56-P Physician Advisory Committee (Credentialing) (Fiscal Impact: None) –
APPROVE

CA-24) Proposed revisions to Policy 4.01-P Credentialing Program and proposed new Policy 4.58-I Credentialing Systems Control (Fiscal Impact: None) –
APPROVE

CA-25) Kern Health Systems Chief Compliance and Fraud Prevention Officer report (Fiscal Impact: None) –
RECEIVE AND FILE

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

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

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

CA-29) Miscellaneous Documents –
RECEIVE AND FILE

A) Minutes for Kern Health Systems Community Advisory Committee meeting on January 23, 2024
B) Minutes for Kern Health Systems Physician Advisory Committee meeting on February 7, 2024
C) Minutes for Kern Health Systems Executive Quality Improvement Health Equity Committee Meeting on February 8, 2024
D) Minutes for Kern Health Systems Finance Committee meeting on February 9, 2024
E) Minutes for Kern Health Systems Fraud, Waste, and Abuse Committee meeting on February 9, 2024
F) Minutes for Kern Health Systems Delegation Oversight Committee meeting on February 26, 2024
G) Minutes for Kern Health Systems Compliance Committee meeting on February 29, 2024
H) Minutes for Kern Health Systems Physician Advisory Committee meeting on March 6, 2024
I) Minutes for Kern Health Systems Governance and Compliance Committee meeting on March 28, 2024

ADJOURN TO JUNE 13, 2024 AT 8:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY

BOARD OF DIRECTORS

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, February 15, 2024

8:00 A.M.

BOARD RECONVENED

Directors: Watson, Thygerson, Patel, Abernathy, Acharya, Bowers, Elliott, Hoffmann, Ma, McGlew, Meave, Patrick, Singh, Tamsi, Turnipseed
ROLL CALL: 14 Present; 1 Absent – Abernathy

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

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

2) CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION - (Government Code § 54956.9 (d) (1) and (g))
Name of case: Krause, Heidi vs KHS – SEE RESULTS BELOW

3) CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION - (Government Code § 54956.9 (d) (1) and (g))
Name of case: Martin, Anita vs KHS – SEE RESULTS BELOW

8:30 A.M.

BOARD RECONVENED

Item No. 1 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **INITIAL CREDENTIALING FOR FEBRUARY 2024** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON BATH, BRACEWELL, CHA, KINAS, OCHOA-FRONGIA, TAN; DIRECTOR ACHARYA ABSTAINED FROM VOTING ON BHURGRI, FERNANDO, MALINI, SONG SEO, KERN PSYCHIATRIC HEALTH AND WELLNESS CENTER, INC.; DIRECTOR BOWERS ABSTAINED FROM VOTING ON BHURGRI, FERNANDO, MALINI, SONG SEO, KERN PSYCHIATRIC HEALTH AND WELLNESS CENTER, INC.; DIRECTOR HOFFMANN ABSTAINED FROM VOTING ON ALCANTAR-GOMEZ, HAN, NUNEZ; DIRECTOR MEAVE ABSTAINED FROM VOTING ON FRANCO-GARCIA, HAN, NUNEZ; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON CARRAWAY, DEL MUNDO, KEENAN, RIVERA

Item No. 1 concerning a Request for Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) RECOMMENDED FOR **RECREDENTIALING FOR FEBRUARY 2024** – HEARD; BY A UNANIMOUS VOTE OF THOSE DIRECTORS PRESENT, THE BOARD APPROVED ALL PROVIDERS RECOMMENDED FOR RECREDENTIALING; DIRECTOR THYGERSON ABSTAINED FROM VOTING ON FREEMAN, RANGANATHAN, LEE, MURUGESAN, SNYDER, TAHER; DIRECTOR ELLIOTT ABSTAINED FROM VOTING ON BULGARELLI, MESA CLINICAL PHARMACY; DIRECTOR BOWERS ABSTAINED FROM VOTING ON SHARMA; DIRECTOR MCGLEW ABSTAINED FROM VOTING ON BULGARELLI, MESA CLINICAL PHARMACY; DIRECTOR MEAVE ABSTAINED FROM VOTING ON DHILLON; DIRECTOR TURNIPSEED ABSTAINED FROM VOTING ON FREEMAN

Item No. 2 concerning a CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION - (Government Code § 54956.9 (d) (1) and (g)) Name of case: Krause, Heidi vs KHS – HEARD; NO REPORTABLE ACTION TAKEN

Item No. 3 concerning a CONFERENCE WITH LEGAL COUNSEL – FORMALLY INITIATED LITIGATION - (Government Code § 54956.9 (d) (1) and (g)) Name of case: Martin, Anita vs KHS – HEARD; NO REPORTABLE ACTION TAKEN

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

4) 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

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

CA-6) Minutes for Kern Health Systems Board of Directors regular meeting on December 14, 2023 (Fiscal Impact: None) – APPROVED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-7) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2023 (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-8) Report on 2023 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) – APPROVED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-9) Report on 2023 Annual Travel Report (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-10) Report on 2023 Annual Report of Disposed Assets (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-11) Report on Governance and Compliance Committee Charter (Fiscal Impact: None) – APPROVED
Patrick-Bowers: 14 Ayes; 1 Absent – Abernathy

CA-12) Report on Compliance Officer Priorities and Program Shifts (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-13) Report on 2024 Compliance Program Description (Fiscal Impact: None) – APPROVED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-14) Report on Final 2023 Compliance Work Plan Review and Proposed 2024 Work Plan Review (Fiscal Impact: None) – APPROVED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-15) Proposed Agreement with Zelis Healthcare, LLC (formerly Payspan), for the procurement of printing and mailing services along with EFT payments to providers, from February 16, 2024 through February 15, 2027 (Fiscal Impact: $1,950,000 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-16) Proposed Agreement with Microsoft Azure AVS, for Business Continuity and Disaster Recovery Solution, from February 16, 2024 through February 15, 2027 (Fiscal Impact: $521,568 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-17) Proposed Agreement with InComm Healthcare, for the Member Rewards Solution, from February 16, 2024 through February 15, 2027 (Fiscal Impact: $2,520,000 over the term of the contract; Budgeted) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

18) Report on Kern Health Systems Health Equity Office 2024 Strategy & Workplan (Fiscal Impact: None) – APPROVED
Bowers-Thygerson: 14 Ayes; 1 Absent - Abernathy

19) Report on Kern Health Systems Strategic Plan for Fourth Quarter Update (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-McGlew: 14 Ayes; 1 Absent - Abernathy

20) Report on Kern Health Systems Financial Statements for November 2023 (Fiscal Impact: None) – RECEIVED AND FILED
Elliott-Hoffmann: 14 Ayes; 1 Absent - Abernathy

CA-21) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2023 and IT Technology Consulting Resources for the period ended November 30, 2023 (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

CA-22) Proposed Kern Health Systems provider contracts (rates confidential per Welfare and Institutions Code Section 14087.38(m)) – APPROVED; AUTHORIZED CHIEF EXECUTIVE OFFICER TO SIGN
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

23) Kern Health Systems Chief Compliance and Fraud Prevention Officer report (Fiscal Impact: None) – RECEIVED AND FILED
McGlew-Patel: 14 Ayes; 1 Absent – Abernathy

CA-24) Report on Kern Health Systems Operation Performance and Review of the Kern Health Systems Grievance Report (Fiscal Impact: None) – RECEIVED AND FILED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

25) Kern Health Systems Chief Medical Officer report (Fiscal Impact: None) – RECEIVED AND FILED
Patel-Meave: 14 Ayes; 1 Absent - Abernathy

26) Kern Health Systems Chief Executive Officer report (Fiscal Impact: None) – RECEIVED AND FILED
McGlew-Thygerson: 14 Ayes; 1 Absent - Abernathy

CA-27) Miscellaneous Documents – RECEIVED AND FILED
Patrick-Bowers: 14 Ayes; 1 Absent - Abernathy

A) Minutes for Kern Health Systems Physician Advisory Committee meeting on November 8, 2023
B) Minutes for Kern Health Systems Drug Utilization Review Committee meeting on November 20, 2023
C) Minutes for Kern Health Systems Quality Improvement Committee meeting on November 30, 2023
D) Minutes for Kern Health Systems Physician Advisory Committee meeting on December 6, 2023
E) Minutes for Kern Health Systems Finance Committee meeting on December 8, 2023
F) Minutes for Kern Health Systems Public Policy Committee meeting on December 12, 2023
G) Minutes for Kern Health Systems Governance and Compliance Committee meeting on January 24, 2024

ADJOURN TO APRIL 18, 2024 AT 8:00 A.M.

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

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Kristen Watson, Chairman

SUBJECT: Kern Health Systems Board of Directors Appointment

DATE: April 18, 2024

Background

On March 19, 2024, the Kern County Board of Supervisors appointed Alex Alva as Second District Community Representative to the Kern Health Systems Board of Directors. Mr. Alva replaces John Nilon.

The Board of Directors of Kern Health Systems welcomes our newest member, Mr. Alva.

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

Requested Action

Receive and File.

BOARD OF SUPERVISORS
COUNTY OF KERN

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

March 19, 2024

Mr. Alex Alva
[redacted]
Bakersfield, CA 93311

Dear Mr. Alva:

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

Enclosed please find the Oath of Office for your appointment as Second District Community Representative Member to the Kern Health Systems Board of Directors, term to expire April 21, 2026. You may take the Oath of Office in the office of the Clerk of the Board located in the Kern County Administrative Center, 1115 Truxtun Avenue, Fifth Floor, Bakersfield, or you may take it before a Notary Public in your vicinity. If the Oath is taken before a Notary Public, please ask the Notary to attach a Jurat. **The Oath must be administered and received by the Clerk of the Board before you can participate on the Kern Health Systems Board of Directors.**

To serve on the Kern Health Systems Board of Directors, you are required to fill out a Form 700, Statement of Economic Interests. Please complete, sign and return the Form 700 (cover page and any applicable schedules) to **Kern Health Systems no later than thirty (30) days from your date of appointment.** For your convenience, a Form 700 packet is enclosed. The form is also available at http://www.fppc.ca.gov/Form700.html.

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

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

Sincerely,

Kathleen Krause

KATHLEEN KRAUSE
Clerk of the Board

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

KERN HEALTH SYSTEMS

BOARD OF DIRECTORS

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

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

1st District Community Representatives
1) Michael Bowers, Vice President of Public Affairs and Government Relations, Centric Healthcare
2) Ross Elliott, ***Treasurer***
Retired

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

2nd District Community Representatives
1) Cathy Abernathy, Cathy Abernathy Consultants
2) Alex Alva, Assistant Chief Financial Officer
County of Kern

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

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

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

4th District Community Representatives
1) Barbara Patrick, Retired
2) Ganesh Acharya, Partner
Genesis Medical Management, LLC

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

5th District Community Representatives
1) Michael Turnipseed, Executive Director
Kern County Taxpayers Association
2) Albert Ma, M.D., Owner
Arise Psychiatric Medical Group

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

Rev. 3/25/24
By: S.Woods

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

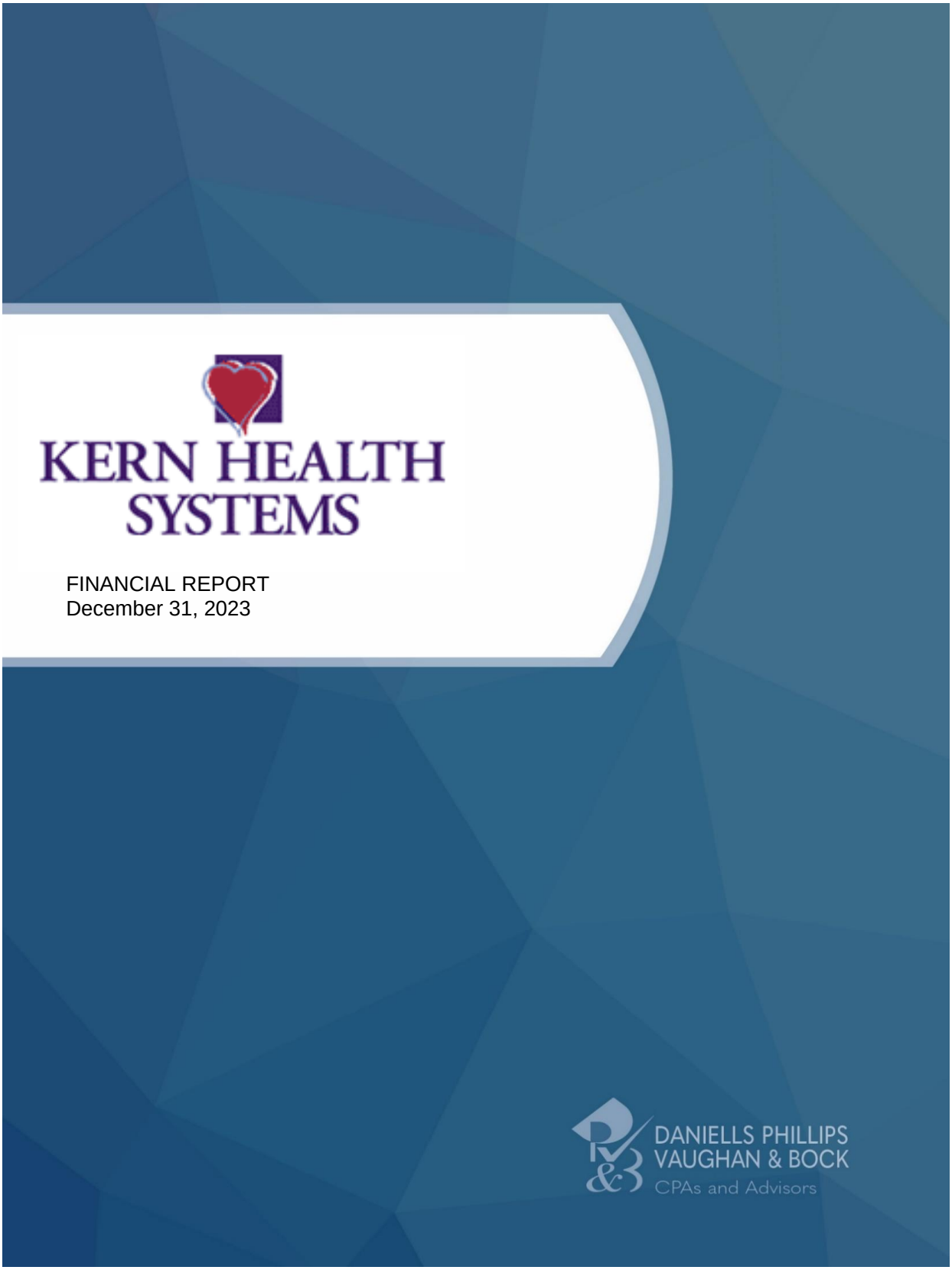
SUBJECT: Report by Daniells Phillips Vaughan & Bock Regarding the 2023 Audit

DATE: April 18, 2024

Attached for your review are the December 31, 2023 audited financial statements for Kern Health Systems. The scope of the audit comprises the Statements of Net Position, the Statements of Revenues, Expenses and Changes in Net Position, Statements of Cash Flows, and the related notes to the financial statements. Representatives from the accounting firm Daniells Phillips Vaughan & Bock will be providing a report on the 2023 audit.

Requested Action

Approve.


KERN HEALTH SYSTEMS
FINANCIAL REPORT
December 31, 2023
DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

CONTENTS

DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

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SHANNON M. WEBSTER

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
Kern Health Systems
Bakersfield, California

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of **Kern Heath Systems**, as of and for the years ended December 31, 2023 and 2022, and the related notes to the financial statements, which collectively comprise **Kern Health System**'s basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of **Kern Health Systems**, as of December 31, 2023 and 2022, and the respective changes in financial position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we

- exercise professional judgment and maintain professional skepticism throughout the audit.
- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances.
- evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about **Kern Health Systems'** ability to continue as a going concern for a reasonable period of time.

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

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedules of proportionate share of the net pension (asset) liability and schedules of pension contributions on pages 4-12 and 42-45 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated April 3, 2024 on our consideration of **Kern Health Systems**' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of **Kern Health Systems**' internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering **Kern Health Systems**' internal control over financial reporting and compliance.

Daniells Phillips Vaughan & Bock

Bakersfield, California
April 3, 2024

KERN HEALTH SYSTEMS

Management's Discussion and Analysis

Our discussion and analysis of Kern Health Systems' ("KHS", "We", "Us", "Our") financial performance provides an overview of KHS' financial activities for the calendar years ended December 31, 2023 and 2022. Presentation of balances in the financial tables may differ from prior periods. Account balances have been reclassified to better present financial categories. Please read the discussion and analysis in conjunction with the KHS financial statements, which begin on page 13.

Overview:

KHS is a County health authority established for the purpose of providing health care services to meet the health care needs of low-income families and individuals in Kern County, California. As a managed care health plan, KHS manages health care services for an enrolled population that qualifies for Medi-Cal, which is California's Medicaid health care program. Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. The Department of Health Care Services ("DHCS") is the single state agency responsible for administering Medi-Cal. In 2023 and 2022, KHS received over 99% of its operating revenue from the State of California. KHS is committed to continually improving the quality of care and service to its members, and to help them access the right care at the right time in the appropriate setting.

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

In general, KHS members are required to use the KHS provider network to receive care. KHS contracts with various health care providers for the provision of medical care services to its members. The provider network consists of primary and specialty care physicians, hospitals, ancillary providers, and pharmacies. Primary Care Physicians (PCPs) along with Physician Assistants and Nurse Practitioners play an integral role in coordinating and managing the care of KHS members by delivering preventive services as well as referring members to other providers for medically necessary services. PCPs are typically trained in internal medicine, pediatrics, family practice and general practice. KHS compensates most of its providers on a fee for services basis. Under fee for service arrangements, KHS retains the financial responsibility for medical care provided and incurs costs based on the actual utilization of services. Additionally, KHS works with the provider network to operate efficiently by providing financial and utilization information, physician and patient educational programs, and disease and medical management programs. In 2023 and 2022, KHS paid approximately 90% and 86%, respectively, of its revenue to providers.

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

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

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

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

Financial Highlights:

- Our net position increased in 2023 by $61.4 million or approximately 19.3% while in 2022 our net position increased by $71.3 million or 28.8%.

- Our Medi-Cal enrollment growth showed an average monthly increase of approximately 29,100 members or 9.1% in 2023 compared to 2022. This compared to an average monthly increase of approximately 32,100 members or 11.1% in 2022 compared to 2021. The change in average monthly membership was due primarily to the State reinstating the annual Medi-Cal eligibility redetermination process in April 2023 to verify enrolled members were still eligible and disenroll those who were not. Prior to April 2023, the eligibility redetermination process had been paused for the last three years in response to the COVID-19 Public Health Emergency (PHE).

- We have a capitated arrangement required by the California Department of Health Care Services (DHCS) with another health plan which allows for that plan to provide health care services for assigned members. Assigned membership to this other health plan was 15,226 members at the end of 2023 compared to 14,635 members at the end of 2022. The premium revenue earned for this population was $37.5 million and $33.9 million for the years ended December 31, 2023 and 2022, respectively. As we have no obligation to provide care for this population, the Premiums earned amount reported for the years ended December 31, 2023 and 2022 is net of the $36.8 million and $33.2 million, respectively, of associated capitated expense and the member months shown have been adjusted to remove capitated member months.

- We reported an operating income of $40.3 million or $9.59 PMPM in 2023 and operating income of $74.6 million or $19.35 PMPM in 2022. The decrease in operating income in 2023 is primarily due to increased medical expense utilization resulting from DHCS program changes and changes in the population of members. On January 1, 2023, additional populations under CalAIM transitioned mandatorily from fee-for-service care to managed care including Long-term Care (LTC) members and Full Dual members.

- Managed Care Organization (MCO) Tax Revenues of $376.7 million or $89.66 PMPM are included in premiums earned in 2023 and $120.2 million or $31.20 PMPM in 2022. Beginning July 1, 2016, under Senate Bill X2-2, the MCO tax methodology changed from a 3.9375% of premium revenue to a fixed PMPM rate. The rate was $113.49 PMPM for the period April 1, 2023 to December 31, 2023 and $33.50 PMPM for the period January 1, 2022 to December 31, 2022. Due to delays with the approval of the MCO Tax federal waiver, the 2023 MCO tax revenue will retroactively be paid in early 2024 and 2023 MCO expense payments will also be due in early 2024. The significant increase in MCO tax revenue will be used to augment Medi-Cal provider rate increases to promote greater provider participation. The tax amounts are based on projected membership and MCO expense is assessed by quarter period. MCO Tax Expense is reported as an operating expense and was $376.5 million or $89.60 PMPM in 2023 and $124.7 million or $32.35 PMPM in 2022.

- The net increase in nonoperating income of $24.4 million between 2023 and 2022 is attributable to a significant increase in investment earnings as the result of higher investment balances and better overall market performance in 2023 as compared to 2022. In 2022, the decrease in nonoperating expense was due to a decrease in Community grant expense in 2022 compared to 2021. In 2021, KHS had increased the amounts of Community grants awarded to assist providers with the implementation of the requirements under the CalAIM initiative which began January 2022. We reported investment and other income of $21.1 million in 2023 or $5.03 PMPM and investment and other income of $1.5 million or $0.38 PMPM in 2022. We reported Community grant expense of $4.8 million or $1.23 PMPM in 2022. We reported no Community grant expense in 2023.

- We continued with provider quality incentive programs and reported expenses of approximately $6.3 million in 2023 to reward providers who demonstrate improved Managed Care Accountability Set (MCAS) outcomes.

2023 Operational Highlights:

While fulfilling our organizational mission and maintaining efficient operations, the following projects and activities were implemented in 2023:

- Created a Board Governance and Compliance Committee whose fiduciary responsibility is to oversee KHS' regulatory Compliance Program to ensure the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations.

- Hired a Chief Compliance and Fraud Prevention Officer to provide leadership to the Compliance department to ensure organizational compliance with all regulatory requirements, contract requirements, company policy and procedures, and for conducting, coordinating and reporting audit and investigative activities for the purpose of preventing and detecting fraud, waste and abuse.

- Hired Chief Health Equity Officer and launched the Health Equity Office. Developed formal Health Equity program strategy, framework, and structure including policies and procedures.

- Developed initiatives for the recruitment and retention of both internal and external workforce required to fulfill KHS' mission.

- Successful completion of the KHS Business Continuity and Disaster Recovery test to ensure that KHS' operational resilience and recovery strategies are both effective and efficient in the face of potential disruptions.

- Entered into agreements with partners for shared office space in Delano, Ridgecrest, Kern River Valley, Mojave, Frazier Park and obtained rental space for Taft to co-locate Member Engagement Representatives throughout Kern County.

- Began work on developing a Medicare Duals Special Needs Plan (D-SNP) new line of business to be in alignment with both state and federal requirements with an expected go-live date of January 1, 2026.

- Continued to prepare for both the Health Plan and Health Equity accreditations through the National Committee for Quality Assurance (NCQA). All applicable Documented Processes and Materials were updated to be in compliance with NCQA Standards.

- Entered into a strategic alignment with Microsoft regarding KHS' new Member Engagement Platform. This initiative will enhance member experience and operational efficiency. The platform is designed to facilitate more personalized, secure, and efficient interactions with our members, supporting our mission to deliver exceptional value and service.

- Established robust data connectivity with Kern Medical, Clinica Sierra Vista, Omni Health and Costal Kids, for a healthcare data exchange. This exchange will enable access to comprehensive, real-time health data, enabling healthcare providers to make informed decisions, optimize care delivery, and ultimately, contribute to the well-being of the communities KHS serves.

- Received more than 4.5 million claims (700,000 more than the previous year) and continued to meet and often exceeded required regulatory compliance standards in all categories for processing claims. In addition, KHS became responsible for processing Long-Term Care Skilled Nursing Facility claims, along with educating providers on the new billing requirements.

- Worked collaboratively with Kern County Department of Human Services in the redetermination process throughout the year. Through direct member, community, provider and partner collaboration and outreach, KHS was successful in helping the County achieve an overall redetermination rate of 79.4% which is towards the higher end when compared to renewal levels experienced by other California Medi-Cal Plans.

- The Information Security (InfoSec) team successfully completed its bi-annual third-party Information Security Audit. The audit was comprehensive, covering all critical areas of the information security framework, including policies, procedures, control systems, and data protection measures. The audit concluded with no significant findings, underscoring the robustness and effectiveness of the KHS information security management system. KHS is committed to maintaining high standards of data security and privacy, ensuring that our member and provider information remains protected.

2023 Member Highlights:

- MCAS Strike Team developed numerous initiatives focused on improving MCAS rates to close gaps in care resulting in 15 of 18 measures trending higher than prior year.

- Member Outreach efforts focused on scheduling preventive health services appointments to close gaps in care. Over 75,000 outreach attempts resulted in over 27,000 gaps closed.

- We created an internal Behavioral Health Department to improve integration, coordination and outcomes for members experiencing behavioral and mental health conditions.

- We improved the integration, coordination and outcomes for members experiencing behavioral and mental health conditions.

- Due to a change in the contract status with the other Medi-Cal health plan in Kern County, we successfully transitioned over 60,000 of their members into our health plan for a January 2024 effective date.

- We continued to monitor the Housing and Homelessness Incentive Program (HHIP) projects. This funding assisted approximately 80 individuals experiencing homelessness with permanent housing. There are currently 64 units under construction, which will serve as additional housing for individuals experiencing homelessness once completed. HHIP funding was utilized to purchase 2 Mobile Clinics dedicated to street medicine services for individuals experiencing homelessness. The program has facilitated the purchase of 3 vehicles intended to transport individuals to appointments, thereby removing barriers and enhancing access to quality care for this vulnerable population.

- We continued the Incentive Payment Program (IPP) Program Year 2 funding provided by DHCS to support the expansion of Enhanced Care Management (ECM) and Community Support Services (CSS) Programs. The allocated incentive funds were distributed among 10 providers and community-based organizations. Notably, 3 new ECM programs were introduced, while seven CSS providers and community-based organizations expanded or initiated CSS services in Arvin, McFarland, Delano, and Bakersfield.

2023 Clinical Highlights:

- Implemented additional 6 Community Supports Services. We now have a total of 14 community-based organization networks offering 12 of the 14 DHCS approved community supports services to coordinate resources to address social determinants of health for our members.

- Expanded the Enhanced Care Management (ECM) program by adding 31 new ECM programs throughout Kern County. Additionally, the ECM program added 3 new Populations of Focus: Adults Living in the Community and At Risk for Long-Term Care Institutionalization, Adult Nursing Facility Residents Transitioning to the Community, and Children/Youth.

- Continued to develop, implement, and grow CalAIM programs such as Population Health Management, Enhanced Care Management, Community Supports, and Long-Term Care.

- Expanded the Transitional Care Program focus to reduce preventable hospital readmissions, coordinate care, and address any unidentified needs during the post-acute discharge planning. Additionally, completed placement of a physician led team in local hospital to evaluate members and provide alternatives to admission as an Emergency Room Diversion program for the prevention of unnecessary admissions. Expanded ER Diversion services to an additional local hospital, making it a total of two 2 local hospitals providing this service.

- Implemented additional 6 Community Supports Services. We now have a total of 14 community-based organization networks offering 12 of the 14 DHCS approved community supports services to coordinate resources to address social determinants of health for our members.

2023 Grants and Community Support:

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

- Supported 73 projects through our Community and School Wellness Grant Programs totaling over $312,000. Funded programs that serve the Bakersfield area as well as outlying Kern communities (1/3 of the programs serve rural Kern communities outside of Bakersfield).

- Donated over $388,000 in sponsorships to 114 different non-profits, community-based organizations, or community events. Since these community partners serve many of the same constituents, many of our members will receive assistance from our sponsorships.

- Continued to work with the 7 awarded schools under the School Wellness Grant Program. Program activities included implementation of school gardens, vape detectors, smoking prevention education, intramural sports, new social and emotional learning curriculums, teacher mindfulness tools, flexible seating and calming corners in classroom.

- Launched the Live Better Program in Buttonwillow and Delano to offer both fitness and health education to these communities. Member wellness and self-care services was expanded to include access to online self-management tools through the KHS website, virtual and in-person health education classes, and the addition of new program offerings: Diabetes Empowerment Education Program, Fresh Start Plus, Activity & Eating, and Eat Healthy, Be Active.

- Established two new scholarship funds at California State University Bakersfield (CSUB). The Kern Family Health Care (KFHC) Nursing Annual Scholarship Fund awarded $3,000 scholarships to 4 CSUB nursing students. The KFHC Master of Social Work (MSW) Annual Scholarship Fund awarded $2,000 scholarships to 2 CSUB MSW students. In addition, KHS created a new scholarship program at Bakersfield College (BC) that awarded $2,000 scholarships to 4 BC nursing students. This is the first time that KHS funded scholarships, with hopes these scholarships will lead to more college students graduating in the nursing and social work fields, which will help ease the shortage of health care professionals in Kern County. This investment, in turn, will lead to better care for KFHC members.

Using this Annual Report

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

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

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

The Statements of Cash Flows

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

Condensed Financial Information

Statements of Net Position

KHS' net position is the difference between its assets and deferred outflows of resources, and liabilities and deferred inflows of resources, as reported in the Statement of Net Position. Our net position increased in 2023 and 2022 by $61.4 million $71.3 million, respectively. Our Statements of Net Position as of December 31, 2023, 2022, and 2021 are as follows:

	2023	2022	2021
Assets			
Cash and cash equivalents	$ 115,782,242	$ 99,137,387	$ 90,414,348
Investments	406,068,694	317,979,108	195,789,809
Premiums receivable	60,525,720	69,627,533	83,797,870
MCO tax receivable	375,849,146	32,650,379	29,682,163
Hospital directed payments receivable	462,027,514	436,815,601	318,427,442
Other current assets	8,821,003	6,253,364	10,266,007
Capital assets, net	59,143,098	64,448,762	65,520,345
Other assets	1,953,788	2,152,854	2,646,723
Total Assets	$1,490,171,205	$1,029,064,988	$ 796,544,707
Deferred Outflows of Resources	$ 8,425,634	$ 8,154,860	$ 3,665,821
Liabilities			
Accrued medical expenses payable	$ 253,813,304	$ 227,819,775	$ 187,168,103
MCO tax liability	375,849,146	32,650,379	29,682,163
Hospital directed payments payable	462,027,514	436,633,259	318,427,442
Accrued expenses	13,894,734	10,911,349	12,118,178
Net pension liability	12,665,462	10,218,206	-
Total Liabilities	$1,118,250,160	$ 718,232,968	$ 547,395,886
Deferred Inflows of Resources	$ 158,303	$ 230,571	$ 5,338,319
Net Position			
Net investment in capital assets	$ 59,143,098	$ 64,448,762	$ 65,520,345
Restricted	300,000	300,000	300,000
Unrestricted	320,745,278	254,007,547	181,655,978
Total Net Position	$ 380,188,376	$ 318,756,309	$ 247,476,323

KHS' net position for 2023, 2022, and 2021 exceeded all regulatory requirements for Tangible Net Equity (TNE).

Statements of Revenues, Expenses and Changes in Net Position

Operating results and changes in our net position show an increase in net position of $61.4 million and $71.3 million for the years ended December 31, 2023 and 2022, respectively. The increases are made up of various components as outlined below:

	2023	2022	2021	2023	2022	2021
Enrollment						
Total member months				4,387,884	4,017,909	3,611,036
Less non-risk capitated member months				(186,108)	(165,042)	(142,638)
Net member months				4,201,776	3,852,867	3,468,398
Average monthly members				350,148	321,072	289,033
				Per Member Per Month in Dollars *		
Operating Revenue						
Premiums earned	$ 1,205,046,814	$ 1,002,268,156	$ 966,948,179	$ 286.79	$ 260.14	$ 278.79
MCO premium tax earned	376,734,270	120,210,024	119,594,632	89.66	31.20	34.48
Hospital directed payments earned	233,292,509	264,306,595	243,729,688	55.52	68.60	70.27
Reinsurance recoveries	2,192,531	497,807	-	0.52	0.13	-
Total operating revenue	1,817,266,124	1,387,282,582	1,330,272,499	432.49	360.07	383.54
Operating Expenses						
Medical and hospital	1,077,563,498	856,089,001	891,828,161	256.45	222.21	257.13
MCO premium tax	376,495,887	124,658,814	112,821,118	89.60	32.35	32.53
Hospital directed payments	231,889,267	264,639,751	242,717,835	55.19	68.69	69.98
Administrative	82,741,418	60,258,858	47,239,327	19.69	15.64	13.62
Depreciation	8,269,844	7,065,025	7,208,071	1.97	1.83	2.08
Total operating expenses	1,776,959,914	1,312,711,449	1,301,814,512	422.90	340.72	375.34
Operating income	40,306,210	74,571,133	28,457,987	9.59	19.35	8.20
Nonoperating Revenue (Expenses)						
Investment and other income (expense)	21,125,857	1,468,465	(172,408)	5.03	0.38	(0.05)
Community grants	-	(4,759,612)	(7,895,437)	-	(1.23)	(2.28)
Total nonoperating revenue (expenses)	21,125,857	(3,291,147)	(8,067,845)	5.03	(0.85)	(2.33)
Changes in net position	61,432,067	71,279,986	20,390,142	14.62	18.50	5.87
Net position, beginning	318,756,309	247,476,323	227,086,181	75.86	64.23	65.47
Net position, ending	$ 380,188,376	$ 318,756,309	$ 247,476,323	$ 90.48	$ 82.73	$ 71.34

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

Operating Income

The first component of the overall change in net position is our operating income. This is the difference between the premiums earned and the cost of medical services. We earned operating income for the years ended December 31, 2023 and 2022 of $40.3 million and $74.6 million, respectively.

The primary components of the operating income for 2023 are:

- Premiums earned increased $202.8 million which is an increase of $26.66 PMPM in 2023 from 2022. The increase in premiums earned is attributed to an increase in membership and the assumption of new membership populations in 2023, increases in premium capitated rates, and the increase in MCO tax revenue from 2022.

- The Medi-Cal average monthly membership increased by approximately 29,100 members or 9.1% over 2023.

- The medical and hospital services costs increased by $221.5 million and $34.26 PMPM between 2023 and 2022. This increase in expense is primarily attributed to the increased medical expense utilization resulting from DHCS program changes and changes in the population of members including the assumption of Long-term Care (LTC) and Full Dual members from FFS.

- Administrative expenses increased by $22.5 million or an increase of $4.05 PMPM over 2022 which is attributed primarily to increased expenses in salaries and benefits, including expenses related to new employees hired throughout 2022 that experienced a full year of compensation in 2023, additional expense for our current year CalPERs adjustment, and expenses for new employees hired in 2023. In addition, there was a significant increase in contracted services used to address the growing needs of the organization, administer new State funded programs, and meet regulatory requirements. Administrative expense as a percentage of total Operation Revenue (excluding MCO tax revenue and Hospital directed payments earned) was 6.85% in 2023 compared to 6.01% in 2022.

Nonoperating Revenues and Expenses

Nonoperating revenues and expenses consist primarily of investment income, community grants and other expenses. In 2023, the net nonoperating income amount was attributed to a significant increase in Investment and Other Income of $19.7 million as the result of higher investment balances and better overall market performance. .

KHS' Cash Flow

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

General Economic and Political Environment Factors

Our continued growth may be affected by a variety of factors, including macro-economic conditions and enacted health care reforms that could affect our results of operations. Our operations depend primarily on the continuation of our contract with and funding by the State for the Two-Plan Model of the Medi-Cal Managed Care Program. We believe that the State and Federal Governments are committed to keeping these programs in place, but they will continue to look for budgetary savings through reductions in health care costs.

Contacting KHS' Financial Management

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

KERN HEALTH SYSTEMS

STATEMENTS OF NET POSITION
December 31, 2023 and 2022

	2023	2022
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current Assets		
Cash and cash equivalents (Note 2)	**$ 115,782,242**	$ 99,137,387
Investments (Notes 2 and 3)	**406,068,694**	317,979,108
Premiums receivable	**60,525,720**	69,627,533
MCO tax receivable	**375,849,146**	32,650,379
Hospital directed payments receivable (Note 4)	**462,027,514**	436,815,601
Other receivables (Note 5)	**1,715,242**	2,192,269
Prepaid expenses	**6,561,513**	3,217,028
Current portion of provider advances (Note 6)	**544,248**	844,067
Total current assets	**1,429,074,319**	962,463,372
Capital Assets (Note 7)		
Land	**4,090,706**	4,090,706
Buildings and improvements	**36,976,735**	36,671,140
Computer hardware and software	**48,793,704**	46,916,577
Furniture and equipment	**4,793,965**	4,395,077
Capital projects in process	**2,295,294**	2,241,699
	96,950,404	94,315,199
Less accumulated depreciation	**37,807,306**	29,866,437
	59,143,098	64,448,762
Other Assets		
Restricted investments (Notes 2, 3 and 11)	**300,000**	300,000
Provider advances, less current portion (Note 6)	**-**	263,964
Split dollar life insurance (Note 8)	**1,653,788**	1,588,890
	1,953,788	2,152,854
Total assets	**1,490,171,205**	1,029,064,988
Deferred Outflows of Resources (Note 12)	**8,425,634**	8,154,860
Total assets and deferred outflows of resources	**$1,498,596,839**	$1,037,219,848

See Notes to Financial Statements.

	2023	2022
LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION		
Current Liabilities		
Accrued medical expenses payable (Note 9)	**$ 253,813,304**	$ 227,819,775
MCO tax liability	**375,849,146**	32,650,379
Hospital directed payments payable (Note 4)	**462,027,514**	436,633,259
Accrued expenses (Note 10)	**13,894,734**	10,911,349
Total current liabilities	**1,105,584,698**	708,014,762
Noncurrent Liabilities		
Net pension liability (Note 12)	**12,665,462**	10,218,206
Commitments and Contingencies (Note 14)		
Deferred Inflows of Resources (Note 12)	**158,303**	230,571
Net Position		
Net investment in capital assets	**59,143,098**	64,448,762
Restricted (Note 11)	**300,000**	300,000
Unrestricted	**320,745,278**	254,007,547
Total net position	**380,188,376**	318,756,309
Total liabilities, deferred inflows of resources and net position	**$1,498,596,839**	$1,037,219,848

KERN HEALTH SYSTEMS

STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
Years Ended December 31, 2023 and 2022

	2023	2022
Operating Revenue		
Premiums earned	**$1,205,046,814**	$1,002,268,156
MCO tax earned	**376,734,270**	120,210,024
Hospital directed payments earned (Note 4)	**233,292,509**	264,306,595
Reinsurance recoveries (Note 13)	**2,192,531**	497,807
Total operating revenue	**1,817,266,124**	1,387,282,582
Operating Expenses		
Medical and hospital	**1,077,563,498**	856,089,001
MCO premium tax (Note 1)	**376,495,887**	124,658,814
Hospital directed payments (Note 4)	**231,889,267**	264,639,751
Administrative	**82,741,418**	60,258,858
Depreciation	**8,269,844**	7,065,025
Total operating expenses	**1,776,959,914**	1,312,711,449
Operating income	**40,306,210**	74,571,133
Nonoperating Revenue (Expenses)		
Investment and other income	**21,125,857**	1,468,465
Community grants	**-**	(4,759,612)
Net nonoperating (expenses)	**21,125,857**	(3,291,147)
Change in net position	**61,432,067**	71,279,986
Net position, beginning	**318,756,309**	247,476,323
Net position, ending	**$ 380,188,376**	$ 318,756,309

See Notes to Financial Statements.

KERN HEALTH SYSTEMS

STATEMENTS OF CASH FLOWS
Years Ended December 31, 2023 and 2022

	2023	2022
Cash Flows From Operating Activities		
Premiums received	**$1,248,434,303**	$1,132,156,123
Hospital directed payments earned	**208,080,596**	145,918,436
Reinsurance recoveries	**2,192,531**	497,807
Medical and hospital payments	**(1,051,569,969)**	(815,437,329)
Hospital directed payments paid	**(206,495,012)**	(146,433,934)
Administrative expenses paid	**(81,371,784)**	(58,360,563)
MCO premium tax expense paid	**(33,297,120)**	(121,696,867)
Net cash provided by operating activities	**85,973,545**	136,643,673
Cash Flows From Noncapital Financing Activities		
Community grants	**-**	(4,759,612)
Nonoperating income	**20,999**	3,355
Net cash provided by (used in) noncapital financing activities	**20,999**	(4,756,257)
Cash Flows From Capital And Related Financing Activities		
Acquisition of capital assets -		
Net cash (used in) capital and related financing activities	**(2,964,583)**	(6,115,997)
Cash Flows From Investing Activities		
Purchases of investments	**(1,475,483,059)**	(1,537,065,555)
Proceeds from maturities of investments	**1,408,474,068**	1,416,117,352
Payments received on provider advances	**688,783**	3,835,702
Proceeds from (payments on) split dollar life insurance	**(64,898)**	64,121
Net cash (used in) investing activities	**(66,385,106)**	(117,048,380)
Net increase in cash and cash equivalents	**16,644,855**	8,723,039
Cash and cash equivalents:		
Beginning	**99,137,387**	90,414,348
Ending	**$ 115,782,242**	$ 99,137,387

See Notes to Financial Statements.

	2023	2022
Reconciliation of operating activities to net cash provided by operating activities		
Operating income	**$ 40,306,210**	$ 74,571,133
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation	**8,269,844**	7,065,025
Provision for allowance for doubtful provider advances	**(125,000)**	125,000
Changes in:		
Deferred outflows of resources	**(270,774)**	(4,489,039)
Net pension liability	**2,447,256**	10,911,918
Deferred inflows of resources	**(72,268)**	(5,107,748)
Changes in working capital components:		
(Increase) decrease in:		
Premiums receivable and other receivables	**9,603,506**	13,638,343
MCO tax receivable	**(343,198,767)**	(2,968,216)
Hospital directed payments receivable	**(25,211,913)**	(118,388,159)
Prepaid expenses	**(3,344,485)**	666,540
Increase (decrease) in:		
Accrued medical expenses payable	**25,993,529**	40,651,672
MCO tax payable	**343,198,767**	2,968,216
Hospital directed payments payable	**25,394,255**	118,205,817
Accrued expenses	**2,983,385**	(1,206,829)
Net cash provided by operating activities	**$ 85,973,545**	$ 136,643,673

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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

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

Redeterminations: For the period during which the Public Health Emergency ("PHE") was in effect, Medicaid programs were required to keep individuals continually enrolled through the end of the PHE. With the passage and signing of the Consolidated Appropriation Act of 2023 (ACT), this situation is expected to change. The Act allows states to restore eligibility verification and to terminate members deemed ineligible as early as April 1, 2023. During 2023 management estimates that KHS lost approximately 40,000 members due to redeterminations. KHS continues to be in close contact with local and state agencies to develop action plans designed to minimize potential disruption of care for its members. KHS has a team of employees ready to support our Medi-Cal eligible members to recertify their Medi-Cal eligibility status.

A summary of KHS' significant accounting policies follows:

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

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

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

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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

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

KHS' capitalization policy is to capitalize all items with a unit cost greater than $5,000 with the exception of computer software which has a per unit capitalization of $10,000 and an expected useful life of greater than one year. Items that do not meet KHS' capitalization policy and that do not have a useful life of greater than one year are expensed in the period acquired.

Accrued compensated absences: KHS employees earn personal time off (PTO) on a bi-weekly or semi-monthly basis at various rates based on continuous years of service. Employees are allowed to accumulate up to three times their annual benefit rate before accruals cease. Unused PTO is carried forward into subsequent years. Any unused accumulated balance will be paid to the employee upon separation of service. Compensated balances are accrued and recorded in accordance with GASB Codification Section C60.

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

- *Net investment in capital assets* consists of capital assets net of accumulated depreciation, reduced by the current balance of any outstanding borrowings used to finance the purchase or construction of those assets.

- *Restricted* net position is non-capital net position that must be used for a particular purpose, as specified by regulators, creditors, grantors, or contributors external to KHS.

- *Unrestricted* net position is the remaining net position that does not meet the definition of *net investment in capital assets* or *restricted*.

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

In 2013, KHS entered into a capitated agreement required by the DHCS with another Health Plan which allows for that plan to provide health care services for their assigned members. As KHS had no obligation to provide care for this population, the Premiums earned amount included as part of operating revenue is reported net of the capitated expense associated with assigned members. Capitated expense was $40.6 million for 15,226 members assigned for the year ended December 31, 2023 and was $33.2 million for 14,635 members assigned for the year ended December 31, 2022. This contract ended on December 31, 2023.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Premiums revenue: Premiums are due monthly from DHCS and are recognized as revenues during the period in which KHS is obligated to arrange payments for managed health care services provided to KHS members. CMS requires that the rates used in KHS' premiums are to be actuarially sound. Premium revenue is fixed in advance of the periods covered on a per member per month (PMPM) basis and are generally not subject to significant accounting estimates. Premium payments received from DHCS are based on an eligibility list produced by DHCS and are subject to eligibility redeterminations and enrollment backlogs related to the renewal of Medi-Cal coverage. Premium payments are required to be returned if DHCS later discovers that the eligibility list contains individuals who were not eligible. Medi-Cal redeterminations had been paused since March 2020, originally tied to the COVID-19 public health emergency (PHE). The passage of the Consolidated Appropriations Act of 2023 in December 2022 allows for the resumption of Medi-Cal redeterminations as early as April 1, 2023. KHS' PMPM rates are typically adjusted annually. KHS receives additional premium revenue in the form of a "maternity kick payment" which is a one-time payment for the delivery of a child. For the years ended December 31, 2023 and 2022, maternity kick payments in the amount of $39.8 million or 3.3% and $40.1 million or 4.0% respectively, of total premium revenue were recognized. KHS also receives premium revenue in the form of a "Behavioral Health Treatment kick payment" based on the utilization by its members diagnosed with specific Autism criteria. For the year ended December 31, 2022 Behavioral Health Treatment payments in the amount of $18.3 million or 1.8% of total premium revenue were recognized. As of January 1, 2023, KHS is no longer receiving additional kick payments for the Behavioral Health Treatment program, as funding is now included in the capitated rates received from DHCS. Beginning in 2021, DHCS began a two-year Behavior Health Integration Incentive Program (BHI) in which funds are received for qualifying providers to assist in the improvement of physical and behavioral health outcomes and care delivery efficiency. For the year ended December 31, 2022 BHI program payments in the amount of $4.5 million or 0.4% of total premium revenue were recognized. The BHI program concluded December 31, 2022.

KHS receives supplemental revenue funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) for the purpose of paying additional amounts for qualifying physician services based on certain specified eligible CPT procedure codes. For the years ended December 31, 2023 and 2022 Proposition 56 payments in the amount of $76 million or 6.3% and $70.5 million or 7.0%, respectively, of total premium revenue were recognized. Proposition 56 physician services supplemental payments ended December 31, 2023 as DHCS has developed Targeted Rate Increases ("TRI") for providers in Medi-Cal effective for dates of service on or after January 1, 2024. The TRI for targeted services is to be no less than 87.5% of the Medicare rate. The calculation methodologies used to determine the 87.5% of Medicare Rate are quite complex and until the TRI are implemented, DHCS expects managed care plans to pay the equivalent value of the former Proposition 56 physician services supplemental payments. KHS also receives supplemental Ground Emergency Medical Transportation (GEMT) revenue provided for the purpose of paying additional amounts to qualifying GEMT providers based on certain specified eligible CPT procedure codes. For the years ended December 31, 2023 and 2022, GEMT payments in the amount of $6.4 million or 0.5% and $7.0 million or 0.7% respectively, of total premium revenue were recognized.

Premiums are also subject to prior year retroactive rate adjustments based on actual and expected health care costs and are recognized when known in the current year. For the years ended December 31, 2023 and 2022 KHS recognized a net reduction of $0.3 million or 0.3% and a net reduction of $3.3 million or 0.03%, respectively, of premium revenue as a result of retroactive membership and rate adjustments.

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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

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

Managed Care Organization Premium taxes: Beginning July 1, 2016, under Senate Bill X2-2, the Managed Care Organization (MCO) tax rate was payable to DHCS on a quarterly basis based on projected annual membership. MCO Tax Revenue is received from DHCS monthly based on actual membership on a per member per month fixed dollar amount. This change in MCO tax methodology puts KHS at risk if the assumed membership used in the calculated tax expense is different than the actual membership KHS experiences during the rate year. The premium revenues received include the premium tax assessment. These amounts are reported on a gross basis and are included in total operating revenues with the MCO tax expense presented separate from all other medical and administrative expense. Due to the pause in member redeterminations, and continued increases in member enrollment, Medi-Cal plans received significantly more MCO tax revenue than was required to be paid in quarterly MCO tax expense. DHCS indicated excess funds received were subject to recoupment. For the year ended December 31, 2022, KHS recorded a liability of approximately $15.9 million payable to DHCS for MCO tax revenue received in excess of the required MCO tax expense for the period July 1, 2020, through December 31, 2022. In December 2023 the MCO Tax was reinstated with an effective date of April 1, 2023 which resulted in approximately $375.8 million of MCO Tax revenue and $376.5 million of MCO Tax expense for the year ended December 31, 2023.

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

Pass-through funding from DHCS: During the years ended December 31, 2023 and 2022, KHS received $92.4 million and $41.1 million, respectively, of supplemental fee revenue from DHCS. KHS passes these funds through to the designated hospitals and providers. This amount is not reflected in the statements of revenues, expenses and changes in net position for the years ended December 31, 2023 and 2022, as this pass-through amount does not meet the requirements for revenue recognition under Governmental Accounting Standards.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Advertising: KHS expenses advertising costs as they are incurred. Advertising expense totaled $1.7 million and $0.6 million for the years ended December 31, 2023 and 2022, respectively.

Reclassifications: Certain items in the 2022 financial statements have been reclassified to conform to the 2023 presentation, with no effect on change in net position.

Subsequent events: KHS has evaluated subsequent events through April 3, 2024, the date on which the financial statements were available to be issued. There were no subsequent events identified by management which would require disclosure in the financial statements.

Authoritative pronouncements not yet adopted: In June 2022, the GASB issued Statement No. 100, *Accounting Changes and Error Corrections – An Amendment of GASB Statement No. 62.* The primary objective of this Statement is to enhance accounting and financial reporting requirements for accounting changes and error corrections to provide more understandable, reliable, relevant, consistent, and comparable information for making decisions or assessing accountability.

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

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

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

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

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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

This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. Leave is attributable to services already rendered when an employee has performed the services required to earn the leave. Leave that accumulates is carried forward from the reporting period in which it is earned to a future reporting period during which it may be used for time off or otherwise paid or settled. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. However, leave that is more likely than not to be settled through conversion to defined benefit postemployment benefits should not be included in a liability for compensated absences.

This Statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. This Statement also requires that a liability for specific types of compensated absences not be recognized until the leave is used.

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

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

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

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

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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

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

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

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

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

Note 2. Cash, Cash Equivalents and Investments

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

Cash and cash equivalents:	
Deposits	$ 9,241,641
Local Agency Investment Fund (LAIF) and money market funds	106,540,401
Cash on hand	200
Total cash and cash equivalents	$ 115,782,242

	Cost	Fair Value
Investments:		
Unrestricted:		
Government agency bonds and notes	$ 327,020,791	$ 327,152,121
Corporate bonds and notes	78,863,931	78,916,573
Total unrestricted	405,884,722	406,068,694
Restricted:		
Certificates of deposit	300,000	300,000
Total investments	$ 406,184,722	$ 406,368,694

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

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

Cash and cash equivalents:	
Deposits	$ 1,859,330
Local Agency Investment Fund (LAIF) and money market funds	97,277,857
Cash on hand	200
Total cash and cash equivalents	$ 99,137,387

	Cost	Fair Value
Investments:		
Unrestricted:		
Government agency bonds and notes	$ 260,934,310	$ 261,167,637
Corporate bonds and notes	58,702,618	56,811,471
Total unrestricted	319,636,928	317,979,108
Restricted:		
Certificates of deposit	300,000	300,000
Total investments	$ 319,936,928	$ 318,279,108

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

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

Investments Authorized by KHS' Investment Policy

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

- Preservation of principal
- Liquidity
- Yield

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

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Authorized Investment Type	Maximum Maturity	Maximum Percentage Of Portfolio	Maximum Investment of Portfolio of One Issuer	Allowed or Maximum Ratings
U.S. Treasury Obligations	5 years	100%	None	Not Rated
Federal Agencies and U.S. Government Enterprises	5 years	100%	35%	Not Rated
State of California and Local Agency Obligations	5 years	100%	5%	A-1
State and Local Agency Obligations outside of California	5 years	20%	5%	A-1
Banker's Acceptances	180 days	40%	(1)	A-1
Commercial Paper	270 days	25%	(2)	A-1
Negotiable Certificates of Deposit	5 years	30%	5% (7)	A-1
Government Repurchase Agreements	1 year	100%	(3)	A-1
Corporate Debt Securities	5 years	30%	(5)	A
Money Market Funds	5 years	20%	(4)	AAA
Mortgage or Asset-Backed Securities	5 years	20%	(6)	AAA
Variable and Floating Rate Securities	5 years	30%	5%	AAA
Local Agency Investment Fund (LAIF)	5 years	50%	5%	Not Rated

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

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

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

(4) May not exceed more than 10% of the money market fund’s assets.

(5) Medium-term notes or other corporate security of any one corporate issuer must not exceed more than 5% of the portfolio.

(6) Rated AAA by a nationally recognized rating service and issued by an issuer having an A or better rating for its long-term debt.

(7) Maturities greater than one year and less than five years may not exceed the FDIC Insurance maximum at the time of purchase.

Disclosures Relating to Interest Rate Risk

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Disclosures Relating to Credit Risk

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

GASB Codification Section 150 requires disclosure of any investments of any single issuer in excess of 5% of its total investments, excluding investments issued or explicitly guaranteed by the U.S. government and investments in mutual funds, external investment pools, and other pooled investments. There were no investments of any single issuer that exceeded 5% of its total investments as of December 31, 2023 or 2022.

Custodial Credit Risk

Custodial credit risk for *deposits* is the risk that, in the event of the failure of a depository financial institution, KHS will not be able to recover its deposits or not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for *investments* is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, KHS will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The California Government Code and KHS' investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits or investments, other than the following provision for deposits: The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies.

Cash Equivalents in State Investment Pool

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

Note 3. Fair Value Measurements

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under ASC 820 are described below:

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

Level 2 — Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;

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- ❖ Inputs other than quoted prices that are observable for the asset or liability;
- ❖ Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

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

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

Following is a description of the valuation methodologies used for assets measured at fair value.

Certificates of deposit: Valued based on amortized cost or original cost-plus accrued interest.

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

All investments held by KHS at December 31, 2023 and 2022 are considered to be level 1 assets.

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

Note 4. Hospital Directed Payments

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

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The projected value of the program payment obligations to designated hospitals are accounted for as medical expenses and paid through additional capitation revenue. Due to the timing of the program acceptance by CMS and delays in funding to MCPs, final rates of the various Hospital Directed Payment programs are not available until paid. KHS accrued Hospital Directed Payments receivable of approximately $462.0 million and Hospital Directed payments payable of approximately $462.0 million reported as of December 31, 2023. For the year ended December 31, 2022 KHS accrued Hospital Directed Payments receivable of approximately $436.8 million and Hospital Directed Payments payable of approximately $436.6 million. The amount of premium revenue for Hospital Directed Payment programs recognized for the years ended December 31, 2023 and 2022 was approximately $233.3 million and $264.3 million, respectively, and is reported as part of operating revenues. Hospital Directed Payment expense obligations recognized for the years ended December 31, 2023 and 2022 were approximately $231.9 million and $264.6 million, respectively, and are reported as part of operating expenses. As stated above, KHS has very little visibility as to the timing of these payments until actually paid by DHCS.

Note 5. Other Receivables

Other receivables consist of the following at December 31, 2023 and 2022:

	2023	2022
Provider receivable	$ 1,146,553	$ 1,603,931
Interest	413,845	389,179
Other	154,844	199,159
	$ 1,715,242	$ 2,192,269

Note 6. Provider Advances

In April 2020 as part of the response to the COVID-19 pandemic and in an effort to support its network of providers of care for the more than 258,000 members served, KHS advanced $5.7 million under a COVID-19 Provider Financial Relief Program. Under the Program, provider advance payments were offered to select local network providers of up to 50% of their average 2019 monthly claim payments multiplied by three months. The no interest payment advances were aimed at providing financial assistance to those network providers experiencing financial hardships due to lower utilization of medical services as the result of the Governor's shelter in place order. Monthly repayments of provider advances began in September 2021 and are due on January 1, 2024. In the event of a program payment default, KHS has the right to offset amounts owed by providers against any future monies owed to the provider. As of December 31, 2023 and 2022, outstanding provider advances due to KHS totaled $0.5 million and $1.1 million, respectively.

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Note 7. Capital Assets

Capital asset activity for the years ended December 31, 2023 and 2022 is as follows:

	Balance January 1, 2023	Additions	Deletions	Transfers	Balance December 31, 2023
Capital Assets Not Being Depreciated:					
Land	$ 4,090,706	$ -	$ -	$ -	$ 4,090,706
Capital projects in progress	2,241,699	1,801,221	-	(1,747,626)	2,295,294
Subtotal	6,332,405	1,801,221	-	(1,747,626)	6,386,000
Capital Assets Being Depreciated:					
Buildings and improvements	36,671,140	-	-	305,595	36,976,735
Computer hardware and software	46,916,577	1,028,492	(315,427)	1,164,062	48,793,704
Furniture and equipment	4,395,077	134,870	(13,951)	277,969	4,793,965
Subtotal	87,982,794	1,163,362	(329,378)	1,747,626	90,564,404
Accumulated Depreciation:					
Buildings and improvements	2,955,942	907,860	-	-	3,863,802
Computer hardware and software	23,757,053	6,713,662	(315,024)	-	30,155,691
Furniture and equipment	3,153,442	648,322	(13,951)	-	3,787,813
Subtotal	29,866,437	8,269,844	(328,975)	-	37,807,306
Net Depreciable Capital Assets	58,116,357	(7,106,482)	(403)	1,747,626	52,757,098
Total Capital Assets	$ 64,448,762	$ (5,305,261)	$ (403)	$ -	$ 59,143,098

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

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Note 8. Split Dollar Life Insurance

In October 2017, KHS entered into a split-dollar life insurance agreement with a key employee and his beneficiary, whereby the employee is eligible to receive distributions, and KHS will receive $774,526 upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $852,762 and $816,478 at December 31, 2023 and 2022, respectively.

In June 2020, KHS entered into a second split-dollar life insurance agreement with the same employee and his beneficiary as the 2017 agreement, whereby the employee is eligible to receive distributions, and KHS will receive $847,832 upon the death of the employee and his beneficiary or termination of the agreement. The policy had a cash surrender value of $801,026 and $772,412 at December 31, 2023 and 2022, respectively.

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

Note 9. Accrued Medical Expenses Payable

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

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

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

KHS consistently applies the IBNR estimation from period to period. Any adjustments from the prior year are included in the current period as a change in accounting estimate. As more complete additional information becomes known, KHS will adjust assumptions accordingly to change the IBNR estimate. KHS recognized $14.1 million and $16.2 million of favorable prior year IBNR adjustments for the years ended December 31, 2023 and 2022, respectively, due to lower-than-expected utilization.

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Proposition 56: On November 8, 2016, California voters approved Proposition 56 to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a portion of the tobacco revenue is allocation to the Department of Health Care Services (DHCS) for use as the nonfederal share of health care expenditures in accordance with the annual state budget process. Proposition 56 appropriated funds resulted in directed payments made to Medi-Cal managed care health plans for the purposes of paying additional amounts for qualifying physician services based on certain specified CPT procedure codes. The directed payments are subject to a minimum medical expenditure percentage and a portion of capitation payments attributed to this directed payment arrangement will be subject to a two-sided risk corridor. At December 31, 2023 and 2022 KHS has accrued $55.8 million and $60.7 million, respectively, in payments to providers for Proportion 56. If less than the targeted amount accrued is paid to providers, amounts will be returned to the State through the performance of DHCS' risk corridor calculation. Proposition 56 physician services supplemental payments ended December 31, 2023, as DHCS has developed Targeted Rate Increases ("TRI") for providers in Medi-Cal effective for dates of service on or after January 1, 2024. The TRI for targeted services are to be no less than 87.5% of the Medicare rate, The calculation methodologies used to determine the 87.5% of Medicare Rate are quite complex and until the TRI is implemented, DHCS expects managed care plans to pay the equivalent value of the former Proposition 56 physician services supplemental payments.

Bridge Risk Corridor: Due to the unprecedented circumstances of the COVID-19 pandemic, DHCS and its contracted actuary determined that a two-sided, symmetrical risk corridor ("Bridge Corridor") would appropriately provide protection for both the State and Medi-Cal managed care plans (MCPs) like KHS. The purpose of the risk corridor is to mitigate potentially significant upward or downward risk associated with COVID-19 that was not determinable at the time of rate development. The Bridge Corridor was retroactive to July 1, 2019 and is based on an estimate provided by guidance obtained from DHCS. At December 31, 2023 and 2022, KHS had accrued $25.5 million owed to the state for the rate period July 1, 2019 through December 31, 2020.

Accrued medical services and related claims adjustment expenses payable consist of the following at December 31, 2023 and 2022:

	2023	2022
Estimated incurred but not reported claims	$ 123,560,618	$ 96,084,096
Supplemental Proposition 56 provider payments	55,819,318	60,729,070
Bridge risk corridor	25,453,666	25,453,666
Claims payable	18,170,423	18,643,959
Major Organ Transplant	11,220,403	3,381,437
Enhanced Care Management (ECM) risk corridor	9,208,423	12,843,453
Provider performance quality incentive	6,253,771	3,505,791
Allowance for claims processing expense	3,776,682	2,831,842
CalAIM Incentive	350,000	4,318,339
Provider vaccine incentive	-	28,122
	$ 253,813,304	$ 227,819,775

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Note 10. Accrued Expenses

Accrued expenses consist of the following at December 31, 2023 and 2022:

	2023	2022
Salaries and employee benefits	$ 5,608,912	$ 4,137,755
Accounts payable	5,089,338	3,777,586
Non-operating passthrough liability	1,306,490	1,058,010
CalPERS employee and employer contributions	778,882	410,699
Other taxes and licenses	646,741	-
Community grants payable	365,150	1,515,321
New building and construction	99,221	11,978
	$ 13,894,734	$ 10,911,349

Note 11. Restricted Investments and Tangible Net Equity

As required by the State of California's Department of Managed Health Care, Section 1300.76.1, KHS has acquired certificates of deposit with three financial institutions totaling $300,000. These certificates of deposit have been assigned to the Director of the Department of Managed Health Care as part of the process of obtaining and maintaining its Knox-Keene license and are legally restricted for this purpose. These certificates of deposit mature in amounts of $100,000 each on January 31, 2024, June 5, 2024 and June 8, 2024.

KHS is a fully licensed health-care service plan under the Knox-Keene Health Care Services Plan Act of 1975 (the "Act"). Under the Act, KHS is required to maintain a minimum level of tangible net equity. The required equity level was approximately $58.2 million and $50.8 million at December 31, 2023 and 2022, respectively. KHS' tangible net equity was approximately $380.2 million and $318.8 million at December 31, 2023 and 2022, respectively.

Note 12. Employee Pension Plans

CalPERS

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

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

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The Plans' provisions and benefits in effect at December 31, 2023 and 2022 are summarized as follows:

		2023		2022	
		Classic	PEPRA	Classic	PEPRA
Hire date	Prior to January 1, 2013	On or after January 1, 2013	On or after January 1, 2013	On or after January 1, 2013	On or after January 1, 2013
Benefit formula	2% @ 60	2% @ 60	2% @ 62	2% @ 60	2% @ 62
Benefit vesting schedule	5 years of service	5 years of service	5 years of service	5 years of service	5 years of service
Benefit payments	Monthly for life	Monthly for life	Monthly for life	Monthly for life	Monthly for life
Retirement age	50	50	52	50	52
Monthly benefits, as a % of eligible compensation	2%	2%	2%	2%	2%
Retirement employee contribution rates	7%	6.93%	7.75%	6.93%	6.75%
Required employer contribution rates	6.709% to 7.159%	8.63% to 10.100%	7.74% to 7.680%	8.65% to 8.630%	7.59% to 7.470%

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

For the years ended December 31, 2023 and 2022, the contributions recognized as part of pension expense were as follows:

	2023	2022
Contributions - employer	$ 4,036,369	$ 3,516,567
Contributions - employee (paid by employer)	$ -	$ -

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

As of December 31, 2023, and 2022, KHS reported a net pension liability for its proportionate share of the net pension liability of $12.7 million and $10.2 million, respectively.

KHS' fiduciary net pension as a percentage of KHS' total pension liability for the years ended December 31, 2023 and 2022 was 86.03% and 87.00%, respectively.

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

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

KHS' net pension liability is measured as the proportionate share of the net pension liability. The net pension liability is measured as of June 30, 2022, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2021 rolled forward to June 30, 2022 using standard update procedures. KHS' proportion of the net pension liability was based on a projection of KHS' long-term share of contributions to the plan relative to the projected contributions of all participating employers, actuarially determined. KHS' proportionate share of the net pension liability as of June 30, 2022 and 2021 was as follows:

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

For the years ended December 31, 2023 and 2022, KHS recognized pension expense of $6.653,389 and $5,608,106, respectively. At December 31, 2023 and 2022, KHS reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	2023		2022	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Pension contributions subsequent to the measurement date	$ 2,964,771	$ -	$ 2,913,850	$ -
Changes in assumptions	1,206,051	-	1,756,640	-
Differences between expected and actual experiences	1,020,491	158,303	344,261	230,571
Net differences between projected and actual earnings on pension plan investments	3,234,321	-	3,140,109	-
Total	$ 8,425,634	$ 158,303	$ 8,154,860	$ 230,571

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$2,964,771 reported as deferred outflows of resources related to contributions subsequent to the measurement date will be recognized as an increase of the net pension liability in the year ending December 31, 2024. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year ended December 31,	
2024	$ 1,660,187
2025	1,107,422
2026	2,442,145
2027	92,806
	$ 5,302,560

Actuarial Methods and Assumptions: The total pension liabilities in the June 30, 2022 and 2021 actuarial valuations were determined using the following actuarial assumptions:

	2023	2022
Valuation date	June 30, 2022	June 30, 2021
Measurement date	June 30, 2023	June 30, 2022
Actuarial cost method	Entry-Age Normal Cost Method	
Actuarial assumptions:		
Discount rate	6.90%	6.90%
Inflation	2.30%	2.30%
Payroll growth	2.80%	2.55%
Projected salary increase	Varies by Entry Age and Service	
Investment rate of return	7.00% (a)	7.00% (a)
Mortality	Derived using CalPERS' Membership Data for all Funds (b)	

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

(b) The mortality table used was developed based on CalPERS' specific data. The rates incorporate Generational Mortality to capture ongoing mortality improvements using 80% of Scale MP 2020 published by the Society of Actuaries.

Discount Rate: The discount rate used to measure the total pension liability was 6.90% as of June 30, 2022 and June 30, 2021. To determine whether the municipal bond rate should be used in the calculation of a discount rate for the plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current discount rate of 6.90% as of June 30, 2022 and 2021 is adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 6.90% will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report that can be obtained from the CalPERS website at http://www.calpers.ca.gov.

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According to Paragraph 30 of Statement 68, the long-term discount rate should be determined without reduction for pension plan administrative expense. The 6.90% as of June 30, 2022 and June 30, 2021, investment return assumption used in this accounting valuation is net of administrative expenses. Administrative expenses are assumed to be 15 basis points. An investment return excluding administrative expenses would have been 7.05% as of June 30, 2022 and 2021. Using this lower discount rate has resulted in a slightly higher Total Pension Liability and Net Pension Liability. CalPERS checked the materiality threshold for the difference in calculation and did not find it to be a material difference.

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

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

Asset Class	New Strategic Allocation	Long-Term Expected Rate of Return
Public Equity (a)	45.1%	8.9%
Private Equity (b)	12.9%	11.8%
Income (a)	26.4%	2.4%
Private Debt (b)	2.2%	-
Real Assets (b)	15.2%	7.7%
Fund financing	-1.8%	0.0%
Total	100%	

(a) Includes exposure from derivatives and repo borrowing used for Total Fund Financing.
(b) Reflect valuation as of March 31, 2023 and are cash adjusted through June 30, 2023.

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

	2023	2022
1% Decrease	5.90%	5.90%
Net Pension Liability	$ 20,439,315	$ 16,603,473
Current Discount Rate	6.90%	6.90%
Net Pension Liability	$ 12,665,462	$ 10,218,206
1% Increase	7.90%	7.90%
Net Pension Liability	$ 6,266,914	$ 4,964,716

Pension Plan Fiduciary Net Position: Detailed information about the pension plan's fiduciary net position is available in the separately issued CalPERS financial reports.

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Retirement Plan

Plan description and funding policy: KHS has a 401(a)-retirement plan, which was approved by the IRS on August 15, 1996. All full-time employees are eligible to participate in the Plan. KHS matches 100% of contributions made by KHS employees to their 457(b) plan up to a maximum of 6% of the employee's salary. KHS contributions do not vest until the employee has been employed for three years when at such time the employee becomes 100% vested. Participants are not allowed to make contributions to the Plan; only employer contributions are allowable. Expense determined in accordance with the plan formula was $2.3 million and $2.0 million for the years ended December 31, 2023 and 2022, respectively.

Note 13. Reinsurance

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

For each of the years ended December 31, 2023 and 2022 coverage provides reimbursement of approximately 90 percent, of the cost of each member's acute care hospital admission(s) in excess of the deductibles, up to a maximum payable of $2,000,000 per member per contract year.

For the years ended December 31, 2023 and 2022 the premium coverage is $0.27 and $0.18 per member per month (PMPM), respectively, with no minimum annual premium requirement.

The deductible for each individual member was $350,000 for each of the years ended December 31, 2023 and 2022, and the Aggregate Specific Retention deductible was $0.23 PMPM and $0.13 PMPM, respectively, for the years ended December 31, 2023 and 2022.

Reinsurance premiums of $1.1 million and $0.6 million are included in medical and hospital expense for the years ended December 31, 2023 and 2022, respectively. Reinsurance recoveries of $2.2 million and $0.5 million are included in operating revenue for the years ended December 31, 2023 and 2022, respectively.

Note 14. Commitments and Contingencies

Litigation

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

Professional Liability Insurance

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Cyber Insurance

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

COVID-19 Vaccination Incentive Program

Kern Health Systems embarked on an aggressive COVID-19 Vaccination Incentive Program that aligns with the Department of Health Care Service's initiative to materially increase vaccines among California's Medi-Cal population. This program focuses on identifying unvaccinated beneficiaries, educating them as to the vaccine's importance, increasing access to COVID-19 vaccination sites and providing incentives to encourage becoming vaccinated. Starting September 1, 2021 through February 28, 2022, KHS offered incentives to members who got fully vaccinated. Providers that were willing to enhance their efforts in getting their assigned members vaccination and became a vaccination site, were also incentivized. KHS also partnered with several community organizations and initiatives that focused on education and access to COVID 19 vaccinations in Kern County. For the year ended December 31, 2022 KHS reported additional Medi-Cal premium revenue of $2.8 million related to Vaccine Incentive Programs and medical expense of $3.5 million.

California Advancing and Innovating Medi-Cal (CalAIM) Program

Effective January 1, 2022, DHCS implemented California Advancing and Innovating Medi-Cal (CalAIM), a multi-year initiative aimed at improving the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of a broad delivery system, and program and payment reform across the Medi-Cal program. CalAIM's Enhanced Care Management (ECM) and Community Support programs required significant investments in care management capabilities in which DHCS provided additional funding to Medi-Cal managed care plans. For the years ended December 31, 2023 and 2022, CalAIM initiative payments, including ECM funding and Housing and Homelessness Incentive Program funds, in the amount of $48.1 million or 4.0% and $41.2 million or 4.1%, respectively, of total premium revenue were recognized.

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by DHCS to implement policy changes with the objectives of:

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

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Regulatory Matters

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

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

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

Information Technology

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

Encounter Data

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

The Health Insurance Portability and Accountability Act

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

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

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

Premium and Eligibility Reconciliations

Premium payments received by KHS from DHCS are based on eligibility lists generated between DHCS and by county agencies that are responsible for determining Medi-Cal eligibility. In a report issued on October 30, 2018 by the California State Auditor, the report indicated “questionable payments” for many counties throughout California, including Kern County. During the period January 1, 2014 through December 31, 2017 amounts of $10.4 million relating to Managed Care Premiums and $2.9 million relating to Fee For Service Payments for a total of $13.3 million of payments by DHCS were identified for Kern County primarily due to beneficiaries being eligible on the DHCS eligibility system and not being eligible on the county agency eligibility system. During the first quarter of 2020, DHCS recouped approximately $0.6 million relating to payments previously received by KHS for members that were determined to be deceased by DHCS. This amount was subtracted from KHS’ 2019 revenues. There were no significant recoupments during the years ended December 31, 2023 or 2022 for deceased members, but it remains unclear if any additional amounts will be recouped by DHCS from KHS. Accordingly, premium revenues could remain subject to reconciliation and recoupment for many years. The refund of a premium overpayment could be significant and would reduce the premium revenue in the year that the repayment obligation is identified.

Bridge Corridor Liability Adjustment

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

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

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

Expansion Risk Corridor Liability Adjustment

The Risk Corridor Liability is based on management's best estimate of a medical loss ratio estimate for KHS Expansion members that have medical expenses below 85% of premiums. KHS is required to refund to the State amounts below 85%. The calculation of the 85% medical loss ratio is subject to the following adjustments:

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

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

This examination has several objectives:

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

As of December 31, 2023, KHS had not received any additional correspondence from CMS or the contractor designated to perform the examinations. It is unknown if there will be any adjustments resulting from the MLR examinations and whether such adjustments would be material.

Any adjustments to the Bridge Risk Corridor Liability or Expansion Risk Corridor Liability amounts could be significant and would increase or decrease reported medical expenses in the year the adjustment is required.

KERN HEALTH SYSTEMS

NOTES TO FINANCIAL STATEMENTS

New Medical Loss Ratio Requirement Beginning January 1,2024

Effective January 1, 2024, managed care plans like KHS must return funds to DHCS if their medical loss ratio falls below 85%.

Targeted Rate Increases effective January 1,2024

DHCS has developed primary care, obstetric, and non-specialty mental health services targeted provider rate increases for providers in Medi-Cal effective for dates of service on or after January 1, 2024. These rate increases will apply to eligible providers in the Fee-For-Service delivery system, as well as eligible network providers contracted with Medi-Cal managed care plans. DHCS increased rates, as applicable, for targeted services to be no less than 87.5% of the Medicare rate, inclusive of eliminating AB 97 provider payment reductions and incorporating applicable Proposition 56 supplemental payments into the base rate. The calculation methodologies used to determine the 87.5% of Medicare Rate are quite complex and it is unknown if the rates received in the KHS base rates will be adequate to fund the Targeted Rate Increases to providers. Until the Targeted Rate Increases are implemented, DHCS expects managed care plans to pay the equivalent value of the former Proposition 56 physician services supplemental payments. which ended on December 31, 2023.

Patient Protection and Affordable Care Act

In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transformed the U.S. health-care system and increased regulations within the U.S. health insurance industry. This legislation expanded the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that took effect from 2010 through 2020, with most measures effective in 2014. Under the Healthcare Reform Legislation, Medi-Cal coverage expanded as of January 2014 to nearly all low-income people under age 65 with income at or below 138% of the federal poverty line. The federal government paid 100% of the entire cost for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, 90% in 2020, 95% in 2021, 85% in 2022 and 86% for 2023. For the years ended December 31, 2023 and 2022, KHS served an average of 98,676 and 89,749 Medi-Cal Expansion members per month, respectively, which generated revenues of approximately $433.9 million and $365.0 million, respectively.

Note 15. Concentration of Revenue

KHS' operating revenue is primarily derived from the California Department of Health Care Services (DHCS). KHS' current contract term with DHCS is to provide health care services through December 31, 2025 and is subject to cancellation upon DHCS providing at least 60 days written notice and KHS providing at least six months written notice. For the years ended December 31, 2023 and 2022, over 99% of KHS' total operating revenues were received from DHCS. Future levels of funding and premium rates received by KHS could be impacted by state and federal budgetary constraints.

REQUIRED SUPPLEMENTARY INFORMATION

KERN HEALTH SYSTEMS

SCHEDULES OF PROPORTIONATE SHARE OF THE NET PENSION (ASSET) LIABILITY
As of December 31, 2023

	2023	2022	2021	2020
CalPERS - Miscellaneous Classic Plan- Last 10 Years*				
Proportion of the net pension liability	0.39949%	0.36636%	0.32206%	0.28810%
Proportionate share of the net pension (asset) liability	$ 12,665,462	$ 10,218,206	$ (693,712)	$ 8,432,377
Covered - employee payroll	$ 21,502,725	$ 21,002,601	$ 20,710,645	$ 19,428,164
Proportionate share of the net pension liability as a percentage of covered-employee payroll	58.90%	48.65%	-3.35%	43.40%
Plan's fiduciary net position (in thousands)	$ 17,692,895	$ 16,770,671	$ 18,065,792	$ 14,702,361
Plan fiduciary net position as a percentage of the total pension liability	77.97%	78.19%	90.49%	77.71%
KHS' fiduciary net position as a percentage of KHS' total pension liability	86.03%	87.00%	101.08%	88.20%

* Fiscal year 2015 was the first year of implementation, therefore only nine years are shown. For the fiscal year ended December 31, 2016 CALPERS combined the Classic and Pepra Plans into one plan. Therefore, the information presented for the years ended 2023 through 2016 for the miscellaneous Classic Plan includes the Pepra Plan.

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

KERN HEALTH SYSTEMS

SCHEDULES OF PROPORTIONATE SHARE OF THE NET PENSION (ASSET) LIABILITY
As of December 31, 2023

		2015
CalPERS - Miscellaneous PEPRA Plan - Last 10 Years **		
Proportion of the net pension liability		0.00362%
Proportionate share of the net pension (asset) liability	$	(30,922)
Covered - employee payroll	$	6,909,343
Proportionate share of the net pension liability as a percentage of covered-employee payroll		-0.45%
Plan's fiduciary net position (in thousands)	$	10,639,461
Plan fiduciary net position as a percentage of the total pension liability		79.89%
KHS' fiduciary net position as a percentage of KHS' total pension liability		83.03%

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

KERN HEALTH SYSTEMS

SCHEDULES OF PENSION CONTRIBUTIONS
Year Ended December 31, 2023

	2023	2022	2021	2020
CalPERS - Miscellaneous Classic Plan - Last 10 Years*				
Contractually required contribution (actuarially determined)	$ 4,036,369	$ 3,516,567	$ 2,951,981	$ 2,536,160
Contributions in relation to the actuarially determined contributions	4,036,369	3,516,567	2,951,981	2,536,160
Contribution deficiency (excess)	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 21,502,725	$ 21,002,601	$ 20,710,645	$ 19,428,164
Contributions as a percentage of covered-employee payroll	18.77%	16.74%	14.25%	13.05%
Notes to Schedule				
Valuation date:	June 30, 2022	June 30, 2021	June 30, 2020	June 30, 2019
Methods and assumptions used to determine contribution rates:				
Actuarial cost method	Entry-Age Normal Cost Method			
Amortization method	Level percentage of assumed future payrolls			
Remaining amortization period	21 years	22 years	23 years	24 years
Asset valuation method	5-year smoothed market			
Inflation	2.30%	2.30%	2.50%	2.50%
Salary increases	2.80%	2.55%	2.75%	2.75%
Investment rate of return (a)	6.90%	6.90%	7.00%	7.15%
Retirement age	50 years and 5 years of service			
Mortality	(b)	(b)	(c)	(c)

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

(b) The mortality table used was developed based on CalPERS' specific data. The rates incorporate Generational Mortality to capture ongoing mortality improvements using 80% of Scale MP 2020 published by the Society of Actuaries.

(c) The mortality table used was developed based on CalPERS' specific data. The table includes 15 years of mortality improvements using Society of Actuaries Scale 90% of scale MP 2016.

* Fiscal year 2015 was the first year of implementation, therefore only nine years are shown. For the fiscal year ended December 31, 2016 CALPERS combined the Classic and Pepra Plans into one plan. Therefore, the information presented for the years ended 2023 through 2016 for the miscellaneous Classic Plan includes the Pepra Plan.

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

KERN HEALTH SYSTEMS

SCHEDULES OF PENSION CONTRIBUTIONS
Year Ended December 31, 2023

	2015
CalPERS - Miscellaneous PEPRA Plan - Last 10 Years*	
Contractually required contribution (actuarially determined)	$ 367,525
Contributions in relation to the actuarially determined contributions	367,525
Contribution deficiency (excess)	$ -
Covered-employee payroll	$ 6,909,343
Contributions as a percentage of covered-employee payroll	5.32%

Notes to Schedule

Valuation date:	June 30, 2014

Methods and assumptions used to determine contribution rates:

Actuarial cost method	Entry-Age Normal Cost Method
Amortization method	Level percentage of assumed future payrolls
Remaining amortization period	29 years
Asset valuation method	5-year smoothed market
Inflation	2.75%
Salary increases	3.00%
Investment rate of return (a)	7.50%
Retirement age	52 years and 5 years of service
Mortality	20 years of projected on-going mortality improvement using Scale BB published by the Society of Actuaries

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

OTHER INDEPENDENT AUDITOR'S REPORT

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SHANNON M. WEBSTER

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Kern Health Systems
Bakersfield, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements of **Kern Heath Systems**, as of and for the year ended December 31, 2023, and the related notes to the financial statements, which collectively comprise **Kern Health Systems**' basic financial statements, and have issued our report thereon dated April 3, 2024.

Report on Internal Control Over Financial Reporting

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

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

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

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

Report on Compliance and Other Matters

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

Purpose of This Report

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

Daniells Phillips Vaughan & Bock

Bakersfield, California
April 3, 2024

KERN HEALTH SYSTEMS

Report to the Finance Committee
April 3, 2024

DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

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Finance Committee
Kern Health Systems

Attention: Ross Elliot, Finance Committee Chair

We are pleased to present this report related to our audit of the financial statements **Kern Health Systems** for the year ended December 31, 2023. This report summarizes certain matters required by professional standards to be communicated to you in your oversight responsibility for **Kern Health Systems**' financial reporting process.

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

Daniells Phillips Vaughan & Bock

April 3, 2024

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Required Communications

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

Area	Comments
Our Responsibilities with regard to the Financial Statement Audit	Our responsibilities under auditing standards generally accepted in the United States of America have been described to you in our arrangement letter dated December 15, 2023. Our audit of the financial statements does not relieve management or those charged with governance of their responsibilities, which are also described in that letter.
Overview of the Planned Scope and Timing of the Financial Statement Audit	We have issued a separate communication regarding the planned scope and timing of our audit and have discussed with you our identification of and planned audit response to significant risks of material misstatement.
Accounting Policies and Practices	**Preferability of Accounting Policies and Practices** Under generally accepted accounting principles, in certain circumstances, management may select among alternative accounting practices. In our view, in such circumstances, management has selected the preferable accounting practice. **Adoption of, or Change in, Accounting Policies** Management has the ultimate responsibility for the appropriateness of the accounting policies used by the Organization. The Organization did not adopt any significant new accounting policies nor have there been any changes in existing significant accounting policies during the current period. **Significant or Unusual Transactions** We did not identify any significant or unusual transactions or significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus. **Management's Judgments and Accounting Estimates** Summary information about the process used by management in formulating particularly sensitive accounting estimates and about our conclusions regarding the reasonableness of those estimates is in the attached "Summary of Significant Accounting Estimates".

Area	Comments
Audit Adjustments	There were no audit adjustments proposed by us to be recorded by **Kern Health Systems**.
Uncorrected Misstatements	Uncorrected misstatements are summarized in the attached “Summary of Uncorrected Misstatements”.
Disagreements with Management	We encountered no disagreements with management over the application of significant accounting principles, the basis for management’s judgments on any significant matters, the scope of the audit, or significant disclosures to be included in the financial statements.
Consultations with Other Accountants	We are not aware of any consultations management had with other accountants about accounting or auditing matters.
Significant Issues Discussed with Management	No significant issues arising from the audit were discussed with or were the subject of correspondence with management.
Letter Communicating Deficiencies in Internal Control over Financial Reporting	We have separately communicated deficiencies in internal control over financial reporting to management identified during our audit of the financial statements, and this communication is attached as Exhibit A.
Certain Written Communications Between Management and Our Firm	Copies of significant written communications between our firm and management of the Organization, including the representation letter provided to us by management, are attached as Exhibit B.

KERN HEALTH SYSTEMS

Summary of Significant Accounting Estimates
Year Ended December 31, 2023

Accounting estimates are an integral part of the preparation of financial statements and are based upon management's current judgment. The process used by management encompasses their knowledge and experience about past and current events and certain assumptions about future events. You may wish to monitor throughout the year the process used to determine and record these accounting estimates. The following describes the significant accounting estimates reflected in the Organization's December 31, 2023, financial statements:

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

KERN HEALTH SYSTEMS

Summary of Uncorrected Misstatements
Year Ended December 31, 2023

During the course of our audit, we accumulated an uncorrected misstatement that was determined by management to be immaterial to the financial position, results of operations, cash flows and related financial statement disclosures. Following is a summary of those differences.

Management has represented that they concluded the misstatement was immaterial to the financial statements through their own internal analysis and research performed related to the implementation of the new Governmental Accounting Standards Board (GASB) 96 statement regarding the recording of software subscription licenses. Management intends to implement GASB 96 during calendar year 2024.

	Effect - Increase (Decrease)				
Description	**Assets**	**Liabilities**	**Equity**	**Income**	**Expenses**
To record the right-of-use-asset and corresponding liability at 12.31.2023 regarding subscription licenses as required by GASB 96	$ 6,799,897	$ 6,799,897	$ -	$ -	$ -

Exhibit A
Letter Communicating Deficiencies in Internal Control over Financial Reporting

DANIELLS PHILLIPS VAUGHAN & BOCK
CPAs and Advisors

An independently owned member RSM US Alliance

Member of AICPA Division for Firms
Private Companies Practice Section

SHANNON M. WEBSTER

To the Board of Directors and Management
Kern Health Systems
Bakersfield, California

In planning and performing our audit of the financial statements of **Kern Health Systems** (the Organization) as of and for the year ended December 31, 2023, in accordance with auditing standards generally accepted in the United States of America, we considered the Organization's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing, or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed or when the person performing the control does not possess the necessary authority or competence to perform the control effectively.

A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Following are descriptions of other identified deficiencies in internal control that we determined did not constitute significant deficiencies or material weaknesses:

Cash Disbursements

Two of thirty cash disbursement transactions lacked evidence of documented review and approval. Both transactions did not contain the required two signatures on the approved invoice list as required for transactions in excess of $50,000, specifically, the lack of a second signature evidencing proper and complete review as required by the Organization's internal control policies and procedures. The Organization should review and adhere to its current internal control policies and procedures regarding the documentation of proper and complete review and approval of transactions.

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

Management's Response

The Organization requires two signatures from Accounting Department Management, indicating review, on the check request form of administrative transactions in excess of $50,000 prior to checks being presented to executives for signatures. The documentation saved for two of the transactions sampled did not contain evidence of a second review signature for items over $50,000 as it was inadvertently missing from our scanned files. Though the Accounting Department has mitigating controls in place to identify unauthorized purchases, such as executive review and signature on all checks, the Organization has since implemented a secondary monthly review process to ensure appropriate documentation is present in our electronic files to support weekly administrative payments transactions and demonstrate compliance with our internal control processes.

Credit Card Statement Review

In our review of credit card statements for the two months tested, we noted no documentation of the review and approval of the respective credit card statements. Though the majority of credit card transactions must have a purchase order prior to the purchase and therefore already have inherent approval, the lack of documented review over the credit card statements could result in unauthorized uses of credit cards. Additionally, the Organization has a function whereby the Accounting Manager reviews the credit card statements for propriety, however, there was no documented evidence of this review. The Organization should establish controls whereby the review and approval of the credit card statements are evidenced by a signature of the reviewer. This will further safeguard against unauthorized or inappropriate credit card purchases and improve controls over credit card users and transactions.

Management's Response

Department Management is responsible for the review of credit card transactions included in the monthly statements. Accounting Department Management matches each credit card transaction to approved purchase orders and verifies no unauthorized charges were present. The Organization has since implemented additional procedures and now requires two signatures included on the electronic transaction forms demonstrating this process of review has taken place.

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

Daniells Phillips Vaughan & Bock

Bakersfield, California
April 3, 2024

Exhibit B
Representation Letter

KERN HEALTH SYSTEMS

April 3, 2024

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

This representation letter is provided in connection with your audits of the basic financial statements of **Kern Health Systems** (the Organization) as of December 31, 2023 and 2022 for the purpose of expressing an opinion on whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP)

We confirm, to the best of our knowledge and belief, that as of April 3, 2024:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated December 15, 2023, for the preparation and fair presentation of the financial statements referred to above in accordance with U.S. GAAP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. In the audit engagement letter dated December 15, 2023, we requested that perform the following accounting services in connection with your audit:

    a. Draft the financial statements;

    b. Proposing adjusting journal entries; and

    c. Provide guidance on new authoritative pronouncements.

    With respect to these services:

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

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

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

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

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

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

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

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

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

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

e. Medical malpractice obligations expected to be incurred with respect to services provided through December 31, 2023.

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

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

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

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

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

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

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

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

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

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

20. In addition, we believe that the actuarial assumptions and methods used by the actuary for funding purposes and for determining the IBNR accrual are appropriate in the circumstances. We did not give instructions, or cause any instructions to be given, to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the Organization's actuary.

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

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

23. We have reviewed the GASB Statements effective for the fiscal year ending December 31, 2023, and concluded the implementation of the following Statements did not have a material impact on the basic financial statements:

    a. GASB Statement No. 96, *Subscription-Based Information Technology Arrangements*.

24. We have informed you of all uncorrected misstatements.

    As of and for the year ended December 31, 2023, we believe that the effects of the uncorrected misstatements aggregated by you and summarized below are quantitatively and qualitatively immaterial, both individually and in the aggregate, to the financial statements. For purposes of this representation, we consider items to be material, regardless of their size, if they involve the misstatement or omission of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

	Effect - Increase (Decrease)				
Description	**Assets**	**Liabilities**	**Equity**	**Income**	**Expenses**
To record the right-of-use-asset and corresponding liability at 12.31.2023 regarding subscription licenses as required by GASB 96	$ 6,799,897	$ 6,799,897	$ -	$ -	$ -

25. We have requested an unsecured electronic copy of the auditor's report and basic financial statements and agree that the auditor's report and basic financial statements will not be modified in any manner.

Information Provided

26. We have provided you with:

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

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

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

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

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

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

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

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

    a. Management.

    b. Employees who have significant roles in internal control.

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

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

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

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

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

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

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

37. We agree with the findings of the specialists in evaluating the incurred but not reported claim liability and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give instructions, or cause any instructions to be given, to the specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialist.

38. We believe that the actuarial assumptions and methods used by the actuary for funding purposes and for determining accumulated plan benefits are appropriate in the circumstances. We did not give instructions, or cause any instructions to be given, to the actuary with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the plan's actuary.

39. The following have been made available to you:

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

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

40. There are no:

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

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

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

Supplementary Information

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

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

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

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

Compliance Considerations

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

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

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

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

46. Is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

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

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

Kern Health Systems

CEO

Emily Duran, Chief Executive Officer

Robert Landis CFO

Robert Landis, Chief Financial Officer

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Alan Avery, Chief Operating Officer

SUBJECT: Provider Satisfaction Survey

DATE: April 18, 2024

BACKGROUND

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

The provider types surveyed are Primary Care Providers, Specialists, Behavioral Health, Hospitals, Urgent Care Facilities, and Ancillary Providers. The survey was conducted over three waves during Q2 2023 and measured the Plan's Calendar Year (CY) 2022 performance.

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

One key rating to highlight is Kern Health Systems' overall satisfaction rating of 90.5%. The Medicaid Line of Business overall satisfaction rate for like plans surveyed was 70.8% satisfaction. KHS also scored much higher when compared to local competitors.

Included is a presentation that summarizes the CY 2022 Provider Satisfaction Survey results and outlines efforts to continue to the Plan’s favorable rating within our Provider Network.

REQUESTED ACTION

Receive and file.

KERN HEALTH SYSTEMS

2023 Provider Satisfaction Survey,
Calendar Year 2022
Survey Results

Report Prepared For
KHS Board of Directors
April 18th, 2024

BACKGROUND/METHODOLOGY

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

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

For 2023, 182 total surveys were received, down from 219 surveys received the prior year. KHS utilizes incentives for provider offices to try and promote survey participation.

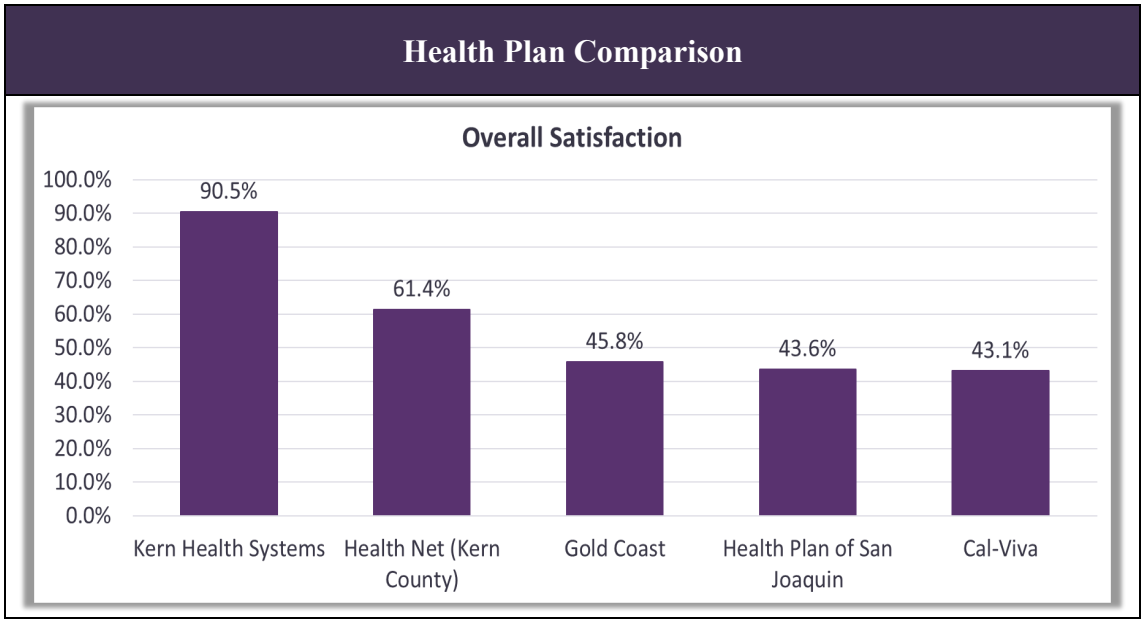
RESULTS

In the tables below, summary rate represents the most favorable response percentages. KHS experienced increases amongst seven (7) of the eight (8) scoring composites when compared to the prior year’s Provider Satisfaction Survey. KHS scored within the 75th percentile or higher in all scoring composites/attributes, with both Utilization Management & Quality Improvement and Provider Relations in the 100th percentile when compared against PG's 2022 Medicaid Book of Business.

Composite Scores: CY 2019 - CY2022				
Composites/ Attributes	KHS CY 2019 Summary Rate	KHS CY 2020 Summary Rate	KHS CY 2021 Summary Rate	KHS CY 2022 Summary Rate
Overall Satisfaction	88.30%	84.70%	85.20%	90.50%
Compared to Other Plans	64.30%	55.70%	62.10%	70.80%
Compensation	58.10%	52.00%	53.50%	58.30%
UM & Quality	54.10%	50.70%	51.50%	64.20%
Network/COC	52.70%	47.70%	55.70%	50.60%
Health Plan Call Center	55.40%	61.10%	50.60%	64.50%
Provider Relations	70.50%	61.70%	70.80%	73.30%
Recommend to Other MDs	96.10%	94.80%	95.30%	98.30%

Composite Scores: KHS vs SPH 2022 Medicaid Book of Business				
Composites/Attributes	KHS 2022 Summary Rate	2022 National Medicaid Summary Scores		Percentile Ranking (At or Above 75th)
Overall Satisfaction	90.50%	71.70%	Favorable	99th
Other Local Plans	70.80%	41.80%	Favorable	99th
Compensation	58.30%	37.80%	Favorable	96th
UM & Quality	64.20%	38.10%	Favorable	100th
Network/COC	50.60%	34.90%	Favorable	95th
Health Plan Call Center	64.50%	41.10%	Favorable	99th
Provider Relations	73.30%	36.60%	Favorable	100th
Would Recommend	98.30%	87.70%	Favorable	98th

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



TRENDS

In comparing the 2023 Provider Satisfaction Survey results, PG Analytics identified measures that had the greatest improvement and decline.

Trending Up, measures that increased significantly compared to prior year:

- Access to knowledgeable UM staff
- Procedures for obtaining pre-certification/referral/authorization information
- Timeliness of obtaining pre-certification/referral/authorization information
- Access to Case/Care Managers from this health plan
- Ease of reaching health plan call center staff over the phone
- Process of obtaining member information
- Helpfulness of plan call center staff in obtaining referrals
- Overall satisfaction with health plan's call center service

Trending Down, measures that decreased significantly compared to prior year:

- None identified.

STRENGTHS/OPPORTUNITIES

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

Strengths

- Timeliness of obtaining pre-certification/referral/authorization information
- Health plan's facilitation/support of appropriate clinical care for patients
- Procedures for obtaining pre-certification/referral/authorization information
- Quality of provider orientation process
- Quality of written communications, policy bulletins, and manuals
- Overall satisfaction with health plan's call center service

Opportunities

- None Identified

LANGUAGE ASSISTANCE PROGRAM ASSESSMENT

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

CULTURAL COMPETENCY

In addition to the language assistance program questions, new cultural competency questions were added as part of the 2023 survey. These questions consisted of multiple topics, including how providers access' patient's cultural needs and what assistance can KHS provide to help providers provide culturally competent care. The results of these questions were shared with the KHS' Health Equity Department.

NEXT STEPS

The Provider Network Management Department met with KHS Department leadership individually and reviewed the survey results. Due to the high satisfaction scores across all departments, no corrective action was requested.

Within the past year, KHS has experienced significant growth within both our membership and our provider network. In January 2024, KHS membership increased by approximately 60,000 members due to the Local Plan transition. As of the close of 2023, KHS had over 3,600 unique providers. Through this period of growth, our goal is to continue to maintain the high provider satisfaction we have seen year over year.

KHS will continue to utilize PG Analytics and the 2024 Provider Satisfaction Survey, CY 2023 will kick off April 2024.

2023 Provider Satisfaction Survey Results

Calendar Year 2022

Board of Directors

April 18th, 2024

KERN HEALTH SYSTEMS

Background & Timeline

- KHS conducts an annual provider satisfaction survey
- The 2023 survey measured the CY 2022 KHS performance with network providers
- Press Ganey (PG) Analytics, formerly SPH Analytics, conducted the survey on behalf of KHS
- KHS Performance is benchmarked to HMO industry performance for similar measures
- Survey was conducted over three (3) waves during Q2 2023

Survey Panel

Surveys were sent to the following provider types:

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

- 182 Total Surveys received
  - *CY 2021:* 219 surveys received
  - Provider offices incentivized for survey completion
- Confidence Level
  - Survey sample at 95% confidence level.

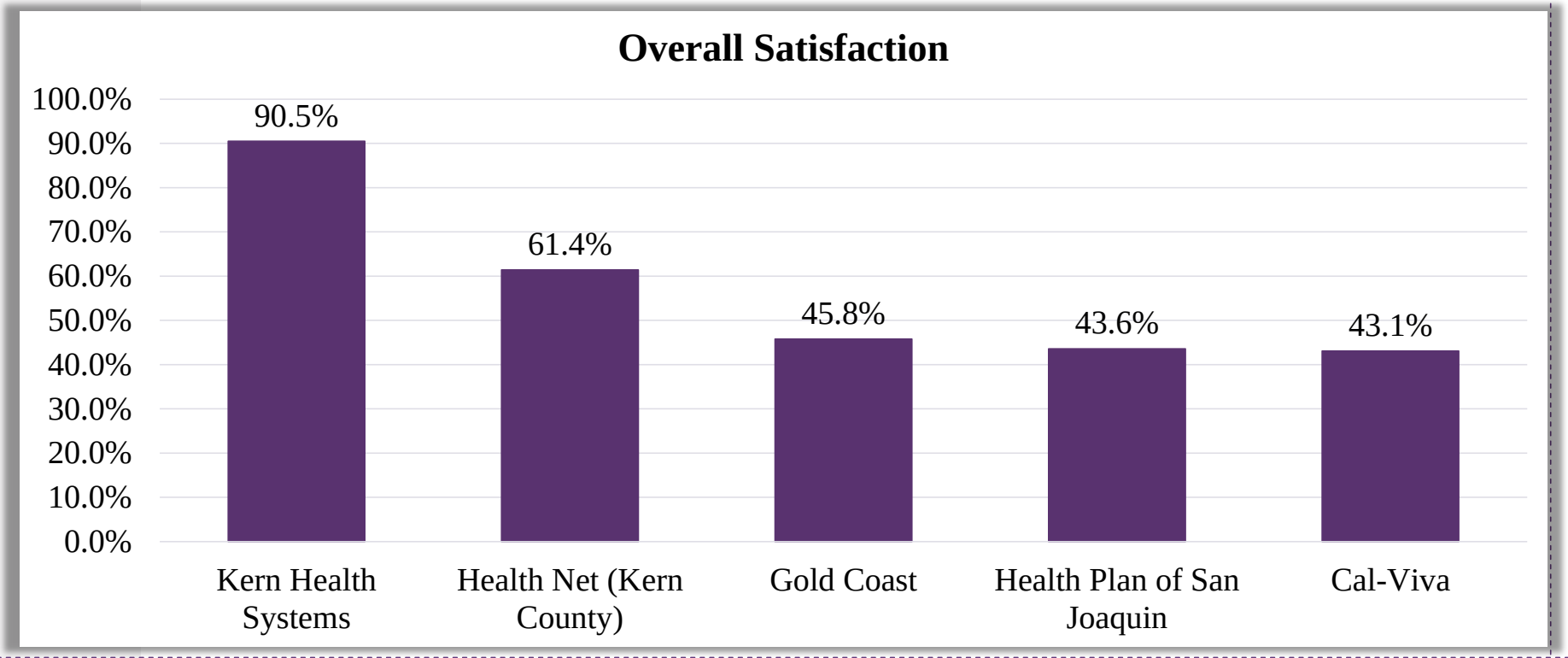
Report Highlights: 2019 - 2022

Composites/ Attributes	KHS CY 2019 Summary Rate	KHS CY 2020 Summary Rate	KHS CY 2021 Summary Rate	KHS CY 2022 Summary Rate
Overall Satisfaction	88.3%	84.7%	85.2%	90.5%
Compared to Other Plans	64.3%	55.7%	62.1%	70.8%
Compensation	58.1%	52.0%	53.5%	58.3%
UM & Quality	54.1%	50.7%	51.5%	64.2%
Network/COC	52.7%	47.7%	55.7%	50.6%
Health Plan Call Center	55.4%	61.1%	50.6%	64.5%
Provider Relations	70.5%	61.7%	70.8%	73.3%
Recommend to Other MDs	96.1%	94.8%	95.3%	98.3%

Report Highlights: 2022

Composites/ Attributes	KHS 2022 Summary Rate	2022 National Medicaid Summary Scores		Percentile Ranking (At or Above 75th)
Overall Satisfaction	90.5%	71.7%	**Favorable**	**99th**
Other Local Plans	70.8%	41.8%	**Favorable**	**99th**
Compensation	58.3%	37.8%	**Favorable**	**96th**
UM & Quality	64.2%	38.1%	**Favorable**	**100th**
Network/COC	50.6%	34.9%	**Favorable**	**95th**
Health Plan Call Center	64.5%	41.1%	**Favorable**	**99th**
Provider Relations	73.3%	36.6%	**Favorable**	**100th**
Would Recommend	98.3%	87.7%	**Favorable**	**98th**

Health Plan Comparison



Trends

Trending Up

Measures that increased significantly compared to prior year

- Access to knowledgeable UM staff
- Procedures for obtaining pre-certification/referral/authorization information
- Timeliness of obtaining pre-certification/referral/authorization information
- Access to Case/Care Managers from this health plan
- Ease of reaching health plan call center staff over the phone
- Process of obtaining member information
- Helpfulness of plan call center staff in obtaining referrals
- Overall satisfaction with health plan’s call center service

Trending Down

Measures that decreased significantly compared to prior year

- None Identified

Strengths/Opportunities

Key measures the drove overall scores within KHS results

Strengths

- Timeliness of obtaining precertification, referral, and authorization information
- Health plan's facilitation/support of appropriate clinical care for patients
- Procedures for obtaining pre-certification/referral/authorization information
- Quality of provider orientation process
- Quality of written communications, policy bulletins, and manuals
- Overall satisfaction with health plan's call center service

Opportunities

- None Identified

Next Steps

- Reviewed survey results/provider feedback with KHS Department leadership - Completed
- Continue to maintain high provider satisfaction scores through period of substantial organization growth
  - Local Plan Transition – additional 60,000 members in January 2024
- Continue to work with third party vendor, PG Analytics to gauge provider satisfaction. CY 2023 survey will kick-off Q2 2024

Questions

For additional information, please contact:

Alan Avery
Chief Operating Officer
(661) 664-5000

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Alan Avery, Chief Operations Officer

SUBJECT: 2023 Member Satisfaction Survey Summary

DATE: April 18, 2024

Background

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

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

2023 was the fourth year KHS selected Press Ganey to conduct the KHS MY 2022 CAHPS® Medicaid Adult Simulation Survey for the 2023 Member Satisfaction Survey. (NCQA made no changes to the survey or program for 2023 which is why the MY 2022 CAHPS® Medicaid Adult Simulation Survey was used again.) NCQA requires health plans to submit CAHPS survey results in compliance with HEDIS® accreditation requirements. The objective of the study is to capture accurate and compete information about member-reported experiences with health care to measure how well health plans are meeting their members' expectations.

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

The 2023 Member Satisfaction Survey results show that KHS has a 72.0% overall satisfaction rate which is higher than the 60.7% Region 9 benchmark. We continue our efforts to encourage members to be engaged in their health care and to use the results of tools such as the Member Satisfaction Survey to listen to their needs and improve our member engagement strategies.

Requested Action

Receive and File.

Kern Family Health Care®

2023 Member Satisfaction Survey

Introduction and Objectives

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

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

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

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

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

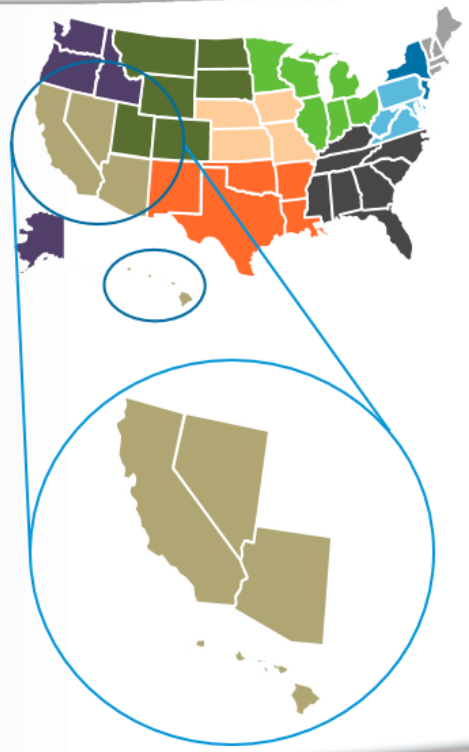
Kern Family Health Care

Methodology

- A sampling of 5,000 KFHC eligible member households was selected and 4997 were eligible.
  - Qualified respondents:
    - 18 years and older (as of December 31st of the measurement year)
    - Continuously enrolled in the plan for at least five of the last six months of the measurement year
  - There were a total of 540 completed responses.
    - 334 completed responses by mail.
    - 206 completed responses on the internet.
    - 10.8% response rate, with a 10.2% ↑ increase versus last year.
- Results were measured in comparison with other plan survey data for the Region
- The study is used to identify areas of needed improvement
- Strategies are developed and implemented to improve member experience and satisfaction

Region 9: San Francisco

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



Kern Family Health Care

Regional Performance

KHS scored significantly higher than the regional rate for *Rating Health Plans* and exceeded the regional rates of other measurement areas. The results for *Getting Care Quickly, Coordination of Care, and How Well Doctors Communicate* show a need for improvement.

Patient Experience	KHS Summary Rate (%)	2023 SPH BoB Region (%)	Performance Indicator
Rating of Health Plan	72.0	60.7	↑
Rating of Health Care	61.5	53.5	↑
Rating of Personal Doctor	71.6	65.1	↑
Getting Needed Care	84.5	78.4	↑
Getting Care Quickly	80.7	75.4	↑
Customer Service	91.6	88.2	↑
Coordination of Care	82.7	83.6	↓
How Well Doctors Communicate	92.5	91.1	↑

Kern Family Health Care

Key Drivers of Rating of Health Plan

TOP 10 KEY DRIVERS

YOUR PLAN

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

INDUSTRY

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

ALIGNMENT *Are your key drivers typical of the industry?*	KEY DRIVER RANK		ATTRIBUTE		SUMMARY RATE SCORE		PG BoB %TILE*		CLASSIFICATION		
	YOUR PLAN	INDUSTRY			YOUR PLAN	INDUSTRY			Sample 1		Sample 2
			Q28	**Rating of Health Plan**	**72.0%**	**63.6%**	**96th**	*(+3)*			
✓	1	1	Q8	Rating of Health Care	61.5%	56.8%	83rd	*(+2)*	Power		Power
✓	2	3	Q18	Rating of Personal Doctor	71.6%	69.2%	68th	*(+37)*	Opp.	→	Power
✓	3	4	Q9	Getting care, tests, or treatment	85.4%	84.8%	55th	*(+14)*	Opp.	→	Power
✓	4	8	Q24	Provided information or help	88.9%	84.5%	82nd	*(+22)*	Power		Power
✓	5	6	Q4	Getting urgent care	83.7%	82.7%	54th	*(+27)*	Opp.	→	Power
✓	6	9	Q13	Dr. listened carefully	92.7%	92.9%	47th	*(+37)*	Wait	→	Opp.
✓	7	7	Q25	Treated with courtesy and respect	94.3%	95.0%	38th	*(-1)*	Wait	→	Opp.
✓	8	2	Q22	Rating of Specialist +	67.5%	67.4%	53rd	*(+6)*	Opp.	→	Power
	9	11	Q20	Getting specialist appointment	83.7%	79.1%	80th	*(+35)*	Opp.	→	Retain
✓	10	10	Q14	Dr. showed respect	96.9%	94.6%	89th	*(+39)*	Wait	→	Retain

CLASSIFICATION LEGEND

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

2024 Performance Improvement Strategy

KHS will implement the following improvement strategies in 2024 based on the 2023 MSS responses.

- Continue to learn of ways to expand member engagement activities to assist members with coordination of care.
- Continue to discover opportunities for ways to improve member and provider communication through technology using multiple modalities.
- Continue ongoing and timely reminders and messaging to promote member rewards programs and encourage member engagement in their own health care.
- Continue efforts to improve customer relations management to improve the member experience.

Kern Family Health Care

2023 Performance Improvement Review

In 2022 the results of the study provided four key areas where there were opportunities for improvement. Listed are the strategies and subsequent efforts adopted by KHS to improve member experience and satisfaction. The 2023 results are evidence that the strategies KHS implemented assisted in improving the summary rate scores.

Recommended Strategy	Result
Evaluate and implement institutionalizing telehealth and street medicine to alleviate access to care challenges.	• KHS is now contracted with 2 street medicine provider groups and 128 telehealth provider groups with a total of 707 providers who provide these services.
Discover opportunities for improved member and provider communication through technology using multiple modalities.	• KHS increased outreach in 2023 through manual outreach calls, robocalls, and text messages. • KHS will soon be adding an email component as another outreach channel and we are looking at chatbot technology as well. • KHS is continuing to explore other opportunities to improve member and provider communication.
Educate and engage members to encourage member action for health status improvement.	• KHS operationalized staffing for satellite offices located in the Northern, Eastern, and Western regions of Kern County. Through this strategy, along with the aforementioned strategy for gaps in care outreach, KHS is working to enhance member education for the goal of encouraging members to be owners of their own care. • KHS has developed a survey to gauge members' understanding of their benefits. Results will be used to improve ways in which we educate our members about their benefits and the importance of taking appropriate action to improve their health status.
Educate and engage providers to encourage improvement for how well doctors communicate with members.	• KHS is utilizing Member Engagement staff to perform outreach to members who have gaps in care to schedule their appointments and connect them with their providers.

Kern Family Health Care

For more information:

Alan Avery

Chief Operating Officer

(661) 664-5000

KERN HEALTH SYSTEMS

MEMORANDUM

TO: KHS Board of Directors

FROM: Martha Tasinga, MD, MPH, MBA, Chief Medical Officer

SUBJECT: Utilization Management Program Documents

DATE: April 18, 2024

Background

The KHS Utilization Management (UM) program is defined by the following three documents:

- The UM Program Description
- The UM Program Evaluation, and
- The UM Program workplan

These documents are updated annually and presented to the Physician Advisory Committee and the KHS Board of Directors for review, input, and approval as defined under our contract with the Department of Health Care Services (DHCS). Opportunities identified n the previous year's program Evaluation are considered in development of the following year's Program Work Plan.

Discussion

The goal of the UM department is to ensure members we serve receive high quality care in the right setting at the right time.

The UM Program Workplan identifies the primary activities that will occur throughout the current year. KHS strategic initiatives, corporate goals and State requirements in combination with outcomes of the previous year UM program evaluation are used to develop the work plan for 2024.

The workplan is a dynamic document that is updated throughout the year based on outcomes realized and priority shifts. Outcomes of the workplan are key to development of the annual program evaluation.

Requested Action

Approve the 2023 UM Program Evaluation, 2024 UM Program Description, and 2024 UM Workplan.

2024: Utilization Management Program

Board of Directors
April 18, 2024

Martha Tasinga, MD, MPH, MBA
Chief Medical Officer

KERN HEALTH SYSTEMS

Agenda

- 2023 Utilization Management Program Evaluation
- 2024 Utilization Management Program Description
- 2024 Utilization Management Workplan
- Program Direction for 2024

Utilization Management 2023 Program Evaluation – Key Actions Completed

Compliance with hierarchy of decision-making and ensuring consistent application of medical necessity determination criteria.	Provided MCG training annually and then and as needed based on changes to the guidelines. And additionally provided annual review of Medi-Cal guideline training and ongoing as needed for changes such as APLs To validate competencies performed inter-rater-reliability audits of UM staff performing prior authorization and institutional reviews to ensure proper application of guidelines. Identified GAPs were addressed with group trainings and one-to-one education as needed. **Goal achieved in performing IRR on all staff 95 percent of staff passed first attempt. 5 percent of staff has completed and passed with second attempt**
Developed and Utilized business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process.	Multiple report monitoring activities were developed to support the management of authorization referral request processing during each business day as a means to effectively assess staff availability matched to volume demands. The reports were run at intervals throughout the day. **The compliance threshold goal for referral processing activities was met at 95%.**
Ensure complian3ce regulatory directives & NCQA Standards by continuous updates of UM Program and P&Ps.	Throughout the year policies and procedures were revised or created to meet to DHCS 2024 Contract Readiness & NCQA Standards. **Goal achieved 100%.**

KERN HEALTH SYSTEMS

Utilization Management- 2024 Program Description

Overview

- Defines UM Program goals, objectives & functions
- Defines reporting structure and accountability
- Identifies Personnel roles and responsibilities
- Defines program scope & integration throughout organization
- Identifies 2024 UM Plan and Program activities
- Defines UM Process and strategies
- Outlines participating provide and involvement in meeting UM Program goals and objectives

Utilization Management- Committee

The Utilization Management committee

KHS committee structure was re-organized in 2023 to ensure the provision of equal and non-biased care for all the population served by KHS, in compliance with the regulatory requirements of the 2024 Department of Health Care Services (DHCS) contract and NCQA. The UM committee reports to the Executive Quality Improvement Health Equity Committee (EQIHEC) and supports the Quality Improvement Committee in the delivery and monitoring of medical services provided by KHS.

2024 Utilization Management Program Description
Key Strategies

The Utilization Management Program(UMP) is intended to provide a reliable mechanism to review, monitor, evaluate, recommend, and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

The UMP defines the processes that are developed and carried out to ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM activities are consistently applied to the management of medical, surgical, mental health, and substance use disorder services and benefits.

The UMP defines oversight activitiesto evaluate the effects of the UM program and process through the use of member and provider satisfaction data, staff performance and/or other appropriate methods. Provisions are in place to ensure separation of medical decisions from fiscal considerations to include the UM Affirmative Statement Attestation.

The KHS UMP promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, credentialing, and population health management activities.

Utilization Management 2024 Work Plan

1. The UM Department has adopted the Health Industry Collaboration Effort (HICE) Work Plan as the standard for analyzing and evaluating utilization management processes to detect potential over-and-under utilization of services and any barriers to access in the authorization process on a monthly and quarterly basis.

2. Identifies the UM program's primary activities throughout current year to include: Measurements of UM Metrics for Prior authorization, Institutional Reviews, Denials, Appeals, Readmissions, ER Usage, and SNF Inter-rater Reliability Audits, and Member and Provider satisfaction outcomes related to UM processes .

3. Establishes goals for the above-mentioned activities and reports quarterly outcomes to the UM Committee to address variances and make modifications to meet defined goals.

Utilization Management Requested Action

Approve:

- 2023 UM Program Evaluation
- 2024 UMN Program Description
- 2024 UM Program Workplan

Thank You

For questions, please contact:

Martha Tasinga, MD, MPH, MBA
Chief Medical Officer

KERN HEALTH SYSTEMS

2024 UTILIZATION MANAGEMENT WORKPLAN

INTRODUCTION:	The goal of the utilization management department is to ensure members we serve receive high quality care in the right setting at the right time. To ensure this goal is met, the utilization management department proposes the following interventions.
GOAL 1:	Ensure that qualified, licensed, healthcare professionals assess clinical information used for clinical decision making.

2023 INTERVENTIONS:	2024 GOAL(s):	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Ensure high quality new hire orientation training is provided to all new clinical staff. 2. Provide annual continuing education opportunities for the clinical staff. 3. Review and revise staff orientation materials, manuals and processes. 4. Implement verification process to validate continuing education completion and verification of certifications.	100% compliance with maintaining records of professional licenses and credentialing for staff that support clinical decision making to ensure KHS members receive medically necessary care at the right time in the most appropriate setting.	Utilization Review Manager	Ongoing

2024 Planned Interventions/Activities:

1. Ensure high quality new hire orientation training is provided to all new clinical and non-clinical staff.
2. Provide annual continuing education opportunities for the clinical and non-clinical staff.
3. Review and revise staff orientation materials, manuals and processes at least annually and as needed.
4. Implement verification process to validate continuing education completion and verification of certifications.
5. For medical necessity nationally recognized criteria, the UM nurses and physician reviewers will continue to utilize the **MCG Guidelines**. MCG guideline criteria sets offer evidence-based care guidelines for various care settings and conditions, developed by clinical editors, and based on peer-reviewed papers and research studies. The care guidelines are utilized by the KHS staff for outpatient referrals and procedures and inpatient concurrent hospital admission stays. The UM licensed staff reviewers will continue to undergo significant training as part of the new hire orientation process and then at regular intervals throughout the year to include, one-to-one training, UM inpatient concurrent review staff huddles, denied, modified case reviews, and inpatient denial reviews. Licensed staff UM reviews are monitored through a random selection of each reviewer's file reviews on a monthly basis as they apply to utilizing MCG guidelines.
6. A specialized training Inservice will be arranged in 2024. The training module included criteria access resource links, best practices, and hierarchical selection requirements in conformance with Medi-Cal regulations. Other aspects of the training covered application of benefits, how to locate and utilize the Medi-

Cal Provider Manuals and specialized Medi-Cal Programs.

7. KHS UM medical leadership will ensure adherence to a designated Medical Criteria policy and procedure developed in 2023 to facilitate more detailed guidance with UM criteria selection process. The proficiency of staff adherence to application of medical necessity is also measured through the Inter-rater Reliability (IRR) audit process as defined in the following goal. **This function will continue for 2024 as part of the new staff onboarding process, ongoing hands-on licensed staff training, formal training modules, and updated procedural guides as needed.**

GOAL 2:	Compliance with hierarchy of decision making, ensuring consistent application of medical necessity determination criteria.		
2023 INTERVENTIONS:	**GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR) 2. MCG training annual and as needed based on changes to the guidelines. 3. Annual review of Medi-Cal guideline training and for hire.	Inter-rater-reliability pass rate of **100%**	Utilization Review Manager	Ongoing

2024 Planned Interventions/Activities:

1. Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR)
2. MCG training annual and as needed based on changes to the guidelines.
3. Annual review of Medi-Cal guideline training and for hire.
4. The Inter-rater-reliability compliance rate will continue to be 100% for licensed reviewers with a passing score of 80% or greater for each IRR Case Review and with the concession that if they failed a case they were educated and retrained and a retest of 2 cases will transpire after the retraining.
5.

Providers Criteria

Regulations and Criteria Guidelines (Hierarchy of Criteria)
KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. Health Plan eligibility and coverage
2. Federal and state mandated criteria
   - California Code of Regulations Title 22,
   - California Code of Regulations Title 28,
   - CMS Code of Regulations Title 42,
   - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
   - Medi-Cal Provider Manuals,
   - CA DHCS All Plan Letters (APL),
   - DMHC All Plan Letters,
   - CA DHCS Policy and Procedure Letters (PPL),
   - 42 CFR section 438.915, 438.206.
   - Standardized Behavioral Health criteria (Title 9, DSM-V)
3. Nationally recognized criteria set
   - MCG Health LLC (Milliman Care Guidelines,)
   - UpToDate
4. Peer Reviewed Journal or Published Resources

Preventive Health
KHS will maintain and communicate preventive care protocols to providers. Preventive care will be provided in accordance with the following accepted guidelines:

- *The Guide to Clinical Preventive Services Report (Report on the US Preventive Services Task Force)*[1]
- *AAP Recommendations for Preventive Pediatric Health Care*
- *CHDP Medical Guidelines*
- *ACOG*

GOAL 3:	Ensure compliance with legislative and regulatory directives.		
2023 INTERVENTIONS:	**GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Participate in all appropriate legislative and regulatory workgroups and/or activities that may impact the UM department. 2. Update department policies and *procedures* to reflect these changes. 3. Implement a policy and procedure review plan to ensure directives are operationalized. 4. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	All new APLs will be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.	Utilization Management Director	Ongoing with Quarterly Review

2024 Planned Interventions/Activities:

1. Continue to participate in all appropriate legislative/regulatory and NCQA accrediting workgroups and/or activities that may impact the UM department.
   a. KHS will continue to demonstrate readiness with the DHCS 2024 Contract driven by the many CalAIM transformational goals to improve more coordinated person centered and equitable health care served.
   b. KHS will adhere to the expanded health services committee structure with the creation of a Quality Improvement Health Equity Transformation Committee (QIHETC) as the umbrella committee for all health service quality functions. The KHS internal existing health service committees as well as newly developed committees were converted to subcommittees to support, monitor and report the 2024 new contract requirements applying to each health services area to ensure compliance. In addition to the 2024 contract, multiple DHCS and Department of Managed Health Care (DMHC) APLs were released to guide operational and administrative requirements.
   c. Continue to comply with 2024 NCQA Standards and Guidelines in preparation for the 2025 NCQA accreditation process. ***The most current 2024 NCQA Accreditation Standards will be cross-walked to KHS health services activities to ensure compliance***.
2. Continue to update department policies and *procedures* to reflect these changes.
3. Implement a policy and procedure review plan to ensure directives are continuously operationalized throughout 2024.
4. Continue to participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.
5. Staff training will be continuous pertaining to the newly instituted documents and activities instituted through review of the policies and programs and collaborative meetings to facilitate best practices.
6. **All new APLs in 2024 will continue to be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.**

GOAL 4:	Ensure separation of medical decisions from fiscal considerations.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness does not compensate physicians or nurse reviewers for denials. KHS does *not* offer incentives to encourage denials of coverage or service". 2. Ensure this education is provided to all Utilization Management staff.	100% compliance with distribution and receipt of completion of affirmative statement about financial incentives.	Utilization Management Manager	Annually

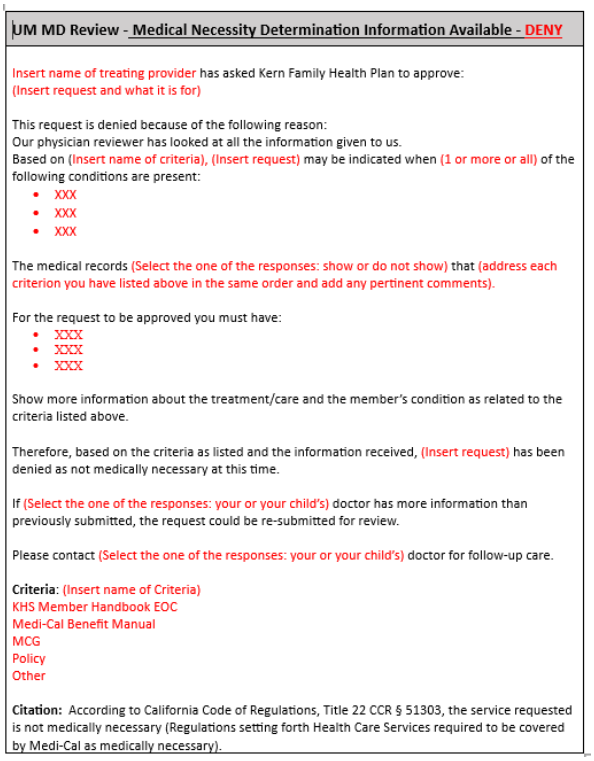
2024 Planned Interventions/ Activities:

1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness does not compensate physicians or nurse reviewers for denials. KHS does *not* offer incentives to encourage denials of coverage or service" in accordance with DHCS and DMHC requirements of ensuring there is separation of financial influences on medical necessity decision making. The Affirmative Statement will be distributed to UM staff by the KHS Human Resources Department.
2. Ensure this education is provided to all Utilization Management staff upon onboarding and annually.
3. The Affirmative Statement is now added as a standing agenda item for the UM Committee and will be required to be signed annually by each committee member as well as throughout the year for any newly participating committee attendee.
4. The KHS website will be updated in 2024 with the affirmative statement under the Utilization Management section.
5. **This Affirmative Statement will be implemented in 2024 and as a regulatory requirement, carried through from year to year.**

GOAL 5:	Ensure compliance with regulatory standards.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. File reviews to validate regulatory standards are met. 2. Education, both ongoing and remedial will be provided to staff on any issues revealed during the file review process	Documented use of guidelines in medical necessity determinations will be in compliance with State, Federal and other regulatory requirements 95%	Utilization Review Manager/Trainor and Supervisor	Quarterly

2024 Planned Interventions/Activities:

1. File reviews will continue to be conducted by UM trainor/designee monthly or as determined by UM leadership. Clinical nurses will at least annually receive training consisting of best practices and compliance requirements for UM medical necessity and application of criteria and benefit review cases to include denial / delay / modified. Methodology will include a selection of 5 random cases from the universe for each staff being reviewed. The case documents, medical necessity criteria selected by the reviewer and the reviewers written rational and decision determinations will be cross referenced to the Notice of Action Letter as follows:
    a. Spelling/Grammar, Verbiage, and Format,
    b. Medi-Cal Criteria applied,
    c. Criteria indicated and attached,
    d. Recommendations to MD indicated.
2. Fille review will ensure 95% compliance with referral decision making and member and provider notification timeliness standards in congruence with regulatory and accrediting standards.
3. Any deficiencies identified will be followed through with one-to-one continued training until they meet the threshold goal of 95%in 2024 (threshold was 85% in 2023).
4. Ongoing remedial training as needed will be provided throughout the year.
5. A new medical review template will be implemented for the UM clinical review team (nurses and physicians). The template is used as a standard in the Medi-Cal industry and encompasses a formatted sequential process to apply medical criteria and rationale for any adverse determinations based on the individual needs of the member.



UM MD Review - Medical Necessity Determination Information Available - DENY

Insert name of treating provider has asked Kern Family Health Plan to approve:
(Insert request and what it is for)

This request is denied because of the following reason:
Our physician reviewer has looked at all the information given to us.
Based on (Insert name of criteria), (Insert request) may be indicated when (1 or more or all) of the following conditions are present:

- XXX
- XXX
- XXX

The medical records (Select the one of the responses: show or do not show) that (address each criterion you have listed above in the same order and add any pertinent comments).

For the request to be approved you must have:

- XXX
- XXX
- XXX

Show more information about the treatment/care and the member's condition as related to the criteria listed above.

Therefore, based on the criteria as listed and the information received, (Insert request) has been denied as not medically necessary at this time.

If (Select the one of the responses: your or your child's) doctor has more information than previously submitted, the request could be re-submitted for review.

Please contact (Select the one of the responses: your or your child's) doctor for follow-up care.

Criteria: (Insert name of Criteria)
KHS Member Handbook EOC
Medi-Cal Benefit Manual
MCG
Policy
Other

Citation: According to California Code of Regulations, Title 22 CCR § 51303, the service requested is not medically necessary (Regulations setting forth Health Care Services required to be covered by Medi-Cal as medically necessary).

6. **This file review audit function will continue for 2024 as a best practice.**

GOAL 6:	Monitoring of the utilization management review process.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Utilize business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process. 2. Assess staffing requirements to complete the prior authorization process timely and ensure an adequate budget is allocated to meet the staffing needs.	Track and trend authorization activity on a monthly basis including: 1. Number of prior authorization requests submitted, approved, deferred, denied, modified and maintain compliance timeliness rate of 95 %. 2. Denials appealed and overturned compliance rate of 5 % or <.	Utilization Management Director and Manager	Monthly

2024 Planned Interventions/Activities:

1. Utilize business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process in a time sensitive, efficient manner while aligning practice with all regulatory and statutory requirements.
2. Assess staffing requirements to complete the prior authorization process timely; maintain compliance threshold goal of 95% or better.
3. Multiple report monitoring activities will continue to be updated/ developed to support the management of authorization referral request processing during each business day serves as a means to effectively assess staff availability matched to volume demands.
4. To mitigate any adverse TAT trends found in each given month, a monthly management UM huddle meeting will continue to transpire to review the processing results, with a drill down on the causation of any cases that failed to meet requirements. This process will be supported with ongoing training of staff and continued evaluation of work processes to identify opportunities for streamlining processes.
5. Ensure an adequate budget is allocated to meet the staffing needs.
6. **This audit function will continue for 2024.**

GOAL 7:	Compliance with timeliness of processing. Turn Around Times (TAT**)**

2023 INTERVENTIONS:	2024 GOAL(s):	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Monitoring of the Turn Around Time (TAT) by type on a routine basis using business intelligence reporting tools. 2. Weekly evaluation to identify barriers to meeting utilization management timeline standards, 3. Develop action plans to address deficiencies. 4. Ongoing focus on meeting TAT requirements. 5. Monthly Management review or TAT results, with drill down on all cases that fail to meet TAT requirements. 6. Ongoing training or staff and evaluation of work processes to identify opportunities for streamlining process.	Compliance with DHCS/ DMHC/NCQA turn-around timeframes. >/= 95% by type of request.	Utilization Review Trainor/ Manager and Supervisor	Daily

2024 Planned Interventions/Activities:

1. Monitoring of the Turn Around Time (TAT) by type on a routine basis using business intelligence reporting tools.
2. Weekly evaluation to identify barriers to meeting utilization management timeline standards.
3. Develop action plans to address deficiencies.
4. Ongoing focus on meeting TAT requirements.
5. Monthly Management review or TAT results, with drill down on all cases that fail to meet TAT requirements multiple monitoring reports to monitor authorization processing TATs were developed.
6. Ongoing training or staff and evaluation of work processes to identify opportunities for streamlining process.
   a. Routine request: the initial time is established from the day following receipt with a TAT of 5 business days to be completed in full.
   b. For time stamped via the urgent the time frame will begin in at the hour, minute, and second of KHS receipt of request. i.e. date provider portal, fax, or call-in requests by which the time of the call in is recorded by the UM representative in receipt of the verbal request. The Turnaround time is 72 hours. Urgent requests will be prioritized.
   c. The compliance goal is 95% for routine and urgent.
7. **This process will continue as part of the 2024 UM Work Plan.**

GOAL 8:	Consistency with which criteria are applied in UM decision-making and opportunities for improvement are acted upon.		
2023 INTERVENTIONS:	**2024 GOAL(s)**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct quarterly interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making.	Physician and nonphysician UM reviews 5 files achieving passing score on	Clinical Supervisor	Quarterly

	MCG IRR Tool.		

2024 Planned Interventions/Activities:

1. Conduct quarterly interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making (clinical – Physician reviewers/nurses and non-clinical staff such as coordinators.
2. For 2024 the IRR testing process will expand to non-licensed UM staff to evaluate and as needed to optimize UM efficiencies. The focus of the non-licensed IRR process will focus on administrative proficiency standards such as verification of benefits, checking the UM system to ensure a service is not duplicative or requested within the benefit period, ensuring medical necessity records are attached and following protocols to collect the records and so on.
3. The file review process will include application of the approved UM criteria.

GOAL 9:	Appeals and Dispute Management Compliance		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times. 2. Analyze the UM appeal review to identify trends. 3. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned. 4. Ensure appeals are processed by specialty-matched physicians.	Ensure >/= 90% accuracy of all determinations while complying with regulatory tum-around times	Utilization Review Manager and Supervisor	Monthly

2024 Planned Interventions/Activities:

1. Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times.
2. Analyze the UM appeal review to identify trends.
3. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned.
4. Ensure appeals are processed by specialty-matched physicians
5. Appeals will continue to be tracked and trended according to the number of Appeals cases overturned, upheld or partially upheld.
6. As a DHCS contractual requirement, KHS will continue to submit Appeals data routinely to the department to include an aging TAT.
7. When there is a specific provider trend of not complying with proper service request medical records and documentation submission in accordance with KHS policies and protocols, the Provider Network Department will be notified to assist in educating the provider and instituting steps to mitigate any adverse trends that may create a barrier to members receiving timely medically necessary services.
8. **2024 Appeals monitoring and reporting will continue as a category in the UM Work Plan.**

GOAL 10:	Monitoring of over and under utilization		
INTERVENTIONS:	**GOAL (s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of stay. Acute care stay, ER visits per thousand. all-cause readmissions, readmissions within 30 days, C-Section ratio. 2. Aggregate LOS specialty referral review Assessments on a biannual basis.	5% improvement of current statistical baseline.	UM Medical Director	Monthly

2024 Planned Interventions/Activities:

1. Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of stay. Acute care stay, ER visits per thousand. all-cause readmissions, readmissions within 30 days, C-Section ratio.
2. Will continue to aggregate LOS specialty referral review Assessments on a biannual basis.
3. **For Underutilization:**
   a. The UM department will continue to perform the following activities and reports the results to the UM/QI Committee at least quarterly:
      - Letters to the member's PCP with a count of their assigned members who still need an IHA. These letters direct the PCP to the Provider Portal to review their list and perform outreach activities.
      - Letters are also mailed to the PCP regarding members who have open authorizations. Open authorizations are defined as any auth that has not expired and has no claim attached to it. The auth does not need to be fulfilled to no longer be considered open.
      - Letters are mailed out to each PCP at each location where they have members assigned.

   b. **Th IHA process will continue in 2024.**
4. **Overutilization**
   a. Track and identify members going to ER during regular PCP business hours for non-emergent conditions
      - Conduct PCP access and availability study during normal business hours.
      - Report of auditor findings will be sent to PCP identifying members who were not able to access PCP.
      - PCPs will do outreach educational calls in collaboration with KHS designated staff as determined.
5. Continue to track & trend over- utilization of non-contracted providers and under-utilization of qualified contracted in-network providers.

GOAL 11:	Consistent referral of members for specialty program consideration originating from utilization management.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**

1. Assessment of each member with an inpatient encounter with the purpose of Identifying a condition that would warrant additional specialty care management and *refer* for consideration prior to encounter closure. 2. Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer.	25% increase of referrals over current baseline each quarter until >/= 90% of eligible members are referred *for* specialty program consideration.	Utilization Review Manager and Supervisor	Ongoing

2024 Planned Interventions/Activities:

1. Assessment of each member with an inpatient encounter with the purpose of Identifying a condition that would warrant additional specialty care management and *refer* for consideration prior to encounter closure.
2. Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer.
3. The referral program strategy and intervention will be carried through to 2024. In 2023, a baseline was established for each service and will be measured and compared throughout 2024 on the reports. Additionally, follow through with the referral will be conducted and documented to provide further insight into the effectiveness of the increased referrals as it pertains to supporting the members with specific goals.

GOAL 12:	Coordination of care with California Children's Services (CCS).		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Daily inpatient census will be reviewed, and any eligible member will be referred to CCS for service authorization request. 2. Weekly review of CCS business intelligence report to validate member's ambulatory referrals are authorized and encounters processed appropriately. 3. Quarterly review or reports to identify CCS eligible members that are near age out and referral to Case Management to facilitate smooth transition of provisions of care.	100% of eligible cases will be identified care will be coordinated with CCS as appropriate.	Utilization Review Manager and Supervisor	Quarterly

2024 Planned Interventions/Activities:

1. California Childrens Services (CCS) will continue to be monitored for inpatient institutional services and ambulatory care services.

   a. Business intelligence reports will continue to be utilized to capture CCS inpatient episodes of care for 2 categories to include general acute care and tertiary care. The episodes are aggregated from the KHS daily inpatient census for pediatric encounters. The inpatient concurrent review nurses will collaboratively verify through the UM designated CCS team to confirm members with a CCS condition if they had been approved by CCS and had a CCS authorization SAR on file as well as confirming the hospital the member was admitted to is CCS paneled. The report reflects this as CCS par (participating or CCS Non-par.

   b. All CCS cases identified through this process that have a SAR are considered a carve out from KHS's management of the actual CCS condition and financial responsibility. The UM and PHM teams will retain responsibility for supporting and authorizing the coordination of all other services not related to the CCS condition for the member, i.e., preventive health, incidental illnesses, routine care, injuries, etc.

2. CCS reporting will continue through 2024 as a UM standard and go through UMC outside of the 2024 work plan. CCS is a carved-out service and is not included in the 2024 HICE Work Plan .

KERN HEALTH SYSTEMS

UTILIZATION MANAGEMENT WORKPLAN 2023 EVALUATION

INTRODUCTION:	The goal of the utilization management department is to ensure members we serve receive high quality care in the right setting at the right time. To ensure this goal is met, the utilization management department proposes the following interventions.
GOAL 1:	Ensure that qualified, licensed, healthcare professionals assess clinical information used for clinical decision making.

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

EVALUATION: GOAL MET

KHS utilizes the following criteria sets for UM decision making.

Regulations and Criteria Guidelines (Hierarchy of Criteria)

KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. **Health Plan eligibility and coverage**
2. **Federal and state mandated criteria**
   - California Code of Regulations Title 22,
   - California Code of Regulations Title 28,
   - CMS Code of Regulations Title 42,
   - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
   - Medi-Cal Provider Manuals,
   - CA DHCS All Plan Letters (APL),
   - DMHC All Plan Letters,
   - CA DHCS Policy and Procedure Letters (PPL),
   - 42 CFR section 438.915, 438.206.
   - Standardized Behavioral Health criteria (Title 9, DSM-V)
3. **Nationally recognized criteria set for application of medical necessity.**
   - MCG Health LLC (Milliman Care Guidelines,)
     - UpToDate
4. **Peer Reviewed Journal or Published Resources**
5. **Preventive Health**
   - *The Guide to Clinical Preventive Services Report (Report on the US Preventive Services Task Force)*[i]
   - *AAP Recommendations for Preventive Pediatric Health Care*
   - *CHDP Medical Guidelines*

Utilization Management (UM) continues to be focused on ensuring KHS members receive medically necessary care at the right time in the most appropriate setting. To achieve this goal, UM works diligently to ensure all department processes are regulatorily compliant, staff is well trained, and all decision are made based on medical necessity and in accordance with regulatory directive and the Plan contract with DHCS.

For medical necessity nationally recognized criteria, the UM nurses and physician reviewers utilize **MCG Guidelines**. MCG guideline criteria sets offer evidence-based care guidelines for various care settings and conditions, developed by clinical editors, and based on peer-reviewed papers and research studies. The care guidelines are utilized by the KHS staff for outpatient referrals and procedures and inpatient concurrent hospital admission stays. The UM licensed staff reviewers undergo significant training as part of the new hire orientation process and then at regular intervals throughout the year to include, one-to-one training, UM inpatient concurrent review staff huddles, denied, modified case reviews, and inpatient denial reviews. Licensed staff UM reviews are monitored through a random selection of each reviewer's file reviews on a monthly basis as they apply to utilizing MCG guidelines.

For other criteria selection and application as listed in the embedded table, these criteria are also included in the trainings. During 2023 a specialized training Inservice was arranged. The training module included criteria access resource links, best practices, and hierarchical selection requirements in conformance with Medi-Cal regulations. Other aspects of the training covered application of benefits, how to locate and utilize the Medi-Cal Provider Manulas and specialized Medi-Cal Programs.

A designated Medical Criteria policy and procedure was developed in 2023 to facilitate more detailed guidance with UM criteria selection process. Previously a short summary of medical necessity criteria was contained within the UM Program.

The proficiency of staff adherence to application of medical necessity is also measured through the Inter-rater Reliability (IRR) audit process as defined in the following goal 2.

This function will continue for 2024 as part of the new staff onboarding process, ongoing hands on licensed staff training, formal training modules, and updated procedural guides as needed.

GOAL 2: GOAL MET	Compliance with hierarchy of decision making, ensuring consistent application of medical necessity determination criteria.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR) 2. MCG training annual and as needed based on changes to the guidelines. 3. Annual review of Medi-Cal guideline training and for hire.	Inter-rater-reliability pass rate of **100%**	Utilization Review Manager	Ongoing

EVALUATION: GOAL MET

For clarification the goal indicator was set at 100% and still stands but with clarification in what constitutes a pass rate as follows:

The Inter-rater-reliability compliance rate is 100% for licensed reviewers with a passing score of 80% or greater for each IRR Case Review and with the concession that if they failed a case they were educated and retrained and a retest of 2 cases transpired after the retraining.

Quarter 1-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	2	32 passed in full. 8 with 1 or 2 case fail	80%	8 retest full pass
Quarter 2-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	2	32 passed in full. 8 with 1 or 2 case fail	80%	8 retest full pass
Quarter 3-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	2	38 passed in full. 2 with 1 or 2 case fail	95%	2 retest full pass
Quarter 4-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	2	38 passed in full. 2 with 1 or 2 case fail	95%	2 retest full pass
YTD Compliance Rate 87.5% = 100% of GOAL				

This audit function will continue for 2024 as part of the KHS HICE Work Plan Report.

For 2024 the UM Work Plan selected by KHS is the Health Industry Collaborative Effort Template. The HICE Work Plan has been adopted by all of the CA Medi-Cal Health Plans as the standard. Within the HICE WP TATS are measured and reported quarterly.

GOAL 3: MET	Ensure compliance with legislative and regulatory directives.

INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Participate in all appropriate legislative and regulatory workgroups and/or activities that may impact the UM department. 2. Update department policies and *procedures* to reflect these changes. 3. Implement a policy and procedure review plan to ensure directives are operationalized. 4. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	All new APLs will be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.	Utilization Management Director	Ongoing with Quarterly Review

EVALUATION: GOAL MET

2023 was a dynamic year for KHS health services due to legislative and regulatory changes pertaining to Medi-Cal Managed Care. The DHCS 2024 Contract driven by the many CalAIM transformational goals to improve more coordinated person centered and equitable health care served as a prerequisite of KHS's obligation to demonstrate readiness with the new DHCS Contract before the 1/1/2024 contract go live date. This process involved substantial revisions of standing programs and policies and procedures as well as the creation of many new ones. In doing this desk top procedures, documentation practices, new job roles and descriptions, and technology and reporting support functions consequently transpired to fulfill the necessary obligatory functions.

The health services committee structure was expanded by the creation of a Quality Improvement Health Equity Transformation Committee (QIHETC) as the umbrella committee for all health service quality functions. The KHS internal existing health service committees as well as newly developed committees were converted to subcommittees to support, monitor and report the 2024 new contract requirements applying to each health services area to ensure compliance. In addition to the 2024 contract, multiple DHCS and Department of Managed Health Care (DMHC) APLs were released to guide operational and administrative requirements.

Staff training pertaining to the newly instituted documents and activities were instituted through review of the policies and programs and collaborative meetings to facilitate best practices. New policies and programs were submitted to the UM/QI Committee for 2023 for review and approval as per the standard.

The Goal was met KHS UM, QI, and PHM departments successfully met the submission requirements in full.

This audit function will continue for 2024 as a compliance requirement. All new APLs will be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.

Of note, in addition to the mandated regulation as defined, KHS is undergoing NCQA Accreditation. A GAP analysis for NCQA Standard adherence was performed throughout 2023. All GAPS were addressed and documents and processes that were identified in the GAP analysis were rectified with implementation, corrections, or augmentation practices to meet 2023 standards. This process will be a carry over for 2024. The most current 2024 NCQA Accreditation Standards will be cross-walked to KHS health services activities to ensure compliance.

GOAL 4: NOT MET	Ensure separation of medical decisions from fiscal considerations.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness does not compensate physicians or nurse reviewers for denials. KHS does *not* offer incentives to encourage denials of coverage or service". 2. Ensure this education is provided to all Utilization Management staff.	100% compliance with distribution and receipt of completion of affirmative statement about financial incentives.	Utilization Management Manager	Annually

EVALUATION: GOAL NOT MET but WITH FOLLOW THROUGH in 2023 to RECTIFY for 2024

The Affirmative Statement was not disseminated to UM staff and the UM Committee participants in a timely manner as planned for 2023. Of note the Conflict-of-Interest Policy and Disclosure Statement was distributed to the committee attendees and UM participating staff but did not fully meet the requirements of the Affirmative Statement. Also, of note in accordance with regulatory requirements the structure of the UM referral review process is organized in accordance with DHCS and DMHC requirements of ensuring there is separation of financial influences on medical necessity decision making.

The Affirmative Statement has been developed for 2024. The Affirmative Statement will be distributed to UM staff by the KHS Human Resources Department. The Affirmative Statement is now added as a standing agenda item for the UM Committee and will be required to be signed annually by each committee member as well as throughout the year for any newly participating committee attendee.

The 2023 UM Program has been updated to include a description and process pertaining to the Affirmative statement.

The KHS website will be updated in 2024 with the affirmative statement under the Utilization Management section.

This Affirmative Statement will be implemented in 2024 and as a regulatory requirement, carried through from year to year.

GOAL 5:	Ensure compliance with regulatory standards.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. File reviews to validate regulatory standards are met. 2. Education, both ongoing and remedial will be provided to staff on any issues revealed during the file review process	Documented use of guidelines in medical necessity determinations will be in compliance with State, Federal and other regulatory requirements 95%	Utilization Review Manager and Supervisor	Quarterly

EVALUATION: GOAL MET

Clinical nurses underwent annual training consisting of best practices and compliance requirements for UM medical necessity and application of criteria and benefit review cases to include denial / delay / modified. The UM supervisor was responsible for performing the monthly audits. The audit entails selecting 5 random cases from the universe for each reviewer for the given audit month. The case documents, medical necessity criteria selected by the reviewer and the reviewers written rational and decision determinations were cross referenced to the Notice of Action Letter as follows:

a. Spelling/Grammar, Verbiage, and Format,
b. Medi-Cal Criteria applied,
c. Criteria indicated and attached,
d. Recommendations to MD indicated.

UM - Referral Notification Compliance

	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Member Notification	90%	97%	98%	98%	100%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	96%	97%	97%	95%	97%
MD Signature Included	100%	100%	100%	99%	100%

Any deficiencies identified were followed through with one-to-one continued training until they met the threshold goal of 85% and then subsequently the threshold was moved up to 95%. Ongoing remedial training as needed was provided throughout the year. The number of UM staff reviewers audited totaled 16 each month. File reviews for physician reviewers were conducted quarterly. The number of MD reviewers audited each month totaled 3.

The Goal was met for all reviewers of meeting an initial threshold 85% and then met or exceeded 95% thereafter.

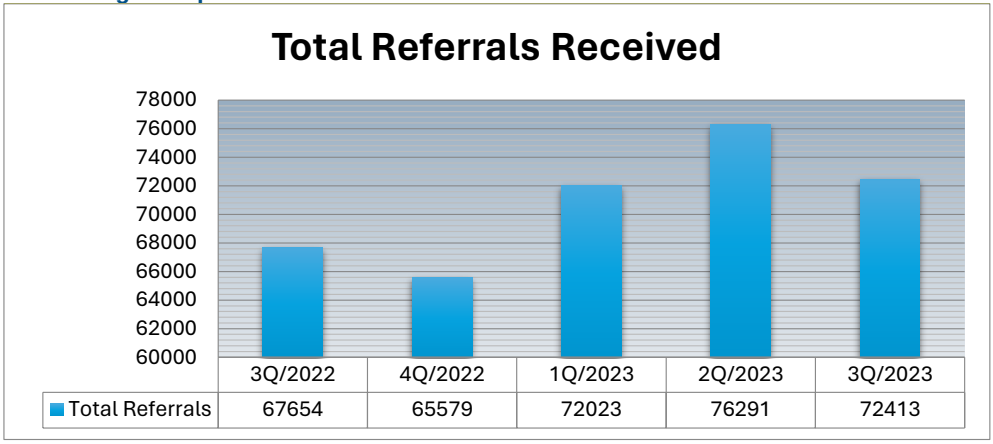
This audit function will continue for 2024 as a best practice.

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

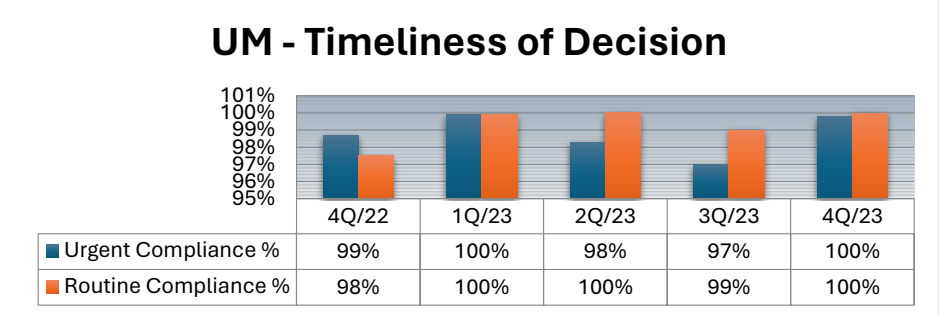
EVALUATION: **GOAL MET**

The Utilization Management Department utilizes business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process as well as continuing to apply the proven principles of managed care through prospective, concurrent, and retrospective review. The goal of the UM Department is to ensure that the medical necessity review process is completed in a time sensitive, efficient manner while aligning practice with all regulatory and statutory requirements.

Report monitoring examples:



	3Q/2022	4Q/2022	1Q/2023	2Q/2023	3Q/2023
Total Referrals	67654	65579	72023	76291	72413



	4Q/22	1Q/23	2Q/23	3Q/23	4Q/23
Urgent Compliance %	99%	100%	98%	97%	100%
Routine Compliance %	98%	100%	100%	99%	100%

	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Member Notification	90%	97%	98%	98%	100%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	96%	97%	97%	95%	97%
MD Signature Included	100%	100%	100%	99%	100%

Multiple report monitoring activities were developed to support the management of authorization referral request processing during each business day serves as a means to effectively assess staff availability matched to volume demands. The reports for timeliness are run at intervals throughout the day. The compliance threshold goal for referral processing timeliness turnaround times (TATS) compliance activities is 95%.

The UM Supervisor is responsible for this function. Monitoring includes measuring ageing from the time each auth requests are received, the status of the request, routine or urgent, the current volume of requests in the queue & the processing of the NOAs evaluated to the number of staff available to meet the demand. For days of high volume and unprocessed auth requests nearing close to the ending turnaround time (TAT), the UM supervisor & UM trainer served as a back-up resource in processing auth requests to assist in maintaining compliance.

To mitigate any adverse TAT trends found in each given month, a monthly management UM huddle meeting transpired to review the processing results, with a drill down on the causation of any cases that fail to meet requirements. This process was supported with ongoing training of staff and continued evaluation of work processes to identify opportunities for streamlining processes.

With these changes KHS facilitated a quarter-over-quarter improvement in cumulative compliance. As follows is an example of monitoring report.

Month	January	February	March
Total Referrals Processed	24,335	22,963	26,776
Total Referrals Delayed	43	55	43
Percent of Delays	<1%	<1%	<1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10 referrals	10 referrals	10 referrals
Number of Referrals in Audit	10	10	10

1

Indicators:

1. Referral Turn-around Time
   - Delays being done on day 5 of original referral – Final decision no later than 14 days for delays and 28 days for extend delays.

The overall 2023 compliance score met the 95% compliance goal.

This audit function will continue for 2024 as part of the KHS HICE Work Plan Report.

For 2024 the UM Work Plan selected by KHS is the Health Industry Collaborative Effort Template. The HICE Work Plan has been adopted by all of the CA Medi-Cal Health Plans as the standard.

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

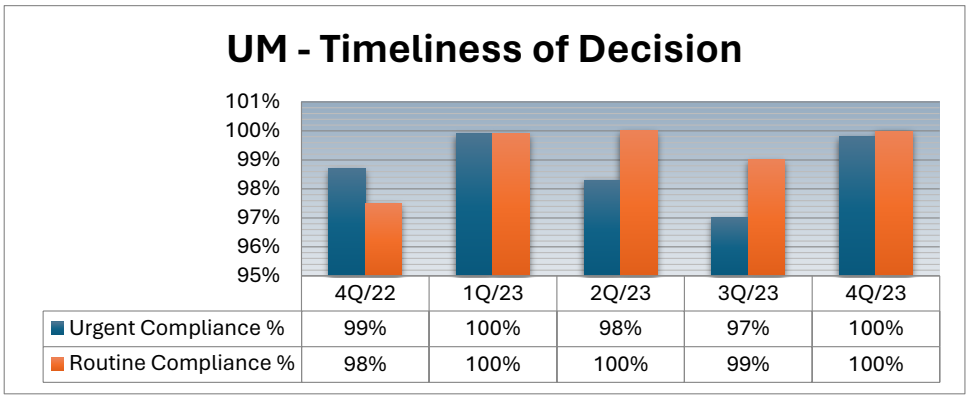
6. Ongoing training or staff and evaluation of work processes to identify opportunities for streamlining process.			

EVALUATION: GOAL MET

As indicated in GOAL # 6, multiple monitoring reports to monitor authorization processing TATs were developed. Training for this topic was done extensively throughout the year to include initially at year opening and then during UM Of them one report specifically monitors the time frame from when the auth was received by the UM Department
As follows: Routine the initial time is established from the day following receipt with a TAT of 5 business days to be completed in full.
For and time stamped via the urgent the time frame begins in at the hour, minute, and second of KHS receipt of the request. i.e. date provider portal, fax, or call-in requests by which the time of the call in is recorded by the UM representative in receipt of the verbal request. The Turn around time is 72 hours. Urgent requests are prioritized.

The compliance goal is 95% for routine and urgent.

This report is run in the a.m. and then at other pre-established intervals with a 2pm final report run to ensure timeliness is meeting regulatory TAT compliance before each business day's end.



	4Q/22	1Q/23	2Q/23	3Q/23	4Q/23
Urgent Compliance %	99%	100%	98%	97%	100%
Routine Compliance %	98%	100%	100%	99%	100%

This process will continue as part of the 2024 UM Work Plan. Within the HICE WP TATS are measured and reported quarterly.

GOAL 8:	Consistency with which criteria are applied in UM decision-making and opportunities for improvement are acted upon.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct quarterly interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making.	Physician and nonphysician UM reviewer 5 file achieving passing score on MCG IRR Tool.	Clinical Supervisor	Quarterly

EVALUATION: GOAL MET

Please refer to goals 2.

For 2024 the IRR testing process will expand to non-licensed UM staff to evaluate and as needed optimize UM efficiencies. The focus of the non-licensed IRR process will focus on administrative proficiency standards such as verification of benefits, checking the UM system to ensure a service is not duplicative or requested within the benefit period, ensuring medical necessity records are attached and following protocols to collect the records and so on..

GOAL 9:	Appeals and Dispute Management Compliance		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times. 2. Analyze the UM appeal review to identify trends. 3. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned. 4. Ensure appeals are processed by specialty-matched physicians.	Ensure >/= 90% accuracy of all determinations while complying with regulatory tum-around times	Utilization Review Manager and Supervisor	Monthly

EVALUATION: GOAL MET

As planned, Appeal outcomes were monitored and reported throughout 2023. Data reports and analytics occurred regarding appeals turn around times and appeals overturn and upheld trends. Appeals were categorized by specific services to include:

1. DME
2. Outpatient
3. Inpatient
    - Acute rehab
    - Inpatient procedures
4. Home Health

The category with the highest number of upheld denial determinations was the DME category reflecting a 57.03% denial upheld rate for not medically indicated or technical denial due to the DME provider not complying with KHS prior authorization procedures.

For all categories, the highest percentage of denial determinations occurred due to lack of information being received during the UM review process to support the medical necessity for the service request. Of note, a denial determination that transpires due to lack of information does not ensue until after 3 provider outreach attempts to collect the necessary information has been performed by UM and the information still has not been received. To comply with regulatory UM medical necessity decision making and timeliness standards a denial is rendered. The denial notification to the member and provider includes a detailed description of the KHS appeals process to serve as an avenue to further facilitate an additional review of the service request if the information is

submitted. A significant number of overturns to approval for the appeals data in general were due to the plan receiving additional information from providers during the appeals process to justify the medical necessity of the request.

This activity is reported in the following format indicating the total number of Appeals service requests and the final determination of overturned, upheld or partially upheld. For 2023 there were no partial upheld determinations.

As a DHCS contractual requirement, KHS submits Appeals data routinely to the department to include an aging TAT.. There have been no derogatory trends identified in terms of TATs.

Appeal Decision Summary Report By Service Type

From: 1/1/2023 To: 12/31/2023

Client: STATE OF CALIFORNIA

Employer: Kern Health Systems (KHS)

Group: Medi-Cal

Appeal Level : All

Service Type	Total Services Requested	Total Number Of Requests Overturned	Total Number Of Request Upheld(Full Upheld)	Full Upheld Rate For Current Reporting Period	Total Number Pending	Total Number Partial Upheld	Full And Partial Upheld Rate
Durable Medical Equipment	612	261	349	57.03%	2	0	57.03%
Outpatient Referral	2026	1251	769	37.96%	6	0	37.96%
Acute Rehab Hospital	3	2	1	33.33%	0	0	33.33%
Home Health	51	35	16	31.37%	0	0	31.37%
Inpatient Procedure	139	111	28	20.14%	0	0	20.14%

When there is a specific provider trend of not complying with proper service request medical records and documentation submission in accordance with KHS policies and protocols, the Provider Network Department is notified to assist in educating the provider and instituting steps to mitigate any adverse trends that may create a barrier to members receiving timely medically necessary services.

For 2024 Appeals monitoring and reporting will continue as a category in the UM Work Plan.

GOAL 10:	Monitoring of over and under utilization		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of stay. Acute care stay, ER visits per thousand. all-cause readmissions, readmissions within 30 days, C-Section ratio. 2. Aggregate LOS specialty referral review Assessments on a biannual basis.	5% improvement of current statistical baseline.	Medical Director	Monthly

EVALUATION: GOAL MET

Multiple activities were planned and carried through to include routine reporting to the UM Committee throughout 2023 to include:

1. Initial Health Assessment (IHA) Letters to Members

Goal ensuring this service is not underutilized and newly assigned and existing members undergo an Initial Health Appointment to ensure they are assessed and receive necessary services and care. The UM department performs the following activities and reports the results to the UMC monthly:

Letters to the member's PCP with a count of their assigned members who still need an IHA. These letters direct the PCP to the Provider Portal to review their list and perform outreach.
Letters are also mailed to the PCP regarding members who have open authorizations.
Open authorizations are defined as any auth that has not expired and has no claim attached to it. The auth does not need to be fulfilled to no longer be considered open.
Letters are mailed out to each PCP at each location where they have members assigned.

Monthly Report Initial Health Appointment IHA and Unused Member Authorizations
July 2023 • IHA Letters Mailed – 370 • Open Authorization letters mailed – 131. August 2023 • IHA Letters Mailed – 363 • Open Authorization letters mailed – 127. September 2023 • IHA Letters Mailed – 360 • Open Authorization letters mailed – 129

For 2024 the IHA process will continue. Additionally, another study will be added to further address over/under utilization practices such as members as a whole with unused authorizations that have been approved to ensure they receive services if still medically indicated by their PCP or specialist.

Referrals for non-contracted providers has been identified to be over-utilized substantially based on the volume of this referral type as well as underutilizing qualified credentialed contracted in-network providers capable of delivering the services. and from a quality management perspective familiar with KHS established policies and procedures and data exchange management. A strategy to reduce these referrals is underway for 2024.

GOAL 11:	Consistent referral of members for specialty program consideration originating from utilization management.

INTERVENTIONS:	GOAL:	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Assessment of each member with an inpatient encounter with the purpose of Identifying a condition that would warrant additional specialty care management and *refer* for consideration prior to encounter closure. 2. Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer.	25% increase of referrals over current baseline each quarter until >/= 90% of eligible members are referred *for* specialty program consideration.	Utilization Review Manager and Supervisor	Ongoing

EVALUATION: **GOAL MET WITH IDENTIFIED EXCEPTION**

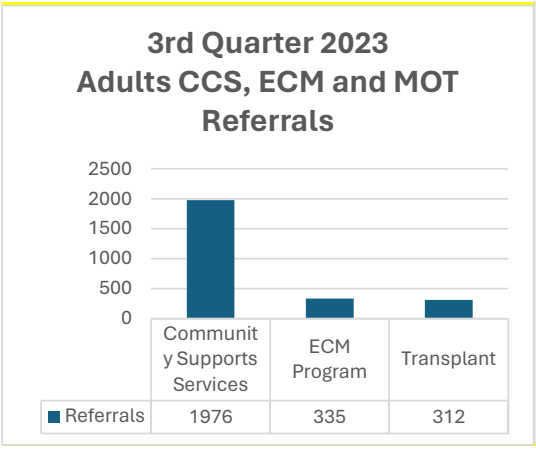
In congruence with the established goal. Multiple program referral strategies were implemented throughout the course of 2023 to ensure the assessment of each member that underwent an episode of an inpatient care encounter and had an identifying condition that would warrant additional specialty care coordination and services would be referred to a supportive service. For those meeting the need for specialized support they were referred to a variety of programs and or services. The 2 areas of referral support involving the highest percentage of referred members were health education and ECM/Community supports.

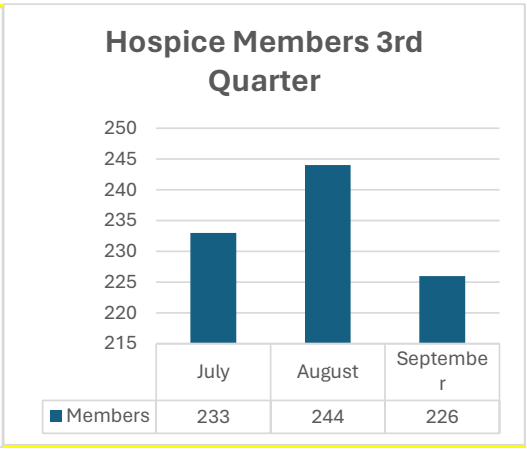
To validate if there was a 25% increase in the specialized program referral volume, multiple referral and tracking report interfaces were put in place to measure those UM referral activities to the other services.

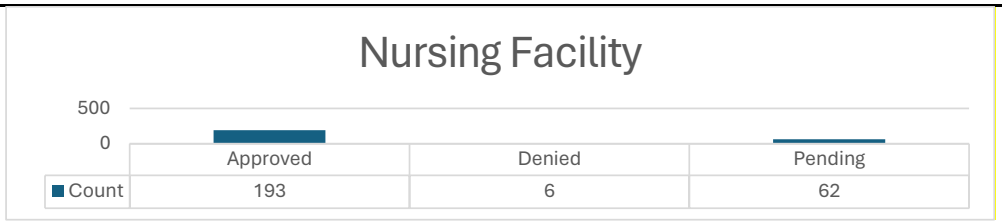
Of note, while the reporting formats did track the referrals no further measurements were incorporated to measure if there was actual member participation and if so the completion of participation with the activities to achieve a specific goal. If there was not member participation there were no efforts to validate why the participation did not occur such as refusal, unable to contact and so forth.

Also the comparative baseline measurement from 2022 to 2023 was unclear.

Examples of the referral to service reports include the following:







Member Specialized Program and Activity Referrals	Count of Activity
Member Outreach	**16**
CM Periscope Review	16
New CM Referral	**34**
CM Periscope Review	1
Member identified intervention	1
Referral to Case Management	31
Referral to Health Education	1
HE Referral - Asthma Education	**8**
HE Referral - Diabetic Education	**16**
New HE Referral - Nutritional Education	**8**
New HE Referral - Pregnancy Referral	**18**
New HE Referral - Smoking Cessation Education	**41**
New HE Referral - Weight Management Education	**15**
Program Referral	**2**
Referral to Case Management	1
Referral to COPD Program	1

Community Supports	Count of Activity
Program Referral (System Generated)	**2054**
Referral to Comm Supports Asthma Remediation Program	443
Referral to Comm Supports Caregiver Respite Program	93
Referral to Comm Supports Comm NF Transition Program	1
Referral to Comm Supports Housing Deposits Program	42
Referral to Comm Supports Housing Navigation Services Program	389
Referral to Comm Supports Housing Sustainability Program	56
Referral to Comm Supports NRSF Diversion Program	5
Referral to Comm Supports Personal Care Services Program	158
Referral to Comm Supports Recuperative Care Program	64
Referral to Comm Supports Short Term Post Hospitalization Program	40
Referral to Comm Supports Sobering Centers Program	186
Referral to Comm Supports Tailored Meals Program	151
Referral to ECM Program	172
Referral to LTC Program	254

The referral program strategy and intervention will be carried through to 2024. For 2024 a 2023 baseline for each service will be measured and compared throughout 2024 on the reports. Additionally follow through with the referral will be conducted and documented to provide further insight into the effectiveness of the increased referrals as it pertains to supporting the members with specific goals.

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

EVALUATION: GOAL MET

As planned California Childrens Services (CCS) were monitored for inpatient institutional services and ambulatory care services.

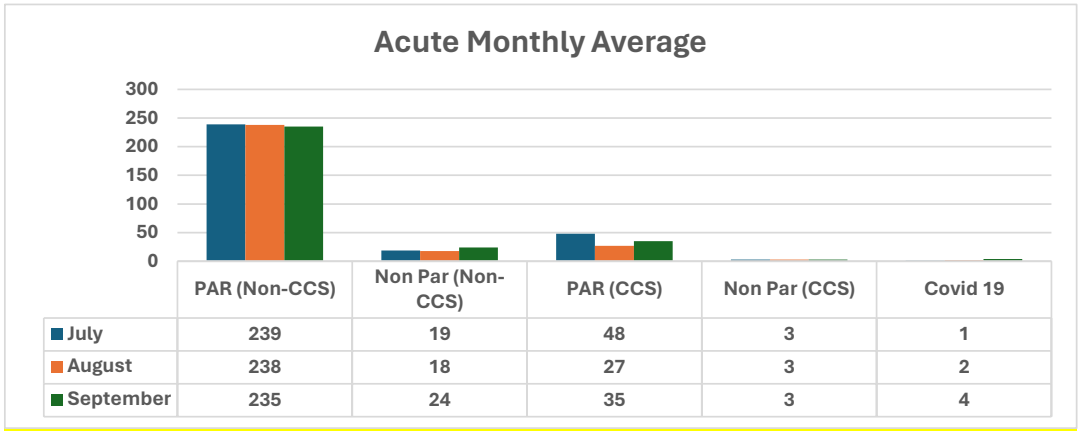
Business intelligence reports were created to capture CCS inpatient episodes of care for 2 categories to include general acute care and tertiary care. The episodes were aggregated from the KHS daily inpatient census for pediatric encounters. The inpatient concurrent review nurses collaboratively verified through the UM designated CCS team to confirm members with a CCS condition if they had been approved by CCS and had a CCS authorization SAR on file as well as confirming the hospital the member was admitted to is CCS paneled.the report reflects this as CCS par (participating or CCS Non-par.

All CCS cases identified through this process that have a SAR are considered a carve out from KHS's management of the actual CCS condition and financial responsibility. The UM team retains responsibility for supporting and authorizing the coordination of all other services not related to the CCS condition for the member, i.e., preventive health, incidental illnesses, routine care, injuries, etc.

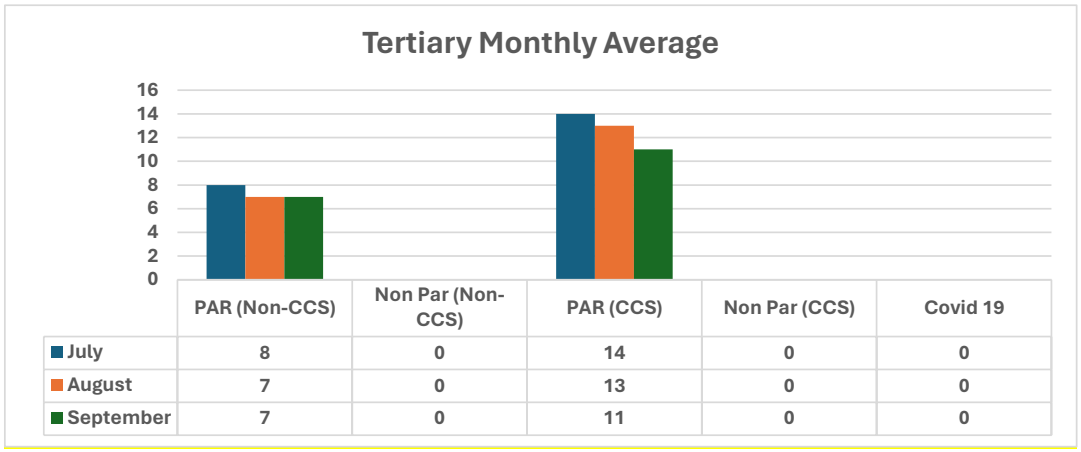
On an average there are approximately 235 inpatient general acute stays for pediatric members with CCS eligible conditions and 10 for tertiary.

In the event a member has a CCS condition but has not undergone an assessment by CCS which is indicated when the member does not have a SAR the UM CCS coordinators/nurses refer the case to CCS.

Example:



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	239	19	48	3	1
August	238	18	27	3	2
September	235	24	35	3	4



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	8	0	14	0	0
August	7	0	13	0	0
September	7	0	11	0	0

2023

CCS Outpatient Report

Case Totals: 480

Authorizations Count: 1050 for CCS Cases

CCS reporting will continue through 2024 as a UM standard and go through UMC outside of the 2024 work plan. CCS because it is a carved out service is not included in the HICE Work Plan

Kern Family Health Care™

UTILIZATION MANAGEMENT

2024 PROGRAM DESCRIPTION

Introduction

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative for the arrangement of medical, social, and behavioral health care for Medi-Cal enrollees in Kern County. KHS is a public agency formed under Section 14087.38 of the California Welfare and Institutions Code. KHS began full operations on September 1, 1996, under the Kern County Board of Supervisors. KHS currently serves more than 330,000 Medi-Cal participants in Kern County. KHS aligns with the California Advancing and Innovating Medi-Cal Initiative by embracing CalAIM's three primary goals:

Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health,

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and

Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to support and elevate the health status of KHS members served.

Purpose

The KHS Utilization Management Program (UMP) serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

The UMP is intended to outline the methods utilized by KHS to provide a supportive system of care arrangements and services in a standardized, simplified, and focused process to efficiently provide members with comprehensive Whole Person Approaches within available resources and achieve an optimum level of quality health care that is cost-effective.

The UMP is a formal Document supported by clinical, operational, and administrative policies and procedures (P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current

NCQA Standards and Guidelines. The UM documents are developed through the involvement of actively involved KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c).

The UM Program and Policies &Procedures go through a formal process of UM Committee review approval and are reported up to the Quality Improvement Committee and the KHS Board of Directors for final review and approval. In turn the UMP and P&Ps are disbursed and or made available to KHS providers and members through various channels of accessibility.

All activities described in the UM Program are conducted with oversight by the Quality Improvement Committee.

The UMP is housed within the KHS Health Services Department and is supported through the coordination between various internal departments to include:

- Population Health Management,
- Pharmacy,
- Enhanced Care Management,
- Health Education,
- Care Coordination,
- LTSS Department
- Quality Improvement

The success of the UM Program begins with positive patient-practitioner relationships and depends, not on the portioning of services, but on the management and delivery of medically necessary, cost-effective health care designed to achieve optimal health status.

UMP Objectives

KHS develops, implements, and updates as needed (at least annually), the utilization management (UM) program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services for KHS Members. This process incorporates provider, practitioner, and member input along with any regulatory and industry changes to maintain current standards of care and technological advances.

An annual evaluation of the UM Program is prepared and includes a description of the accomplishments of the Plan, work plan, program evaluations, policies, and procedures. It shall also include reporting on the Plan's operation using statistical data and other information regarding the care delivered to members and any suggested revisions. The UM WP & Evaluation will be submitted to the QIC who is responsible for approving the updated UM program.

The UMP is intended to provide a reliable mechanism to review, monitor, evaluate, recommend, and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

The UMP and the UM Department are adequately supported by a designated medical director with sufficient knowledge of managed care and UM process requirements to serves as a departmental resource and oversee that the review process is conducted in accordance with H&S Code section 1367.01.

KHS UMP prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue medically necessary services.

The KHS UMP will define the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review.

KHS will make available to network providers and members all relevant UM policies and procedures upon request: and, make available to members clinical criteria used by KHS and as applicable subcontractors, and downstream subcontractors, for assessing medical necessity for covered services.

The UMP and processes are developed and carried out to ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical, surgical, mental health, and substance use disorder services and benefits.

Through the UMP the monitoring of UM data is performed to detect potential under and over-utilization. Data are monitored across practices and provider sites of PCPs and specialists. Appropriate interventions are implemented whenever under- or over-utilization is identified. Interventions are measured to determine their effectiveness, and further strategies may be implemented to achieve appropriate utilization.

When UM processes are delegated under the UMP KHS will evaluates the ability of the delegates to perform UM activities and monitor performance continuously to ensure delegate compliance and adherence in alignment with the KHS UMP and policies and procedures.

The KHS UMP promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, credentialing, and population health management activities.

The UMP accommodates member access to Standing Referrals as outlined in H&S Code section, 1374.16.

The UMP accommodates member access to Second Opinions in accordance with 42 CFR section 438.206.

The UMP supports a process of thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues.

There are mechanisms to evaluate the effects of the UM program and process using member and provider satisfaction data, staff interviews and/or other appropriate methods. Identified

sources of dissatisfaction are addressed. When opportunities for improvement are identified, the UMC makes appropriate interventions to change the process.

Statements and Protections

Non-Discrimination Statement

KHS complies with applicable Federal Civil Rights Laws and does not discriminate, exclude people, or treat them differently on the discriminating based on race, color, national origin, religion, ancestry, ethnic group identification, sex, gender identity (including gender expression), sexual orientation, mental disability, medical disability, age, marital status, family/parental status, or income.

KHS will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available.

In accordance with the Americans with Disabilities Act, KHS will ensure that deliverables developed and produced shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

> KHS will provide persons with disabilities who require alternative means of communication for program information to the appropriate alternate format to support their communication needs (e.g., Braille, large print, audiotape, American Sign Language, etc.)

KHS provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified sign language interpreters,
- Information written in other languages,
- Use of California Relay Services for hearing impaired.

Confidentiality Statement

KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and

federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process.

Confidentiality of provider and member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the UM QI and PAC Committees are required to sign a confidentiality statement that will be maintained in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the UM, QI, and PAC Committees (PAC performs credentialing conducts Peer Review, Complaints and Grievance, and PQI reviews), and reporting bodies as specifically authorized.
- Confidential documents may include, but are not limited to: UM, QI, and PAC Committees meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- The confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to UM Physicians and staff on the Kaiser Permanente Intranet compliance site. Ongoing mandatory education is required annually for all staff.

Conflict of Interest Statements

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the UM, QI, and PAC are required to review and sign a conflict-of-interest statement, agreeing to abide by its terms.

SCOPE of Care Services

The KHS UMP incorporates the monitoring and evaluation for prior authorization, concurrent review, retrospective review, exceptions to prior authorization services and reviews and updates policies and procedures as appropriate at least annually for the following.

- Acute hospital services,
- Subacute services,
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility services,
- Ambulatory Services,
- Rehabilitative services,
- Emergency and urgent care services,
- Durable Medical Equipment and supplies,
- Ancillary care services, including but not limited to home health care, skilled nursing care,
- Transportation services,
- Selected pharmaceutical services - physician administered drugs (medical drug benefit),
- Laboratory and radiology services,
- Transportation services-Medical and Non-Medical,
- Non-Specialty Mental Health and Substance Use Disorder Services as applicable to KHS contracted scope of coverage in accordance with DHCS KHS 22-20201 Contract Exhibit A. Attachment III,
- Out of Network Care.

Exceptions to the requirement of prior authorization include but are not limited to:

- Primary Care Provider Services,
- Specific OB/GYN services, including midwifes and free-standing birth center facility,
- Abortion Services,
- Dialysis,
- Hospice Care,
- Sexually Transmitted Disease treatments,
- HIV Services,
- Family Planning Services,
- Mental Health evaluations,
- Maternity Care,
- Vision,
- Sensitive Services, both child and adult
- Emergent/Urgent Care, and,
- Other procedures as identified.

Authority and Responsibility

KHS Board of Directors

The Kern Health Systems, the County Health Authority, is an independent public agency that governs Kern Family Health Care. The Board of Directors are appointed by the Kern County Board of Supervisors and includes major healthcare stakeholders, such as physicians, safety-net providers, hospitals, pharmacies, and community representatives. Board meetings are held bi-monthly in: February, April, June, August, October, and December**,** and are open to the public. The Board of Directors (BOD) for KHS assigns the responsibility to lead, direct, and monitor the activities of the UM Program to the KHS Quality Improvement and Utilization Management Committees.

The Board is directly involved with the UM process in the following ways:

- Delegates responsibility for the day-to-day activities and execution of the UMP to the Keren Health System Chief Medical Officer (CMO),
- Approves and supports the UM Program direction, evaluate effectiveness, and resource allocation,
- Appoints individual and/or departments within the KHS organization to provide oversight of the UM Program,
- Evaluate and approve the UM Program Description and UM Program Evaluation annually, providing recommendations as appropriate and track findings.
- Approve the UM policies and procedures needed to maintain the UM Program,
- Receive reports representing UMP activity outcomes, actions taken, and improvements made by the UMC, at a minimum on a quarterly basis.

Program Structure

The UM Program is comprised of various systems and processes which interface with other departments and administrative systems in the delivery of quality and value enhanced care. The link between UM and other clinical and administrative systems must be collaborative to deliver quality care and effective resource management.

The utilization management team of physicians, licensed staff, and unlicensed staff are trained and qualified to assess the clinical information which is used to make utilization management decisions and provide the service within their respective scope of practice. Appropriately licensed health professionals supervise all review decisions.

- KHS utilizes licensed health care professionals to supervise UM activities to:

  a. Provide day to day supervision of assigned UM staff. UM staff who are not qualified health care professionals may approve services when they meet explicit UM auto authorization guidelines under the supervision of a licensed professional
  b. Participate in staff training.

Commented [YB1]: UM Element 1 A.1- UM staff assigned activities

Commented [PT2R1]: Per original DRR UM1A.1: "Met on pg 53. Clarify is the annual eval gets approved by the Board or the QM/UM Committees"

Commented [YB3R1]: P. 5-" UM Objectives" - QIC submission ; Pg. 10 "authority & Resp - bullet # 4- approved by board- signature page usually shows signature by cmte & board.

c. Monitor for consistent application of UM criteria by UM staff for each level of UM decision.
d. Monitor documentation for adequacy of relevant clinical information to support non-behavioral, behavioral and /or pharmacy UM decision making.
e. Be available to UM staff on site or by telephone.

- A non-licensed staff may:

a. Review an authorization request against the UM auto approval matrix where no clinical judgment is warranted. If clinical review is warranted, it is routed to the nurse reviewer and to a physician reviewer when further review is needed.

This section outlines the individual program staff and their assigned activities, including approval authority and the involvement of designated physicians.

Chief Medical Officer (CMO)

The Chief Medical Officer is assigned by the KHS BOD to provide oversight of the UMP and UM Department undertakings. He/she holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act. The CMO is responsible for ensuring that the process by which KHS reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to KHS members, complies with the requirements of H&S Code 1367.01. The CMO must have the ability to effectively function as a member of the UM team and serves a resource to the UM staff for clinical matters. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the UM Program. The CMO is the UM Committee Chair and or at his or her discretion assigns the UM Chair position to a qualified physician.

The CMO aids with study development and coordination of the UM Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Chief Network Administration Officer with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members. Other responsibilities include but are not limited to:

- Provide direction for all medical aspects of KHS, preparation, implementation and oversight of the UM Program, medical services management, resolution of medical disputes and grievances,
- Principal accountabilities include development and implementation of medical policy for utilization functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, review of UM cases, participation in the UM committee,
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation,
- Evaluates the overall effectiveness of the UM program,

- Evaluates and uses provider and member experience data when evaluating the UM program,
- Ensures that medical decisions are rendered by qualified medical personnel,
- Ensures UM decision making is not influenced by fiscal or administrative management considerations,
- Ensures that the medical care provided meets the current standards for acceptable care,
- Ensure that medical protocols and rules of conduct for practitioner or plan medical personnel are followed.

Medical Director

The Medical Director will provide clinical leadership and guidance in the development and measurement of UM performance improvements and patient satisfaction, and safety and serves as a resource to the UM Department in the day-to-day operations. As determined by the CMO, the Medical Director assists in short-and long-range program planning, total quality management (quality improvement) and external relationships, as well as develops and implements systems and procedures for the medical components of health plan UM and care coordination services.

In collaboration with the Chief Medical Officer and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and UM and QI Committees. Additionally, he or she represents the health plan on various committees to include credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets. Responsibilities include, but are not limited to:

- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS,
- Develops and implements medical policy,
- Resolve grievances related to medical quality of care and service,
- Participates and provide direction in the administration of the QI, UM, and Credentialing Programs by attending committee meetings,
- Detects and corrects inadequate practitioners/provider organizations performance within responsibility level,
- Participates in the development and selection of medical necessity criteria sets used for UM processes,
- Responsible for monitoring and controlling the appropriate utilization of health care services to achieve high quality outcomes in the most cost-effective manner,
- Directly communicates with primary care physicians and other referring physicians to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines, and
- Supports, communicates, and collaborates with KHS UM Department staff to ensure efficient UM processes and decision-making practices are compliant,
- Support case managers to resolve case management and referral issues,

- Supports the CMO with projects as assigned.

Director of Utilization Management

, Under the direction of the Chief Medical Officer, the Director of Utilization Management will oversee and participate in activities related to Utilization Management (UM) for the organization and membership by monitoring, assessing, and improving performance in ambulatory and inpatient health care delivery or health care related services. The UM Director will assist in the implementation of the KHS Utilization Management Program Plan and Evaluation and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

This position is responsible for collaborative oversight of the Utilization Management functions for KHS. The UM Director will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. This position will assist in ensuring compliance with Medi-Cal contractual stipulations for UM programs. The UM Director will make an effective contribution to KHS's business planning and fiscal processes and will remain clear about departmental objectives and resource requirements. Responsibilities include, but are not limited to:

- Maintains delegated responsibility for activities within the Utilization Management departments,
- Oversees quality of care investigations and reporting,
- Works closely with the Director of Case Management to facilitate needs for members identified as High Risk or requiring coordination of services,
- Ensure coordination of medically necessary services within the plan and with community,
- Coordinates UM activities and data collection between KHS departments and KHS contracted providers,
- Serves as resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee, and other committees, as appropriate,
- Works in a coordinated effort with the UM Health Services Manager and Health Services Program Administrator to ensure the smooth and efficient operations of the outpatient processes,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards; Coordinates and conducts in-depth chart analysis, data collection, and report preparation,
- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review,
- In coordination with the UM Auditor, performs periodic audits of the Clinical Intake Coordinators and Social Workers of outpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit; and

- Implements and facilitate internal audit studies and work groups for continuous improvement within the organization.

UM Clinical Manager

Under direction of the Director of Utilization Management, this position manages, leads, acts as a subject matter expert, and provides guidance on unit functions and departmental operations, including regarding clinical health outcomes related to population health management, clinical data management and retrieval, reporting standards and State policy and procedure implementation. Develops implements and evaluates clinical programs related to Health Services initiatives. Manages, supervises, mentors and trains assigned staff. Responsibilities include, but are not limited to:

- Direct activities of the Utilization Management staff,
- Oversee staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination, and other clinical and medical management programs. These responsibilities extend to behavioral health care services,
- Ensure effective daily operation of the Utilization Management Department utilizing all applicable statutory provisions, contracts and established policies and administrative procedures,
- Maintain optimal staffing patterns based on contractual obligations and current Utilization Management budget,
- Prepare reports and conduct analysis of operations / services as required by departmental, corporate, regulatory, and State requirements,
- Work collaboratively with QI and Pharmacy Departments on identifying required data for reporting,
- Assist in preparation, coordination, and follow up of Utilization Management audits, such as readiness review and DHCS site visits, pertaining to the Utilization Management Department,
- Partner with community agencies and contracted vendors to develop and maintain collaborative contact to assure members have access to the appropriate resources and to avoid duplication of efforts,
- Act as a liaison with outside entities, including but not limited to physicians, hospitals, health care vendors, social services agencies, member advocates, county, and other care entities,
- Participate in coordination of internal and external Provider and Member directed communication regarding issues impacting Utilization Management coordination and delivery, such as medication management, use of generic medications, etc.,
- Establish action plan for assessment and resolution of identified issues,
- Oversee the collaborative efforts of the Supervisors to ensure that all new and existing staff are oriented to organizational and department policies and procedures,
- Ensure that credentials of all licensed staff are verified in accordance with licensing agency initially and prior to expiration date. Maintain current and accurate files of such licensure and ongoing education status,

- Ensure that staff meets minimal skill and clinical knowledge requirements to be successful in assigned role,
- Participate in current process review and development of new and / or revised work processes, policies and procedures relating to Utilization Management responsibilities,
- Provide input into the development of educational material and programs necessary to meet business objectives, members' needs, contractual and regulatory guidelines, and staff professional development,
- Comply with Corporate, Federal, and State confidentiality standards to ensure the appropriate protection of member identifiable health information.

Health Services Manager

The Health Services Manager reports to the Director of Utilization Management and is responsible for the daily management, evaluation, and operations of the health services administrative processes, provide supervisory support to Utilization Management (UM) staff and assist with defining and creation of reports in collaboration with the, UM Analyst/Trainer, and Non clinical staff.

This position will work with the administrative support staff to promote the delivery of quality health care to Kern Health System (KHS) members through comprehensive case management, compliance with KHS policies and procedures, and maintenance of a positive and safe work environment leading to maximum departmental efficiency, accuracy, and quality. Responsibilities include but are not limited to:

- Supervise the functions and activities of the clerical support staff,
- Monitors and reports production and quality of work by clinical and clerical staff,
- Works with clerical staff to achieve production, timeliness, and quality of work,
- Participate with Inter-departmental process improvement teams and planned quality management,
- Assist with development and formalization of departmental budget,
- Assist with development and updating of UM criteria, guidelines, and policies,
- Monitor UM processes for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Train staff, as appropriate, regarding use of the Medical Management systems,
- Generates reports for CMO and Chief Health Services Officer to support business decisions,
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental analyst(s) and Senior Health Services Program Administrator,

UM Outpatient Clinical Supervisor

The UM Outpatient Clinical Supervisor reports to the Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Outpatient Medical, Behavioral, Mental Health, and Social Services within the UM

Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient, and productive operations within the UM Department, This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. KHS uses licensed health care professionals to make UM decisions that require clinical judgment. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills,
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Participation on inter-departmental process improvement teams and KHS quality management,
- Monitor UM nursing staff (clinical and non-clinical) referral and documentation for accuracy and appropriateness,
- Supervise staff who are not qualified health care professionals when there are explicit UM criteria and no clinical judgment is required, e.g., auto-approvals,
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines,
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policy and Procedures,
- Monitors and reports production and quality of work by outpatient clinical staff,
- Works with staff to achieve production, timeliness, accuracy, and quality of work,
- Summarize and prepare necessary production reports for management,
- Perform periodically scheduled audits of outpatient clinical decisions for appropriateness and accuracy of documentation,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards,
- Ensure coordination of medically necessary services within the plan and with community,
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions,
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.
- Availability to UM staff onsite or by telephone.

UM Inpatient Clinical Supervisor

The UM Inpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Inpatient Medical, Mental, Behavioral, and Social Services within the UM Department. The UM Inpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient, and productive operations within the UM Department, This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the

smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills,
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Participation on inter-departmental process improvement teams and KHS quality management,
- Monitor UM nursing staff referral and documentation for accuracy and appropriateness,
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines,
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policies and Procedures,
- Monitors and reports production and quality of work by inpatient clinical staff,
- Reviews decisions regarding hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership as related to coordination of services upon discharge,
- Assists with coordinating discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Mental Health, Long Term Care, State Waiver Programs,
- Works closely with the Transitional Care team to facilitate needs for members identified as High Risk or requiring coordination of services,
- Identify members who may quality for the Health Homes Program,
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges,
- In coordination with the UM Clinical Auditor, perform periodic audits of the UM Nurse RN of inpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit,
- Works with staff to achieve production, timeliness, accuracy, and quality of work,
- Summarize and prepare necessary production reports for management,
- Perform periodically scheduled audits of inpatient clinical decisions for appropriateness and accuracy of documentation,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards,
- Ensure coordination of medically necessary services within the plan and with community,
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions,
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

UM Nurse and Clinical Intake Coordinators (RN)

Under the direction of the Kern Health Systems (KHS) Director of Utilization Management, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The UM Nurse and Clinical Intake Coordinators are supported by a non-clinical team for administrative duties and coordination. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent, and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload monthly. Responsibilities, include, but are not limited to:

- Promote coordination and continuity of care and quality improvement in both the inpatient and ambulatory care setting,
- Evaluate the appropriateness of care using established criteria and KHS' benefit guidelines,
- Support KHS developed programs through member identification for participation, i.e., Diabetic Clinic, Health Home, Complex Case Management, Recuperative, Palliative, Transitional Care, Health Home, and Social Worker interventions,
- Review and approve specialty and ancillary service referrals using established criteria for purposes of pre-authorization of payment,
- Review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership,
- Coordinates discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Long Term Care, State Waiver Programs,
- Participates in UM and QI data and statistical gathering, collation, and reporting; and
- Assess for over and underutilization and identify potential fraud, waste, and abuse.

Clinical Auditor/Trainer (RN)

Under the direction of the Director of Utilization Management, the UM Clinical Auditor and Trainer RN is responsible for reviewing Utilization Management (UM) policy and guidelines to ensure staff compliance with policies. Responsibilities include ensuring coordination of services not only within inpatient and outpatient groups, but also between the groups and community. Perform audits on various project reports, Notice of Action notifications, and referrals for compliance. Responsible for reporting findings to management for review and possible corrective action. Provide recommendation for process improvement and assist with action plans for making those corrections. The Clinical Auditor and Trainer RN will work in a coordinated effort with UM Clinical Supervisor(s), Health Services Manager, and Business Analyst to ensure smooth, efficient, and productive operations within the UM Department as directed by the Director of Utilization Management. This position will work closely with the Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Train other UM clinical licensed staff as appropriate regarding use of all platforms and core adjudication system as it relates to the UM process,
- Develop and implement staff training for new and existing employees along with internal findings,
- Responsible for written and verbal communication with contract providers and internal KHS staff to promote timely coordination of care and dissemination of KHS policies and procedures,
- In coordination with the UM Senior Auditor/Analyst, perform spot audits of performance of UM Clinical Intake Coordinators and Social Workers and summarize and report the results of the audit to UM Management for process improvement,
- Perform periodic spot audits of inpatient and outpatient clinical decisions for appropriateness and accuracy of documentation,
- Assists in data collection and compilation, of various committee and quarterly reports; and
- Summarize and prepare necessary production reports for management.

Claims and Disputes Review Nurse (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Medical Claims Review RN will be responsible for retroactive review of medical service claims and disputes for payment and medical necessity following accurate contract and non-contract guidelines for both Inpatient and Outpatient services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Responsibilities include, but are not limited to:

- Reports, track and documents all claims, and disputes review activity in appropriate programs such as QNXT, as well as specially developed internal logs for tracking and trending purposes,
- Perform retro review and approval of specialty and ancillary services referrals using established criteria for purposes of payment,
- Perform retro review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Long Term Care, State Waiver Programs.

Long Term Care Nurse Reviewer (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Long-Term Care Nurse reviewer performs a comprehensive assessment and ongoing reassessments for members referred for long term care (LTC) placement. The assessment process evaluates benefit and medical necessity application of criteria to assure that the member is placed in a health care facility that provides the level of care most appropriate to the member's medical needs. Considerations for placement include:

- Self-determined directive of the member/care giver for the placement,

- Geographical location of placement to maintain members in the community of their choice,
- The unique medical and psychosocial needs of the member,
- Exhaustion of community options/settings to safely maintain the member's health.

Essential Functions:

- Conducts remote and or onsite assessments of member (s) for comprehensive health re-assessments regarding clinical, behavioral and ADL requirements,
- Communicates with LTC Staff and attending health care providers involved in care of the member to coordinate TAR service requests by obtaining complete and accurate information as needed,
- Collects information concerning ongoing eligibility,
- Coordinates with Care Management team and provides updates regarding member health status,
- Participates in collaboration as necessary in member case management and ICT conferences,
- Adheres to all HIPPA standards and confidentiality requirements.

Analyst/Trainer – Removed Senior.

The purpose of this position is to provide support to the UM Management team for report generation, data collection for providing to the UM Clinical Auditor for review. Based on feedback from the UM Auditor, management, and clinical staff, assist in training criteria for staff improvement along with providing one-on-one training to improve staff efficiencies. Responsibilities include, but are not limited to:

- Performs utilization management activities related to data collection, data review and report preparation per KHS Utilization Management Program,
- Assists in the reporting of DHCS and DMHC required reports and Utilization Management's quality studies to meet State contractual requirements,
- Develop and implement staff training for new and existing employees along with internal findings as it relates to the duties of Utilization Management.

Auditor/Analyst (Removed Senior)

This position provides the vital link between inpatient and outpatient as it relates to case managing members moving from hospital to home care. This position will ensure that processes are in place and followed in support of all members seeking care. This is a proactive audit of UM processes as they are in motion to catch and prevent errors. This position will link the social worker, case managers and medical directors in direct support of members under case management. Responsibilities include, but are not limited to:

- Performs audit of staff referral processing as it relates to compliance, accuracy, and performance levels,

- Reviews available reports and data to analyze the accuracy of staff performance as it relates to timeliness of referral processing, accuracy of data entry and appropriateness of decisions,
- Prepares State mandated report requirements as scheduled by the DHCS for management review and approvals,
- Reviews post-activity audit findings to UM Management to ensure compliance and to review where further training opportunity exist.

Director of Pharmacy

Qualifications for the Pharmacy Director include possession of a California State Board of Pharmacy registered pharmacy license, two years of health plan related pharmacy experience at a supervisory level or four years of pharmacy practice in a similar setting as a hospital or group purchasing organization. This position reports to the Chief Medical Officer (CMO).

KHS performs drug utilization reviews (DUR) to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care. Responsibilities include, but are not limited to:

- Participates and serves as the Chairperson on the Pharmacy & Therapeutics/Drug Utilization Review (P&T/DUR) Committee,
- Medication coverage management Development of applicable policies and guidelines Drug utilization review,
- Drug prior authorization for medications covered under the medical benefit,
- Implementation of cost-effective utilization management measures for medications covered under the medical benefit,
- Participation in provider education initiatives such as academic detailing with plan physicians,
- Assisting with development of Clinical Practice Guidelines,
- Other duties as assigned by the Chief Medical Officer,
- Coordination for opioid prescriptions and safeguards to prevent overutilization,
- Creation of clinically efficacious and cost-effective management programs,
- Development, implementation, and monitoring of clinical strategies to improve quality of care for members as well as provide clinical consultative services to contracting providers and KHS staff as necessary to support clinical programs,

Commented [EE4]: Inserted language per Bruce W request

Behavioral Health Director

The KHS Behavioral Health Director is an LFMT who is actively involved in implementing and evaluating the behavioral health aspects of the UM program supported by a PsyD BH Provider for clinical input. This Director provides administrative oversight of KHS's behavioral health activities including coordinating substance use services, behavioral health screening processes and collaborates with the DHCS managed behavioral health

organization(s) designated to provide specialty mental health services to Kern members. The Behavioral Health Director works in tandem with the various department, UM, Health Education, Health Equity, quality Management in supporting behavioral delivery of services optimally. The assigned activities for this position include:

- Supports quality improvement activities applicable to behavioral health,
- Facilitates network adequacy,
- Participates in collaborative department activities processes,

Behavioral Health Clinical Provider

Is a Licensed PsyD and supports the Behavioral Health Director with clinical matters pertaining to BH as follow:

- Reviews UM behavioral cases and evaluates behavioral health treatment services requests,
- Reviews BH treatment requests for autism spectrum disorders,
- Assists in the selection and distribution of BH educational resources and information to support primary care providers in BH processes,
- Serves on the QI, UM, Pharmacy and Therapeutics and Credentials Committees and Internal Quality Improvement committee including Substance Use Internal Quality Improvement Subcommittee
- Involved in the review, update and approval of behavioral health criteria

Committees

Utilization Management Committee

The Utilization Management (UM) Committee is established as a standing sub-committee of the KHS Quality Improvement Committee and reports to the Governing Board through the Standing Committee. The Committee structures and processes are clearly defined, and responsibility is assigned to appropriate individuals. The UMC is reliant on the involvement of appropriate, actively practicing practitioners representing primary and specialty care. A quorum of at least 3 physicians must be present at each meeting. The UM Committee meets on a regular basis, at least quarterly. Only physicians have voting privileges on the UM Committee. Additional UM Committee meetings or subcommittee meetings are scheduled at the discretion of the UM Committee Chairman. The UM Committee members serve a two-year term with the possibility of reappointment, and terms are staggered to allow for continuity on the Committee. During the period of time between UM Committee meetings, the Medical Director or physician designee may function as an interim decision-maker to resolve any UM issues that may need expediting.

Minutes of committee actions are documented and maintained.

The Utilization Management Committee oversees the implementation of the UMP and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM

Committee is multi-disciplinary and monitors continuity and coordination of care as well as under and overutilization of services. Any perceived or actual utilization management problems are reviewed by the UM Committee. The Quality Improvement and Utilization Management Committees work together on overlapping issues. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information. and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under and utilization patterns.

Key Activities include:

1. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for institutional, ambulatory, and ancillary services.
2. Ensure that UM decisions:
    - Are made independent of financial incentives or obligations,
    - Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management,
    - Physician compensation plans do not include incentives for denial decisions,
    - Physician and UM decision designees are not rewarded for utilization review decisions.
3. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
4. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
5. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
6. Initiate necessary procedural revisions to prevent the recurrence of problematic utilization issues.
7. Identify specific services that are over-utilized or under-utilized and develop appropriate responses to these findings.
8. Continually monitor and evaluate utilization practice patterns of staff and contracted practitioners and vendors and identify variations in care.
9. Review state regulatory oversight of LTC and CBAS facilities.
10. Develop and maintain a process to identify and address quality issues for submission to QI and credentialing, recredentialing and ongoing monitoring process.
11. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
12. Facilitate and ensure continuity of care for members within and outside of KHS network.
13. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

UMC Reports

Oversight of Utilization of services through review of reports regarding major aspects of the Utilization Management Program of the Plan. The analysis of, and the actions taken in respect to, these reports are submitted quarterly to the UMC. They are prepared by various UM Department designees for presentation. Such reports may include, but are not limited to, the following:

a. Quarterly Utilization Management Work Plan Metrics with Quantitative and Qualitative analytics measured against industry and KHS internal benchmarks & Goals,
b. Summaries of UM Program updates,
c. Behavioral Health,
d. Pharmacy,
e. Updates / revisions to UMP policies and procedures,
f. Criteria for UM decision-making,
g. Status of completed and on-going UM activities,
h. Organizational changes made throughout the year,
i. Inter-Rater Reliability Audits,
j. Response to new legislation that affect the UM process,
k. Analysis of the outcomes of improvement activities,
l. Under and Over Utilization Studies,
m. Barriers encountered which defer or delay the achievement of UM goals,
n. Evaluation of overall effectiveness of the UM program,
o. Satisfaction surveys,
p. UM auditing activities,
q. UM/QI Interface Activities,
r. UM/ Credentialing Interface Activities.

Utilization Management and Quality Improvement Interface

The Utilization Management Committee and Quality Improvement Committee interact to ensure that services delivered and managed are of high quality and are appropriate, cost-effective, efficient, and accessible. The UMC employs a system of reporting utilization information and identifying areas of service such as medical, surgical, ancillary, pharmacy, and behavioral health. Through the aggregation and evaluation of UM data, when patterns of care or service issues suggest they are inappropriate or deviate from industry standard, they are reported for further evaluation to the QI Committee.

The QI Committee performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. This committee also develops and enforces the quality improvement process with respect to contracting providers, and other health plan functional areas with oversight by the CMO.

Key components of the QI Program structure and requirements include the continuous review of the quality of care provided to members, to assure that quality, comprehensive health care,

and services are provided to KHS members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement to include:

- A level of care which meets professionally recognized standards of practice is being delivered to all members,
- Quality of care problems are identified and corrected for all provider entities,
- Physicians and appropriate licensed behavior providers to include psychologists are an integral part of the QA program,
- Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
- KHS does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership. The UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

Through UM data aggregation and analytics when adverse QI patterns are discovered they will be submitted to the QI Committee through formal reports for review and to make recommendations and take action as are necessary to ameliorate the conditions. These activities will be documented in the meeting minutes.

Data Sources

KHS has identified the following as sources that may provide useful and meaningful data for analyzing compliance with standards of utilization as well as those of quality:

a. Access to care studies,
b. Providers' telephone triage systems,
c. Medication utilization reports for prescription medications,
d. Institutional Data,
e. Claims Data,
f. Referral Patterns,
g. Timeliness of Service,
h. Ancillary Service utilization,
i. Outpatient Data,
j. Member Complaints/Grievances,
k. Appeals Review,
l. Provider surveys,

m. Satisfaction surveys,
n. Care follow-up, especially ER and Urgent Care facilities,
o. Medical Records Reviews.

Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities related to UM and QI to include, serving as the KHS Credentialing and Peer Review QI Subcommittee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates as necessary the need to add practitioners to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care and includes at least one behavioral health provider. The PAC is also involved in developing, adopting, and reviewing criteria. All protocols, technology, and criteria sets are reviewed and approved or modified as needed on current clinical and medical evidence

Commented [YB5]: Addresses recommendation from auditor-DRR dated 7-28-2023 - UM 1.4 & UM 1.5

PAC- Credentialing and Peer Review

In accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain standards for the education, training, and licensure of the KHS network of Participating Practitioners and Health Delivery Organizations, and establish and maintain credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. UM information is shared with the PAC. The PAC may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Activities:

1. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards,
2. Promote continuous improvement in the quality of the care and service provided by the KHS Providers,
3. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
4. Provide guidance on the overall direction of the credentialing program,
5. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process,

6. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards,
7. Monitoring the reporting of Provider Preventable Conditions.

PAC-Medical Technologies and Clinical Criteria Sets

1. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members. PAC also reviews and modifies all protocols, technologies, and criteria sets as needed based on current clinical, and medical evidence.
2. Preforms reviews of technologies for use by medical and behavioral staff in the utilization review process,
3. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations,
4. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience,
5. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers.

Commented [YB6]: Addresses auditor's (AB) recommendation for PAC function regarding criteria

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations,
2. Protection of member identifiable health information by ensuring members' protected health information (PHI) is only released in accordance with federal, state, and all other regulatory agencies,
3. Providing oversight in strategies to reduce FWA in provider networks.

Reporting Relationship

- The PAC reports recommendations to the QI and UM Committee quarterly,
- The QI and/UM Committees report PAC recommendations to the Board of Directors quarterly through the Chief Medical Officer or their designee.

Pharmacy and Therapeutics/Drug Utilization Review Committee (P&T/DUR)

Key Responsibilities

Commented [EE7]: Added section per Bruce W request

- ♦ Objectively appraise, using principles of evidence-based medicine to evaluate and select pharmaceutical products. This is an ongoing process to ensure the optimal use

of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use and cost;
- Evaluate the clinical use of medications and develop policies for managing drug use and administration;
- Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
- Provide recommendations regarding protocols and procedures for the use of non-preferred medications;
- Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
- Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions;
- Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling;
- Review elements and format of the preferred drug lists, including prior authorization lists;
- Review parameters of prescribing practices for frequency of refills and the number of refills that may be dispensed at one time;
- Make recommendations to the QI/UM Committee for prescribing parameters;
- Review quality of care issues that arise pertaining to the prescribing and dispensing of medications;
- Report to the QI/UM Committee situations that may indicate substandard quality of care.

Membership

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Pharmacy (Alternate Chairperson)
1	KHS Board Member
1	Retail/Independent Pharmacist
1	Retail Chain Pharmacist
1	Specialty Practice Pharmacist
1	Geriatric Practice Pharmacist
1	Geriatric Practice Physician
1	Pediatrician
1	Internist
1	PCP/General Practice Medical Doctor
1	OB/GYN Practitioner
1	BH Provider MD or PsyD
1	Provider at Large

Reporting Relationship

- The P&T meets quarterly with additional meetings as necessary.
- The P&T/DUR reports recommendations to the QI and UM Committee quarterly,

Utilization Management Process

Medical Necessity and Clinical Criteria

The KHS UM Program and contracted entities in accordance with KHS performing utilization management review functions utilize nationally recognized evaluation criteria and standards that are objective and based on medical evidence in making decisions to approve, modify, defer, deny, or terminate services. KHS has specific criteria to determine the medical necessity and clinical appropriateness of medical, behavioral, and pharmaceutical services requiring approval. The criteria or guidelines are:

- Developed with involvement from actively practicing health care providers (behavioral and non-behavioral), including non-staff network practitioners to apply, adopt, and review criteria

- All criteria sets will be reviewed and evaluated, updated, and modified as necessary, at least annually and when appropriate by the Physician Advisory Committee (PAC) and the QI/UM Committee.

- Any new criteria that KHS would like to adopt will be subjected to review and evaluation by the PAC and the QI/UM Committee prior to its approval and implementation by the organization.

Regulations and Criteria Guidelines (Hierarchy of Criteria)
KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. Health Plan eligibility and coverage
2. Federal and state mandated criteria

    - California Code of Regulations Title 22,
    - California Code of Regulations Title 28,
    - CMS Code of Regulations Title 42,
    - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
    - Medi-Cal Provider Manuals,
    - CA DHCS All Plan Letters (APL),
    - DMHC All Plan Letters,
    - CA DHCS Policy and Procedure Letters (PPL),
    - 42 CFR section 438.915, 438.206.
    - Standardized Behavioral Health criteria (Title 9, DSM-V)

3. Nationally recognized criteria set

Commented [YB8]: UM Element 2A.1 criteria is objective & evidence-based

Commented [PT9R8]: From original DRR for UM1A.5: Mostly met on pg 29. Need to include "How the organization reviews, updates and modifies criteria". Please confirm this is evidence you'd like to present for UM1A.5?

Commented [YB10R8]: addressed on pg. 30 1st bullet - highlighted - correction to be made in comment

Commented [YB11]: UM Element 1A.5.- 1st bullet

Commented [YB12R11]: Correction made

Commented [YB13]: Addressed TMG auditor (AB) re: annual approval of existing criteria and new criteria

Commented [YB14]: UM 1A.6 TMG DRR auditor (AB) findings addressed priority of criteria

- MCG Health LLC (Milliman Care Guidelines,)
- UpToDate

4. Peer Reviewed Journal or Published Resources

In January 2019, a new law was passed requiring the Medi-Cal pharmacy benefits and services to be administered by the Department of Health Care Services in the fee-for-service delivery system, known as "Medi-Cal Rx.". With the exception of medically administered drugs, pharmacy is carved-out to DHCS.

Commented [AD15]: Pharmacy carve-out

Commented [YB16R15]: Additional recommendation from TMG auditor (AB)

UM decision making criteria shall be available to the public upon request. When making UM determinations KHS shall disclose the criteria or guidelines for the specific procedures or conditions requested. If it is determined to apply charges in disclosing criteria, the charges will be limited to reasonable fees for copying and postage costs when electronic communication means of disclosing criteria is not available.

For those instances when criteria are applied as the basis of a decision to modify, delay, or deny services in a specified case under review, the criteria shall be disclosed to the provider and the enrollee used in that specified case.

All criteria disclosures will be accompanied with the following clause, "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The KHS UM Program will also review and present internally generated and other outside criterions to the Physician Advisory Committee (PAC) and the QI/UM Committee for direction in the development and/or adoption of specific criteria to be utilized by the KHS UM staff.

When making medical necessity decisions, UM staff obtains relevant clinical information such as patient medical records from the requesting provider and appropriate specialists by telephone or by fax to finalize the UM decision. Clinical information is provided to the Chief Medical Officer or their designee to support the decision-making process. Examples of clinical information include the following but is not limited to:

Commented [YB17]: Added to meet UM 1A.5

- History and physicals,
- Office and ancillary service notes,
- Treatment plans and Progress notes,
- Health Risk Assessments,
- Psychosocial history,
- Risk Stratification,
- Diagnostic results, such as laboratory results, or radiology results,
- Specialty Consultation records, including photographs, operative, and pathology reports,
- Pharmacy profiles,

- Telehealth communications,
- Behavioral Health/Mental Health records,
- Information regarding benefits and any changes as required under the Department of Healthcare Services (DHCS) contract and Department of Managed Healthcare (DMHC) Knox Keene Licensure.

The review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may be modified to a given instance. Medical judgment and decision making is individualized based on the member's condition and as applicable, discussed with the physician/practitioner reviewer, and requesting physician to render an appropriate decision relative to Kern's policies:

- Age,
- Sex/gender,
- Comorbidities,
- Complications,
- Home environment, as appropriate,
- Progress toward accomplishing treatment goals,
- Family support,
- Previous treatment regimens,
- Psychosocial situation and needs,
- Benefit structure including coverage for post-acute or home care services when needed.

Consideration of the delivery system and availability of services to include but not be limited to:

- Availability of inpatient, outpatient, and transitional services,
- Availability of highly specialized services, such as transplant facilities or cancer centers,
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge,
- Availability of outpatient services in lieu of inpatient services such as surgery-centers vs inpatient surgery,
- Local hospitals' ability to provide all recommended services within the estimated length of stay,

Criteria Notifications

Members are notified of the availability of UM criteria either in writing upon request or on the website and through the EOC Member Handbook mailed to all members.

Availability of the UM criteria upon request may be done in person or by telephone.

Practitioners are notified of the availability of UM criteria, either in writing upon request or on the website and through the provider manual upon onboarding, provider portal, and annual Provider network education. Providers are also notified, annually, through Plan newsletters and mailings, of the process by which such information may be obtained. KHS may also mail

Commented [YB18]: UM 2A.2 individual needs

Commented [PT19R18]: I think we need a DP as well

Commented [YB20R18]: DP documented process example: policy or workflow - refer to NCQA standards pg. 253-254-1-3 factors: structural requirement- only needs P&P in the look back period

Commented [YB21]: UM 2 A.3 local delivery system

Commented [PT22R21]: I think this needs to be in a DP as well

Commented [YB23R21]: DP documented process example: policy or workflow- refer to NCQA standards pg. 253-254-1-3 factors: structural requirement- only needs P&P in the look back period

Commented [YB24]: UM Element 2B.1- How practitioners can obtain UM criteria

Commented [PT25R24]: Great this is in PD. Per DRR, need to show materials used in provider communications

the criteria to practitioners who do not fax, email or have internet access. KHS maintains a UM Criteria Disclosure log to document a criteria request made by a practitioner or a member & member representative. The UM Department maintains a UM Disclosure Log to document any criteria requests made by a member or its representative or practitioner and peer-to-peer review requests.

Members receive pertinent criteria information with every -Notice of Action (NOA)-denial letter, by mail.

KHS also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.

The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature.

For complex specialty reviews the UM medical staff refers the case for review to a licensed, board- certified practitioner in the same or similar specialty as the requested service.

Referral Management

Referral management is designed to determine medical necessity utilizing established criteria based on an assessment of the member's clinical condition, diagnosis and requested treatment plan. Each case is evaluated individually, and sound medical criteria applied as appropriate.

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the KHS UM department by fax or through KHS's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information,
- Provider demographic information,
- Requested service/procedure to include specific CPT/HCPCS code(s),
- Member diagnosis (Using current ICD Code sets),
- Clinical indications necessitating service or referral,
- Pertinent medical history, treatment, or clinical data,
- Location of service to be provided,
- Requested length of stay for all inpatient requests,
- Proposed date of procedure for all outpatient surgical requests.

Pertinent data and information are required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Contract providers are obligated to refer members to KHS network providers, and/or providers approved through the Utilization Management Letter of Agreement process, unless medical necessity or emergency dictates otherwise. Physician requested Out of Area/Out of Network

Commented [YB26]: UM Element 2B.2 - - UM criteria Disclosure
Log- documents criteria request made by practitioners.

Commented [PT27R26]: I think we need to submit Template as evidence that would be used in survey. Should be dated to prove in place during look back period

Commented [YB28R26]: Submitted 2022 UM disclosure log - No requests; template for 2023 to be populated accordingly.

referrals are processed through Provider Relations Department with Letters of Agreement (LOA) for financial reimbursement methodology. KHS utilizes a member centric medical management documentation platform, JIVA system by ZeOmega, to house all clinical information for each member.

Emergency Room Visits

Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Pre-authorization

With the exception of specific services that do not require medical necessity or prior authorization to include but are not limited the following: OB/GYN, Abortion Services, treatment for Sexually Transmitted Disease, HIV services, Sensitive services, Family Planning Services, Maternity Care, Transportation, Vision, COVID 19 Vaccines Emergent/Urgent care, and Mental Health (initial mental health and substance use disorder (SUD) assessments), PCP services from a KHS contract PCP, and services listed outside of the Prior Authorization List, most non-urgent specialty care must be pre-authorized by KHS in accordance with KHS referral policy and procedures in accordance with H&S Code section 1367.01. Requests for services are submitted either by fax or electronic online submission to KHS for review and processing.

For those services requiring pre-authorization, only KHS UM Clinical Staff and/or KHS Chief Medical Officer or designee(s), including the Physician Advisory Panel staff, may give authorization for payment by KHS. Denials, delays/extended delay, modifications, and terminations are performed in accordance with the Knox Keene license and DHCS contract. Only qualified health care professionals with appropriate clinical expertise in treating medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs supervise the review of decisions including service reductions and denials made in whole or in part, based on medical necessity. KHS utilizes both board certified internal MD staff as well as contracted vendor(s), Advanced Medical Review (AMR), for medical necessity reviews as additional guidance and evidence based scholarly references to ensure appropriate medical decision making. KHS maintains a list of board-certified consultants that includes contact information, e.g., phone numbers, names, specialties) and makes the list available to all UM staff as a reference for contacting those consultants. When external consultants are not able to share their names for proprietary reasons, they will provide KHS with centralized contact information and a list of the specialties of all board-certified consultants

KHS will review prior authorizations for physician administered drugs, medical supplies, and enteral nutritional products billed on a medical claim.

Physician administered drugs (PAD) and others that are managed as part of the medical benefit will be managed by common pharmaceutical utilization management and coverage tools. Generic versions of the branded drug, biosimilars, and follow on drugs are the preferred drugs. Preferred drug lists and prior authorization lists are derived from this concept. Any limitations

associated with these drugs will be communicated. Appropriate professionals of physicians and pharmacists from the P&T/DUR committee will approve protocols and policies regarding this governance annually. KHS will monitor quality and safety measures for those drugs under its purview. PAD drugs and others that fall under the management of KHS as they apply, will be reviewed to enhance the safety and quality of our members. Drug recalls, those identified on the Beers list of potentially inappropriate for the elderly, and opioid and similar controlled drugs as identified in SUPPORT Act are monitored.

Regular analytics are completed to reevaluate the need for prior authorization requirements as part of over and underutilization monitoring. KHS has a specialty referral system to track and monitor referrals requiring prior authorization. All network providers are made aware of the specialty referral processes and tracking procedures.

Concurrent Review

A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Requests for authorization are reviewed within 5 working days or 72 hours based on the urgency of the request.

Inpatient Concurrent Review and Continued Stay

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a hospital admission in order to justify the continued level of care. The concurrent review process is conducted by California licensed Registered Nurses by review of the member's medial record, reviewing the hospital's case management notes, dialoguing with the attending physician and other members of the health care team, and speaking with the patient and/or family or significant other, as needed.

Hospitalizations are concurrently reviewed for appropriate length of stay and discussed during scheduled rounding meetings with the KHS CMO (or designee) if medical necessity cannot be established. Concurrent reviews are performed collaboratively with KHS contracted hospitalist groups and/or providers and KHS RN staff to determine medical necessity of admission, length of stay, and post discharge dispositions.

Through the hospitalist program, the UM Nurse can authorize referral requests for member discharge planning and coordination of services for post-acute care.

Discharge Planning

UM Nurse and/or the UM Social Worker will assess member's post hospital continuing care needs and will collaborate with the provider organization's discharge planning staff to make arrangements for appropriate post-acute services pertinent to the member's recovery such as SNF, Acute Rehabilitation, DME, Home Health, specialist follow-up visits, community resources, and any other services identified. Recuperative Care and Transitional Care Clinics

are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review

Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written KHS medical policy, Title 22 criteria, and/or MCG Criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to KHS case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Retrospective Review

For those services requiring prior authorization, retrospective review for payment of claims is initiated when no prior authorization was obtained by the practitioner or provider organization. Retrospective review is also initiated for services performed by a non-contracted provider or when no authorization was obtained before completion of the service. Members, practitioners, and provider organizations are notified by mail/online of the UM/ claims decision.

Utilization Management Decision Timeframes

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member's condition. KHS remains compliant with the defined timelines under the DHCS contract. When the member faces an imminent and serious threat to his or her health, including, but not limited to, potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests from provider, shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make a determination.

- **Emergency Care**: no prior authorization is required.
- **Post-Stabilization**: within 30 minutes of a provider's request for authorization, or the service is deemed approved.
- **Non-Urgent Care** following an exam in the emergency room: KHS must respond to a provider's request for post-stabilization services within 30 minutes or the service is deemed approved.
- **Concurrent Review** of authorization for a treatment regimen: 5 working days or less, consistent with the urgency of the member's medical condition.
- **Retrospective Authorization**: retrospective authorization requests are processed within a reasonable established time limit, not to exceed 365 calendar days from the

date of services; decisions to the provider and member are made within 30 calendar days of the receipt of information.

- **Routine Authorizations**: no longer than 5 working days from receipt of information and no longer than 14 calendar days from the receipt of the request; an extra 14 calendar days may be extended when member or provider requests an extension, and justified by KHS upon request by DHCS and in the member's best interest.
- **Expedited Authorization:** Decision must be made no longer than 72 hours after receipt of the request for services. Extension may be granted to an additional 14 calendar days when member or provider requests an extension.
  and justified by KHS upon request by DHCS and in the member's best interest.
- **Hospice Services:** No prior authorization is required for inpatient and outpatient hospice services.
- **Therapeutic Enteral Formula**: KHS complies with applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.
- **Physician Administered Drugs**: KHS complies with same timeframes as other medical services.

Inter-Rater Reliability (IRR)

KHS assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Bi-annually, both physicians and staff involved with making UM decisions participate in the IRR process. The Director of UM selects specific topics for completion by the UM clinical staff. The IRR training module records the completion for each user, along with the test results. KHS UM Management staff evaluates competency utilizing the MCG IRR training module for necessary remediation and education. Successful completion is required as a fulfillment of the clinical staff outlined job duties. The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services,
- Nurse Coordinator Review of Outpatient Services,
  Nurse Coordinator Review of Long-Term Care Services,
- Physician Reviewers,
- Behavioral Health Reviewer,
- Nurse Coordinator Review of Claims/Disputes and Appeals review for Outpatient Services and Inpatient Services.
- Non-licensed UM and Care Management Coordinators processing referral requests.

Ongoing Training

KHS provides and encourages ongoing staff training. Areas of opportunity includes seminars, conferences, workshops, training by KHS Learning and Development department, and specialty specific training by contracted practitioners and provider organizations. Network providers also receive training on the procedures and services requiring prior authorization for medically necessary services including the necessary timeframes within 30 days of start of

contract. The role of Analyst /Trainer and UM Clinical Auditor/Trainer receives direction on the training needs of specific staff members from the UM Department leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

The Clinical Intake Coordinators and UM Nurse staff utilize established criteria for referral review and determination. Quarterly random audits are conducted to ensure compliance of the referral process and inter-rater reliability and are reported to UM Management for process improvement and staff education. Results of the findings are presented to the CMO and reported to the QI/UM Committee.

UM Determinations

Denial Determinations

Denial determinations may occur at any time during the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity.

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered. (Peer to Peer)

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization when the requested service is not medically indicated.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient,
- When an inpatient facility fails to notify KHS of an admission within one business day of the admission or appropriate clinical information is not received,
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary,
- A denial may also occur for inappropriate levels of care or inappropriate care.

Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

KHS offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Chief Medical Officer, or a physician reviewer designee.

The referring practitioner, provider and member are notified of the denial through a Notice of Action (NOA) letter, translated in both English and Spanish with non-discrimination clauses and tagline notations.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination, so the member and provider have a clear understanding of the rationale for the denial and enough information to file an appeal.

All recommended denials are reviewed by the CMO or designee(s), except for administrative denials that are not based on medical necessity and performed by the UM RN Clinical Intake Coordinators/UM Nurse. Services denied, delayed/extended delay, terminated, or modified based on medical necessity may be eligible for an Independent Medical Review.

The Department of Health Care Services and Department of Managed Health Care provide direction to and oversight of the process of issuing written notification of non-coverage to KHS members.

KHS complies with DHCS Notice of Action Template requirements for Medi-Cal to include applicable inserts on how to file an appeal, DMHC information, translation services. This process is outlined in the KHS policies and procedures related to processing referrals.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Appeals of Adverse Medical Necessity Denials and Benefit Determinations

A member, a member's authorized representative, or a provider acting on behalf of a member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter. A member or a member's authorized representative may initiate an appeal by contacting KHS's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the KHS Grievance and Appeals department for processing. A provider may also request an appeal on behalf of a member, with written consent from that member, by faxing or writing KHS's UM Department.

After receipt of the request for appeal, KHS will provide written acknowledgement to the member and provider that is dated and postmarked within five (5) business days of receipt of the appeal. KHS has 30 calendar days from the receipt of the appeal request to render a determination.

The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity. The Chief Medical Officer or physician designee may request further information from the provider such as:

- Diagnostic information,
- Clinical justification,
- Previous treatment,
- Opinions from specialists or other providers,
- Evidence from the scientific literature prior to processing the request.

The provider is expected to respond to a request for further information within the 30-calendar day determination time frame. If the provider does not respond to the request for further information within that time frame, the appeal can be extended no more than 14 calendar days.

When a decision has been made, the provider and/or member, if applicable, are notified in writing within five (5) business days with a Notice of Appeal Resolution (NAR) letter. KHS is not required to notify the member of a decision when the member is not at financial risk for the services being requested (post stabilization concurrent reviews).

If the provider or member is dissatisfied with the appeal determination, a second level appeal or grievance may be filed.

If KHS's determination specifies the requested service is not a covered benefit, KHS shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service.

The response shall either identify the document and page where the provision is found, direct the provider and member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.

Expedited Appeals of Adverse Benefit Determinations

Expedited appeals may be initiated by the member or the provider. A member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a member with written consent by faxing or writing the KHS UM Department. If the request for expedited appeal is not accompanied by written consent from the member, the Plan will proceed with the request.

Expedited appeals are performed by KHS only when, in the judgment of the Chief Medical Director or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the member.

KHS refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the request for an expedited appeal.

Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

KHS provides verbal confirmation of its decisions concurrent with mailing of written notification no later than 72 hours after receipt of an expedited appeal. If the expedited appeal involves a concurrent review determination, the member continues to receive services until a decision is made and written notification is sent to the provider. KHS is not required to notify

the member of a concurrent decision as the member is not at financial risk for the services being requested.

Appeal Rights

A member may ask for assistance from a patient advocate, provider, ombudsperson or any other person to represent them in their request.

A member may also request a State Hearing if a member has filed an appeal and received a "Notice of Appeal Resolution" letter upholding the initial denial of service or in instances of deemed exhaustion. Information on how to obtain an expedited State Hearing is included as a part of the "Notice of Appeal Resolution" letter to the member.

Member grievance and appeal information is included in the member handbook, distributed annually in the member newsletter, and is posted on the KHS website.

It is the responsibility of the Member Services Director and the Member Services Department to ensure:

- Member Rights and Responsibilities are included in the member handbook which is mailed to all new members and posted on the KHS website,
- Members are advised of their appeals rights when the adverse determination NOA is mailed to them.

Members are notified of all revisions to the Member Rights and Responsibilities statement in the member newsletter following revisions.

Independent Medical Review

Medi-Cal members can request independent medical review (IMR) on denied appeals involving medical necessity, including requests related to experimental/investigational services and receipt of out of Plan Emergency Department services. The DMHC administers the IMR program in the State of California at no cost to the member in compliance with applicable statutory requirements and accreditation standards. The IMR decision is binding on KHS.

Depending on the complexity of certain medical condition, KHS may require additional expertise in determining medical necessity for certain diagnosis and related procedures. Utilizing a nationally recognized and comprehensive review solution as a supplement to these difficult cases will provide the KHS CMO and Medical Directors with comprehensive medical recommendations utilizing case-specific patient information and history and industry standard guidelines including treatment protocols supported by current scientific evidence-based medicine to promote quality health care. Each review will be assigned to the IMR Reviewer who will be in an appropriate specialty or who will possess specific knowledge appropriate to the request of the treating provider. The IMR Physician Advisors will be specifically trained in Medicare/Medicaid rules and regulations based upon California state guidelines and remain

well versed in the ongoing regulatory landscape to ensure up to date legislative rulings are current in the review process.

All services will be performed based on specific turnaround times which are calculated from the time the request and all related materials are received by the IMR reviewer. Submission of requests via a secure portal are completed by the KHS Clinical Intake Coordinator (CIC) on behalf of the CMO or designee at their direction only. It is the responsibility of the submitting CIC to track the progress of the review to ensure receipt based on the recommended turnaround timeline. The designated turnaround times will align with all DHCS timelines for medical decision making as outlined in KHS contract.

UM Programs and Service Descriptions

Mental (Behavioral) Health Services

KHS responsibilities are limited to mild to moderate mental health conditions rendered in the outpatient setting. Psychotropic drug therapy remains carved out and provided under the Fee for Service MCAL payment structure by the County Mental Health Plan. Referrals for mental health services may be generated by the practitioner, KHS Social Workers, KHS' 24-hour contracted advice and triage nurses, school systems, employers, family, or the member.

KHS do not administer triage and referral process.

Members needing immediate crisis intervention may self-refer to the Emergency Room or to the Kern County Behavioral and Recovery Services' Crisis Stabilization Unit. This information is provided to the members through the member handbook, and periodically, through the member newsletter. Mental Health Services for Medi-Cal participants are a covered benefit as described under the Kern Health Systems Health Plan in the contract with the Department of Health Care Services (DHCS).

KHS administers the mental health benefit as well as coordinating the benefit with the Kern Behavioral Health and Recovery Services (KBHRS) through a Memorandum of Understanding (MOU) and other contracted provider groups for their covered services. Quality issues including those occurring in different sites of behavioral healthcare services such as psychology groups or levels of behavioral healthcare such as outpatient psychiatrist visits are assessed through review of member grievances, member satisfaction study results, interactions with members, and quarterly meetings with KBHRS. KHS UM staff is available to assist KBHRS with complex cases and facilitate coordination and continuity of care between providers when transitioning between mild to moderate and extreme and pervasive mental health conditions.

Members who meet medical necessity criteria for medical conditions may receive Voluntary Inpatient Detoxification (VID) services in a general acute care hospital. VID services are carved-out (non-capitated) of the managed care contract and covered through the Medi-Cal

Fee for Service program. Inpatient detoxification must be the primary reason for the member's voluntary inpatient admission.

KHS complies with Mental Health Parity requirements as required by Title 42, CFR, §438.930. The policies and procedures are consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

KHS adheres to appropriate utilization management processes to review, approve, modify, deny, and delay the provision of medical, mental health, and substance use disorder services to demonstrate compliance with mental health parity.

Behavioral Health Therapy (BHT) and Behavioral Intervention Services (BIS)

KHS provides coverage for all medically necessary BHT services for eligible beneficiaries under 21 years of age. This applies to any health condition, including children diagnosed with autism spectrum disorder (ASD)4 and children for whom a licensed physician, surgeon, or psychologist determines that BHT services are medically necessary.

Transitional Care Program

The Transitional Care Model (TCM) is an evidence-based solution to these challenges. The TCM has consistently demonstrated improved quality and cost outcomes for high-risk, cognitively intact, and impaired older adults when compared to standard care in reductions; in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs.

- *Avoidance of hospital readmissions for primary and complicating conditions.* TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are re-hospitalized, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.

- *Enhancement in patient and family caregiver experience with care.* Overall patient satisfaction is increased among patients receiving TCM. In ongoing studies, TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

- *Improvements in health outcomes after hospital discharge.* Patients who received TCM have reported improvements in physical health, functional status, and quality of life.

Collaborative care is the cornerstone of the TCM model. Collaborating partner's staff will form the interdisciplinary clinic that provides biopsychosocial and diagnostic screenings and

evaluations, medication management, care management, treatment planning and intervention services, as well as general medical services for the identified population. The main goals of integration include:

- Foster cross-system partnerships,
- Quality and value-based system of care,
- Create robust inpatient discharge coordination and develop cross-system transfer of care protocols,
- Expand strategies and educational opportunities,
- Improve patient experience and quality outcomes; and
- Implement model of care that is sustainable and cost effective.

Major Organ Transplant

Effective January 1, 2022, KHS will expand coverage to cover all major organ transplants, in addition to the current benefit of kidney transplant services. The UM Nurse and Clinical Intake Coordinator will work closely with the Major Organ Transplant Program team to ensure these vulnerable members are connected to this care coordination program to help assist and support them in navigating this complex process.

Long Term Care

Effective January 1, 2023, KHS will be administering the Medi-Cal Long Term Benefit for qualifying members. Long term care may be required due to physical or mental conditions that need continuous skilled nursing services; for Medi-Cal managed care, the LTC benefit for these services includes room and board and other covered services medically necessary for care. Kern Health Systems ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities may include, a. Skilled Nursing Facilities b. Sub-acute Facilities (pediatric and adult), and c. Intermediate Care Facilities. A member in need of long-term care is identified by his/her physician, health care clinician, acute care attending physician, case managers or discharge planners. To support appropriate utilization management, case management and service coordination to maintain the member at the LTC level of care, KHS follows specific protocols and standards for determining levels of care and authorizing services that are consistent with policies established by the Federal Centers for Medicare and Medicaid Services (CMS) and in accordance with: a. 22 CCR § 51335 Title 22. Social Security Division 3. Health Care Services Subdivision 1. California Medical Assistance Program (Refs & Annos) Chapter 3. Health Care Services Article 4. Scope and Duration of Benefits § 51335. Skilled Nursing Facility Services.

Second Opinions

Members have a right to a second opinion by a qualified medical professional. A request for second opinion is reviewed to determine whether KHS has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed within the plan to obtain

second opinion. When an appropriate, qualified physician is not available within the plan, an out of area/out of network referral with LOA is authorized.

Telemedicine/Telehealth

Telemedicine and other remote monitoring capability are a growing trend in the evaluation of a member's health. Telemedicine allows for HIPAA compliant medical information to be exchanged from one site to another via electronic communications to improve the member's clinical health status using two-way video, email, smart phones, wireless tools, and other virtual/telephonic communication modalities technology. No additional prior authorization is required for telemedicine, only the service is subject to those contained in the Prior Authorization list and limited to those KHS contracted providers who have demonstrated adequate office space, availability of a patient navigator, and suitable telemedicine equipment to connect with a remote medical group. This allows KHS additional options to serve members in both local and rural areas to improve primary care and specialty access and reduce wait times.

Emergency Services

KHS complies with all applicable requirements of Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Health and Safety Code Section 1371.4. KHS shall reimburse providers for emergency services and care provided to members, until the care results in stabilization of the member. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention may be expected to result in any of the following:

- An imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- A delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.

KHS strives to strengthen our collaborations with community entities to reduce costs, improve the patient experience, and improve the health of the populations we serve. Strategies are reviewed annually to determine the best approach to reducing inappropriate ER utilization. These include:

- Broaden access to Primary Care Services,
- Focus/enroll high utilizers into Case Management programs,
- Target members with behavioral health problems.

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization

KHS does not require prior authorization for emergency services. Post-service claims review (for out of plan emergency care) considers whether the member's decision to Present to the Emergency Department was reasonable under the circumstance.

Post-stabilization

KHS requires review and authorization for all out of plan post-stabilization care, and follows all statutory requirements and accreditation standards in making post-stabilization care authorization decisions.

Completion of Covered Services

KHS, at the request of a member, provides for the completion of covered services by a terminated provider or by a nonparticipating provider. The completion of the covered service shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services to include:

- Acute Condition,
- Chronic Condition,
- Pregnancy,
- Terminal Illness,
- Care of a Newborn (between birth and 36 months of age),
- Performance of a surgery or other procedure authorized by the plan as part of a course of treatment,
- Applied Behavioral Analysis,
- Mental Health Condition.

The plan may require a non-participating provider, whose services are continued, to agree in writing to the same contractual terms and conditions that are imposed upon providers under current contract.

Standing Referrals

Occasionally a member will have a disease that requires prolonged treatment by or numerous visits to a specialty care provider. Once it is apparent that a member will require prolonged specialty services, UM may issue a standing referral and provide a determination within three working days from the request date made by the member or the PCP after obtaining all appropriate medical records and information. The referral must be made within four working days of the date of the proposed treatment plan. A standing referral is an authorization that covers more visits than an initial consultation and customary follow-up visits and typically includes proposed diagnostic testing or treatment. Members are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity.
A standing referral may be limited by number of visits and/or length of time. It is only valid during periods when the member is eligible with KHS. A standing referral may be issued to contracted or non-contracted providers as deemed appropriate by the Chief Medical Officer, or their designee(s). The Director of Provider Relations will negotiate letters of agreement for services not available within the network.

Collaboration of Services

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership.

Continuity of Care is provided upon enrollment for those members with established relationships with Primary Care Providers, Specialists, and ancillary providers to promote uninterrupted services that may have been initiated prior to the member's enrollment with KHS.

KHS is also required to provide beneficiaries with continuity of care from a non-participating provider or from a terminated provider, subject to certain conditions. The beneficiaries must be given the option to continue treatment for up to 12 months.

KHS must provide continuity of care with an out-of-network provider when KHS is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider); the provider is willing to accept the higher of the KHS's contract rates or Medi-Cal Fee for Service rates; and the provider meets KHS's applicable professional standards and has no disqualifying quality of care issues.

Collaboration with other outside agencies such as Kern Regional Center, Department of Public Health, Department of Mental Health, Homeless Coalition and Housing Authority, Department of Aging and Health and Human Services, California Children Services, Denti-Cal, and other internal KHS departments and coordination of services for the KFHC membership is an important aspect of the UM process. The UM Nurse and Clinical Intake Coordinator assist the members in obtaining carved-out services and when necessary, coordinate and provide services not covered by the carved-out practitioner/provider.

The UM Nurse and Clinical Intake Coordinator coordinates Mental Health services with Kern Behavioral Health and Recovery Services through a Memorandum of Understanding pursuant to a contract between the County and the State. This coordination is essential to provide members with a seamless transition between mental health services beyond the scope of KHS responsibility to manage mild to moderate symptomatology and the more severe diagnosis under the responsibility of the County System of Care.

In addition, KHS UM staff also coordinates autism spectrum disorder (ASD) and Behavioral Intervention services with Kern Regional Center (KRC) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical and supportive services as they transition between the systems of care.

The UM Nurse and Clinical Intake Coordinator also coordinates Specialty children's services with California Children's Services (CCS) through a Memorandum of Understanding. This

coordination is essential in order to provide members with uninterrupted medical services as they transition between the systems of care.

Regularly scheduled quarterly (or more often if deemed necessary) Joint Operations Meetings are held with Mental Health, CCS, and Regional Center partners to promote coordination, quality, and timely decisions regarding member's identified needs.

The UM Nurse and Clinical Intake Coordinator also identifies members who are eligible and could benefit from KHS internal programs such as Health Homes Program, Complex Case Management, Disease Management, and Transitional Care programs in order to link them to additional supportive services to improve member health outcomes. Member health education and disease management are important components in member Case Management. Improvement of the member's health is a collaborative effort between the member and the member's practitioner, KHS Health Education, Disease management, UM Nurse and Clinical Intake Coordinator, and numerous community partnerships.

Continuity of Care

Continuity of Care with an Out-of-Network Provider for Medi-Cal Members Transitioning into Medi-Cal Managed Care

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care assigned to KHS have the right to request continuity of care in accordance with state law, DHCS All Plan Letter (APL18-008) and the DHCS-KHS contract, with some exceptions. All KHS members with pre-existing provider relationships who make a continuity of care request to KHS will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan. The following guidelines will be applied:

1. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider):
    a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All-Plan Letter (APL18-008).
2. The provider is willing to accept the higher of KHS's contract rates or Medi-Cal FFS rates,
3. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality-of-care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS members),
4. The provider is a California State Plan approved provider,

5. The provider supplies KHS with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

Continuity of Care – Terminated Providers

Continuity of care will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources: California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96.

Upon member request, KHS' Utilization Management (UM) Department will utilize defined guidelines as outlined in California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96 to authorize as appropriate continuity of care with a terminated provider who has been providing care for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester. In cases involving an acute condition or a serious chronic condition, KHS shall furnish the member with health care services on a timely and appropriate basis from the terminated provider for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. In the case of a pregnancy, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice.

Continuity of care will not be authorized with a provider whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason[i] or fraud or other criminal activity.

Delegation

Delegation of Utilization Management Functions

KHS has the discretion to delegate, and the responsibility to oversee, UM functions performed by either Kaiser Foundations Health Plan in support of the KHSUM goals and objectives. KHS also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KHS retains accountabilities for all delegated Utilization Management activities conducted for members and ensures that delegated UM processes are designed to meet member service and access needs.

On an annual basis, KHS performs a comprehensive assessment of the delegated UM activities to include a UM file review. The entity's annual evaluation of delegated UM functions and assessment summaries of activities are presented to KHS Medical leadership for review and approval.

Should there be any concerns regarding failure of a delegated entity to carry out delegated activities, KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

UM Delegation to Affiliated Providers

When UM activities are delegated to contract affiliated providers, KHS retains responsibility and oversight of the delegated functions. The delegation is subject to an executed delegation agreement in which UM activities are clearly defined, including:

- Reporting requirements for the delegated entity,
- Reporting requirements for KHS to the delegated entity,
- Evaluation process of the delegated entity's responsibilities,
- KHS Approval of the delegated entity's UM program and processes,
- Mechanisms for evaluating the delegated entity's program reports,
- The delegated entity's ability to collect performance data necessary to assess member experience and clinical experience, as applicable,
- KHS right to revoke and terminate a delegation agreement.

Delegation of UM Activities

KHS has delegation oversight activities/processes for pre-delegation evaluation, delegation oversight activities, and regular reporting used to monitor delegates according to the standards established by KHS, licensing, and regulatory bodies. KHS may delegate Utilization Management (UM) and Pharmacy functions/activities to entities with established Quality Improvement and Utilization Management programs and policies consistent with licensure and regulatory requirements.

KHS remains accountable for and has appropriate structures and mechanisms to oversee delegated activities even if it delegates all or part of these activities. KHS tracks and processes all KHS member's UM activity internally with the exception of Kaiser assigned MCAL members whose UM functions are delegated as part of a two-way agreement under contractual requirement with DHCS.

Delegation Agreement Process

KHS provides ongoing monitoring of UM activities that are delegated to contract providers. The delegated functions are reviewed and approved on an annual basis by the QI/UM and Delegation committees. A comprehensive delegation audit is conducted by KHS at a minimum annually. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and KHS.

The delegation agreement outlines the responsibilities and activities of the physician network and the managed care organization that is delegated to provide utilization management services.
Delegates undergo a pre-delegation audit (survey) conducted by KHS to assure that the Medical Group/IPA is capable in its ability to meet the standards of the Plan and those of the Act and the rules there under and has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
The delegation agreement includes the following:

- Mutually agreed upon before delegation starts,
- Describes the delegated activities and the responsibilities of KHS and those of the contracted entity and the delegated activities,
- For each activity, KHS has identified the documented reporting requirements at least semi-annually and delegated activities of the delegated entity to KHS,
- Describes the process by which KHS evaluates the delegated entity's performance for providing member experience and clinical performance data to its delegates when requested,
- Describes the remedies available if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Joint Operations meetings are conducted quarterly in addition to an annual delegation audit to ensure compliance with DHCS regulatory requirements.

Delegated Triage Services

KHS contracts with a third-party vendor to provide 24/7, weekend and holiday triage services for all KHS members. The vendor provides not only triage services but also supports a member-initiated Health Library to promote education on a varying number of topics. Reports are generated monthly to monitor their activities as well as identify member patterns during execution of after hour services. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

Delegated Vision Care

Vision Care is delegated to a 3rd party vendor and capitated for all vision services. Reports are generated monthly to monitor their activities as well as identify utilization patterns. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

KHS contracts with a vendor, Health Dialog, to perform 24-hour Nurse Advice and triage call center activity and provides summary reports detailing the utilization of services at scheduled intervals. The report is reviewed for trending of ER and Urgent Care usage based on total usage compared against deferment back to the PCP and Home/Self Help care. Monthly touchpoints are scheduled to address any issues or trends identified. Actions plans are developed if utilization patterns raise concerns for escalation. Health Dialog provides a Health

Audio Library for member self-service of specific health topics or acute/chronic condition education.

All delegated entities are required to support and adhere to the same regulatory reporting and access standards as KHS. KHS has the responsibility to the Delegated or Subcontractor's agreement to revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or KHS determine that the Subcontractor has not performed satisfactorily.

Complete delegated oversight audits are conducted at least annually, and more often if warranted, to ensure all aspects of KHS's contract are performed to the standards outlined by DHCS and DMHC.

KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

Under and Over Utilization

KHS monitors under- and over-utilization of services through various aspects of the UM process including Behavioral Health Services. Through the referral authorization process, the UM Clinical Intake Coordinator/UM Nurse monitors under and over-utilization of services and intervenes accordingly including non-specialty mental health services utilization data for both adult and pediatric members.

- The UM department monitors underutilization of health service activities through collaboration with the QI department. The UM department sends correspondence notifying the practitioners and members of the carved-out services and a reminder to see their primary care provider for all other health care services not addressed by the carved-out specialty care provider for gaps in care closure,
- Over-utilization of services is monitored through several functions. Reports are reviewed to analyze unfulfilled authorizations or gaps in care to determine interventions directed to ameliorate any identified adverse trends,
- Upon request, KHS will report to DHCS all its internal reporting mechanisms used to detect member utilization and provider prescribing patterns,
- KHS monitors utilization data to appropriately identify members eligible for

Medical Loss Ratio

Medical Loss Ratio (MLR) is a metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues. KHS has placed major emphasis on the reduction of MLR to monitor and manage utilization within the health plan. Areas of focus include achieving an overall Key Performance Indicators (KPI) metrics Goal of <92% across all lines of business-SPD, Family/Other, and Expansion. Dashboards provide transparency to the plan's Executive leadership of all identified KPI.

Resource Management

Resource Management activities focus on the prudent and clinically appropriate allocation of resources for the provision of health care services. These activities are not subject to direct regulation under the Knox-Keene Act. The UM Program monitors and provides oversight of coordinated performance related to Utilization/Resource Management across the continuum to include:

- Drug Utilization,
- Laboratory Utilization,
- Product Utilization,
- Radiology Utilization,
- Surgical Utilization.

Evaluation of New Medical Technologies

KHS evaluates a variety of web-based interactive applications for future consideration of medical technologies adoption. KHS MIS department develops and implements new technologies as they emerge to provide efficient methods of tracking member activity and report generation. UM clinical staff have direct access to various websites for review and reference for discussions on innovative methods not currently in use by KHS that may be implemented in the delivery of healthcare to KHS members. New technologies are vetted with MCAL guidelines for coverage, then forwarded to the PAC and QI/UM committees before board approval.

KHS evaluates and addresses new developments in technology and new applications of existing technology for inclusion in its benefit plan to keep pace with changes and to ensure members have equitable access to safe and effective care.

Written process includes an evaluation of the following:

- Medical Procedures,
- Behavioral healthcare procedures,
- Pharmaceuticals,
- Devices.

Description of the Evaluation Process- KHS written evaluation process includes the following:

- The process and decision variables KHS use to make determinations,
- A review of information from appropriate government regulatory bodies,
- A review of information from published scientific evidence,
- A process for seeking input form relevant specialists and professionals with expertise in the technology.

The following information is gathered, documented, and considered for determination:

- Proposed procedure/treatment/medication device,
- Length of time the treating practitioner has been performing the procedure/treatment,
- Number of cases the practitioner has performed,

- Privileging or certification requirements to perform this procedure,
- Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated,
- Identification of other treatment modalities available,
- Consideration as to whether Medicare/Medi-Cal approves the service/procedure,
- Whether the medication/procedure is FDA approved,
- Literature search findings,
- Input from network Specialist.

The CMO, or designee, or other clinical department directors, consult specialists, market colleagues, the Physicians Advisory Committee (PAC) and/or the Pharmacy and Therapeutics Committee (P&T) as needed to assist in making coverage determinations and/or recommendations.

Medical Reviews and Audits by Regulatory Agencies

KHS' Director of Compliance and Regulatory Affairs, in collaboration with the CMO, Chief Health Services Officer, and other Health Services clinical leadership, provides direct oversight to all KHS medical audits and other inquiries by our regulatory agencies, DHCS and DMHC. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

Integration of Study Outcomes with KHS Operational Policies and Procedures

KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed, and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

Provider and Member Satisfaction

Satisfaction Surveys are conducted annually by the KHS Member Services and Provider Relations Department. Results are shared with the Executive leadership and other KHS departments. Any unsatisfactory areas of the UM process are re-evaluated by the KHS Chief Medical Officer or designee, Chief Health Services Officer, and the Director of Utilization Management to develop and implement strategies to ameliorate deficiencies.

KHS participates in the Consumer Assessment of Health Plan Survey (CAHPS) Member Satisfaction Survey and utilizes these results in the assessment of member experience with the UM program. Analysis of grievance and appeal data related to UM is also monitored as a part of the member experience review.

KHS contracts with physicians and other types of health care providers. Provider Relations conducts assessments of the network adequacy of contracting providers. All PCPs and

specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff and includes other information related to disability accommodations and hours of operation. The Provider Directory is 274 compliant with DHCS requirements and is available to members in printed or electronic versions.

Annual Program Evaluation

On an annual basis, KHS evaluates and revises as necessary, the UM Program Description and Evaluation. The Chief Medical Officer, in collaboration with the Chief Health Services Officer, documents a yearly summary of all completed and ongoing UM Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms. The UM summary also includes the program scope, processes, information sources used to determine benefit coverage and medical necessity, and the level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program. A written evaluation of the UM Program is prepared and reported to the QI/UM Committee and Board of Directors annually.

As Part of the annual evaluation an Executive Summary is developed to analyze and evaluate the annual undertakings and effectiveness of the UM Program Where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Descriptions.

On an annual basis, the QI/UM Committee and Board of Directors will set thresholds for at least four data types, such as admission data, ER utilization, practitioner performance and behavioral health against the established thresholds to detect under-and over utilization.

Record Retention

KHS maintains all records and documents necessary to disclose how it discharges its obligations under the state contract. These records and documents will disclose the quantity of Covered Services provided, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the way KHS administered its daily business, and the cost thereof.

In addition, and in accordance with 42 CFR section 438.3(u), KHS will retain the following information for no less than ten years and allow auditing entities to inspect and audit:

- Member Grievance and Appeal records as required in 42 CFR section 438.416,
- Base data as defined in 42 CFR section 438.5(c),
- MLR reports as required in 42 CFR section 438.8(k), and
- Data, information, and documentation specified in 42 CFR section 438.604, 438.606, 438.608, and 438.610.

Records relating to prior authorization requests, including any Notices of Action (NOA) will meet the retention requirements as described in Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities).

_____ Date _____

KHS Board of Directors (Chair/Designee)

_____ Date _____

Chief Executive Officer

_____ Date _____

Chief Medical Officer

[i] As defined in B&P Code §805(a)

KERN HEALTH SYSTEMS

MEMORANDUM

TO: KHS Board of Directors

FROM: Martha Tasinga, MD, MPH, MBA, Chief Medical Officer

SUBJECT: 2024 Quality Improvement Program Documents

DATE: April 18, 2024

Background

The Medi-Cal Managed Care Plan Quality Improvement (QI) Program is defined by three documents:

- The Quality Improvement Program Description,
- The Quality Improvement Program Evaluation, and
- The Quality Improvement Program Workplan

These documents are updated annually and presented to the Executive Quality Improvement Health Equity Committee, and the KHS Board of Directors for review, input, and approval. All program documents were presented and approved in the 1st Quarter 2024 Executive Quality Improvement Health Equity Committee.

Discussion

2023 QI Program Evaluation: The QI Program evaluation presents a summary of the outcomes for the 2023 QI program. It includes outcomes for the workplan along with outcomes for special projects or initiatives. This evaluation plays a key role in the development of the next year's QI Program Description leveraging successes and lessons learned.

2024 QI Program Description: This document provides a comprehensive description of KHS' Quality Improvement Program including governance and key activities of the program. It incorporates new strategies and activities based on results from the previous year's program evaluation as well as new regulatory requirements.

2024 QI Program Work Plan*:* The QI Program Workplan identifies the primary activities that will occur throughout the current year. Some of them are required from a regulatory standpoint and some are strategic initiatives aimed at improving specific aspects of the QI program such as our Managed Care Accountability Set (MCAS) performance. The activities may be ongoing, recurring, or special projects or improvement plans.

The workplan is a dynamic document that is updated throughout the year based on outcomes realized and priority shifts. Outcomes of the workplan are key to development of the annual program evaluation.

Requested Action

Approve the 2023 QI Program Evaluation, 2024 QI Program Description, and 2024 QI Workplan.

2024: Quality Improvement Program

Board of Directors
April 18, 2024

Martha Tasinga, MD, MPH, MBA
Chief Medical Officer

KERN HEALTH SYSTEMS

Agenda

- 2023 Quality Improvement Program Evaluation
- 2024 Quality Improvement Program Description
- 2024 Quality Improvement Workplan
- Program Direction for 2024

Quality Improvement 2023 Program Evaluation
Key Actions Completed

MCAS

- Completed analysis of MCAS non-compliance and followed through on strategic action plan for 2023
- Completed 3 Member Engagement & Rewards Campaign
- Added additional sources of data to measure MCAS compliance for greater accuracy with compliance rates
- Implemented team of temporary staff for direct member outreach to set appointments & assist with travel for MCAS gap closure
- Conducted quarterly quality meetings with network providers for MCAS compliance collaboration
- Hosted a Provider education program on the management of Hypertension

NCQA Accreditation

- Achieved 67% of points overall for Health Plan Accreditation, and 22% for Health Equity Accreditation.

Grievances and Potential Quality of Care Issues

- Introduced increased clinical review of grievances to ensure identification of quality of care issue

Quality Improvement
2024 Program Description

Overview

- Defines QI Program goals, objectives & functions
- Defines reporting structure and accountability
- Identifies Personnel roles and responsibilities
- Defines program scope & integration throughout organization
- Identifies 2024 QI Plan and Program activities
- Defines QI Process and strategies
- Outlines Provider involvement in meeting QI Program goals and objectives

QI Program Direction for 2024
Key Strategies

- Continue strategic action plan for MCAS with year-round direct member outreach to support members
- Complete readiness review & action plan for National Committee for Quality Assurance (NCQA) - Health Plan & Health Equity Accreditation to close 44 gaps and increase the percentage of overall points considered passing to 99%
- Align Health Equity Program with the Quality Improvement Program
- Re-structure Quality Improvement-Utilization Management Committee to align with DHCS Comprehensive Quality Strategy Plan – Executive Quality Improvement Health Equity Committee
- Expand KHS use and availability of mobile providers including street medicine teams for preventive health services
- Develop and implement Clinical Network Oversight Team to ensure Providers are following evidence-based practices & guidelines

Quality Improvement 2024 Workplan

1. Meets NCQA Standards

2. Identifies program's primary activities throughout current year

- Example: MCAS quality measures monitoring, access to care monitoring, grievance investigation involving quality of care.

3. Outlines: QI Work Activity, Special Projects and Performance Improvement Plans

4. Provides feedback for the 2023 QI Program Evaluation Results

- Identifies areas for improvement
- Validates and reinforces initiatives leading to favorable outcomes

5. Continuity and coordination between medical care and Behavioral Health

Quality Improvement Requested Action

Approve:

- 2023 QI Program Evaluation
- 2024 QI Program Description
- 2024 QI Program Workplan

Thank You

For questions, please contact:

John Miller, M.D. – Quality Medical Director

Magdee Hugais – Director, Quality Improvement

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

Kern Health Systems
2023 Quality Improvement Program Work plan

2023 Evaluation

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
I. QUALITY MANAGEMENT AND IMPROVEMENTS					
A. Annual Review/Approval of QI Program (QIP) Documents					
1. Approval QI Evaluation	Approval of 2022 QI Program Evaluation	5/31/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2. Review/Update and Approval of QI Program Description	Approval of 2023 QI Program Description	5/31/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
3. Review/Update and Approval of QI Work Plan	Approval of 2023 QI Work Plan	9/2/2022	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
B. Clinical - Focused Studies					
1. State Required				None, Met Goal	**Complete**
1.a Asthma Medication Ration PIP - Improving Asthma Medication Ratio Compliance in Children 5-21 years of age	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with the Asthma Disease Management Program and Asthma Mitigation Project to increase correct medication usage by asthmatic members	06/30/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
1.b. Improving the Health and Well Being of low income children, ages 3- 21 years, through Well Child Visits (WCV)	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with increasing the number of children ages 3 - 21 years old with completing an annual well care visit.	06/30/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
C. MCAS Quality Measurements Monitoring & Support					
1. MCAS Audit and Rate Submission MY2022/RY2023	Report to State via NCQA and EQRO Auditor, HSAG	7/31/2023	Director of QI Director of Business Intelligence (BI)	None, Met Goal	**Complete**
2 Configure MCAS/HEDIS software for new measures (Cotiviti) MY2022/RY2023	Vendor, Cotiviti, to have all new measures configured, tested and changes approved by NCQA	3/31/2023	QI Director/ BI Director	None, Met Goal	**Complete**
3 Configure KHS data and reports for new measures	KHS to modify data receipt, storage and reports to meet new DHCS MCAS specifications	3/31/2023	QI Director/ BI Director	None, Met Goal	**Complete**
4. Educate KHS Staff on MY2023 measures	KHS to educate internal staff on new requirements for MCAS	3/31/2023	Chief Medical Officer (CMO)/ QI Director	None, Met Goal	**Complete**
5. Educate providers on MY2023 measures	KHS to educate providers on new requirements for MCAS	3/31/2023	Chief Medical Officer (CMO)/ QI Director/ Senior Director Provider Network	None, Met Goal	**Complete**
6. Meet MCAS Compliance Rates for MY2023	Monitor progress in meeting Minimum Performance Level (MPL) of each MCAS measure for 2023 monthly. This will be used to evaluate improvement activities toward meeting all MCAS MPLs.	12/31/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
Behavioral Health Domain 6.a Depression Remission or Response for Adolescents and Adults (DRR-E) 6.b Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) 6.c Follow-Up After ED Visit for Mental Illness – 30 days (FUM) 6.d Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	Meet MPLs ~~DRR-E MPL rate not yet provided by DHCS~~ ~~DSF-E MPL rate not yet provided by DHCS~~ FUM 54.51 FUA 21.24		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Childhood Health Domain 6.e Child and Adolescent Well – Care Visits (WCV) 6.f Childhood Immunization Status – Combination 10 (CIS-10) 6.g Developmental Screening in the First Three Years of Life (DEV) 6.h Immunizations for Adolescents – Combination 2 (IMA-2) 6.i Lead Screening in Children (LSC) 6.j Topical Fluoride for Children (TFL-CH) 6.k Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits (W30-6+) 6.l Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits (W30-2+)	Meet MPLs WCV 48.93 CIS-10 34.79 DEV MPL rate not yet provided by DHCS IMA-2 35.04 LSC 63.99 TFL-CH MPL rate not yet provided by DHCS W30-+6 55.72 W30-+2) 65.83		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Chronic Disease Management Domain 6.m Asthma Medication Ratio (AMR) 6.n Controlling High Blood Pressure (CBP) 6.o Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%) (HBD)	Meet MPLs AMR 64.26 CBP 59.85 HBD 39.9		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Reproductive Health Domain 6.p Chlamydia Screening in Women (CHL) 6.q Prenatal and Postpartum Care: Postpartum Care (PPC-Pst) 6.r Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	Meet MPLs CHL 55.32 PPC-Pst 77.37 PPC-Pre 85.4		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Cancer Prevention Domain 6.s Breast Cancer Screening (BCS) 6.t Cervical Cancer Screening (CCS)	Meet MPLs BCS 50.95 CCS 57.64		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
7. MCAS Improvement Activities	Meet MPL for each MY 2023 MCAS measure	12/31/2023	Chief Medical Officer	None, Met Goal	**Complete**
7.a Health Information Exchange	Establish HIE to support clinical information data sharing that allows timely and accurate data capture for MCAS compliance monitoring	12/31/2023	Business Intelligence Director	None, Met Goal	**Complete**

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
7.b Provider Electronic Clinical Data Upload	Establish process to upload electronic medical record data upload from providers to support clinical information data access and timely and accurate data capture for MCAS compliance monitoring	12/31/2023	Business Intelligence Director	None, Met Goal	**Complete**
7c. Clinical Assessments in Community Settings	Establish process for KHS Population Health Management and Community & Social Services staff to conduct assessments such as - Health Risk Assessments - Depression Screening - Substances Use Screening in community settings such as homeless shelters, Department of Motor Vehicle offices, Social Security Office, etc. to support identification of member health care needs.	12/31/2023	Population Health Management Director; Director of Community & Social Services	None, Met Goal	**Complete**
7.d. Member Engagement & Rewards Program	Establish year-round, member outreach program focused on members with gaps in care. Redesign MCAS member rewards program to increase motivation for compliance with obtaining preventive health services and follow through with chronic condition self-care.	12/31/2023	Senior Director of Marketing and Member Engagement; Chief Medical Officer	None, Met Goal	**Complete**
7.e. Mobile Preventive Health Services Program	Establish network of providers to provide mobile health care services that will allow KHS to increase access to preventive health services in rural areas of Kern County and in ad hoc community events	6/1/2023	Senior Director of Provider Network; Deputy Director of Provider Contracts	None, Met Goal	**Complete**
7.f. Urgent Care Utilization to Close Gaps in Care	Establish agreements with select urgent care providers to deliver services to close member gaps in care at their center	7/1/2023	Senior Director of Provider Network; Deputy Director of Provider Contracts	None, Met Goal	**Complete**
7.g Provider Collaboration Meetings	Conduct monthly meetings with higher volume providers to review MCAS measure compliance and establish practice interventions to improve rates	6/1/2023	Chief Medical Officer; Director of Quality Improvement; Senior Director of Provider Network	None, Met Goal	**Complete**
7.g. Red Tier Action: Establish process for timely, complete, & accurate MCAS data	Develop process for timely, complete, & accurate data to measure MCAS compliance for strategy development and outcomes analysis	6/1/2023	Director of Business Intelligence; Director of Quality Improvement	None, Met Goal	**Complete**
7.h. Red Tier Action: Develop a Quality education program	Develop a quality education program to enable KHS staff & providers to develop & implement effective MCAS improvement strategies	6/1/2022	Director of Quality Improvement; Chief Medical Officer; Senior Director of Provider Network	None, Met Goal	**Complete**

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
7.i Red Tier Action: Communication process for organization-wide MCAS information sharing	Establish a communication process that supports strategic thought partnership, transparency, & decision-making for MCAS compliance throughout all levels of the organization	6/1/2023	Executive Leadership Team	None, Met Goal	**Complete**
D. Other On-going Monitoring					
1. 30 day re-admissions	Conduct audit quarterly of 50 30-day hospital readmissions to identify trending related to quality of care and readmission prevention	Quarterly	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2. Potential Quality of Care Issues (PQI)	Complete investigation of all PQIs and any corrective action plans issued	Annually	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2.a. Grievances	Review all grievances for Quality of Care issues and refer those identified to QI Dept as a PQI	Annually	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
3. Facility Site Reviews (FSR)	Provider review of physical offices to ensure DHCS site safety and other requirements are met.	Quarterly	Chief Medical Officer (CMO)/ Director QI	None, Met Goal	**Complete**
3.a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.b. Initial Health Appointment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.c. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.d. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.e. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.f. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.g. Safety of Care - Autoclave - Bio-hazardous waste - Infection Control	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.h. Bi-annual repot to DHCS of FSRs completed	Generate and submit report of all site and medical record reviews (both initial, periodic and focus) to DHCS for January through June and July through December in accordance with DHCS report requirements	January 31st July 31st	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
F. Provider Availability					
1. Primary Care Practitioners				None, Met Goal	**Complete**
1.a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2. Specialty Practitioners				None, Met Goal	**Complete**
2.a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2.b. Geographic Standard - Network Capacity Report	Measure and Report	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
G. Provider Access					
1. Primary Care Appointments					
1.a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**

KERN HEALTH SYSTEMS
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ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
1.b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network,Director of Compliance	None, Met Goal	Complete
1.c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
1.d. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network,Director of Compliance	None, Met Goal	Complete
2. Telephone access to Member Services			Senior Director of Provider Network, Director of Compliance		
2.a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
2.b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
3. Mental Health Appointment	Quarterly MOU Meetings/Grievances	As necessary	Director of UM; Director of Population Health Management	None, Met Goal	Complete
2.a Life-threatening Emergency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
2.b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
2.c Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
2.d Routine office visit Standard (visit within 10 working days)	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
2.e Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
- Caller reaches non-recorded voice	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
- Abandonment rate	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	Complete
H. Encounters, Complaints, Grievances and Appeals Data Analysis	Report aggregate data quarterly to QI/UM Committee	Quarterly	Director of Member Services	None, Met Goal	Complete
I. CAHPS Survey	State administered survey every 2 years - Survey being administered for 2022 in Q1 of 2023 by DHCS/HSAG	9/30/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	Complete
1. Member data provided to EQRO for 2022	Provide 2022 member data per EQRO specifications	Jan-23	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	Complete
2. Results reported to QI/UM Committee	Present summary of report to QI/UM Committee for review and identification of improvement actions	12/31/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	Complete
3. Results reported to practitioners and providers	Report to Physician Advisory Committee	12/31/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	Complete
J. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None, Met Goal	Complete
2. PCP & Mental Health	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None, Met Goal	Complete
3. Specialist	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None, Met Goal	Complete
K. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes evaluation of QI program activities delegated through quarterly and annual report monitoring	12/31/2022	QI Director	None, Met Goal	Complete
L. Annual Review of QI Policies and Procedures	Submit to QI/UM Committee and DHCS	Annually and as necessary	Chief Medical Officer (CMO) / QI Director/Director of Compliance	None, Met Goal	Complete
M. QI/UM Committee					
1. Reports and agenda items	Gathered from pertinent departments	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	Complete
2. Minutes	Attached to next meetings agenda and sent to Board of Directors	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	Complete
3. Form 700 (Statement of Economic Interests)	Send to all committee members yearly	Initial / Yearly December	Chief Medical Officer (CMO) /QI Director	None, Met Goal	Complete
4. PO's and Check Requests	Fill out for each member attending meeting	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	Complete

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
N. MCAS Member Engagement & Incentive Program	Conduct at least 3 campaigns using Interactive Voice Recognition, Text messaging and Mailers to contact members with Gaps in Care related to the MCAS measures. Outreach is focused on providing health education or reminders about preventive health measures and incentivizing them with a reward for closing a care gap.	Campaign 1 within 1st quarter Campaign 2 within 2nd quarter Campaign 3 within 3rd quarter	QI Director/Health Education Director	None, Met Goal	**Complete**
O. MCAS Committee	Multi-department committee focused on providing strategic direction and oversight of KHS' level of compliance with the MCAS measures. Committee meets at least quarterl.	12/31/2023	Chief Medical Officer	None, Met Goal	**Complete**
1. Update and disseminate MCAS Provider Guide and MCAS Coding Card for MY2022 MCAS Measures	Update the KHS MCAS Provider Guide to reflect measures for MY2023. The guide provides a definition and specifications for each measure, diagnosis and service codes as applicable and tips for achieving compliance. The guide is made available to all KHS providers accountable to meet these measures. The coding card lists the most commonly used service and diagnosis codes for documenting completion of MCAS measures.	3/31/2022	Director of Quality Improvement/Deputy Director of Provider Network	None, Met Goal	**Complete**
NCQA Accreditation	Complete readiness review to identify gaps in compliance with NCQA accreditation for Medicaid Health Plans and separate accreditation for Health Equity. Establish action plan to remediate accreditation compliance gaps. Initiate carrying out action plan that supports KHS to achieve NCQA accreditation for Medicaid Health Plan and for Health Equity no later than 12/31/2025	12/31/2023	Chief Medical Officer Director of Quality Improvement Chief Health Equity Officer	None, Met Goal	**Complete**
II. UTILIZATION MANAGEMENT - See UM Work Plan					
A. Annual Review/Approval of UM Program Documents by KHS QI/UMC and Board of Directors.	Program Description 2023	4/30/2023	Chief Medical Officer (CMO) / UM Director	None, Met Goal	**Complete**
	Program Evaluation 2022	4/30/2023	Chief Medical Officer (CMO) / UM Director	None, Met Goal	**Complete**
III. CREDENTIALING AND RECREDENTIALING					
A. Initial Credentialing Site Visit & Medical Record	Site and Medical Record Reviews done to validate new provider's compliance with DHCS regulatory requirements. Both reviews must be passed before a provider can be added to the KHS Provider Network.	Ongoing	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/Compliance/MS for any opportunities for improvement identified. QI Department performs review of readmissions within 30 days of discharge and member deaths notifications for potential inappropriate care issues.	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**
1. Hospitals	Tracking grievances, PIC referrals, Deaths Notifications with potential Quality issues, and a sampling of readmissions within 30 days of discharge for possible quality issues related to readmission	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
2. SNF's	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
3. Home Health Agencies	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
4. Free-Standing Surgery Centers	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**

KERN HEALTH SYSTEMS
2023 QUALITY IMPROVEMENT WORK PLAN

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

KERN HEALTH SYSTEMS
Quality Improvement Program Description
2024

Mission, Purpose, Goals and Objectives

I. Mission

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

II. Purpose

The KHS Quality Improvement Program Description is a written description of the overall scope and responsibilities of the QI Program. The QI Program actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.

KHS recognizes that a strong QI Program must be the foundation for a successful Managed Care Plan (MCP). In the basic program design and structure, KHS QI systems and processes have been developed and implemented to improve, monitor, and evaluate the quality and safety of care and service provided by contracting providers for all aspects of health care delivery consistent with standards and laws.

The KHS Quality Improvement Program is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. This structure is designed to:

- Monitor and identify opportunities to monitor, evaluate, and take action to address needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
- Maintain a process and structure for quality improvement with contracting providers that includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and take action to support health equity.
- Oversee and direct processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
- Monitor and improve the quality and safety of clinical care for covered services for KHS members.
- Ensure members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).

This is accomplished through the development and maintenance of an interactive health care

system that includes the following elements:

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
2. A process and structure for quality improvement with contracting providers. This includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
3. Oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).
5. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

III. Goals and Objectives:

KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. An evaluation of program objectives and progress is performed by the QI Department on an annual basis with modifications as directed by the KHS Board of Directors. The results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QI Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.
4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers to seek solutions to problems that will lead to improved health care delivery systems.
5. Monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information including:
    - Over and underutilization data
    - Grievances
    - Potential and actual quality of care issues
    - Accessibility of health care services
    - Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services
    - Pharmacy services
    - Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance

with State and Federal requirements

7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
10. Reviewing concerns regarding quality-of-care issues for members that are identified from grievances, the Public Policy/Community Advisory Committee (PP/CAC), or any other internal, provider, or other community resource.
11. Identifying and meeting external federal and state regulatory requirements for licensure.
12. Continuously monitoring internal processes to improve and enhance services to members and contracting providers.
13. Performing an annual assessment and evaluation of the effectiveness of the QI Program and its activities to determine
    a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care
    b. The quality of service provided to members
    c. Modifications needed to the QI Program
    d. Results of the annual evaluation are presented to the EQIHEC and Board of Directors

Kern Health Care System - Overview

I. Background

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative managing the medical and mild to moderate behavioral health care for Medi-Cal enrollees in Kern County. Specialty mental health care and substance use disorder benefits are carved out from the KHS Medi-Cal plan and covered by Kern County Behavioral Health and Recovery Services pursuant to a contract between the County and the State. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serve as the governing body for KHS.

KHS recognizes that a strong QI Program must be the foundation for a successful Managed Care Plan (MCP). In the basic program design and structure, KHS QI systems and processes have been developed and implemented to improve, monitor, and evaluate the quality and safety of care and service provided by contracting providers for all aspects of health care delivery consistent with standards and laws.

KHS total membership in 2024 is over 405,000 members with 59% assigned to the County Hospital system and two large Federally Qualified Health Centers (FQHC).

The KHS Quality Improvement Program Description is a written description of the overall scope and responsibilities of the QI Program. The QI Program actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.

Characteristics of the KHS population include:

- 46% are male and 54% are female.
- 70% of the population have English as their primary language and 29% use Spanish. The remaining 1% is a mix of other languages.
- As of 2021, Kern County ranked 51st out of 58 for residents with a high school diploma or higher and 47th out of 58 with a Bachelor's degree or higher.
- A majority of members reside in Bakersfield. However, the remaining 33.1% are in more rural areas.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	No	264,377	65.27%
Delano & North Kern	Yes	34,141	8.43%
Arvin/Lamont	Yes	26,008	6.42%
Shafter/Wasco	Yes	24,597	6.10%
California City & Southeast Kern	Yes	14,187	3.50%
Taft & Southwest Kern	Yes	10,528	2.60%
Tehachapi	Yes	6,967	1.72%
Ridgecrest & Northeast Kern	Yes	9,879	2.44%
Lake Isabella & Kern River Valley	Yes	5,385	1.33%
Lost Hills & Northwest Kern	Yes	2,771	0.68%
Frazier Park & South Kern	Yes	1,941	0.48%
Outside Service Area	N/A	4,274	1.06%

- The following is a breakdown by race and ethnicity of the KHS population:

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

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

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

Additional facts about Kern County's Health Behaviors as presented by County Health Rankings &

Roadmaps include higher rates of adult smoking, adult obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births compared to state-wide statistics. Kern County ranked better than California state averages for the food environment index (combination of % of low income and low access to a grocery store), and excessive drinking.

II. Scope:

The KHS QI Program applies to all programs, services, facilities, and individuals that have direct or indirect influence over the delivery of health care to KHS members. This may range from choice of contracted provider to the provision and a commitment to activities that improve clinical quality of care (including behavioral health), promotion of safe clinical practices and enhancement of services to members throughout the organization.

In 2023, KHS developed a Health Equity Program that will integrate and coordinate with the QI Program. The Health Equity Program includes assessment of needs based on race/ethnicity, language, cultural preferences, health disparities and stakeholder engagement. Understanding health disparities is critical to identify the differences in treatment provided to members of different racial/ethnic or cultural groups that are not justified by the underlying health conditions or treatment preferences of patients. KHS will implement multiple programs to monitor, assess and improve healthcare services to reduce health disparities within its membership.

Health Factors

Health Behaviors	Kern (KE) County	California	United States
Adult Smoking	15%	10%	16%
Adult Obesity	36%	26%	32%
Food Environment Index	7.4	8.9	7.8
Physical Inactivity	33%	22%	26%
Access to Exercise Opportunities	82%	93%	80%
Excessive Drinking	16%	19%	20%
Alcohol-Impaired Driving Deaths	32%	28%	27%
Sexually Transmitted Infections	763.8	599.1	551.0
Teen Births	32	16	19

The scope of the QI Program includes the following elements:

1. The QI Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
   a. KHS will not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
   b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QI Program reflects the population served and applies equally to covered medical and behavioral health services.

2. The QI Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings. New this year is the addition of street medicine providers. Street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be living.

3. The QI Program assessment activities encompass all diagnostic and therapeutic activities, and outcomes affecting members, including primary care and specialty practitioners, vision providers, behavioral health care providers, pharmaceutical services, preventive services, prenatal care, and family planning services in all applicable care settings, including emergency, inpatient, outpatient, and home health.

4. The QI Program evaluates quality of service, including the availability of practitioners, accessibility of services, coordination, and continuity of care. Member input is obtained through member participation on the Public Policy/Community Advisory Committee (PP/CAC), grievances, and member satisfaction surveys.

5. The QI Program activities are integrated internally across appropriate KHS departments. This occurs through multi-departmental representation on the EQIHEC Committee.

6. Mental health care is covered jointly by KHS and Kern County Department of Health. It is arranged and covered, in part, by Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

Application of the Quality Improvement Program occurs with all procedures, care, services, facilities, and individuals with direct or indirect influence over the delivery of health care to members.

Quality Improvement Integration: the QI Program includes quality improvement, quality performance, utilization management, risk management, credentialing, member's rights and responsibilities, and preventive health & health education.

As part of KHS' commitment to ensure the rights of our members to quality health care, the following six (6) Rights to Quality Health Care have been adopted:

1. Right to Needed Care
    - Accurately diagnosed and treated.
    - Care is coordinated across all the doctors and specialists.

2. Right to Equitable Care
    - All people, regardless of their gender, race, ethnicity, geographical location, or socioeconomic status receive the good quality health care they need.
    - Developing culturally competent care; for example, by expanding medical

translation services, after-hours appointments, mobile health clinics or telehealth, etc.

3. Right to Place of Care
    - Did the patient go to the right place for care?
    - Is the patient going to the ER or Urgent Care for primary care?
    - Is the patient transitioned to the right place for care?

4. Right to Timely Care
    - Timely access to care.
    - How long did the patient have to wait to get health care appointments and telephone advice?
    - Is the patient up-to-date with their preventative care?

5. Right to Be Part of Your Care
    - Patients and their families are part of the care team and play a role in decisions.
    - Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.

6. Right to Safe Care
    - Conduct continuous quality assurance and improvement.
    - Customer and provider satisfaction surveys or interviews.
    - Chart audits.
    - Site reviews.
    - Administration of medications.

Executive QI Health Equity Committee Structure and Responsibilities

I. Board of Directors (BOD)

The Kern Health System (KHS) Board of Directors (Board) has final authority and accountability for the KHS Quality Improvement Health Equity Program (QIHEP). The Board has delegated the responsibility for development and implementation of the QIHEP to the Executive Quality Improvement Health Equity
Committee (EQIHEC). The EQIHEC is chaired by the KHS's Chief Medical Officer (CMO) and Co-Chaired by the KHS Health Equity Officer. KHS' Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the BOD and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QIHE Program and assigns authority for aspects of the program to the Chief Equity Officer and Quality Medical Director.

II. Executive Quality Improvement Health Equity Committee (EQIHEC)

The EQIHEC provides overall direction for the continuous improvement process and monitors

that activities are consistent with KHS's strategic goals and priorities. The EQIHEC addresses equity, quality, and safety, of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues from prior years, and conducts an annual evaluation of the overall effectiveness of the Quality Improvement Health Equity Program (QIHEP) and its progress toward influencing network-wide safe clinical practices. The QIHEP utilizes a population management approach to members, providers, and the community, and collaborates with Local, State, and Federal Public Health Agencies and Programs.

The EQIHEC consists of actively participating clinical and non-clinical providers. The physicians are voting members for clinical decision making. The EQIHEC is comprised of internal and community participants. This process promotes an interdisciplinary and inter-departmental and community approach and drives actions when opportunities for improvement are identified.

The QIHEC members consist of:

Community Attendees:

- Two (2) Participating Primary Care Physicians
- Two (2) Participating Specialty Physicians
- One (1) Federally Qualified Health Center (FQHC) Provider
- Two (2) CAC members
- One (1) Member of Board of Directors consumer
- One (1) Community consumer
- One (1) Pharmacy Provider
- One (1) Kern County Public Health Officer or Representative
- One (1) Home Health/Hospice Provider
- One (1) DME Provider
- One (1) Behavioral Health Provider

Internal KHS

Attendees:

Chief Medical Officer
Health Equity Officer
Chief Operating Officer
Quality Improvement Medical Director
Director Quality Improvement
Director Quality Performance
Director Utilization Management
Director Population Health Management
Director Behavioral Health
Director of Pharmacy
Health Education & C&L
Director Health Equity
Manager
Provider Relations Director

The EQIHEC Committee is required to meet at least four (4) times annually and more frequently as determined. The activities of the EQIHEC and subcommittees providing information to the EQIHEC are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and required follow-up. Key activities of the EQIHEC are the review and approval of the QIHE Program and Work-Plan, and QIHE quarterly and annual evaluations. The EQIHEC's findings and recommendations are reported quarterly by the CMO to the BOD.

The EQIHEC monitors and evaluates equity, quality, safety, appropriateness and outcomes of care and services to KHS members.

Activities:

1. Formulates organization-wide improvement activities with QIHE subcommittee support.
2. Identifies appropriate performance measures, standards, and opportunities for performance improvement.
3. Assures QIHE Program activities are compliant with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, and NCQA.
4. Identifies actions to improve quality and prioritize based on analysis and significance; and indicate how the Committee determines these actions to ensure satisfactory outcomes.
5. Works closely with the IT Department for collection of data strategy and analytics to effectively analyze data related to the goals and objectives and establish performance goals to monitor improvement.
6. Ensures all departments can align project goals and map out responsibilities and deadlines prior to project implementation.
7. Ensures outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks.
8. Reviews the analysis and evaluation of QIHE activities of subcommittees and identifies needed actions and ensures follow up as appropriate.
9. Ensures that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions.
10. Reviews and modifies the QIHE program description, annual QI Work Plan, quarterly work plan reports and annual evaluation of the QIHE program as necessary to maintain goals and priorities.
11. Communicates the quality health equity improvement process to practitioners/providers and members through appropriate persons and venues.
12. Ensures that the information available to the Plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services.
13. Ensures the annual HEDIS, CAHPS and Health Outcomes Survey (HOS) submissions are delivered according to technical specifications and deadlines.
14. Support and assist practitioners and providers to improve safety within their practices.
15. Design and implement strategies to improve compliance.
16. Develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines.
17. Meets healthcare industry standards of practice.

18. Improves quality, safety, and equity of care and service to members.
19. Conducts facility site and medical record reviews to ensure and support safe and effective provision of equitable clinical service.
20. Reviews, evaluates, and makes recommendations regarding oversight of delegated activities, such as audit findings, trending, and reports.

III. Quality Improvement Sub-Committees

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

IV. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on the UM activities. The UM Committee supports the EQIHEC in the area of appropriate provision of medical services and provides recommendations for UM activities. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information with the involvement of appropriate, actively practicing practitioners; and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under utilization patterns.

Activities:

1. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient and ancillary services.
2. Ensure that UM decisions:
    - Are made independent of financial incentives or obligations.
    - Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management.
    - Physician compensation plans do not include incentives for denial decisions.
    - Physician and UM decision designees are not rewarded for utilization review decisions.
3. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
4. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
5. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
6. Continually monitor and evaluate utilization practice patterns of staff and contracted

practitioners and vendors and identify variations in care.
7. Review state regulatory oversight of LTC and CBAS facilities and develop and maintain a process to identify and address quality issues through the credentialing, recredentialing and ongoing monitoring process.
8. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
9. Facilitate and ensure continuity of care for members within and outside of KHS network.
10. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

V. Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities to include, serving as the KHS Credentialing and Peer Review QI Subcommittee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates as necessary the need to add practitioners to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care and includes at least one behavioral health provider.

PAC-Credentialing and Peer Review
In accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain standards for the education, training, and licensure of the KHS network of Participating Practitioners and Health Delivery Organizations, and establish and maintain credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. The Credentialing Committee may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Activities:
1. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.
2. Promote continuous improvement in the quality of the care and service provided by the KHS Providers.
3. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
4. Provide guidance on the overall direction of the credentialing program.
5. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS

credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process.
6. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
7. Monitoring the reporting of Provider Preventable Conditions and make recommendations for corrective actions, if appropriate.

PAC-Medical Technologies and Clinical Criteria Sets

1. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members.
2. Preforms reviews of technologies for use by medical and behavioral staff in the utilization review process.
3. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations.
4. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.
5. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers.

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
2. Protection of member identifiable health information by ensuring members' protected health
information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.
3. Providing oversight in strategies to reduce FWA in provider networks.

Appeals Reviews

The PAC will review aggregate data on member appeals and individual cases as needed. The committee is charged with evaluating and analyzing appeals data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members by recommending necessary changes and process improvements for any adverse trends identified.

VI. Population Health Management Committee (PHMC)

KHS follows the NCQA definition for Population Health Management: "Population Health Management is a model of care that addresses individuals' health needs at all points along the continuum of care with a "Whole Person" approach supported through participation,

engagement, and targeted interventions for a defined population". The Population Health Management Committee oversees the Population Health Management (PHM) Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHM MOC is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions.

The PHMC is a collaborative group that engages business units from multiple KHS departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health. Each year a Population Needs Assessment (PNA) is conducted by KHS. The annual PNA describes the overall health and social needs of KHS's membership by analyzing service utilization patterns, disease burden, and gaps in care of members, considering their risk level, geographic location, and age groups. The PHMC members focus on strategies related to the PNA identified gaps and adverse patterns and outcomes to improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions. The following departments support the PHMC:

- Care Management
- Case Management
- Utilization Management
- Disease Management
- Social Services
- Quality Management

These departments provide the analysis of service utilization patterns, disease burden, health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs, and other gaps in care for KHS members.

The following programs are incorporated into PHM and fall under the administration of the aforementioned Departments:

- Long Term Care (LTC) and Long Term Services and Supports (LTSS)
- Major Organ Transplants (MOT)
- Transitions of Care (TOC)
- California Children's Services (CCS)
- Enhanced Care Management (ECM)
- Community Support Services (CSS)
- Behavioral Health

The PHM strategy focuses on the "whole person" throughout the care continuum to:

- Provide wellness services and intervene on the highest-risk members.
- Improve clinical health outcomes.
- Promote efficient and coordinated health care utilization.
- Maintain cost-effectiveness and quality care.
- Improve access to essential medical, mental health, and social services.
- Improve access to affordable care.

- Ensure appropriate utilization of services.
- Improve coordination of care through an identified point of contact.
- Improve continuity of services for members across transitions in healthcare settings, providers, and health services.
- Improve access to preventive health services.
- Improve beneficiary health outcomes.

Activities:

1. Responsibilities of the committee include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimizing programing, ensuring that PHM addresses health at all points on the continuum of care.
2. Ensures that the medical care provided meets the community standards for acceptable medical care.
3. Collaborates with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
4. Improve communications (exchange of information/data sharing) between primary care practitioners, specialists, behavioral health practitioners, and health delivery organizations and ancillary care providers.
5. Monitors appropriate use and monitoring of psychopharmacological medications.
6. Incorporates Population Health Management Model into policies, procedures, and workflows.
7. Improving member access to primary and specialty care, ensuring members with complex health conditions receive appropriate service.
8. Identifies and reduces barriers to needed healthcare and social services for members with complex health conditions.
9. Supports a process for members in resolving their individual barriers to physical and mental wellness.
10. Improve member health status through the delivery of wellness and disease prevention services, programs, and resources by educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve, and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions.
11. Ensures continuity in treatment access and follow-up for members with co-occurring medical, behavioral health, and Substance Use Disorder (SUD) conditions.
12. Promotes routine depression, anxiety, trauma-based care, and SUD screenings are completed and appropriate follow-up referrals are made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period.
13. Link members to ECM, CSS, SUD Providers and other community-based programs with comprehensive and holistic approaches.

VII. Quality Improvement Health Equity Sub-Committee (HEC)

The Quality Improvement Health Equity Sub-Committee (HEC) is responsible for identification and

management of equity efforts throughout the organization including the planning, organization, and the direction, of the Health Equity Program. The HEC is charged with systematic analysis to identify root causes of health disparities impacting KHS members and collaborating across the organization, with providers, and with other community agencies to eradicate inequities for KHS members served. The HEC reviews and updates relevant health equity policies and procedures and the annual Population Needs Assessment (PNA). From this, the HEC formulates the PNA Action Plan for addressing and mitigating the disparities identified in the PNA. Community Agency Representatives are active HEC participants. The HEC shall monitor, evaluate, and take timely action to address necessary improvements in the quality and equity of care delivered by Network Providers in any setting and take appropriate action to improve upon quality improvement and health equity goals.

The Health Equity Department Manager reports to the Health Equity Officer and is charged with overseeing the day-to-day operations of the Health Equity Department and is responsible for organizing and preparing the HEC agenda, minutes, reporting and committee activities to the Executive Quality Improvement Health Equity Committee (EQIHEC).

The HEC has established objectives to address health disparities to include:

1. Increase the awareness of health equity and quality and implement strengthened, expanded and/or new health equity and quality activities to support providers and members ultimately reducing health inequities within KHS membership.
2. Ensure services provided to members promote equity and are free of implicit bias or discrimination.
3. Implement programs that address the causes of inequity that members and their communities experience including food insecurity, housing problems, tobacco use, and other concerns.
4. Analyze the existence of significant health care disparities in clinical areas.
5. Reduce health disparities among members by implementing targeted quality improvement programs.
6. Promote physician involvement in health equity/disparities and activities.
7. Conduct focused groups or key informant interviews with cultural or linguistic minority members to determine how to meet their needs.
8. Address social determinants of health.

VIII. Grievance Review Committee

The Grievances process addresses the receipt, handling, and disposition of Member Grievances in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters. KHS maintains written records of each Grievance as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations. This committee is a subcommittee of the EQIHEC.

All complaints, grievances, investigations, follow-up, tracking and trending reports are submitted to the Grievance Review Committee. The Grievance Review Committee meets at a minimum four (4) times a year.

Under the direction and oversight of the Chief Operations Officer (COO) or designee, individual and aggregate data on member grievances is reviewed by the Grievance Review Committee. The COO is supported by KHS staff Medical Directors. The committee is charged with evaluating and analyzing Grievance data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members by implementing necessary changes and process improvements for any adverse trends identified.

Grievances may address, but are not limited to, the following issues:

1. Difficulty obtaining an appointment.
2. Customer service at the provider or practitioner office.
3. Billing issues.
4. Difficulty accessing specialists.
5. Facility Conditions.
6. Confidentiality issues.
7. Refusals of PCP to refer the member for care.
8. Cultural Issues.

All Grievance review reports and discussions and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

IX. Behavioral Health Advisory Committee (BHAC)

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee to the EQIHEC and is charged with facilitating collaborative coordination of medical and behavioral health services. The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS and the County Mental Health Plan (MHP) and the Drug Medi-cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the MHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care, and provide resources for members with mental illness and/or substance use disorder.

Activities:

1. Review quality monitoring activities conducted by the Plan to measure compliance for network providers, corrective actions, and regulatory requirements regarding behavioral health services, network accessibility and delegation oversight.
2. Provide feedback on implementation of BH clinical guidelines, new BH technology, quality monitoring tools, site/chart review(s), tracking access to care standards, and treatment innovations.
3. Review Plan's adherence and achievement of Medi-Cal Managed Care Accountability Set (MCAS) targets focused on BH.
4. Review Plan's adherence to the quantitative and qualitative analysis for the Evaluation of BH member complaints, appeals, and experience.
5. Review Plan's process for continuity and coordination medical and behavioral health services, methods to exchange information.

6. Review and approve the BH Program Description annually.
7. Review Plan's compliance with overseeing MOU with KBHRS.
8. Provides support to KHS management based on their regular and direct interactions with KHS Members receiving BH Services.

The BHAC is chaired by the KHS Director of Behavioral Health or designee and a credentialed and participating behavioral health provider with an M.D. or approved BH Licensure. BHAC will require two-thirds of the members to be present to establish a quorum. The committee meets at a minimum four (4) times a year.

All BHAC review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

X. Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee

The Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee is a subcommittee that reports to the EQIHEC. The P&T/DUR committee is comprised of KHS pharmacists and contracted providers in the community serving KHS members. The P&T/DUR is responsible for reviewing matters related to the use of medications provided by the KHS contracted provider network. The basic objectives are to specify drugs of choice and address alternatives, based on safety and efficacy; to minimize therapeutic redundancies; and to maximize cost-effectiveness pertaining to drugs administered in the outpatient settings by physicians under KHS' division of responsibility. Medi-Cal RX retains responsibility for formulary drugs carved out to them by the DHCS.

Activities:

1. Pharmacy and formulary utilization, guidelines, and policies and procedures based on clinical evidence and DHCS contractual requirements.
2. Drug Utilization Review.
3. Review of reports to identify members and providers with potentially inappropriate/excessive utilization of medication therapy.

The P&T/DUR Committee meets at a minimum (four) times a year. All P&T/DUR review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

XI. Access and Availability and Delegated Vendor Oversight Committee (AADVOC)

The Access & Availability and Delegated Vendor Oversight Committee (AADVOC) is charged with monitoring member accessibility to obtain covered services within the Plan's contracted network of providers and evaluating and overseeing any functions and responsibilities delegated to a subcontracted entity. Access & Availability includes appointment availability, geographic access, and network adequacy, monitored through provider surveys, grievance reviews, geographic

mapping and analysis, and provider to member ratio reviews. Delegation reporting will include pre-delegation evaluation, ongoing delegation oversight activities, and results of any conducted audits.

All AADVOC review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

Activities:

1. Ensuring Network accessibility and transparency align with DHCS and DMHC requirements through established quantifiable standards for both geographic distribution and number (ratio of providers to members) of PCPs, high-volume and high impact specialists, including high volume behavioral health practitioners and specific high volume ancillary providers.
2. Ensure the performance of the annual network certification meets requirements.
3. Consistent monitoring of practitioner availability and accessibility of services.
4. Efficient collection and analysis of provider-experience data.
5. Address complex and problematic provider-related issues, grievances, and concerns timely, effectively, and appropriately.
6. Ensure provider adherence to all regulatory and legal requirements in the contracting process.
7. Ensure providers receive training and education in accordance with KHS policies and procedures.
8. Ensure KHS First Tier Entity, Downstream Entity, or Related Entity ("delegated vendor entities") can perform the delegated functions that they are contracted to perform and that they can meet the requirements of all applicable laws and regulations.
9. Pre-delegation and annual audits, review of delegated entity reports.
10. Maintenance of an informed provider network regarding regulatory updates and program requirements.
11. Use data to drive practice improvements.
12. Design and monitor Pay-for-Performance (P4P).

XII. Quality Improvement Committee (QIC)

The QIC is a subcommittee of the EQIHEC. The committee will be chaired by the Chief Medical Officer or designee. The Committee is responsible for ensuring the development, implementation, and monitoring of the KHS QI Program.

The focus of the QIC is on clinical quality, patient safety, and patient and provider experience in four functional areas: HEDIS/Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, Quality Improvement, and Network Clinical Oversight.

Activities:

1. Review and approve the QI Program Description, the annual Work Plan, and annual Evaluation of the work plan.
2. Ensure compliance with DHCS facility site review requirements.
3. Review aggregate data of potential quality of care issues (PQIs), identify areas of improvement, and oversee implementation of improvements.

4. Oversee KHS safety program.
5. Oversee the identification of quality-of-care trends and recommend corrective action as needed.
6. Monitor evidence-based care through the HEDIS and Managed Care Accountability Set (MCAS) audit and make recommendations for areas of improvement.
7. Monitor member satisfaction by reviewing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Outcomes and address measures of dissatisfaction.

XIII. Public Policy Community Advisory Committee (PP/CAC)

The PP/CAC reports directly to the KHS BOD. The PP/CAC is comprised of a diverse membership pursuant to 22 CCR section 53876(c), comprised primarily of KHS Members, representing member and community engagement stakeholders, community advocates, and traditional and Safety-Net Providers. The goal of the PP/CAC is to establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan supported by acts performed by KHS or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public. The PP/CAC is a standing Committee within KHS and provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. Information from the PP/CAC is reported to the EQIHEC to heighten awareness and incorporate PP/CAC recommendations into quality improvement activities.

Activities:

1. Review changes in policy or procedures that affect KHS Members.
2. Provide updates on state policies or issues that affect KHS Members.
3. Allow committee members to have input on issues that have an impact on KHS Members (i.e. marketing materials, KHS website including the web Provider Directory or Doctor Search, the Evidence of Coverage, brochures, flyers, Health Education materials, Radio/TV/Billboard advertisements, incentive ideas/items, etc.).
4. Allow committee members to share experiences that will help KHS improve how care is delivered.
5. Advise on educational and operational issues affecting groups who speak a primary language other than English.
6. Advise on cultural competency.

XIV. Other EQIHEC Formal Informational Reporting Sources

Member Services Information:

Incorporates member experience and data-analysis to identify opportunities for improvement in member satisfaction as identified from Member Satisfaction Surveys, and Member Retention Reports.

Patient Safety:

Patient safety and promoting a supportive environment for network practitioners and other providers to improve patient health outcome and safety. Information about safety issues is received

from multiple sources including, but not limited to: member and practitioner grievances, care management and utilization management activities, adverse issues, pharmacy data such as polypharmacy, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components.

Hospital Quality and Safety
KHS tracks and trends hospital performance to reduce variation and assure consistent and standardized metrics across all contracted hospitals. Sources include: Cal Hospital Compare supplemented with data and reports from Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and the California Maternity Quality Care Collaborative (CMQCC). Each of these entities provides performance comparisons across hospitals along with regional and national benchmarks of quality and safety. Other sources include sentinel event reporting.

Nurse Advice Line (NAL)
Review of KHS contracted nurse advice line reports to include aggregated data sets for assessment and evaluation for the provision of triage and screening.

Data Sources
Data sources include but are not limited to: encounters/claims, pharmacy and lab data through direct, supplemental or health information exchanges, medical record review or facility site review results, and other monitoring and audit results as well as grievances, appeals, and denial overturns, HEDIS results, quality and performance reports, member and provider satisfaction survey results, network access and availability reports, utilization management metrics, annual population health assessment, and the annual QI work Plan evaluation.

Personnel

Reporting relationships, qualifications and position responsibilities are defined as follows:

I. Chief Executive Officer (CEO)
Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include: KHS direction, organization and operation, developing strategies for each department including the QI Program, Human Resources direction and position appointments, fiscal efficiency, public relations, governmental and community liaison, and contract approval. The CEO directly supervises the Chief Financial Officer (CFO), CMO, Compliance Department, and the Director of Marketing and Member Services. The CEO interacts with the CMO regarding ongoing QI Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

II. Chief Medical Officer (CMO)
The KHS CMO must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including

professional input and oversight of all medical activities of the QI Program.

The CMO reports to the CEO and communicates directly with the Board of Directors. The CMO devotes the majority of the time to quality improvement activities.

The responsibilities of the CMO include:

- Supervising the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Health Education and Disease Management.
- Supervising all QI activities performed by the Quality Improvement Department.
- Providing direction for all medical aspects of KHS, preparation, implementation and oversight of the QI Program, medical services management, resolution of medical disputes and grievances, and medical oversight on provider selection, provider coordination, and peer review.
- Developing and implementing medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality. These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).
- Providing direction to the EQIHEC Committee and associated committees including PAC and P&T/DUR.
- Providing assistance with the study, development and coordination of the QI Program in all areas to provide continued delivery of quality health care for members.
- Assisting the Director of Provider Network Management with provider network development.
- Communicating with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.
- Providing oversight for the development and ongoing revision of the Provider Policy and Procedure Manual related to health care services.
- Executing, maintaining, and updating a yearly QI Program for KHS and an annual summary of the QI Program activities to be presented to the Board of Directors.
- Assuring timely resolution of medical disputes and grievances.
- Working with the appropriate departments to develop culturally and linguistically appropriate member and provider materials that identify benefits, services, and quality expectations of KHS.
- Providing continuous assessment of monitoring activities, direction for member, provider education, and coordination of information across all levels of the QI Program and among KHS functional areas and staff.
- Providing direction for internal and external QI Program functions, and supervision of KHS staff including:
    a. Application of the QI Program by KHS staff and contracting providers.
    b. Participation in provider quality activities, as necessary.
    c. Monitoring and oversight of provider QI programs, activities, and

processes.

d. Oversight of KHS delegated and non-delegated credentialing and recredentialing activities.
e. Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care.
f. Monitoring and oversight of any delegated UM activities.
g. Supervision of Health Services staff in the QI Program including: Director of Quality Improvement, Director of Health Education and Cultural & Linguistics Services, Population Health Management (PHM) Director, Utilization Management (UM) Director, Pharmacy Director, and other related staff.
h. Supervision of all Quality Improvement Activities performed by the QI Department.
i. Monitoring covered medical and behavioral health care provided to ensure they meet industry and community standards for acceptable medical care.
j. Active participation in the functioning of the plan grievance procedures.

III. Chief Operating Officer (COO)

Under direction of the CEO, plans, directs, monitors, coordinates, interprets and administers all functional activities and policies related to Claims, Member Services , and AIS/Compliance departments. The COO is responsible for directing all activities of the Claims, Provider Relations, Member Services, and AIS/Compliance departments for a Knox-Keene Act-licensed health maintenance organization. COO maintains authority for setting policies and procedures for the departments, that are consistent with the policies and procedures set by the KHS Board of Directors and the CEO, and fall in compliance with regulatory requirements. Executive is responsible for and has decision making authority regarding the organization in the absence of the CEO.

IV. Medical Director of Quality

The Medical Director of Quality must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The Medical Director will provide clinical leadership and guidance in the development and measurement of the strategic approach to quality, performance improvement, and patient satisfaction, and safety. As determined by the plan CMO, the Medical Director assists in short- and long-range program planning, total quality management including quality improvement, and external relationships, as well as develops and implements systems and procedures for all medical components of health plan operations.

In collaboration with the CMO and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and EQIHEC. Additionally, he or she represents the health plan on various committees and routinely reports to the Board of Directors on credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance

targets.

Under direction of the Chief Medical Officer:

- Serve as a member of the following committees of the KHS Board of Directors: EQIHEC, PAC, P&T/DUR, Quality Improvement Committee, and Grievance Committee.
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS.
- Is responsible for reviewing and managing utilization of health care services at all levels of care to achieve high quality outcomes in the most cost-effective manner.
- Provides clinical leadership to the clinical departments staff and works collaboratively with the directors of the other Departments of KHS to ensure compliance with the contractual and regulatory requirements.
- Provide clinical support and education to the network provider in support of standards of care and evidence-based medicine and use of clinical criteria in decision management.
- Represents KHS in the medical community and in general community public relations.
- Participates in the implementation of the KHS Credentialing Program.
- Responsible for Review and identification of area for improvement and provide clinical leadership in the implementation of KHS Quality Improvement Plan and the Utilization Management Plan.
- Lead and/or attend and actively participate in meetings and committees as assigned by the CMO.
- Actively Participates as a member of the Health Services management team.
- Performs duties and responsibilities identified for the Medical Director under the Quality Improvement Plan, the Utilization Management Plan.

V. Behavioral Health Provider

The Behavioral Health Provider is a participating BH provider with an MD or PhD in Psychology and is licensed to practice in California. The Behavioral Provider is involved in all behavioral health aspects of the QI and UM Programs and advises the BHAC Committee aimed at improving behavioral healthcare services. Responsibilities include acting as the chairperson in the KHS Behavioral Health Advisory Committee (BHAC), reports to EQIHEC and provides reports on the key BHAC monitoring activities including but not limited to:

- Exchange of information between PCPs and behavioral health specialists.
- Coordination between KHS and Kern County Managed Behavioral Health Organization (MBHO) and certified SUD providers for substance use disorder services to promote continuity of care.
- Supervision of diagnosis, treatment and referral for members with co-existing medical and behavioral conditions.
- Collaboration with pharmacy for the use of psycho-pharmaceutical medications.
- Identification of social determinants of health, and other potential barriers to receiving BH care, including access.
- Providing substantial involvement in BHAC Committee and other sub-committees through collaboration with CMO.
- Establishing QI and UM policies and procedures relating to behavioral healthcare.
- Participating in quality activities related to continuity and coordination of care between

medical and BH practitioners.

VI. Director of Quality Improvement

Under the direction of the KHS CMO, the Director of Quality Improvement will oversee and participate in activities related to quality improvement for the organization and membership by monitoring, assessing and improving performance in ambulatory and inpatient health care delivery or health care related services. The Director will implement the KHS Quality Management Plan and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

This position is responsible for quality improvement, health education and disease management functions for KHS. This professional will be responsible for ensuring compliance with the QI work plan, oversight of the design, implementation, analysis and dissemination of utilization and accessibility studies and member and provider satisfaction studies. The Director of QI will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. The Director of QI is also responsible for maintaining compliance with Medi-Cal contractual stipulations for Quality programs. Makes an effective contribution to the KHS business planning and fiscal processes. Is clear about departmental objectives and resource requirements.

The QI Director will keep the KHS quality plan "front and center", reinforcing a shared sense of purpose throughout the organization. Takes a mentoring role and strongly encourages the growth of team members. Ensures that professional development goals are incorporated into team members' annual performance objectives, and regular reviews progress towards attaining them.

Under direction of the CMO and QI Medical Director:

- Designs and implements QI programs that meet the goals of the KHS QI plan and complies with regulatory, contractual, and NCQA requirements.
- Maintains responsibility for all activities of the Quality Improvement staff including policies, procedures, and operations.
- Works in coordination with the Provider Relations Manager of Special Programs to develop grant programs.
- Maintains overall direction and supervision for all ongoing and new projects for the QI program.
- Provides leadership and support to QI staff involved in QI projects.
- Annually updates QI policies and procedures with input from the Quality Improvement Committee.
- Participates as an active member of plan committees requiring preparation, research, and follow-up as requested by the CMO.
- Oversees credentialing processes and all HEDIS related activities.
- Supervises quality of care investigations and reporting.
- Represents KHS as the QI liaison for external subcommittees, behavioral health subcontractor, QI workgroups, etc.
- Assists with interviews, selects, trains, develops and evaluates subordinate staff; provides input to Human Resources regarding disciplinary issues, as required.
- Coordinates QI activities and data collection between KHS departments and KHS contracted providers.

- Prepares the organization for review and the accreditation processes by monitoring of external contract providers and internal processes.
- Contributes to the overall design of the Pay for Performance Incentive Program in collaboration with Provider Relations department.
- Coordinates and conducts in-depth chart analysis, data collection, and report preparation.
- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review.
- Identifies and recommends the initiation of quality improvement studies related to multi-disciplinary quality issues and State required studies.
- Serves as staff support and resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee and other committees, as appropriate.
- Assists in problem identification, data analysis, conclusions, recommendation, action-plan design, follow-up and tracking.
- Implements and facilitate internal Quality Improvement studies and work groups for continuous improvement within the organization.

VII. Senior Director of Contracting and Quality Performance

Under the direction of the COO and CMO, the Senior Director of Contracting and Quality Performance will be responsible for managing the provider contracting and quality performance functions for KHS. This includes maintenance of provider agreements, process improvements, contract and quality performance management, negotiation and re-negotiation of contracts in coordination with Executive Leadership, the Senior Director of Provider Network Management, KHS attorney and staff; oversee and participate in activities related to QI for the organization and membership by monitoring, assessing and improving performance in all health care settings.

Oversees, plans, and implements new and existing healthcare QI and practice transformation initiatives, and education programs specific to the Provider Network; ensures maintenance of Provider QI programs, Pay for Performance, and MCAS in accordance with prescribed quality standards; conducts data collection, reporting and monitoring for key performance measurement activities, leads improvement in operational efficiency, financial performance, staff engagement, and health equity.

This position provides the vital role of maintaining network contracting integrity for KHS. This position will ensure that processes are in place and followed in all negotiations, contracting and payment set-up functions. This position also requires a developed understanding of practice operations, revenue cycle management, performance improvement methods, and QI operations as a whole. Also essential is the ability to direct multi-faceted projects across various settings, departments, and programs. Strong leadership and consensus-building skills are essential.

Essential Functions include:

- Developing and maintaining contracting templates which comply with regulatory and legal requirements, effectively implementing strategic initiatives which meet KHS business needs.
- Mitigating risk and liability when negotiating agreements and informing and advising appropriate KHS staff, CEO and KHS attorney of such risks.

- Developing and maintaining a work plan and timeline for completing contract development/negotiations, ensuring that contracts and amendments are implemented in a timely fashion.
- Plan, implement and manage contracting strategies to ensure development of contracted providers to support existing and future product lines.
- Oversee technical products/software related to fiscal impact reports and rate development for provider contracts.
- Oversee the negotiations for Letter of Agreements and administer the Agreements.
- Negotiate Provider contracts for the provision of all covered benefits including physicians, behavioral health, ancillaries, and hospital agreements.
- Oversight responsibility for the Contract Administration unit including contract development, processing, and maintenance of the Agreements.
- Responsible for coordinating payment with Finance Department for special funding sources such as Provider Proposition initiatives, Hospital Directed payments, and any other provider payments not included in the overall contractual payment structure.
- Responsible for validating provider eligibility of special provider funding and oversight of payouts. This includes auditing payments and creating departmental procedures to ensure compliance of such funding distributions.
- Work closely with the KHS Legal to ensure compliance with regulatory agencies, KHS Policies and Procedures and KHS legal requirements.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Identify opportunities for increased provider practice efficiency and leveraging health IT and data to deliver high-quality, culturally competent, equitable, and comprehensive primary, specialty, and ancillary health care.
- Develop practice transformation processes and tools, aimed at building practices' overall capacity for ongoing and sustainable change into high-performing, quality medical practices.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Assist in the contracting portion of KHS Grant process including but not limited to RFP development, grant review, grant contract development.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Leads quality improvement activities meetings and discussions with and between other departments within the organization or with and between key provider network partners.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Any other duties as required ensuring the Health Plan operations are successful.
- Provide oversight of contract system configuration and provider set-up.
- Responsible for Credentialing staff and processes.
- Responsible for Facility Site Review processes.

VIII. Director of Quality Performance

Under the direction of the Senior Director of Contract and Quality Performance, the Director of Quality Performance is responsible for oversight, implementation, and management of new quality improvement initiatives specific to the Provider Network. This includes being responsible for HEDIS and MCAS functions and collaborating and supporting providers to improve health outcomes related to those measures. The Director is also responsible for quality improvement initiatives related to Performance Improvement Projects (PIPs) and Facility Site Reviews (FSRs). The Director will communicate and coordinate with contract providers regarding required studies, participation, and improvement projects. Related duties include ongoing data collection, medical record reviews, report writing, and collaboration with other KHS departments, as well as outside agencies.

The Director of Quality Performance is responsible for HEDIS/MCAS and performance components of the Quality Improvement Program. This position will be responsible for oversight of maintaining compliance with Medi-Cal contractual stipulations for the performance of KHS and KHS contracted providers. In addition, this person will be an effective contributor to the KHS business planning and fiscal processes.

Essential Functions include:

- Builds and develops collaborative relationships vital to the success of programs.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Responsible for Quality Performance staff and processes.
- Work collaboratively with Senior Director and Provider Network team to develop physician practice performance profiling on MCAS/HEDIS/STAR metrics, identify opportunities for improvement, and support/manage change implementation.
- Establishes and maintains tracking and monitoring systems for health care quality improvement activities according to regulatory requirements, policies and procedures, and contractual agreements.
- Track and monitor the HEDIS improvement operations.
- Identify opportunities and potential barriers in MCAS/HEDIS
- Research and documents current health care standards for use in performance improvement study design and methodologies related to health outcomes.
- Provides guidance, and oversight to staff regarding study design, methodology, data analysis and reporting of Quality performance improvement projects.
- Works with staff to achieve production, timeliness, accuracy, and quality of work.
- Remains current with Department of Health Care Services and Department of Managed Care policy implementation or revisions.
- Participates in the development, review and updating of policies and procedures.
- Manages and evaluates performance of department staff.

- Coordinates guidelines, studies, and performance improvement activities in concert with the utilization management, quality management, pharmacy services, and population health management teams.
- Remains current with HEDIS/MCAS requirements and participates in planning and implementation of methods to improve HEDIS/MCAS performance.
- Education of providers on HEDIS/MCAS and program goals.
- Ensures compliance with applicable regulatory and reporting requirements.
- Coordinates the regular and systematic review of all potential quality of care issues in accordance with state statute.
- Develops and analyzes reports to monitor and evaluate quality performance in meeting established goals.

IX. Quality Managers

The Quality Manager possesses a master's degree in health or business administration or bachelor's or Associates Degree in Nursing and five (5) years of experience in the direct patient care setting or operations management, or teaching adult learners, and one (1) year of experience in health care Quality Improvement, Utilization Management, or Process Improvement, and two (2) years of management experience.

Under the direction of the Director, the Quality Manager conducts oversight and management of state and regulatory and contractual compliance for the QI program. This includes managing the HEDIS and Managed Care Accountability Set (MCAS) audit and initiatives to improve health outcomes related to those measures. They also manage quality improvement initiatives for Performance Improvement Projects (PIPs), Improvement Plans (IPs), Facility Site Reviews (FSRs), delegation audits, and other external quality reviews. The manager applies clinical knowledge and analytical skills to manage and oversee day-to-day operations of the QI team.

X. QI Program Staffing

The QI and QP Directors oversee staff consisting of the following members:

QI Registered Nurses: The QI nurses possess a valid California Registered Nursing license and three years registered nurse experience in an acute health care setting preferably in emergency, critical and/or general medical-surgical care. The QI nurses assist in the implementation of the QI Program and Work Plan through the quality monitoring process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of responsibilities for the QI Program development and implementation. Additionally, the QI nurses teach contracting providers DHCS MMCD standards and KHS policies and procedures to assist them in maintaining compliance.

MCAS/HEDIS Program Manager: The Program Manager possesses a bachelor's degree or higher in Healthcare, Business, Data Science, Project Management or related field. They have at least 2 years' experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years' experience in project management work. Under the direction of the Director, the Program Manager manages, plans, coordinates, and monitors Quality Special Programs including but not limited to:

- Annual Managed Care Accountability Set (MCAS) audit and measurement results submission.

- QI Department Strategic Goals and Projects, and Special Programs (such as member incentives and engagement, DHCS-required project improvement plans, site reviews, etc.).

Senior QI Operations Analyst: The Senior QI Operations Analyst reports to the Director and has a master's degree in Business, Statistics, Mathematics, or other related field with academic demonstration of analytical skills from an accredited school or equivalent AND three (3) years working experience with a Managed Care Organization (MCO) or similar type organization. This position provides primary oversight, management and validation of data and reports submission for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QI Department, vendors and internal KHS Department such as IT. They provide similar management and support for other department audits. They are responsible for providing operational department support for department processes, projects, or other assignments and provide data and reports for ongoing activities such as performance improvement projects.

Senior QI Coordinator: The Senior QI Coordinator roles report to the QI Manager. He/she is a high school graduate and is licensed/certified in CA as either a certified medical assistant (CMA) or licensed vocational nurse (LVN) with either five (5) years of experience for a CMA or two (2) years experience for a LVN in a physician's office. The Senior QI Coordinator assists in department functions related to data collection, data entry, report preparation, record maintenance, and collaboration with other departments, regulatory and contracted agencies. This position will work extensively with MCAS methodology, data collection and intervention development and implementation. The Senior QI Coordinator assists with medical record requests and record preparation for any QI activity. The role also provides administrative support for provider site review activities.

Other KHS Department Leads as needed.

Quality Program Components

I. Population Health Management (PHM)

KHS supports its PHM delivery infrastructure that ensures the needs of its entire population and the delivery of quality care and services to each member are met. Through the Population Needs Assessment (PNA) conducted annually by KHS, the members' health and social needs are identified, and quality-driven strategies are developed to assist these members to the appropriate services offered by the following:

- Care Management Program
- Enhanced Care Management (ECM)
- Complex Case Management
- Transitional Care Services

The following is a list of all PHM Programs:

1. Basic Population Health Management
   - Community Supports Services
   - Maternal Health Outcomes – Baby Steps
2. Wellness and Prevention Programs
   - Nutrition Education Program

- Diabetes Prevention Program
- Diabetes Education Program
- Asthma Education
- School Wellness Grant Program

3. Care Management Programs
   - Care Coordination (i.e., Skilled Nursing Facility Coordination)
   - Complex Case Management (CCM)
4. Special Programs
   - COPD Clinic
   - Transition of Care (TOC) Program
   - ER Navigation
   - Palliative Care Program
   - CHF Clinic
   - Comprehensive Diabetes Program
   - Potentially Preventable Admission (PPA) Program
   - Homebound Program
5. Enhanced Care Management (ECM)

Continuous Quality Assurance and Improvement
Performance metric data are collected monthly, quarterly and aggregated annually to identify and analyze opportunities for improvement of performance. Feedback obtained from the Nurse Case Managers (NCM) and from members via the satisfaction survey are analyzed, trended over time, and correlated to the quality measures and care workflows.

The PHM Program is overseen by the PHM subcommittee and reports to the EQIHEC for all its activities and outcomes of performances.

The PHM Director oversees the Population Health Program and reports to the Chief Medical Officer. There are several different staff involved to support the population health initiatives including but not limited to:

- Case Managers
- Care Coordinators
- Health Educators
- Member outreach staff

The Business Intelligence unit provides the majority of data guiding the population health program. The Quality Performance Department provides HEDIS reporting and analysis, including Gap in Care reporting. There is collaboration between all departments on initiatives and interventions that are part of the Population Health Program.

II. Health Equity Program

a. Cultural and Linguistics
b. Diversity, Equality and Inclusion

KHS gathers race/ethnicity, language, gender identity and sexual orientation data to assist in

providing culturally and linguistically appropriate services (CLAS).

Key Functional Areas

I. Member Grievances and Appeals System

KHS Member Grievance and Appeal system complies with the requirements set forth in the 42 Code of Federal Regulations Sections 438.228 and 438.400 – 424, 28 California Code of Regulations Sections 1300.68 and 1300.68.01, and 22 CCR Section 53858. KHS use all notice templates included in the All-Plan letter 21-011 and ensures timely written acknowledgement and a notice of resolution to the member as quickly as possible.

Grievances with a Potential Quality Issue (PQI) identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues are reviewed by the KHS CMO or their designee to determine the severity level and follow-up actions needed. All cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include tracking and trending a provider for additional PQIs and/or request(s) for a corrective action plan (CAP) for issues or concerns identified during review. The CMO or their designee may present select cases to the PAC for review and direction as needed.

KHS regularly analyzes grievance and appeals data to identify, investigate, report and act upon trends impacting health care access and delivery to the members.

Grievance Satisfaction Data – KHS reviews Member grievances and satisfaction study results as methods for identifying patient safety issues.

II. Behavioral Health

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

For substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

III. Health Education

The Plan's Health Education Department conducts a field-testing process to ensure that written health education materials are understood by members and accessible for the targeted member audience. Newly developed or adapted materials provides opportunities for Plan Members and

their families to review materials prior to their release or publication. Mechanisms for field testing may include, but are not limited to:

1. Review during the PP/CAC meeting.
2. Key informant reviews with Members.
3. Focus groups with targeted members to determine relevance and effectiveness.

All field testing is overseen by a KHS health educator to monitor its appropriateness. Members or the parents/guardians of Members have the opportunity to provide input for the materials being presented including how better to engage the targeted audience. The effectiveness of the chosen mechanism is taken into consideration for future field testing.

IV. Member Services

KHS implements and maintains written policies and procedures that set forth the Member's rights and responsibilities and shall communicate its policies to its Members, Providers, and, upon request, potential members.

Members are also assured of their rights to confidentiality, right to advance directives, and rights to linguistic services.

V. Pharmacy Services

Safety Monitoring: Pharmacy will expand on the current monitoring of opioids/controlled substances as defined by the SUPPORT Act. Though previously managed via prospective Pharmacy Benefit Manager (PBM) rules, KHS will retrospectively review claims for possible action in regard to the Beer's list for geriatric members. KHS will also monitor drug recalls issued by the FDA or manufacturer. Currently for monitoring the potentially inappropriate use of opioids, either, high dose, those without naloxone, and/or in combination with other agents acting on the central nervous system such as benzodiazepines, and muscle relaxants, KHS sends notification letters to the physician on record to evaluate the appropriateness of the regimen for that member.

The Director of Pharmacy or designee participates in interdisciplinary teams weekly to discuss drug regimens of select members. KHS also sends letters to providers regarding drug profiles of members that have been identified as having drug duplications, interactions, and/or missing therapies.

Pharmacy is developing a series of report suites that will identify all HEDIS/MCAS measures we are held accountable for or will be added in the following year (2024). These reports identify members who are non-compliant for that measure, and we will be working with other depts to best close the gap. The approach will incorporate brining in the local pharmacies to help with outreach to the members and providers.

VI. Provider Network

The Provider Network Management (PNM) department is responsible for growing and overseeing the Plan's network of providers and is comprised of: Contracting, Credentialing, Provider Relations, Provider Grants, and Analytics and Regulatory Reporting. The PNM department is headed by the Senior Director of Provider Network. The Deputy Director of Provider Contracts

reports to the Senior Director of Provider Network and oversees Contracting and Credentialing. The Deputy Director of Provider Network reports to the Senior Director of Provider Network and oversees Provider Relations, and Provider Grants, and Analytics and Regulatory Reporting.

The Contracting Team is comprised of a Provider Contracts Supervisor, Contract Specialists, Coordinators. The Contracting Team is responsible for contracting with providers within and adjacent to the network service area to ensure network adequacy for all specialty types. The Contracting department also works with contracted providers to negotiate rates and implement special programs. As needed the Contracting team will negotiate single-case, Letter of Agreements (LOAs) with out-of-network providers.

The Credentialing Team is comprised of a Credentialing Manager and five Credentialing Coordinators. The PNM Credentialing team monitors and tracks provider licenses, certificates, training, Medi-Cal enrollment, and other applicable provider requirements. The Credentialing team also aids in maintaining accurate provider data utilized within Plan's regulatory reporting and provider directory.

The Provider Relations Representative Team is comprised of a Provider Relations Supervisor and seven Provider Relations Representatives. The Provider Relations Representatives are the direct link between the Plan and the Provider. The Provider Representatives are responsible for provider communication and education and conduct outreach to noncontracted providers for potential recruitment.

The Grants Team is comprised of a Grants Manager and a Grants Specialist. The Grants Team is responsible for developing grant programs and identifying and reaching out to providers who may qualify for certain grants from the Plan. The Grants team is responsible for creation and tracking of appropriate grant's milestones and goals. The KHS grant program works to financially aid and encourage innovative efforts to bring beneficial services to our community.

The PNM Analyst team is comprised of the Provider Network Manager, Provider Network Analytics Program Manager, and three Senior Provider Network Analysts. The PNM Analyst Team is responsible for, monitoring network accessibility, network-related regulatory reporting (DMHC Timely Access and Annual Network Review, DHCS Annual Network Certification), the Provider Satisfaction Survey and maintaining the provider directory (in conjunction with credentialing team).

Provider network accessibility is primarily monitored via the Provider Network Management, Quarterly Network Review. The Quarterly Network Review includes, but is not limited to an Access Grievance Review, Provider Accessibility Monitoring Survey, Geographic Accessibility Review, and Network Adequacy/Provider Counts. These reports track and monitor the Plan's regulatory compliance to standards such as: PCP to member and Physician to Member ratios, Appointment Availability, Provider Response times, Provider After-Hours availability, and In-Office wait times. The PNM Analytics Team monitors and tracks members' geographic access to PCP, Specialist, Non-Physician Mental Health, Specialty OB/GYN, and Hospital providers and confirms the geographic access is within regulatory standards. If any provider type/geographic region is not meeting regulatory standards, it is the responsibility the PNM Analytics Team to request an Alternative Access Standard and identify potential providers for recruitment/contracting

activities. The PNM Analytics Team reviews Access Grievance data to determine if any provider, group, or specialty is experiencing the same access issue on a continuous basis. The PNM Analytics Team reports all findings to PNM leadership and the EQIHEC committee.

VII. Utilization Management (Adverse Events/Sentinel Event)

Utilization Management is responsible for coordinating and conducting prospective, concurrent, and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care/continuum of care, and continued inpatient stay, as appropriate.

The QI Department reviews a sampling of hospital re-admissions that occurred within 30 days of the first hospital discharge each quarter to identify and follow-up on potential inappropriate care issues.

Any issue that warrants further investigation of potential inappropriate care is forwarded from the Utilization Management Department, Member Services Department, or any other KHS Department, to the QI Department for determination whether a PQI issue exists and follow up corrective action based on the severity level of PQI identified. These referrals may include member deaths, delay in service or treatment, or other opportunities for care improvement.

VIII. Business Intelligence (BI) Unit

Functions include:

- Establish advanced health analytics to ensure that leadership has full purview into the population to improve individual experience of care; improve the health of the population while reducing per capital cost of care for populations.
- Create, manage, and continuously improve Corporate Key Performance Indicators (KPI's)
- Reduce operational silos and proactively manage and improve overall operations.
- Provide and validate standard metrics and information around process improved to ensure that project goals, objectives, or Return on Investments (ROI) are achieved.
- Establish data governance over various systems to ensure that reliable data can be consumed for analytics and reporting.
- Manage all operational and regulatory reporting inventory for the organization.

IX. Management and Information System (MIS)

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments.

KHS MIS has the capability to capture, edit, and utilize various data elements for both internal management use and to meet the data quality and timeliness requirements. These include DHCS' encounter data, network provider data, program data, and template data submissions and processes. MIS also has the ability to meet Population Health Management data integration requirements and is able to provide the requested data to DHCS and Centers for Medicare and Medicaid Services upon request.

KHS (MIS) has the capacity to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks.

KHS MIS supports at a minimum:

- All Medi-Cal eligibility data.
- Information on members enrolled with Kern Health Systems.
- Provider claims status and payment data.
- Health care services delivery encounter data.
- Network provider data.
- Program data.
- Template data.
- Screening and assessment data.
- Referrals including tracking of referred services to follow up with Members to ensure that services were rendered.
- Electronic health records.
- Prior auth requests and specialty referral system.
- Care Management data.
- Care Coordination data.
- Financial information.
- Social drivers of health data.
- Grievance and appeal information.

Quality Work Plan and Activities

The annual QI Work Plan is designed to target specific QI activities, projects, tasks to be completed during the upcoming year, and monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QI Program, including accomplishments and impact on members. Evaluation and planning the QI Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

- The Work Plan is developed by the Quality Improvement Department on an annual basis and is presented to the PAC, EQIHEC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
- The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care and the quality of service provided to members.
- After review and approval of quality study results including action plans initiated by the EQIHEC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS Provider bulletins to contracting providers.
- The activities in the QI Work Plan are annually evaluated for effectiveness.
- QI Work Plan responsibilities are assigned to appropriate individuals.

Components of the QI Work Plan:

Quality and Safety of Clinical Care: KHS evaluates the effect of activities implemented to improve patient safety. Safety measures are monitored by the QI Department in collaboration with other KHS departments, including:

- **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.

- **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
- **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

1. Quality of Clinical Care

a. Managed Care Accountability Set (MCAS) Measures

KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by DHCS. The measures are a combination of ones selected by DHCS from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO to validate that the data collection, data used and calculations meet the specifications assigned by DHCS.

DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50th percentile based on outcomes published in the latest edition of NCQA's Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan's (MCP) compliance. When an MCP does not meet the 50th percentile or better for a measure, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2024. Results for the 2023 measures will be calculated and submitted in report year (RY) 2023. The MCAS Measures include:

#	**MEASURE** Total Number = 36 (10 Hybrid and 26 Administrative)	**MEASURE ACRONYM**	**MEASURE TYPE METHODOLOGY**	**HELD TO MPL?**
Behavioral Health Domain				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
Children's Health Domain				
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid/Admin**	Yes
5	Developmental Screening in the First Three Years of Life	DEV	Administrative	Yesiii
6	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid/Admin**	Yes
7	Lead Screening in Children	LSC	Hybrid/Admin**	Yes

8	Topical Fluoride for Children	TFL-CH	Administrative	Yesiii
9	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	Yes
Chronic Disease Management Domain				
11	Asthma Medication Ratio*	AMR	Administrative	Yes
12	Controlling High Blood Pressure*	CBP	Hybrid/Admin**	Yes
13	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid/Admin**	Yes
Reproductive Domain				
14	Chlamydia Screening in Women	CHL	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid/Admin**	Yes
Cancer Prevention Domain				
17	Breast Cancer Screening*	BCS	ECDS & Admin***	Yes
18	Cervical Cancer Screening	CCS	Hybrid/Admin**	Yes
Report only Measures to DHCS				
19	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
22	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
23	Colorectal Cancer Screening*	COL-E	ECDS	No^^
24	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
25	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
#	**MEASURE** Total Number = 36 (10 Hybrid and 26 Administrative)	**MEASURE ACRONYM**	**MEASURE TYPE METHODOLOGY**	**HELD TO MPL?**

26	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No^^
27	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No^^
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
30	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	No
31	Follow-Up Care for Children Prescribed Attention- Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed Attention- Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
35	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	No^^
36	Plan All-Cause Readmissions*	PCR ii	Administrative	No
37	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No^^
38	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No^^
39	Prenatal Immunization Status	PRS-E	ECDS	No^^
Long Term Care Report Only Measures to DHCS				
40	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative^	No
41	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*	SNF-HAI	Administrative^	No
42	Potentially Preventable 30-day Post-Discharge Readmission*	PPR	Administrative^	No

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or that is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. Managed Care Plans are required to meet or exceed the performance levels set forth by Department Health Care Services (DHCS) as outlined in their contract. Based on KHS' compliance level for MCAS measures for MY2022, KHS was placed in the orange tier and is completing a cause-and-effect analysis to understand the barriers of not meeting the MPLs.

b. DHCS-required Studies: Performance Improvement Projects (PIP)

KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 36 month time frame and are each broken out into four (4) modules. Each module is submitted

to HSAG/DHCS for review, input, and approval incrementally throughout the project.

The two new PIPS required by DHCS will include annual submissions for 3 years from 2023-2026. The framework for the new PIPs has been updated by DHCS to align with the CMS protocol.

Clinical PIP:
The new cycle of PIPs began in August 2023 and will run through 2026. The clinical PIP is focused on Health Equity, specific to the W30 0-15 months African American population. KHS submitted the first phase of the PIP design to HSAG in August.

Non-Clinical PIP:
The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions. We will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders. KHS also submitted the first phase of the PIP design to HSAG in August. HSAG validated and approved the submission with minor feedback to improve the framework.

2. Safety of Clinical Care

a. **Facility Site and Medical Record Review** – Facility site and medical record reviews are performed before a provider is awarded participation privileges and every three years thereafter. As part of the facility review, KHS QI Nurses review for the following potential safety issues:

- Medication storage practices to ensure that oral and injectable medications, and "like labeled" medications, are stored separately to avoid confusion.
- The physical environment is safe for all patients, personnel, and visitors.
- Medical equipment is properly maintained.
- Professional personnel have current licenses and certifications.
- Infection control procedures are properly followed.
- Medical record review includes an assessment for patient safety issues and sentinel events.
- Bloodborne pathogens and regulated wastes are handled according to established laws.

b. Credentialing/Recredentialing

Assessment and Monitoring: To monitor that contracting providers have the capacity and capability to perform required functions, KHS has a pre-contractual and post- contractual assessment and monitoring system. Details of the activities with standards, tools and processes are found in specific policies and include:

Pre-contractual Assessment of Providers – All providers desiring to contract with KHS must, prior to contracting with KHS, complete a document that includes the following sections:

- Health Care Delivery Systems, including clinical safety, access/waiting, referral tracking, medical records, and health education.
- Credentialing information.

c. **Drug Utilization Review** – KHS performs drug utilization reviews to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care.

d. **Clinical Practice and Preventive Health Guidelines** – Clinical Practice Guidelines are developed using current published literature, current practice standards and expert opinions. They are directed toward specific medical problems commonly found with members. The PAC reviews and approves all Clinical Practice Guidelines and/or Preventive Health Guidelines prior to presentation to EQIHEC Committee. The EQIHEC Committee is responsible for adopting and disseminating Clinical Practice Guidelines for acute, chronic, and behavioral health care services. Guidelines are reviewed every two years and updated if necessary.

3. **Quality of Service**

a. **Primary Care Physician (PCP) and Specialist Access Studies** – KHS performs physician access studies per KHS Policy 4.30, Accessibility Standards. Reporting of access compliance activities is the responsibility of the Provider Network Management Manager and is reported annually.

b. **PCP and Specialist** Appointment Availability Study KHS members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization[1]	Within 48 hours of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

c. **PCP After-Hours Access**

KHS contracts with an after-hours triage service to facilitate after-hours member access to

care. The Director of UM reviews monthly reports for timeliness, triage response and availability of contracting providers. Results of the access studies are shared with contracting providers, EQIHEC Committee, Board of Directors and DHCS.

4. Member Safety

KHS continuously monitors patient safety for members and develops appropriate interventions as follows:

- **Coordination of Care Studies** – KHS performs Coordination of Care Studies to reduce the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.
- **Interventions** – KHS initiates interventions appropriate to identified issues. Such interventions are based on evaluation of processes and could include distribution of safety literature to members, education of contracting providers, streamlining of processes, development of guidelines, and/or promotion of safe practices for members and providers.

KHS evaluates the effect of activities implemented to improve patient safety. Safety measures are monitored by the QI Department in collaboration with other KHS departments, including:

- **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.
- **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
- **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

The Director of Member Services presents reports regarding customer service performance and grievances monthly to the CEO, CMO and Chief Operations Officer. At least quarterly, reports are presented to the EQIHEC Committee for review and recommendations.

Member Information on QI Program Activities – A description of QI activities are available to members upon request. Members are notified of their availability through the Member Handbook. The KHS QI Program Description and Work Plan are available to contracting providers upon request.

QUALITY IMPROVEMENT PROCESS

a. **Prioritization of Identified Issues** – Action is taken on all issues identified to have a direct or indirect impact on the health and clinical safety of members. These issues are reviewed by appropriate Health Services staff, including the CMO, and prioritized according to the severity of impact, in terms of severity and urgency, to the member.

b. **Corrective Actions** – Corrective Action Plans (CAP) are designed to eliminate deficiencies, implement appropriate actions, and enhance future outcomes when an issue is identified. CAPs are issued in accordance with *KHS Policy and Procedure 2.70-I Potential Quality of Care Issues (PQI)*. All access compliance activities are reported to the Senior Director of Provider Network who prepares

an activity report and presents all information to the CEO, CMO, Chief Operations Officer, Sen, and EQIHEC Committee.

c. **Quality Indicators** – Ongoing review of indicators is performed to assess progress and determine potential problem areas. Clinical indicators are monitored and revised as necessary by the EQIHEC Committee and PAC. Clinical practice guidelines are developed by the DUR Committee and PAC based on scientific evidence. Appropriate medical practitioners are involved in review and adoption of guidelines. The PAC re-evaluates guidelines every two years with updates as needed.

KHS targets significant chronic conditions and develops educational programs for members and practitioners. Members are informed about available programs through individual letters, member newsletters and through KHS Member Services. Providers are informed of available programs through KHS provider bulletins and the KHS Provider Manual. Tracking reports and provider reports are reviewed and studies performed to assess performance. KHS assesses the quality of covered health care provided to members utilizing quality indicators developed for a series of required studies. Among these indicators are the MCAS measures developed by NCQA and CMS. MCAS reports are produced annually as well as throughout the year and have been incorporated into QI assessments and evaluations.

Quality Improvement Strategies

I. Quality Improvement Strategies

The following strategies and key action items were identified for improvement of 3 focused areas:

a. Data Accuracy, Completeness, & Timeliness,
b. QI Training & Resources for KHS staff & providers, and
c. Collaboration & Communication.

Strategies and key action items for the 3 focus areas are as follows:

- Data Accuracy, Completeness, & Timeliness
  - Strategy: Develop process for timely, complete, & accurate data to measure MCAS compliance for strategy development and outcomes analysis
  - Key Actions:
    * Implement an organizational standard data QA process
    * Evaluate options to support consistent data exchange with providers
    * Analyze audit and perform risk management and remediation on any findings to close the gaps
    * Analyze data by geographic areas and identify areas with higher gaps in care
      - Special programs with providers in remote geographic areas (geographic barriers)
      - Mobile clinics in underserved areas
      - Onsite visits to LTC facilities
    * KHS members are stratified by Race, ethnicity & other SDoH data used to target interventions & develop special programs.
    * Utilization & outcome data is stratified to identify areas of underutilization such as low performance scores on preventive services
      - Target services for CHWs, home visits, doulas etc.
      - Basic Population Health Management Program supported with mobile

clinics, and home visits to close gaps

- Training & Resources
  - Strategy: Develop a quality education program to enable KHS staff & providers to develop & implement effective MCAS improvement strategies
  - Key Actions:
    * Develop e-learning courses for KHS staff & providers that align with industry-standard, QI principles and methods. Courses will cover current MCAS measures
    * Identify organizational structure for the role of a Health Equity Officer, as required in the DHCS CQS. This position will be responsible for carrying out the CQS strategies in collaboration with the Quality Improvement and Population Health Management departments
    * Identify and assess members risks guiding the development of care management programs and focused strategies
    * Create strategies to engage members as "owners of their own care". Member Engagement Program - Develop a robust member and community engagement program
    * Develop communication strategies that will focus on keeping families and communities healthy via prevention
    * Create early interventions for rising risk and patient centered chronic disease management
    * Expand on programs that focus on whole person care for high-risk populations, addressing drivers of health
    * Implementation of strategic & corporate goals to incorporate equity in internal staffing recruitment, network development/expansion and implementation of PHM programs

- Collaboration & Communication
  - Strategy: To establish a communication process that supports strategic thought partnership, transparency, & decision-making for MCAS compliance throughout all levels of the organization.
  - Key Actions:
    * Executive Leadership Team will establish a process for communication & collaboration of QI strategies & activities at all levels of the organization.
    * Plan project with CHWs in underserved areas to engage and support members to close care gaps , home visits, working with community centers where members go to meet members,
    * Street medicine – leveraging CalAIM Incentive Program (HHIP)
    * Schools with school wellness program, SBHIP (CalAIM Incentive program), use of school clinics for immunizations, screenings and possible health fairs to close gaps in care
    * Partner with Department of Public Health for early pregnancy identification and support to initiate prenatal care
    * ECM sites to close gaps in care,
    * Utilize specialist for diabetes management for those with HgA1c above 9,
    * PCP incentive programs supporting practice transformation

* Grant funding for telehealth
* Expand transportation providers for members in more remote areas of the county by partnering with CBOs and Provider Practices

Integration of Study Outcomes with KHS Operational Policies and Procedures: KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

As previously described, a Strike Team is in place to focus on initiatives that will improve KHS' MCAS scores. The strike team is made up of marketing/member engagement, business intelligence, provider network management, quality, and population health. With this diverse team, key strategies will be developed and monitored closely to identify what the most effective approach in getting members to close their gaps in care and into their primary care physicians for their preventive health services appointments.

Evaluation of KHS' Quality Program

Annual Evaluation of the KHS Quality Improvement Program

On an annual basis, KHS evaluates the effectiveness and progress of the QI Program and Work Plan, and updates the program as needed. The CMO, with assistance from the Quality Medical Director, Director of QI, Pharmacy Director, Director of Health Education and Cultural & Linguistics Services, Director of Marketing, Director of Member Services and Senior Director of QP and Provider Network, documents a yearly summary of all completed and ongoing QI Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

The report includes pertinent results from QI Program studies, member access to care surveys, physician credentialing and facility review compliance, member satisfaction surveys, and other significant activities affecting medical and behavioral health care provided to members. The report demonstrates the overall effectiveness of the QI Program. Performance measures are trended over time to determine service, safety, and clinical care issues, and then analyzed to verify improvements. The CMO presents the results to the EQIHEC Committee for comment, suggested program adjustments and revision of procedures or guidelines, as necessary. Also included is a Work Plan for the coming year. The Work Plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

The yearly QI Program summary and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the coming year, and approval of changes in the QI Program. The Board of Directors is responsible for the direction of the QI Program and actively evaluates the annual plan to determine areas for improvement. Board of Director Comments, actions and responsible parties assigned to changes are documented in the minutes. The status of delegated follow-up activities is presented in subsequent Board meetings. A summary of QI activities and progress toward meeting QI goals is available to members and contracting providers upon request by contacting KHS Member Services.

KHS Providers

Provider Participation
KHS contracts with physicians and other types of health care providers. The Provider Network Management Department conducts a quarterly assessment of the adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff.

Provider Information – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.

Provider Cooperation – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

Provider and Hospital Contracts
Participating provider and hospital contracts contain language that designates access for KHS to perform monitoring activities and require compliance with KHS QI Program activities, standards, and review system.

Provider contracts include provisions for the following:

a. An agreement to participate in the KHS QI Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.
b. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.
c. Cooperation with the KHS QI Program including access to applicable records and information.
d. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.

Hospital contracts include provisions for the following:

a. An agreement to participate in the KHS QI Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.
b. Development of an ongoing QI Program to address the quality of care provided by the hospital including CAPs for identified quality issues.
c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.
d. Cooperation with the KHS QI Program, including access to applicable records and information.

Conflict of Interest:
All committee members are required to sign a conflict-of-interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

Confidentiality

All members, participating staff and guests of the EQIHEC Committee and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hire. Confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Member's Right to Confidentiality:
KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. The EQIHEC Committee reviews practices regarding the collection, use and disclosure of medical information.

Information Security

Fraud, Waste, and Abuse (FWA) – The Quality Improvement Department provides support to the KHS Fraud, Waste, and Abuse program in the following ways:

a. **PQI Referrals** – In the course of screening and investigating PQI referrals, the QI Department consistently evaluates for any possible FWA concerns. All FWA concerns are referred to the KHS Compliance Department for further evaluation and follow up.

b. **FWA Investigations** – The QI Department clinical staff may provide clinical review support to the Compliance Department for FWA referrals being screened or investigated.

c. **FWA Committee –** The Director of QI or their designee is an active member of the KHS FWA Committee to provide relevant input and suggestions for topics and issues presented.

External Audits/Regulatory Audits and Oversight

Enforcement/Compliance: The Director of Quality Improvement is responsible for monitoring and oversight of the QI Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in policies. Compliance activities not under the oversight of QI are the responsibility of the Compliance Department.

Medical Reviews and Audits by Regulatory Agencies – The KHS Director of Compliance & Regulatory Affairs, in collaboration with the CHSO and the Director of Quality Improvement manages KHS medical reviews and

medical audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI Program. CAPs for medical matters are approved and monitored by the EQIHEC Committee.

Delegation

Delegation: KHS delegates quality improvement activities as follows:

1. In collaboration with other Kern County Health Plans – delegation for Site Reviews as described in APL 20-006, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.
2. VSP – delegation of QI and UM processes with oversight through the EQIHEC committee.

KHS Board of Directors (Chair)	Date
Chief Executive Officer	Date
Chairman EQIHE COMMITTEE	Date

Kern Health Systems

2024 Quality Improvement Program Work plan

Source	Key Performance Measure	Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Person
QUALITY PROGRAM STRUCTURE							
NCQA 1A	QI Program Description	QI Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Program to BOD and QIC for review and approval.	April 15, 2024	QI Director
NCQA 1B	Annual QI Work Plan	Yearly planned objectives and activities	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Work Plan to BOD and QIC for review and approval.	April 15, 2024	QI Director
NCQA 1C	Annual QI Evaluation	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Evaluation to BOD and QIC for review and approval	July 31, 2024	QI Director
NCQA; DHCS	Policies and Procedures	Review of organization's policies and procedures	No issues identified	Annual approval by the QIC	Presentation of the QI Evaluation to QIC for review and approval	April 15, 2024	QI Director
NCQA 1A	Quality Improvement Health Equity Committee (QIHEC)	Quarterly meetings and maintenance of minutes	New committee establishing 2024	Conduct quarterly meetings, as required by the QM Program	Meet quorum of voting members +at every meeting	December 31, 2024	QI Director
Quality of Clinical Care							
DHCS	MCAS Measures	18 MCAS measures mandated by DHCS to meet minimum performance levels (MPLs)	KHS placed in red tier status due to overall MCAS rates. Improved from Red Tier to Orange Tier from MY2021-MY2022.	All DHCS- mandated MCAS measures must meet the MPL at the 50th percentile 1. Timely Submission of all 18 measures. 2. Meet MPL for all 18 measures we are held accountable.	Based on the Fishbone diagram submitted to DHCS (RED Tier) a) Data management b) Training and resources c) Collaboration and communication	Q1 - April 30, 2024 Q2 - July 31, 2024 Q3 - November 30, 2024 Q 4 - January 31, 2025	QI Director
DHCS	Performance Improvement Projects (PIPs)		PIP topics are selected based on MCAS performance. Childrens Domain and BH are areas of focus				
	Clinical PIP: The clinical PIP will be focused on Health Equity, specific to the W30 0-15 months African American Population.	2023-2026 performance improvement project (PIP) overseen by HSAG focused on increasing the number of children ages 0 - 15 months old with completing an annual well care visit.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.	Interventions to be established in 2024	December 31, 2024	QI Director
	Non-Clinical PIP: The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department and interventions.	2023-2026 performance improvement project (PIP) overseen by HSAG focused on improving Behavioral Health measures through provider notifications with in 7-days of the ER visits.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG	Interventions to be established in 2024	December 31, 2024	QI Director
DHCS	Potential Quality of care Issue (PQI)	Monitoring of PQI volume month over month.	No issues identified	Monitor if the volume is below the median value of last 12 months.	Monitor Trending Reports	by the end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QI Analyst
		PQI Volume by Provider and by Severity	No issues identified	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	QI Analyst
		PQI Volume by Ethnicity and by Severity	No issues identified	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	QI Analyst
NCQA QI 3	Continuity and Coordination of Medical Care - Transitions of Care:	*Collecting data, identifying improvement opportunities and measuring effectiveness*	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI Director
	a) Movement of Members Between Practitioners	example – consult report received by PCPs	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	FSR Nurse QI Director
	b) Movement of Members Across	example – post partum rate	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI MCAS Analyst

	Settings	Example – post partum rate		Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI Director
NCQA QI 4	Continuity and Coordination Between Medical Care and Behavioral Healthcare –	*Collecting data, identifying improvement opportunities and evaluation of effectiveness that improve coordination of behavioral and general medical care:*	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	a) Exchange of information	*Ambulatory Medical Record Review :* Example - Presence of consult reports Example – PCP survey regarding satisfaction with coordination of care with BH practitioners	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	b) Appropriate diagnosis, treatment and referral of BH disorders seen in primary care	Example – Antidepressant Medication Management (AMM) Example – Follow-up Care or Children Prescribed ADHD medications (ADD)	No issues identified	Increase MCAS result by 2 percentage points from previous year	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	c) Appropriate use of psychotropic medications	Examples: AMM ; ADD Analysis of pharmaceutical data for appropriateness of a psychopharmacological medication	No issues identified	Increase MCAS result by 2 percentage points from previous year	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	d) Management of coexisting medical and behavioral disorders	Example: FUH	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	a) Primary or secondary preventive behavioral healthcare implementation	Examples: Data on need for stress management program for adults Data on need for prevention of substance abuse program Data on the need for developmental screening of children in primary care settings Data on the need for ADHD screening of children in primary care settings Data on the need for postpartum depression screening	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	b) Special needs of members with serious mental illness or serious emotional disturbance	Example: HEDIS measure Diabetes Monitoring for People with Diabetes and Schizophrenia	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
Safety of Clinical Care							
DHCS	Facility Site Review	*Conduct on site reviews at the time of initial credentialing or contracting, and every three years thereafter, as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program*	*Issues were identified in Critical Elements while conducting FSR.*	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	FSR Nurse
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified.	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coordinator will schedule and complete all PARS due 2024	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	FSR Nurse
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1. Emergency contact not documented 2. Dental/Oral Assessment not documented 3. HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	December 31, 2024	FSR Nurse
Kern	Drug Utilization Review	TAR PAD	None	Turnaround Time Timeliness - reviewed and returned in 1 business day TAR=24hrs PAD=5 days routine 3days=urgent	None	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Pharmacy Director
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No QOC trends for provider re-credentialing in 2023 to prevent moving forward from a QI perspective	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review Q3 years	December 31, 2024	Credentialing staff
Quality of Service							
NCQA; DHCS	Grievance and Appeals	a) Timeliness of acknowledgment letters		Within 5 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
		b) Timeliness of resolution		Within 30 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
DHCS; NCQA	Potential Quality of Care Issues (PQI)	a) Timeliness of acknowledgment letters		Within 5 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
		b) Timeliness of resolution		Within 30 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
NCQA; DHCS	Access to Care - PCP	*PCP access for preventive, routine care, urgent care, and after-hours access* Urgent care – w/in 48 hrs. Routine care – 10 business days	Identified Providers that are noncompliant with appointment availability standards	80%	Provider Accessibility Monitoring Survey	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	PNM
		Access to specialty care Urgent care – w/in 48 hrs. a) Routine care – 15 business days				March 31, 2024 June 30, 2024	

	Access to Care - SCP			80%	Provider Accessibility Monitoring Survey	September 30, 2024 December 31, 2024	PNM
DHCS; NCQA	Telephone access to Member Services	a) Speed of answer		≤ 30 seconds	Perform quarterly telephone access audit	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Customer Service Manager
		b) Call abandonment rate		5%		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Customer Service Manager
Members' Experience							
Kern	CAHPS survey	Adult and Child Medicaid Survey	Getting Needed Care scored lowest in the Adult Survey categories	Monitor CAHPS Results and establish baseline for Getting Care needed measure	Trending report on CAHPS results by survey questions	31-Dec-24	QI Analyst Health Education TBD
	Member Engagement / Rewards	Establish year-round, member outreach program focused on members with gaps in care. Redesign MCAS member rewards program to increase motivation for compliance with obtaining preventive health services and follow through with chronic condition self-care.	Did not meet MPL	Increase the included MCAS Measure Rates by 2% points by end of the year.	a) Text Messages to members encouraging the scheduling of their appointments for gaps in care with a focus on: Breast Cancer Screening Blood Lead Screening Initial Health Appointment Chlamydia Screening Cervical Cancer Screening Prenatal & Postpartum Care Well-Care Visits Well-Baby Visits in first 30 Months of Life b) Robocalls will be sent out to members that do not receive text messages FUM Got Approved for incentives for MY2024. FUA is Pending Approval	by end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QP Director
Provider Engagement							
Kern	Provider Satisfaction Survey				Trend PSS results by survey questions	December 31, 2024	TBD - PNM
	Provider Incentive Program	Improve HBD Measure rate	KHS placed in red tier status due overall MCAS rates	Improve HBD A1C level	Dr. Duggal began a pilot for members with Diabetes. With this pilot, Dr. Duggal is provided a group of members with uncontrolled Diabetes and help get their A1C controlled with the appropriate interventions. This will be an incentive-based reimbursement structure.	by end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QI Coordinator
	Provider education	Improve MCAS Measure Rates	Did not Meet MPL	Meet Providers Quarterly	QI coordinator meet Providers to update them on the MCAS Measure Rate performance	by end of every month January 31, 2024 February 29, 2024 March 31, 2024	PNO representative QI Coordinators

Performance Measure		**Barrier/Opportunity for Improvement**	**Previously Identified Issue**	**Intervention**	**Outcome**	**Outcome**	**Outcome**
Program Structure							
Quality of Clinical Care							
MCAS Measures:	MY 2023 MCAS Results:	Providers close to meeting MPL for MCAS Measure Compliance.	Not Meeting MPL	End of the year push through Provider outreach	Baseline data for MY2023		
AMR	<50th percentile	Monitor Measure performance month over month	Report only for MY2022. No issue	none	TBD		
BCS	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
CHL	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
CCS	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
CIS-10	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
CBP	<50th percentile	Monitor Measure performance month over month	Report only for MY2022. No issue	none	TBD		
DEV	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
IMA-2	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
LSC	<50th percentile	Did not meet MPL	Not Meeting MPL	QI Senior Co-ordinators reached out to Top 10 provider that have less than 150 members to complete Lead Screening in Children before the 2 years of age (LSC)	% members successfully completed Lead Screening.		
FUA-30Day follow up	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	% members successfully completed follow-up visit.		
FUM-30Day follow up	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	% members successfully completed follow-up visit.		
HBD	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	none	TBD		

PPC-Pre	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
PPC-Post	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
TFL-CH	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
W30(0-15M)	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
W30(15-30M)	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
WCV	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Diurectors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Compliance Code of Conduct

DATE: April 18, 2024

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 Governance and Compliance Committee has the fiduciary responsibility to oversee Kern Heath System's (KHS) regulatory Compliance Program and shall ensure the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations.

Kern Health System's Code of Conduct articulates the standards of behavior that is demonstrated by all KHS employees and Board Members This Committee assists the Board to improve its functioning, structure, and infrastructure. Adherence to the Code of Conduct demonstrates the organizational commitment to comply with all regulatory requirements, state, and federal laws.

As a core function of the KHS's Governance and Compliance Committee, advancing transparency of all Compliance related activities, serves to mitigate risk to the organization through a centrally comprised oversight committee.

REQUESTED ACTION

Receive and File.

KERN HEALTH SYSTEMS

Doing the right thing while
serving the community...

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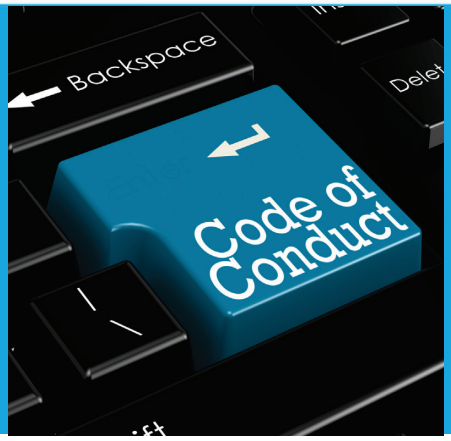


The KHS Code of Conduct is a living document that will be reviewed on an annual basis and updated as necessary to reflect the needs of the organization. A copy can be downloaded from the KHS Intranet as well as our website - kernfamilyhealthcare.com.

Doing the right thing while
serving the community.

Code of Conduct

At Kern Health Systems (KHS), compliance and ethical conduct mean doing the right thing while serving the community. The Code of Conduct is a valuable guide to help us choose wisely when faced with an ethical dilemma. All employees including members of the KHS Board of Directors are required to perform consistently with the Code.

These three fundamental values: TRUST, INTEGRITY, and RESPECT, remind us that preserving an ethical workplace is critical to our long-term success as an organization. The Code articulates the standards of behavior that each one of us is expected to observe while performing our jobs, as well as our commitment to complying with all regulatory requirements, state, and federal laws.

As employees, we are all required to ensure compliance and report any potential issues, ethical concerns, or violations of this Code of Conduct in accordance with policies and procedures. For additional information please refer to the Compliance Program Description, Compliance Guide, Employee Handbook, and Policies and Procedures located on the KHS Intranet website.

Thank you for reading and adhering to the KHS Code of Conduct.

Emily Duran
Chief Executive Officer

KERN HEALTH SYSTEMS

Our Mission:

Kern Health Systems is dedicated to improving the health status of our members through an integrated managed health care delivery system.

When you hear

Code of Conduct

think

3

1	2	3
TRUST	**RESPECT**	**INTEGRITY**
Trust is gained by treating others with integrity and respect.	Treat employees and the public with dignity and respect.	Be open, honest, and ethical in all of our dealings.

The Code of Conduct is a cornerstone of the Kern Health Systems Compliance Program and articulates the standards of behavior that each one of us is expected to observe while performing our jobs.

KHS employees are expected to comply with the Code, the KHS Compliance Program, and all governing laws, regulations, and requirements.

1 Trust

Gain trust by treating others with integrity & respect.

MAKE ETHICAL DECISIONS

- Follow KHS policies.
- Talk to your peers, manager, or other KHS management.
- Use the Headline Test, see page 8.

COOPERATE WITH INVESTIGATIONS

- Cooperate with all internal investigations and audits.
- Be truthful when responding to an investigation or audit.
- Never alter or destroy records in response to an investigation or audit.

TAKE ACTION ON NON-COMPLIANCE OR MISCONDUCT

- Advocate KHS values without concern for retaliation.
- Report any alleged non-compliance or misconduct immediately using our OPEN DOOR POLICY. If this does not seem appropriate, go to another member of management, Compliance, Human Resources, or report through our Ethics Hotline: 1-833-607-6589.

REMEMBER: Compliance is everyone's responsibility

2 Respect

Treat employees and the public with dignity, thoughtfulness, and value.

TREAT OTHERS WITH RESPECT

- Be open and honest with one another.
- Do not discriminate on the basis of race, color, religion, gender, sexual orientation, gender identity or expression of national origin, disability, age, covered veteran status, or any other characteristic protected by law.

PROTECT HEALTH INFORMATION

- Secure confidential patient information.
- Only disclose PHI in accordance with state and federal regulations.

HARASSMENT-FREE ENVIRONMENT

- Encourage a harassment-free work environment.
- Refuse to accept or tolerate sexual harassment, including unwelcome sexual advances, requests for sexual favors, or other unwelcome verbal or physical conduct of a sexual nature.

3 Integrity

Be open, honest, and ethical in all of our dealings.

ASSETS

- Do not allow others, including friends and family, to use KHS resources.
- Do not use KHS equipment or systems to violate the law or create, store, or send offensive content.
- Avoid any usage that might lead to loss or damage, including the introduction of viruses or a breach of KHS IT security.

CONFLICTS OF INTEREST

- Make decisions in the best interest of KHS' mission.
- Avoid situations that create or appear to create a conflict between personal interests and the interests of KHS.
- Accepting outside employment requires approval from management.

ACCURATE BUSINESS RECORDS

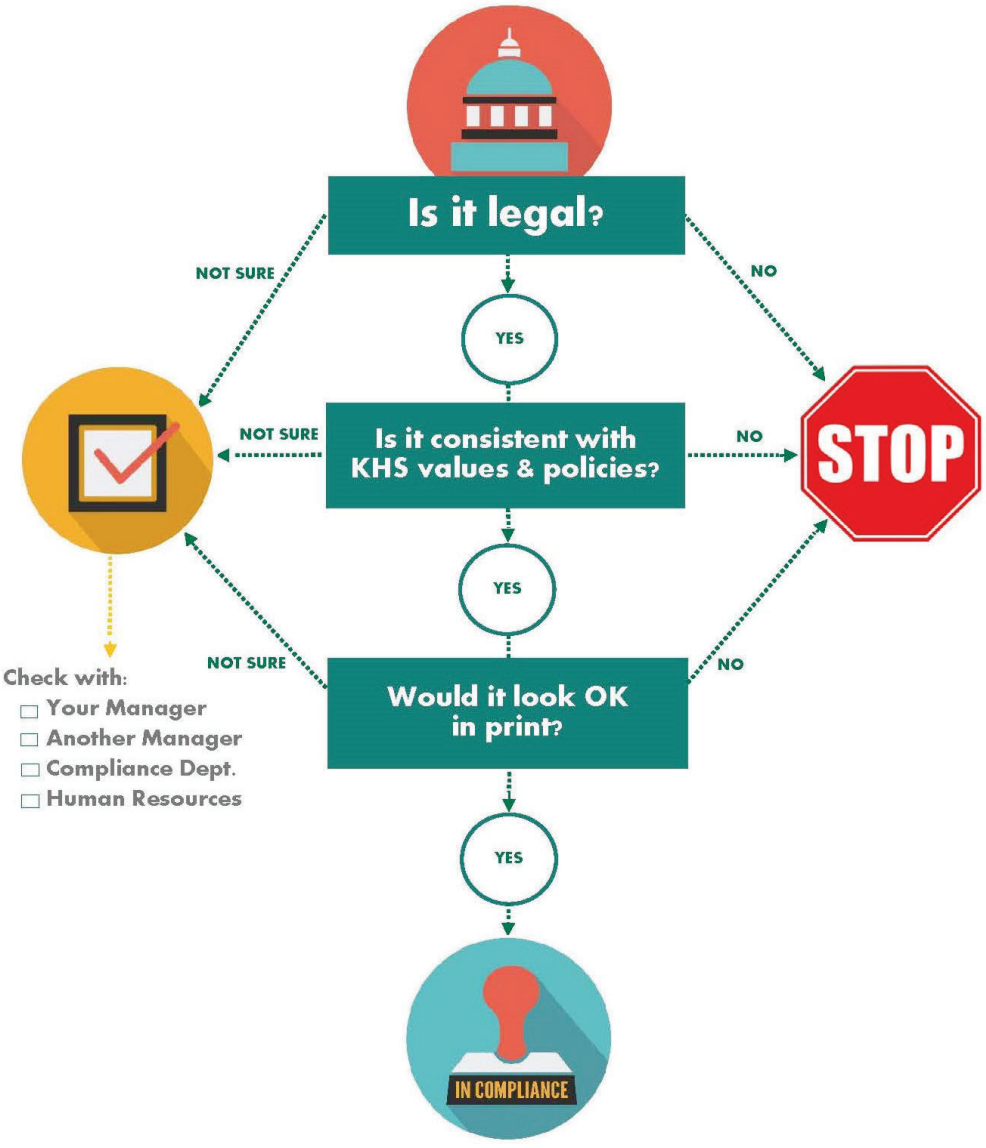
- Email and other electronic communications may be business records; avoid exaggeration, derogatory language, and other expressions that could be taken out of context.
- Retain, protect, and dispose of records according to policy.

GIFTS

- Do not solicit gifts, favors, or entertainment.
- Report gifts from outside vendors or providers for values greater than $150.

The Headline Test

Use the Headline Test below when faced with an ethical dilemma.



Ask yourself if what you said, did, or didn't say or didn't do became a headline on the front page of the newspaper- would you be embarrassed or proud?

Thank you for carefully reading the KHS Code of Conduct and supporting our culture of compliance!

KERN HEALTH SYSTEMS

Revised 05/2023
DHCS Approved: 06/13/2023

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Compliance Guide

DATE: April 18, 2024

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 Governance and Compliance Committee ensures the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations.

Kern Health System's Compliance Guide offers a self-study reference guide in support of KHS's commitment to acting ethically and responsibly in a culture of compliance, ethics, and integrity. Additional resources are available in the KHS Employee Handbook and policies and procedures.

Educational support to all staff and Board Members for managing organizational risks related to Fraud, Waste, and Abuse (FWA) and Privacy and Security issues under the Health Insurance Portability and Accountability Act (HIPAA) ensures the organization is provided the necessary tools to protect KHS members' personal health information and KHS's proprietary activities.

As a core function of the KHS's Governance and Compliance Committee, advancing transparency of all Compliance related activities, serves to mitigate risk to the organization through a centrally comprised oversight committee.

REQUESTED ACTION

Receive and File.

KERN HEALTH SYSTEMS

Self-Study Employee Guide

HIPAA Fraud, Waste, or Abuse Code of Conduct

2024

KHS Self-Study Employee Guide

HIPAA Fraud, Waste, or Abuse Code of Conduct

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A message from the Compliance Department

At Kern Health Systems we are deeply committed to acting ethically and responsibly in a culture of compliance, ethics, and integrity. To support that commitment, we have created this Self-Study Employee Guide that will cover general information regarding HIPAA, Fraud, Waste, or Abuse, and the KHS Code of Conduct.

Additional information can be found in the Employee Handbook as well as polices and procedures located on the KHS Intranet.

Should you have questions regarding any of the topics in this guide, please contact or visit the Compliance Department on the 2nd floor.

Thank you,

KHS Compliance Team
Compliance@khs-net.com

KHS employees can also report suspected ethical abuses and fraud by calling the Ethics Hotline at:

1-833-607-6589

Available 24/7. All calls are strictly confidential.

HIPAA

What does it mean to you?

At Kern Health Systems every employee is responsible for the health records of over 400,000 Members. It's important to understand the state and federal laws that regulate the privacy and protection of Member information, as necessary to carry out KHS workforce functions.

HEALTH
I NSURANCE
P ORTABILITY
ACCOUNTABILITY
ACT

WHAT DOES THE LAW SAY?

The Health Insurance Portability and Accountability Act of 1996 or (HIPAA) is a federal law designed to protect a subset of sensitive information known as protected health information or (PHI) shared with health plans, doctors, hospitals and others who provide and pay for healthcare. In 2009, HIPAA was expanded and strengthened by the HITECH Act (Health Information Technology for Economic and Clinical Health).

What is PHI, ePHI, and PI?

The HIPAA Privacy Rule protects the privacy of individually identifiable health information, called protected health information (PHI).

PHI (Protected Health Information) is any information that can be used to identify a Member, whether living or deceased - that relates to the patient's past, present, or future physical or mental health or condition.

The HIPAA Security Rule protects information which is individually identifiable health information received, maintained or transmitted in electronic form. The Security Rule calls this information "electronic protected health information" (e-PHI).

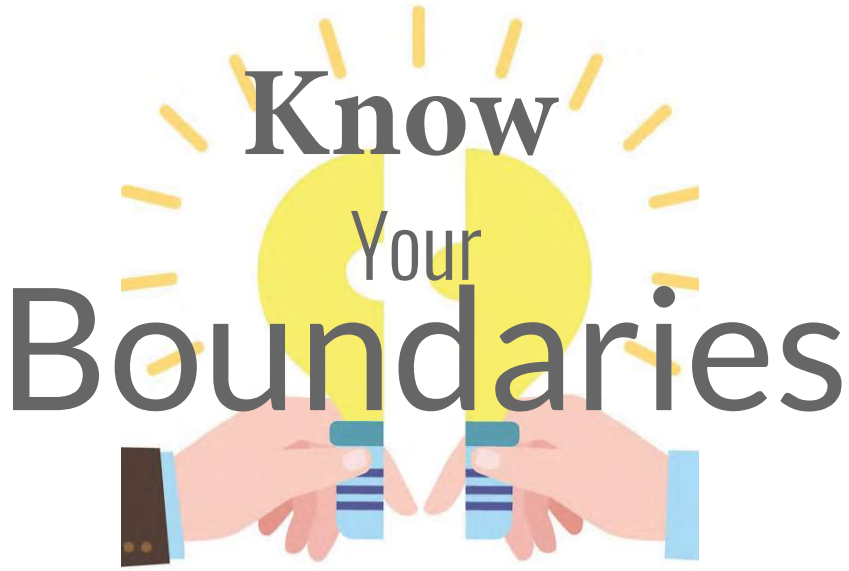
PI (Personal Information) is any information that is not public and maintained by an agency that identifies or describes an individual. This may include two or more pieces of information such as first and last name with a social security number and or date of birth.

Examples of PI

- Name (first and last)
- Social Security Number
- Physical Description
- Home Address
- Home Telephone Number
- Education
- Financial Matters
- Medical or Employment History
- Statements made by or attributed to the individual

Employees may access Member PHI, ePHI or PI ONLY when necessary to perform their job-related duties.

You must take immediate action and report all privacy breaches to your Supervisor and the KHS Compliance and Fraud Prevention Officer.



A privacy breach is an unauthorized disclosure of PHI, ePHI, or PI in any manner (paper, electronic or verbal) that violates either Federal or State laws.

TYPES OF BREACHES

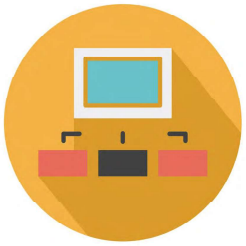
Paper Breach
Misdirected paper faxes with PHI outside of KHS, loss or theft of paper documents containing PHI, mailings with PHI to incorrect providers or members.

Electronic Breach
Stolen, unencrypted laptops, hard drives, PCs with ePHI, stolen unencrypted USB devices (memory sticks, thumb drive, etc.), misdirected e-fax to an unauthorized party.

Verbal Breach
Sharing PHI with friends or family outside of work, over the phone to a person not authorized by law or permission.

Privacy & Security Tips

Protect PHI and ePHI at all times – your job and reputation may depend on it.



- Cover, turn over, or lock up PHI and lock your computer screen when you're away from your workstation.
- Use encryption for emails containing ePHI.
- Do not discuss PHI outside of work under any circumstances.
- Protect PHI on computers, laptops, copy machines, or other electronic devices.
- When faxing member information, double check the recipient's number.
- Promptly pick up your copies containing PHI from copy machines.
- Report accidental or willful disclosures of PHI and security violations to your Supervisor and the KHS Privacy Officer by using the HIPAA Team email node - HIPAATeam@khs-net.com.
- Do not leave your passwords exposed.
- Use confidential shredding bins to dispose of PHI.

Accessing or disclosing Member's PHI is only permitted when it pertains to the employee's job duties.

Penalties for Breaches

Breaches of the HIPAA Privacy and Security Rules have serious ramifications that may result in civil and criminal penalties.

CIVIL

HIPAA civil financial penalties apply to covered entities and its employees which may include: $100 - $50,000 fines or more for single violation up to $1.5 million for multiple violations in 1 year.

CRIMINAL

Criminal penalties for knowingly obtaining, using or disclosing PHI in violation of HIPAA may include fines up to $50,000 to $250,000 and up to 10 years in prison.

Sources: 45 C.F. R. § 160.404,
42 U.S. Code § 1320d-6

Violations of KHS policies may also result in disciplinary action, up to and including termination of employment.

Minimum Necessary

Provide only the information that is necessary in order to minimize risk to the security of a member's PHI.

Follow minimum necessary principles for using confidential information:

- If you don't need confidential information to complete a task, don't access it.
- If specific information is requested, such as a list of specific members or a person's name, send only that.
- If you need to reply to or forward an email or text message, remove all non-essential PHI from the message before you send it.
- Leave minimal information necessary on voicemail or answering machines.

HIPAA requirements state that when you access, use, or disclose PHI, only access, use, or disclose the minimum necessary information to accomplish the intended purpose.

Sources: 45 C.F. R. § 164.502(b), 45 C.F.R. 164.514(d)

We are ALL responsible for reporting suspected cases of FWA.

Fraud, Waste, or Abuse

What is FRAUD?

The intentional deception or misrepresentation of an act knowingly made by an individual or entity where the result was of benefit to the individual or entity.

WASTE?

Waste happens when there is no intent to deceive or misrepresent, but the outcome results in an overpayment of funds.

or ABUSE?

Abuse may be intentional and is a practice that results in unnecessary costs such as billing for services that were not medically necessary.

WHAT DOES THE LAW SAY?

The False Claims Act (FCA) (31 U.S.C. §3729-3733), protects the government from being overcharged or sold substandard goods or services. The FCA imposes liability on any person who submits a claim to the federal government that he or she knows is false.

Examples of
Fraud, Waste, or Abuse

Provider FWA

- Billing for services not rendered
- Sending Members a bill after the plan has made payment
- Coding a New Patient Visit instead of an Established Patient Visit
- Soliciting or receiving kickbacks
- Questionable prescribing practices

Member FWA

- Ambulance abuse and overuse of Emergency Rooms
- Sharing ID card, benefit sharing
- Illegal doctor shopping & drug-seeking behavior
- Deliberately providing misinformation to retrieve services
- Selling and forging prescriptions

Report FWA

Speak Up!

Report suspicious activities to your Supervisor and the Director of Compliance by using the Fraud Team email node. You can also make anonymous reports by calling the Ethics Hotline at 1-833-607-6589, available 24/7. All calls to the hotline are strictlyconfidential.

Do the right thing

Anyone with information about possible fraud, waste, or abuse can make a confidential report.

Kern Health Systems does NOT allow or tolerate retaliation against those who, in good faith, report potential Fraud, Waste, or Abuse (FWA) to the Compliance Department.

Report FWA concerns:

- To your Supervisor or Management Team
- Email the Fraud Team at, FraudTeam@khs-net.com
- In person to the Compliance Team, 2nd Floor
- Call the Ethics Hotline, 1-833-607-6589

When you report, you're protected.

KHS employees can report suspected ethical abuses and fraud by calling the Ethics Hotline at:

1-833-607-6589

Available 24/7. All calls are strictly confidential.

Do the right thing while serving the community.

Code of Conduct

At Kern Health Systems (KHS), compliance and ethical conduct mean doing the right thing while serving the community.

The KHS' Code of Conduct is a set of values outlining the responsibilities for you as an employee and KHS as an organization.

These three fundamental values: TRUST, INTEGRITY, and RESPECT, remind us that preserving an ethical workplace is critical to our long-term success as an organization. The Code articulates the standards of behavior that each one of us is expected to observe while performing our jobs.

KHS maintains a non-retaliation policy. As employees we are encouraged to, in good faith, report compliance issues, ethical concerns, or violations of this Code of Conduct in accordance with KHS policies.

KERN HEALTH SYSTEMS

Our Mission:

Kern Health Systems is dedicated to improving the health status of our members through an integrated managed health care delivery system.

When you hear

Code of Conduct

think

3

1	2	3
TRUST	RESPECT	INTEGRITY
Gain trust by treating others with integrity & respect.	Treat employees and the public with dignity, thoughtfulness, and value.	Be open, honest, and ethical in all of our dealings.

The Code of Conduct is a cornerstone of the Kern Health Systems Compliance Program and articulates the standards of behavior that each one of us is expected to observe while performing our jobs.

1 Trust

Gain trust by treating others with integrity and respect.

MAKE ETHICAL DECISIONS

- Follow KHS policies.
- Talk to your peers, manager, or other KHS management.
- Use the Headline Test, see page 18.

COOPERATE WITH INVESTIGATIONS

- Cooperate with all internal investigations and audits.
- Be truthful when responding to an investigation or audit.
- Never alter or destroy records in response to an investigation or audit.

TAKE ACTION ON MISCONDUCT

- Advocate KHS values without concern for retaliation.
- Report any alleged misconduct immediately using the Open Door Policy. If this does not work or seem appropriate, go to another member of management, Human Resources, or Compliance.

2 Respect

Treat employees and the public with dignity, thoughtfulness, and value.

TREAT OTHERS WITH RESPECT

- Be open and honest with one another.
- Do not discriminate on the basis of race, color, religion, gender, sexual orientation, gender identity or expression of national origin, disability, age, covered veteran status, or any other characteristic protected by law.

PROTECT HEALTH INFORMATION

- Secure confidential patient information.
- Only disclose PHI in accordance with state and federal regulations.

HARASSMENT-FREE ENVIRONMENT

- Encourage a harassment-free work environment.
- Refuse to accept or tolerate sexual harassment, including unwelcome sexual advances, request for sexual favors, or other unwelcome verbal or physical conduct of a sexual nature.

3 Integrity

Be open, honest, and ethical in all of our dealings.

ASSETS

- Do not allow others including friends and family to use KHS resources.
- Do not use KHS equipment or systems to violate the law or create, store,or send offensive content.
- Avoid any usage that might lead to loss or damage, including theintroduction of viruses or a breach of KHS IT security.

CONFLICTS OF INTEREST

- Make decisions in the best interest of KHS' mission.
- Avoid situations that create or appear to create a conflict betweenpersonal interests and the interests of KHS.
- Accepting outside employment requires approval from management.

ACCURATE BUSINESS RECORDS

- Email and other electronic communications may be business records;avoid exaggeration, derogatory language, and other expressions thatcould be taken out of context.
- Retain, protect, and dispose of records according to policy.

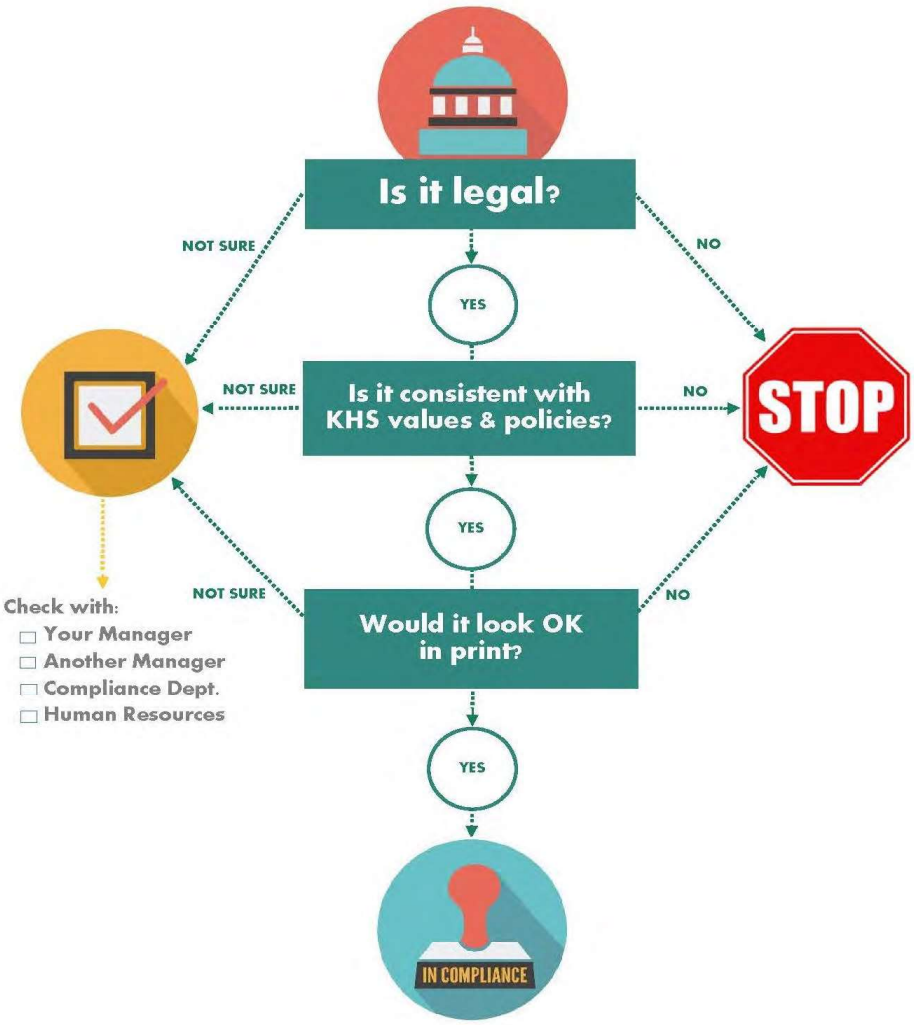
GIFTS

- Do not solicit gifts, favors, or entertainment.
- Report gifts from outside vendors or providers for values greater than$150.

The Headline Test

It's decision time...

Use the Headline Test below when faced with an ethical dilemma.



Ask yourself if what you said, did, or didn't say or didn't do became a headline on the front page of the newspaper- would you be embarrassed or proud?

Rev. 1/2024

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Annual Compliance Survey

DATE: April 18, 2024

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 Governance and Compliance Committee ensures the establishment and maintenance of an effective compliance and ethics program by assuring compliance activities are reasonably designed, implemented, and generally effective in preventing and detecting risks or compliance violations.

An important aspect of evaluating the effectiveness of KHS's Compliance Program is to establish an Annual Employee Compliance Awareness Survey. Open lines of communication encourage participants to voice compliance, quality, or other suggestions for improvement without fear of retaliation. Conducting the survey enables the Compliance department to learn about issues that are identified, generate faster responses, and addressing concerns earlier through creation of an action plan for remediation.

KHS strives to provide the foundation for the development and sustainment of an effective compliance program. By fostering a true cultural shift for the organization from "following" risk management to "living" risk management, KHS strengthens its enterprise-wide approach to compliance and governance.

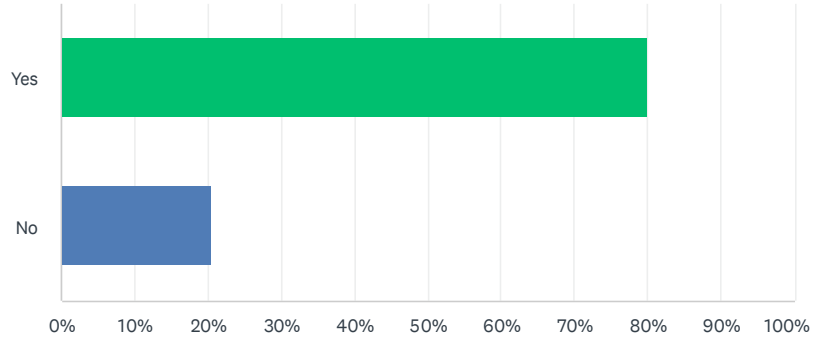
REQUESTED ACTION

Receive and File.

KHS Compliance Awareness Survey

Q1 Do you know who the Chief Compliance and Fraud Prevention Officer is?

Answered: 255 Skipped: 0

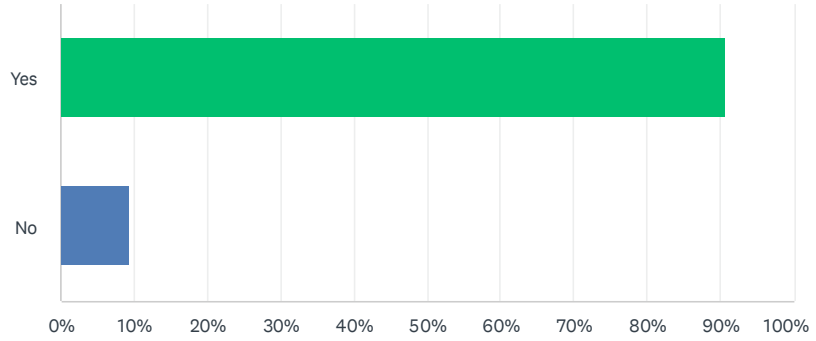


ANSWER CHOICES	RESPONSES	
Yes	80.00%	204
No	20.39%	52
Total Respondents: 255		

KHS Compliance Awareness Survey

Q2 Do you know how to find the Code of Conduct?

Answered: 255 Skipped: 0

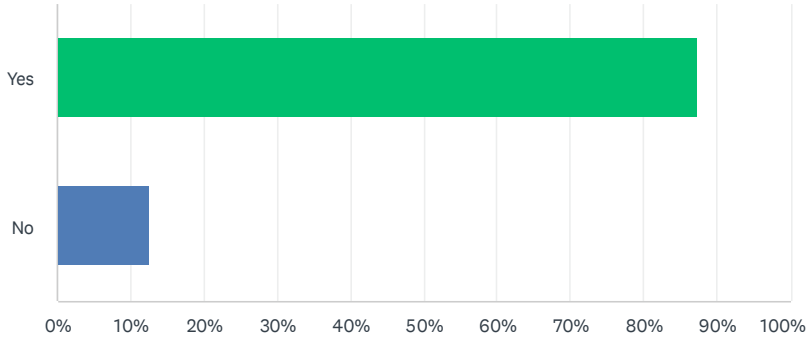


ANSWER CHOICES	RESPONSES	
Yes	90.59%	231
No	9.41%	24
Total Respondents: 255		

KHS Compliance Awareness Survey

Q3 Do you know how to find Policies?

Answered: 255 Skipped: 0

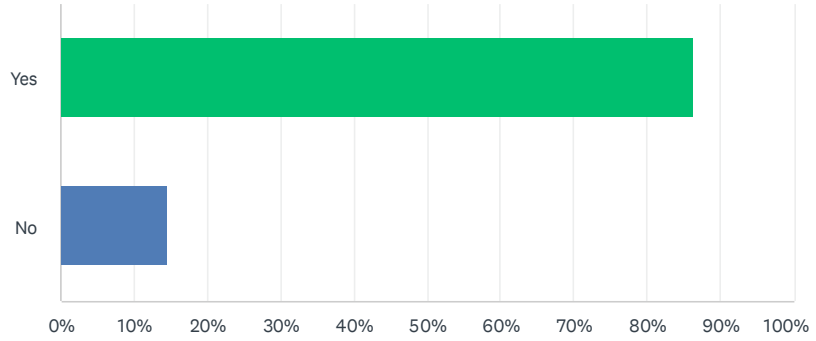


ANSWER CHOICES	RESPONSES	
Yes	87.45%	223
No	12.55%	32
Total Respondents: 255		

KHS Compliance Awareness Survey

Q4 Do you know how to report Compliance concerns?

Answered: 255 Skipped: 0

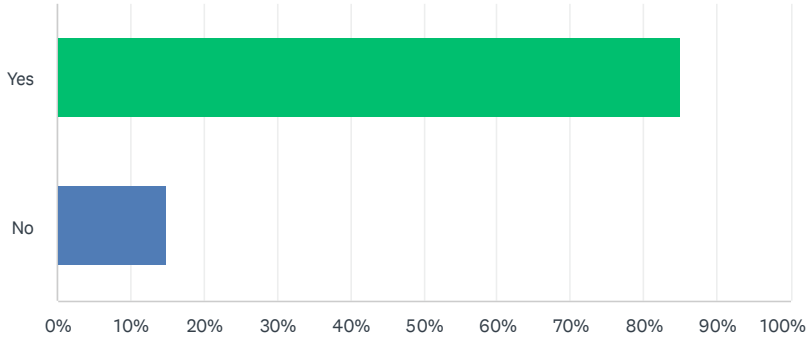


ANSWER CHOICES	RESPONSES	
Yes	86.27%	220
No	14.51%	37
Total Respondents: 255		

KHS Compliance Awareness Survey

Q5 If you have any questions about Compliance, are you aware of who to contact and how?

Answered: 255 Skipped: 0

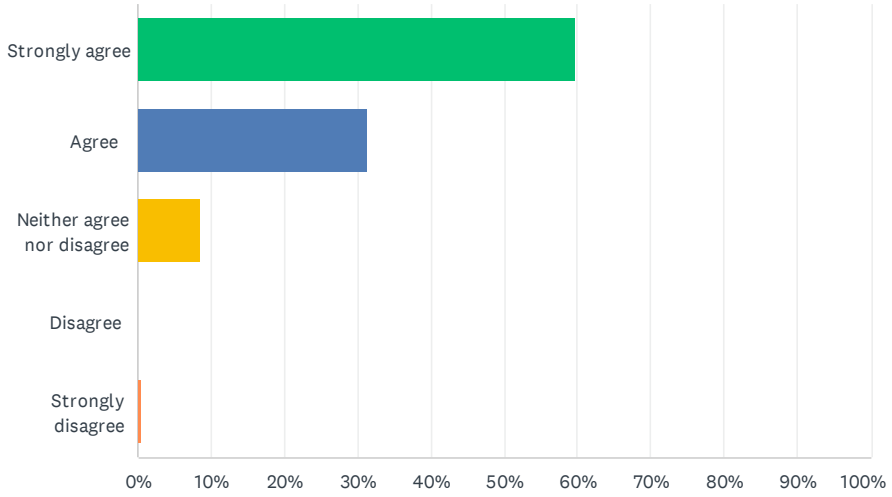


ANSWER CHOICES	RESPONSES	
Yes	85.10%	217
No	14.90%	38
Total Respondents: 255		

KHS Compliance Awareness Survey

Q6 I trust that if I report a concern to Compliance, it will be addressed.

Answered: 255 Skipped: 0

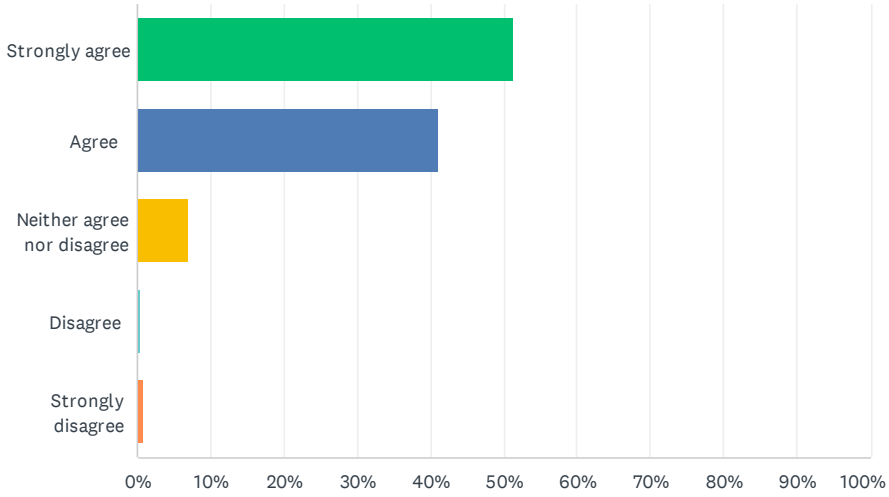


ANSWER CHOICES	RESPONSES	
Strongly agree	59.61%	152
Agree	31.37%	80
Neither agree nor disagree	8.63%	22
Disagree	0.00%	0
Strongly disagree	0.39%	1
TOTAL		255

KHS Compliance Awareness Survey

Q7 I am confident that my co-workers act with integrity.

Answered: 255 Skipped: 0

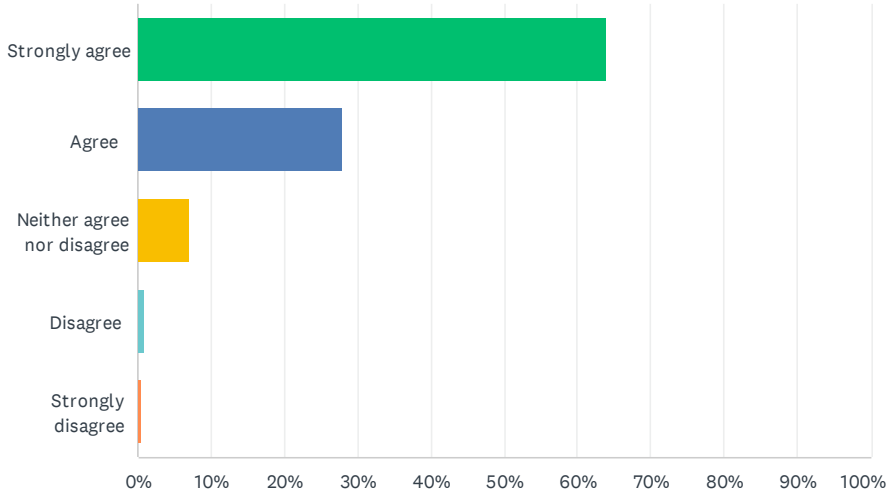


ANSWER CHOICES	RESPONSES	
Strongly agree	51.37%	131
Agree	41.18%	105
Neither agree nor disagree	7.06%	18
Disagree	0.39%	1
Strongly disagree	0.78%	2
Total Respondents: 255		

KHS Compliance Awareness Survey

Q8 I am confident that my direct supervisor and department managers act with integrity.

Answered: 255 Skipped: 0

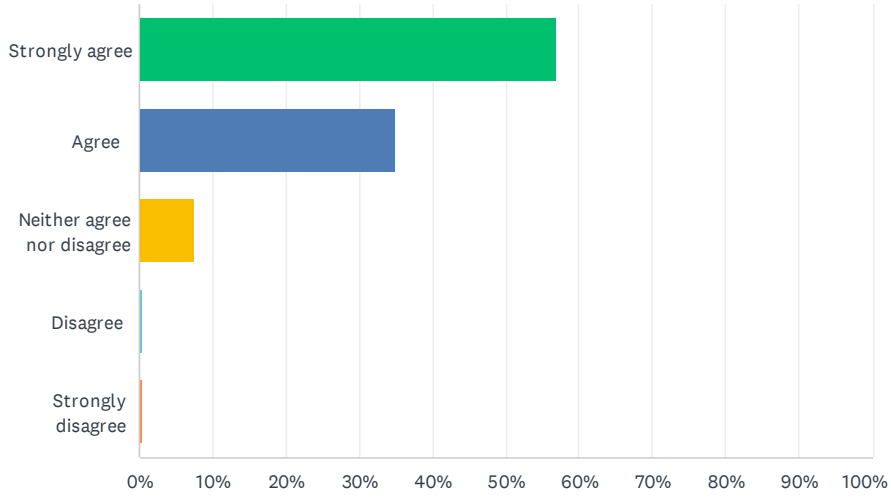


ANSWER CHOICES	RESPONSES	
Strongly agree	63.92%	163
Agree	27.84%	71
Neither agree nor disagree	7.06%	18
Disagree	0.78%	2
Strongly disagree	0.39%	1
TOTAL		255

KHS Compliance Awareness Survey

Q9 I am confident that the KHS organization leaders act with integrity.

Answered: 255 Skipped: 0

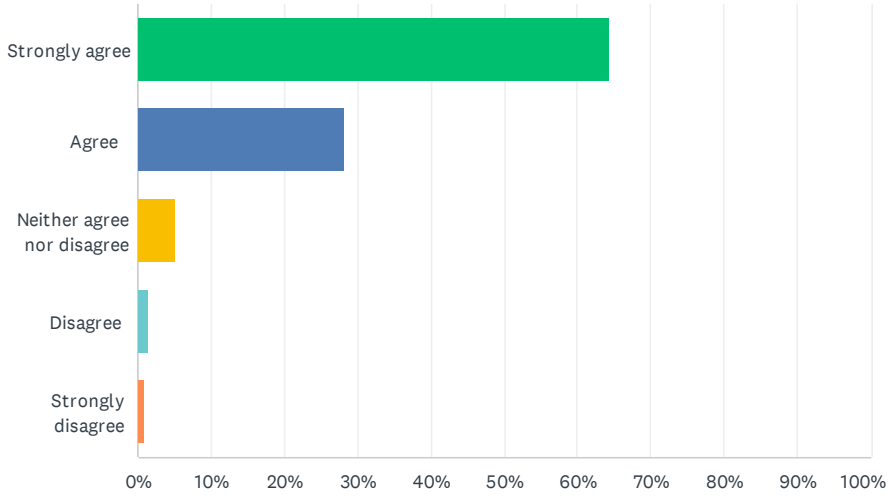


ANSWER CHOICES	RESPONSES	
Strongly agree	56.86%	145
Agree	34.90%	89
Neither agree nor disagree	7.45%	19
Disagree	0.39%	1
Strongly disagree	0.39%	1
TOTAL		255

KHS Compliance Awareness Survey

Q10 I am comfortable reporting a compliance concern to my department leadership (supervisor/manager)

Answered: 255 Skipped: 0

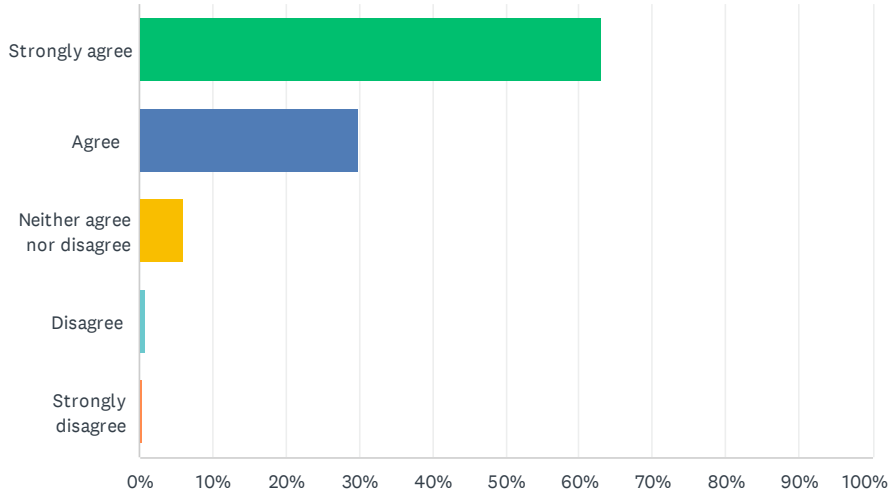


ANSWER CHOICES	RESPONSES	
Strongly agree	64.31%	164
Agree	28.24%	72
Neither agree nor disagree	5.10%	13
Disagree	1.57%	4
Strongly disagree	0.78%	2
TOTAL		255

KHS Compliance Awareness Survey

Q11 I am comfortable reporting a compliance concern to Compliance.

Answered: 255 Skipped: 0

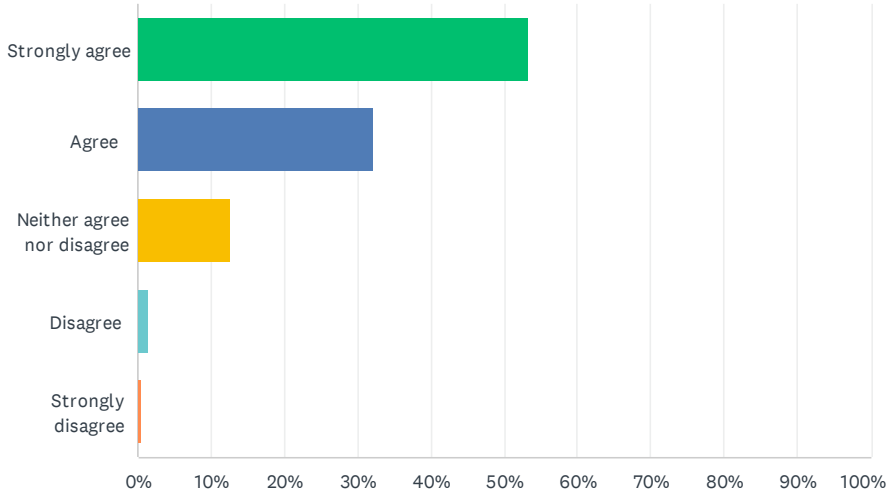


ANSWER CHOICES	RESPONSES	
Strongly agree	63.14%	161
Agree	29.80%	76
Neither agree nor disagree	5.88%	15
Disagree	0.78%	2
Strongly disagree	0.39%	1
TOTAL		255

KHS Compliance Awareness Survey

Q12 I am confident that if I report a compliance concern, I will not be retaliated against.

Answered: 255 Skipped: 0

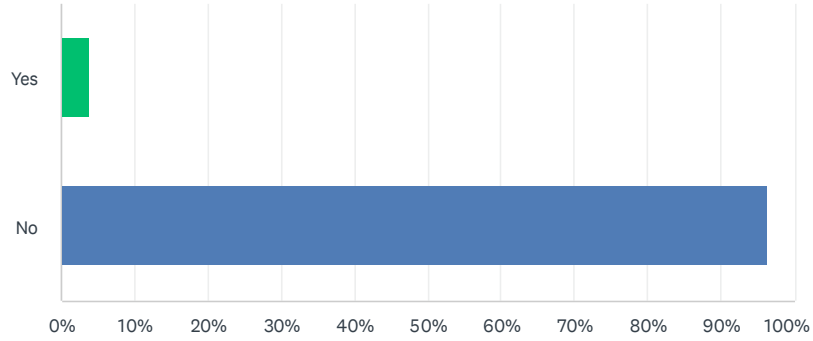


ANSWER CHOICES	RESPONSES	
Strongly agree	53.33%	136
Agree	32.16%	82
Neither agree nor disagree	12.55%	32
Disagree	1.57%	4
Strongly disagree	0.39%	1
TOTAL		255

KHS Compliance Awareness Survey

Q13 Have you observed any violations to our code of conduct or regulatory requirements within the past 12 months?

Answered: 255 Skipped: 0

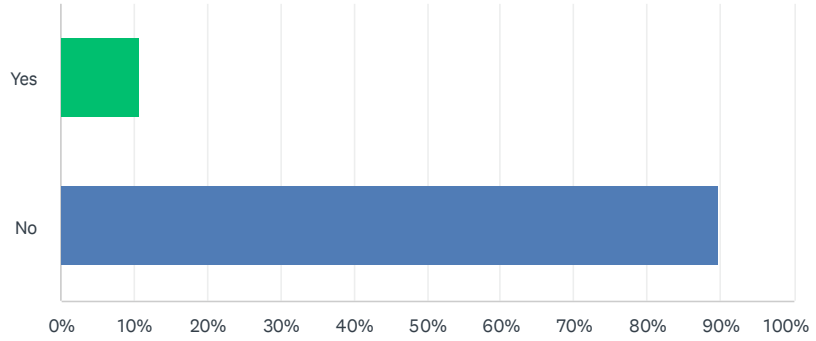


ANSWER CHOICES	RESPONSES	
Yes	3.92%	10
No	96.47%	246
Total Respondents: 255		

KHS Compliance Awareness Survey

Q14 Are there areas relating to Compliance that you would like additional training regarding?

Answered: 255 Skipped: 0

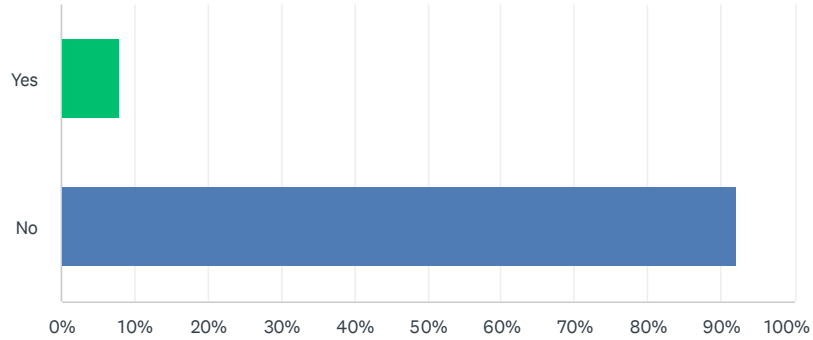


ANSWER CHOICES	RESPONSES	
Yes	10.59%	27
No	89.80%	229
Total Respondents: 255		

KHS Compliance Awareness Survey

Q15 Identifying and responding to compliance concerns: Can you think of a time when you saw or overheard something that didn't sit quite right with you?

Answered: 255 Skipped: 0

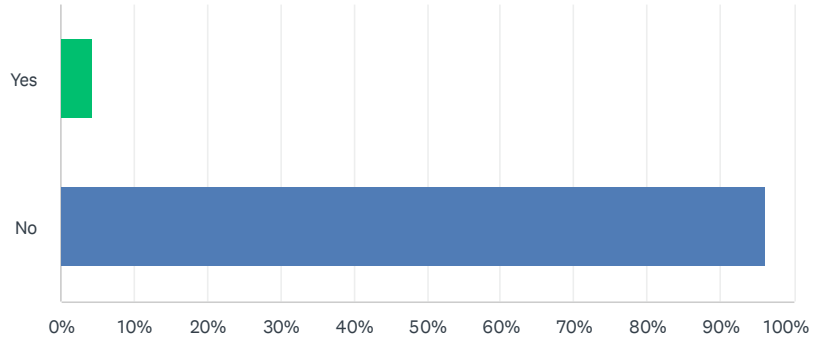


ANSWER CHOICES	RESPONSES	
Yes	7.84%	20
No	92.16%	235
Total Respondents: 255		

KHS Compliance Awareness Survey

Q16 Management response to concerns: Can you think of a time when you felt that your supervisor/manager didn't listen to you or act on a compliance and ethics issue that you raised?

Answered: 255 Skipped: 0

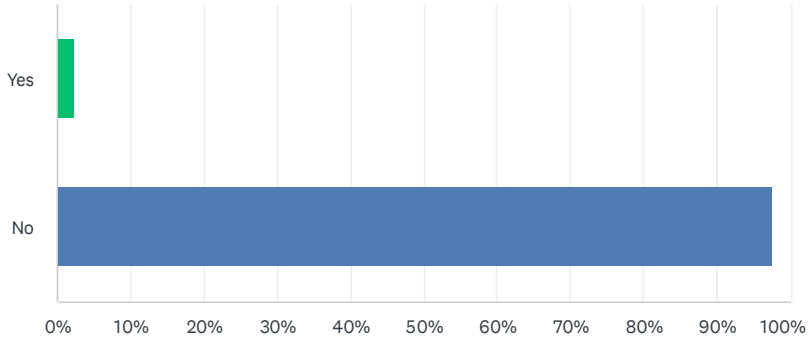


ANSWER CHOICES	RESPONSES	
Yes	4.31%	11
No	96.08%	245
Total Respondents: 255		

KHS Compliance Awareness Survey

Q17 Compliance response to concerns: Can you think of a time when you felt that Compliance didn't listen to you or act on a compliance and ethics issue that you raised?

Answered: 255 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	2.35%	6
No	97.65%	249
Total Respondents: 255		

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: 2023 Department of Health Care Services Audit

DATE: April 18, 2024

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.

At least annually, or on a cadence prescribed by DHCS, KHS is evaluated for compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. Staff interviews are conducted with additional medical record and file review, questionnaire responses, and process demonstrations.

The audit was conducted November 27, 2023, through December 8, 2023, and reviewed the plan's compliance for audit review period of November 1, 2022, through October 31, 2023. The plan was found to be deficient in only one area involving Administrative and Organizational Capacity. KHS submitted a Corrective Action Plan that is currently under review for approval and closure with DHCS.

REQUESTED ACTION

Receive and File.

Department of Health Care Services

Managed Care Plan: Kern Health Systems dba Kern Family Health Care
Report Year: 2023
Draft Audit Report Response

Finding 6.2.1: The Plan and did not report potential FWA to DHCS within ten working days.

Recommendation: Report potential FWA to the DHCS PIU within ten working days from the date of discovery or when it is notified of such activity.

Plan Agreement: Partially Agree with Finding

Relevant information for consideration before the final audit report is issued:
KHS partially agrees with the finding. We agree with two of the samples reviewed being untimely; however, please see attached supporting documentation for our calculation regarding the other two samples.

KHS would also like to request confirmation of how DHCS calculates the ten days so we can ensure our timeliness is being tracked appropriately. We have already adjusted our process to count the day of receipt as day one (1) to align with how it appears DHCS is counting; however, we request DHCS review and advise.

In addition, while KHS continues to strive to achieve 100% compliance, we did monitor the timeliness and take corrective actions as needed during the audit timeframe (and continue to do so). Please see our supporting documentation attached:

- 6.2.1_KHS Response Timeliness
- 6.2.1_Supporting Documentation_20240312

DHCS Comments to Plan's Response:
Click or tap here to enter DHCS comments to the Plan's response.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: 2023 Department of Managed Health Care Audit

DATE: April 18, 2024

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.

On a cadence prescribed by DMHC, KHS is evaluated for compliance with its license and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity. Staff interviews are conducted with additional medical record and file review, questionnaire responses, and process demonstrations.

The audit was conducted January 18, 2023, through January 20, 2023, and reviewed the plan's compliance for audit review period of September 1, 2020, through August 31, 2022. The plan was identified to be deficient in twenty-four (24) areas involving grievances and appeals, access and availability, utilization management, emergency services and care, and prescription drug coverage.

KHS is currently working on submitting a Corrective Action for review, approval and closure with DMHC.

REQUESTED ACTION

Receive and File.

Kern Health Systems
Routine Survey Preliminary Report
March 7, 2024

EXECUTIVE SUMMARY

On August 29, 2022, the California Department of Managed Health Care (Department) notified Kern Health Systems (Plan) that it would conduct the Plan's scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from January 18, 2023 through January 20, 2023.

The Department assessed Plan operations in the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Continuity of Care
Emergency Services and Care
Prescription Drug Coverage

The Department identified **24** deficiencies during the Routine Survey, as identified in the **2023** Survey Deficiencies Table below.

2023 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT
	GRIEVANCES AND APPEALS
1	**The Plan's online grievance form fails to correctly display the statement required by Section 1368.015(c)(3).** Section 1368.015(a) and (c)(3).
2	**The Plan does not consistently identify all issues within exempt grievances and fails to consistently document adequate consideration, investigation, and resolution of exempt grievances.** Section 1368(a)(1); Rule 1300.68(a)(1), (4) and (e)(2).
3	**The Plan fails to consistently identify potential quality issues within exempt grievances.** Rule 1300.70(a)(1) and (3), (b)(1)(A) and (B).
4	**Upon receipt of an expedited grievance, the Plan does not consistently provide immediate notification to the enrollee of the right to notify the Department of the grievance.** Section 1368.01(b); Rule 1300.68.01(a)(1).
5	**The Plan's written responses to grievances do not consistently include a clear and concise explanation of the Plan's decision.** Section 1368(a)(5); Rule 1300.68(d)(3).

6	**The Plan's written responses to grievances involving delay, denial, or modification of health care services based on medical necessity do not consistently include a description of the criteria or guideline used and the clinical reasons for the Plan's decision.** Section 1368(a)(5); Rule 1300.68(d)(4).
7	**The Plan's written grievance communications fail to consistently publish or fail to correctly publish the statement required by Section 1368.02(b).** Section 1368.02(b).
8	**The Plan's independent medical review (IMR) policy improperly states the Department's IMR process is not available to Medi-Cal members when the Plan has denied a requested service because it is not a covered benefit.** Rule 1300.68(d)(5).
	ACCESS AND AVAILABILITY OF SERVICES
9	**The Plan's advanced written notice to contracted providers affected by a corrective action did not include the telephone number of the person authorized to respond to provider concerns regarding the Plan's corrective actions.** Rule 1300.67.2.3(a)(3).
10	**The Plan does not include a hyperlink to a form in its online provider directory to allow enrollees, potential enrollees, other providers, or the public to directly report possible inaccurate, incomplete, or misleading information to the Plan.** Section 1367.27(m)(3).
11	**The Plan's documentation in response to receipt of a report of a potential directory inaccuracy does not comply with statutory requirements.** Section 1367.27(o)(2)(B).
	UTILIZATION MANAGEMENT
12	**The Plan does not consistently make denial, modification and concurrent review decisions in a timely manner and does not consistently notify the enrollee in writing of the decision in the required timeframe.** Section 1367.01(h)(1)-(3).
13	**The Plan's utilization management decision letters do not correctly display the required paragraph as set forth at Section 1368.02(b).** Section 1368.02(b).

14	**The Plan's utilization management decision letters do not consistently include a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.** Section 1367.01(h)(4).
15	**The Plan's utilization management denial and modification decision letters do not include the direct telephone number or an extension of the healthcare professional responsible for the decision.** Section 1367.01(h)(4).
16	**The Plan has not established an effective quality assurance process to assess and evaluate compliance with Section 1367.01(h).** Section 1367.01(j).
17	**The Plan fails to consistently ensure its delegate complies with required utilization management notification standards.** Section 1367.01(a); Section 1367.01(h)(4); Section 1368.02(b).
18	**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).
	EMERGENCY SERVICES AND CARE
19	**The Plan inappropriately denies post-stabilization care and is operating at variance with policies filed with the Department.** Section 1262.8(d)(1)(A) and (B), (d)(2), (i), and (j); Section 1363.5(a); Section 1367.01(b); Section 1371.4(a), (d), (j)(1) and (2); Section 1386(b)(1); Rule 1300.71.4(b) and (c).
20	**The Plan improperly denied payment for emergency services and treatment.** Section 1371.4(b) and (c).
	PRESCRIPTION DRUG COVERAGE
21	**The Plan's written notifications to enrollees regarding a decision to deny or modify a request for a formulary exception request on the basis of medical necessity, do not consistently include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reason(s) for the decision.** Section 1367.01(h)(4).

22	**The informational section of the Plan's formularies does not include all required information.** Rule 1300.67.205(d)(8), (9), (13), 18 and (19).
23	**The Plan fails to correctly publish the statement required by Section 1368.02(b) within its written formulary exception request denial notices to enrollees.** Section 1368.02(b).
24	**The Plan failed to demonstrate that it requires members of its pharmacy and therapeutics committee to abstain from voting on any issue for which the member may have a conflict of interest, and that at least 20% of the committee has no conflict of interest with respect to any pharmaceutical issuer or manufacturer.** Section 1367.41(c) and (d).

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: 2024 Compliance Work Plan Q1 Update

DATE: April 18, 2024

BACKGROUND

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

The U.S. Health and Human Services Office of Inspector General (OIG) outlines a structure for implementing an ongoing evaluation process which is critical to a successful compliance program. Through annual review and renewal, KHS can adjust the work plan accordingly to align with the changing healthcare landscape and regulatory requirements.

KHS prepares a Compliance workplan after reviewing the latest Department of Health Care Services (DHCS) and Department of Managed Care (DMHC) priorities, recent enforcement activities, previous internal and external audit findings and other relevant topics that necessitate additional scrutiny. Additionally, the workplan includes a list of areas that the Compliance Department will audit and monitor as a risk mitigation strategy for ongoing compliance under KHS's contract and licensure.

REQUESTED ACTION

Receive and File.

KERN HEALTH SYSTEMS
2024
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
Compliance Plan									
A. Annual Review/Update of Compliance Documents and Written Policies and Procedures									
1. 2024 Compliance Work Plan	Create 2024 Compliance Plan		Chief Compliance Officer Director of Compliance						
1a. Obtain Board Approval	Obtain Board Approval of Compliance Work Plan	2/15/2024	Chief Compliance Officer		**Complete**				
2. Review/Update and Approval of Compliance Code of Conduct	Update Code of Conduct to align with 2024 DHCS Contract and obtain Board approval		Chief Compliance Officer Director of Compliance						
2a. Obtain Board Approval of Compliance Code of Conduct	Obtain Board Approval of Compliance Code of Conduct	4/11/2024	Chief Compliance Officer		**In Progress**				
3. Review/Update and Approval of Compliance Guide	Update Code of Conduct and obtain Board approval		Chief Compliance Officer Director of Compliance						
3a. Obtain Compliance Committee Approval of Compliance Guide	Obtain Compliance Committee Approval of Compliance Guide	4/11/2024	Chief Compliance Officer		**In Progress**				
3b. Obtain Board approval of Compliance Guide	Obtain Board approval of Compliance Guide	4/11/2024	Chief Compliance Officer		**In Progress**				
4. Create 2024 Compliance Program	Create 2024 Compliance Program		Chief Compliance Officer Director of Compliance						
4a. Obtain Compliance Committee Approval of Compliance Program	Obtain Compliance Committee Approval of Compliance Program	3/29/2024	Chief Compliance Officer		**Complete**				
4b. Obtain Board approval of Compliance Program	Obtain Board approval of Compliance Program	2/15/2024	Chief Compliance Officer		**Complete**				
5. Coordinate Departmental Review/Update of all Policy and Procedures	Create schedule & ensure all policies		Compliance Manager Compliance Analyst Compliance Specialist						
5a. Create schedule and distribute to stakeholders	Create schedule for policy reviews and distribute	4/1/2024	Compliance Manager		**In Progress**				
5b. Track to completion	All policies to be reviewed by end of year	12/31/2024	Compliance Manager Compliance Analyst Compliance Specialist		**In Progress**				
5c. Report Policy Review Status in Compliance Committee Meetings	Provide quarterly update to Compliance Committee (number reviewed/to be reviewed by department)	Quarterly	Compliance Manager Compliance Analyst Compliance Specialist		**In Progress**				
6. Review/Update Compliance Policy & Procedures	Review/Update all Compliance owned policy and procedures		Director of Compliance Compliance Manager						
6a. Create Public versions of policies where needed (e.g. FWA, HIPAA)	Create public facing versions of identified policies (e.g. HIPAA; FWA; etc)	6/1/2024	Director of Compliance Compliance Analyst		**In Progress**				
B. Compliance Committee and Oversight									
1. Conduct Committee Meetings at least quarterly									
1a. Conduct Compliance Committee meetings at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		**In Progress**	Held February 29, 2024			
1b. Conduct Fraud, Waste, and Abuse Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		**In Progress**	Held February 9, 2024			
1c. Conduct Delegation Oversight Committee at least quarterly	Create agenda, minutes and action items, related reporting and documents for review and hold meeting quarterly	Quarterly	Director of Compliance Compliance Manager		**In Progress**	Held February 26, 2024			
2. Review/update Committee Charters at least annually	Review/Update Charters and obtain Committee Approvals								
2a. Compliance Committee	Review/Update Charter	3/1/2024	Chief Compliance Officer		**In Progress**				
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q2 2024	Chief Compliance Officer		**In Progress**				
2b. FWA Committee	Review/Update Charter	3/1/2024	Chief Compliance Officer		**In Progress**				
2a.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q2 2024	Chief Compliance Officer		**In Progress**				
2c. Delegation Oversight Committee	Review/Update Charter	3/1/2024	Chief Compliance Officer		**In Progress**				
2c.1 Obtain Committee Approval	Obtain Committee Approval on updated Charter	Q2 2024	Chief Compliance Officer		**In Progress**				
3. Provide regular Compliance Updates to the Board of Directors		Bi-Monthly BOD Meetings	Chief Compliance and Fraud Prevention Officer						
C. Effective Training and Education									

KERN HEALTH SYSTEMS
2023
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
1. In coordination with HR, review/update Corporate Compliance Training for calendar year 2024									
1a. Compliance Training	Review/update Compliance Training	4/1/2024	Director of Compliance		In Progress	Compliance working with Human Resources Learning and Development team to revise/refresh content and delivery of training			
1b. Fraud, Waste, and Abuse Training	Review/Update FWA Training	4/1/2024	Director of Compliance		In Progress	Compliance working with Human Resources Learning and Development team to revise/refresh content and delivery of training			
1c. HIPAA/Privacy Training	Review/Update HIPAA/Privacy Training	4/1/2024	Director of Compliance		In Progress	Compliance working with Human Resources Learning and Development team to revise/refresh content and delivery of training			
2. In coordination with HR, track/report on completion of mandatory training (Compliance, FWA, HIPAA)	Track annual training to completion		Director of Compliance (HR resource TBD)						
2a. Report training status in quarterly Compliance Committee Meetings	Report status of training completions, by department, in quarterly Compliance Committee Meetings	Quarterly	Director of Compliance (HR resource TBD)		In Progress	Reported out in Compliance Committee Meeting 02/29/2024; will also be Q2 agenda item			
3. Review/Update New Hire Orientation Overview	Review/Update Compliance New Hire Orientation Overview	1/1/2024	Chief Compliance and Fraud Prevention Officer		Complete	Updated for 2024 in HR scheduled onboarding			
4. Compliance & Ethics Week	Plan and Execute activities for annual Compliance & Ethics Week	11/15/2024	Compliance Manager Compliance Team Members		In Progress				
5. Establish Compliance Training for Subcontractors	Establish content and method for delegated entity/subcontractor Compliance training	4/1/2024	Compliance Manager Director of Compliance						
5a. Identify Delegated Entities/Subcontractors to receive training	Identify subcontractors to which Compliance Training applies	3/1/2024	Compliance Manager Director of Compliance		Complete	American Logistics VSP Health Dialog Language Line			
5b. Implement Compliance Training for Subcontractors	Implement delegated entity/identified subcontractor training	4/1/2024	Compliance Manager Director of Compliance		In Progress	Initial discussions with HR on potential use of new training platform. Currently re-reviewing DHCS contract to determine topics for delegate training.			
6. Review and provide feedback on content of Provider Manual	Review and continually expand upon content of Provider Manual for Compliance-related topics	Quarterly	Compliance Manager Director of Compliance		In Progress	Director of Compliance added HIPAA/FWA language			
7. Compliance distributes notifications to key stakeholders of any DHCS-related meeting/webinar/presentations	Receive, review, distribute regulatory updates regarding trainings, webinars, meetings to relevant stakeholders	Ongoing	Compliance Manager		In Progress	Emails, webinar invitations, etc.			
8. 2024 DHCS Contract Monitoring Activities	Compliance coordinates with project team and key stakeholders	Ongoing	Director of Compliance Compliance Analyst		In Progress	DHCS submissions/AIR completion Compliance Dashboard Health Equity Dashboard Reports for PHM, UM, WP, PNM QNXT Config Updates MOU Status Reporting & Execution			
9. Compliance key personnel attend regulatory-focused meetings:	Attend calls and report relevant updates to key stakeholders								
9a. LHPC call (weekly)		Weekly	Director of Compliance		In Progress	Attended by Director of Compliance and CCO			
9b. CAHPS meeting (weekly)		Weekly	Manager of Compliance		In Progress	Attended by Director of Compliance and CCO			
9c. DHCS Plan Call (including Payment Call) (weekly)		Weekly	Director of Compliance		In Progress	Attended by Director of Compliance and CCO			
9d. DHCS topic-specific webinars/meetings (ad hoc)		As scheduled	Director of Compliance Compliance Manager		In Progress	Attended by Director of Compliance and CCO			
9e. DMHC Roundtable Meetings (quarterly)		Quarterly	Director of Compliance		In Progress	Attended by Director of Compliance and CCO			
9f. LHPC Compliance Officer Meetings (monthly)		Monthly	Chief Compliance Officer Director of Compliance		In Progress	Attended by Director of Compliance and CCO			

KERN HEALTH SYSTEMS
2023
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
D. Effective Lines of Communication									
1. Distribute Monthly "Compliance Capsule" email communications	Distribute monthly Compliance Capsule email communication by the 15th of each month	1/15/2024-12/15/2024	Compliance Manager Compliance Analysts		In Progress	January 29, 2024-Remote Work and Member Privacy February 26, 2024-Privacy Protections/Permissions March			
2. Conduct Compliance Awareness Survey	Compliance will implement a compliance survey to obtain feedback from employees to evaluate how well the compliance program is functioning and identify areas that can be strengthened.	3/1/2024	Compliance Manager / Director of Compliance		Complete	Conducted 3/4/2024 (255 respondents)			
3. Focus at least one monthly Compliance Capsule email on methods for communication with Compliance		6/1/2024	Director of Compliance		In Progress	Privacy protections Q1 focus			
4. Compliance Updates									
4a. Compliance provide updates at monthly in Executive Officers Meeting		Monthly	Chief Compliance Officer		In Progress	January 20, 2024-Chat GPT/AI Governance			
4b. Compliance provides updates at least every-other-month in Operations Meeting		Ad hoc	Chief Compliance Officer Director of Compliance		In Progress	Regulatory Calendar Process			
4c. Compliance provide updates at BI-monthly Board meetings		Bi-monthly	Chief Compliance Officer		In Progress	BOD February 2024			
5. Compliance continues to coordinate communication and hold meetings as needed regarding regulatory updates (APLs, emails, DHCS weekly meetings, etc.)		Ongoing	Compliance Manager Director of Compliance		In Progress	DHCS APL 23-001, 002, 003, 004, 005			
6. Participate in weekly Grievance & Appeals review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance Compliance Auditor		In Progress	Director of Compliance attended weekly and provided feedback; transition to review of agenda by Compliance Auditor with oversight from Director of Compliance			
7, Participate in weekly Discriminations review meetings	review materials, attend meetings, request updates, provide education in weekly meetings	weekly	Director of Compliance		In Progress	Director of Compliance attended weekly meeting and responded to additional email reviews as needed.			
E. Well Publicized Disciplinary Standards									
1. In coordination with HR, ensure review of new hires against exclusionary databases and report out in Compliance Committee		Ongoing	Director of Compliance		In Progress	New hire onboarding includes review of exclusionary databases			
2. Incorporate further emphasis on disciplinary standards into Compliance materials, trainings, policies, and new hire orientation		Ongoing	Director of Compliance		In Progress	Updated Compliance program to outline disciplinary standards			
F. Routine Monitoring and Identification of Compliance Risks									
1. Complete Risk Assessments and incorporate into Compliance Auditing/Monitoring Plan for 2025			Director of Compliance						
1a. 2023 APLs		8/30/2024	Director of Compliance		In Progress				
1b. 2023 DHCS Medical Survey Findings		8/30/2024	Director of Compliance		In Progress				
1c. 2023 DMHC Medical Survey Findings		8/30/2024	Director of Compliance		In Progress				
1d. Prior Regulatory Audits		8/30/2024	Director of Compliance		In Progress				
3. Establish Routine monthly Operational Reporting for Monitoring/Oversight/Identification of Potential Compliance Issues (e.g. Grievance timeliness)		4/30/2024	Director of Compliance		In Progress	Currently working on development of Compliance Dashboard and identifying additional reports to be included in Q2 Compliance Committee			
4. Report on items being monitored in quarterly Compliance Committee Meeting		Quarterly	Director of Compliance		In Progress	Currently working on development of Compliance Dashboard and identifying additional reports to be included in Q2 Compliance Committee			

KERN HEALTH SYSTEMS
2023
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
5. Conduct and report out on all audits in the Compliance Committee Meeting (# TBD)		Q3 2024	Director of Compliance		In Progress				
G. Procedures and Systems for Prompt Response to Compliance Issues									
1. Create Compliance Issues Tracking Log			Director of Compliance						
1a. Report on status of Compliance Issues in quarterly Compliance Committee Meetings		Quarterly	Director of Compliance Manager of Compliance		In Progress	Tracking Log has been created and will be reported upon in 1st quarter 2024 Compliance Committee Meeting (April/May)			
2. Create Compliance Policy for Prompt Response to compliance Issues (include tracking mechanism, reporting, CAP process)			Director of Compliance		In Progress	Policy drafted; will be routed for signatures in published by Q2.			
2b. Report on status of CAPS in quarterly Compliance Committee Meetings		Quarterly	Director of Compliance		In Progress	VSP Cap discussed in 4th Quarter Delegation Oversight Committee meeting held 02/26/2024 FWA CAP discussed in FWA Subcommittee 02/09/2024			
H. Fraud, Waste, and Abuse (FWA)									
1. Attend DOJ FWA Trainings		Quarterly/ Annual	Director of Compliance Chief Compliance Officer Compliance Analyst		In Progress	Q1 meeting schedule 3/26/2024-FWA/SIU and Manager Audits and Investigations attending			
2. Review/Update Annual FWA Plan	Review, update, and submit annual FWA plan to DMHC	4/1/2024	Director of Compliance		In Progress	Began review and on track to submit to DMHC by target date			
3. Facilitate FWA Data Mining Workgroup at least every other month	Facilitate workgroup meetings and prioritize	Ongoing	Chief Compliance and Fraud Prevention Officer Director of Compliance		In Progress				
3b. Faciiltate FWA Workgroup per quarter focused on complicated/high risk/Corrective Action Plans		Ongoing	Director of Compliance / Compliance Analyst FWA/CAP Workgroup		In Progress				
4. Conduct investigations regarding potential FWA and provide Updated FWA Reporting to FWA Committee		Ongoing	Director of Compliance / Compliance Analyst		In Progress	Updates reported in 02/09/2024 FWA Subcommittee Meeting			
I. Delegation Oversight									
1. Schedule & Coordinate Annual Delegation Oversight Audits									
1a. VSP		4/1/2024	Compliance/PNM/UM		In Progress	Audit Entrance Letter finalized and provided to VSP; finalizing dates of audit			
1b. American Logistics (AL)		4/1/2024	Compliance/Member Services Marketing		In Progress	Unannounced portion of audit (required by 2024 DHCS Contract) scheduled for 03/21/2024. Audit letter drafted			
1c. Health Dialog		4/1/2024	UM		In Progress				
1d. Language Line		4/1/2024	Compliance/Cultural and Linguistics Health Equity		In Progress				
2. Participate in quarterly delegated subcontractor joint operating meetings (JOM)									
3a. Kaiser		Ongoing	Director of Compliance		In Progress	Kaiser JOM no longer occurring due to termination of contract effective 12/31/2023			
3b. VSP		Ongoing	Director of Compliance		In Progress	Director of Compliance attended Q1 meeting 02/01/2024			
3c. AL		Ongoing	Director of Compliance		In Progress	Director of Compliance attended Q1 meeting 02/29/2024			

KERN HEALTH SYSTEMS
2023
Compliance Program

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS	Q1 COMMENTS	Q2 COMMENTS	Q3 COMMENTS	Q4 COMMENTS
3d. Health Dialog		Ongoing	Director of Compliance		In Progress	Director of Compliance attended Q1 meeting 02/22/2024			
3e. Language Line		Ongoing	Director of Compliance		In Progress				
4. Create delegation reporting and compliance plan			Director of Compliance						
4a. Delegation Function Matrix Updates		6/1/2024	Director of Compliance		In Progress				
4b. Delegation Justification and Plan		6/1/2024	Director of Compliance		In Progress				
4c. Contract Requirements Grid		6/1/2024	Director of Compliance		In Progress				
5. Track Delegated Entity Compliance with APLs through APL grid attestation at least quarterly	Distribute APL grid and follow up as needed with subcontractors to complete; report out on status in Delegation Oversight Committee quarterly	5th of the month following each quarter	Compliance Manager						
5a. Report status of Delegates APL compliance quarterly	Report status in Delegation Oversight Committee meeting quarterly	Quarterly	Compliance Manager		In Progress				
5b. Determine if/how to incorporate other subcontractors and which subcontractors and begin distribution/tracking	Distribute APL grid and track to ensure responses received	Quarterly	Compliance Manager		In Progress				

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Richard Pruitt, Chief Information Officer

SUBJECT: Outpatient Clinical Utilization Management Resource Services

DATE: April 18, 2024

Background

In response to the evolving healthcare landscape dictated by the State of California, Kern Health Systems (KHS) is committed to embracing the diversity of new programs and innovative operational models. Recognizing the ongoing staffing challenges in Kern County within our industry, KHS is dedicated to establishing a partnership with the selected Outpatient Clinical Utilization Management Resource Services vendor. This partnership will focus on expanding KHS operational capabilities through a service model for the Outpatient Utilization Management team. Our goal is to ensure sustainable, efficient, high-quality healthcare delivery that aligns with the dynamic needs and expectations of our community providers and contractual agreements.

Discussion

KHS' Executive Management is requesting that Outpatient Clinical Utilization Management Resource Services be provided by AllMed Healthcare Management, LLC for a three (3) year term. This partnership will support NCQA/Medicare guidelines, ensuring patient care is optimal. Our efforts to improve access to nursing and medical staff aim to address staffing ratio challenges, reduce turnover, and stabilize recruitment. Although KHS currently does not have specialty peer-to-peer review, we are focused on enhancing authorization expertise and consistency in policies and procedures. This partnership offers a comprehensive suite of services to dynamically adjust to volume increases.

Financial Impact

Cost for a three (3) year term not to exceed $19,076,145 in budgeted expenses.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

Outpatient Clinical Utilization Management Resource Services

Richard Pruitt, CIO

Representing RFP Selection Committee

April 18, 2024

Agenda

- Overview
- Sequence of Events
- Operational Strategy
- Current / Future Model
- RFP Committee / Examples of Selection Criteria
- Benefits of New Vendor
- Cost Assessment
- Selection Matrix
- Board Request

Overview

In response to the evolving healthcare landscape dictated by the State of California, Kern Health Systems (KHS) is committed to embracing the diversity of new programs and innovative operational models. Recognizing the ongoing staffing challenges in Kern County within our industry, KHS is dedicated to establishing a partnership with the selected Outpatient Clinical Utilization Management Resource Services vendor. This partnership will focus on expanding KHS' operational capabilities through a service model for the Outpatient Utilization Management team. Our goal is to ensure sustainable, efficient, high-quality healthcare delivery that aligns with the dynamic needs and expectations of our community providers and contractual agreements.

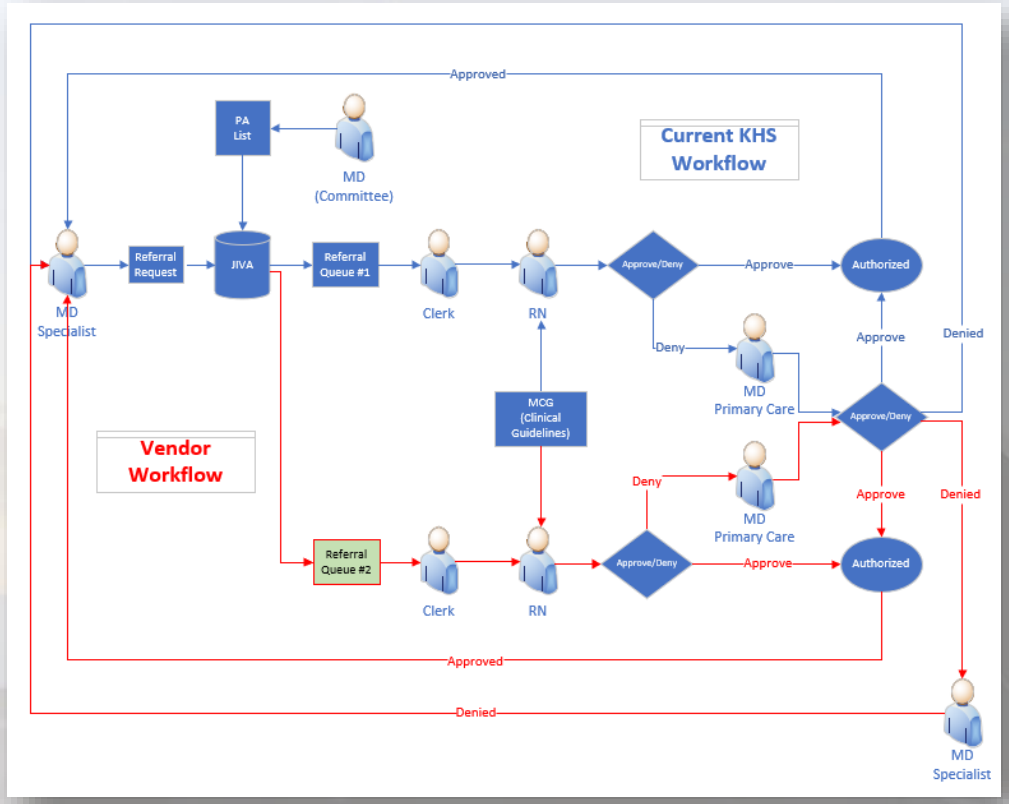
Sequence of Events

- October 2023 – Developed Operational Strategy
- November 2023 – Finalized Strategy /Draft RFP
- December 2023 – Posted RFP
- January 2024 – RFP Proposals Due
- April 2024 – Board Presentation and Request for Approval
- TBD – Project Kick Off (April 2024)
- TBD – Go Live (July 2024)

Operational Strategy

- Modified Prior Authorization Lists
  - Refined and updated the current prior authorization list
  - List contains all codes that require prior authorization
- Technology Integration Enhancements
  - Integration of Clinical Guidelines (MCG) with Medical Management System (JIVA)
  - Goal to streamline manual prior authorization review
- Contract with Clinical Utilization Management Resource Services
  - Outpatient services
  - Three (3) year contract

Current/Future Model



RFP Committee

- Chief Medical Officer, Medical Directors (2), Chief Compliance Officer, Chief Operations Officer, Chief Information Officer, Chief Financial Officer
- Received Seven (7) RFP's and Narrowed to Three (3) Vendors
- Developed Clinical, Operations, Security, and Technical Selection Criteria
- Reviewed and Interviewed RFP and Systems with Vendors
- Created Final Recommendation

Examples of Selection Criteria

- Requires Medi-Cal/MCG Clinical Guidelines for Criteria
- Adherence to NCQA Standards
- Use KHS Policies and Procedures
- Zero Provider Disruption
- All Resources Must be US-Based
- Workforce Must Hold a Current Medical License in California
- Minimal Cyber Security risk

Benefits of New Vendor

- Maintain Compliance & Quality Standards
  - Urgent 72 Hours / Routine 5 Days
  - Realign FTE's to delegation oversight in support of NCQA/Medicare and to fill budgeted open positions within KHS
- Improved and Expedited Access to Nursing and Medical Staff
  - Persistent challenges in achieving optimal staffing ratios
  - Decrease turnover costs and stabilizes recruitment efforts
- Specialty to Specialty Peer Review
  - Expertise in authorization and Peer-to-Peer reviews.
  - KHS currently does not offer Specialty Peer-to-Peer review.
- Consistency in Policies and Procedures
- Ability to Adjust to Increases in Volume Dynamically
- Partnership with a Vendor that Offers a Wide Range of Additional Services
  - Inpatient Utilization Management Services
  - RN Weekend On Call Services

Cost Assessment

	Year[1]	Dates	Volume	RN Review Case Rate *100%*	MD Review Case Rate [3,4] *20%*	Appeals *10% of MD Review (Includes Specialty Review)*	Grand Total
VENDOR	1 30%	7/24 - 6/25	56,888	$ 40.50 $ 2,303,944	$ 74.70 $ 389,111	$ 234.70 $ 606,800	$ 3,299,854
	2 60%	7/25 - 6/26	119,464	$ 40.50 $ 4,838,282	$ 74.70 $ 817,132	$ 234.70 $ 606,800	$ 6,262,214
	3 90%	7/26 - 6/27	188,155	$ 40.50 $ 7,620,294	$ 74.70 $ 1,286,983	$ 234.70 $ 606,800	$ 9,514,077
						$1,820,400	***$19,076,145[5]***

	Year[1]	Dates	Volume	RN Review Case Rate [2] *100%*	MD Review Case Rate [2,3,4] *20%*	Appeals [2] *10% of MD Review (MD Reviewer-to-Ordering Provider review)*	Total Cost
KHS	1 30%	7/24 - 6/25	56,888	$ 28.68 $ 1,631,534	$ 86.37 $ 656,394	$ 131.37 $ 170,663	$ 2,458,590
	2 60%	7/25 - 6/26	119,464	$ 29.83 $ 3,563,269	$ 89.83 $ 1,433,565	$ 136.63 $ 177,489	$ 5,174,323
	3 90%	7/26 - 6/27	188,155	$ 31.02 $ 5,836,635	$ 91.02 $ 2,257,865	$ 142.09 $ 193,691	$ 8,288,190
						$541,842	***$15,921,104***

Outpatient Authorization Volume Assumptions:

1. % of delegated annual cases (assumes 5% annual increase in volume)
2. KHS rates assume 4% annual salary increase
3. Medical Director Reviewer-to-Ordering Provider discussion of denial is included in MD Review Case Rate cost
4. MD Review Case is RN Review + MD Case Rate
5. Does not include any reduction of medical expenses from reduced utilization of services

Selection Matrix

	Weight	Vendor 1	Vendor 2	Vendor 3	Vendor 4
Market	10%	3	3	2	2
Price	20%	3	1	2	4
Company	10%	4	2	4	3
Clinical	45%	4	3	2	3
Technical	15%	4	4	4	4
TOTAL		18	13	14	16

0 = Does not Meet RFP Requirements
1 = Meets Some RFP Requirements
2 = Meets RFP Minimum Requirements
3 = Meets More than RFP Minimum Requirements
4 = Exceeds RFP Minimum Requirements

Board of Directors Request

Authorize the CEO to sign a three (3) year contract with AllMed Healthcare Management, LLC to implement and perform KHS Outpatient Clinical Utilization Management Resource Services for an amount not to exceed $19,076,145 in medical operating expenses.

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

Questions

Please contact:

Richard M. Pruitt
Chief Information Officer
661-664-5078
richard.pruitt@khs-net.com

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robin Dow-Morales, Senior Claims Director

SUBJECT: Optum Prospective Payment System

DATE: April 18, 2024

Background

In July 2013, the California Legislature directed the Department of Health Care Services (DHCS) to change the reimbursement methodology for hospital inpatient services to use the National All Patient refined Diagnosis Related Group ("APR-DRG") codes. As a result, KHS was required to reimburse non-contracted hospitals using the APR-DRG mechanism. Most participating facilities are also reimbursed with the APR-DRG payment methodology.

Outpatient Prospective Payment System (OPPS) identifies payment methodologies for Outpatient Facility claims, which consists of Ambulatory Payment Classification (APC) for Hospitals and an Ambulatory Surgical Center Payment System (ASC) for Ambulatory Surgical Centers.

Discussion

KHS has moved most of its hospital contracts to DRG type methodology which encompasses MS-DRG(Medicare), APR-DRG(Med-Cal), and/or OPPS pricing. This tool prices hospital claims accurately based on contractual platform, as well as adheres to DHCS Contract requirements to pay certain hospital services such as Major Organ Transplants and Non-Participating Provider authorized claims. More than 80% of Inpatient claims are paid based on an APR-DRG methodology and more than 70% of Surgery Center Claims Auto Adjudicate based on OPPS Pricing.

Financial Impact

Cost for a five (5) year term not to exceed $3,411,038 in budgeted expenses.

Requested Action

Approve; Authorize Chief Executive Officer to Sign.

Claim Facility Pricing Tools

Robin Dow-Morales, Senior Claims Director

Optum Prospective Payment System Software (PPS)

April 18, 2024

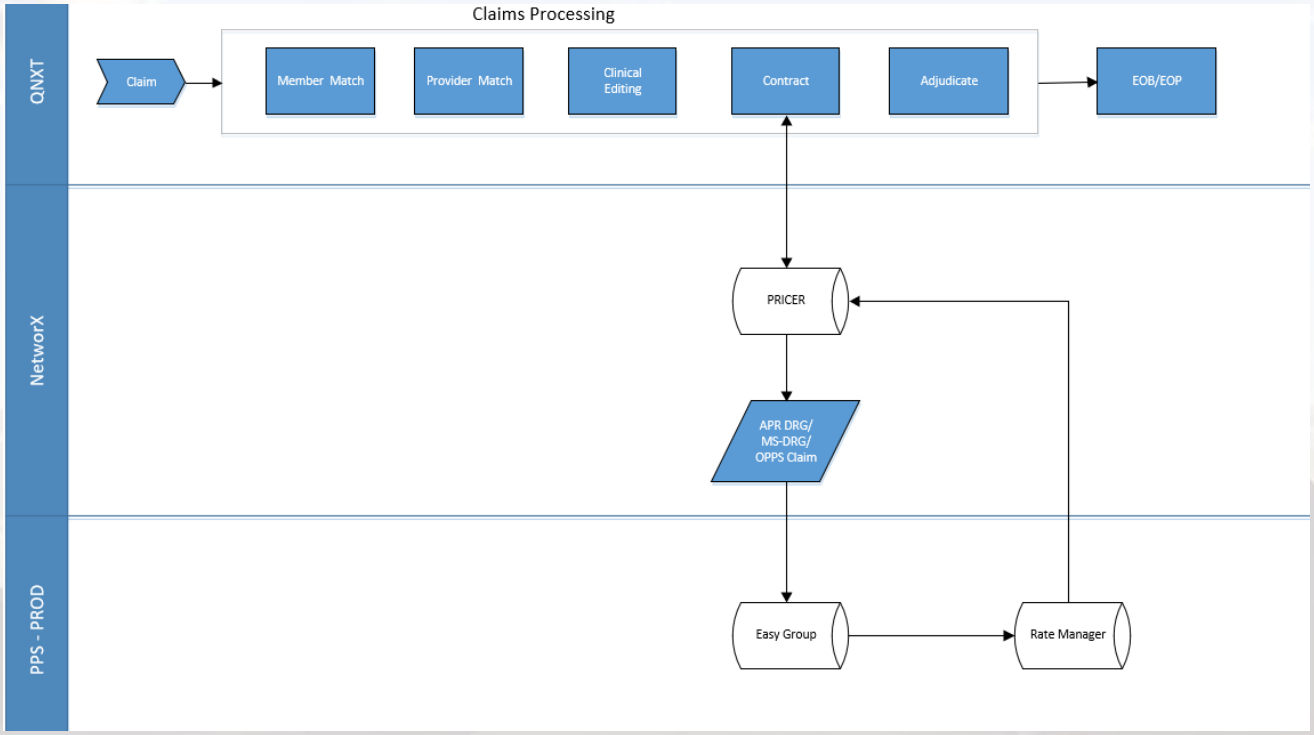
Agenda

- Background/Purpose
- System Function/Design
- Effectiveness
- Expenditure
- Board Request

Background

- KHS uses the Optum Prospective Payment System (PPS) in tandem with the QNXT claims processing system and NetworX Pricer system to group and price hospital claims.
- Optum is the only vendor that integrates with QNXT; and is managed onsite through a monthly download process. Optum will not have access to KHS systems, nor does KHS interface with Optum's systems.
- KHS has moved most of its hospital contracts to DRG type methodology which encompasses MS-DRG(Medicare), APR-DRG(Med-Cal), and/or OPPS pricing(Outpatient Prospective Payment System[APC and ASC]). This tool prices hospital claims accurately based on contractual platform, as well as adheres to DHCS Contract requirements to pay certain hospital services such as Major Organ Transplants and Non-Participating Provider authorized claims.
- Contributes to the Auto Adjudication that KHS leverages to reduce manual processing by staff and helps to keep provider disputes at a minimum due to accuracy of the application of the payment methodology.

System Design/Function



Effectiveness

Year	Total Inpatient Claims	Claims with APR-DRG Pricing	% of Claims with APR-DRG Pricing	Claims with APR-DRG Pricing Auto A	% of claim with APR-DRG Auto Adjudication
2019	16,019	5,216	33%	1,095	21%
2020	18,499	5,790	31%	873	15%
2021	21,086	13,495	64%	3,563	26%
2022	22,086	15,865	72%	4,280	27%
2023	25,440	21,001	83%	6,402	30%

Year	Total Surgery Center Claims	Surgery Center Claims AA	% of Surgery Center Claims AA
2019	21,003	9,017	43%
2020	22,879	11,871	52%
2021	27,716	16,685	60%
2022	29,918	19,789	66%
2023	35,443	24,866	70%

Year	Total Medicare OP Claims Requiring OPPS Pricing
2019	n/a
2020	n/a
2021	53
2022	635
2023	4,796

New Contract (2024-2029)

Optum

Quote Date: 3/25/2024

Kern Health System - PPS Client Quote

Quote Expiration: 6/23/2024

Product	Covered Lives	05/01/24 - 04/30/25 Year 1	05/01/25 - 04/30/26 Year 2	05/01/26 - 04/30/27 Year 3	05/01/27 - 04/30/28 Year 4	05/01/28 - 04/30/29 Year 5	Total
PPS Implementation		$ 40,000	$ -	$ -	$ -	$ -	$ 40,000
Payment Systems:							
Medicare:							
Inpatient Payment System	3,000	$ 30,610	$ 31,528	$ 32,474	$ 33,448	$ 34,451	$ 162,511
Outpatient Payment System	3,000	$ 30,610	$ 31,528	$ 32,474	$ 33,448	$ 34,451	$ 162,511
Ambulatory Surgery Centers (ASC)	3,000	$ 25,756	$ 26,529	$ 27,325	$ 28,145	$ 28,989	$ 136,744
Medicaid:							
California Medicaid APR-DRG (3M - payer specific)	375,000	$388,755	$400,418	$412,431	$424,804	$ 437,548	$ 2,063,956
3M Royalty - California APR-DRG	375,000	$111,656	$117,239	$123,101	$129,256	$ 135,719	$ 616,971
Optum-Hosted PSI:							
Hosting, Infrastructure, & Maintenance	N/A	$ 43,010	$ 44,300	$ 45,629	$ 46,998	$ 48,408	$ 228,345
	TOTAL	**$670,397**	**$651,542**	**$673,434**	**$696,099**	**$ 719,566**	**$ 3,411,038**

Financial Notes:
- This proposal is for illustrative purposes only. This document is not legally binding. The executed Product Schedule and/or amendment will prevail.
- Client quote is valid for 90 days.
- Pricing is subject to change if product mix, covered lives, or term is adjusted.
- Pricing is for EASYGroup - C and PSIOptum-Hosted Analytics/Modeling on the TriZetto - Facets/NetworX platform.
- Implementation quote assumes 2 environments for EASYGroup and 2 environments for PSI.
- 3M Royalties include a 5% annual escalator.
- Fees for each payment system will increase annually at the higher of 3% or the Employment Cost Index: Management, professional and related occupations, Private industry (as published by the Bureau of Labor Statistics).

Contract Pricing Comparison to Last Contract

	Current Contract Yr 5	New Contract Yr 1	New Contract Yr 2	New Contract Yr 3	New Contract Yr 4	New Contract Yr 5
APR-DRG/MS-DRG, OPPS	$410,543.00	$670,397(a)	$651,542	$673,434	$696,099	$719,566
Membership change	255,000	378,000	378,000	378,000	378,000	378,000
Averages PMPY for comparison purposes	$1.61	$1.77(a)	$1.72	$1.78	$1.840	$1.90

(a) Includes $40,000 of Implementation Costs

Board of Directors Request

Authorize the CEO to approve the renewal of the Optum Prospective Payment (PPS) contract in the amount not to exceed **$3,411,038** in operating expense for a five (5) year term.

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

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: December 2023 Financial Results

DATE: April 18, 2024

The December results reflect a $32,910,438 Net Decrease in Net Position which is a $32,421,853 unfavorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $334.2 million favorable variance primarily due to:

   A) $375.8 million favorable variance in Premium-MCO Tax due to an agreement between CMS and DHCS signed in December 2023 reinstating the MCO Tax for the period April 1, 2023 - December 31,2023 offset against amounts included under the MCO Tax Expense line item on the Income Statement.
   (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).

   B) $21.6 million unfavorable variance due to a "Population Accuity Adjustment Update" e-mail received by KHS from DHCS on February 2, 2024. Please note that all health plans received a similar e-mail. KHS' adjustment equated to a 2% adjustment compared to a statewide average of 1.7%. In summary the email stated:
   "The original CY 2023 adjustment was conservative in the health plans' favor, due to uncertainty on the actual acuity differential of members who would have otherwise disenrolled. More recent analyses have demonstrated a larger differential than was originally assumed in the CY 2023 rates. We note that Mercer is not intending to fully update the acuity assumptions produced by the more recent analyses (and used in the CY 2024 capitation rates). Rather Mercer will utilize a blend of the original and updated analyses to inform the update. DHCS/Mercer are monitoring the health plans' financials across CY 2023 based on quarterly financial reporting (Q1-Q3 for now). This reporting is showing strong positive profit margins. For our purposes, this adds further context and support for recognizing that surplus "leavers" are lower acuity, driving down average PMPM costs for the health plans."

C) $2.6 million favorable variance in Investment Earnings and Other Income primarily due from higher than forecasted interest rates being earned on the investment portfolio.

D) $26.3 million unfavorable variance in Rate Adjustments-Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2022 from DHCS in January 2024 offset against amounts included in 2E below.

2) Total Medical Costs reflect a $11.2 million favorable variance primarily due to:

A) $2.0 million favorable variance in Physician Services primarily due to lower-than-expected utilization over the last several months for Family Members.

B) $7.2 million unfavorable variance in Inpatient primarily due from unfavorable utilization from the June 30, 2023 Milliman Actuary Review liability estimate of $6.1 million and approximately $1.1 million due to higher-than-expected utilization along with hospital rate increases over the last several months.

C) $5.8 million unfavorable variance in Outpatient Hospital primarily due from unfavorable utilization from the June 30, 2023 Milliman Actuary Review liability estimate of $2.6 million and approximately $3.2 million primarily due to higher-than-expected utilization along with rate increases over the last several months.

D) $2.1 million unfavorable variance in Other Medical primarily from:

1) $1.7 million unfavorable variance in Ambulance and Non-emergency Medical Transportation (“NEMT”) due to higher-than-expected utilization of NEMT services over the last several months by our members.

2) $4.3 million favorable variance in Long Term Care expense primarily due from favorable utilization from the June 30, 2023 Milliman Actuary Review liability estimate.

3) $.7 million unfavorable variance in Enhanced Case Management primarily due to better-than-expected outcome performance measures paid to our ECM providers.

4) $3.6 million unfavorable variance in CalAim Incentive Programs due to timing differences of receiving provider invoices.

E) $26.3 million favorable variance in Hospital Directed Payments primarily due to receiving updated rate information for Calendar Year 2021 from DHCS in January 2024 offset against amounts included in 1D above.

F) $1.6 million unfavorable variance in Non-Claims Expense Adjustment primarily from adjustments made by DHCS relating to the Proposition 56 risk corridor for the period July 1, 2019 -December 31, 2020.

3) Total Administrative Expenses reflect a $1.6 million unfavorable variance primarily due to:

   A) $1.6 million unfavorable variance in Administrative Expense Adjustment relating to the CalPERS Net Pension True-up Adjustment for the period July 1, 2022 to June 30, 2023 required under GASB 68 ($1.0 million); and an increase in the Allowance for Claims Processing Expense which is a statutory requirement ($.6 million).

The December Medical Loss Ratio is 127.7% which is unfavorable to the 92.9 % budgeted amount for the reasons described in items 1 & 2 above. The December Administrative Expense Ratio is 10.3% which is unfavorable to the 7.0% budgeted amount for the reasons described in item 3 above.

The results for the 12 months ended December 31, 2023 reflects a Net Increase in Net Position of $61,432,068. This is a $67,196,549 favorable variance to budget and includes approximately $17.9 million of favorable adjustments from the prior year. The year-to-date Medical Loss Ratio is 87.7% which is favorable to the 92.9% budgeted amount. The year-to-date Administrative Expense Ratio is 7.0% which is slightly unfavorable to the 6.9% budgeted amount.

Kern Health Systems
Financial Packet
December 2023

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

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

ASSETS	DECEMBER 2023	NOVEMBER 2023	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 115,782,242	$ 154,655,404	$ (38,873,162)
Short-Term Investments	406,068,694	335,398,973	70,669,721
Premiums Receivable - Net	436,374,866	105,258,688	331,116,178
Premiums Receivable - Hospital Direct Payments	462,027,514	466,676,049	(4,648,535)
Interest Receivable	413,845	246,011	167,834
Provider Advance Payment	544,248	600,309	(56,061)
Other Receivables	1,301,397	1,093,786	207,611
Prepaid Expenses & Other Current Assets	6,561,514	6,847,848	(286,334)
Total Current Assets	$ 1,429,074,320	$ 1,070,777,068	$ 358,297,252
CAPITAL ASSETS - NET OF ACCUM DEPRE:			
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,017,404	1,073,216	(55,812)
Computer Hardware and Software - Net	18,637,824	18,203,902	433,922
Building and Building Improvements - Net	33,101,870	33,178,692	(76,822)
Capital Projects in Progress	2,295,294	3,172,786	(877,492)
Total Capital Assets	$ 59,143,098	$ 59,719,302	$ (576,204)
LONG TERM ASSETS:			
Restricted Investments	300,000	300,000	-
Officer Life Insurance Receivables	1,653,788	1,602,024	51,764
Total Long Term Assets	$ 1,953,788	$ 1,902,024	$ 51,764
DEFERRED OUTFLOWS OF RESOURCES	$ 8,425,634	$ 8,886,257	$ (460,623)
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 1,498,596,840	$ 1,141,284,651	$ 357,312,189
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Accrued Salaries and Employee Benefits	$ 5,609,620	$ 5,498,052	111,568
Accrued Other Operating Expenses	5,966,734	5,780,331	186,403
Accrued Taxes and Licenses	376,495,887	-	376,495,887
Claims Payable (Reported)	18,170,423	17,431,722	738,701
IBNR - Inpatient Claims	67,512,855	61,245,072	6,267,783
IBNR - Physician Claims	20,579,692	20,023,139	556,553
IBNR - Accrued Other Medical	35,468,070	28,882,708	6,585,362
Risk Pool and Withholds Payable	6,253,771	5,730,689	523,082
Statutory Allowance for Claims Processing Expense	3,776,682	3,195,869	580,813
Other Liabilities	103,723,449	101,411,211	2,312,238
Accrued Hospital Directed Payments	462,027,513	466,738,264	(4,710,751)
Total Current Liabilities	$ 1,105,584,696	$ 715,937,057	$ 389,647,639
NONCURRENT LIABILITIES:			
Net Pension Liability	12,665,462	12,018,206	647,256
TOTAL NONCURRENT LIABILITIES	$ 12,665,462	$ 12,018,206	$ 647,256
DEFERRED INFLOWS OF RESOURCES	$ 158,303	$ 230,571	$ (72,268)
NET POSITION:			
Net Position - Beg. of Year	318,756,311	318,756,311	-
Increase (Decrease) in Net Position - Current Year	61,432,068	94,342,506	(32,910,438)
Total Net Position	$ 380,188,379	$ 413,098,817	$ (32,910,438)
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	$ 1,498,596,840	$ 1,141,284,651	$ 357,312,189

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

CURRENT MONTH MEMBERS				YEAR-TO-DATE MEMBER MONTHS		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
209,502	209,600	(98)	Family Members	2,537,268	2,551,100	(13,832)
96,647	90,900	5,747	Expansion Members	1,184,117	1,119,400	64,717
19,044	17,400	1,644	SPD Members	220,960	212,900	8,060
456	650	(194)	LTC Members	4,522	6,150	(1,628)
23,072	23,700	(628)	Other Members	254,909	269,400	(14,491)
15,226	14,000	1,226	Kaiser Members	186,108	168,000	18,108
363,947	356,250	7,697	Total Members - MCAL	4,387,884	4,326,950	60,934
			REVENUES			
31,950,410	42,452,432	(10,502,022)	Title XIX - Medicaid - Family and Other	501,903,375	512,578,036	(10,674,661)
24,978,895	33,363,262	(8,384,367)	Title XIX - Medicaid - Expansion Members	433,907,548	410,814,753	23,092,795
20,323,529	19,891,129	432,400	Title XIX - Medicaid - SPD Members	232,629,848	243,380,542	(10,750,694)
3,471,936	4,566,444	(1,094,508)	Title XIX - Medicaid - LTC Members	33,811,426	43,362,864	(9,551,438)
375,849,146	-	375,849,146	Premium - MCO Tax	375,849,146	-	375,849,146
21,621,168	20,518,406	1,102,762	Premium - Hospital Directed Payments	259,574,363	251,186,273	8,388,090
3,055,067	426,727	2,628,340	Investment Earnings And Other Income	21,105,981	5,158,950	15,947,031
-	75,407	(75,407)	Reinsurance Recoveries	-	916,322	(916,322)
(26,269,704)	-	(26,269,704)	Rate Adjustments - Hospital Directed Payments	(26,281,856)	-	(26,281,856)
494,645	-	494,645	Rate/Income Adjustments	5,872,277	-	5,872,277
455,475,092	121,293,807	334,181,285	TOTAL REVENUES	1,838,372,108	1,467,397,740	370,974,368
			EXPENSES			
			Medical Costs:			
19,159,973	21,134,251	1,974,278	Physician Services	248,539,633	257,437,542	8,897,909
6,239,186	6,872,573	633,387	Other Professional Services	74,223,386	83,181,267	8,957,881
5,539,233	5,661,934	122,701	Emergency Room	62,781,286	68,945,681	6,164,395
30,332,453	23,100,955	(7,231,498)	Inpatient	279,067,571	282,068,728	3,001,157
2,098	75,407	73,309	Reinsurance Expense	1,131,168	916,322	(214,846)
16,089,590	10,292,117	(5,797,473)	Outpatient Hospital	136,030,602	124,949,111	(11,081,491)
28,055,063	25,961,965	(2,093,098)	Other Medical	283,889,750	306,344,431	22,454,681
523,082	513,163	(9,919)	Pay for Performance Quality Incentive	6,300,881	6,238,425	(62,456)
21,621,168	20,518,406	(1,102,762)	Hospital Directed Payments	259,574,363	251,186,273	(8,388,090)
(26,331,918)	-	26,331,918	Hospital Directed Payment Adjustment	(27,685,097)	-	27,685,097
1,576,733	-	(1,576,733)	Non-Claims Expense Adjustment	(53,945)	-	53,945
106,835	-	(106,835)	IBNR, Incentive, Paid Claims Adjustment	(14,346,840)	-	14,346,840
102,913,496	114,130,771	11,217,275	Total Medical Costs	1,309,452,758	1,381,267,779	71,815,021
352,561,596	7,163,036	345,398,560	GROSS MARGIN	528,919,350	86,129,961	442,789,389
			Administrative:			
3,776,320	4,009,842	233,522	Compensation	47,221,608	48,193,093	971,485
1,707,545	1,690,082	(17,463)	Purchased Services	18,835,449	20,280,981	1,445,532
421,461	227,316	(194,145)	Supplies	2,116,403	2,727,795	611,392
756,211	649,950	(106,261)	Depreciation	8,269,844	7,799,394	(470,450)
402,950	449,119	46,169	Other Administrative Expenses	5,949,936	5,389,423	(560,513)
1,580,392	-	(1,580,392)	Administrative Expense Adjustment	3,727,294	-	(3,727,294)
8,644,879	7,026,308	(1,618,571)	Total Administrative Expenses	86,120,534	84,390,686	(1,729,848)
111,558,375	121,157,079	9,598,704	TOTAL EXPENSES	1,395,573,292	1,465,658,465	70,085,173
343,916,717	136,728	343,779,989	OPERATING INCOME (LOSS) BEFORE TAX	442,798,816	1,739,275	441,059,541
376,495,887	-	(376,495,887)	MCO TAX	376,495,887	-	(376,495,887)
(32,579,170)	136,728	(32,715,898)	OPERATING INCOME (LOSS) NET OF TAX	66,302,929	1,739,275	64,563,654
			NONOPERATING REVENUE (EXPENSE)			
25,418	-	25,418	Provider Grants/CalAIM/Home Heath	24,875	-	24,875
(356,686)	(625,313)	268,627	D-SNP Expenses	(4,895,736)	(7,503,756)	2,608,020
(331,268)	(625,313)	294,045	TOTAL NONOPERATING REVENUE (EXPENSE)	(4,870,861)	(7,503,756)	2,632,895
(32,910,438)	(488,585)	(32,421,853)	NET INCREASE (DECREASE) IN NET POSITION	61,432,068	(5,764,481)	67,196,549
127.7%	92.9%	-34.8%	MEDICAL LOSS RATIO	87.7%	92.9%	5.3%
10.3%	7.0%	-3.3%	ADMINISTRATIVE EXPENSE RATIO	7.0%	6.9%	-0.1%

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

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
209,502	209,600	(98)	Family Members	2,537,268	2,551,100	(13,832)
96,647	90,900	5,747	Expansion Members	1,184,117	1,119,400	64,717
19,044	17,400	1,644	SPD Members	220,960	212,900	8,060
456	650	(194)	LTC Members	4,522	6,150	(1,628)
23,072	23,700	(628)	Other Members	254,909	269,400	(14,491)
15,226	14,000	1,226	Kaiser Members	186,108	168,000	18,108
363,947	356,250	7,697	Total Members - MCAL	4,387,884	4,326,950	60,934
			REVENUES			
137.38	181.96	(44.59)	Title XIX - Medicaid - Family and Other	179.75	181.73	(1.98)
258.45	367.03	(108.58)	Title XIX - Medicaid - Expansion Members	366.44	367.00	(0.56)
1,067.19	1,143.17	(75.98)	Title XIX - Medicaid - SPD Members	1,052.81	1,143.17	(90.35)
7,613.89	7,025.30	588.60	Title XIX - Medicaid - LTC Members	7,477.10	7,050.87	426.22
1,077.79	0.00	1,077.79	Premium - MCO Tax	89.45	0.00	89.45
62.00	59.95	2.05	Premium - Hospital Directed Payments	61.78	60.40	1.38
8.76	1.25	7.51	Investment Earnings And Other Income	5.02	1.24	3.78
0.00	0.22	(0.22)	Reinsurance Recoveries	0.00	0.22	(0.22)
(75.33)	0.00	(75.33)	Rate Adjustments - Hospital Directed Payments	(6.25)	0.00	(6.25)
1.42	0.00	1.42	Rate/Income Adjustments	1.40	0.00	1.40
1,306.13	354.40	951.73	TOTAL REVENUES	437.52	352.83	84.69
			EXPENSES			
			Medical Costs:			
54.94	61.75	6.81	Physician Services	59.15	61.90	2.75
17.89	20.08	2.19	Other Professional Services	17.66	20.00	2.34
15.88	16.54	0.66	Emergency Room	14.94	16.58	1.64
86.98	67.50	(19.48)	Inpatient	66.42	67.82	1.41
0.01	0.22	0.21	Reinsurance Expense	0.27	0.22	(0.05)
46.14	30.07	(16.07)	Outpatient Hospital	32.37	30.04	(2.33)
80.45	75.86	(4.59)	Other Medical	67.56	73.66	6.09
1.50	1.50	(0.00)	Pay for Performance Quality Incentive	1.50	1.50	0.00
62.00	59.95	(2.05)	Hospital Directed Payments	61.78	60.40	(1.38)
(75.51)	0.00	75.51	Hospital Directed Payment Adjustment	(6.59)	0.00	6.59
4.52	0.00	(4.52)	Non-Claims Expense Adjustment	(0.01)	0.00	0.01
0.31	0.00	(0.31)	IBNR, Incentive, Paid Claims Adjustment	(3.41)	0.00	3.41
295.12	333.47	38.35	Total Medical Costs	311.64	332.12	20.48
1,011.01	20.93	990.08	GROSS MARGIN	125.88	20.71	105.17
			Administrative:			
10.83	11.72	0.89	Compensation	11.24	11.59	0.35
4.90	4.94	0.04	Purchased Services	4.48	4.88	0.39
1.21	0.66	(0.54)	Supplies	0.50	0.66	0.15
2.17	1.90	(0.27)	Depreciation	1.97	1.88	(0.09)
1.16	1.31	0.16	Other Administrative Expenses	1.42	1.30	(0.12)
4.53	0.00	(4.53)	Administrative Expense Adjustment	0.89	0.00	(0.89)
24.79	20.53	(4.26)	Total Administrative Expenses	20.50	20.29	(0.20)
319.91	354.00	34.09	TOTAL EXPENSES	332.14	352.41	20.27
986.22	0.40	985.82	OPERATING INCOME (LOSS) BEFORE TAX	105.38	0.42	104.97
1,079.65	0.00	(1,079.65)	MCO TAX	89.60	0.00	(89.60)
(93.42)	0.40	(93.82)	OPERATING INCOME (LOSS) NET OF TAX	15.78	0.42	15.36
			NONOPERATING REVENUE (EXPENSE)			
0.00	0.00	0.00	Gain on Sale of Assets	0.00	0.00	0.00
0.07	0.00	0.07	Reserve Fund Projects/Community Grants	0.01	0.00	0.01
(1.02)	(1.83)	0.80	Health Home	(1.17)	(1.80)	0.64
(0.95)	(1.83)	0.88	TOTAL NONOPERATING REVENUE (EXPENSE)	(1.16)	(1.80)	0.65
(94.37)	(1.43)	(92.95)	NET INCREASE (DECREASE) IN NET POSITION	14.62	(1.39)	16.01
127.7%	92.9%	-34.8%	MEDICAL LOSS RATIO	87.7%	92.9%	5.3%
10.3%	7.0%	-3.3%	ADMINISTRATIVE EXPENSE RATIO	7.0%	6.9%	-0.1%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH DECEMBER 31, 2023	DECEMBER 2022	JANUARY 2023	FEBRUARY 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
ENROLLMENT							
Members - MCAL	336,514	332,387	349,492	351,010	353,005	355,915	357,008
REVENUES							
Title XIX - Medicaid - Family and Other	34,345,215	38,355,206	40,922,562	41,044,003	41,661,492	44,450,874	45,303,824
Title XIX - Medicaid - Expansion Members	30,862,645	35,864,920	36,154,732	35,902,983	36,465,640	38,238,101	38,910,749
Title XIX - Medicaid - SPD Members	15,500,822	18,119,057	19,012,691	19,068,659	19,567,025	19,083,062	19,664,806
Title XIX - Medicaid - LTC Members	-	201,227	2,814,382	2,968,601	2,968,602	3,026,025	3,130,269
Premium - MCO Tax	10,883,460	-	-	-	-	-	-
Premium - Hospital Directed Payments	27,573,903	21,209,673	21,515,947	21,609,701	21,948,157	21,792,771	22,188,234
Investment Earnings And Other Income	714,738	1,400,146	440,597	2,337,674	1,314,336	651,530	1,485,525
Reinsurance Recoveries	152,481	-	-	-	-	-	-
Rate Adjustments - Hospital Directed Payments	12,446,127	(684,297)	33,520	32,816	37,815	5,509	15,555
Rate/Income Adjustments	333,950	(968,410)	350,076	1,115,116	978,086	1,497,916	213,618
TOTAL REVENUES	132,813,341	113,497,522	121,244,507	124,079,553	124,941,153	128,745,788	130,912,580
EXPENSES							
Medical Costs:							
Physician Services	16,678,607	20,302,072	19,187,941	20,648,045	21,262,722	21,747,296	21,895,594
Other Professional Services	6,175,363	5,493,905	5,413,638	6,067,168	5,720,799	6,643,597	6,838,173
Emergency Room	5,082,054	5,195,994	4,633,288	5,199,635	5,262,548	5,131,679	5,555,164
Inpatient	12,591,938	22,641,712	21,804,027	22,997,133	23,980,922	21,382,030	19,096,686
Reinsurance Expense	59,818	90,859	180,937	94,363	94,773	95,311	96,097
Outpatient Hospital	9,093,742	9,616,781	9,652,797	11,362,056	10,886,974	11,009,988	10,557,328
Other Medical	6,543,097	15,528,820	23,011,370	23,040,484	22,948,410	22,151,470	25,626,415
Pay for Performance Quality Incentive	504,771	498,590	524,238	526,516	529,507	533,873	533,872
Hospital Directed Payments	27,573,903	21,209,673	21,515,947	21,609,701	21,948,157	21,792,771	22,188,234
Hospital Directed Payment Adjustment	12,446,126	(684,297)	33,520	(869,333)	37,816	123,932	15,555
Non-Claims Expense Adjustment	(1,071,264)	(128,832)	3,429	72,961	177,517	(2,449,080)	3,040
IBNR, Incentive, Paid Claims Adjustment	(6,704,318)	9,076	32,166	(4,009,312)	(4,430,362)	(4,472,016)	(4,829,330)
Total Medical Costs	88,973,837	99,774,353	105,993,298	106,739,417	108,419,783	103,690,851	107,576,828
GROSS MARGIN	43,839,504	13,723,169	15,251,209	17,340,136	16,521,370	25,054,937	23,335,752
Administrative:							
Compensation	4,707,264	3,547,045	3,492,028	3,754,627	3,614,954	3,792,281	3,620,970
Purchased Services	1,262,419	939,926	1,549,694	1,516,766	1,481,551	1,530,859	1,863,224
Supplies	220,189	87,606	161,043	106,568	113,296	134,551	30,404
Depreciation	627,772	680,616	679,350	682,158	684,369	685,407	685,551
Other Administrative Expenses	966,290	660,263	384,578	557,118	442,055	441,734	562,847
Administrative Expense Adjustment	508,526	109,675	301,496	320,296	300,000	300,950	501,326
Total Administrative Expenses	8,292,460	6,025,131	6,568,189	6,937,533	6,636,225	6,885,782	7,264,322
TOTAL EXPENSES	97,266,297	105,799,484	112,561,487	113,676,950	115,056,008	110,576,633	114,841,150
OPERATING INCOME (LOSS) BEFORE TAX	35,547,044	7,698,038	8,683,020	10,402,603	9,885,145	18,169,155	16,071,430
MCO TAX	10,883,459	-	-	-	-	-	-
OPERATING INCOME (LOSS) NET OF TAX	24,663,585	7,698,038	8,683,020	10,402,603	9,885,145	18,169,155	16,071,430
TOTAL NONOPERATING REVENUE (EXPENSE)	(34,557)	(60,423)	(153,079)	(672,750)	(310,622)	(300,144)	(672,234)
NET INCREASE (DECREASE) IN NET POSITION	24,629,028	7,637,615	8,529,941	9,729,853	9,574,523	17,869,011	15,399,196
MEDICAL LOSS RATIO	59.8%	85.2%	84.7%	84.0%	84.0%	76.5%	78.5%
ADMINISTRATIVE EXPENSE RATIO	10.1%	6.5%	6.6%	6.8%	6.4%	6.4%	6.7%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - ROLLING 13 MONTHS THROUGH DECEMBER 31, 2023	JULY 2023	AUGUST 2023	SEPTEMBER 2023	OCTOBER 2023	NOVEMBER 2023	DECEMBER 2023	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	355,448	356,881	352,039	344,282	345,588	348,721	4,538,290
REVENUES							
Title XIX - Medicaid - Family and Other	45,811,582	41,688,820	43,328,819	42,099,200	45,286,583	31,950,410	536,248,590
Title XIX - Medicaid - Expansion Members	38,966,690	37,219,564	38,490,002	36,217,555	36,497,717	24,978,895	464,770,193
Title XIX - Medicaid - SPD Members	19,655,340	19,355,872	19,937,702	19,485,313	19,356,792	20,323,529	248,130,670
Title XIX - Medicaid - LTC Members	2,933,682	3,019,928	3,149,260	2,973,589	3,153,925	3,471,936	33,811,426
Premium - MCO Tax	-	-	-	-	-	375,849,146	386,732,606
Premium - Hospital Directed Payments	21,822,439	21,933,791	21,801,472	21,376,726	20,754,284	21,621,168	287,148,266
Investment Earnings And Other Income	1,706,041	1,300,264	1,438,685	2,404,743	3,571,373	3,055,067	21,820,719
Reinsurance Recoveries	-	-	-	-	-	-	152,481
Rate Adjustments - Hospital Directed Payments	(15,187)	421,005	139,435	4,262	(2,585)	(26,269,704)	(13,835,729)
Rate/Income Adjustments	1,690	(38,135)	2,226,733	(20,585)	21,527	494,645	6,206,227
TOTAL REVENUES	130,882,277	124,901,109	130,512,108	124,540,803	128,639,616	455,475,092	1,971,185,449
EXPENSES							
Medical Costs:							
Physician Services	20,488,109	20,619,449	21,311,972	20,657,868	21,258,592	19,159,973	265,218,240
Other Professional Services	5,443,151	6,830,704	6,391,087	6,402,687	6,739,291	6,239,186	80,398,749
Emergency Room	4,984,270	5,600,554	5,694,566	5,063,129	4,921,226	5,539,233	67,863,340
Inpatient	22,316,634	20,877,596	24,726,100	25,452,067	23,460,211	30,332,453	291,659,509
Reinsurance Expense	96,097	96,688	95,910	96,625	91,410	2,098	1,190,986
Outpatient Hospital	10,233,407	10,613,553	11,158,217	12,146,983	12,702,928	16,089,590	145,124,344
Other Medical	22,600,808	23,390,986	26,396,360	23,481,299	27,658,265	28,055,063	290,432,847
Pay for Performance Quality Incentive	535,512	534,172	529,365	513,772	518,382	523,082	6,805,652
Hospital Directed Payments	21,822,439	21,933,791	21,801,472	21,376,726	20,754,284	21,621,168	287,148,266
Hospital Directed Payment Adjustment	(15,187)	426,925	(423,787)	4,263	(2,586)	(26,331,918)	(15,238,971)
Non-Claims Expense Adjustment	639,578	3,672	52,429	(4,730)	(662)	1,576,733	(1,125,209)
IBNR, Incentive, Paid Claims Adjustment	707,021	438,520	701,159	614,589	784,814	106,835	(21,051,158)
Total Medical Costs	109,851,839	111,366,610	118,434,850	115,805,278	118,886,155	102,913,496	1,398,426,595
GROSS MARGIN	21,030,438	13,534,499	12,077,258	8,735,525	9,753,461	352,561,596	572,758,854
Administrative:							
Compensation	3,743,082	4,035,666	4,036,689	4,152,627	5,655,319	3,776,320	51,928,872
Purchased Services	1,454,753	1,385,358	1,774,151	1,715,078	1,916,544	1,707,545	20,097,868
Supplies	196,052	395,025	210,861	128,415	131,121	421,461	2,336,592
Depreciation	686,781	693,125	693,125	657,439	685,712	756,211	8,897,616
Other Administrative Expenses	623,127	435,112	436,285	505,416	498,451	402,950	6,916,226
Administrative Expense Adjustment	300,183	12,969	267	-	(260)	1,580,392	4,235,820
Total Administrative Expenses	7,003,978	6,957,255	7,151,378	7,158,975	8,886,887	8,644,879	94,412,994
TOTAL EXPENSES	116,855,817	118,323,865	125,586,228	122,964,253	127,773,042	111,558,375	1,492,839,589
OPERATING INCOME (LOSS) BEFORE TAX	14,026,460	6,577,244	4,925,880	1,576,550	866,574	343,916,717	478,345,860
MCO TAX	-	-	-	-	-	376,495,887	10,883,459
OPERATING INCOME (LOSS) NET OF TAX	14,026,460	6,577,244	4,925,880	1,576,550	866,574	(32,579,170)	467,462,401
TOTAL NONOPERATING REVENUE (EXPENSE)	(307,680)	(457,916)	(481,380)	(632,933)	(490,432)	(331,268)	(4,905,418)
NET INCREASE (DECREASE) IN NET POSITION	13,718,780	6,119,328	4,444,500	943,617	376,142	(32,910,438)	462,556,983
MEDICAL LOSS RATIO	80.7%	86.8%	89.4%	91.5%	91.0%	127.7%	85.9%
ADMINISTRATIVE EXPENSE RATIO	6.4%	6.8%	6.6%	6.9%	8.2%	10.3%	7.2%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH DECEMBER 31, 2023	DECEMBER 2022	JANUARY 2023	FEBRUARY 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
ENROLLMENT							
Members - MCAL	336,514	332,387	349,492	351,010	353,005	355,915	357,008
REVENUES							
Title XIX - Medicaid - Family and Other	156.69	175.30	175.80	175.43	177.53	187.74	190.94
Title XIX - Medicaid - Expansion Members	323.22	373.01	369.48	365.87	367.09	381.03	383.36
Title XIX - Medicaid - SPD Members	897.35	1,038.82	1,030.33	1,029.51	1,052.05	1,037.24	1,052.72
Title XIX - Medicaid - LTC Members	0.00	7,452.85	7,425.81	7,477.58	7,440.11	7,546.20	7,506.64
Premium - MCO Tax	32.34	0.00	0.00	0.00	0.00	0.00	0.00
Premium - Hospital Directed Payments	81.94	63.81	61.56	61.56	62.18	61.23	62.15
Investment Earnings And Other Income	2.12	4.21	1.26	6.66	3.72	1.83	4.16
Reinsurance Recoveries	0.45	0.00	0.00	0.00	0.00	0.00	0.00
Rate Adjustments - Hospital Directed Payments	36.99	(2.06)	0.10	0.09	0.11	0.02	0.04
Rate/Income Adjustments	0.99	(2.91)	1.00	3.18	2.77	4.21	0.60
TOTAL REVENUES	394.67	341.46	346.92	353.49	353.94	361.73	366.69
EXPENSES							
Medical Costs:							
Physician Services	49.56	61.08	54.90	58.82	60.23	61.10	61.33
Other Professional Services	18.35	16.53	15.49	17.28	16.21	18.67	19.15
Emergency Room	15.10	15.63	13.26	14.81	14.91	14.42	15.56
Inpatient	37.42	68.12	62.39	65.52	67.93	60.08	53.49
Reinsurance Expense	0.18	0.27	0.52	0.27	0.27	0.27	0.27
Outpatient Hospital	27.02	28.93	27.62	32.37	30.84	30.93	29.57
Other Medical	19.44	46.72	65.84	65.64	65.01	62.24	71.78
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.50	1.50	1.50
Hospital Directed Payments	81.94	63.81	61.56	61.56	62.18	61.23	62.15
Hospital Directed Payment Adjustment	36.99	(2.06)	0.10	(2.48)	0.11	0.35	0.04
Non-Claims Expense Adjustment	(3.18)	(0.39)	0.01	0.21	0.50	(6.88)	0.01
IBNR, Incentive, Paid Claims Adjustment	(19.92)	0.03	0.09	(11.42)	(12.55)	(12.56)	(13.53)
Total Medical Costs	264.40	300.18	303.28	304.09	307.13	291.34	301.33
GROSS MARGIN	130.28	41.29	43.64	49.40	46.80	70.40	65.36
Administrative:							
Compensation	13.99	10.67	9.99	10.70	10.24	10.66	10.14
Purchased Services	3.75	2.83	4.43	4.32	4.20	4.30	5.22
Supplies	0.65	0.26	0.46	0.30	0.32	0.38	0.09
Depreciation	1.87	2.05	1.94	1.94	1.94	1.93	1.92
Other Administrative Expenses	2.87	1.99	1.10	1.59	1.25	1.24	1.58
Administrative Expense Adjustment	1.51	0.33	0.86	0.91	0.85	0.85	1.40
Total Administrative Expenses	24.64	18.13	18.79	19.76	18.80	19.35	20.35
TOTAL EXPENSES	289.04	318.30	322.07	323.86	325.93	310.68	321.68
OPERATING INCOME (LOSS) BEFORE TAX	105.63	23.16	24.84	29.64	28.00	51.05	45.02
MCO TAX	32.34	0.00	0.00	0.00	0.00	0.00	0.00
OPERATING INCOME (LOSS) NET OF TAX	73.29	23.16	24.84	29.64	28.00	51.05	45.02
TOTAL NONOPERATING REVENUE (EXPENSE)	(0.10)	(0.18)	(0.44)	(1.92)	(0.88)	(0.84)	(1.88)
NET INCREASE (DECREASE) IN NET POSITION	73.19	22.98	24.41	27.72	27.12	50.21	43.13
MEDICAL LOSS RATIO	59.8%	85.2%	84.7%	84.0%	84.0%	76.5%	78.5%
ADMINISTRATIVE EXPENSE RATIO	10.1%	6.5%	6.6%	6.8%	6.4%	6.4%	6.7%

KERN HEALTH SYSTEMS MEDI-CAL STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION BY MONTH - PMPM ROLLING 13 MONTHS THROUGH DECEMBER 31, 2023	JULY 2023	AUGUST 2023	SEPTEMBER 2023	OCTOBER 2023	NOVEMBER 2023	DECEMBER 2023	13 MONTH TOTAL
ENROLLMENT							
Members - MCAL	355,448	356,881	352,039	344,282	345,588	348,721	4,538,290
REVENUES							
Title XIX - Medicaid - Family and Other	195.08	177.66	185.02	183.11	196.69	137.38	177.80
Title XIX - Medicaid - Expansion Members	409.60	390.36	385.48	378.12	378.15	258.45	363.05
Title XIX - Medicaid - SPD Members	1,127.03	1,110.24	1,081.04	1,071.80	1,052.11	1,067.19	1,040.55
Title XIX - Medicaid - LTC Members	7,445.89	7,530.99	7,892.88	7,342.20	7,368.98	7,613.89	7,477.10
Premium - MCO Tax	0.00	0.00	0.00	0.00	0.00	1,077.79	85.22
Premium - Hospital Directed Payments	61.39	61.46	61.93	62.09	60.05	62.00	63.27
Investment Earnings And Other Income	4.80	3.64	4.09	6.98	10.33	8.76	4.81
Reinsurance Recoveries	0.00	0.00	0.00	0.00	0.00	0.00	0.03
Rate Adjustments - Hospital Directed Payments	(0.04)	1.18	0.40	0.01	(0.01)	(75.33)	(3.05)
Rate/Income Adjustments	0.00	(0.11)	6.33	(0.06)	0.06	1.42	1.37
TOTAL REVENUES	368.22	349.98	370.73	361.74	372.23	1,306.13	434.35
EXPENSES							
Medical Costs:							
Physician Services	57.64	57.78	60.54	60.00	61.51	54.94	58.44
Other Professional Services	15.31	19.14	18.15	18.60	19.50	17.89	17.72
Emergency Room	14.02	15.69	16.18	14.71	14.24	15.88	14.95
Inpatient	62.78	58.50	70.24	73.93	67.88	86.98	64.27
Reinsurance Expense	0.27	0.27	0.27	0.28	0.26	0.01	0.26
Outpatient Hospital	28.79	29.74	31.70	35.28	36.76	46.14	31.98
Other Medical	63.58	65.54	74.98	68.20	80.03	80.45	64.00
Pay for Performance Quality Incentive	1.51	1.50	1.50	1.49	1.50	1.50	1.50
Hospital Directed Payments	61.39	61.46	61.93	62.09	60.05	62.00	63.27
Hospital Directed Payment Adjustment	(0.04)	1.20	(1.20)	0.01	(0.01)	(75.51)	(3.36)
Non-Claims Expense Adjustment	1.80	0.01	0.15	(0.01)	(0.00)	4.52	(0.25)
IBNR, Incentive, Paid Claims Adjustment	1.99	1.23	1.99	1.79	2.27	0.31	(4.64)
Total Medical Costs	309.05	312.06	336.43	336.37	344.01	295.12	308.14
GROSS MARGIN	59.17	37.92	34.31	25.37	28.22	1,011.01	126.21
Administrative:							
Compensation	10.53	11.31	11.47	12.06	16.36	10.83	11.44
Purchased Services	4.09	3.88	5.04	4.98	5.55	4.90	4.43
Supplies	0.55	1.11	0.60	0.37	0.38	1.21	0.51
Depreciation	1.93	1.94	1.97	1.91	1.98	2.17	1.96
Other Administrative Expenses	1.75	1.22	1.24	1.47	1.44	1.16	1.52
Administrative Expense Adjustment	0.84	0.04	0.00	0.00	(0.00)	4.53	0.93
Total Administrative Expenses	19.70	19.49	20.31	20.79	25.72	24.79	20.80
TOTAL EXPENSES	328.76	331.55	356.74	357.16	369.73	319.91	328.94
OPERATING INCOME (LOSS) BEFORE TAX	39.46	18.43	13.99	4.58	2.51	986.22	105.40
MCO TAX	0.00	0.00	0.00	0.00	0.00	1,079.65	2.40
OPERATING INCOME (LOSS) NET OF TAX	39.46	18.43	13.99	4.58	2.51	(93.42)	103.00
TOTAL NONOPERATING REVENUE (EXPENSE)	(0.87)	(1.28)	(1.37)	(1.84)	(1.42)	(0.95)	(1.08)
NET INCREASE (DECREASE) IN NET POSITION	38.60	17.15	12.63	2.74	1.09	(94.37)	101.92
MEDICAL LOSS RATIO	80.7%	86.8%	89.4%	91.5%	91.0%	127.7%	85.9%
ADMINISTRATIVE EXPENSE RATIO	6.4%	6.8%	6.6%	6.9%	8.2%	10.3%	7.2%

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

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			REVENUES			
			Title XIX - Medicaid - Family & Other			
23,891,508	33,846,153	(9,954,645)	Premium - Medi-Cal	395,454,352	408,423,682	(12,969,330)
3,396,280	2,782,482	613,798	Premium - Maternity Kick	32,663,403	33,389,784	(726,381)
661,268	675,691	(14,423)	Premium - Enhanced Care Management	7,823,474	8,055,366	(231,892)
207,651	151,941	55,710	Premium - Major Organ Transplant	2,515,477	1,849,363	666,114
-	509,241	(509,241)	Premium - Cal AIM	9,438,601	6,210,079	3,228,522
3,520,646	3,590,602	(69,956)	Premium - Provider Enhancement	42,789,856	43,819,793	(1,029,937)
161,675	183,386	(21,711)	Premium - Ground Emergency Medical Transportation	1,978,584	2,240,546	(261,962)
-	245,400	(245,400)	Premium - Student Behavioral Health Incentive	4,372,077	2,944,800	1,427,277
-	352,514	(352,514)	Premium - Housing and Homelessness Incentive	3,487,489	4,230,168	(742,679)
111,382	115,022	(3,640)	Other	1,380,062	1,414,457	(34,395)
31,950,410	42,452,432	(10,502,022)	Total Title XIX - Medicaid - Family & Other	501,903,375	512,578,038	(10,674,663)
			Title XIX - Medicaid - Expansion Members			
21,218,067	29,355,581	(8,137,514)	Premium - Medi-Cal	382,829,268	361,528,795	21,300,474
678,203	236,486	441,717	Premium - Maternity Kick	6,546,037	2,837,831	3,708,206
793,084	919,926	(126,842)	Premium - Enhanced Care Management	9,607,906	11,333,406	(1,725,500)
329,207	229,758	99,449	Premium - Major Organ Transplant	3,965,893	2,830,598	1,135,295
-	390,382	(390,382)	Premium - Cal AIM	3,994,124	14,199,143	(10,205,019)
1,690,823	1,523,047	167,776	Premium - Provider Enhancement	20,376,011	7,796,638	12,579,373
234,212	198,579	35,633	Premium - Ground Emergency Medical Transportation	2,827,542	2,369,548	457,994
-	195,905	(195,905)	Premium - Student Behavioral Health Incentive	1,854,243	3,034,940	(1,180,697)
-	281,415	(281,415)	Premium - Housing and Homelessness Incentive	1,478,208	1,392,132	86,076
35,299	32,184	3,115	Other	428,316	363,456	64,860
24,978,895	33,363,262	(8,384,367)	Total Title XIX - Medicaid - Expansion Members	433,907,548	407,686,486	26,221,062
			Title XIX - Medicaid - SPD Members			
18,915,033	18,111,312	803,721	Premium - Medi-Cal	215,204,656	221,603,353	(6,398,697)
441,676	497,466	(55,790)	Premium - Enhanced Care Management	5,053,530	6,086,811	(1,033,281)
264,720	158,166	106,554	Premium - Major Organ Transplant	3,000,545	1,935,261	1,065,284
-	242,205	(242,205)	Premium - Cal AIM	746,383	3,052,331	(2,305,948)
552,258	450,649	101,609	Premium - Provider Enhancement	6,295,225	5,513,973	781,252
149,842	139,374	10,468	Premium - Ground Emergency Medical Transportation	1,712,197	1,705,329	6,868
-	119,827	(119,827)	Premium - Student Behavioral Health Incentive	346,311	1,437,924	(1,091,613)
-	172,130	(172,130)	Premium - Housing and Homelessness Incentive	271,001	2,065,560	(1,794,559)
20,323,529	19,891,129	432,400	Total Title XIX - Medicaid - SPD Members	232,629,848	243,400,542	(10,770,694)
			Title XIX - Medicaid - LTC Members			
3,447,630	4,530,470	(1,082,840)	Premium - Medi-Cal	33,549,021	39,019,080	(5,470,059)
10,517	14,512	(3,995)	Premium - Enhanced Care Management	102,103	138,022	(35,919)
12,686	21,119	(8,433)	Premium - Major Organ Transplant	121,384	201,989	(80,605)
-	-	-	Premium - Cal AIM	16,987	-	16,987
247	343	(96)	Premium - Provider Enhancement	1,867	3,773	(1,906)
856	-	856	Premium - Ground Emergency Medical Transportation	6,716	-	6,716
-	-	-	Premium - Student Behavioral Health Incentive	7,441	-	7,441
-	-	-	Premium - Housing and Homelessness Incentive	5,907	-	5,907
3,471,936	4,566,444	(1,094,508)	Total Title XIX - Medicaid - LTC Members	33,811,426	39,362,864	(5,551,438)

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

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
4,091,872	4,363,619	271,747	Primary Care Physician Services	48,405,552	53,037,826	4,632,274
13,148,947	14,255,326	1,106,379	Referral Specialty Services	174,915,890	173,828,034	(1,087,856)
1,909,854	2,506,006	596,152	Urgent Care & After Hours Advise	25,108,691	30,462,182	5,353,491
9,300	9,300	-	Hospital Admitting Team	109,500	109,500	-
19,159,973	21,134,251	1,974,278	TOTAL PHYSICIAN SERVICES	248,539,633	257,437,542	8,897,909
			OTHER PROFESSIONAL SERVICES			
344,282	350,482	6,200	Vision Service Capitation	4,190,121	4,258,989	68,868
259,281	312,866	53,585	221 - Business Intelligence - UM Allocation *	3,355,236	3,754,388	399,152
584,297	817,442	233,145	310 - Health Services - Utilization Management - UM Allocation *	7,407,126	9,809,302	2,402,176
219,720	304,571	84,851	311 - Health Services - Quality Improvement - UM Allocation *	3,401,421	3,654,847	253,426
207,359	227,968	20,609	312 - Health Services - Education - UM Allocation *	2,551,339	2,735,618	184,279
71,806	97,289	25,483	313 - Health Services - Pharmacy - UM Allocation *	971,819	1,167,467	195,648
286,692	306,190	19,498	314 - Enhanced Care Management - UM Allocation *	3,214,061	3,674,277	460,216
378,857	475,548	96,691	316 -Population Health Management - UM Allocation *	4,341,945	5,706,578	1,364,633
80,752	110,899	30,147	317 - Community Based Services - UM Allocation *	862,631	1,330,792	468,161
(20)	15,414	15,434	318 - Housing & Homeless Incentive Program - UM Allocation *	272,859	184,971	(87,888)
16,868	22,975	6,107	319 - CalAIM Incentive Payment Program - UM Allocation *	153,962	275,705	121,743
44,807	62,940	18,133	601 - Behavioral Health - UM Allocation *	369,671	755,276	385,605
71,172	50,515	(20,657)	602 - Quality & Health Equity - UM Allocation *	687,746	606,180	(81,566)
65,689	-	(65,689)	604 - Clinical Operations, Straegy, and Analytics*	167,686	-	(167,686)
44,992	-	(44,992)	605 - Quality Performance*	78,785	-	(78,785)
2,052,611	1,433,112	(619,499)	Behavior Health Treatment	22,165,659	17,412,897	(4,752,762)
199,971	427,839	227,868	Mental Health Services	2,706,114	5,209,230	2,503,116
1,310,050	1,856,524	546,474	Other Professional Services	17,325,205	22,644,751	5,319,546
6,239,186	6,872,573	633,387	TOTAL OTHER PROFESSIONAL SERVICES	74,223,386	83,181,267	8,957,881
5,539,233	5,661,934	122,701	EMERGENCY ROOM	62,781,286	68,945,681	6,164,395
30,332,453	23,100,955	(7,231,498)	INPATIENT HOSPITAL	279,067,571	282,068,728	3,001,157
2,098	75,407	73,309	REINSURANCE EXPENSE PREMIUM	1,131,168	916,322	(214,846)
16,089,590	10,292,117	(5,797,473)	OUTPATIENT HOSPITAL SERVICES	136,030,602	124,949,111	(11,081,491)
			OTHER MEDICAL			
3,353,558	1,625,230	(1,728,328)	Ambulance and NEMT	30,209,009	19,770,330	(10,438,679)
845,801	985,388	139,587	Home Health Services & CBAS	8,947,775	12,024,455	3,076,680
1,113,241	1,592,010	478,769	Utilization and Quality Review Expenses	12,227,711	19,104,116	6,876,405
5,687,565	10,028,361	4,340,796	Long Term/SNF/Hospice	80,353,869	112,641,055	32,287,186
5,475,775	5,272,574	(203,201)	Provider Enhancement Expense - Prop. 56	65,989,810	64,103,974	(1,885,836)
886,031	495,272	(390,759)	Provider Enhancement Expense - GEMT	7,723,329	6,072,699	(1,650,630)
2,654,725	2,002,215	(652,510)	Enhanced Care Management	24,063,438	24,332,920	269,482
762,346	532,935	(229,411)	Major Organ Transplant	9,123,135	6,476,350	(2,646,785)
5,972,483	2,383,569	(3,588,914)	Cal AIM Incentive Programs	29,330,536	29,075,977	(254,559)
1,303,538	1,044,413	(259,125)	DME/Rebates	15,921,138	12,742,556	(3,178,582)
28,055,063	25,961,965	(2,093,098)	TOTAL OTHER MEDICAL	283,889,750	306,344,431	22,454,681
523,082	513,163	(9,919)	PAY FOR PERFORMANCE QUALITY INCENTIVE	6,300,881	6,238,425	(62,456)
21,621,168	20,518,406	(1,102,762)	HOSPITAL DIRECTED PAYMENTS	259,574,363	251,186,273	(8,388,090)
(26,331,918)	-	26,331,918	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(27,685,097)	-	27,685,097
1,576,733	-	(1,576,733)	NON-CLAIMS EXPENSE ADJUSTMENT	(53,945)	-	53,945
106,835	-	(106,835)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(14,346,840)	-	14,346,840
102,913,496	114,130,771	11,217,275	Total Medical Costs	1,309,452,758	1,381,267,779	71,815,021

* Medical costs per DMHC regulations

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

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			PHYSICIAN SERVICES			
11.73	12.75	1.02	Primary Care Physician Services	11.52	12.75	1.23
37.71	41.65	3.95	Referral Specialty Services	41.63	41.80	0.17
5.48	7.32	1.85	Urgent Care & After Hours Advise	5.98	7.32	1.35
0.03	0.03	0.00	Hospital Admitting Team	0.03	0.03	0.00
54.94	61.75	6.81	TOTAL PHYSICIAN SERVICES	59.15	61.90	2.75
			OTHER PROFESSIONAL SERVICES			
0.99	1.02	0.04	Vision Service Capitation	1.00	1.02	0.03
0.74	0.91	0.17	221 - Business Intelligence - UM Allocation *	0.80	0.90	0.10
1.68	2.39	0.71	310 - Health Services - Utilization Management - UM Allocation *	1.76	2.36	0.60
0.63	0.89	0.26	311 - Health Services - Quality Improvement - UM Allocation *	0.81	0.88	0.07
0.59	0.67	0.07	312 - Health Services - Education - UM Allocation *	0.61	0.66	0.05
0.21	0.28	0.08	313 - Health Services - Pharmacy - UM Allocation *	0.23	0.28	0.05
0.82	0.89	0.07	314 - Enhanced Care Management - UM Allocation *	0.76	0.88	0.12
1.09	1.39	0.30	316 -Population Health Management - UM Allocation *	1.03	1.37	0.34
0.23	0.32	0.09	317 - Community Based Services - UM Allocation *	0.21	0.32	0.11
(0.00)	0.05	0.05	318 - Housing & Homeless Incentive Program - UM Allocation *	0.06	0.04	(0.02)
0.05	0.07	0.02	319 - CalAIM Incentive Payment Program - UM Allocation *	0.04	0.07	0.03
0.13	0.18	0.06	601 - Behavioral Health - UM Allocation *	0.09	0.18	0.09
0.20	0.15	(0.06)	602 - Quality & Health Equity - UM Allocation *	0.16	0.15	(0.02)
0.19	0.00	(0.19)	604 - Clinical Operations, Straegy, and Analytics*	0.04	0.00	(0.04)
0.13	0.00	(0.13)	605 - Quality Performance*	0.02	0.00	(0.02)
5.89	4.19	(1.70)	Behavior Health Treatment	5.28	4.19	(1.09)
0.57	1.25	0.68	Mental Health Services	0.64	1.25	0.61
3.76	5.42	1.67	Other Professional Services	4.12	5.44	1.32
17.89	20.08	2.19	TOTAL OTHER PROFESSIONAL SERVICES	17.66	20.00	2.34
15.88	16.54	0.66	EMERGENCY ROOM	14.94	16.58	1.64
86.98	67.50	(19.48)	INPATIENT HOSPITAL	66.42	67.82	1.41
0.01	0.22	0.21	REINSURANCE EXPENSE PREMIUM	0.27	0.22	(0.05)
46.14	30.07	(16.07)	OUTPATIENT HOSPITAL SERVICES	32.37	30.04	(2.33)
			OTHER MEDICAL			
9.62	4.75	(4.87)	Ambulance and NEMT	7.19	4.75	(2.44)
2.43	2.88	0.45	Home Health Services & CBAS	2.13	2.89	0.76
3.19	4.65	1.46	Utilization and Quality Review Expenses	2.91	4.59	1.68
16.31	29.30	12.99	Long Term/SNF/Hospice	19.12	27.08	7.96
15.70	15.41	(0.30)	Provider Enhancement Expense - Prop. 56	15.71	15.41	(0.29)
2.54	1.45	(1.09)	Provider Enhancement Expense - GEMT	1.84	1.46	(0.38)
7.61	5.85	(1.76)	Enhanced Care Management	5.73	5.85	0.12
2.19	1.56	(0.63)	Major Organ Transplant	2.17	1.56	(0.61)
17.13	6.96	(10.16)	Cal AIM Incentive Programs	6.98	6.99	0.01
3.74	3.05	(0.69)	DME	3.79	3.06	(0.73)
80.45	75.86	(4.59)	TOTAL OTHER MEDICAL	67.56	73.66	6.09
1.50	1.50	(0.00)	PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	0.00
62.00	59.95	(2.05)	HOSPITAL DIRECTED PAYMENTS	61.78	60.40	(1.38)
(75.51)	0.00	75.51	HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(6.59)	0.00	6.59
4.52	0.00	(4.52)	NON-CLAIMS EXPENSE ADJUSTMENT	(0.01)	0.00	0.01
0.31	0.00	(0.31)	IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	(3.41)	0.00	3.41
295.12	333.47	38.35	Total Medical Costs	311.64	332.12	20.48

* Medical costs per DMHC regulations

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH FOR THE MONTH ENDED DECEMBER 31, 2023	JANUARY 2023	FEBRUARY 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
PHYSICIAN SERVICES						
Primary Care Physician Services	4,153,283	3,799,063	3,973,992	4,241,474	4,159,263	4,419,579
Referral Specialty Services	14,090,583	13,535,172	14,603,368	14,737,274	15,505,030	15,425,047
Urgent Care & After Hours Advise	2,048,906	1,845,306	2,061,385	2,274,974	2,073,703	2,041,968
Hospital Admitting Team	9,300	8,400	9,300	9,000	9,300	9,000
TOTAL PHYSICIAN SERVICES	20,302,072	19,187,941	20,648,045	21,262,722	21,747,296	21,895,594
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	332,837	342,049	345,365	351,010	353,005	355,915
221 - Business Intelligence - UM Allocation *	262,834	243,530	245,518	266,409	276,847	276,024
310 - Health Services - Utilization Management - UM Allocation *	555,681	539,746	572,464	475,795	521,721	872,799
311 - Health Services - Quality Improvement - UM Allocation *	284,682	284,411	334,968	276,552	241,613	226,739
312 - Health Services - Education - UM Allocation *	195,507	202,444	207,789	196,257	208,817	208,588
313 - Health Services - Pharmacy - UM Allocation *	83,674	85,448	79,846	73,351	78,358	73,856
314 - Enhanced Care Management - UM Allocation *	233,834	209,336	244,620	223,024	252,924	244,364
316 -Population Health Management - UM Allocation *	303,368	305,490	366,061	321,471	357,151	343,070
317 - Community Based Services - UM Allocation *	57,244	64,612	68,615	59,149	68,281	75,135
318 - Housing & Homeless Incentive Program - UM Allocation *	29,439	27,963	8,208	7,194	228	(76)
319 - CalAIM Incentive Payment Program - UM Allocation *	-	3,721	10,674	15,231	15,978	8,891
601 - Behavioral Health - UM Allocation *	-	-	21,314	21,307	12,237	43,136
602 - Quality & Health Equity - UM Allocation *	23,077	32,268	33,887	43,348	54,197	46,221
604 - Clinical Operations, Straegy, and Analytics*	-	-	-	-	-	-
605 - Quality Performance*	-	-	-	-	-	-
Behavior Health Treatment	1,234,423	1,340,804	1,751,711	1,545,908	2,409,753	2,090,128
Mental Health Services	378,598	277,029	277,573	229,037	195,793	258,806
Other Professional Services	1,518,707	1,454,787	1,498,555	1,615,756	1,596,694	1,714,577
TOTAL OTHER PROFESSIONAL SERVICES	5,493,905	5,413,638	6,067,168	5,720,799	6,643,597	6,838,173
EMERGENCY ROOM	5,195,994	4,633,288	5,199,635	5,262,548	5,131,679	5,555,164
INPATIENT HOSPITAL	22,641,712	21,804,027	22,997,133	23,980,922	21,382,030	19,096,686
REINSURANCE EXPENSE PREMIUM	90,859	180,937	94,363	94,773	95,311	96,097
OUTPATIENT HOSPITAL SERVICES	9,616,781	9,652,797	11,362,056	10,886,974	11,009,988	10,557,328
OTHER MEDICAL						
Ambulance and NEMT	1,792,123	1,754,080	2,159,726	2,210,825	2,254,991	2,412,744
Home Health Services & CBAS	970,272	809,536	996,283	547,188	451,622	374,989
Utilization and Quality Review Expenses	776,558	583,384	940,138	1,342,680	785,929	1,393,601
Long Term/SNF/Hospice	2,732,047	9,988,072	8,775,140	8,087,627	4,695,700	8,480,647
Provider Enhancement Expense - Prop. 56	5,430,893	5,482,690	5,503,401	5,566,537	5,561,460	5,630,380
Provider Enhancement Expense - GEMT	496,477	513,773	505,452	469,079	562,775	502,239
Enhanced Care Management	1,428,973	1,778,842	1,790,813	1,814,108	1,811,803	2,586,249
Major Organ Transplant	751,183	712,804	753,883	766,976	758,618	774,606
Cal AIM Incentive Programs	30,326	279,307	295,429	917,196	3,833,523	2,195,256
DME	1,119,968	1,108,882	1,320,219	1,226,194	1,435,049	1,275,704
TOTAL OTHER MEDICAL	15,528,820	23,011,370	23,040,484	22,948,410	22,151,470	25,626,415
PAY FOR PERFORMANCE QUALITY INCENTIVE	498,590	524,238	526,516	529,507	533,873	533,872
HOSPITAL DIRECTED PAYMENTS	21,209,673	21,515,947	21,609,701	21,948,157	21,792,771	22,188,234
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(684,297)	33,520	(869,333)	37,816	123,932	15,555
NON-CLAIMS EXPENSE ADJUSTMENT	(128,832)	3,429	72,961	177,517	(2,449,080)	3,040
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	9,076	32,166	(4,009,312)	(4,430,362)	(4,472,016)	(4,829,330)
Total Medical Costs	99,774,353	105,993,298	106,739,417	108,419,783	103,690,851	107,576,828

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH FOR THE MONTH ENDED DECEMBER 31, 2023	JULY 2023	AUGUST 2023	SEPTEMBER 2023	OCTOBER 2023	NOVEMBER 2023	DECEMBER 2023	YEAR TO DATE 2023
PHYSICIAN SERVICES							
Primary Care Physician Services	4,057,408	3,995,558	3,960,025	4,184,532	3,369,503	4,091,872	48,405,552
Referral Specialty Services	14,306,450	14,487,772	14,834,237	14,803,542	15,438,468	13,148,947	174,915,890
Urgent Care & After Hours Advise	2,114,951	2,126,819	2,508,710	1,660,494	2,441,621	1,909,854	25,108,691
Hospital Admitting Team	9,300	9,300	9,000	9,300	9,000	9,300	109,500
TOTAL PHYSICIAN SERVICES	20,488,109	20,619,449	21,311,972	20,657,868	21,258,592	19,159,973	248,539,633
OTHER PROFESSIONAL SERVICES							
Vision Service Capitation	355,915	358,101	355,222	357,871	338,549	344,282	4,190,121
221 - Business Intelligence - UM Allocation *	278,865	285,634	296,637	305,896	357,761	259,281	3,355,236
310 - Health Services - Utilization Management - UM Allocation *	573,715	611,666	589,366	1,021,727	488,149	584,297	7,407,126
311 - Health Services - Quality Improvement - UM Allocation *	206,718	227,323	446,819	375,132	276,744	219,720	3,401,421
312 - Health Services - Education - UM Allocation *	203,829	198,765	207,644	319,646	194,694	207,359	2,551,339
313 - Health Services - Pharmacy - UM Allocation *	77,186	72,378	76,140	125,186	74,590	71,806	971,819
314 - Enhanced Care Management - UM Allocation *	229,403	273,551	273,515	412,850	329,948	286,692	3,214,061
316 -Population Health Management - UM Allocation *	334,283	376,626	371,930	499,787	383,851	378,857	4,341,945
317 - Community Based Services - UM Allocation *	58,113	66,912	71,282	116,845	75,691	80,752	862,631
318 - Housing & Homeless Incentive Program - UM Allocation *	76	(153)	200,000	-	-	(20)	272,859
319 - CalAIM Incentive Payment Program - UM Allocation *	11,528	16,606	15,123	15,715	23,627	16,868	153,962
601 - Behavioral Health - UM Allocation *	34,331	44,857	42,393	46,136	59,153	44,807	369,671
602 - Quality & Health Equity - UM Allocation *	62,428	73,734	73,325	76,872	97,217	71,172	687,746
604 - Clinical Operations, Straegy, and Analytics*	-	-	-	-	101,997	65,689	167,686
605 - Quality Performance*	-	-	-	-	33,793	44,992	78,785
Behavior Health Treatment	1,277,790	2,543,178	1,969,644	1,543,818	2,405,891	2,052,611	22,165,659
Mental Health Services	246,684	204,118	209,930	162,248	66,327	199,971	2,706,114
Other Professional Services	1,492,287	1,477,408	1,192,117	1,022,958	1,431,309	1,310,050	17,325,205
TOTAL OTHER PROFESSIONAL SERVICES	5,443,151	6,830,704	6,391,087	6,402,687	6,739,291	6,239,186	74,223,386
EMERGENCY ROOM	4,984,270	5,600,554	5,694,566	5,063,129	4,921,226	5,539,233	62,781,286
INPATIENT HOSPITAL	22,316,634	20,877,596	24,726,100	25,452,067	23,460,211	30,332,453	279,067,571
REINSURANCE EXPENSE PREMIUM	96,097	96,688	95,910	96,625	91,410	2,098	1,131,168
OUTPATIENT HOSPITAL SERVICES	10,233,407	10,613,553	11,158,217	12,146,983	12,702,928	16,089,590	136,030,602
OTHER MEDICAL							
Ambulance and NEMT	2,238,756	2,359,014	3,325,205	2,757,669	3,590,318	3,353,558	30,209,009
Home Health Services & CBAS	586,872	916,002	721,387	612,929	1,114,894	845,801	8,947,775
Utilization and Quality Review Expenses	788,697	2,133,022	668,619	1,481,065	220,777	1,113,241	12,227,711
Long Term/SNF/Hospice	6,335,360	3,942,751	9,336,639	6,249,427	6,042,894	5,687,565	80,353,869
Provider Enhancement Expense - Prop. 56	5,547,690	5,566,967	5,521,458	5,414,023	5,288,536	5,475,775	65,989,810
Provider Enhancement Expense - GEMT	899,077	868,900	684,302	675,052	660,172	886,031	7,723,329
Enhanced Care Management	1,717,288	2,733,244	1,974,662	1,512,905	2,259,826	2,654,725	24,063,438
Major Organ Transplant	765,681	770,746	817,599	755,216	733,477	762,346	9,123,135
Cal AIM Incentive Programs	2,372,608	2,549,680	2,057,802	2,587,965	6,238,961	5,972,483	29,330,536
DME	1,348,779	1,550,660	1,288,687	1,435,048	1,508,410	1,303,538	15,921,138
TOTAL OTHER MEDICAL	22,600,808	23,390,986	26,396,360	23,481,299	27,658,265	28,055,063	283,889,750
PAY FOR PERFORMANCE QUALITY INCENTIVE	535,512	534,172	529,365	513,772	518,382	523,082	6,300,881
HOSPITAL DIRECTED PAYMENTS	21,822,439	21,933,791	21,801,472	21,376,726	20,754,284	21,621,168	259,574,363
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(15,187)	426,925	(423,787)	4,263	(2,586)	(26,331,918)	(27,685,097)
NON-CLAIMS EXPENSE ADJUSTMENT	639,578	3,672	52,429	(4,730)	(662)	1,576,733	(53,945)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	707,021	438,520	701,159	614,589	784,814	106,835	(14,346,840)
Total Medical Costs	109,851,839	111,366,610	118,434,850	115,805,278	118,886,155	102,913,496	1,309,452,758

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM FOR THE MONTH ENDED DECEMBER 31, 2023	JANUARY 2023	FEBRUARY 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
PHYSICIAN SERVICES						
Primary Care Physician Services	12.50	10.87	11.32	12.02	11.69	12.38
Referral Specialty Services	42.39	38.73	41.60	41.75	43.56	43.21
Urgent Care & After Hours Advise	6.16	5.28	5.87	6.44	5.83	5.72
Hospital Admitting Team	0.03	0.02	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	61.08	54.90	58.82	60.23	61.10	61.33
OTHER PROFESSIONAL SERVICES						
Vision Service Capitation	1.00	0.98	0.98	0.99	0.99	1.00
221 - Business Intelligence - UM Allocation *	0.79	0.70	0.70	0.75	0.78	0.77
310 - Health Services - Utilization Management - UM Allocation *	1.67	1.54	1.63	1.35	1.47	2.44
311 - Health Services - Quality Improvement - UM Allocation *	0.86	0.81	0.95	0.78	0.68	0.64
312 - Health Services - Education - UM Allocation *	0.59	0.58	0.59	0.56	0.59	0.58
313 - Health Services - Pharmacy - UM Allocation *	0.25	0.24	0.23	0.21	0.22	0.21
314 - Enhanced Care Management - UM Allocation *	0.70	0.60	0.70	0.63	0.71	0.68
316 -Population Health Management - UM Allocation *	0.91	0.87	1.04	0.91	1.00	0.96
317 - Community Based Services - UM Allocation *	0.17	0.18	0.20	0.17	0.19	0.21
318 - Housing & Homeless Incentive Program - UM Allocation *	0.09	0.08	0.02	0.02	0.00	(0.00)
319 - CalAIM Incentive Payment Program - UM Allocation *	0.00	0.01	0.03	0.04	0.04	0.02
601 - Behavioral Health - UM Allocation *	0.00	0.00	0.06	0.06	0.03	0.12
602 - Quality & Health Equity - UM Allocation *	0.07	0.09	0.10	0.12	0.15	0.13
604 - Clinical Operations, Straegy, and Analytics*	0.00	0.00	0.00	0.00	0.00	0.00
605 - Quality Performance*	0.00	0.00	0.00	0.00	0.00	0.00
Behavior Health Treatment	3.71	3.84	4.99	4.38	6.77	5.85
Mental Health Services	1.14	0.79	0.79	0.65	0.55	0.72
Other Professional Services	4.57	4.16	4.27	4.58	4.49	4.80
TOTAL OTHER PROFESSIONAL SERVICES	16.53	15.49	17.28	16.21	18.67	19.15
EMERGENCY ROOM	15.63	13.26	14.81	14.91	14.42	15.56
INPATIENT HOSPITAL	68.12	62.39	65.52	67.93	60.08	53.49
REINSURANCE EXPENSE PREMIUM	0.27	0.52	0.27	0.27	0.27	0.27
OUTPATIENT HOSPITAL SERVICES	28.93	27.62	32.37	30.84	30.93	29.57
OTHER MEDICAL						
Ambulance and NEMT	5.39	5.02	6.15	6.26	6.34	6.76
Home Health Services & CBAS	2.92	2.32	2.84	1.55	1.27	1.05
Utilization and Quality Review Expenses	2.34	1.67	2.68	3.80	2.21	3.90
Long Term/SNF/Hospice	8.22	28.58	25.00	22.91	13.19	23.75
Provider Enhancement Expense - Prop. 56	16.34	15.69	15.68	15.77	15.63	15.77
Provider Enhancement Expense - GEMT	1.49	1.47	1.44	1.33	1.58	1.41
Vaccine Incentive Program Expense	0.00	0.00	0.00	0.00	0.00	0.00
Behaviorial Health Integration Program	0.00	0.00	0.00	0.00	0.00	0.00
Enhanced Care Management	4.30	5.09	5.10	5.14	5.09	7.24
Major Organ Transplant	2.26	2.04	2.15	2.17	2.13	2.17
Cal AIM Incentive Programs	0.09	0.80	0.84	2.60	10.77	6.15
DME	3.37	3.17	3.76	3.47	4.03	3.57
TOTAL OTHER MEDICAL	46.72	65.84	65.64	65.01	62.24	71.78
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.50	1.50	1.50	1.50	1.50	1.50
HOSPITAL DIRECTED PAYMENTS	63.81	61.56	61.56	62.18	61.23	62.15
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(2.06)	0.10	(2.48)	0.11	0.35	0.04
NON-CLAIMS EXPENSE ADJUSTMENT	(0.39)	0.01	0.21	0.50	(6.88)	0.01
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	0.03	0.09	(11.42)	(12.55)	(12.56)	(13.53)
Total Medical Costs	300.18	303.28	304.09	307.13	291.34	301.33

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF MEDICAL COSTS BY MONTH - PMPM FOR THE MONTH ENDED DECEMBER 31, 2023	JULY 2023	AUGUST 2023	SEPTEMBER 2023	OCTOBER 2023	NOVEMBER 2023	DECEMBER 2023	YEAR TO DATE 2023
PHYSICIAN SERVICES							
Primary Care Physician Services	11.41	11.20	11.25	12.15	9.75	11.73	11.52
Referral Specialty Services	40.25	40.60	42.14	43.00	44.67	37.71	41.63
Urgent Care & After Hours Advise	5.95	5.96	7.13	4.82	7.07	5.48	5.98
Hospital Admitting Team	0.03	0.03	0.03	0.03	0.03	0.03	0.03
TOTAL PHYSICIAN SERVICES	57.64	57.78	60.54	60.00	61.51	54.94	59.15
OTHER PROFESSIONAL SERVICES							
Vision Service Capitation	1.00	1.00	1.01	1.04	0.98	0.99	1.00
221 - Business Intelligence - UM Allocation *	0.78	0.80	0.84	0.89	1.04	0.74	0.80
310 - Health Services - Utilization Management - UM Allocation *	1.61	1.71	1.67	2.97	1.41	1.68	1.76
311 - Health Services - Quality Improvement - UM Allocation *	0.58	0.64	1.27	1.09	0.80	0.63	0.81
312 - Health Services - Education - UM Allocation *	0.57	0.56	0.59	0.93	0.56	0.59	0.61
313 - Health Services - Pharmacy - UM Allocation *	0.22	0.20	0.22	0.36	0.22	0.21	0.23
314 - Enhanced Care Management - UM Allocation *	0.65	0.77	0.78	1.20	0.95	0.82	0.76
316 -Population Health Management - UM Allocation *	0.94	1.06	1.06	1.45	1.11	1.09	1.03
317 - Community Based Services - UM Allocation *	0.16	0.19	0.20	0.34	0.22	0.23	0.21
318 - Housing & Homeless Incentive Program - UM Allocation *	0.00	(0.00)	0.57	0.00	0.00	(0.00)	0.06
319 - CalAIM Incentive Payment Program - UM Allocation *	0.03	0.05	0.04	0.05	0.07	0.05	0.04
601 - Behavioral Health - UM Allocation *	0.10	0.13	0.12	0.13	0.17	0.13	0.09
602 - Quality & Health Equity - UM Allocation *	0.18	0.21	0.21	0.22	0.28	0.20	0.16
604 - Clinical Operations, Straegy, and Analytics*	0.00	0.00	0.00	0.00	0.30	0.19	0.04
605 - Quality Performance*	0.00	0.00	0.00	0.00	0.10	0.13	0.02
Behavior Health Treatment	3.59	7.13	5.59	4.48	6.96	5.89	5.28
Mental Health Services	0.69	0.57	0.60	0.47	0.19	0.57	0.64
Other Professional Services	4.20	4.14	3.39	2.97	4.14	3.76	4.12
TOTAL OTHER PROFESSIONAL SERVICES	15.31	19.14	18.15	18.60	19.50	17.89	17.66
EMERGENCY ROOM	14.02	15.69	16.18	14.71	14.24	15.88	14.94
INPATIENT HOSPITAL	62.78	58.50	70.24	73.93	67.88	86.98	66.42
REINSURANCE EXPENSE PREMIUM	0.27	0.27	0.27	0.28	0.26	0.01	0.27
OUTPATIENT HOSPITAL SERVICES	28.79	29.74	31.70	35.28	36.76	46.14	32.37
OTHER MEDICAL							
Ambulance and NEMT	6.30	6.61	9.45	8.01	10.39	9.62	7.19
Home Health Services & CBAS	1.65	2.57	2.05	1.78	3.23	2.43	2.13
Utilization and Quality Review Expenses	2.22	5.98	1.90	4.30	0.64	3.19	2.91
Long Term/SNF/Hospice	17.82	11.05	26.52	18.15	17.49	16.31	19.12
Provider Enhancement Expense - Prop. 56	15.61	15.60	15.68	15.73	15.30	15.70	15.71
Provider Enhancement Expense - GEMT	2.53	2.43	1.94	1.96	1.91	2.54	1.84
Vaccine Incentive Program Expense	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Behaviorial Health Integration Program	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Enhanced Care Management	4.83	7.66	5.61	4.39	6.54	7.61	5.73
Major Organ Transplant	2.15	2.16	2.32	2.19	2.12	2.19	2.17
Cal AIM Incentive Programs	6.67	7.14	5.85	7.52	18.05	17.13	6.98
DME	3.79	4.35	3.66	4.17	4.36	3.74	3.79
TOTAL OTHER MEDICAL	63.58	65.54	74.98	68.20	80.03	80.45	67.56
PAY FOR PERFORMANCE QUALITY INCENTIVE	1.51	1.50	1.50	1.49	1.50	1.50	1.50
HOSPITAL DIRECTED PAYMENTS	61.39	61.46	61.93	62.09	60.05	62.00	61.78
HOSPITAL DIRECTED PAYMENT ADJUSTMENT	(0.04)	1.20	(1.20)	0.01	(0.01)	(75.51)	(6.59)
NON-CLAIMS EXPENSE ADJUSTMENT	1.80	0.01	0.15	(0.01)	(0.00)	4.52	(0.01)
IBNR, INCENTIVE, AND PAID CLAIMS ADJUSTMENT	1.99	1.23	1.99	1.79	2.27	0.31	(3.41)
Total Medical Costs	309.05	312.06	336.43	336.37	344.01	295.12	311.64

KERN HEALTH SYSTEMS
MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED DECEMBER 31, 2023

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
720,433	503,778	(216,655)	110 - Executive	7,487,553	6,120,367	(1,367,186)
261,717	269,724	8,007	210 - Accounting	3,089,070	3,236,693	147,623
271,674	388,290	116,616	220 - Management Information Systems	4,131,362	4,659,478	528,116
32,405	26,642	(5,763)	221 - Business Intelligence	466,671	319,694	(146,977)
402,342	421,256	18,914	222 - Enterprise Development	4,620,182	5,055,071	434,889
200,987	201,164	177	223 - Enterprise Configuration	2,069,153	2,413,968	344,815
867,405	675,880	(191,525)	225 - Infrastructure	7,961,175	8,110,553	149,378
627,569	690,414	62,845	230 - Claims	8,004,852	8,284,959	280,107
323,256	272,021	(51,235)	240 - Project Management	3,302,904	3,264,244	(38,660)
117,347	145,307	27,960	310 - Health Services - Utilization Management	2,119,282	1,743,684	(375,598)
282	51,625	51,343	311 - Health Services - Quality Improvement	8,403	619,500	611,097
-	143	143	312 - Health Services - Education	231	1,716	1,485
26,445	70,663	44,218	313- Pharmacy	529,117	847,956	318,839
7,262	3,292	(3,970)	314 - Enhanced Care Management	36,762	39,504	2,742
78,994	78,415	(579)	316 -Population Health Management	900,261	940,980	40,719
-	1,218	1,218	317 - Community Based Services	767	14,616	13,849
-	31,941	31,941	318 - Housing & Homeless Incentive Program	-	383,292	383,292
-	134,370	134,370	319 - CAL AIM Incentive Payment Program (IPP)	461,580	1,612,440	1,150,860
-	947	947	601 - Behavioral Health	-	11,364	11,364
525	4,315	3,790	602 - Quality & Health Equity	21,801	51,780	29,979
	-	-	604 - Clinical Operations, Straegy, and Analytics	-	-	-
	-	-	605 - Quality Performance	-	-	-
330,212	345,411	15,199	320 - Provider Network Management	4,209,018	4,144,932	(64,086)
1,257,257	1,205,474	(51,783)	330 - Member Services	12,148,136	14,465,687	2,317,551
930,872	871,256	(59,616)	340 - Corporate Services	11,272,773	10,455,072	(817,701)
182,380	145,475	(36,905)	360 - Audit & Investigative Services	2,076,613	1,745,700	(330,913)
136,723	56,416	(80,307)	410 - Member Engagement	1,078,435	676,992	(401,443)
155,476	210,572	55,096	420 - Sales/Marketing/Public Relations	2,234,047	2,526,864	292,817
62,424	361,965	299,541	510 - Human Resourses	4,092,591	4,343,580	250,989
1,580,392	(141,666)	(1,722,058)	Administrative Expense Adjustment	3,727,294	(1,700,000)	(5,427,294)
8,574,379	7,026,308	(1,548,071)	Total Administrative Expenses	86,050,034	84,390,686	(1,659,348)

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED DECEMBER 31, 2023	JANUARY 2023	FEBRUARY 2023	MARCH 2023	APRIL 2023	MAY 2023	JUNE 2023
110 - Executive	687,266	488,878	631,414	573,435	605,342	763,935
210 - Accounting	228,231	226,501	220,815	257,429	255,614	247,295
220 - Management Information Systems (MIS)	365,046	378,747	348,807	339,302	365,330	355,130
221 - Business Intelligence	63,805	672	10,109	15,308	26,942	22,540
222 - Enterprise Development	353,608	328,061	331,145	334,228	376,413	412,669
223 - Enterprise Configuration	104,241	216,683	121,896	146,738	136,105	171,714
225 - Infrastructure	412,631	771,628	668,401	676,609	498,225	515,544
230 - Claims	620,932	609,445	645,581	630,955	672,659	645,714
240 - Project Management	140,118	191,244	253,669	237,154	320,496	264,636
310 - Health Services - Utilization Management	194,388	186,938	208,456	255,118	260,301	(106,448)
311 - Health Services - Quality Improvement	89	90	(97)	1,758	598	783
312 - Health Services - Education	88	297	(8)	417	89	385
313- Pharmacy	39,747	39,846	37,420	25,750	36,574	122,778
314 - Enhanced Care Management	475	20,697	(112)	7,231	(223)	829
316 -Population Health Management	62,921	63,361	75,452	67,203	74,045	71,685
317 - Community Based Services	165	821	(711)	22	5	29
318 - Housing & Homeless Incentive Program	-	1,200	(1,185)	6	6	23
319 - CAL AIM Incentive Payment Program (IPP)	-	84,699	51,654	42,927	-	97,232
601 - Behavioral Health	-	-	-	-	11,639	(11,571)
602 - Quality & Health Equity	-	1,665	-	-	(1,665)	194
320 - Provider Network Management	317,123	285,888	388,095	306,789	329,256	327,933
330 - Member Services	802,035	804,897	998,660	856,559	908,944	1,002,188
340 - Corporate Services	892,136	958,999	902,329	890,795	984,437	921,752
360 - Audit & Investigative Services	138,360	130,101	142,110	145,775	140,250	157,915
410 - Member Engagement	68,972	61,237	45,193	56,083	69,262	27,762
420 - Sales/Marketing/Public Relations	60,714	98,793	207,085	121,647	169,876	370,758
510 - Human Resourses	362,364	315,305	331,059	346,987	344,312	379,592
Total Department Expenses	5,915,456	6,266,693	6,617,237	6,336,225	6,584,832	6,762,996
ADMINISTRATIVE EXPENSE ADJUSTMENT	109,675	301,496	320,296	300,000	300,950	501,326
Total Administrative Expenses	6,025,131	6,568,189	6,937,533	6,636,225	6,885,782	7,264,322

KERN HEALTH SYSTEMS MEDI-CAL SCHEDULE OF ADMIN EXPENSES BY DEPT BY MONTH FOR THE MONTH ENDED DECEMBER 31, 2023	JULY 2023	AUGUST 2023	SEPTEMBER 2023	OCTOBER 2023	NOVEMBER 2023	DECEMBER 2023	YEAR TO DATE 2023
110 - Executive	537,480	554,501	589,441	615,688	719,740	720,433	7,487,553
210 - Accounting	254,446	260,708	241,094	298,742	336,478	261,717	3,089,070
220 - Management Information Systems (MIS)	300,962	346,145	309,488	341,003	409,728	271,674	4,131,362
221 - Business Intelligence	(10,946)	55,044	10,407	33,085	207,300	32,405	466,671
222 - Enterprise Development	370,744	410,421	413,359	419,658	467,534	402,342	4,620,182
223 - Enterprise Configuration	181,934	171,194	164,140	202,802	250,719	200,987	2,069,153
225 - Infrastructure	851,074	671,727	761,903	578,661	687,367	867,405	7,961,175
230 - Claims	601,430	591,293	676,078	742,776	940,420	627,569	8,004,852
240 - Project Management	198,543	275,339	319,567	378,484	400,398	323,256	3,302,904
310 - Health Services - Utilization Management	180,999	179,406	206,469	178,405	257,903	117,347	2,119,282
311 - Health Services - Quality Improvement	471	(1,012)	(336)	76	5,701	282	8,403
312 - Health Services - Education	262	(1,093)	(206)	-	-	-	231
313- Pharmacy	37,659	35,247	37,033	54,125	36,493	26,445	529,117
314 - Enhanced Care Management	366	(1,236)	882	277	314	7,262	36,762
316 -Population Health Management	69,897	76,157	76,989	103,493	80,064	78,994	900,261
317 - Community Based Services	209	(162)	-	1,663	(1,274)	-	767
318 - Housing & Homeless Incentive Program	25	(75)	-	-	-	-	-
319 - CAL AIM Incentive Payment Program (IPP)	45,332	9,851	110,045	72,320	(52,480)	-	461,580
601 - Behavioral Health	-	(68)	-	-	-	-	-
602 - Quality & Health Equity	20	(41)	20,083	403	617	525	21,801
320 - Provider Network Management	362,501	357,061	338,081	379,808	486,271	330,212	4,209,018
330 - Member Services	960,300	1,041,329	989,617	968,800	1,557,550	1,257,257	12,148,136
340 - Corporate Services	943,747	1,018,956	926,670	879,023	1,023,057	930,872	11,272,773
360 - Audit & Investigative Services	171,929	191,794	194,623	243,004	238,372	182,380	2,076,613
410 - Member Engagement	78,964	113,512	141,555	94,610	184,562	136,723	1,078,435
420 - Sales/Marketing/Public Relations	119,606	255,433	254,996	213,868	205,795	155,476	2,234,047
510 - Human Resourses	445,841	332,855	369,133	358,201	444,518	62,424	4,092,591
Total Department Expenses	6,703,795	6,944,286	7,151,111	7,158,975	8,887,147	6,993,987	82,322,740
ADMINISTRATIVE EXPENSE ADJUSTMENT	300,183	12,969	267	-	(260)	1,580,392	3,727,294
Total Administrative Expenses	7,003,978	6,957,255	7,151,378	7,158,975	8,886,887	8,574,379	86,050,034

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

ASSETS	DECEMBER 2023	NOVEMBER 2023	INC(DEC)
CURRENT ASSETS:			
Cash and Cash Equivalents	$ 1,171,884	$ 1,163,609	8,275
Interest Receivable	11,795	6,000	5,795
TOTAL CURRENT ASSETS	$ 1,183,679	$ 1,169,609	$ 14,070
LIABILITIES AND NET POSITION			
CURRENT LIABILITIES:			
Other Liabilities	-	-	-
TOTAL CURRENT LIABILITIES	$ -	$ -	$ -
NET POSITION:			
Net Position- Beg. of Year	1,130,625	1,130,625	-
Increase (Decrease) in Net Position - Current Year	53,054	38,984	14,070
Total Net Position	$ 1,183,679	$ 1,169,609	$ 14,070
TOTAL LIABILITIES AND NET POSITION	$ 1,183,679	$ 1,169,609	$ 14,070

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

CURRENT MONTH				YEAR-TO-DATE		
ACTUAL	BUDGET	VARIANCE		ACTUAL	BUDGET	VARIANCE
			ENROLLMENT			
-	-	-	Members	-	-	-
			REVENUES			
-	-	-	Premium	-	-	-
5,795	-	5,795	Interest	39,081	-	39,081
8,275	-	8,275	Other Investment Income	13,973	-	13,973
14,070	-	14,070	TOTAL REVENUES	53,054	-	53,054
			EXPENSES			
			Medical Costs			
-	-	-	IBNR and Paid Claims Adjustment	-	-	-
-	-	-	Total Medical Costs	-	-	-
14,070	-	14,070	GROSS MARGIN	53,054	-	53,054
			Administrative			
-	-	-	Management Fee Expense and Other Admin Exp	-	-	-
-	-	-	Total Administrative Expenses	-	-	-
-	-	-	TOTAL EXPENSES	-	-	-
14,070	-	14,070	OPERATING INCOME (LOSS)	53,054	-	53,054
-	-	-	TOTAL NONOPERATING REVENUE (EXPENSES)	-	-	-
14,070	-	14,070	NET INCREASE (DECREASE) IN NET POSITION	53,054	-	53,054
0%	0%	0%	MEDICAL LOSS RATIO	0%	0%	0%
0%	0%	0%	ADMINISTRATIVE EXPENSE RATIO	0%	0%	0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2023 MEMBER MONTHS	JAN'23	FEB'23	MAR'23	APR'23	MAY'23	JUN'23	JULY'23	AUG'23	SEPT'23	OCT'23	NOV'23	DEC'23
ADULT AND FAMILY													
ADULT	**783,970**	58,409	65,757	66,276	66,418	67,971	67,525	66,503	67,740	65,809	64,032	63,616	63,914
CHILD	**1,753,298**	149,881	145,505	145,753	146,329	146,573	147,108	146,933	146,846	145,234	143,582	143,966	145,588
SUB-TOTAL ADULT & FAMILY	**2,537,268**	**208,290**	**211,262**	**212,029**	**212,747**	**214,544**	**214,633**	**213,436**	**214,586**	**211,043**	**207,614**	**207,582**	**209,502**
OTHER MEMBERS													
PARTIAL DUALS - FAMILY	**9,744**	851	875	903	822	853	818	837	787	756	740	800	702
PARTIAL DUALS - CHILD	**0**	0	0	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	**120**	6	10	10	10	16	11	12	10	8	9	8	10
FULL DUALS (SPD)													
SPD FULL DUALS	**245,045**	9,649	20,632	21,019	21,092	21,349	21,374	21,218	21,406	21,540	21,551	21,855	22,360
SUBTOTAL OTHER MEMBERS	**254,909**	**10,506**	**21,517**	**21,932**	**21,924**	**22,218**	**22,203**	**22,067**	**22,203**	**22,304**	**22,300**	**22,663**	**23,072**
TOTAL FAMILY & OTHER	**2,792,177**	**218,796**	**232,779**	**233,961**	**234,671**	**236,762**	**236,836**	**235,503**	**236,789**	**233,347**	**229,914**	**230,245**	**232,574**
SPD													
SPD (AGED AND DISABLED)	**220,960**	17,442	18,453	18,522	18,599	18,398	18,515	18,518	18,448	18,443	18,180	18,398	19,044
MEDI-CAL EXPANSION													
ACA Expansion Adult-Citizen	**1,163,977**	94,512	96,241	96,427	97,590	98,512	99,338	99,216	99,510	98,130	94,244	95,031	95,226
ACA Expansion Duals	**20,140**	1,637	1,613	1,703	1,746	1,842	1,908	1,809	1,716	1,720	1,539	1,486	1,421
SUB-TOTAL MED-CAL EXPANSION	**1,184,117**	**96,149**	**97,854**	**98,130**	**99,336**	**100,354**	**101,246**	**101,025**	**101,226**	**99,850**	**95,783**	**96,517**	**96,647**
LONG TERM CARE (LTC)													
LTC	**364**	27	-1	33	34	35	38	35	35	40	24	29	35
LTC DUALS	**4,158**	0	380	364	365	366	373	367	383	359	381	399	421
TOTAL LTC	**4,522**	**27**	**379**	**397**	**399**	**401**	**411**	**402**	**418**	**399**	**405**	**428**	**456**
TOTAL KAISER	**186,108**	**14,759**	**14,960**	**15,308**	**15,562**	**15,699**	**15,881**	**15,869**	**15,966**	**15,838**	**15,617**	**15,423**	**15,226**
TOTAL MEDI-CAL MEMBERS	**4,387,884**	**347,173**	**364,425**	**366,318**	**368,567**	**371,614**	**372,889**	**371,317**	**372,847**	**367,877**	**359,899**	**361,011**	**363,947**

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

SUBJECT: January 2024 Financial Results

DATE: April 18, 2024

The January results reflect a $2,616,800 Net Increase in Net Position which is a $1,813,579 favorable variance to the budget. Listed below are the major variances for the month:

1) Total Revenues reflect a $6.6 million unfavorable variance primarily due to:

   A) $1.1 million unfavorable variance in Premium Revenue primarily due to unfavorable **timing differences** on waiting for DHCS approval under the CalAim Incentive Payment Program and the Student Behavioral Health Incentive Program.

   B) $7.3 million unfavorable variance in MCO Tax Premium primarily due to receiving revised MCO Tax information from DHCS offset against a favorable variance included in the MCO Tax Expense line item on the Income Statement for the same amount.

   C) $1.3 million favorable variance in Premium-Hospital Directed Payments primarily due to receiving updated rate information from DHCS offset against amounts included in 2D below.

2) Total Medical Costs reflect a $.3 million favorable variance primarily due to:

   A) $2.2 million favorable variance in Other Professional Services primarily due to the timing of hiring 2024 Budgeted Utilization Management Employees during the first quarter of 2024.

   B) $1.0 million unfavorable variance in Inpatient primarily due to higher-than-expected utilization during the month of January by SPD members.

   C) $.7 million favorable variance in Other Medical primarily due to timing differences relating to issuing member incentive gift cards.

   D) $1.3 million unfavorable variance in Hospital Directed Payments primarily due to receiving updated rate information offset against amounts included in 1C above.

The January Medical Loss Ratio is 91.5% which is favorable to the 92.3% budgeted amount. The January Administrative Expense Ratio is 5.9% which is slightly unfavorable to the 5.7% budgeted amount.

Financial Packet
January 2024

KHS – Medi-Cal Line of Business

KHS Group Health Plan – Healthy Families Line of Business

KHS Administrative Analysis and Other Reporting

MEDI-CAL
STATEMENT OF NET POSITION
AS OF JANUARY 31, 2024

ASSETS	January	December	Increase/ (Decrease)
Cash and Cash Equivalents	190,265,601	115,782,242	74,483,359
Short-Term Investments	309,754,179	406,068,694	(96,314,515)
Premiums Receivable	105,661,795	76,374,079	29,287,715
Premiums Receivable - MCO Tax	405,475,994	360,000,786	45,475,208
Premiums Receivable - Hospital Directed Payments	486,352,051	462,027,514	24,324,537
Interest Receivable	138,013	413,845	(275,832)
Provider Advance Payment	537,974	544,248	(6,274)
Other Receivables	1,362,944	1,301,396	61,548
Prepaid Expenses & Other Current Assets	7,723,254	6,561,514	1,161,739
Total Current Assets	1,507,271,804	1,429,074,318	78,197,485
Land	4,090,706	4,090,706	-
Furniture and Equipment - Net	1,048,794	1,017,404	31,390
Computer Equipment - Net	20,242,666	18,637,824	1,604,842
Building and Improvements - Net	33,123,383	33,101,870	21,513
Capital Projects In Process	882,182	2,295,294	(1,413,113)
Total Capital Assets	59,387,731	59,143,099	244,633
Restricted Assets	300,000	300,000	-
Officer Life Insurance Receivables	1,653,788	1,653,788	-
Total Long-Term Assets	1,953,788	1,953,788	-
Deferred Outflow of Resources	8,425,634	8,425,634	-
Total Assets and Deferred Outflows of Resources	1,577,038,957	1,498,596,839	78,442,118
CURRENT LIABILITIES			
Accrued Salaries and Benefits	6,352,760	5,609,620	743,140
Accrued Other Operating Expenses	5,882,262	5,966,734	(84,472)
MCO Tax Payable	415,975,589	376,495,887	39,479,703
Claims Payable (Reported)	14,580,120	18,170,423	(3,590,303)
IBNR - Inpatient Claims	70,678,932	67,512,856	3,166,077
IBNR - Physician Claims	21,088,370	20,579,692	508,678
IBNR - Accrued Other Medical	36,655,966	35,468,070	1,187,896
Risk Pool and Withholds Payable	5,507,584	6,253,771	(746,187)
Allowance for Claims Processing Expense	3,776,682	3,776,682	-
Other Liabilities	114,259,697	103,723,449	10,536,248
Accrued Hospital Directed Payments	486,352,051	462,027,514	24,324,537
Total Current Liabilities	1,181,110,013	1,105,584,695	75,525,318
NONCURRENT LIABILITIES			
Net Pension Liability	12,965,462	12,665,462	300,000
Total NonCurrent Liabilities	12,965,462	12,665,462	300,000
Deferred Inflow of Resources	158,303	158,303	-
NET POSITION:			
Net Position at Beginning of Year	380,188,379	318,756,311	61,432,068
Increase (Decrease) in Net Position - Current Year	2,616,800	61,432,068	(58,815,268)
Total Net Position	382,805,179	380,188,379	2,616,800
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION	1,577,038,957	1,498,596,839	78,442,118

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Budget	Variance	Year to date Month 1	Budget	Variance
Family Members	242,848	253,144	(10,296)	242,848	253,144	(10,296)
Expansion Members	117,232	117,811	(579)	117,232	117,811	(579)
SPD Members	21,942	20,927	1,015	21,942	20,927	1,015
LTC Members	489	555	(66)	489	555	(66)
Other Members	22,324	24,164	(1,840)	22,324	24,164	(1,840)
Total Members - MCAL	404,835	416,600	(11,765)	404,835	416,600	(11,765)
REVENUES						
Medicaid - Family and Other	53,027,216	54,523,713	(1,496,497)	53,027,216	54,523,713	(1,496,497)
Medicaid - Expansion Members	46,811,852	47,288,398	(476,546)	46,811,852	47,288,398	(476,546)
Medicaid - SPD Members	23,417,694	22,008,125	1,409,569	23,417,694	22,008,125	1,409,569
Medicaid - LTC Members	3,975,666	4,470,309	(494,642)	3,975,666	4,470,309	(494,642)
Premium - MCO Tax	39,388,230	46,650,868	(7,262,638)	39,388,230	46,650,868	(7,262,638)
Premium - Hospital Directed Payments	24,282,372	22,944,345	1,338,026	24,282,372	22,944,345	1,338,026
Investment Earnings And Other Income	2,539,805	2,137,284	402,521	2,539,805	2,137,284	402,521
Reinsurance Recoveries	-	116,648	(116,648)	-	116,648	(116,648)
Rate Adjustments - Hospital Directed Payments	42,165	-	42,165	42,165	-	42,165
Rate/Income Adjustments	83,075	-	83,075	83,075	-	83,075
Total Revenues	193,568,075	200,139,691	(6,571,615)	193,568,075	200,139,691	(6,571,615)
EXPENSES						
MEDICAL COSTS						
Physician Services	30,082,718	30,313,724	231,006	30,082,718	30,313,724	231,006
Other Professional Services	13,699,554	15,895,218	2,195,664	13,699,554	15,895,218	2,195,664
Emergency Room	6,905,833	6,760,402	(145,432)	6,905,833	6,760,402	(145,432)
Inpatient	30,185,040	29,181,341	(1,003,700)	30,185,040	29,181,341	(1,003,700)
Reinsurance Expense	96,765	116,648	19,883	96,765	116,648	19,883
Outpatient Hospital	13,495,747	13,468,482	(27,265)	13,495,747	13,468,482	(27,265)
Other Medical	23,466,463	24,184,348	717,885	23,466,463	24,184,348	717,885
Pay for Performance Quality Incentive	607,242	624,900	17,658	607,242	624,900	17,658
Hospital Directed Payments	24,282,372	22,944,345	(1,338,026)	24,282,372	22,944,345	(1,338,026)
Hospital Directed Payment Adjustment	42,165	-	(42,165)	42,165	-	(42,165)
Non-Claims Expense Adjustment	141,502	-	(141,502)	141,502	-	(141,502)
IBNR, Incentive, Paid Claims Adjustment	164,572	-	(164,572)	164,572	-	(164,572)
Total Medical Costs	143,169,973	143,489,408	319,434	143,169,973	143,489,408	319,434
GROSS MARGIN	50,398,102	56,650,283	(6,252,181)	50,398,102	56,650,283	(6,252,181)
ADMINISTRATIVE COSTS						
Compensation	3,586,265	4,098,286	512,021	3,586,265	4,098,286	512,021
Purchased Services	2,026,416	1,739,891	(286,525)	2,026,416	1,739,891	(286,525)
Supplies	354,637	372,344	17,708	354,637	372,344	17,708
Depreciation	725,712	710,921	(14,791)	725,712	710,921	(14,791)
Other Administrative Expenses	663,019	554,843	(108,176)	663,019	554,843	(108,176)
Administrative Expense Adjustment	258,024	-	(258,024)	258,024	-	(258,024)
Total Administrative Expenses	7,614,072	7,476,286	(137,787)	7,614,072	7,476,286	(137,787)
TOTAL EXPENSES	150,784,046	150,965,693	181,647	150,784,046	150,965,693	181,647
OPERATING INCOME (LOSS) BEFORE TAX	42,784,029	49,173,997	(6,389,968)	42,784,029	49,173,997	(6,389,968)
MCO TAX	39,388,230	46,650,868	7,262,638	39,388,230	46,650,868	7,262,638
OPERATING INCOME (LOSS) NET OF TAX	3,395,799	2,523,129	872,670	3,395,799	2,523,129	872,670
NON-OPERATING REVENUE (EXPENSE)						
Gain on Sale of Assets	-	-	-	-		
Provider Grants/CalAIM/Home Heath	(454,380)	(859,954)	405,574	(454,380)	(859,954)	405,574
D-SNP Expenses	(324,620)	(859,954)	535,334	(324,620)	(859,954)	535,334
Total Non-Operating Revenue (Expense)	(778,999)	(1,719,908)	940,909	(778,999)	(1,719,908)	940,909
NET INCREASE (DECREASE) IN NET POSITION	2,616,800	803,222	1,813,579	2,616,800	803,222	1,813,579
MEDICAL LOSS RATIO	91.5%	92.3%	0.8%	91.5%	92.3%	0.8%
ADMINISTRATIVE EXPENSE RATIO	5.9%	5.7%	-0.1%	5.9%	5.7%	-0.1%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Budget	Variance	Year to Date	Budget	Variance
Family Members	242,848	253,144	(10,296)	242,848	253,144	(10,296)
Expansion Members	117,232	117,811	(579)	117,232	117,811	(579)
SPD Members	21,942	20,927	1,015	21,942	20,927	1,015
LTC Members	489	555	(66)	489	555	(66)
Other Members	22,324	24,164	(1,840)	22,324	24,164	(1,840)
Total Members - MCAL	404,835	416,600	(11,765)	404,835	416,600	(11,765)
REVENUES						
Medicaid - Family and Other	199.97	196.62	3.35	199.97	196.62	3.35
Medicaid - Expansion Members	399.31	401.39	(2.08)	399.31	401.39	(2.08)
Medicaid - SPD Members	1,067.25	1,051.67	15.59	1,067.25	1,051.67	15.59
Medicaid - LTC Members	8,130.20	8,058.24	71.96	8,130.20	8,058.24	71.96
Premium - MCO Tax	1,764.39	1,930.63	(166.24)	1,764.39	1,930.63	(166.24)
Premium - Hospital Directed Payments	59.98	55.08	4.91	59.98	55.08	4.91
Investment Earnings And Other Income	6.27	5.13	1.14	6.27	5.13	1.14
Reinsurance Recoveries	-	0.28	(0.28)	-	0.28	(0.28)
Rate Adjustments - Hospital Directed Payments	0.10	-	0.10	0.10	-	0.10
Rate/Income Adjustments	0.21	-	0.21	0.21	-	0.21
Total Revenues	478.14	480.41	(2.27)	478.14	480.41	(2.27)
EXPENSES						
MEDICAL COSTS						
Physician Services	74.31	72.76	(1.54)	74.31	72.76	(1.54)
Other Professional Services	33.84	38.15	4.31	33.84	38.15	4.31
Emergency Room	17.06	16.23	(0.83)	17.06	16.23	(0.83)
Inpatient	74.56	70.05	(4.51)	74.56	70.05	(4.51)
Reinsurance Expense	0.24	0.28	0.04	0.24	0.28	0.04
Outpatient Hospital	33.34	32.33	(1.01)	33.34	32.33	(1.01)
Other Medical	57.97	58.05	0.09	57.97	58.05	0.09
Pay for Performance Quality Incentive	1.50	1.50	0.00	1.50	1.50	0.00
Hospital Directed Payments	59.98	55.08	(4.91)	59.98	55.08	(4.91)
Hospital Directed Payment Adjustment	0.10	-	(0.10)	0.10	-	(0.10)
Non-Claims Expense Adjustment	0.35	-	(0.35)	0.35	-	(0.35)
IBNR, Incentive, Paid Claims Adjustment	0.41	-	(0.41)	0.41	-	(0.41)
Total Medical Costs	353.65	344.43	(9.22)	353.65	344.43	(9.22)
GROSS MARGIN	124.49	135.98	(11.49)	124.49	135.98	(11.49)
ADMINISTRATIVE COSTS						
Compensation	8.86	9.84	0.98	8.86	9.84	0.98
Purchased Services	5.01	4.18	(0.83)	5.01	4.18	(0.83)
Supplies	0.88	0.89	0.02	0.88	0.89	0.02
Depreciation	1.79	1.71	(0.09)	1.79	1.71	(0.09)
Other Administrative Expenses	1.64	1.33	(0.31)	1.64	1.33	(0.31)
Administrative Expense Adjustment	0.64	-	(0.64)	0.64	-	(0.64)
Total Administrative Expenses	18.81	17.95	(0.86)	18.81	17.95	(0.86)
TOTAL EXPENSES	372.46	362.38	(10.08)	372.46	362.38	(10.08)
OPERATING INCOME (LOSS) BEFORE TAX	105.68	118.04	(12.35)	105.68	118.04	(12.35)
MCO TAX	97.29	111.98	14.69	97.29	111.98	14.69
OPERATING INCOME (LOSS) NET OF TAX	8.39	6.06	2.33	8.39	6.06	2.33
NON-OPERATING REVENUE (EXPENSE)						
Provider Grants/CalAIM/Home Heath	(0.80)	(2.06)	1.26	(0.80)	(2.06)	1.26
D-SNP Expenses	(1.12)	(2.06)	0.94	(1.12)	(2.06)	0.94
Total Non-Operating Revenue (Expense)	(1.92)	(4.13)	2.20	(1.92)	(4.13)	2.20
NET INCREASE (DECREASE) IN NET POSITION	6.46	1.93	4.54	6.46	1.93	4.54
MEDICAL LOSS RATIO	-21.8%	-19.2%	2.6%	-21.8%	-19.2%	2.6%
ADMINISTRATIVE EXPENSE RATIO	-1.4%	-1.2%	0.2%	-1.4%	-1.2%	0.2%
	(0.00)	(0.00)		(0.00)	(0.00)	

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS
FOR THE MONTH ENDED JANUARY 31, 2024

	2023 - Q1	2023 - Q2	2023 - Q3	2023 - Q4	Rolling 4-Quarter Totals	CURRENT QUARTER 2024 - Q1
Total Members - MCAL	1,032,889	1,065,928	1,064,368	1,038,591	4,201,776	404,835
REVENUES						
Medicaid - Family and Other	120,321,770	131,416,191	130,829,220	119,336,194	501,903,375	53,027,216
Medicaid - Expansion Members	107,922,635	113,614,490	114,676,254	97,694,167	433,907,546	46,811,852
Medicaid - SPD Members	56,200,407	58,314,893	58,948,915	59,165,633	232,629,847	23,417,694
Medicaid - LTC Members	5,984,210	9,124,896	9,102,869	9,599,451	33,811,426	3,975,666
Premium - MCO Tax	-	-	-	375,849,146	375,849,146	39,388,230
Premium - Hospital Directed Payments	64,335,321	65,929,161	65,557,702	63,752,178	259,574,363	24,282,372
Investment Earnings And Other Income	4,178,417	3,451,390	4,444,990	9,031,183	21,105,981	2,539,805
Rate Adjustments - Hospital Directed Payments	(617,962)	58,880	545,253	(26,268,027)	(26,281,856)	42,165
Rate/Income Adjustments	496,782	2,689,620	2,190,288	495,587	5,872,277	83,075
Total Revenues	358,821,583	384,599,520	386,295,491	708,655,511	1,838,372,105	193,568,075
EXPENSES						
MEDICAL COSTS						
Physician Services	60,138,058	64,905,613	62,419,530	61,076,433	248,539,633	30,082,718
Other Professional Services	16,974,710	19,202,567	18,664,943	19,381,164	74,223,384	13,699,554
Emergency Room	15,028,917	15,949,392	16,279,390	15,523,588	62,781,286	6,905,833
Inpatient	67,442,872	64,459,638	67,920,330	79,244,732	279,067,571	30,185,040
Reinsurance Expense	366,159	286,181	288,694	190,133	1,131,168	96,765
Outpatient Hospital	30,631,634	32,454,291	32,005,177	40,939,501	136,030,602	13,495,747
Other Medical	61,580,673	70,726,296	72,388,155	79,194,627	283,889,750	23,466,463
Pay for Performance Quality Incentive	1,549,344	1,597,253	1,599,049	1,555,236	6,300,881	607,242
Hospital Directed Payments	64,335,321	65,929,161	65,557,702	63,752,178	259,574,363	24,282,372
Hospital Directed Payment Adjustment	(1,520,110)	177,303	(12,049)	(26,330,241)	(27,685,097)	42,165
Non-Claims Expense Adjustment	(52,442)	(2,268,523)	695,678	1,571,341	(53,945)	141,502
IBNR, Incentive, Paid Claims Adjustment	(3,968,070)	(13,731,707)	1,846,700	1,506,238	(14,346,840)	164,572
Total Medical Costs	312,507,065	319,687,464	339,653,299	337,604,928	1,309,452,755	143,169,973
GROSS MARGIN	46,314,517	64,912,057	46,642,192	371,050,583	528,919,349	50,398,102
ADMINISTRATIVE COSTS						
Compensation	10,793,705	11,028,203	11,815,434	13,584,268	47,221,610	3,586,265
Purchased Services	4,006,386	4,875,634	4,614,262	5,339,166	18,835,448	2,026,416
Supplies	355,217	278,251	801,939	680,996	2,116,403	354,637
Depreciation	2,042,124	2,055,327	2,073,030	2,099,363	8,269,844	725,712
Other Administrative Expenses	1,601,959	1,446,637	1,797,993	1,406,817	6,253,406	663,019
Administrative Expense Adjustment	731,466	1,102,277	9,949	1,580,132	3,423,824	258,024
Total Administrative Expenses	19,530,857	20,786,329	21,112,607	24,690,742	86,120,535	7,614,072
TOTAL EXPENSES	332,037,922	340,473,793	360,765,906	362,295,670	1,395,573,290	150,784,046
OPERATING INCOME (LOSS) BEFORE TAX	26,783,660	44,125,728	25,529,585	346,359,841	442,798,814	42,784,029
MCO TAX	-	-	-	376,495,887	376,495,887	39,388,230
OPERATING INCOME (LOSS) NET OF TAX	26,783,660	44,125,728	25,529,585	(30,136,046)	66,302,928	3,395,799
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	(886,252)	(1,282,998)	(1,246,978)	(1,454,633)	(4,870,861)	(778,999)
NET INCREASE (DECREASE) IN NET POSITION	25,897,408	42,842,730	24,282,607	(31,590,679)	61,432,067	2,616,800
MEDICAL LOSS RATIO	84.6%	79.6%	85.6%	101.6%	87.7%	91.5%
ADMINISTRATIVE EXPENSE RATIO	6.6%	6.5%	6.6%	8.4%	7.0%	5.9%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY QUARTER
ROLLING 4 QUARTERS PMPM
FOR THE MONTH ENDED JANUARY 31, 2024

KERN HEALTH SYSTEMS

	2023 - Q1	2023 - Q2	2023 - Q3	2023 - Q4	Rolling Quarter Totals	CURRENT QUARTER 2024 - Q1
Total Members - MCAL	1,032,889	1,065,928	1,064,368	1,038,591	4,201,776	404,835
REVENUES						
Medicaid - Family and Other	116.49	123.29	122.92	114.90	119.45	130.98
Medicaid - Expansion Members	104.49	106.59	107.74	94.06	103.27	115.63
Medicaid - SPD Members	54.41	54.71	55.38	56.97	55.36	57.85
Medicaid - LTC Members	5.79	8.56	8.55	9.24	8.05	9.82
Premium - MCO Tax	-	-	-	361.88	89.45	97.29
Premium - Hospital Directed Payments	62.29	61.85	61.59	61.38	61.78	59.98
Investment Earnings And Other Income	4.05	3.24	4.18	8.70	5.02	6.27
Rate Adjustments - Hospital Directed Payments	(0.60)	0.06	0.51	(25.29)	(6.25)	0.10
Rate/Income Adjustments	0.48	2.52	2.06	0.48	1.40	0.21
Total Revenues	347.40	360.81	362.93	682.32	437.52	478.14
EXPENSES						
MEDICAL COSTS						
Physician Services	58.22	60.89	58.64	58.81	59.15	74.31
Other Professional Services	16.43	18.01	17.54	18.66	17.66	33.84
Emergency Room	14.55	14.96	15.29	14.95	14.94	17.06
Inpatient	65.30	60.47	63.81	76.30	66.42	74.56
Reinsurance Expense	0.35	0.27	0.27	0.18	0.27	0.24
Outpatient Hospital	29.66	30.45	30.07	39.42	32.37	33.34
Other Medical	59.62	66.35	68.01	76.25	67.56	57.97
Pay for Performance Quality Incentive	1.50	1.50	1.50	1.50	1.50	1.50
Hospital Directed Payments	62.29	61.85	61.59	61.38	61.78	59.98
Hospital Directed Payment Adjustment	(1.47)	0.17	(0.01)	(25.35)	(6.59)	0.10
Non-Claims Expense Adjustment	(0.05)	(2.13)	0.65	1.51	(0.01)	0.35
IBNR, Incentive, Paid Claims Adjustment	(3.84)	(12.88)	1.74	1.45	(3.41)	0.41
Total Medical Costs	302.56	299.91	319.11	325.06	311.64	353.65
GROSS MARGIN	44.84	60.90	43.82	357.26	125.88	124.49
ADMINISTRATIVE COSTS						
Compensation	10.45	10.35	11.10	13.08	11.24	8.86
Purchased Services	3.88	4.57	4.34	5.14	4.48	5.01
Supplies	0.34	0.26	0.75	0.66	0.50	0.88
Depreciation	1.98	1.93	1.95	2.02	1.97	1.79
Other Administrative Expenses	1.55	1.36	1.69	1.35	1.49	1.64
Administrative Expense Adjustment	0.71	1.03	0.01	1.52	0.81	0.64
Total Administrative Expenses	18.91	19.50	19.84	23.77	20.50	18.81
TOTAL EXPENSES	321.47	319.42	338.95	348.83	332.14	372.46
OPERATING INCOME (LOSS) BEFORE TAX	25.93	41.40	23.99	333.49	105.38	105.68
MCO TAX	-	-	-	362.51	89.60	97.29
OPERATING INCOME (LOSS) NET OF TAX	25.93	41.40	23.99	(29.02)	15.78	8.39
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	(0.86)	(1.20)	(1.17)	(1.40)	(1.16)	(1.92)
NET INCREASE (DECREASE) IN NET POSITION	25.07	40.19	22.81	(30.42)	14.62	6.46
MEDICAL LOSS RATIO	84.6%	79.6%	85.6%	101.6%	87.7%	91.5%
ADMINISTRATIVE EXPENSE RATIO	6.6%	6.5%	6.6%	8.4%	7.0%	5.9%

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
ROLLING 13 MONTHS
FOR THE MONTH ENDED JANUARY 31, 2024

	JULY 2023	AUGUST 2023	SEPTEMBER 2023	OCTOBER 2023	NOVEMBER 2023	DECEMBER 2023	Prior 6 Month YTD	JANUARY 2024	Year to Date Total	
Total Members - MCAL	355,448	356,881	352,039	344,282	345,588	348,721	2,102,959	404,835	404,835	
REVENUES										
Medicaid - Family and Other	45,811,581	41,688,821	43,328,818	42,099,200	45,286,584	31,950,410	250,165,414	53,027,216	53,027,216	
Medicaid - Expansion Members	38,966,690	37,219,564	38,490,000	36,217,557	36,497,717	24,978,893	212,370,421	46,811,852	46,811,852	
Medicaid - SPD Members	19,655,340	19,355,872	19,937,703	19,485,313	19,356,789	20,323,530	118,114,547	23,417,694	23,417,694	
Medicaid - LTC Members	2,933,681	3,019,929	3,149,260	2,973,590	3,153,923	3,471,937	18,702,320	3,975,666	3,975,666	
Premium - MCO Tax	-	-	-	-	-	375,849,146	375,849,146	39,388,230	39,388,230	
Premium - Hospital Directed Payments	21,822,439	21,933,792	21,801,471	21,376,726	20,754,284	21,621,168	129,309,880	24,282,372	24,282,372	
Investment Earnings And Other Income	1,706,041	1,300,264	1,438,685	2,404,743	3,571,373	3,055,066	13,476,173	2,539,805	2,539,805	
Rate Adjustments - Hospital Directed Payments	(15,187)	421,004	139,435	4,262	(2,585)	(26,269,704)	(25,722,774)	42,165	42,165	
Rate/Income Adjustments	1,691	(38,135)	2,226,732	(20,585)	21,528	494,694	2,685,925	83,075	83,075	
Total Revenues	130,882,275	124,901,111	130,512,105	124,540,806	128,639,613	455,475,142	1,094,951,052	193,568,075	193,568,075	-
EXPENSES										
MEDICAL COSTS										
Physician Services	20,488,108	20,619,450	21,311,972	20,657,868	21,258,593	19,159,973	123,495,963	30,082,718	30,082,718	
Other Professional Services	5,443,151	6,830,706	6,391,086	6,402,688	6,739,289	6,239,187	38,046,107	13,699,554	13,699,554	
Emergency Room	4,984,270	5,600,554	5,694,567	5,063,129	4,921,226	5,539,233	31,802,978	6,905,833	6,905,833	
Inpatient	22,316,634	20,877,596	24,726,099	25,452,068	23,460,211	30,332,453	147,165,061	30,185,040	30,185,040	
Reinsurance Expense	96,097	96,687	95,910	96,625	91,410	2,097	478,827	96,765	96,765	
Outpatient Hospital	10,233,408	10,613,552	11,158,217	12,146,983	12,702,928	16,089,590	72,944,678	13,495,747	13,495,747	
Other Medical	22,600,584	23,391,210	26,396,360	23,481,298	27,658,264	28,055,064	151,582,781	23,466,463	23,466,463	
Pay for Performance Quality Incentive	535,512	534,173	529,364	513,773	518,382	523,082	3,154,285	607,242	607,242	
Hospital Directed Payments	21,822,439	21,933,792	21,801,471	21,376,726	20,754,284	21,621,168	129,309,880	24,282,372	24,282,372	
Hospital Directed Payment Adjustment	(15,187)	426,924	(423,786)	4,262	(2,585)	(26,331,918)	(26,342,290)	42,165	42,165	
Non-Claims Expense Adjustment	639,578	3,672	52,429	(4,729)	(662)	1,576,732	2,267,020	141,502	141,502	
IBNR, Incentive, Paid Claims Adjustment	707,021	438,519	701,159	614,589	784,814	106,835	3,352,937	164,572	164,572	
Total Medical Costs	109,851,615	111,366,836	118,434,848	115,805,278	118,886,154	102,913,496	677,258,227	143,169,973	143,169,973	-
GROSS MARGIN	21,030,660	13,534,275	12,077,257	8,735,528	9,753,459	352,561,646	417,692,825	50,398,102	50,398,102	-
ADMINISTRATIVE COSTS										
Compensation	3,743,078	4,035,668	4,036,688	4,152,628	5,655,320	3,776,320	25,399,702	3,586,265	3,586,265	
Purchased Services	1,454,754	1,385,357	1,774,151	1,715,078	1,916,544	1,707,545	9,953,428	2,026,416	2,026,416	
Supplies	196,053	395,024	210,861	128,415	131,121	421,461	1,482,935	354,637	354,637	
Depreciation	686,781	693,125	693,125	657,439	685,712	756,212	4,172,393	725,712	725,712	
Other Administrative Expenses	926,819	434,888	436,285	505,417	498,451	402,950	3,204,810	663,019	663,019	
Administrative Expense Adjustment	(3,286)	12,968	267	-	(259)	1,580,391	1,590,080	258,024	258,024	
Total Administrative Expenses	7,004,199	6,957,030	7,151,377	7,158,977	8,886,888	8,644,878	45,803,349	7,614,072	7,614,072	-
TOTAL EXPENSES	116,855,814	118,323,866	125,586,225	122,964,255	127,773,042	111,558,374	723,061,576	150,784,046	150,784,046	-
OPERATING INCOME (LOSS) BEFORE TAX	14,026,461	6,577,245	4,925,880	1,576,551	866,571	343,916,768	371,889,476	42,784,029	42,784,029	-
MCO TAX	-	-	-	-	-	376,495,937	376,495,937	39,388,230	39,388,230	-
OPERATING INCOME (LOSS) NET OF TAX	14,026,461	6,577,245	4,925,880	1,576,551	866,571	(32,579,169)	(4,606,461)	3,395,799	3,395,799	-
NON-OPERATING REVENUE (EXPENSE)										
Total Non-Operating Revenue (Expense)	(307,682)	(457,916)	(481,380)	(632,934)	(490,432)	(331,267)	(2,701,610)	(778,999)	(778,999)	-
NET INCREASE (DECREASE) IN NET POSITION	13,718,779	6,119,328	4,444,500	943,617	376,139	(32,910,436)	(7,308,071)	2,616,800	2,616,800	
MEDICAL LOSS RATIO	80.7%	86.8%	89.4%	91.5%	91.0%	127.7%	93.3%	91.5%	91.5%	
ADMINISTRATIVE EXPENSE RATIO	6.4%	6.8%	6.6%	6.9%	8.2%	10.3%	7.4%	5.9%	5.9%	

MEDI-CAL - ALL COA
STATEMENT OF REVENUE, EXPENSES, AND CHANGES
IN NET POSITION BY MONTH
PMPM ROLLING 13 MONTHS
FOR THE MONTH ENDED JANUARY 31, 2024

KERN HEALTH SYSTEMS

	AUGUST 2023	SEPTEMBER 2023	OCTOBER 2023	NOVEMBER 2023	DECEMBER 2023	6 Month Prior YTD	JANUARY 2024	Year to Date Total
Total Members - MCAL	356,881	352,039	344,282	345,588	348,721	2,102,959	404,835	404,835
REVENUES								
Medicaid - Family and Other	176.06	185.68	183.11	196.69	137.38	178.90	199.97	199.97
Medicaid - Expansion Members	367.69	385.48	378.12	378.15	258.45	359.31	399.31	399.31
Medicaid - SPD Members	1,049.21	1,081.04	1,071.80	1,052.11	1,067.19	1,063.80	1,067.25	1,067.25
Medicaid - LTC Members	7,224.71	7,892.88	7,342.20	7,368.98	7,613.90	7,457.07	8,130.20	8,130.20
Premium - MCO Tax	-	-	-	-	1,077.79	178.72	97.29	97.29
Premium - Hospital Directed Payments	61.46	61.93	62.09	60.05	62.00	61.49	59.98	59.98
Investment Earnings And Other Income	3.64	4.09	6.98	10.33	8.76	6.41	6.27	6.27
Rate Adjustments - Hospital Directed Payments	1.18	0.40	0.01	(0.01)	(75.33)	(12.23)	0.10	0.10
Rate/Income Adjustments	(0.11)	6.33	(0.06)	0.06	1.42	1.28	0.21	0.21
Total Revenues	349.98	370.73	361.74	372.23	1,306.13	520.67	478.14	478.14
EXPENSES								
MEDICAL COSTS								
Physician Services	57.78	60.54	60.00	61.51	54.94	58.72	74.31	74.31
Other Professional Services	19.14	18.15	18.60	19.50	17.89	18.09	33.84	33.84
Emergency Room	15.69	16.18	14.71	14.24	15.88	15.12	17.06	17.06
Inpatient	58.50	70.24	73.93	67.88	86.98	69.98	74.56	74.56
Reinsurance Expense	0.27	0.27	0.28	0.26	0.01	0.23	0.24	0.24
Outpatient Hospital	29.74	31.70	35.28	36.76	46.14	34.69	33.34	33.34
Other Medical	65.54	74.98	68.20	80.03	80.45	72.08	57.97	57.97
Pay for Performance Quality Incentive	1.50	1.50	1.49	1.50	1.50	1.50	1.50	1.50
Hospital Directed Payments	61.46	61.93	62.09	60.05	62.00	61.49	59.98	59.98
Hospital Directed Payment Adjustment	1.20	(1.20)	0.01	(0.01)	(75.51)	(12.53)	0.10	0.10
Non-Claims Expense Adjustment	0.01	0.15	(0.01)	(0.00)	4.52	1.08	0.35	0.35
IBNR, Incentive, Paid Claims Adjustment	1.23	1.99	1.79	2.27	0.31	1.59	0.41	0.41
Total Medical Costs	312.06	336.43	336.37	344.01	295.12	322.05	353.65	353.65
GROSS MARGIN	37.92	34.31	25.37	28.22	1,011.01	198.62	124.49	124.49
ADMINISTRATIVE COSTS								
Compensation	11.31	11.47	12.06	16.36	10.83	12.08	8.86	8.86
Purchased Services	3.88	5.04	4.98	5.55	4.90	4.73	5.01	5.01
Supplies	1.11	0.60	0.37	0.38	1.21	0.71	0.88	0.88
Depreciation	1.94	1.97	1.91	1.98	2.17	1.98	1.79	1.79
Other Administrative Expenses	1.22	1.24	1.47	1.44	1.16	1.52	1.64	1.64
Administrative Expense Adjustment	0.04	0.00	-	(0.00)	4.53	0.76	0.64	0.64
Total Administrative Expenses	19.49	20.31	20.79	25.72	24.79	21.78	18.81	18.81
TOTAL EXPENSES	331.55	356.74	357.16	369.73	319.91	343.83	372.46	372.46
OPERATING INCOME (LOSS) BEFORE TAX	18.43	13.99	4.58	2.51	986.22	176.84	105.68	105.68
MCO TAX	-	-	-	-	1,079.65	179.03	97.29	97.29
OPERATING INCOME (LOSS) NET OF TAX	18.43	13.99	4.58	2.51	(93.42)	(2.19)	8.39	8.39
NON-OPERATING REVENUE (EXPENSE)								
Total Non-Operating Revenue (Expense)	(1.28)	(1.37)	(1.84)	(1.42)	(0.95)	(1.28)	(1.92)	(1.92)
NET INCREASE (DECREASE) IN NET POSITION	17.15	12.63	2.74	1.09	(94.37)	(3.48)	6.46	6.46
MEDICAL LOSS RATIO	86.8%	89.4%	91.5%	91.0%	127.7%	93.3%	91.5%	91.5%
ADMINISTRATIVE EXPENSE RATIO	6.8%	6.6%	6.9%	8.2%	10.3%	7.4%	5.9%	5.9%

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Budget	Variance	Year to date Month 1	Budget	Variance
REVENUES						
Premium - Medi-Cal	47,241,506	47,692,367	(450,861)	47,241,506	47,692,367	(450,861)
Premium - Maternity Kick	2,781,366	3,354,888	(573,522)	2,781,366	3,354,888	(573,522)
Premium - Enhanced Care Management	1,360,425	1,421,497	(61,071)	1,360,425	1,421,497	(61,071)
Premium - Major Organ Transplant	242,912	244,307	(1,395)	242,912	244,307	(1,395)
Premium - Provider Enhancement	1,115,725	1,114,154	1,571	1,115,725	1,114,154	1,571
Premium - GEMT	187,833	192,309	(4,476)	187,833	192,309	(4,476)
Premium - Cal AIM	-	341,912	(341,912)	-	341,912	(341,912)
Premium - Student Behavioral Health Incentive	-	162,280	(162,280)	-	162,280	(162,280)
Other	97,449	-	97,449	97,449	-	97,449
TOTAL MEDICAID - FAMILY & OTHER	53,027,216	54,523,713	(1,496,497)	53,027,216	54,523,713	(1,496,497)
Premium - Medi-Cal	43,459,690	43,628,897	(169,207)	43,459,690	43,628,897	(169,207)
Premium - Maternity Kick	576,986	445,438	131,547	576,986	445,438	131,547
Premium - Enhanced Care Management	1,651,191	1,670,267	(19,076)	1,651,191	1,670,267	(19,076)
Premium - Major Organ Transplant	432,007	436,961	(4,954)	432,007	436,961	(4,954)
Premium - Provider Enhancement	373,632	373,833	(201)	373,632	373,833	(201)
Premium - GEMT	271,454	276,757	(5,302)	271,454	276,757	(5,302)
Premium - Cal AIM	-	309,397	(309,397)	-	309,397	(309,397)
Premium - Student Behavioral Health Incentive	-	146,848	(146,848)	-	146,848	(146,848)
Other	46,893	-	46,893	46,893	-	46,893
TOTAL MEDICAID - EXPANSION MEMBERS	46,811,852	47,288,398	(476,546)	46,811,852	47,288,398	(476,546)
Premium - Medi-Cal	22,135,884	20,566,289	1,569,595	22,135,884	20,566,289	1,569,595
Premium - Enhanced Care Management	802,416	764,247	38,169	802,416	764,247	38,169
Premium - Major Organ Transplant	289,069	276,580	12,488	289,069	276,580	12,488
Premium - Provider Enhancement	27,257	25,945	1,312	27,257	25,945	1,312
Premium - GEMT	163,069	155,332	7,737	163,069	155,332	7,737
Premium - Cal AIM	-	149,009	(149,009)	-	149,009	(149,009)
Premium - Student Behavioral Health Incentive	-	70,723	(70,723)	-	70,723	(70,723)
TOTAL MEDICAID - SPD MEMBERS	23,417,694	22,008,125	1,409,569	23,417,694	22,008,125	1,409,569
Premium - Medi-Cal	3,950,994	4,395,083	(444,089)	3,950,994	4,395,083	(444,089)
Premium - Enhanced Care Management	9,002	10,315	(1,313)	9,002	10,315	(1,313)
Premium - Major Organ Transplant	13,131	15,235	(2,104)	13,131	15,235	(2,104)
Premium - Provider Enhancement	3	4	(1)	3	4	(1)
Premium - GEMT	2,536	3,176	(640)	2,536	3,176	(640)
Premium - Cal AIM	-	31,530	(31,530)	-	31,530	(31,530)
Premium - Student Behavioral Health Incentive	-	14,965	(14,965)	-	14,965	(14,965)
TOTAL MEDICAID - LTC MEMBERS	3,975,666	4,470,309	(494,642)	3,975,666	4,470,309	(494,642)

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF REVENUES - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2024

	January	YTD
REVENUES		
Premium - Medi-Cal	47,241,506	47,241,506
Premium - Maternity Kick	2,781,366	2,781,366
Premium - Enhanced Care Management	1,360,425	1,360,425
Premium - Major Organ Transplant	242,912	242,912
Premium - Provider Enhancement	1,115,725	1,115,725
Premium - GEMT	187,833	187,833
Other	97,449	97,449
TOTAL MEDICAID - FAMILY & OTHER	53,027,216	53,027,216
Premium - Medi-Cal	43,459,690	43,459,690
Premium - Maternity Kick	576,986	576,986
Premium - Enhanced Care Management	1,651,191	1,651,191
Premium - Major Organ Transplant	432,007	432,007
Premium - Provider Enhancement	373,632	373,632
Premium - GEMT	271,454	271,454
Other	46,893	46,893
TOTAL MEDICAID - EXPANSION MEMBERS	46,811,852	46,811,852
Premium - Medi-Cal	22,135,884	22,135,884
Premium - Enhanced Care Management	802,416	802,416
Premium - Major Organ Transplant	289,069	289,069
Premium - Provider Enhancement	27,257	27,257
Premium - GEMT	163,069	163,069
TOTAL MEDICAID - SPD MEMBERS	23,417,694	23,417,694
Premium - Medi-Cal	3,950,994	3,950,994
Premium - Enhanced Care Management	9,002	9,002
Premium - Major Organ Transplant	13,131	13,131
Premium - Provider Enhancement	3	3
Premium - GEMT	2,536	2,536
TOTAL MEDICAID - LTC MEMBERS	3,975,666	3,975,666

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Budget	Variance	Year to date Month 1	Budget	Variance
Physician Services						
Primary Care Physician Services	6,499,076	5,837,420	(661,656)	6,499,076	5,837,420	(661,656)
Referral Specialty Services	21,255,092	21,704,881	449,790	21,255,092	21,704,881	449,790
Urgent Care & After Hours Advice	2,319,250	2,762,122	442,872	2,319,250	2,762,122	442,872
Hospital Admitting Team	9,300	9,300	-	9,300	9,300	-
Total Physician Services	30,082,718	30,313,724	231,006	30,082,718	30,313,724	231,006
Other Professional Services						
Vision Service Capitation	140,322	354,110	213,788	140,322	354,110	213,788
221 - Business Intelligence	166,419	162,112	(4,307)	166,419	162,112	(4,307)
310 - Health Servcies - Utilization Management	852,585	1,163,127	310,543	852,585	1,163,127	310,543
311 - Health Services - Quality Improvement	240,989	351,063	110,074	240,989	351,063	110,074
312 - Health Services Education	238,074	401,142	163,068	238,074	401,142	163,068
313 - Pharmacy	117,253	141,792	24,539	117,253	141,792	24,539
314 - Enhanced Care Management	296,401	440,319	143,917	296,401	440,319	143,917
316 - Population Health Management	495,663	683,785	188,122	495,663	683,785	188,122
317 - In Lieu of Services	88,658	143,949	55,290	88,658	143,949	55,290
321 - Homeless Management Information Services	-	34,417	34,417	-	34,417	34,417
330 - Member Services	996,071	1,106,858	110,787	996,071	1,106,858	110,787
331 - Member Outreach	-	351,173	351,173	-	351,173	351,173
410 - Member Engagement	68,866	79,106	10,241	68,866	79,106	10,241
601 - Behavioral Health	63,991	177,549	113,559	63,991	177,549	113,559
602 - Quality & Health Equity	76,057	77,136	1,079	76,057	77,136	1,079
604 - Clinical Operations, Strategy, and Analytics	77,153	133,675	56,522	77,153	133,675	56,522
Behavior Health Treatment	3,612,672	3,881,666	268,993	3,612,672	3,881,666	268,993
Mental Health Services	1,525,645	1,123,026	(402,620)	1,525,645	1,123,026	(402,620)
Other Professional Services	4,642,734	5,089,214	446,480	4,642,734	5,089,214	446,480
Total Other Professional Services	13,699,554	15,895,218	2,195,664	13,699,554	15,895,218	2,195,664
Emergency Room	6,905,833	6,760,402	(145,432)	6,905,833	6,760,402	(145,432)
Inpatient Hospital	30,185,040	29,181,341	(1,003,700)	30,185,040	29,181,341	(1,003,700)
Reinsurance Expense Premium	96,765	116,648	19,883	96,765	116,648	19,883
Outpatient Hospital	13,495,747	13,468,482	(27,265)	13,495,747	13,468,482	(27,265)
Other Medical						
Ambulance and NEMT	3,214,531	2,875,978	(338,553)	3,214,531	2,875,978	(338,553)
Home Health Services & CBAS	821,583	906,891	85,309	821,583	906,891	85,309
Utilization and Quality Review Expenses	778,360	1,793,060	1,014,700	778,360	1,793,060	1,014,700
Long Term/SNF/Hospice	8,782,404	9,185,998	403,594	8,782,404	9,185,998	403,594
Provider Enhancement Expense - Prop. 56	1,440,786	1,848,724	407,938	1,440,786	1,848,724	407,938
Provider Enhancement Expense - GEMT	697,353	185,711	(511,642)	697,353	185,711	(511,642)
Enhanced Care Management	3,631,882	3,699,088	67,205	3,631,882	3,699,088	67,205
Major Organ Transplant	928,263	924,429	(3,834)	928,263	924,429	(3,834)
Cal AIM Incentive Programs	1,210,017	790,255	(419,762)	1,210,017	790,255	(419,762)
Student Behavioral Health Incentive	-	375,075	375,075	-	375,075	375,075
Housing and Homelessness Incentive	516,672	-	(516,672)	516,672	-	(516,672)
DME/Rebates	1,444,613	1,599,139	154,525	1,444,613	1,599,139	154,525
Total Other Medical	23,466,463	24,184,348	717,885	23,466,463	24,184,348	717,885
Pay for Performance Quality Incentive	607,242	624,900	17,658	607,242	624,900	17,658
Hospital Directed Payments	24,282,372	22,944,345	(1,338,026)	24,282,372	22,944,345	(1,338,026)
Hospital Directed Payment Adjustment	42,165	-	(42,165)	42,165	-	(42,165)
Non-Claims Expense Adjustment	141,502	-	(141,502)	141,502	-	(141,502)
IBNR, Incentive, Paid Claims Adjustment	164,572	-	(164,572)	164,572	-	(164,572)
Total Medical Costs	143,169,973	143,489,408	319,434	143,169,973	143,489,408	319,434

* MEDICAL COSTS PER DMHC REGULATIONS

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Budget	Variance	Year to Date	Budget	Variance
TOTAL MEMBERS - MCAL	404,835	416,600	(11,765)	404,835	416,600	(11,765)
Physician Services						
Primary Care Physician Services	16.05	14.01	(2.04)	16.05	14.01	(2.04)
Referral Specialty Services	52.50	52.10	(0.40)	52.50	52.10	(0.40)
Urgent Care & After Hours Advice	5.73	6.63	0.90	5.73	6.63	0.90
Hospital Admitting Team	0.02	0.02	(0.00)	0.02	0.02	(0.00)
Total Physician Services	74.31	72.76	(1.54)	74.31	72.76	(1.54)
Other Professional Services						
Vision Service Capitation	0.35	0.85	0.50	0.35	0.85	0.50
221 - Business Intelligence	0.41	0.39	(0.02)	0.41	0.39	(0.02)
310 - Health Servcies - Utilization Management	2.11	2.79	0.69	2.11	2.79	0.69
311 - Health Services - Quality Improvement	0.60	0.84	0.25	0.60	0.84	0.25
312 - Health Services Education	0.59	0.96	0.37	0.59	0.96	0.37
313 - Pharmacy	0.29	0.34	0.05	0.29	0.34	0.05
314 - Enhanced Care Management	0.73	1.06	0.32	0.73	1.06	0.32
316 - Population Health Management	1.22	1.64	0.42	1.22	1.64	0.42
317 - In Lieu of Services	0.22	0.35	0.13	0.22	0.35	0.13
321 - Homeless Management Information Services	-	0.08	0.08	-	0.08	0.08
330 - Member Services	2.46	2.66	0.20	2.46	2.66	0.20
331 - Member Outreach	-	0.84	0.84	-	0.84	0.84
410 - Member Engagement	0.17	0.19	0.02	0.17	0.19	0.02
601 - Behavioral Health	0.16	0.43	0.27	0.16	0.43	0.27
602 - Quality & Health Equity	0.19	0.19	(0.00)	0.19	0.19	(0.00)
604 - Clinical Operations, Strategy, and Analytics	0.19	0.32	0.13	0.19	0.32	0.13
Behavior Health Treatment	8.92	9.32	0.39	8.92	9.32	0.39
Mental Health Services	3.77	2.70	(1.07)	3.77	2.70	(1.07)
Other Professional Services	11.47	12.22	0.75	11.47	12.22	0.75
Total Other Professional Services	33.84	38.15	4.31	33.84	38.15	4.31
Emergency Room	17.06	16.23	(0.83)	17.06	16.23	(0.83)
Inpatient Hospital	74.56	70.05	(4.51)	74.56	70.05	(4.51)
Reinsurance Expense Premium	0.24	0.28	0.04	0.24	0.28	0.04
Outpatient Hospital	33.34	32.33	(1.01)	33.34	32.33	(1.01)
Other Medical						
Ambulance and NEMT	7.94	6.90	(1.04)	7.94	6.90	(1.04)
Home Health Services & CBAS	2.03	2.18	0.15	2.03	2.18	0.15
Utilization and Quality Review Expenses	1.92	4.30	2.38	1.92	4.30	2.38
Long Term/SNF/Hospice	21.69	22.05	0.36	21.69	22.05	0.36
Provider Enhancement Expense - Prop. 56	3.56	4.44	0.88	3.56	4.44	0.88
Provider Enhancement Expense - GEMT	1.72	0.45	(1.28)	1.72	0.45	(1.28)
Enhanced Care Management	8.97	8.88	(0.09)	8.97	8.88	(0.09)
Major Organ Transplant	2.29	2.22	(0.07)	2.29	2.22	(0.07)
Cal AIM Incentive Programs	2.99	1.90	(1.09)	2.99	1.90	(1.09)
Student Behavioral Health Incentive	-	0.90	0.90	-	0.90	0.90
Housing and Homelessness Incentive	1.28	-	(1.28)	1.28	-	(1.28)
DME/Rebates	3.57	3.84	0.27	3.57	3.84	0.27
Total Other Medical	57.97	58.05	0.09	57.97	58.05	0.09
Pay for Performance Quality Incentive	1.50	1.50	0.00	1.50	1.50	0.00
Hospital Directed Payments	59.98	55.08	(4.91)	59.98	55.08	(4.91)
Hospital Directed Payment Adjustment	0.10	-	(0.10)	0.10	-	(0.10)
Non-Claims Expense Adjustment	0.35	-	(0.35)	0.35	-	(0.35)
IBNR, Incentive, Paid Claims Adjustment	0.41	-	(0.41)	0.41	-	(0.41)
Total Medical Costs	353.65	344.43	(9.22)	353.65	344.43	(9.22)

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Year to Date 2024
Physician Services		
Primary Care Physician Services	6,499,076	6,499,076
Referral Specialty Services	21,255,092	21,255,092
Urgent Care & After Hours Advice	2,319,250	2,319,250
Hospital Admitting Team	9,300	9,300
Total Physician Services	30,082,718	30,082,718
Other Professional Services		
Vision Service Capitation	140,322	140,322
221 - Business Intelligence	166,419	166,419
310 - Health Servcies - Utilization Management	852,585	852,585
311 - Health Services - Quality Improvement	240,989	240,989
312 - Health Services Education	238,074	238,074
313 - Pharmacy	117,253	117,253
314 - Enhanced Care Management	296,401	296,401
316 - Population Health Management	495,663	495,663
317 - In Lieu of Services	88,658	88,658
330 - Member Services	996,071	996,071
410 - Member Engagement	68,866	68,866
601 - Behavioral Health	63,991	63,991
602 - Quality & Health Equity	76,057	76,057
604 - Clinical Operations, Strategy, and Analytics	77,153	77,153
Behavior Health Treatment	3,612,672	3,612,672
Mental Health Services	1,525,645	1,525,645
Other Professional Services	4,642,734	4,642,734
Total Other Professional Services	13,699,554	13,699,554
Emergency Room	6,905,833	6,905,833
Inpatient Hospital	30,185,040	30,185,040
Reinsurance Expense Premium	96,765	96,765
Outpatient Hospital	13,495,747	13,495,747
Other Medical		
Ambulance and NEMT	3,214,531	3,214,531
Home Health Services & CBAS	821,583	821,583
Utilization and Quality Review Expenses	778,360	778,360
Long Term/SNF/Hospice	8,782,404	8,782,404
Provider Enhancement Expense - Prop. 56	1,440,786	1,440,786
Provider Enhancement Expense - GEMT	697,353	697,353
Enhanced Care Management	3,631,882	3,631,882
Major Organ Transplant	928,263	928,263
Cal AIM Incentive Programs	1,210,017	1,210,017
Housing and Homelessness Incentive	516,672	516,672
DME	1,444,613	1,444,613
Total Other Medical	23,466,463	23,466,463
Pay for Performance Quality Incentive	607,242	607,242
Hospital Directed Payments	24,282,372	24,282,372
Hospital Directed Payment Adjustment	42,165	42,165
Non-Claims Expense Adjustment	141,502	141,502
IBNR, Incentive, Paid Claims Adjustment	164,572	164,572
Total Medical Costs	143,169,973	143,169,973

* MEDICAL COSTS PER DMHC REGULATIONS

MEDI-CAL
SCHEDULE OF MEDICAL COSTS - ALL COA
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Year to Date
Physician Services		
Primary Care Physician Services	16.05	16.05
Referral Specialty Services	52.50	52.50
Urgent Care & After Hours Advice	5.73	5.73
Hospital Admitting Team	0.02	0.02
Total Physician Services	74.31	74.31
Other Professional Services		
Vision Service Capitation	0.35	0.35
221 - Business Intelligence	0.41	0.41
310 - Health Servcies - Utilization Management	2.11	2.11
311 - Health Services - Quality Improvement	0.60	0.60
312 - Health Services Education	0.59	0.59
313 - Pharmacy	0.29	0.29
314 - Enhanced Care Management	0.73	0.73
316 - Population Health Management	1.22	1.22
317 - In Lieu of Services	0.22	0.22
330 - Member Services	2.46	2.46
410 - Member Engagement	0.17	0.17
601 - Behavioral Health	0.16	0.16
602 - Quality & Health Equity	0.19	0.19
604 - Clinical Operations, Strategy, and Analytics	0.19	0.19
Behavior Health Treatment	8.92	8.92
Mental Health Services	3.77	3.77
Other Professional Services	11.47	11.47
Total Other Professional Services	33.84	33.84
Emergency Room	17.06	17.06
Inpatient Hospital	74.56	74.56
Reinsurance Expense Premium	0.24	0.24
Outpatient Hospital	33.34	33.34
Other Medical		
Ambulance and NEMT	7.94	7.94
Home Health Services & CBAS	2.03	2.03
Utilization and Quality Review Expenses	1.92	1.92
Long Term/SNF/Hospice	21.69	21.69
Provider Enhancement Expense - Prop. 56	3.56	3.56
Provider Enhancement Expense - GEMT	1.72	1.72
Enhanced Care Management	8.97	8.97
Major Organ Transplant	2.29	2.29
Cal AIM Incentive Programs	2.99	2.99
Housing and Homelessness Incentive	1.28	1.28
DME	3.57	3.57
Total Other Medical	57.97	57.97
Pay for Performance Quality Incentive	1.50	1.50
Hospital Directed Payments	59.98	59.98
Hospital Directed Payment Adjustment	0.10	0.10
Non-Claims Expense Adjustment	0.35	0.35
IBNR, Incentive, Paid Claims Adjustment	0.41	0.41
Total Medical Costs	353.65	353.65

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Budget	Variance	Year to date Month 1	Budget	Variance
110 - Executive	624,355	542,745	(81,611)	624,355	542,745	(81,611)
112 - Government Relations	68,770	47,358	(21,412)	68,770	47,358	(21,412)
210 - Accounting	304,846	351,597	46,752	304,846	351,597	46,752
220 - Management Information Systems (MIS)	391,965	276,982	(114,983)	391,965	276,982	(114,983)
221 - Business Intelligence	269,666	223,141	(46,526)	269,666	223,141	(46,526)
222 - MIS Development	377,641	381,923	4,283	377,641	381,923	4,283
223 - Enterprise Configuration	174,793	178,406	3,612	174,793	178,406	3,612
225 - Infrastructure	617,597	859,136	241,539	617,597	859,136	241,539
226 - Technical Administrative Services	49,489	220,111	170,623	49,489	220,111	170,623
230 - Claims	819,584	795,470	(24,115)	819,584	795,470	(24,115)
240 - Project Development	347,377	417,789	70,412	347,377	417,789	70,412
310 - Health Services - Utilization Management	30,997	60,287	29,289	30,997	60,287	29,289
311 - Health Services - Quality Improvement	8,514	49,746	41,232	8,514	49,746	41,232
312 - Health Services - Education	341	357	16	341	357	16
313 - Pharmacy	21,270	38,333	17,063	21,270	38,333	17,063
314 - Enhanced Care Management	44,036	27,349	(16,687)	44,036	27,349	(16,687)
316 - Population Health Management	656	2,975	2,319	656	2,975	2,319
317 - Community Support Services	34	1,625	1,591	34	1,625	1,591
318 - Housing & Homeless Incentive Program (HHIP)	3	-	(3)	3	-	(3)
319 - CAL AIM Incentive Payment Program (IPP)	22,503	-	(22,503)	22,503	-	(22,503)
320 - Provider Network Management	386,421	469,568	83,147	386,421	469,568	83,147
321 - Homeless Management Information Services	-	34,246	34,246	-	34,246	34,246
322 - Delegation & Oversight	21,948	-	(21,948)	21,948	-	(21,948)
330 - Member Services	667,205	282,921	(384,284)	667,205	282,921	(384,284)
340 - Corporate Services	1,024,905	1,034,659	9,754	1,024,905	1,034,659	9,754
360 - Audit & Investigative Services	195,508	241,240	45,732	195,508	241,240	45,732
410 - Member Engagement	76,778	113,644	36,866	76,778	113,644	36,866
420 - Sales/Marketing/Public Relations	177,987	270,104	92,117	177,987	270,104	92,117
510 - Human Resourses	447,072	464,570	17,498	447,072	464,570	17,498
601 - Behavioral Health	43	1,779	1,736	43	1,779	1,736
602 - Quality & Health Equity	40,103	42,027	1,923	40,103	42,027	1,923
604 - Clinical Operations, Strategy & Analytics	-	479	479	-	479	479
605 - Quality Performance	143,642	45,718	(97,924)	143,642	45,718	(97,924)
Administrative Expense Adjustment	258,024	-	(258,024)	258,024	-	(258,024)
Total Administrative Expenses	7,614,072	7,476,286	(137,787)	7,614,072	7,476,286	(137,787)

KERN HEALTH SYSTEMS

MEDI-CAL
SCHEDULE OF ADMINISTRATIVE EXPENSES BY DEPT
FOR THE MONTH ENDED JANUARY 31, 2024

	January	YTD TOTALS
110 - Executive	624,355	624,355
112 - Government Relations	68,770	68,770
210 - Accounting	304,846	304,846
220 - Management Information Systems (MIS)	391,965	391,965
221 - Business Intelligence	269,666	269,666
222 - MIS Development	377,641	377,641
223 - Enterprise Configuration	174,793	174,793
225 - Infrastructure	617,597	617,597
226 - Technical Administrative Services	49,489	49,489
230 - Claims	819,584	819,584
240 - Project Development	347,377	347,377
310 - Health Services - Utilization Management	30,997	30,997
311 - Health Services - Quality Improvement	8,514	8,514
312 - Health Services - Education	341	341
313 - Pharmacy	21,270	21,270
314 - Enhanced Care Management	44,036	44,036
316 - Population Health Management	656	656
317 - Community Support Services	34	34
318 - Housing & Homeless Incentive Program (HHIP)	3	3
319 - CAL AIM Incentive Payment Program (IPP)	22,503	22,503
320 - Provider Network Management	386,421	386,421
322 - Delegation & Oversight	21,948	21,948
330 - Member Services	667,205	667,205
340 - Corporate Services	1,024,905	1,024,905
360 - Audit & Investigative Services	195,508	195,508
410 - Member Engagement	76,778	76,778
420 - Sales/Marketing/Public Relations	177,987	177,987
510 - Human Resourses	447,072	447,072
601 - Behavioral Health	43	43
602 - Quality & Health Equity	40,103	40,103
605 - Quality Performance	143,642	143,642
Administrative Expense Adjustment	258,024	258,024
Total Administrative Expenses	7,614,072	7,614,072

GROUP HEALTH PLAN - HFAM
STATEMENT OF NET POSITION
AS OF JANUARY 31, 2024

ASSETS	January 2024	December 2023	Increase/ (Decrease)
Cash and Cash Equivalents	1,183,679	1,171,884	11,795
Interest Receivable	4,000	11,795	(7,795)
Total Current Assets	1,187,679	1,183,679	4,000
CURRENT LIABILITIES			
Other Liabilities	-	-	-
Total Current Liabilities	-	-	-
NET POSITION:			
Net Position at Beginning of Year	1,183,679	1,130,625	53,054
Increase (Decrease) in Net Position - Current Year	4,000	53,054	(49,054)
Total Net Position	1,187,679	1,183,679	4,000
TOTAL LIABILITIES AND NET POSITION	1,187,679	1,183,679	4,000

GROUP HEALTH PLAN - HFAM
STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN NET POSITION
FOR THE MONTH ENDED JANUARY 31, 2024

	January	Budget	Variance	Year to Date	Budget	Variance
REVENUES						
Premium	-	-	-	-	-	-
Interest	-	-	-	-	-	-
Other Investment Income	4,000	-	4,000	4,000	-	4,000
Total Revenues	4,000	-	4,000	4,000	-	4,000
EXPENSES						
MEDICAL COSTS						
IBNR and Paid Claims Adjustment	-	-	-	-	-	-
Total Medical Costs	-	-	-	-	-	-
GROSS MARGIN	4,000	-	4,000	4,000	-	4,000
ADMINISTRATIVE COSTS						
Management Fee Expense and Other Admin Exp	-	-	-	-	-	-
Total Administrative Expenses	-	-	-	-	-	-
TOTAL EXPENSES	-	-	-	-	-	-
OPERATING INCOME (LOSS) BEFORE TAX	4,000	-	4,000	4,000	-	4,000
NON-OPERATING REVENUE (EXPENSE)						
Total Non-Operating Revenue (Expense)	-	-	-	-	-	-
NET INCREASE (DECREASE) IN NET POSITION	4,000	-	4,000	4,000	-	4,000
MEDICAL LOSS RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ADMINISTRATIVE EXPENSE RATIO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

KERN HEALTH SYSTEMS
MONTHLY MEMBERS COUNT

KERN HEALTH SYSTEMS

MEDI-CAL	2024 MEMBER MONTHS	JAN'24	FEB'24	MAR'24	APR'24	MAY'24	JUN'24	JUL'24	AUG'24	SEP'24	OCT'24	NOV'24	DEC'24
ADULT AND FAMILY													
ADULT (SEE COMMENT)	***73,352***	73,352	0										
CHILD	***169,496***	169,496	0										
SUB-TOTAL ADULT & FAMILY	***242,848***	***242,848***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
OTHER MEMBERS													
PARTIAL DUALS - FAMILY	***774***	774	0										
PARTIAL DUALS - CHILD	***0***	0	0	0	0	0	0	0	0	0	0	0	0
PARTIAL DUALS - BCCTP	***6***	6	0										
BCCTP - TABACCO SETTLEMENT	***0***	0	0	0	0	0	0	0	0	0	0	0	0
FULL DUALS (SPD)													
SPD FULL DUALS	***21,544***	21,544	0										
SUBTOTAL OTHER MEMBERS	***22,324***	***22,324***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
TOTAL FAMILY & OTHER	***265,172***	***265,172***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
SDP MEMBERS													
SPD (AGED AND DISABLED)	***21,942***	21,942	0										
TOTAL CLASSIC MEMBERS	***287,114***	***287,114***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
ACA OE - MEDI-CAL OPTIONAL EXPANSION													
ACA Expansion Adult-Citizen	***115,850***	115,850	0										
EXPANSION DUALS	***1,382***	*1,382*	*0*										
TOTAL ACA OE	***117,232***	***117,232***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
LONG TERM CARE (LTC)													
LTC	***38***	38	0										
LTC DUALS	***451***	451	0										
TOTAL LTC	***489***	***489***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
GRAND TOTAL	***404,835***	***404,835***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Robert Landis, Chief Financial Officer

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

DATE: April 18, 2024

Attached for your review are the following items:

1) Accounts Payable Vendor Report listing of payments over $20,000 for the months of December 2023 and January 2024.

2) Administrative Contract Report listing for contracts between $50,000 and $200,000 for December 2023 and January 2024.

3) IT Technology Consulting Resources Report for the period ending December 31, 2023.

Requested Action

Receive and File.

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	640,160.90	7,261,385.20	DEC. 2023 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE	495,533.39	5,865,607.26	NOV. 2023 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T5466	ZIPARI, INC ****	303,289.68	903,835.36	HOSTED MEMBER AND PROVIDE PORTAL 12/23-05/24	MIS INFRASTRUCTURE
T2458	HEALTHCARE FINANCIAL, INC ****	253,155.43	804,883.65	AUG. - NOV. 2023 CONSULTING	ADMINISTRATION
WT/ACH	USPS	250,000.00	500,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES
T1408	DELL MARKETING L.P.	247,135.85	1,795,748.37	(78) MONITORS W/ 3YR SERVICES, (2) OPTIPLES, AND JAN-JUL AZURE OVERAGES	MIS INFRASTRUCTURE
T4737	TEKSYSTEMS, INC.	230,101.50	2,908,188.55	NOV. 2023 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T5684	REBELLIS GROUP LLC	214,288.75	1,513,803.71	OCT. 2023 MAPD BUSINESS CONSULTING	MEDICARE
T3001	MERCER ****	185,000.00	185,000.00	NOV. & DEC. 2023 COMPENSATION STUDY	ADMINISTRATION
T4733	UNITED STAFFING ASSOCIATES	156,379.16	968,767.53	NOV. 2023 TEMPORARY HELP - (1) FIN: (1) UM: (24) MS: (1) AD: (1) CS	VARIOUS
T1128	HALL LETTER SHOP, INC	130,794.90	351,047.33	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS	VARIOUS
T3088	GLEN BROWN CONSULTING ****	117,693.75	253,193.75	OCT. & NOV. 2023 CONSULTING	BUSINESS INTELLEGENCE
T5781	SCHELLMAN COMPLIANCE LLC	97,750.00	155,950.00	SECURITY ASSESSMENT SERVICES	CAPITAL
T1180	LANGUAGE LINE SERVICES INC ****	89,572.01	869,993.53	OCT. & NOV. 2023 INTERPRETATION SERVICES	HEALTH EDUCATION

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC ****	89,219.57	1,337,901.72	AUG. - NOV. 2023 PROFESSIONAL SERVICES & EDI CLAIM PROCESSING	VARIOUS
T5337	CAZADOR CONSULTING GROUP INC	86,659.88	1,132,180.81	NOV. 2023 TEMPORARY HELP - (16) MS: (1) CS: (1) AD	VARIOUS
T5292	ALL'S WELL HEALTH CARE SERVICES ****	69,095.15	381,944.58	OCT. & NOV. 2023 TEMPORARY HELP	HEALTH SERVICES - QI
T4237	FLUIDEDGE CONSULTING, INC ****	68,240.00	577,627.50	OCT. & NOV. 2023 CONSULTING SERVICES	VARIOUS
T5022	SVAM INTERNATIONAL INC ****	61,150.00	601,867.57	NOV. 2023 PROFESSIONAL SERVICES	MIS ADMINISTRATION
T5658	THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	52,360.83	590,822.18	DEC. 2023 VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T5344	SIGNATURE STAFF RESOURCES LLC	50,548.00	392,407.00	NOV. 2023 PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE
T5696	ASA GLOBAL HEALTHCARE SERVICES PC ****	42,000.00	73,000.00	AUG. & NOV. 2023 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2584	UNITED STATES POSTAL SVC. - HASLER	40,000.00	370,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5583	THE MIHALIK GROUP, LLC ****	38,715.00	185,077.50	AUG. & SEPT. 2023 CONSULTING SERVICES	HEALTH SERVICES - QI
T5435	TEGRIA SERVICES GROUP - US, INC ****	37,537.50	74,037.50	OCT. & NOV. 2023 CONSULTING SERVICES	BUSINESS INTELLIGENCE
T4708	WAKELY CONSULTING GROUP, LLC FRMLY HEALTH MANAGEMENT ASSOCIATES, INC.	36,840.00	211,710.00	PROFESSIONAL SERVICES	ADMINISTRATION
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	36,300.00	427,162.50	NOV. 2023 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4452	WELLS FARGO ACH	31,638.18	347,768.33	NOV. 2023 MISC CREDIT CARD PURCHASES	VARIOUS

KERN·HEALTH SYSTEMS

December AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Year-to-Date	Description	Department
T2167	PG&E	31,546.76	412,121.47	DEC. 2023 UTILITIES	CORPORATE SERVICES
T4657	DAPONDE SIMPSON ROWE PC	29,298.00	465,942.07	OCT. 2023 LEGAL FEES	VARIOUS
T5520	BG HEALTHCARE CONSULTING, INC	29,100.00	277,687.50	NOV. 2023 PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T1861	CERIDIAN HCM, INC.	27,067.56	334,728.01	NOV. & DEC. 2023 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T4255	HANSON BRIDGETT LLP ****	25,042.65	44,846.70	OCT. & NOV. 2023 LEGAL SERVICES	ADMINISTRATION
T3011	OFFICE ALLY, INC	23,743.59	346,796.07	NOV. 2023 EDI CLAIM PROCESSING	CLAIMS
T5298	TOTALMED, INC	23,402.91	125,819.48	NOV. 2023 TEMPORARY HELP	VARIOUS
T1183	MILLIMAN USA ****	22,084.00	93,156.50	OCT. 2023 CONSULTING SERVICES	ADMINISTRATION
T5496	GAMEDAY SPORTS ACADEMY ****	21,600.00	29,100.00	SPONSORSHIP FOR SPORTS ACTIVITIES	HEALTH EDUCATION
T5509	NGUYEN CAO LUU-TRONG ****	21,487.50	229,423.00	NOV. 2023 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	20,169.37	245,508.14	NOV. 2023 EDI CLAIM PROCESSING	CLAIMS
		4,425,701.77			
	TOTAL VENDORS OVER $20,000	4,425,701.78			
	TOTAL VENDORS UNDER $20,000	527,468.04			
	TOTAL VENDOR EXPENSES- DECEMBER	**$ 4,953,169.82**			

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

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1045	KAISER FOUNDATION HEALTH - HMO	7,261,385.20	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4350	COMPUTER ENTERPRISE	5,865,607.26	PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T5452	BLACKHAWK ENGAGEMENT SOLUTIONS INC	3,816,884.00	PREFUND MEMBER INCENTIVES & MCAS MEMBER REWARDS PROGRAM	UTILIZATION MANAGEMENT-HE & QI
T4737	TEKSYSTEMS, INC.	2,908,188.55	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T1408	DELL MARKETING L.P.	1,795,748.37	COMPUTER EQUIPMENT & SOFTWARE MAINTENANCE	MIS INFRASTRUCTURE
T5155	A-C ELECTRIC COMPANY	1,659,450.37	CARPOOL SOLAR PROJECT	CAPITAL
T3449	CDW GOVERNMENT	1,563,709.78	NUTANIX RENEWAL & ADOBE LICENSES	MIS INFRASTRUCTURE
T5684	REBELLIS GROUP LLC	1,513,803.71	MAPD BUSINESS CONSULTING	MEDICARE
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC	1,337,901.72	PROFESSIONAL SERVICES & ANNUAL LICENSING	VARIOUS
T3130	OPTUMINSIGHT, INC	1,270,750.51	ANNUAL LICENSED SOFTWARE	MIS INFRASTRUCTURE
T2704	MCG HEALTH LLC	1,186,808.43	ANNUAL HEALTH CARE MANAGEMENT & SOFTWARE LICENSE	UTILIZATION MANAGEMENT
T5337	CAZADOR CONSULTING GROUP INC	1,132,180.81	TEMPORARY HELP	VARIOUS
T2686	ALLIANT INSURANCE SERVICES INC.	1,123,000.03	2023 -2024 INSURANCE PREMIUMS	ADMINISTRATION

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T1845	DEPARTMENT OF MANAGED HEALTH CARE	1,016,951.10	2023-2024 MCAL ANNUAL ASSESSMENT	ADMINISTRATION
T4733	UNITED STAFFING ASSOCIATES	968,767.53	TEMPORARY HELP	VARIOUS
T1071	CLINICA SIERRA VISTA	912,881.47	HEALTH HOMES GRANT & PROVIDER CARE QUALITY GRANT PROGRAM	COMMUNITY GRANTS
T5466	ZIPARI, INC	903,835.36	2023 JIVA MEMBER PORTAL	MIS INFRASTRUCTURE
T1180	LANGUAGE LINE SERVICES INC	869,993.53	INTERPRETATION SERVICES	HEALTH EDUCATION
T2458	HEALTHCARE FINANCIAL, INC	804,883.65	PROFESSIONAL SERVICES	ADMINISTRATION
T4699	ZEOMEGA, INC	775,936.13	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T5432	CATALYST SOLUTIONS, LLC	662,854.37	PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE
T5503	SECURE-CENTRIC INC	660,258.41	RUBRIK ENTERPRISE SUPPORT	MIS INFRASTRUCTURE
T5022	SVAM INTERNATIONAL INC	601,867.57	PROFESSIONAL SERVICES	MIS ADMINISTRATION
T5658	THE PRUDENTIAL INSURANCE COMPANY OF AMERICA	590,822.18	VOLUNTARY LIFE, AD&D INSURANCE PREMIUM	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC	577,627.50	CONSULTING SERVICES	VARIOUS
WT/ACH	USPS	500,000.00	FUND KHS POSTAL ONE/EPS ACCOUNT	CORPORATE SERVICES
T5421	PREMIER ACCESS INSURANCE COMPANY	486,158.89	EMPLOYEE DENTAL BENEFITS 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
T4331	COTIVITI, INC	477,025.92	2023 HEDIS LICENSE & PROFESSIONAL SERVICES	HEALTH SERVICES - QI
T4657	DAPONDE SIMPSON ROWE PC	465,942.07	LEGAL FEES	VARIOUS
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	427,162.50	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T5701	THE GRANGER NETWORK LLC	416,468.86	SUPERVISOR BOOTCAMP	ADMINISTRATION/HR
T2167	PG&E	412,121.47	UTILITIES	CORPORATE SERVICES
T2918	STINSON'S	393,228.10	OFFICE SUPPLIES	VARIOUS
T5344	SIGNATURE STAFF RESOURCES LLC	392,407.00	2023 PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE
T5292	ALL'S WELL HEALTH CARE SERVICES	381,944.58	TEMPORARY HELP	VARIOUS
T2584	UNITED STATES POSTAL SVC - HASLER	370,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T5562	JDM SOLUTIONS INC	365,320.00	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T1128	HALL LETTER SHOP	351,047.33	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS	VARIOUS
T4452	WELLS FARGO	347,768.33	ACH- MISC CREDIT CARD PURCHASES	VARIOUS
T3011	OFFICE ALLY, INC	346,796.07	EDI CLAIM PROCESSING	CLAIMS
T4165	SHI INTERNATIONAL CO.	339,510.68	NETWORK SWITCHES WITH SUPPORT	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
T1861	CERIDIAN HCM, INC.	334,728.01	MONTHLY SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T2726	DST PHARMACY SOLUTIONS, INC	304,745.63	PHARMACY CLAIMS	PHARMACY
T5520	BG HEALTHCARE CONSULTING, INC	277,687.50	PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T4353	TWE SOLUTIONS, INC	256,517.54	CORTEX XDR PRO LICENSES	MIS INFRASTRUCTURE
T3088	GLEN BROWN CONSULTING	253,193.75	CONSULTING	HEALTH SERVICES - IPP
T4460	PAYSPAN, INC	246,667.69	ELECTRONIC CLAIMS/PAYMENTS	FINANCE
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	245,508.14	2023 EDI CLAIM PROCESSING	CLAIMS
T5509	NGUYEN CAO LUU-TRONG	229,423.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T5486	ALLIED GENERAL CONTRACTORS, INC	224,750.00	OFFICE PAINTING & CONSTRUCTION	CAPITAL
T4695	EDIFECS, INC.	218,582.73	ANNUAL TSM MAINTENANCE	MIS INFRASTRUCTURE
T4708	WAKELY CONSULTING GROUP, LLC FRMLY HEALTH MANAGEMENT ASSOCIATES, INC.	211,710.00	PROFESSIONAL SERVICES	ADMINISTRATION
T2413	TREK IMAGING INC	209,529.46	COMMUNITY AND MARKETING EVENTS, MEMBER & HEALTH ED INCENTIVES, EMPLOYEE EVENTS, NEW HIRE SHIRTS	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4514	A.J. KLEIN, INC T.DENATALE, B. GOLDNER	200,413.12	LEGAL FEES	ADMINISTRATION
T2469	DST HEALTH SOLUTIONS, LLC	199,100.00	ANNUAL ACG LICENSE & SUPPORT	BUSINESS INTELLEGENCE
T4501	ALLIED UNIVERSAL SECURITY SERVICES	196,310.86	ONSITE SECURITY	CORPORATE SERVICES
T1960	LOCAL HEALTH PLANS OF CALIFORNIA	191,356.01	WEBINAR REGISTRATIONS & SPECIAL DUES ASSESSMENT	VARIOUS
T5145	CCS ENGINEERING FRESNO INC	188,409.98	JANITORIAL SERVICES	CORPORATE SERVICES
T5546	BITWISE TECHNOLOGY CONSULTING, LLC	188,131.80	OCR SERVICES AND PROFESSIONAL SERVICES	VARIOUS
T5583	THE MIHALIK GROUP, LLC	185,077.50	NCQA TRAINING	HEALTH SERVICES - QI
T3001	MERCER ****	185,000.00	CONSULTING SERVICES	HUMAN RESOURCES
T5340	GARTNER INC	178,380.00	ANNUAL LEADERS INDIVIDUAL ACCESS ADVISOR - PROFESSIONAL SERVICES	MIS ADMINISTRATION
T5111	ENTISYS 360, E360	173,563.05	NUTANIX ACROPOLIS SOFTWARE LICENSE	MIS INFRASTRUCTURE
T2969	AMERICAN BUSINESS MACHINES INC	167,674.74	HARDWARE AND MAINTENANCE	CORPORATE SERVICES
T5781	SCHELLMAN COMPLIANCE LLC	155,950.00	SECURITY ASSESSMENT SERVICES	CAPITAL
T5121	TPX COMMUNICATIONS	152,818.60	LOCAL CALL SERVICES; LONG DISTANCE CALLS; INTERNET SERVICES; 800 LINES	MIS INFRASTRUCTURE
T2955	DELTA ELECTRIC INC	152,755.00	BUILDING IMPROVEMENT/MAINTENANCE	CORPORATE SERVICES
T5291	PINNACLE RECRUITMENT SERVICES LLC	152,678.40	TEMPORARY HELP	VARIOUS

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2933	SIERRA PRINTERS, INC	152,460.64	PRINTING OF MEMBER EDUCATION MATERIAL/PROVIDER DIRECTORY/BUSINESS CARDS	VARIOUS
T1022	UNUM LIFE INSURANCE CO.	151,784.77	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5329	RELAY NETWORK, LLC	144,999.91	TEXT MESSAGING SUBSCRIPTION	CAPITAL PROJECT
T1005	COLONIAL LIFE & ACCIDENT	142,580.74	LIFE INSURANCE PREMIUM	VARIOUS
T1272	COFFEY COMMUNICATIONS INC	134,017.42	MEMBER NEWSLETTER/WEBSITE IMPLEMENTATION	HEALTH EDUCATION/MEDIA & ADVERTISING
T5298	TOTALMED, INC	125,819.48	TEMPORARY HELP	VARIOUS
T5738	INSURICA - WALTER MORTENSEN INSURANCE	118,943.00	2023-2024 ANNUAL WORKERS' COMP PREMIUM	ADMINISTRATION
T4985	CYBERCODERS, INC	114,039.40	PROFESSIONAL SERVICES	MIS ADMINISTRATION
T4963	LINKEDIN CORPORATION	112,372.50	ANNUAL ONLINE TRAINING FOR ALL EMPLOYEES	HUMAN RESOURCES
T4503	VISION SERVICE PLAN	110,938.57	EMPLOYEE HEALTH BENEFITS	VARIOUS
T4902	CHANGE HEALTHCARE TECHNOLOGIES, LLC	102,482.32	2023 EDI CLAIM PROCESSING	CLAIMS
T2941	KERN PRINT SERVICES INC	100,293.27	OTHER PRINTING COSTS, ENVELOPES, LETTERHEAD	VARIOUS
T5734	CAROL ANN STILTNER	94,605.89	PROFESSIONAL SERVICES	MEDICARE
T2961	SOLUTION BENCH, LLC	94,001.55	M-FILES SOFTWARE ANNUAL RENEWAL	MIS INFRASTRUCTURE
T1183	MILLIMAN USA	93,156.50	CY2021/2022 TNE & IBNP CONSULTING - ACTUARIAL	ADMINISTRATION

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T2509	USPS	91,780.14	PERMIT #88 SUMMER ISSUE FAMILY HEALTH MAGAZINE POSTAGE FUNDING	HEALTH EDUCATION
T4785	COMMGAP	86,901.25	INTERPRETATION SERVICES	HEALTH EDUCATION
T4217	CONTEXT 4 HEALTHCARE, INC	86,083.12	ANNUAL RENEWAL AMA FEES & CPT LICENSE	MIS INFRASTRUCTURE
T5319	CITIUSTECH INC	84,996.00	FAST+ ANNUAL MAINTENANCE & SUPPORT	MIS INFRASTRUCTURE
T4483	INFUSION AND CLINICAL SERVICES, INC	80,177.67	DIABETIC GRANT PROGRAM	COMMUNITY GRANTS
T4265	SIERRA SCHOOL EQUIPMENT COMPANY	80,127.61	BOARDROOM FURNITURE	CORPORATE SERVICES
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	78,000.00	2023 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4484	JACOBSON SOLUTIONS	76,148.22	TEMPORARY HELP	HEALTH SERVICES - UM
T5435	TEGRIA SERVICES GROUP - US, INC	74,037.50	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T5550	CHARTER COMMUNICATIONS OPERATING, LLC	73,803.45	INTERNET SERVICES	MIS INFRASTRUCTURE
T5696	ASA GLOBAL HEALTHCARE SERVICES PC	73,000.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T2446	AT&T MOBILITY	71,598.80	CELLULAR PHONE/INTERNET USAGE	MIS INFRASTRUCTURE
T4792	KP LLC	70,149.79	PROVIDER DIRECTORIES	PROVIDER NETWORK MANAGEMENT
T3986	JACQUELYN S JANS	65,970.00	CONSULTING FOR KHS PUBLIC IMAGE CAMPAIGN	ADMINISTRATION/ MARKETING

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5741	HEALTHWISE, INCORPORATED	65,009.58	MEMBER SELF MANAGEMENT TOOLS	HEALTH EDUCATION
T5805	MAGNOLIA OPTIMA LLC	64,417.53	CONSULTING SERVICES	HUMAN RESOURCES
T5392	THE KNOWLEDGE ACADEMY INC	61,485.00	CA PROJECT MANAGEMENT TRAINING	MIS ADMINISTRATION
T2851	SINCLAIR TELEVISION OF BAKERSFIELD, LLC	60,870.00	ADVERTISEMENT - MEDIA	MARKETING
T4216	NEXSTAR BROADCASTING INC	59,770.00	ADVERTISEMENT - MEDIA	MARKETING
T5436	THE BEACON STUDIOS LLC	59,702.00	TV COMMERCIAL PRODUCTION	MEDIA & ADVERTISING
T4585	DELANO UNION SCHOOL DISTRICT	59,000.00	SCHOOL WELLNESS GRANT	COMMUNITY GRANTS
T5524	REST & REASSURE, LLC	58,500.00	2023 PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T5743	INTEL AGREE, COLABS	58,375.00	CONTRACTING MANAGEMENT SOFTWARE	CAPITAL
T5751	EXCELL HCA, LLC	57,400.00	PROFESSIONAL SERVICES	PROJECT MANAGEMENT
T4934	APPLE INC.	55,236.44	EQUPMENT - CELL PHONES	VARIOUS
T5592	BRAND CO MARKETING	53,011.55	KHS STORE INVENTORY ITEMS & PROMOTIONAL ITEMS	VARIOUS
T4607	AGILITY RECOVERY SOLUTIONS INC	52,545.47	PROFESSIONAL SERVICES	ADMINISTRATION
T5109	RAND EMPLOYMENT SOLUTIONS	52,410.84	TEMPORARY HELP	VARIOUS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5201	JAC SERVICES, INC	52,344.58	AC MAINTENANCE & SERVICE	CORPORATE SERVICES
T5199	MOSSMAN COFFEE SHOPS & CATERING, INC	52,333.52	ANNUAL STAFF PICNIC CATERING	HUMAN RESOURCES
T3972	JOURNEY AIR CONDITIONING CO., INC	51,989.00	HVAC NEW UNIT & INSTALL	CAPITAL
T4415	DANIELLS PHILLIPS VAUGHAN AND BOCK	51,900.00	2022 AUDIT FEES	FINANCE
T2441	LAURA J BREZINSKI	51,000.00	MARKETING MATERIALS	MARKETING
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	50,677.00	2023 ANNUAL DUES ASSESSMENT	ADMINISTRATION
T4182	THE LAMAR COMPANIES	50,482.42	OUTDOOR ADVERTISEMENT - BILLBOARDS	ADVERTISING
T5644	JENNIFER ELIZABETH CLANCY	49,500.00	PROFESSIONAL SERVICES	MIS INFRASTRUCTURE
T2580	GOLDEN EMPIRE TRANSIT DISTRICT	48,900.00	OUTDOOR ADVERTISEMENT - BUSES	ADVERTISING
T5429	JANE MACADAM	48,775.18	2022/2023 HYBRID COMMUTING	COMPLIANCE
T5479	TRANSFORMING LOCAL COMMUNITIES, INC	48,611.30	2022/2023 PROVIDER GRANT PROGRAM	COMMUNITY GRANTS
T5802	MOTOR VEHICLE NETWORK	47,430.00	ADVERTISING -MOTOR VEHICLE NETWORK	MARKETING
T1655	KERN,KKXX,KISV,KGEO,KGFM,KEBT,KZOZ,KKJG,KVEC,KSTT, KRQK,KPAT	47,425.00	RADIO ADVERTISING	MARKETING

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5408	MARY HARRIS	47,124.00	PROFESSIONAL SERVICES	HEALTH SERVICES - UM
T2641	MARANATHA GARDENING & LANDSCAPING, INC	46,277.50	2023 BUILDING MAINTENANCE	CORPORATE SERVICE
T2869	COMMUNITY ACTION PARTNERSHIP OF KERN	46,200.00	2023 COMMUNITY GRANT	COMMUNITY GRANTS
T5480	PRESS GANEY ASSOCIATES LLC	46,002.00	2023 ECM & PROVIDER SATISFACTION SURVEYS	VARIOUS
T5645	RIDGECREST REGIONAL HOSPITAL	45,000.00	PROVIDER QUALITY CARE GRANT PROGRAM	COMMUNITY GRANTS
T4255	HANSON BRIDGETT LLP ****	44,846.70	LEGAL FEES	ADMINISTRATION
T5107	CITRIX SYSTEMS, INC	42,619.20	CITRIX LICENSE RENEWAL	MIS INFRASTRUCTURE
T4605	KERNVILLE UNION SCHOOL DISTRICT	42,000.00	SCHOOL WELLNESS GRANT	COMMUNITY GRANTS
T5687	IRISE EXECUTIVE COACHING LLC	42,000.00	EXECUTIVE RETREAT	ADMINISTRATION
T5313	HEALTH LITERACY INNOVATIONS, LLC	40,498.00	LITERACY ADVISOR ANNUAL SOFTWARE LICENSE	HEALTH EDUCATION
T1347	ADVANCED DATA STORAGE	40,303.60	STORAGE AND SHREDDING SERVICES	CORPORATE SERVICES
T4993	LEGALSHIELD	40,032.55	EMPLOYEE PAID VOLUNTARY COVERAGE	PAYROLL DEDUCTION
T5535	PANAMA-BUENA VISTA UNION SCHOOL DISTRICT	40,000.00	SCHOOL WELLNESS GRANT	COMMUNITY GRANTS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5367	ADVENTIST HEALTH DELANO	39,910.73	PROVIDER GRANT PROGRAM	COMMUNITY GRANT
T5467	MOSS ADAMS LLP	37,597.00	2023 CLAIMS AUDIT TOOL SUPPORT & LICENSES	MIS INFRASTRUCTURE
T5026	TEL-TEC SECURITY SYSTEMS	37,315.22	MONITORING SERVICES	CORPORATE SERVICES
T1694	KERN COUNTY FAIR	35,625.00	2023 FAIR SIGNAGE, EMPLOYEE TICKETS & PARKING	HUMAN RESOURCES & MARKETING
T4228	THE SSI GROUP, LLC	35,365.00	2023 EDI CLAIM PROCESSING	CLAIMS
T4059	KERN VALLEY HEALTHCARE DISTRICT	35,327.26	PROVIDER GRANT PROGRAM	COMMUNITY GRANT
T5757	BITFOCUS, INC ****	35,244.20	ENTERPRISE SOFTWARE LICENSING & DATA MODELING	CAPITAL PROJECT
T2578	AMERICAN HEART ASSOCIATION - KERN COUNTY	35,000.00	SPONSORSHIP	MEDIA & ADVERTISING
T1097	NCQA	34,502.56	HEDIS, VOL 2 PLUS QUALITY COMPASS AND POPULATION HEALTH PROGRAM ACCREDIATION	HEALTH SERVICES - QI
T4230	COFFEE BREAK SERVICE, INC.	34,475.96	COFFEE SUPPLIES	CORPORATE SERVICES
T2921	DOUBLETREE BY HILTON BAKERSFIELD	34,303.43	PROVIDER FORUM EDUCATIONAL EVENT	PROVIDER NETWORK MANAGEMENT
T5831	CCS FACILITY SERVICES - FRESNO INC	34,158.70	JANITORIAL SERVICES	CORPORATE SERVICES
T5321	TYK TECHNOLOGIES LTD	34,000.00	TYK LICENSE RENEWAL 23/24	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
T3084	KERN COUNTY-COUNTY COUNSEL	32,578.00	LEGAL SERVICES	EXECUTIVE
T1007	FEDERAL EXPRESS CORP.	32,285.69	DELIVERY SERVICES	VARIOUS
T5568	MICHELLE OXFORD	30,910.89	CONSULTING SERVICES	EXECUTIVE
T5574	CARMAX AUTO SUPERSTORES, INC	30,451.85	COMPANY VEHICLE	CORPORATE SERVICES
T5012	KERN MEDICAL CENTER FOUNDATION	30,000.00	VALLEY FEVER WALK SPONSOSHIP	MARKETING
T5613	SMARTY, LLC	30,000.00	US ADDRESS VERIFICATION LICENSE	BUSINESS INTELLIGENCE
T5653	SUN OUTDOOR ADVERTISING LLC	29,935.00	OUTDOOR ADVERTISEMENT - BILLBOARDS	ADVERTISING
T4249	LOTUS BAKERSFIELD CORP	29,750.00	RADIO ADVERTISING	MARKETING
T4577	LA CAMPESINA, KBDS, KUFW, KMYX, KSEA, KBHH, KYLI, KCEC, KNAI	29,622.00	RADIO ADVERTISING	MARKETING
T5778	CONTOUR DATA SOLUTIONS, LLC ****	29,400.00	ANNUAL DATA SOLUTIONS	CAPITAL PROJECT
T5496	GAMEDAY SPORTS ACADEMY ****	29,100.00	COMMUNITY SPONSORSHIP	HEALTH EDUCATION
T4554	THE KEN BLANCHARD COMPANIES	28,845.93	LEADERSHIP TRAINING COURSES	HUMAN RESOURCES
T4982	NGC US, LLC	28,550.00	PREFUND MEMBER INCENTIVES - COVID 19 INCENTIVE PROGRAM	VARIOUS

KERN·HEALTH SYSTEMS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T4195	SCRIPPS MEDIA, INC. DBA KERO-TV	28,015.00	ADVERTISEMENT - MEDIA	MARKETING
T5494	LDP ASSOCIATES, INC	27,300.00	2023/2024 DISASTER RECOVERY & PC COOLING MAINT.	VARIOUS
T5395	LIVONGO HEALTH, INC	27,258.00	EMPLOYEE MENTAL HEALTH BENEFITS PREMIUM	VARIOUS
T5652	RACHAEL L HOBBS	27,153.00	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T4375	EQUIFAX WORKFORCE SOLUTIONS, LLC	26,828.39	EMPLOYEE RECRUITMENT	HUMAN RESOURCES
T5300	CENTRAL VALLEY OCCUPATION MEDICAL GROUP, INC	26,780.00	COVID-19 TESTING	HUMAN RESOURCES
T5759	SHELLBY ROSE P DUMLAO	26,600.00	CONSULTING SERVICES	POPULATION HEALTH MANAGEMENT
T5791	WEINTRAUB TOBIN ****	26,580.00	LEGAL SERVICES	ADMINISTRATION
T4424	GUROCK SOFTWARE GmbH	26,565.97	TESTRAIL SOFTWARE RENEWAL	MIS INFRASTRUCTURE
T4417	KAISER FOUNDATION HEALTH PLAN - OR	26,382.36	EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T4544	BARNES WEALTH MANAGEMENT GROUP	26,260.00	RETIREMENT CONSULTING SERVICES	EXECUTIVE
T4523	BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA	26,190.47	EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5420	PAYPRO ADMINISTRATORS	25,769.80	FSA EMPLOYEE BENEFIT	VARIOUS
T5578	KIMBERLY A MARTIN	25,665.50	PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM

KERN·HEALTH SYSTEMS

Year to Date AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5260	HD DYNAMICS SOFTWARE SOLUTIONS, CORP	25,625.00	CONSULTING FEES	PROVIDER NETWORK MANAGEMENT
T4731	GO TO TECHNOLOGY CONSULTING, LLC	25,062.00	INTERNET SERVICES	MIS INFRASTRUCTURE
T3057	TOUCH OF GLASS ****	24,225.00	EXTERIOR WINDOW CLEANING	CORPORATE SERVICES
T4611	LAMONT SCHOOL DISTRICT	24,000.00	SCHOOL WELLNESS GRANT	COMMUNITY GRANTS
T5530	JONES LANG LASALLE AMERICAS, INC	23,960.00	CUBICLE SCHEDULING APP IMPLEMENTATION & TRAIING	CORPORATE SERVICES
T2787	SAGE SOFTWARE, INC	23,561.11	SAGE 300 CLOUD SOFTWARE ANNUAL RENEWAL	FINANCE
T5585	LIFETIME FITNESS INC	23,300.00	LIVE BETTER PROGRAM BUTTONWILLOW & DELANO	HEALTH EDUCATION
T5317	PRESIDIO NETWORKED SOLUTIONS GROUP LLC	23,125.00	NUTANIX HARDWARE & SOFTWARE - SECURITY PROGRAM ASSESSMENT	MIS INFRASTRUCTURE
T2601	RHL FIRE PROTECTION, INC ****	22,669.50	SPRINKLER INSPECTION & REPAIR	CORPORATE SERVICES
T2449	ASTRID ENRIQUEZ	22,556.83	CONSULTING SERVICES	HEALTH EDUCATION
T5159	AT&T CORP	22,352.80	INTERNET SERVICES	MIS INFRASTRUCTURE

KERN·HEALTH SYSTEMS

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Amounts over $20,000.00

Vendor No.	Vendor Name	Year-to-Date	Description	Department
T5669	THE OPEN DOOR NETWORK	21,418.00	2023 SPONSORSHIPS & COMMUNITY GRANT	MARKETING
T5843	SEVEN OAKS COUNTRY CLUB ****	21,336.08	MANAGEMENT FORUM & PROVIDER BANQUETS	VARIOUS
T4466	MENTORS MOVING & STORAGE ****	20,459.00	STORAGE & MOVING LABOR	CORPORATE SERVICES
T5711	CALABRIO, INC.	20,159.50	TELEOPTI WFM LICENSES	MIS INFRASTRUCTURE
T4476	KERN PARTNERSHIP FOR CHILDREN AND FAMILIES	20,000.00	SPONSORSHIP & COMMUNITY GRANT	MARKETING
		60,444,349.05		
	TOTAL VENDORS OVER $20,000	60,444,349.05		
	TOTAL VENDORS UNDER $20,000	2,282,532.17		
	TOTAL VENDOR EXPENSES- DECEMBER	$ **62,726,881.22**		

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

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Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T1408	DELL MARKETING L.P.	966,802.45	(100) MONITORS, (50) LAPTOPS, ENTERPRISE AGREEMENT YR2, MICROSOFT LICENSES YR 3, AND OCT-DEC AZURE OVERAGES	MIS INFRASTRUCTURE
T1045	KAISER FOUNDATION HEALTH - HMO	797,552.29	JAN. 2024 EMPLOYEE HMO HEALTH BENEFITS PREMIUM	VARIOUS
T3130	OPTUMINSIGHT, INC	746,059.00	CLAIMS EDITING SOFTWARE LICENSE RENEWAL	MIS INFRASTRUCTURE
T5111	ENTISYS 360, E360	707,112.71	VMWARE SOFTWARE LICENSE RENEWAL	MIS INFRASTRUCTURE
T4350	COMPUTER ENTERPRISE	403,858.19	DEC. 2023 PROFESSIONAL SERVICES/CONSULTING SERVICES	VARIOUS
T5684	REBELLIS GROUP LLC	250,337.50	NOV. 2023 MAPD BUSINESS CONSULTING	MEDICARE
T3022	MICROSOFT CORPORATION	219,030.00	NOV. - DEC. CONSULTING SERVICES	ENTERPRISE CONFIGURATION
T2469	DST HEALTH SOLUTIONS, LLC	200,350.00	ANNUAL ACG LICENSE FEE AND SUPPORT	BUSINESS INTELLIGENCE
T5340	GARTNER INC	189,765.00	ANNUAL LICENSES FOR EXECUTIVE LEADERSHIP TEAM	TECHNICAL ADMINISTRATIVE SERVICES
T1180	LANGUAGE LINE SERVICES INC	142,289.40	NOV. & DEC.. 2023 INTERPRETATION SERVICES	HEALTH EDUCATION
T4733	UNITED STAFFING ASSOCIATES	130,931.54	DEC. 2023 & JAN. 2024 TEMPORARY HELP - (1) FIN: (1) UM: (24) MS: (1) AD: (1) CS	VARIOUS
T5337	CAZADOR CONSULTING GROUP INC	113,236.80	NOV. 2023 TEMPORARY HELP - (16) MS: (1) CS: (1) AD	VARIOUS
T4722	COGNIZANT TRIZETTO SOFTWARE GROUP, INC	102,772.61	DEC. 2023 PROFESSIONAL SERVICES & EDI CLAIM PROCESSING	VARIOUS
T4737	TEKSYSTEMS, INC.	89,389.70	DEC. 2023 PROFESSIONAL SERVICES	MIS INFRASTRUCTURE

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Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T4054	ASSOCIATION FOR COMMUNITY AFFILIATED PLANS	85,000.00	2024 MEMBER DUES	ADMINISTRATION
T5865	HARTE-HANKS RESPONSE MANAGEMENT/AUSTIN, INC	77,128.25	DEC. 2023 PROFESSIONAL SERVICES	MEMBER SERVICES
T5571	GHA TECHNOLOGIES INC	71,550.61	FORTINET SECURITY RENEWAL	MIS INFRASTRUCTURE
T3449	CDW GOVERNMENT	68,590.15	ANNUAL ADOBE RENEWAL	MIS INFRASTRUCTURE
T4963	LINKEDIN CORPORATION	65,388.50	LINKEDIN LEARNING 2024	HUMAN RESOURCES
T1272	COFFEY COMMUNICATIONS INC	59,379.32	WINTER MEMBER NEWSLETTER/WEBSITE IMPLEMENTATION	HEALTH EDUCATION/MEDIA & ADVERTISING
T4792	KP LLC	55,549.18	DEC. 2023 SUPPORT AND PROVIDER DIRECTORIES	PROVIDER NETWORK MANAGEMENT
T5022	SVAM INTERNATIONAL INC	54,265.00	DEC. 2023 PROFESSIONAL SERVICES	MIS ADMINISTRATION
T5751	EXCELL HCA, LLC	52,500.00	NOV. & DEC. 2023 PROFESSIONAL SERVICES	PROJECT MANAGEMENT
T1404	CALIFORNIA ASSOCIATION OF HEALTH PLANS	51,521.00	2024 ANNUAL DUES	ADMINISTRATIVE
T5292	ALL'S WELL HEALTH CARE SERVICES	50,636.81	DEC. 2023 TEMPORARY HELP	HEALTH SERVICES - QI
T5421	PREMIER ACCESS INSURANCE COMPANY	46,074.50	JAN. 2024 EMPLOYEE HEALTH BENEFITS PREMIUM	VARIOUS
T4237	FLUIDEDGE CONSULTING, INC	45,337.50	NOV. & DEC. 2023 CONSULTING SERVICES	VARIOUS
T3088	GLEN BROWN CONSULTING	43,837.50	DEC. 2023 CONSULTING	BUSINESS INTELLEGENCE

KERN·HEALTH SYSTEMS

January AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T5890	DELTA DENTAL OF CALIFORNIA	42,762.47	JAN. 2024 EMPLOYEE DENTAL HEALTH BENEFITS PREMIUM	VARIOUS
T5564	CLARISHEALTH, INC	42,019.27	DEC. 2023 DRG AUDIT RECOVERIES	ADMINISTRATIVE
T4353	TWE SOLUTIONS, INC	41,803.56	2 JUNIPER SWITCHES, LICENSES AND SUPPORT	CAPITAL
T5344	SIGNATURE STAFF RESOURCES LLC	40,700.00	DEC. 2023 PROFESSIONAL SERVICES	BUSINESS INTELLIGENCE
T4563	SPH ANALYTICS	40,096.50	HEDIS CAHPS & ECM SURVEYS	MEMBER SERVICES & ECM
T2584	UNITED STATES POSTAL SVC. - HASLER	40,000.00	POSTAGE (METER) FUND	CORPORATE SERVICES
T4708	WAKELY CONSULTING GROUP, LLC FRMLY HEALTH MANAGEMENT ASSOCIATES, INC.	39,472.50	OCT. & NOV. 2023 PROFESSIONAL SERVICES	VARIOUS
T2941	KERN PRINT SERVICES INC	39,075.90	ENVELOPES AND LETTERHEAD	CORPORATE SERVICES
T2167	PG&E	38,796.87	JAN. 2024 UTILITIES	CORPORATE SERVICES
T5076	MERIDIAN HEALTH SYSTEMS, P.C.	38,100.00	DEC. 2023 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5420	PAYPRO ACH	35,762.87	JAN. 2024 EMPLOYEE PREMIUM	PAYROLL DEDUCTION
T5520	BG HEALTHCARE CONSULTING, INC	34,800.00	NOV. 2023 PROFESSIONAL SERVICES	POPULATION HEALTH MANAGEMENT
T2562	CACTUS SOFTWARE LLC	33,506.15	ANNUAL CREDENTIALING SOFTWARE RENEWAL	MIS INFRASTRUCTURE
T5742	INCLUSIVE INSIGHTS	30,000.00	DEC. - MAR. CONSULTING SERVICES	QUALITY & HEALTH EQUITY

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Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T5291	PINNACLE RECRUITMENT SERVICES LLC	29,123.55	DEC. 2023 TEMPORARY HELP - (1) FIN: (2) CLM: (1) PNM; (1) MS: (1) HR	VARIOUS
T1861	CERIDIAN HCM, INC.	27,064.32	DEC. 2023 & JAN. 2024 SUBSCRIPTION FEES/PROFESSIONAL SERVICES/ DAYFORCE HUMAN CAPITAL MANAGEMENT	HUMAN RESOURCES
T5583	THE MIHALIK GROUP, LLC	26,717.50	OCT. 2023 CONSULTING SERVICES	HEALTH SERVICES - QI
T1128	HALL LETTER SHOP, INC	26,614.65	MEMBER ID CARDS, MEMBER SURVEY & MAIL PREP, NEW MEMBER PACKETS	VARIOUS
T4985	CYBERCODERS, INC	26,000.00	DEC. 2023 PROFESSIONAL SERVICES	MIS ADMINISTRATION
T3011	OFFICE ALLY, INC	23,619.39	DEC. 2023 EDI CLAIM PROCESSING	CLAIMS
T5435	TEGRIA SERVICES GROUP - US, INC	22,400.00	DEC. 2023 CONSULTING SERVICES	BUSINESS INTELLIGENCE
T1183	MILLIMAN USA	22,082.25	NOV. 2023 CONSULTING SERVICES	ADMINISTRATION
T2413	TREK IMAGING INC	21,980.96	MEMBER PROMOTIONAL ITEMS, LANYARDS & HEART CLIPS FOR EMPLOYEES & KHS STORE INVENTORY	VARIOUS
T4501	ALLIED UNIVERSAL SECURITY SERVICES	21,403.13	DEC. 2023 & JAN. 2024 SECURITY	CORPORATE SERVICES
T5319	CITIUSTECH INC	21,249.00	FAST + SUBSCRIPTION Q4 2023	MIS INFRASTRUCTURE
T5509	NGUYEN CAO LUU-TRONG	21,187.50	DEC. 2023 PROFESSIONAL SERVICES	UTILIZATION MANAGEMENT-UM
T5701	THE GRANGER NETWORK LLC	21,146.71	5 OF 12 EXECUTIVE COACHING & TRAVEL EXPENSES	ADMINISTRATION

KERN·HEALTH SYSTEMS

January AP Vendor Report

Amounts over $20,000.00

Vendor No.	Vendor Name	Current Month	Description	Department
T5298	TOTALMED, INC	20,884.48	DEC. 2023 TEMPORARY HELP	VARIOUS
T4452	WELLS FARGO ACH	20,793.31	DEC. 2023 MISC CREDIT CARD PURCHASES	VARIOUS
T4657	DAPONDE SIMPSON ROWE PC	20,508.00	NOV. 2023 LEGAL FEES	VARIOUS
T4538	CHANGE HEALTHCARE SOLUTIONS, LLC	20,109.50	DEC. 2023 EDI CLAIM PROCESSING	CLAIMS
		6,816,025.85		
	TOTAL VENDORS OVER $20,000	6,816,025.85		
	TOTAL VENDORS UNDER $20,000	714,407.16		
	TOTAL VENDOR EXPENSES- JANUARY	**$ 7,530,433.01**		

Vendor Name	Contract Amount	Budgeted	Department	Department Head	Services that this vendor will provide to KHS	Effective Date	Termination Date
December 2023							
Harte Hanks	$73,802.60	Yes	MS	Nate Scott	New Member Welcome Calls	12/1/2023	12/31/2023
Cotiviti	$199,999.00	Yes	QP	Jake Hall	Medical Record Retrieval (MRR) services	12/5/2023	12/4/2024
Dell	$120,600.40	Yes	IT	Richard Pruitt	(50) Laptops & (100) Monitors	12/11/2023	12/10/2027
KP	$56,064.74	Yes	MRKT	Louie Iturriria	13,000 Provider Directories	12/15/2023	N/A
Preparis	$103,425.84	Yes	CS	Andrea Hylton	Audit of Crisis management plans (Emergency Action, Disaster Recovery, and Business Continuity)	12/18/2023	12/17/2026
January 2024							
Press Ganey/SPH Analytics	$81,696.00	Yes	ECM	Loni Hill-Pirtle	ECM Member Satisfaction Survey	1/1/2024	12/31/2026
HD Dynamics	$50,000.00	Yes	PNM	Amisha Pannu	Consulting services for CRM process	1/2/2024	12/31/2024
Harte Hanks	$198,064.00	Yes	MS	Nate Scott	Up to (3,200) New Member Welcome calls	1/1/2024	12/31/2024
E360	$51,837.28	Yes	IT	Richard Pruitt	(52) licenses for VMware maintenance & technical support	1/1/2024	12/31/2024
Reliable Janitorial	$199,008.00	Yes	CS	Andrea Hylton	Janitorial services	1/11/2024	1/10/2025
GHA Technologies	$71,550.61	Yes	IT	Richard Pruitt	Fotinet-Fortigate Maintenance & Support for Security Appliances	1/1/2024	12/31/2024
Poppyrock	$120,000.00	Yes	MRKT	Louie Iturriria	KHS & KFHC Graphic Design	1/2/2024	12/31/2025
Gartner	$189,765.00	Yes	IT	Richard Pruitt	Executive Program Leadership licenses (3)	1/1/2024	12/31/2024
CDW-G	$67,761.50	Yes	IT	Richard Pruitt	All Adobe licenses annual renewal (257)	1/26/2024	1/25/2025
The Granger Network	$198,800.00	Yes	HR	Alan Avery	Front Lines Activation and Manager Bootcamp	1/1/2024	6/30/2024
BG Healthcare	$199,000.00	Yes	QI	Dr. Martha Tasinga	Consulting services for the QI dept	1/1/2024	12/31/2024
BG Healthcare	$199,000.00	Yes	PHM	Michelle Curiouso	Consulting services for the PHM dept	1/1/2024	12/31/2024
CAQH	$50,000.00	Yes	PNM	Amisha Pannu	Access to real-time Provider applications	1/25/2024	1/24/2025
Michael Nguyen	$197,500.00	Yes	Health Equity	Traco Matthews	Consulting services	1/1/2024	12/31/2024

2023 TECHNOLOGY CONSULTING RESOURCES																	
ITEM	PROJECT	CAP/EXP	BUDGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	YTD TOTAL	REMAINING BALANCE
#	Project Name																
1	*Member Engagement*	*CAP*	$158,500	$23,832	$22,640	$26,215	$23,832	$26,215	$26,215	$0	$0	$0	$0	$0	$0	$148,949	$9,551
2	*DSNP MCAS Star Software*	*CAP*	$158,500	$0	$0	$0	$0	$0	$0	$17,476	$21,602	$18,447	$20,631	$17,719	$20,631	$116,506	$41,994
3	*Population Health Management*	*CAP*	$356,407	$34,348	$32,436	$38,231	$36,047	$40,719	$39,839	$41,432	$27,407	$23,832	$0	$0	$0	$314,291	$42,116
4	*DSNP JIVA Medicare Module*	*CAP*	$81,750	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,215	$19,066	$21,449	$66,730	$15,020
5	*Data Lineage and Cataloging System*	*CAP*	$91,012	$0	$0	$0	$0	$0	$0	$0	$18,480	$17,600	$19,360	$10,560	$9,680	$75,680	$15,332
6	*IT Staff Augmentation*	*EXP*	$6,519,524	$549,087	$472,083	$607,699	$248,118	$570,405	$545,734	$469,708	$545,286	$432,175	$569,888	$528,279	$724,164	$6,262,626	$256,898
7	*PM Staff Augmentation*	*EXP*	$1,185,600	$17,940	$91,885	$142,020	$391,554	$157,653	$147,951	$134,758	$133,185	$171,713	$239,501	$209,419	$211,253	$2,048,832	($863,232)
8	*DSNP Staff Augmentation*	*EXP*	$6,515,185	$81,624	$309,241	$386,281	$412,738	$221,676	$587,520	$438,419	$445,508	$423,600	$395,917	$414,457	$368,039	$4,485,019	$2,030,166
	Totals:	**Totals**	**$15,066,478**	**$706,831**	**$928,285**	**$1,200,446**	**$1,112,289**	**$1,016,668**	**$1,347,258**	**$1,101,793**	**$1,191,467**	**$1,087,367**	**$1,271,512**	**$1,199,500**	**$1,355,216**	**$13,518,632**	**$1,547,846**

Updated 03/25/24

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
April 18, 2024

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 03/06/2024				
AB Non-Emergency Medical Transport Inc dba: AB Medical Transport	Transportation/NMT	10605 Barichello St Bakersfield CA		4/1/2024
Bloomfield West Inc	ICF/DD Facility	3333 E. Imperial Hwy Lynwood CA		4/1/2024
Family HealthCare Network	ECM - Case Management	1230 Jefferson Ave Delano CA		Retro-Eff 3/1/2024
Family HealthCare Network	Primary Care	1230 Jefferson Ave Delano CA	Change of Ownership R. Bansal MD / Comprehensive Medical Group	Retro-Eff 3/1/2024
Geri-Care IV, LLC dba: Antelope Valley Care Center	SNF	44567 North 15th Street West Lancaster CA		4/1/2024
Hunger Not Impossible Inc dba: Bento Foods	CSS - Med Tailored Meals	628 California Avenue Venice CA		4/1/2024
InspireMe Counseling and Wellness Center	Mental Health - LCSW	1701 Westwind Dr. #106 Bakersfield CA	Niehsa Davis LCSW	4/1/2024
Montera Health Texas LLC	ABA - Telehealth Only	440 N Barranca Ave #9605 Covina CA		4/1/2024
Reliable Healthcare LLC	Home Health	200 New Stine Rd # 250 Bakersfield CA		4/1/2024
Seva Home Health	Home Health	661 N Prospect St Porterville CA		4/1/2024
San Joaquin Valley Surgery Center LLC	Ambulatory Surgery Center	2620 Chester Ave #400 Bakersfield CA	*PAC Approved Credentialing on 2/7/24 Under AH-Delano Existing Contract / New Contract under individual TIN.	Retro-Eff 3/1/2024
Today's Applied Behavior Analysis LLC	ABA	2049 W. Union Avenue Porterville, CA 93257	*Existing Prov: Jose Rodriguez	Retro-Eff 3/1/2024
VSC HBO LLC dba: Healthbridge Children's Hospital	Pediatric Acute/Rehab/ SubAcute	393 S. Tustin Street Orange CA		4/1/2024

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
April 18, 2024

Legal Name DBA	Specialty	Address	Comments	Contract Effective Date
PAC 04/03/2024				
Advanced Artificial Eye Inc	Prosthetics & Orthotics	18455 Burbank Blvd. #202 Tarzana, CA		5/1/2024
Darbun Enterprises Inc dba: All Saints HealthCare	Skilled Nursing Facility Pediatrics	11810 Saticoy St North Hollywood CA		5/1/2024
Bakersfield Care Pharmacy Inc dba: Bakersfield Care Pharmacy	Pharmacy	4701 Panama Ln Ste E2 Bakersfield CA		5/1/2024
Geri-Care V LLC dba: Wellsprings Post Acute Center	Skilled Nursing Facility	44445 North 15th St. West Lancaster CA		5/1/2024
Kelly & Scotts Care Home Inc	ICF/DD Facility	2212 5th Drive #1 Delano 1324 5th Place #2 Delano 332 N Indiana #3 Porterville		5/1/2024
Bhatti Enterprise LLC dba: Prince NEMT	Transportation	5405 Stockdale Hwy Bakersfield CA		5/1/2024
Sabo Physical Therapy, Inc	Physical Therapy Clinic	11006 Brimhall Rd, Ste A Bakersfield CA		5/1/2024
Sukhmander S. Dhillon dba: New Medical	DME / Oxygen	4300 Ashe Road Ste. 111 Bakersfield CA		5/1/2024
Sun Valley Specialty Healthcare Inc dba: Totally Kids Specialty Healthcare	Skilled Nursing Facility Pediatrics	10716 La Tuna Canyon Rd Sun Valley CA		5/1/2024
Verdugo Logistics LLC	Transportation	4900 California Ave #210 Bakersfield CA		5/1/2024
Nikki Avila In the Waiting Doula Services	Doula	1701 18th Street Ste. 205 Bakersfield CA		5/1/2024

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
TERMED CONTRACTS
April 18, 2024

Legal Name DBA	Specialty	Address	Comments	Contract Term Date
United Care Facilities Inc	Congregate Living Facility	3850 Pelona Vista Drive Lancaster CA	Locations Closed - No notice	2/4/2024
LifeWatch Services, Inc.	DME	10255 W Higgins Rd Ste. 100 Rosemont IL	Change of Ownership	2/9/2024
Amirpasha Ehsan, MD, Inc.	Physical Medicine & Rehab	5001 Commerce Avenue Bakersfield CA	provider moved out of area	2/11/2024
C TON Laboratory	Laboratory	2920 H Street, Ste 129 Bakersfield CA	Collection site located at Bakersfield has been closed as of 2/18/2023.	2/18/2023
Telemedicine Group PC dba: TeleMed2U	Telehealth Group	3400 Douglas Blvd Ste. 225 Roseville cA	Resigned	2/19/2024
Radhey S. Bansal, MD Inc. dba: Comprehensive Medical Group	Primary Care	1230 Jefferson Street Delano CA	Change of Ownership	2/28/2024
Montebello Home Health Care, Inc. dba: Aasta Home Health	Home Health Agency	2920 H Street Ste 110 Bakersfield CA	Due to non-response for recredentialing requirements.	2/29/2024
Hospitalist Medicine Physicians of California, Inc.	Hospitalist Group	2615 Chester Avenue Bakersfield CA	Contract ended with Adventist	3/5/2024
Sound Physicians Emergency Medicine of Southern California, PC	ER Group	2615 Chester Avenue Bakersfield CA	Contract ended with Adventist	3/5/2024
Pinnacle Women's Health Group, Inc.	OB/GYN	1700 Mt Vernon Avenue Bakersfield CA	Business Dissolved	3/5/2024
Heart Hospital of BK, LLC dba: Bakersfield Heart Hospital	Acute Care Hospital	3001 Sillect Avenue Bakersfield CA	Change of Ownership	3/8/2024
Redwood Bakersfield LLC dba: Redwood Senior Living Bakersfield	Assisted Sr. Living Facility	810 S Union Avenue Bakersfield CA	Resigned	3/18/2024
Comprehensive Neurosurgery and Spine Institute	Neurosurgery	2001 F Street Bakersfield CA	provider is moving to Lancaster and joining another group	5/1/2024

KERN HEALTH SYSTEMS

MEMORANDUM

TO: KHS Board of Directors

FROM: Martha Tasinga MD, KHS CMO

SUBJECT: REVISED POLICY AND PROCEDURE – 4.01-P Credentialing Program
NEW POLICIES: 4.55-I Assessment of Organizational Providers
NEW POLICIES: 4.56-P Physician Advisory Committee (Credentialing)

DATE: April 18, 2024

Background

On 2/7/2024, PAC approved additional modifications to KHS policy PNM 4.01-P Credentialing Program Policy and Procedure have been made as a result of NCQA preparations. The enclosed document (red-lined) shows the modifications to P&P 4.01-P and the specific changes. New Policies have been written and approved as required by NCQA regarding Assessment of Organization Providers and Credentialing Committee "Physician Advisory Committee".

Policy Section (REVISED)	Policy Changes
4.01 Credentialing Non-Discriminatory Credentialing of Providers Page 3	• Changed dates of semi-annual reporting to February & August) • Added Summary Report of providers credentialed to include age, gender and specialty type.
4.01 Credentialing Section 7.0 Additional Information Page 13	• Added Section 7.3.1 "Intermediate Care Facilities with Developmental Disabilities" – Credentialing requirements per DHCS APL 23-023
NEW POLICIES	**New Policy & Procedures**
4.55-I Credentialing Assessment of Organizational Providers	• New P&P Required by NCQA Credentialing Standards CR.7 outlining the process in which KHS Credentialing will conduct initial assessments to confirm organizational providers are in good standing with state and federal bodies.
4.56-P Credentialing Physician Advisory Committee (Credentials Committee)	• New P&P designating Physician Advisory Committee (PAC) as the Credentialing Committee outlining the committee responsibilities to evaluate the credentials of all practitioners in a non-discriminatory manner; responsible for the oversight of the credentialing program; delegated credentialing oversight; conducting performance monitoring from quality improvement activities; and member complaints; having the final authority to approve or disapprove applicants for initial and recredentialing; and recommending corrective or disciplinary action concerning network participation in the KHS Provider Network.
4.57-I Confidentiality & Non-Discriminatory Process	• All discussions, information and records generated in connection with the Physician Advisory Committee credentialing activities are considered to be confidential peer review material, protected under California Business and Professions Evidence Code 1157 and California Health and Safety Code Section 1370. No voluntary disclosure shall be made of confidential information by any committee member to any unauthorized entity or person. Each committee member must agree

Policy Section (REVISED)	Policy Changes
	to maintain confidentiality and agree to conduct all credentialing and recredentialing activities in a manner that is non-discriminatory

Requested Action

Approve.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Credentialing Program				POLICY #: 4.01-P	
DEPARTMENT: Provider Network Management					
Effective Date:	Review/Revised Date:	DMHC	X	PAC	X
01/1997	~~1/5/2024~~2/7/2024	DHCS	X	QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Senior Director of Provider Network

POLICY:
Kern Health Systems ("KHS") members are entitled to quality health care. It is the policy of KHS that every reasonable effort is made to verify health care providers with whom KHS contracts meet the basic standards of training, certification, and performance. Credentialing and recredentialing requirements are applicable to all licensed practitioners, non-physician practitioners, ancillary and facility providers contracted with KHS (collectively referred to herein as "provider(s)"). A contracted provider must be credentialed with KHS in order to treat KHS members.

PROCEDURES:
Credentialing is defined as the recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership. It is the process by which health care providers are evaluated and approved for provider status as contractors and subcontractors in the KHS network. The credentialing program has been developed in accordance with state and federal requirements, accreditation guidelines and comply with the Department of Managed Health Care ("DMHC") and the Department of Health Care Services

("DHCS") requirements, including DHCS All Plan Letter ("APL") 22-013 and subsequent updates to this APL, if any. KHS meets all DMHC and DHCS requirements, and has established credentialing criteria, including the verification sources used, based on state, federal and current accreditation guidelines from the National Committee for Quality Assurance ("NCQA") credentialing standards.

SCOPE OF PROVIDERS COVERED BY CREDENTIALING

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

1. All providers who have a contracted, independent relationship with KHS.
2. All providers who see KHS members outside the inpatient hospital setting.
3. All providers who see KHS members in outpatient ambulatory free-standing facilities.
4. All physician executives who serve in an administrative capacity for KHS.
5. All providers who are hospital based but render services or care to KHS members as a result of their independent relationship with KHS. Examples include: an anesthesiologist who is contracted to provide pain management to KHS members in an outpatient setting.
6. All providers who practice as a hospitalist or Skilled Nursing Facility (SNF).
7. All providers who provide telemedicine consults interacting with members.
8. All non-physician practitioners who may or may not have an independent relationship with KHS.
9. All behavioral health care providers such as doctoral or master's-level psychologists, clinical social workers, psychiatric nurses, or other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently.
10. All ancillary, pharmacies and organization providers who have a contract with KHS.

PROVIDERS WHO DO NOT NEED TO BE CREDENTIALED

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

1. Hospitalist practicing exclusively in an inpatient setting.
2. Radiologist practicing in an outpatient setting.
3. Anesthesiologist in an ambulatory care setting or practicing in an office setting specific to pain management.

NON-DISCRIMINATORY CREDENTIALING FOR PROVIDERS

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

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

Monitoring will be conducted semi-annually (~~June~~ February & ~~December~~August) by tracking and identifying discrimination in the credentialing and recredentialing processes to assure discriminatory practices do not occur. Any Executive Officer, provider, or employee who believes or becomes aware of any discriminatory act shall promptly report any violation in person or in writing to their supervisor or directly to the KHS Credentialing Manager. The Credentialing Manager reports semi-annually to the Physician Advisory Committee the number of complaints made alleging discrimination at credentialing or recredentialing. Additionally, a detailed summary of the credentialed and recredentialed practitioners age, gender and specialty type is presented semi-annually to the Physicians Advisory Committee (report excludes organization providers).

1.0 APPLICATION

Application for provider status is made by submitting a completed application together with the applicable and required supporting documents to the Provider Network Management Department. Application forms are available through the Provider Network Management Department and are available electronically on the KHS Provider Portal.

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

No application shall be acted upon unless it is complete, signed and dated, which includes completion of the application form, attestation questionnaire, release of information and submission of all supporting documents, including any additional information requested by the PAC. If the provider is notified that the application (or supporting documents) is incomplete or illegible, the provider must provide the missing information for the credentialing process to continue within 10-calendar days. The provider is responsible for providing the information to satisfy the process or request by the PAC. It is the provider's burden to provide all information requested and to resolve any difficulties in verifying or obtaining the documentation required to satisfy the credentialing requirements. If the provider fails to provide this information, the credentialing application will be deemed incomplete and will result in an administrative denial or withdrawal of application from the KHS network. Providers who fail to provide this burden of proof do not have the right to submit an appeal. Applications are evaluated according to the credentialing criteria and verification sources set forth in Attachments A & B. An application that does not satisfy these criteria, as determined

by the PAC or Board of Directors, may be denied. The PAC may deny provider status if the information submitted is insufficient to resolve reasonable doubts as to the provider's qualifications. KHS reserves the right to exercise discretion when applying any criteria and to exclude providers who do not meet the criteria. KHS Board of Directors, after considering PAC recommendation, may waive any requirement for network participation established by these policies and procedures for good cause if it is determined that such waiver is necessary to meet the needs of KHS and the community it serves. The refusal to waive any requirement shall not entitle the provider to a hearing or any other rights of review.

1.1 Required Attestation

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

A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation, and reasons for the same.
B. History of loss of license and/or felony conviction(s), including plea of nolo contendere.
C. History of loss or limitation of privileges and/or disciplinary activity.
D. Lack of present illegal drug use.
E. A current and signed attestation by the applicant of the accuracy and completeness of the application.

2.0 APPLICATION REVIEW/COMMITTEE AND BOARD REVIEW

2.1 Application Review

The PAC shall serve as the Credentials Committee and shall be responsible for the review of all applications.

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

A. The appropriate license and/or board certification or registration to practice in California. (Verification Source: applicable state licensing or certifying agency via verbal, written or internet/electronic method.)
B. Evidence of graduation or completion of any required education (Verification Source: AMA Masterfile, AOA Official Osteopathic Master file, ABMS Board Certification or directly from primary source Medical, Residency, Fellowship or Professional training Program.)
C. Proof of completion of any relevant medical residency and/or specialty training. (Verification Source: AMA Masterfile, AOA Official Osteopathic Master file, ABMS Board Certification or directly from primary source Medical, Residency, Fellowship or Professional training Program.)
D. Proof of completion of any relevant professional training (non-physicians) (Verification Source: National Student Clearinghouse or appropriate board/registry when the board or registry performs primary source verification of education.)
E. Work history (Verification Source: Documented on application or curriculum vitae/resume in month/year format)
F. Hospital and clinic privileges in good standing (Verification Source: Verbal,

written or internet/electronic verification directly with the institution, hospital letter or directory.)

G. History of suspension or curtailment of hospital and clinic privileges (Verification Source: NPDB with Continuous Query)

H. Current Drug Enforcement Administration identification number. (Verification Source: DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile, DEA or CDC Certificate or photocopy of the certificate, or visual inspection of the original DEA or CDS Certificate including DEA waivers)

I. National Provider Identifier number (Verification Source: NPPES Registry)

J. Current malpractice or professional insurance in an adequate amount, as required for the particular provider type. (Verification Source: Copy of certificate face-sheet, Federal Tort Letter, or if the provider's malpractice insurance coverage is current and provided in the application.)

K. History of liability claims against the provider (Verification Source: NPDB with Continuous Query)

L. Provider information, if any, entered in the National Practitioner Data Bank, when applicable (Verification Source: NPDB with Continuous Query)

M. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network. (Verification Source: NPDB with Continuous Query and/or including but not limited to; OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database.)

N. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the relevant DHCS All Plan Letter and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy. (Verification Source: CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion.)

2.2 Discrepancies in Credentialing Information

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

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

Providers will only be credentialed in the area of practice in which they have adequate education and training verified through primary source verification, if applicable, from an ACGME accredited residency and/or fellowship as set forth by the American Board of Medical Specialties ("ABMS") or American Osteopathic Association ("AOA") for requested sub-specialties (see credentialing requirements in Attachments A). KHS

uses specialties and sub-specialties recognized by the ABMS and AOA. It is expected that providers confine their practice to their credentialed specialty when providing services to KHS members. KHS will list provider specialties in member materials and practitioner directories that are consistent with the information obtained during the credentialing process including education/training verified through primary source, board certification specialties recognized according to ABMS/AOA, or as verified on other professional license certificate.

2.4 Provider Rights

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

A. **Right to review credentials information:** The provider may request to review information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. This includes information obtained from outside sources such as malpractice carriers or state licensing agencies, and/or board certification, but does not extend to review of information from peer reference recommendations, hospital privileges verifications or other information protected by law from disclosure including peer review protected information. Providers may submit their request for review to their Provider Relations Representative via written request, certified mail. The Credentialing Manager or Coordinator will coordinate a time and date for such access during regular business hours and in the presence of a credentialing staff personnel, KHS Chief Medical Officer or KHS Executive Officer within 72-hours of request. The provider is not permitted to remove, destroy or photocopy documentation from the credentials file except what was originally provided by the provider upon application.

B. **Right to correct erroneous/inaccurate information:** The provider may correct erroneous or inaccurate information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application in the event that credentialing information obtained from primary sources varies substantially from that provided by a provider. The provider will have the opportunity to correct information in the application which is inconsistent with the information received via primary source verification process. The Credentialing Coordinator will notify the provider within fourteen (14) days via email, letter or fax of the discrepancy and will include the items found to be inconsistent. Such notice will not contain protected peer review information or copies of the NPDB Summary. The provider shall respond within 48-hours of the plan's notification or within 24-hours of provider's credentialing file review, in writing via email, letter or fax, regarding the inconsistent information on the application and return a formal response to the Credentialing Staff, PR Representative, or KHS CMO, within fourteen (14) days. The Credentialing Staff will reverify the primary source information until the discrepancy is resolved. If the discrepancy is not resolved within ninety (90) days or within 180-days from attestation date, whichever is sooner, the application will be deemed incomplete and will be considered administratively withdrawn and the file closed with no further action.

C. **Right to request/receive status update on application**: The provider may request review of information obtained by KHS for the purpose of evaluating their

credentialing and recredentialing application.. Providers may submit their request for review to their Provider Relations Representative via email, letter, or fax. The Credentialing Manager or Coordinator will review and provide the requested information in a timely and courteous manner no more than seven 7-business days of the request.

2.5 Confidentiality

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

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

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

2.6 Credentialing File Review

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

All providers participating in the KHS network must be approved by the PAC. The CMO has the authority to determine whether or not credentialing or recredentialing files are "clean" and meet established criteria. A file must meet the following criteria to be considered a "clean file":

A. No malpractice cases that resulted in settlement or judgment paid on behalf of the provider within the previous 5-years for initial applicants or since the last credentialing/recredentialing review date.
B. No 805/805.1 reports, State Licensing accusations, limitations, or sanctions on licensure.
C. No adverse events from other regulatory, state, or federal agencies, i.e., OIG, NPDB, Medicare Opt-Out, Medi-Cal Suspended or Ineligible list, System for Award Management, etc.
D. Current and signed attestation confirming correctness and completeness of application.
E. For those offices requiring an office site visit, overall score of 90% or higher.
F. For recredentialing, no more than seven (7) member complaints, no internal

quality of care case reviews, no utilization management or compliance issues or trends in the prior 3-years.

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

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

2.7 Comprehensive Reviews

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

The CMO or his/her designee reviews the applications and prepares his/her approval or recommendations to the PAC, as follows:

A. The recommendation is reviewed by the PAC which prepares its approval or recommendation, such as modification or denial, which is submitted to the Board of Directors.

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

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

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

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

2.8 Provisional Approval/Clean file Approval

In the circumstance where a provider file is ready for presentation to the PAC, however there is no PAC meeting scheduled, or was cancelled due to member scheduling conflicts, including but not limited to; lack of quorum to vote on matters, prior to the next Board of Directors meeting, the CMO may recommend the applicant(s) to the Board of Directors for provisional/clean file approval. In order to be considered for provisional approval, the applicant must meet the criteria in the applicable exhibit (Attachments A& B) and have no malpractice action (pending or closed) within the previous five years (three years if the applicant is being recredentialed). In the case of recredentialing, in addition, there may not be any pending or current issues, requiring comprehensive review, reported by the Quality Improvement, Utilization Management, Member Services or Compliance Departments in the interval since the applicant was last credentialed.

If provisional/clean file approvals are granted by the CMO, the applicant shall be presented to the PAC at its next meeting for ratification. The CMO approval date

becomes the official approval date.

2.9 Locum Tenens

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

A. Locum Tenens must be of the same provider type and specialty as the provider on leave, e.g., a physician must substitute for a physician in same designated specialty; a non-physician for a non-physician.
B. KHS must be notified of the request for Locum Tenens in writing from the existing contracted group or provider.
C. If the request is received after services are rendered, KHS will only retroactively pay for services rendered within the prior fourteen (14)-days. Claims for services outside that timeframe may be denied.
D. KHS must be provided with a copy of a current, valid, and unrestricted California medical license.
E. KHS must be provided with a copy of a current, valid, and unrestricted DEA issued with a California address, if applicable
F. KHS must have copy of the practitioner's professional liability insurance in the amounts of $1,000,000.00 per occurrences and $3,000,000.00 in aggregate.
G. In order to be considered for Locum Tenens, the applicant must meet the established clean file criteria, and have no malpractice actions (pending or closed).

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

If the Locum Tenens status is approved by KHS, the Locum Tenens provider will be compensated for services at the same rate as the KHS contracted provider. However, KHS is not responsible for the compensation arrangement between the provider on leave and the Locum Tenens provider. The use of the same Locum Tenens provider will be limited to 90 consecutive days. KHS reserves the right to approve a Locum Tenens status extension due to extenuating circumstances.

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

2.10 PAC Decision Regarding Credentialing

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

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

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

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

2.11 Effective Date

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

2.12 Notification of Decisions Regarding Initial Applicants

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

2.13 Notification of Adverse Decisions Regarding Recredentialing

KHS will notify, in writing, recredentialing applicants of any adverse recredentialing decisions, including denial of recredentialing, within 60-days from the date of the PAC's credentialing decision.

3.0 PROVIDER RESPONSIBILITY TO REPORT CHANGES

Once approved, each provider shall remain in compliance with the credentialing criteria and report to the CMO all of the following:

A. The commencement or resolution of any civil action against the provider for professional negligence
B. Any change in the provider's license or DEA status
C. The initiation of and reason for any investigation or the filing of any complaint against the provider by any government agency
D. Any adverse determination by any facility or entity with a credentialing or peer review process concerning provider's quality of care.
E. A change in any hospital or practice privilege granted to the practitioner by any facility

or entity with a credentialing or peer review process

F. Any change in the provider's errors and omissions or professional negligence insurance coverage including changes affecting coverage of specific clinical procedures or privileges of the practitioner
G. Conviction of the provider or entry of a plea of nolo contendere to any felony.
H. Conviction of a provider or entry of a plea of nolo contendere to any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services
I. Conviction of the provider of any crime or an entry of a plea of nolo contendere to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to practice medicine or deliver health care services
J. The filing of any charges against the provider alleging unlawful sale, use, or possession of any controlled substance.
K. Suspension from the federal Medicare or Medicaid programs for any reason.
L. Lost or surrendered a license, certificate, or approval to provide health care.
M. Any other adverse occurrence that relates to the provider's license or practice, including but not limited to revocation or suspension of a license by a federal, California, or another state's licensing, certification, or approval authority.
N. If the provider is a clinic, group, corporation or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization of any crimes set forth above.

4.0 RECREDENTIALING AND COMPLIANCE WITH LAWS

Each provider is recredentialed every 36-months. However, recredentialing may be made sooner when required by a change in relevant provider information or if the PAC makes such recommendation.[ii] The process includes a review of all applicable areas for credentialing.

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

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

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

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

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

These credentialing policies shall be reviewed at least annually by the PAC which may recommend revisions or amendments to the Board of Directors.

5.0 HEARING RIGHTS

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

6.0 RELEASE

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

7.0 ADDITIONAL INFORMATION

7.1 Specialists Practicing Primary Care

Providers with sub-specialties recognized by the ABMS or one of its Member Boards may function in the role of a Primary Care Practitioner (PCP) if they meet the requirements to be a PCP (See Attachment A). However, KHS credentialed specialists functioning as a KHS credentialed PCP may not self-refer for specialty care. If the provider sees a member assigned to him/her for primary care, he/she may not bill as a specialist even if that member's condition is within the provider's sub-specialty. The provider may accept authorized sub-specialty referrals from providers outside of his/her group for those services provided as a sub-specialist.

7.2 Scope of Mid-Level Practitioners

KHS members either select or are randomly assigned to a contracted PCP. The PCP may choose to arrange with a mid-level practitioner to provide primary care to assigned members but must provide active supervision of the care delivered.

A current specialty practitioner may employ a mid-level practitioner and may permit this practitioner to participate in the care delivered to members in accordance with the Standardized Procedure Guidelines, Delegation of Services Agreement, and KHS Policy and Procedure 4.04-P Non-Physician Medical Practitioners. Mid-level practitioners will be credentialed in the specific specialty in which they will be working. The credentialing will be dependent on the training and experience in the field in which the mid-level is requesting to be credentialed.[iii]

KHS will require either 6 months formal training in a program or one year of full-time experience in the field which credentialing is requested.

Nurse Practitioners with a furnishing license may furnish drugs. Physician Assistants

may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to the guidelines in California Business and Professions Code, Section 3502.1 subdivisions (c) and (d).

7.3 Facility and Ancillary Providers/ Assessment of Organizational Providers

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

A. Provider must be physically located in and providing services in Kern County for one year prior to application.
B. must be in good standing with KHS.
C. must be able to submit claims electronically.
D. must be able to participate in the KHS electronic funds transfer (EFT) program.
E. laboratory providers must be able to submit lab results/data to KHS electronically.
F. Durable medical equipment (DME) providers must be able to service KFHC Members seven (7) days a week.
G. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the DHCS APL 19-004 and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy.

KHS will conduct an initial and ongoing assessment of the providers with which it contracts. The assessment of the health care delivery provider will be conducted before it contracts with a provider, and for at least every 36-months thereafter, in accordance with KHS Policy & Procedure 4.55-I "Assessment of Organizational Providers & Behavioral Health Providers"

7.3.1 Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD)

Effective January 1, 2024, KHS will maintain an adequate Network consisting of ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes licensed and certified by the California Department of Public Health (CDPH). *To meet KHS credentialing requirements, ICF-DD Homes must submit:*

- *KHS Organizational/Ancillary/Facility Application –*
- *An annual ICF/DD Attestation[1] under penalty of perjury that the following credentialing requirements are satisfied:*
  - *Completion of the MCP's specific Provider Training within the last two (2) years*
  - *Facility Site Audit from State Agency*
  - *No Change in 5% Ownership Disclosure since the last submission to MCP*
  - *Possess an active CDPH License and CMS Certification*
  - *In good standing as a Regional Center Vendor*
- *For the **initial** credentialing, ICF/DD Homes must submit the below items in addition to the annual ICF/DD Attestation:*
- *W-9 Request for Taxpayer Identification Number and Certification*

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- *MCP Ancillary Facility Network Provider Application*
- *Certificates of Insurance (Professional and General Liability)*
- *City or County Business License (excludes ICF/DD-H and -N homes with six or less residents)*
- *5% Ownership Disclosure*

*For the **recredentialing**, ICF/DD Homes must submit the below items every 2-years:*

- *KHS Organizational/Ancillary/Facility Application –*
- *An annual ICF/DD Attestation[2] under penalty of perjury that the following credentialing requirements are satisfied:*
  - *Completion of the MCP's specific Provider Training within the last two (2) years*
  - *Facility Site Audit from State Agency*
  - *No Change in 5% Ownership Disclosure since the last submission to MCP*
  - *Possess an active CDPH License and CMS Certification*
  - *In good standing as a Regional Center Vendor*

For **changes** in between credentialing cycles, the ICF/DD Home must report that change to KHS Credentialing including any required documentation within 90-days of when the change occurred.

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7.4 Medical Transportation Providers (Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT)

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

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

7.5 Enhanced Care Management (ECM) and Community Supports (CS) Providers

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

requirements, and other DHCS guidance, including relevant APLs and Policy Letters.

7.6 HIV/AIDS Provider

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

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

A. Whether they wish to be designated an HIV/AIDS specialist
B. Whether they meet the defined criteria as per California H&S Code 1374.16

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

7.7 Mental Health and Substance use Disorder Provider Credentials

Effective January 1, 2023, Managed Care Plans that cover and who credential health care providers in mental health and substance use disorder services for its network, will assess and verify the qualifications of a health care provider within 60-calendar days after receiving a completed provider credentialing application.

Upon receipt of an application from a mental health or substance abuse provider, the KHS Credentialing Staff will notify the applicant within seven (7) business days of receiving the application to verify receipt and inform the applicant whether the application is complete. Applications returned as "incomplete" will be given 15-calendar days to return any incomplete or missing required information.

A mental health or substance abuse provider application is considered complete based on the requirements set forth in this Policy and Procedure, Sections 1.0 Application, Section 2.0 Application Review and Attachment B – Behavioral Health Practitioner Provider Specific Credentialing Criteria.

Pursuant to Section 2.8, Provisional Approval will be granted and approved for those applicants whose credentialing file meet clean file criteria and are absent of , but not limited to, any adverse actions, disciplinary licensing actions, including conduct or professional competency. Files with adverse actions or information will be reviewed at the next scheduled Physician Advisory Committee for determination. [Reference: AB 2581 (Salas, CH. 533, Stats. 2022)]

7.8 Community Health Worker (CHW)

CHW Providers must have a lived experience that aligns with and provides a connection between the CHW, and the member or population being served. CHW Providers are not licensed providers, require a Supervising Provider, do not follow traditional credentialing requirements, and do not have a corresponding state-level enrollment pathway.

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the CHW Provider meets the requirements outlined in the DHCS APL 22-016 Community Health Worker, including but not limited to having valid NPI Number, possess lived experience that aligns with and provides a connection between the CHW and the member or population being served; has obtained a minimum of six (6) hours of additional relevant training annually; has a Supervising Provider employed by the same organization overseeing the CHW with which is KHS Contracted. CHW Providers are required to demonstrate, and Supervising Provider must maintain evidence of, minimum qualifications through a Certificate Pathway or a Lived Experience Pathway consistent with APL 22-016, or any superseding APL. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

Supervising Providers, with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS' Provider Enrollment Division. For the Supervising Providers that do not have a corresponding state-level enrollment pathway, they will not be required to enroll in the Medi-Cal program. Supervising Providers, without a state level enrollment pathway, must complete the appropriate provider application, Supervising Attestation and Acknowledgement form for submission to KHS Credentialing for review and approval. KHS will verify the supervising provider meets the qualification as a licensed provider, or other acceptable supervising provider designated within a hospital, outpatient clinic, local health jurisdiction (LHJ) or a community-based organization (CBO), employing or otherwise overseeing the CHW, with which Kern Health Systems (KHS) contracts.

7.9 Doula Providers

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the doula provider meets the requirements outlined in the DHCS All Plan Letter (APL) 22-031 Doula Services, or any superseding APL. Doulas are not licensed providers, do not require supervision, do not follow traditional credentialing requirements, and have a corresponding state-level pathway for enrolling in Medi-Cal. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

7.10 Dyadic Service Care Providers / Non-Specialty Mental Health Services Provider Manual (NSMHS)

KHS Provider Network will include Psychiatric and Psychological Service providers as outlined in the DHCS NSMHS provider manual and/or who provide Dyadic Care Services by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Additionally, Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render these services under the supervision of credentialed practitioner, who is qualified to provide supervision and whose licensure is not currently suspended, limited/restricted or on probation.

Network Providers who are licensed independent practitioners will be subject to the credentialing and enrollment process outlined in Section 1.0 -6.0 of this policy and are required to enroll as Medi-Cal Providers, consistent with APL 22-013, or any superseding APL, if there is a state-level enrollment pathway for them to do so. For Associate or Assistant provider types, when there is no state-level enrollment pathway, the KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate these providers meets the requirements outlined in the DHCS NSMHS Provider Manual and/or DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

ATTACHMENTS:

- Attachment A: Provider Specific Credentialing Criteria – Practitioners
- Attachment B: Provider Specific Credentialing Criteria – BH-Practitioners
- Attachment C: Org-Facilities, Ancillary Services, Pharmacies
- Attachment D: Non-Licensed Other Provider Types

REFERENCE:

Revisions 01/09/2024: Section 7.3.1 added in accordance with DHCS APL 23-023 ICF/DD Credentialing Requirements.
Revisions 11-2023: Section 2.1 Recommended by NCQA Consultants to add Primary Verification Approved Sources used by Credentialing to verify each item; Section 2.4 Provider Rights: Language restructured as recommended by NCQA Consultant to match Provider Rights Addendum; Section 2.8 revised to include CR1A-Factors 3-5 for Managing files that meet clean-file criteria and approval by CMO; **Revisions 08-2023:** Credentialing Policy Section 2.9 – Added time-limited retroactive payment of 14-days on Locum Tenens request received after services are rendered as approved by Executive Roundtable on 07/25/23. **Revision 06-2023:** NCQA CR1A-6 added Nondiscriminatory monitoring; NCQA CR1A-11 - 2.3 added process to ensure information in member materials is consistent with information obtained in credentialing; NCQA CR1B-1-3 Practitioner Rights added language regarding all practitioners rights; Section 2.5 added PAC Members will annually sign confidentiality statements; NCQA CR1A-8 Section 2.13 added Notification of adverse recred decision; NCQA CR7 added language regarding assessment of organizational providers. **Revision 04-2023:** Credentialing Policy Section 7.0 has been revised to add related credentialing requirements specific to Doula Service Providers, Dyadic Care Service Providers and Community Health Workers.
References include: APL 22-016 Community Health Workers; APL 22-031 Doula Services; DHCS APL 22-029 Dyadic Services, DHCS Provider Manual NSMHS & CA Board of Behavioral Sciences. Approved by DMHC 11/2/2023 for

DMHC APL 22-031. Approved by DHCS File and use 5/26/2023 and 8/2/2023 for DHCS APL 22-029. **Revision 03-2023:** Credentialing Policy Section 7.0 has been revised to add section related to compliance with Assembly Bill 2581 Health Care Coverage: Mental Health and Substance Use Disorders – Provider Credentials. **Revision 01-2023:** Credentialing Policy has gone through a comprehensive revision by KHS PNM Management and legal review with DSR Health Law to bring into current practice and compliance with all state, federal, DHCS APLs and NCQA credentialing standards. In addition, DSR Health Law performed a regulatory review making further updates and revisions to bring into compliance with DHCS Contract language, DHCS All Plan Letters related to credentialing and screening/enrollment processes, CalAIM and California Business and Professions Code where applicable. KHS PAC Approved 2/1/2023 and KHS BOD Approved 2/16/2023**.** DHCS File and Use disposition given on 6/2/2023. **Revision 2015-06:** QAS Provider requirements per DHCS 14-026; and Behavioral Health Provider requirements. Revision **2014-12:** Item B. in Section 7.4 "cannot be physician owned, either directly or indirectly;" was deleted as requested by Compliance Director 10/01/2014. SBIRT training removed from Policy 2.22-I Facility Site Review and added to credentialing per COO. **Revision 2013-07**: New Attachment "N" Walk in Clinic Providers. Approved at the Physician Advisory Committee (PAC) Meeting on March 6, 2013. [1]**Revision 2012-10:** Language added to allow Mid-levels participate in a specialty settings and perform initial evaluations. The specialty physician must see the patient at lease every third visit. **Revision 2012-08**: Deleted requirement for non-physicians to pay $100 Credentialing process fee. R**evision 2012-01:** Revisions to attachments only. **Revision 2011-06:** Policy approved by management 11/15/10. However additional changes we provided by Director of Claims and Provider Relations regarding SPD members, Specialists and Emergency Room Physicians. Policy KHS Board approved 4/14/11. Revision to Attachments A and D regarding credentialing criteria. Board approved on 10/14/2010. Additional language added (01/2011) per Director of Claims and Provider Relations see Section 7.3 and 7.4 language from policies 4.4-P and 4.25-P respectively. **Revision 2010-05:** Physicians Advisory Committee added clarification of credentialing requirements in Attachment A #6. **Revision 2009-09: Revised by Provider Relation Director. Revision 2007-03:** Revised per DHS/DMHC Medical Review Audit (YE 10/31/06). **Revision 2005-11:** Revised per DHS Work Plan (07/10/05). **Revision 2005-04**: **Revision 2003-06**: Revised per DHS comment letter 03/04/03. **Revision 2002-08:** Routine review/revision. Revised per DHS Comment (10/30/01). Hospital Based Physicians section added per request of Medical Director. Radiology claims section added per request of Medical Director. Policy #4.03 – Pharmacy Credentialing deleted, and necessary information added to this policy. Pharmacy portion revised per DHS Comment (09/19/01). Revised per MMCD Policy Letter 02-03.

[i] DHS Contract Section 6.5.4.2
[ii] MMCD Policy Letter 02-03 § II

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Assessment of Organizational Providers				POLICY #: 4.55-I	
DEPARTMENT: Provider Network Management					
Effective Date: 01/01/2024	Review/Revised Date: 02/07/2024	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Chief Executive Officer

_____ Date _____

_____ Date _____

_____ Date _____

POLICY:
Prior to contracting with Organizational Providers "Providers", Kern Health Systems "KHS" will conduct an initial assessment to confirm the provider is in good standing with state and federal regulatory bodies, the provider has been reviewed and approved by an accrediting body or there is documentation of an on-site quality assessment if the provider is not accredited. Ongoing assessments will be conducted every 36-months thereafter.

DEFINITIONS:

Behavioral Healthcare Facility Providers	A behavioral healthcare facility provider refers to psychiatric hospitals and clinics; addiction disorder facilities; and residential treatment centers for psychiatric and addiction disorders.
Organizational Provider	An organizational provider refers to facilities providing services to members and where members are directed for services rather than being directed to a specific practitioner. This element applies to all organizational providers with which the organization contracts.

PURPOSE:
The purpose of this policy is to describe KHS' responsibility for the initial and ongoing assessment of contracted organizational providers that render services to KHS beneficiaries.

A. The Provider types included in KHS' assessment include, but are not limited to: Hospitals, Home Health Agencies, Skilled Nursing Facilities and Free-Standing Surgical Centers. Additionally, KHS assesses Hospice, Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy Providers, Outpatient Speech Pathology Providers, End-stage Renal Disease Services (Dialysis), Outpatient Diabetics Self-Management Training providers, and Portable X-Ray Supplier.

B. KHS' assessment of free-standing surgical centers confirms that the organizational provider is accredited by an acceptable accrediting body as required by Policy and Procedure 4.01-P Credentialing Program.

C. KHS is responsible for the initial and recredentialing of behavioral and mental health practitioners. Behavioral health facilities or substance abuse services in an inpatient setting, ambulatory or residential treatment facilities are not covered by this policy as these services are not a covered benefit.

Commented [YH1]: CR7-E for TMG Review

D. Any Provider who fails to meet KHS requirements may result in adverse action up to and including: implementing corrective action plan, non-renewal or termination of the contract agreement.

PROCEDURES:

1.0 ***Confirmation with State and Federal regulatory bodies****:* All Organizational Providers directly contracted with KHS must meet the following requirements before KHS contracts with a provider and at least every thirty-six (36)-months thereafter as follows:

1.1 KHS Credentialing Staff utilize the following sources to confirm that the providers are in good standing with state and federal requirements, that include but are not limited to:

1.1.1 State Department of Health Care Services regulatory body;

1.1.1.1 California Department of Healthcare Services (CDPH) Healthcare facility report

1.1.1.2 Copy of the State License with expiration date

1.1.1.3 Copy of State License not issued by DHCS should also have a business license or certificate of occupancy.

1.1.1.4 No negative licensing actions that may impact participation.

1.1.1.5 Physician owned clinics are not required to be licensed by DHCS, but must be accredited by an agency approved by the Medical Board of California.

2.0 ***Confirmation of review and approval by an accrediting body***: Prior to contracting with an organizational provider, and at least every thirty-six (36)-months thereafter, KHS Credentialing Staff will confirm and review the approval by an accrediting body.

2.1 KHS Credentialing Staff utilize the following sources to confirm the provider's accreditation status:

2.1.1 Accreditation report from the accrediting bodies website; or

2.1.2 Letter or Email from the accrediting body or from the agent of the applicable accrediting body

2.1.3 Copies of credentials (e.g. accreditation report, certificate or decision letter) from the provider.

2.1.4 An attestation from the provider to the organization regarding the provider's accreditation status is not an acceptable source of confirmation.

2.2 Accreditation and licensure must be maintained throughout the duration of the provider's participation in the KHS network. KHS recognizes the following accreditations by organizational provider type:

2.2.1 ***Clinical Laboratories***: **TJC** – The Joint Commission; **CLIA** – Clinical Laboratory Association Improvement Certificate or Waiver; **COLA** – Commission on Office Laboratory Accreditation; **CAP** – College of American Pathology

2.2.2 ***Comprehensive Outpatient Rehabilitation Facilities***: **TJC** – The Joint Commission; or **CARF** – Commission on Accreditation or Rehabilitation Facilities.

2.2.3 ***Dialysis/End-Stage Renal Disease Facilities***: **TJC** – The Joint Commission; **ACHC** – Accreditation Commission for Healthcare Inc; **NDAC** – National Dialysis Accreditation Commission

2.2.4 ***Free-Standing Surgical Centers (ASC – Ambulatory Surgery Centers***: **TJC** – The Joint Commission; **AOA/HFAP** – Healthcare Facilities Accreditation Program; **AAAASF/Quad A** – Quad A formerly American Association for Ambulatory Surgical Facilities; **AAAHC** – Accreditation Association for Ambulatory Health Care; **ACHC** – Accreditation Commission for Healthcare Inc. ****Accreditation is a requirement***

2.2.5 ***Hospice***: **TJC** – The Joint Commission; **CHAP** – Community Health Accreditation Program; or **ACHC** – Accreditation Commission for Healthcare Inc (CMS Approved).

2.2.6 ***Hospitals***: **TJC** – The Joint Commission; **AOA/HFAP** – Healthcare Facilities Accreditation Program; **DNV** – Det Norske Veritas National Integrated Accreditation of Healthcare Organizations; or **CIHQ** – Center for Improvement in Healthcare Quality.

2.2.7 ***Home Health Agencies:*** **TJC** – The Joint Commission; **CHAP** – Community Health Accreditation Program; or **ACHC** – Accreditation Commission for Health Care Inc.

2.2.8 ***Portable X-Ray Supplier:*** **FDA** – Federal Drug Administration Certification

2.2.9 ***Skilled Nursing Facilities***: **TJC** – The Joint Commission; **CARF** – Commission on Accreditation or Rehabilitation Facilities; or **CCAC** – Continuing Care Accreditation Commission. (***Exception: Congregate Health Living Facilities***)

3.0 ***Site Visits for Unaccredited Facilities:***

An on-site quality assessment must be conducted if the provider is not accredited. KHS On-Site quality assessment criteria for each type of non-accredited provider includes, but is not limited to:

3.1 A process for ensuring that the organizational providers credential their practitioners.

3.2 A CMS or state review in lieu of a site visit that is no more than three (3)-years old

3.3 A copy of survey report, letter from CMS or the state, from either the organizational provider or the agency, stating that the facility was reviewed and passed inspection. **Note**: Medicare certification number is not an acceptable for use in lieu of a site visit.

3.4 If the organizational provider is located in a rural area, defined by the US Census Bureau, and the state or CMS has not conducted a site review, KHS is not required to conduct a site review.

5.0 ***Assessing Medical Providers***

KHS assess contracted organizational providers against the established requirements and within the time frame utilizing the following:

5.1 A comprehensive spreadsheet of the assessment mechanism used to document the confirmation dates and statuses of the organizational providers licensing & regulatory agencies, accrediting body or site review validations and that the provider is in good standing.

6.0 ***Changes in Accreditation, Licensure, Certification, CMS Site Survey, or Sanctions***

If KHS Contracting Department and/or KHS Credentialing Staff become aware of changes in the organizational providers accreditation status, lack of CMS or State Survey, Licensure, Certification, state/federal sanctions, exclusions or debarments, fraudulent activity or other legal or remedial actions taken against a provider requires immediate notification as follows:

6.1 Notification to the Compliance Department via email immediately or within five (5)-business days of discovering an adverse event involving a KHS Contracted provider having been disciplined or on exclusionary state or federal list.

6.2 The Senior Deputy Director of Contracting, in coordination with the Credentialing Manager, informs the provider in writing that the adverse action or exclusion status is in violation of the contractual provider agreement and initiates appropriate actions pursuant to the terms and conditions outlined in the provider agreement, including but not limited to the following:

6.2.1 Suspending or terminating the contract for cause, with appropriate notice as defined in the KHS Provider Agreement.

6.2.2 Reporting the termination of the provider agreement to regulatory agencies as per contractual requirements. Any services provided after the date of exclusion is not reimbursable or may be subject to recoupment, is at the discretion of KHS.

ATTACHMENT:
A – HICE Organizational Provider Worksheet (Spreadsheet)_02-05-21

REFERENCES:
Legislation/Regulation:
NCQA Health Plan Credentialing Standards 2023 – CR.7 Assessment of Organizational Providers

KERN HEALTH SYSTEMS

Physician Advisory Committee
Charter (Proposed)

This charter shall constitute the structure, operation, membership and responsibilities of the Physician Advisory Committee (PAC).

Purpose of the PAC:
PAC is established to provide counsel and evaluating the credentials of all current and prospective practitioners and providers in a non-discriminatory manner; responsible for the oversight of the credentialing program; delegated credentialing oversight; conducting performance monitoring from quality improvement activities and member complaints in the recredentialing decision making process; having the final authority to approve or disapprove applicants for initial and recredentialing; and recommending corrective or disciplinary action concerning network participation in the KHS Provider Network.

Additionally, it is proposed that PAC include [Quality Performance Purpose]

Responsibilities and Membership of the PAC:
The PAC is responsible for coordinating the credentialing process for the KHS Provider Network to assure support of the organization's mutual goals to improve the quality of care rendered by the contracted and credentialed practitioners ensuring all appointees meet the educational, training, and appropriate licensure defined by the KHS Policy and Procedures 4.01-P Credentialing Program. PAC Membership is defined per KHS Policy and Procedure 4.XX-P Physician Advisory Committee.

The PAC is further responsible for coordinating [Quality Performance Responsibilities]

Decision-Making Context and Scope

1. The PAC provides counsel and input to the Executive Quality Improvement Health Equity Committee (QIHEC) and the Chief Executive Officer (CEO) regarding its provider network, clinical criteria sets, reviews of sentinel conditions or adverse events related to quality concerns including provider grievances and/or appeals related to provider quality issues.
2. The QIHEC provides overall direction for the continuous improvement process and monitors the activities to be consistent with KHS's strategic goals, initiatives and priorities and shall provide feedback and opinion on PAC activities.
4. Members of the PAC will strive for consensus. When consensus is not immediately reached, discussion will continue to re-word, resolve, or propose a resolution. If consensus cannot be reached a vote will be taken according to Robert's Rule of Order to help members hold orderly meetings that allow the majority vote to rule while allowing minority voices to be heard.

Defined Goals, Monitoring, Reporting and Accountability:
The PAC shall establish metrics and monitoring tracking process to evaluate progress on the following primary goals:

1. Annual review of Credentialing Policy and Procedures include procedures related to the credentialing program and delegated credentialing activities.

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2. Take formal action on provider credentialing requests in a non-discriminatory manner and within the established timeframes of a properly completed application.
3. Recommending corrective or disciplinary action concerning network participants when there is a quality of care concern or issue.
4. Monitor monthly reports of all regulatory state, federal and state licensing agencies verifying provider continued eligibility, ensuring compliance and good standing with these agencies in between credentialing cycles.
5. Determines the review and approval of clinical criteria sets for the organization.
6. Incorporate findings from KHS Quality Performance Improvement Program into the re-credentialing process.

Roles and Responsibilities

1. Chairperson – Runs the meeting and maintains order; serves as the point of contact for the committee; is accountable for representing the committee and making reports on behalf of the committee. The KHS Chief Medical Officer is the designated chairperson and if unavailable shall assign a designated KHS Medical Director in his/her absence.
2. Facilitator - Assists with chairperson duties detailed above, provides assistance on KHS policies, credentialing information, state/federal and NCQA regulations. The KHS Deputy Director of Contracting shall serve as the PAC Facilitator.
3. Recorder -prepares the agenda and all related materials. Assists with chairperson duties detailed above, takes minutes at the meeting and prepares the final set of minutes including meeting discussions, decisions, and actions. The Health Services Executive Administrator shall serve as the PAC Facilitator.
4. Member – An appointed member is a voting member. All members shall participate in the PAC discussions in accordance with established ground rules.

Member Conduct/Ground Rules:

Members of the KHS PAC seek a meeting culture that is professional, productive, and comfortable. The following ground rules have been adopted:

1. Respect of others:
    - Only one person speaks at a time; no one will interrupt while someone is speaking.
    - Each person expresses their own views, rather than speaking for others or attributing motives.
    - No sidebars or interruptions.
    - Members will avoid extended comments/speaking, allowing everyone and opportunity and fair chance to speak.
    - Refrain from personal or individual attacks; disparaging comments.
    - Questions of clarification are encouraged and seek focus on merit making a good faith effort to understand the concerns of others.

Meetings

1. Regular Meetings: The PAC shall meet at least ten (10) times per year
2. Special Meetings: Special meetings of the PAC will occur ad hoc as necessary to conduct the immediate or time sensitive discussions or actions. Special Meetings may be call by the Chairperson, Deputy Director of Contracting or the Credentialing Manager.
3. Meeting Materials: the agenda and related materials (non-confidential and non-peer review related) will be distributed in advance of the meeting. Credentialing and peer review materials will be available at the meeting.

4. Attendance at Meetings: meetings and decisions may take place in form of real-time, virtual meetings (e.g. through video conferencing or web conferencing with audio). Meetings may not be conducted through only email.
5. Location: On-Site meetings are held at KHS Offices located at 2900 Buck Owens Blvd. Bakersfield California

KERN HEALTH SYSTEMS

MEMORANDUM

TO: KHS Board of Directors

FROM: Martha Tasinga MD, KHS CMO

SUBJECT: REVISED POLICY AND PROCEDURE – 4.01-P Credentialing Program
NEW POLICIES: 4.58-I Credentialing Systems Control

DATE: April 18, 2024

Background

On 3/6/2024, PAC approved additional modifications to KHS policy PNM 4.01-P Credentialing Program Policy and Procedure as a result of NCQA preparations. The enclosed document (red-lined) shows the modifications to P&P 4.01-P and the specific changes. New Policy has been written and approved as required by NCQA regarding Credentialing System Controls.

Policy Section (REVISED)	Policy Changes
4.01 Credentialing Non-Discriminatory Credentialing of Providers Page 3	• Added language pursuant to DMCH APL 23-025 Abortion: Provider Protections Codified under H&S Code Section 1375.61 **prohibiting discrimination against providers disciplined in other states that interfere with person's right to receive care that is lawful in this state**
NEW POLICIES	**New Policy & Procedures**
4.58-I Credentialing System Controls A. Credentialing System Controls Annual Audit Report B. Annual Confidentiality Agreement – Credentialing Staff Annual Credentialing System Controls Agreement – Symplr System Users	• New P&P 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; titles and roles of staff authorized to review, modify and delete information; the security in place to protect the information from unauthorized modifications; and how the organization monitors its compliance at least annually.

Requested Action

Approve.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Credentialing Program				POLICY #: 4.01-P	
DEPARTMENT: Provider Network Management					
Effective Date:	Review/Revised Date:	DMHC	X	PAC	X
01/1997	~~1/5/2024~~2/7/2024 3/6/2024	DHCS	X	QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Senior Director of Provider Network

POLICY:
Kern Health Systems ("KHS") members are entitled to quality health care. It is the policy of KHS that every reasonable effort is made to verify health care providers with whom KHS contracts meet the basic standards of training, certification, and performance. Credentialing and recredentialing requirements are applicable to all licensed practitioners, non-physician practitioners, ancillary and facility providers contracted with KHS (collectively referred to herein as "provider(s)"). A contracted provider must be credentialed with KHS in order to treat KHS members.

PROCEDURES:
Credentialing is defined as the recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership. It is the process by which health care providers are evaluated and approved for provider status as contractors and subcontractors in the KHS network. The credentialing program has been developed in accordance with state and federal requirements, accreditation guidelines and comply with the Department of Managed Health Care ("DMHC") and the Department of Health Care Services

("DHCS") requirements, including DHCS All Plan Letter ("APL") 22-013 and subsequent updates to this APL, if any. KHS meets all DMHC and DHCS requirements, and has established credentialing criteria, including the verification sources used, based on state, federal and current accreditation guidelines from the National Committee for Quality Assurance ("NCQA") credentialing standards.

SCOPE OF PROVIDERS COVERED BY CREDENTIALING

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

1. All providers who have a contracted, independent relationship with KHS.
2. All providers who see KHS members outside the inpatient hospital setting.
3. All providers who see KHS members in outpatient ambulatory free-standing facilities.
4. All physician executives who serve in an administrative capacity for KHS.
5. All providers who are hospital based but render services or care to KHS members as a result of their independent relationship with KHS. Examples include: an anesthesiologist who is contracted to provide pain management to KHS members in an outpatient setting.
6. All providers who practice as a hospitalist or Skilled Nursing Facility (SNF).
7. All providers who provide telemedicine consults interacting with members.
8. All non-physician practitioners who may or may not have an independent relationship with KHS.
9. All behavioral health care providers such as doctoral or master's-level psychologists, clinical social workers, psychiatric nurses, or other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently.
10. All ancillary, pharmacies and organization providers who have a contract with KHS.

PROVIDERS WHO DO NOT NEED TO BE CREDENTIALED

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

1. Hospitalist practicing exclusively in an inpatient setting.
2. Radiologist practicing in an outpatient setting.
3. Anesthesiologist in an ambulatory care setting or practicing in an office setting specific to pain management.

NON-DISCRIMINATORY CREDENTIALING FOR PROVIDERS

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

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

Monitoring will be conducted semi-annually (~~June~~ February & ~~December~~August) by tracking and identifying discrimination in the credentialing and recredentialing processes to assure discriminatory practices do not occur. Any Executive Officer, provider, or employee who believes or becomes aware of any discriminatory act shall promptly report any violation in person or in writing to their supervisor or directly to the KHS Credentialing Manager. The Credentialing Manager reports semi-annually to the Physician Advisory Committee the number of complaints made alleging discrimination at credentialing or recredentialing. Additionally, a detailed summary of the credentialed and recredentialed practitioners age, gender and specialty type is presented semi-annually to the Physicians Advisory Committee (report excludes organization providers).

Pursuant to DMHC APL 23-025 - Senate Bill 487 (Atkins, Ch.261, Stats. 2023) Abortion: Provider Protections Codified under Health and Safety Code, Section 1375.61, prohibits discriminating, with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California.

1.0 APPLICATION

Application for provider status is made by submitting a completed application together with the applicable and required supporting documents to the Provider Network Management Department. Application forms are available through the Provider Network Management Department and are available electronically on the KHS Provider Portal.

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

No application shall be acted upon unless it is complete, signed and dated, which includes completion of the application form, attestation questionnaire, release of information and submission of all supporting documents, including any additional information requested by the PAC. If the provider is notified that the application (or supporting documents) is incomplete or illegible, the provider must provide the missing information for the credentialing process to continue within 10-calendar days. The provider is responsible for providing the information

to satisfy the process or request by the PAC. It is the provider's burden to provide all information requested and to resolve any difficulties in verifying or obtaining the documentation required to satisfy the credentialing requirements. If the provider fails to provide this information, the credentialing application will be deemed incomplete and will result in an administrative denial or withdrawal of application from the KHS network. Providers who fail to provide this burden of proof do not have the right to submit an appeal. Applications are evaluated according to the credentialing criteria and verification sources set forth in Attachments A & B. An application that does not satisfy these criteria, as determined by the PAC or Board of Directors, may be denied. The PAC may deny provider status if the information submitted is insufficient to resolve reasonable doubts as to the provider's qualifications. KHS reserves the right to exercise discretion when applying any criteria and to exclude providers who do not meet the criteria. KHS Board of Directors, after considering PAC recommendation, may waive any requirement for network participation established by these policies and procedures for good cause if it is determined that such waiver is necessary to meet the needs of KHS and the community it serves. The refusal to waive any requirement shall not entitle the provider to a hearing or any other rights of review.

1.1 Required Attestation

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

A. Any limitation or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation, and reasons for the same.
B. History of loss of license and/or felony conviction(s), including plea of nolo contendere.
C. History of loss or limitation of privileges and/or disciplinary activity.
D. Lack of present illegal drug use.
E. A current and signed attestation by the applicant of the accuracy and completeness of the application.

2.0 APPLICATION REVIEW/COMMITTEE AND BOARD REVIEW

2.1 Application Review

The PAC shall serve as the Credentials Committee and shall be responsible for the review of all applications.

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

A. The appropriate license and/or board certification or registration to practice in California. (Verification Source: applicable state licensing or certifying agency via verbal, written or internet/electronic method.)
B. Evidence of graduation or completion of any required education (Verification Source: AMA Masterfile, AOA Official Osteopathic Master file, ABMS Board Certification or directly from primary source Medical, Residency, Fellowship or Professional training Program.)
C. Proof of completion of any relevant medical residency and/or specialty training. (Verification Source: AMA Masterfile, AOA Official Osteopathic Master file, ABMS Board Certification or directly from primary source Medical,

Residency, Fellowship or Professional training Program.)

D. Proof of completion of any relevant professional training (non-physicians) (Verification Source: National Student Clearinghouse or appropriate board/registry when the board or registry performs primary source verification of education.)

E. Work history (Verification Source: Documented on application or curriculum vitae/resume in month/year format)

F. Hospital and clinic privileges in good standing (Verification Source: Verbal, written or internet/electronic verification directly with the institution, hospital letter or directory.)

G. History of suspension or curtailment of hospital and clinic privileges (Verification Source: NPDB with Continuous Query)

H. Current Drug Enforcement Administration identification number. (Verification Source: DEA Office of Diversion Control, AMA Masterfile, AOA Official Osteopathic Masterfile, DEA or CDC Certificate or photocopy of the certificate, or visual inspection of the original DEA or CDS Certificate including DEA waivers)

I. National Provider Identifier number (Verification Source: NPPES Registry)

J. Current malpractice or professional insurance in an adequate amount, as required for the particular provider type. (Verification Source: Copy of certificate face-sheet, Federal Tort Letter, or if the provider's malpractice insurance coverage is current and provided in the application.)

K. History of liability claims against the provider (Verification Source: NPDB with Continuous Query)

L. Provider information, if any, entered in the National Practitioner Data Bank, when applicable (Verification Source: NPDB with Continuous Query)

M. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network. (Verification Source: NPDB with Continuous Query and/or including but not limited to; OIG-Office of the Inspector General LEIE Database, CMS Medicare Opt Out Affidavit, DHCS Medi-Cal Suspended/Ineligible List, DHCS Restricted Provider List (RPD) and the SAM-System for Award Management Database.)

N. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the relevant DHCS All Plan Letter and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy. (Verification Source: CHHS Portal for Enrolled Medi-Cal Fee For Service Provider; Copy of welcome/approval letter from DHCS; DHCS Medi-Cal Ordering, Referring & Prescribing (ORP) Portal; Other health plan attestation of enrollment at KHS discretion.)

2.2 Discrepancies in Credentialing Information

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

within 10-calendar days of the notification.

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

Providers will only be credentialed in the area of practice in which they have adequate education and training verified through primary source verification, if applicable, from an ACGME accredited residency and/or fellowship as set forth by the American Board of Medical Specialties ("ABMS") or American Osteopathic Association ("AOA") for requested sub-specialties (see credentialing requirements in Attachments A). KHS uses specialties and sub-specialties recognized by the ABMS and AOA. It is expected that providers confine their practice to their credentialed specialty when providing services to KHS members. KHS will list provider specialties in member materials and practitioner directories that are consistent with the information obtained during the credentialing process including education/training verified through primary source, board certification specialties recognized according to ABMS/AOA, or as verified on other professional license certificate.

2.4 Provider Rights

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

A. **Right to review credentials information:** The provider may request to review information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. This includes information obtained from outside sources such as malpractice carriers or state licensing agencies, and/or board certification, but does not extend to review of information from peer reference recommendations, hospital privileges verifications or other information protected by law from disclosure including peer review protected information. Providers may submit their request for review to their Provider Relations Representative via written request, certified mail. The Credentialing Manager or Coordinator will coordinate a time and date for such access during regular business hours and in the presence of a credentialing staff personnel, KHS Chief Medical Officer or KHS Executive Officer within 72-hours of request. The provider is not permitted to remove, destroy or photocopy documentation from the credentials file except what was originally provided by the provider upon application.

B. **Right to correct erroneous/inaccurate information:** The provider may correct erroneous or inaccurate information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application in the event that credentialing information obtained from primary sources varies substantially from that provided by a provider. The provider will have the opportunity to correct information in the application which is inconsistent with the information received via primary source verification process. The Credentialing Coordinator will notify the provider within fourteen (14) days via email, letter or fax of the discrepancy and will include the items found to be inconsistent. Such notice will not contain protected peer review information or copies of the NPDB Summary. The provider shall respond within 48-hours of the plan's notification or within 24-hours of provider's credentialing file review, in writing via email, letter or fax, regarding the inconsistent information on the application and return a formal response to the

Credentialing Staff, PR Representative, or KHS CMO, within fourteen (14) days. The Credentialing Staff will reverify the primary source information until the discrepancy is resolved. If the discrepancy is not resolved within ninety (90) days or within 180-days from attestation date, whichever is sooner, the application will be deemed incomplete and will be considered administratively withdrawn and the file closed with no further action.

C. **Right to request/receive status update on application**: The provider may request review of information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application.. Providers may submit their request for review to their Provider Relations Representative via email, letter, or fax. The Credentialing Manager or Coordinator will review and provide the requested information in a timely and courteous manner no more than seven 7-business days of the request.

2.5 Confidentiality

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

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

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

2.6 Credentialing File Review

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

All providers participating in the KHS network must be approved by the PAC. The CMO has the authority to determine whether or not credentialing or recredentialing files are "clean" and meet established criteria. A file must meet the following criteria to be considered a "clean file":

A. No malpractice cases that resulted in settlement or judgment paid on behalf of the provider within the previous 5-years for initial applicants or since the last credentialing/recredentialing review date.

B. No 805/805.1 reports, State Licensing accusations, limitations, or sanctions on

licensure.

C. No adverse events from other regulatory, state, or federal agencies, i.e., OIG, NPDB, Medicare Opt-Out, Medi-Cal Suspended or Ineligible list, System for Award Management, etc.
D. Current and signed attestation confirming correctness and completeness of application.
E. For those offices requiring an office site visit, overall score of 90% or higher.
F. For recredentialing, no more than seven (7) member complaints, no internal quality of care case reviews, no utilization management or compliance issues or trends in the prior 3-years.
G. The CMO will have the discretion to refer any member complaint or quality of care concern for a comprehensive review by the PAC regardless of the severity score.
H. Those files determined by the CMO not meeting the above criteria or at his/her sole discretion, will require comprehensive review by the PAC.

2.7 Comprehensive Reviews

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

The CMO or his/her designee reviews the applications and prepares his/her approval or recommendations to the PAC, as follows:

A. The recommendation is reviewed by the PAC which prepares its approval or recommendation, such as modification or denial, which is submitted to the Board of Directors.
B. If the PAC recommends the denial of the application based on:
    a. A perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; and/or
    b. A perceived issue with conduct or professional competence which affects or could affect adversely the health or welfare of a patient or patients.

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

2.8 Provisional Approval/Clean file Approval

In the circumstance where a provider file is ready for presentation to the PAC, however there is no PAC meeting scheduled, or was cancelled due to member scheduling conflicts, including but not limited to; lack of quorum to vote on matters, prior to the next Board of Directors meeting, the CMO may recommend the applicant(s) to the Board of Directors for provisional/clean file approval. In order to be considered for provisional approval, the applicant must meet the criteria in the applicable exhibit (Attachments A& B) and have no malpractice action (pending or closed) within the

previous five years (three years if the applicant is being recredentialed). In the case of recredentialing, in addition, there may not be any pending or current issues, requiring comprehensive review, reported by the Quality Improvement, Utilization Management, Member Services or Compliance Departments in the interval since the applicant was last credentialed.

If provisional/clean file approvals are granted by the CMO, the applicant shall be presented to the PAC at its next meeting for ratification. The CMO approval date becomes the official approval date.

2.9 Locum Tenens

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

A. Locum Tenens must be of the same provider type and specialty as the provider on leave, e.g., a physician must substitute for a physician in same designated specialty; a non-physician for a non-physician.
B. KHS must be notified of the request for Locum Tenens in writing from the existing contracted group or provider.
C. If the request is received after services are rendered, KHS will only retroactively pay for services rendered within the prior fourteen (14)-days. Claims for services outside that timeframe may be denied.
D. KHS must be provided with a copy of a current, valid, and unrestricted California medical license.
E. KHS must be provided with a copy of a current, valid, and unrestricted DEA issued with a California address, if applicable
F. KHS must have copy of the practitioner's professional liability insurance in the amounts of $1,000,000.00 per occurrences and $3,000,000.00 in aggregate.
G. In order to be considered for Locum Tenens, the applicant must meet the established clean file criteria, and have no malpractice actions (pending or closed).

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

If the Locum Tenens status is approved by KHS, the Locum Tenens provider will be compensated for services at the same rate as the KHS contracted provider. However, KHS is not responsible for the compensation arrangement between the provider on leave and the Locum Tenens provider. The use of the same Locum Tenens provider will be limited to 90 consecutive days. KHS reserves the right to approve a Locum

Tenens status extension due to extenuating circumstances.

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

2.10 PAC Decision Regarding Credentialing

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

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

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

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

2.11 Effective Date

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

2.12 Notification of Decisions Regarding Initial Applicants

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

2.13 Notification of Adverse Decisions Regarding Recredentialing

KHS will notify, in writing, recredentialing applicants of any adverse recredentialing decisions, including denial of recredentialing, within 60-days from the date of the PAC's credentialing decision.

3.0 PROVIDER RESPONSIBILITY TO REPORT CHANGES

Once approved, each provider shall remain in compliance with the credentialing criteria and report to the CMO all of the following:

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

professional negligence

B. Any change in the provider's license or DEA status
C. The initiation of and reason for any investigation or the filing of any complaint against the provider by any government agency
D. Any adverse determination by any facility or entity with a credentialing or peer review process concerning provider's quality of care.
E. A change in any hospital or practice privilege granted to the practitioner by any facility or entity with a credentialing or peer review process
F. Any change in the provider's errors and omissions or professional negligence insurance coverage including changes affecting coverage of specific clinical procedures or privileges of the practitioner
G. Conviction of the provider or entry of a plea of nolo contendere to any felony.
H. Conviction of a provider or entry of a plea of nolo contendere to any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services
I. Conviction of the provider of any crime or an entry of a plea of nolo contendere to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to practice medicine or deliver health care services
J. The filing of any charges against the provider alleging unlawful sale, use, or possession of any controlled substance.
K. Suspension from the federal Medicare or Medicaid programs for any reason.
L. Lost or surrendered a license, certificate, or approval to provide health care.
M. Any other adverse occurrence that relates to the provider's license or practice, including but not limited to revocation or suspension of a license by a federal, California, or another state's licensing, certification, or approval authority.
N. If the provider is a clinic, group, corporation or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization of any crimes set forth above.

4.0 RECREDENTIALING AND COMPLIANCE WITH LAWS

Each provider is recredentialed every 36-months. However, recredentialing may be made sooner when required by a change in relevant provider information or if the PAC makes such recommendation.[ii] The process includes a review of all applicable areas for credentialing.

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

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

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

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

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

These credentialing policies shall be reviewed at least annually by the PAC which may recommend revisions or amendments to the Board of Directors.

5.0 HEARING RIGHTS

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

6.0 RELEASE

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

7.0 ADDITIONAL INFORMATION

7.1 Specialists Practicing Primary Care

Providers with sub-specialties recognized by the ABMS or one of its Member Boards may function in the role of a Primary Care Practitioner (PCP) if they meet the requirements to be a PCP (See Attachment A). However, KHS credentialed specialists functioning as a KHS credentialed PCP may not self-refer for specialty care. If the provider sees a member assigned to him/her for primary care, he/she may not bill as a specialist even if that member's condition is within the provider's sub-specialty. The provider may accept authorized sub-specialty referrals from providers outside of his/her group for those services provided as a sub-specialist.

7.2 Scope of Mid-Level Practitioners

KHS members either select or are randomly assigned to a contracted PCP. The PCP may choose to arrange with a mid-level practitioner to provide primary care to assigned members but must provide active supervision of the care delivered.

A current specialty practitioner may employ a mid-level practitioner and may permit this practitioner to participate in the care delivered to members in accordance with the Standardized Procedure Guidelines, Delegation of Services Agreement, and KHS Policy and Procedure 4.04-P Non-Physician Medical Practitioners. Mid-level practitioners will be credentialed in the specific specialty in which they will be

working. The credentialing will be dependent on the training and experience in the field in which the mid-level is requesting to be credentialed.[iii]

KHS will require either 6 months formal training in a program or one year of full-time experience in the field which credentialing is requested.

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

7.3 Facility and Ancillary Providers/ Assessment of Organizational Providers

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

A. Provider must be physically located in and providing services in Kern County for one year prior to application.
B. must be in good standing with KHS.
C. must be able to submit claims electronically.
D. must be able to participate in the KHS electronic funds transfer (EFT) program.
E. laboratory providers must be able to submit lab results/data to KHS electronically.
F. Durable medical equipment (DME) providers must be able to service KFHC Members seven (7) days a week.
G. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the DHCS APL 19-004 and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy.

KHS will conduct an initial and ongoing assessment of the providers with which it contracts. The assessment of the health care delivery provider will be conducted before it contracts with a provider, and for at least every 36-months thereafter, in accordance with KHS Policy & Procedure 4.55-I "Assessment of Organizational Providers & Behavioral Health Providers"

7.3.1 Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD)

Effective January 1, 2024, KHS will maintain an adequate Network consisting of ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes licensed and certified by the California Department of Public Health (CDPH). *To meet KHS credentialing requirements, ICF-DD Homes must submit:*

- *KHS Organizational/Ancillary/Facility Application –*
- *An annual ICF/DD Attestation[1] under penalty of perjury that the following credentialing requirements are satisfied:*
  - *Completion of the MCP's specific Provider Training within the last two (2) years*
  - *Facility Site Audit from State Agency*

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- *No Change in 5% Ownership Disclosure since the last submission to MCP*
- *Possess an active CDPH License and CMS Certification*
- *In good standing as a Regional Center Vendor*

- *For the **initial** credentialing, ICF/DD Homes must submit the below items in addition to the annual ICF/DD Attestation:*
- *W-9 Request for Taxpayer Identification Number and Certification*
- *MCP Ancillary Facility Network Provider Application*
- *Certificates of Insurance (Professional and General Liability)*
- *City or County Business License (excludes ICF/DD-H and -N homes with six or less residents)*
- *5% Ownership Disclosure*

*For the **recredentialing**, ICF/DD Homes must submit the below items every 2-years:*

- *KHS Organizational/Ancillary/Facility Application –*
- *An annual ICF/DD Attestation[2] under penalty of perjury that the following credentialing requirements are satisfied:*
  - *Completion of the MCP's specific Provider Training within the last two (2) years*
  - *Facility Site Audit from State Agency*
  - *No Change in 5% Ownership Disclosure since the last submission to MCP*
  - *Possess an active CDPH License and CMS Certification*
  - *In good standing as a Regional Center Vendor*

For **changes** in between credentialing cycles, the ICF/DD Home must report that change to KHS Credentialing including any required documentation within 90-days of when the change occurred.

7.4 Medical Transportation Providers (Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT)

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

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

7.5 Enhanced Care Management (ECM) and Community Supports (CS) Providers

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

7.6 HIV/AIDS Provider

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

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

A. Whether they wish to be designated an HIV/AIDS specialist
B. Whether they meet the defined criteria as per California H&S Code 1374.16

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

7.7 Mental Health and Substance use Disorder Provider Credentials

Effective January 1, 2023, Managed Care Plans that cover and who credential health care providers in mental health and substance use disorder services for its network, will assess and verify the qualifications of a health care provider within 60-calendar days after receiving a completed provider credentialing application.

Upon receipt of an application from a mental health or substance abuse provider, the KHS Credentialing Staff will notify the applicant within seven (7) business days of receiving the application to verify receipt and inform the applicant whether the application is complete. Applications returned as "incomplete" will be given 15-calendar days to return any incomplete or missing required information.

A mental health or substance abuse provider application is considered complete based on the requirements set forth in this Policy and Procedure, Sections 1.0 Application, Section 2.0 Application Review and Attachment B – Behavioral Health Practitioner Provider Specific Credentialing Criteria.

Pursuant to Section 2.8, Provisional Approval will be granted and approved for those applicants whose credentialing file meet clean file criteria and are absent of , but not

limited to, any adverse actions, disciplinary licensing actions, including conduct or professional competency. Files with adverse actions or information will be reviewed at the next scheduled Physician Advisory Committee for determination. [Reference: AB 2581 (Salas, CH. 533, Stats. 2022)]

7.8 Community Health Worker (CHW)

CHW Providers must have a lived experience that aligns with and provides a connection between the CHW, and the member or population being served. CHW Providers are not licensed providers, require a Supervising Provider, do not follow traditional credentialing requirements, and do not have a corresponding state-level enrollment pathway.

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the CHW Provider meets the requirements outlined in the DHCS APL 22-016 Community Health Worker, including but not limited to having valid NPI Number, possess lived experience that aligns with and provides a connection between the CHW and the member or population being served; has obtained a minimum of six (6) hours of additional relevant training annually; has a Supervising Provider employed by the same organization overseeing the CHW with which is KHS Contracted. CHW Providers are required to demonstrate, and Supervising Provider must maintain evidence of, minimum qualifications through a Certificate Pathway or a Lived Experience Pathway consistent with APL 22-016, or any superseding APL. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

Supervising Providers, with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS' Provider Enrollment Division. For the Supervising Providers that do not have a corresponding state-level enrollment pathway, they will not be required to enroll in the Medi-Cal program. Supervising Providers, without a state level enrollment pathway, must complete the appropriate provider application, Supervising Attestation and Acknowledgement form for submission to KHS Credentialing for review and approval. KHS will verify the supervising provider meets the qualification as a licensed provider, or other acceptable supervising provider designated within a hospital, outpatient clinic, local health jurisdiction (LHJ) or a community-based organization (CBO), employing or otherwise overseeing the CHW, with which Kern Health Systems (KHS) contracts.

7.9 Doula Providers

KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate the doula provider meets the requirements outlined in the DHCS All Plan Letter (APL) 22-031 Doula Services, or any superseding APL. Doulas are not licensed providers, do not require supervision, do not follow

traditional credentialing requirements, and have a corresponding state-level pathway for enrolling in Medi-Cal. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

7.10 Dyadic Service Care Providers / Non-Specialty Mental Health Services Provider Manual (NSMHS)

KHS Provider Network will include Psychiatric and Psychological Service providers as outlined in the DHCS NSMHS provider manual and/or who provide Dyadic Care Services by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists. Additionally, Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render these services under the supervision of credentialed practitioner, who is qualified to provide supervision and whose licensure is not currently suspended, limited/restricted or on probation.

Network Providers who are licensed independent practitioners will be subject to the credentialing and enrollment process outlined in Section 1.0 -6.0 of this policy and are required to enroll as Medi-Cal Providers, consistent with APL 22-013, or any superseding APL, if there is a state-level enrollment pathway for them to do so. For Associate or Assistant provider types, when there is no state-level enrollment pathway, the KHS Provider Network Management's Credentialing Staff will conduct an assessment to validate these providers meets the requirements outlined in the DHCS NSMHS Provider Manual and/or DHCS APL 22-029 Dyadic Care Services and Family Therapy Benefit. Refer to provider specific criteria is listed in "Attachment D Non-Licensed Other Provider Types" of this policy.

ATTACHMENTS:

- Attachment A: Provider Specific Credentialing Criteria – Practitioners
- Attachment B: Provider Specific Credentialing Criteria – BH-Practitioners
- Attachment C: Org-Facilities, Ancillary Services, Pharmacies
- Attachment D: Non-Licensed Other Provider Types

REFERENCE:

Revisions 03/2024: Page 3 – Non-Discriminatory Credentialing added DMHC APL 23-025 Section 12 Abortion-Provider Protections language prohibiting discrimination against providers disciplined in other states that interfere with person's right to receive care that is lawful in this state.
Revisions 02/2024: Section 7.3.1 added in accordance with DHCS APL 23-023 ICF/DD Credentialing Requirements and Page 3 - changed Non-Discriminatory Credentialing report dates to February & August.
Revisions 11-2023: Section 2.1 Recommended by NCQA Consultants to add Primary Verification Approved Sources used by Credentialing to verify each item; Section 2.4 Provider Rights: Language restructured as recommended by NCQA Consultant to match Provider Rights Addendum; Section 2.8 revised to include CR1A-Factors 3-5 for Managing

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files that meet clean-file criteria and approval by CMO; **Revisions 08-2023:** Credentialing Policy Section 2.9 – Added time-limited retroactive payment of 14-days on Locum Tenens request received after services are rendered as approved by Executive Roundtable on 07/25/23. **Revision 06-2023:** NCQA CR1A-6 added Nondiscriminatory monitoring; NCQA CR1A-11 - 2.3 added process to ensure information in member materials is consistent with information obtained in credentialing; NCQA CR1B-1-3 Practitioner Rights added language regarding all practitioners rights; Section 2.5 added PAC Members will annually sign confidentiality statements; NCQA CR1A-8 Section 2.13 added Notification of adverse recred decision; NCQA CR7 added language regarding assessment of organizational providers. **Revision 04-2023:** Credentialing Policy Section 7.0 has been revised to add related credentialing requirements specific to Doula Service Providers, Dyadic Care Service Providers and Community Health Workers.
References include: APL 22-016 Community Health Workers; APL 22-031 Doula Services; DHCS APL 22-029 Dyadic Services, DHCS Provider Manual NSMHS & CA Board of Behavioral Sciences. Approved by DMHC 11/2/2023 for DMHC APL 22-031. Approved by DHCS File and use 5/26/2023 and 8/2/2023 for DHCS APL 22-029. **Revision 03-2023:** Credentialing Policy Section 7.0 has been revised to add section related to compliance with Assembly Bill 2581 Health Care Coverage: Mental Health and Substance Use Disorders – Provider Credentials. **Revision 01-2023:** Credentialing Policy has gone through a comprehensive revision by KHS PNM Management and legal review with DSR Health Law to bring into current practice and compliance with all state, federal, DHCS APLs and NCQA credentialing standards. In addition, DSR Health Law performed a regulatory review making further updates and revisions to bring into compliance with DHCS Contract language, DHCS All Plan Letters related to credentialing and screening/enrollment processes, CalAIM and California Business and Professions Code where applicable. KHS PAC Approved 2/1/2023 and KHS BOD Approved 2/16/2023**.** DHCS File and Use disposition given on 6/2/2023. **Revision 2015-06:** QAS Provider requirements per DHCS 14-026; and Behavioral Health Provider requirements. Revision **2014-12:** Item B. in Section 7.4 "cannot be physician owned, either directly or indirectly;" was deleted as requested by Compliance Director 10/01/2014. SBIRT training removed from Policy 2.22-I Facility Site Review and added to credentialing per COO. **Revision 2013-07**: New Attachment "N" Walk in Clinic Providers. Approved at the Physician Advisory Committee (PAC) Meeting on March 6, 2013. [1]**Revision 2012-10:** Language added to allow Mid-levels participate in a specialty settings and perform initial evaluations. The specialty physician must see the patient at lease every third visit. **Revision 2012-08**: Deleted requirement for non-physicians to pay $100 Credentialing process fee. R**evision 2012-01:** Revisions to attachments only. **Revision 2011-06:** Policy approved by management 11/15/10. However additional changes we provided by Director of Claims and Provider Relations regarding SPD members, Specialists and Emergency Room Physicians. Policy KHS Board approved 4/14/11. Revision to Attachments A and D regarding credentialing criteria. Board approved on 10/14/2010. Additional language added (01/2011) per Director of Claims and Provider Relations see Section 7.3 and 7.4 language from policies 4.4-P and 4.25-P respectively. **Revision 2010-05:** Physicians Advisory Committee added clarification of credentialing requirements in Attachment A #6. **Revision 2009-09: Revised by Provider Relation Director. Revision 2007-03:** Revised per DHS/DMHC Medical Review Audit (YE 10/31/06). **Revision 2005-11:** Revised per DHS Work Plan (07/10/05). **Revision 2005-04**: **Revision 2003-06**: Revised per DHS comment letter 03/04/03. **Revision 2002-08:** Routine review/revision. Revised per DHS Comment (10/30/01). Hospital Based Physicians section added per request of Medical Director. Radiology claims section added per request of Medical Director. Policy #4.03 – Pharmacy Credentialing deleted, and necessary information added to this policy. Pharmacy portion revised per DHS Comment (09/19/01). Revised per MMCD Policy Letter 02-03.

[i] DHS Contract Section 6.5.4.2
[ii] MMCD Policy Letter 02-03 § II

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Credentialing System Security Controls				POLICY #: New 4.X-I	
DEPARTMENT:					
Effective Date: ~~08/01/2023~~01/01/2024	Review/Revised Date: New ~~10/17/2023~~~~12/27/2023~~ 03/06/2024	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Chief Executive Officer

_____ Date _____

_____ Date _____

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PURPOSE:
The purpose of this policy is to maintain compliance with the National Committee for Quality Assurance (NCQA) standards related to CR1 Element C & D, Credentialing System Controls.

POLICY:
Ensuring all credentialing activities related to receiving, verifying, and processing an application for initial and/or recredentialing to Kern Health Systems (KHS) health plan network are part of the protected and confidential quality improvement and peer review processes, even if such activities occur prior to any action taken by the Physician Advisory Committee (PAC) with respect to the application.

DEFINITIONS:

NCQA	National Committee for Quality Assurance
PAC	Physician Advisory Committee (Credentialing Committee)

PROCEDURES:

1.0 Primary Source Verification Information (CR 1.C.1)

1.1 Applications for initial credentialing and/or recredentialing, including supporting documents, are received by email, fax or mail. Applications and supporting documents received via mail (hard copy) are scanned as pdf documents.

1.2 The Credentialing Coordinator reviews the applications for any missing or deficient information. Three attempts are made to request the missing or deficient information to providers as needed. Applications are then closed and considered administratively withdrawn after the fourth and final attempt is unsuccessful.

1.3 Applications and supporting documents undergo an intake process and are tracked throughout the credentialing process as follows: using the Credentialing Software "Symplr" database and by use of an electronic Adobe PDF processing sheet (Checklist).

1.3.1 Using the Credentialing Database "Symplr", all credentialing data is entered, updated, and modified by the Credentialing Manager and Credentialing Coordinators.

1.3.2 Symplr database has an automated "Audit Log Viewer" that tracks all data including date/time when records were entered, changed or deleted; the old-value and new-value; and records the person who made the entry. The "Audit Log Viewer" is accessible on-demand or by an audit log report generated from Symplr Report Query.

1.4 Applications, and supporting documents and primary source verifications are stored electronically, using Adobe Professional, on our secured credentialing network Provider Relations Drive (V/S:ProviderNetwork) Credentialing.

1.4.1 Access to the Credentialing folders are set to user functions (edit, add, delete) and are only viewed by the approved is issued to the Credentialing Team members only upon approval by the Credentialing Manager.

1.4.2 Credentialing Team members are issued Adobe Professional on their computers and through their unique user login and password into the KHS system, they are capable of generating a stamp palette indicating "Received, Reviewed and/or Revised" that includes their username, time and date.

1.5 Processed applications, supporting documents and primary source verifications are stamped via Adobe PDF Stamp (Received Stamp: includes unique user name, date & time) or an electronic date/time stamp generated by the (Internet)browser that includes the URL Website Address, date, time and username on the electronic filedocument.

1.6 The electronic credential file is stored on a secured network Provider Relations Drive (V/S:ProviderNetwork) Credentialing and the Credentialing Manager or designee (Credentialing Coordinators) attends the PAC meeting to display and review the credentialing and recredentialing files submitted for review and approval.

1.7 The credentialing database is not used to monitor or track primary source verifications.

2.0 Tracking and Dating Modifications (CR 1.C.2)

2.1 Primary source verifications that are printed electronically to PDFobtained from the approved internet source include the electronic real-time stamp with unique user name, date/time, and URL and are saved to the provider's electronic working file in PDF Format. Primary source verifications that are documented on a KHS approved form or source are saved to PDF and are stamped via Adobe PDF "Received Stamp" by the Credentialing Coordinator that includes unique user name, date/time and are also saved to the provider's electronic working file.

2.2 Provider data is manually entered by Credentialing Coordinators into the credentialing database database for specific data elements stored in the credentialing databaseprovider's profile. Primary source verifications are tracked through the application processing checklist that is saved to the provider's electronic working file.

2.3 Provider data entered into the credentialing database database is tracked via an audit log

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functionality of the system. System controls within the ~~database~~ database are in place to limit access to update, modify, add or delete provider data to the Credentialing Coordinators, Credentialing Lead and/or the Credentialing Manager.

2.4 For primary source verification modifications to the electronic credentialing document, the Credentialing Coordinator, Credentialing Lead or Credentialing Manager, will document the date the modification was made using the Adobe PDF "Reviewed Stamp" indicating the user name, date/time modification was made with explanation or reason for modification.

2.4.1 An asterisk will be indicated on the provider's processing checklist to indicate a ~~change~~ modification has been made.

2.4.2 A note by the Credentialing Coordinator or Credentialing Lead will be added to the processing checklist "Red Flag-Notes" area to indicate how and why the modification was made. (Implemented 1/1/2024)

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2.5 ~~For modifications to a provider's profile within the credentialing database, all changes are tracked by a system audit log which records the unique user, date of change, type of change, new data and prior data in the field.~~

3.0 Authorized Staff for Reviewing, Modifying and Deleting Provider Data (CR 1.C.3)

3.1 KHS Credentialing Coordinators, Credentialing Leads and the Credentialing Manager are authorized to create, edit and delete data within the provider's profile in the credentialing ~~database~~ database.

3.2 Primary source verifications may be modified by Credentialing Coordinators, Credentialing Leads and the Credentialing Manager when verification information changes in the credentialing and recredentialing electronic file processing.

3.3 KHS Credentialing Staff, whenever possible, should not delete a provider from the credentialing database, even if duplicate provider record has been created or provider has withdrawn their application.

3.3.1 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.

3.3.2 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 entered as "Withdrawn" to indicated abandonment of the record and include notes as to the date and person submitting the request to withdraw application.

3.4 ~~**Examples of appropriate**~~ **Appropriate modifications to credentialing information, include** ~~**but are not limited to**~~**:**

3.4.1 To reply to an inquiry, requesting a provider's profile to be updated such as changes or updates to education, training and designated specialties or provider type

3.4.2 Updating information during credentialing or recredentialing, including credentialing decision letters and credentialing signature pages

3.4.3 Updating information between credentialing cycles

3.4.4 Updates to expired licensure, certification, or other documents types and dates

3.4.5 To make name changes

3.4.6 To correct and/or remove erroneous data, including data entry errors/typos

3.4.7 Information is inaccurate, misleading, irrelevant or serves no purpose

3.4.8 Documents appended to incorrect provider profile

3.4.9 Other updates approved by the Credentialing Manager.

3.5 ~~**Examples of *inappropriate***~~ ***Inappropriate*** **modifications to credentialing information, include but are not limited to**:

3.5.1 Altering credentialing approval dates – ***Exception***: Credentialing Staff should consult with Credentialing Lead/Manager, if for any reason, the approval date requires modification. If modification is approved, an entry is made in Provider Contacts, indicating the reason ~~for the change~~, the approval ~~for the change~~ and date of the ~~change~~ modification reason.

3.5.2 Altering dates on primary source verifications
3.5.3 Unauthorized deletion of provider files, profile or documentation

4.0 Security Controls to Protect Information from Unauthorized Modification (CR.1.C.4)

4.1 **Limiting Physical Access**: Only authorized staff are granted access, via physical ID badge access, to secure locations that house KHS computer servers, hardware and physical records and files. Physical access to provider files stored in the electronic credentialing drive and credentialing software accessible to only authorized individuals who require access based on business need.

4.2 **Preventing Unauthorized Access**: KHS installs and maintains a firewall configuration to protect sensitive information as detailed in KHS Policy and Procedure 70.49-I: Firewall Policy. Only authorized individuals have access to KHS credentialing system database and credentialing network folder. Access is determined and granted upon hire for job necessity for having access to the credentialing system. Credentialing Leads/Managers work in conjunction with IT Security to enable appropriate access for appropriately identified staff. Credentialing system is hosted on the KHS secure intranet and password protected to allow access to only authorized individuals. Electronic credentials file are maintained on a secure server that requires individual authorization to access the information. Electronic communications receive the same protection as previous hard-copy documents regarding confidentiality and disclosure policy.

4.3 **Password-Protecting Electronic Systems**: All password-based systems on KHS workstations are designed to obscure the passwords so that unauthorized persons are not able to observe them. Authorized users are assigned unique username and are given the ability to create unique and strong password utilizing upper and lower case characters and special characters. Grace login after a required password change is allowed once, thereafter the system is locked and staff must contact the Credentialing Manager to reset password. Staff are instructed to avoid writing down passwords and passwords must be changed immediately if the user suspects their unique password to be compromised. Role-based security prevents unauthorized access to information and unauthorized modifications to information within the credentialing software through the grouping of users based on job description. The Credentialing Manager is responsible for the maintenance of credentialing system users and groups.

There are three-(3) group levels of access:

4.3.1 Credentialing Coordinators, Leads & Manager – System Administrators (default group): **Full** access to read, add, edit, delete, and set security within the credentialing system's forms, queries, documents, reports, reference lists, system forms, packets and web applications.

4.3.2 Information Technology & Provider Analyst – System Users: **Moderate** access to read/view within the credentialing system's forms (provider demographic information); full access to run queries/reporting ability, and access to web applications (system configurations).

4.3.3 Provider Relations Reps and Support: **Limited** access to read/view within the credentialing system's forms (provider demographic information).

4.4 **Deactivation**: If an employee who has access to the credentialing system or network folder leaves, all access to the healthcare network system, credentialing database and primary

source verification website logins and passwords are deactivated. Deactivation requests are processed by the KHS IT Department immediately upon resignation and/or termination of employment. The Credentialing Manager will inactivate the user access in the credentialing system database.

4.5 **When credentialing information may be released**: Access to the provider profiles is limited to job classification and business need for provider specific information which prevents unauthorized access, changes to and when credentialing information may be released.

Examples when credentialing information may be released:

4.5.1 Requests from KHS Compliance & Regulatory Affairs Department, Corporate attorney, Chief Medical Officer, Physician Advisory Committee (Credentialing Committee), Chief Executive Officer, Board of Directors and corporate attorneys.

4.5.2 Regulatory or accreditation agencies who have provided a written statement or request for the materials sought and are directly relevant to the matter being reviewed and/or investigated. The materials released shall be the most direct and least intrusive to carry out the survey or pending investigation, bearing in mind that credential files regarding individual providers are strictly confidential.

4.5.3 Third parties or organizational requests & Subpeonas (health plan, hospitals, MCOs etc) – the request must be accompanied by the provider's signed consent for the release of information and/or statement. Routine requests will include notification that the provider is a member of the KHS Participating Network (or past participant) limiting the disclosure of information to the following: practitioner name, status, specialty[ies] and dates of affiliation. If practitioner is subject to disciplinary action or peer review investigation, all responses to such inquires will be reviewed and approved by the Credentialing Manager who will seek consultation with KHS Compliance & Regulatory Affairs and/or corporate attorneys. On-Premise audits must be in the presence of the Credentialing Manager, designee or other KHS Provider Network Administrator to ensure no originals or copies are removed from the premises. Desk-top audits require secured email attachments, flash/thumb drive password protection, overnight mail service (FedEx or UPS) or virtual access/remote in presence of Credentialing Manager or designee.

5.0 ~~Credentialing Process Audit~~ Monitoring (CR1.C.5)

Credentialing Leads/Manager will review and monitor the Credentialing Coordinators work at the time of initial credentialing and recredentialing when the electronic file is "Ready for Final Review" and will be signed and dated by the Credentialing Lead or Credentialing Manager.

5.1 **Access and Passwords:**

5.1.1 The Credentialing Manager will conduct an annual review of job roles and current user access, to the credentialing ~~database~~system, to ensure system access is still appropriate for the role requirements.

5.1.2 For password procedures, all staff, with credentialing ~~database~~ database access, are required to annually attest that they comply with the password procedures.

5.2 Credentialing Database Audit Log Report

5.2.1 Annually, ~~or at regular monthly intervals,~~ the Credentialing Manager will audit, a system-generated report, from the credentialing system Symplr, a comprehensive listing of all data modifications, changes and updates to confirm accuracy, appropriateness and timeliness.

5.2.2 The Credentialing Manager will monitor the report and identify outliers as follows:

- Modifications that did not meet policy and procedure
- Analysis of modifications being made
- Actions taken on modification that did not meet policy and procedure
- Quarterly review & follow-up to track improvement, if applicable.

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5.3 Credentialing Electronic Files

5.3.1 Annually, at the end of each year, the Credentialing Manager is responsible for oversight of the monitoring process and will conduct an audit utilizing the 5% or 50-file audit method from each file type (credentialing and recredentialing).

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Example: Total practitioner files (initial and recredential): [10,000]

5% or 50 files calculation: [(10,000 practitioners x .05) = 500 files.]

Minimum sample size for audit: 50 files.

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5.3.2 ~~(~~ 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~~).~~

5.3.3 The file universe includes all files, with or without modifications. The sample that will be audited must only include files with modifications.

5.3.4 Since modifications are noted on the processing sheets, the Credentialing Manager will randomly select a sample from the modified files to be reviewed.

- ~~The audit ensures the credentialing processes are being followed.~~
- 5.3.5 The Credentialing Manager reviews the image documents, stored in the electronic working file, for the required elements for internet, verbal and written verifications, including the credentialing processing checklist during the audit. The Credentialing Manager audits the following in each file:
  a. Primary source verification information is received, dated and stored according to the Section 1.0 above.
  b. Modifications are tracked and dated from initial verification according to Section 2.0.
  c. Modifications and deletions are made by the staff authorized in Section 3.0.
  d. Security controls were in place to protect the information from unauthorized modification as described in Section 4.0.

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- 5.3.6 Audit results, will be recorded in the Credentialing System Controls Annual Audit Report Form by the Credentialing Manager who will submit the report to the Physician Advisory Committee.
- Elements identified as non-compliant or incorrect are addressed immediately between the Credentialing Manager and ~~with~~ the appropriate Credentialing Coordinator for correction, including but not limited to: coaching, remediation or additional training, imposing corrective action plan and termination, if warranted.
- ~~The Credentialing Manager will audit, a system-generated report, from the credentialing database, of all date modifications to identify modifications that did not meet policy and~~

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~~procedure and will take appropriate actions to update credentialing system controls accordingly, include but limited to recredentialing next cycle dates, licensure/certification expiration dates~~.

5.4 Oversight (CR.1.D.1-3)

The Credentialing Manager oversees the monitoring process and will record identified deficiencies on the Non-Compliant Modifications Report and report the deficiencies to the Physician Advisory Committee as follows:

- description of the modification that did not meet requirement(s);
- ~~action(s) taken, to correct the modification that did not meet requirement;~~
- qualitative and quantitative review – root, cause analysis, examining the underlying reason for the deficiency or process that may create barriers to improve or cause additional failures and includes the number or percentage of noncompliant files;
- action(s) taken or plans to take, to ~~correct~~ address the modification that did not meet requirement(s);
-
- quarterly monitoring to assess the effectiveness of the action to demonstrate improvement over at least three consecutive quarters.

6.0 Confidentiality

Annually, the Credentialing Coordinators, Credentialing Leads and Credentialing Manager will attest and sign confidentiality statements agreeing to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with all credentialing activities and agree not make any voluntary disclosure of such confidential information except as otherwise described in this policy section 4.5.

ATTACHMENTS:

A. Credentialing System Controls Annual Audit Report (v.~~10.17~~12.~~27~~.2023)
~~**B. Non-Compliant Modifications Report (v.2023)**~~
B. Annual Credentialing Staff Confidentiality Agreement (v.~~10.17.2023~~03.2024)
C. Annual Credentialing System Controls Agreement Symplr System Users (v.03.2024)

REFERENCE:
NCQA Health Plan Credentialing Standards 2023, (CR.1.C1-4)
Health Industry Collaboration Effort, Inc (HICE) CA Credentialing Team Documents

- **NCQA 2022 Credentialing System Control Guide**
- **Credentialing System Controls Annual Audit Report (v.~~05.02~~12.2023)**
- **Non-Compliant Modifications Report (v.2023)**

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CR 1- D Credentialing System Controls Oversight (1-3)

Auditor's Name:	Yolanda Herrera, CPMSM, CPCS
Title who conducted audit:	KHS Credentialing Manager
Date Audit Completed:	
Audit Frequency:	Annually
Date Range of Audit:	
Total Number of Cred/Recred Providers from Date Range:	

Paper/Electronic PDF Files	System Database	Both
☑	☐	☐

Audit Methodology Used:

5% or 50 Files	All Files with Modifications	Total File Universe
☐	☑	☐

Audit Files Reviewed:

Initial Files reviewed with Modifications:	
Recred Files reviewed with Modifications:	

Non-Compliant Modifications Identified:

Initial Files with Modifications:	
Recred Files with Modifications:	

Audit Results (Quantative Analysis & Compliance Rate):

there were no modifications identified as non-compliant based off our policies and procedures.

An audit of modifications to the credentialing files has been compleed and **non-compliant modifications** were identified based off our policies and procedures. **Please see report tab of all Non-Compliant Modifications**

Audit Results (Qualitative Analysis):

Actions/Interventions/Recommendations:

Requested Action of PAC:

Approval of Annual Credentialing System Controls Audit Summary 2023

KERN HEALTH SYSTEMS

ANNUAL CREDENTIALING SYSTEM CONTROLS AGREEMENT – SYMPLR SYSTEM USERS

YEAR _____

As part of the New Credentialing System Control Policy and Procedure and NCQA Credentialing Standards CR.1.C.5, the Credentialing Manager will conduct an annual review of job roles, and current user access to the credentialing database "Symplr" to ensure system access is still appropriate and necessary for your job duties.

You have been identified as an active user of the credentialing database Symplr (formerly Cactus):

- I understand that by approving this email, I am binding myself to maintain such confidentiality of the credentialing information accessed and stored in Symplr;
- I agree that I will not make any voluntary disclosure of such confidential information except to persons authorized to receive such information.
- I agree to avoid writing down or sharing passwords and understand passwords must be changed immediately if I suspects my unique password to be compromised per KHS P&P 7.27-I Employee User Access
    - Contact Yolanda Herrera, at yolanda.herrera@khs-net.com for password resets for the Symplr database.
- All information obtained from Symplr is still appropriate and necessary for my job duties and shall be maintained as confidential.

*Sent Via Email with Accept or Decline Voting Buttons

v.03.2024

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KERN HEALTH SYSTEMS

ANNUAL CONFIDENTIALITY AGREEMENT – CREDENTIALING STAFF

YEAR _____

As part of the Credentialing Staff of KHS Provider Network Management, I agree to comply with KHS's Policy 4.01-I Credentialing Program related to Section 2.5 Confidentiality as follows:

- I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with collecting and gathering primary source verifications including all other related credentialing activities;
- I understand that by signing this form, I am binding myself to maintain such confidentiality;
- I agree that I will not make any voluntary disclosure of such confidential information except to persons authorized to receive such information.
- I understand, the electronic credentialing files will be maintained in a central repository that can only be accessed by PNM/Credentialing Staff who have been issued access using their unique electronic identifier and user-specific password for access to prevent unauthorized access or release of information;
- I agree to avoid writing down or sharing passwords and understand passwords must be changed immediately if I suspects my unique password to be compromised;
- All information collected during the credentialing, recredentialing and through the proceedings of my job duties as part of the Credentialing Staff shall be maintained as confidential and protected from discovery pursuant to California Evidence Code Section 1157 and Health and Safety Code 1370.

*Sent Via Email with Accept or Decline Voting Buttons

v.03.2024

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KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Deborah Murr, Chief Compliance and Fraud Prevention Officer

SUBJECT: Compliance Program Update

DATE: April 18, 2024

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.

Regulatory guidance and filings are anticipated to increase in the foreseeable future as new services and programs are mandated under our contract and license with the State of California and Federal Government.

Regulatory audits for 2022-2023 have been completed with Corrective Action Plans currently in various stages of finalization and approval by DHCS and DMHC.

This report provides the 2023-year end and Quarter 1, 2024 update on the KHS Compliance Program activities with the corresponding updates.

REQUESTED ACTION

Receive and file.

Compliance KPI's
Year End – Q1 2024

KERN HEALTH SYSTEMS

Compliance Communications

Department of Managed Health Care (DMHC)

- Annual audit conducted January 2023; preliminary report received 03/07/2024.

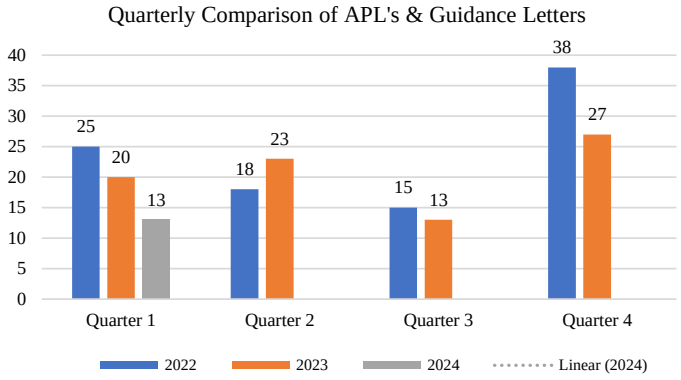
Department of Health Care Services (DHCS)

- 2023 Limited Scope Medical Audit and Focused Audit – Final Audit Report Received (additional information in narrative portion of report below)
  - 1 Deficiency: Potential FWA not reported to DHCS timely (2 of 108 records reported to Compliance late)
  - KHS Corrective Action Plan due 4/25/2024

Compliance Capsules:

- February: Privacy Protections
- March: Fraud, Waste, and Abuse Detection & Prevention

All Plan Letter (APL's) & Guidance Letters



All Plan Letters and Guidance Letters Received		
2022	2023	2024
96	83	13

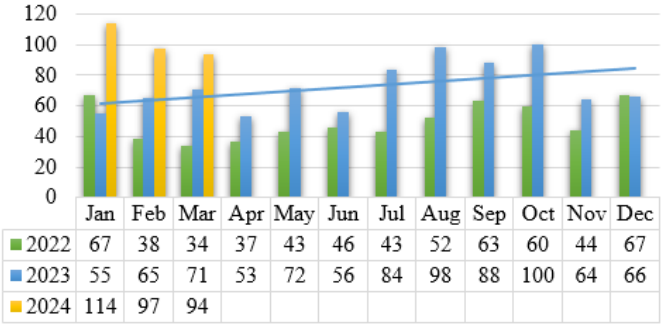
Retrospective Audits & Reviews

Year	APL Number	APL Name	Status
2022	APL 22-005	No Wrong Door for Mental Health Services Policy	Completed
2022	APL 22-006	Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services	Completed
2022	APL 22-020	Community-Based Adult Services Emergency Remote Services	Completed
2022	APL 22-028	Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services	Completed
2023	APL 23-009	Authorizations for Post-Stabilization Care Services	Completed
2023	APL 23-004	Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care	Completed
2023	APL 23-005	Requirements for Coverage of Early & Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21	Completed
2022	APL 21-017	Community Supports Requirements (revised)	Completed
2022	APL 22-030	Initial Health Appointment	Completed
2023	APL 21-004	Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (revised)	Completed
2023	APL 21-011	Grievance and Appeal Requirements, Notice and "Your Rights" Templates (revised)	Completed
2022	APL 22-016	Community Health Workers Services Benefit (revised)	Completed
2023	APL 23-010	Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21	Completed
2022	APL 22-002	Alternative Format Selection for Members with Visual Impairments	Completed

Regulatory Reports & Filings

Regulatory Reports & Filings Submissions to Government Agencies		
Regulatory Agency	**February 2024**	**March 2024**
DHCS Total	84	81
DMHC Total	13	13

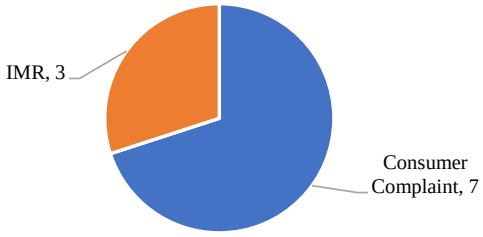
Number of Plan to Regulator Submissions 2022, 2023, & 2024



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	67	38	34	37	43	46	43	52	63	60	44	67
2023	55	65	71	53	72	56	84	98	88	100	64	66
2024	114	97	94									

DMHC Consumer Complaints & Independent Medical Reviews (IMR)

IMR vs. Consumer Compliants



KHS Decision	
Uphold	6
Overturn	0
Return to plan (RTP)	0
Misdirected	2
New Grievance to Plan/approved request	1
New Grievance to Plan/denied request	1
Potential Quality Issue (PQI)	1
Grand Total	**10**

DHMC Decision	
Closed	4
Favor of Plan	3
Favor of Member	1
In Review	2
Withdrawn	0
Grand Total	**10**

HIPPA Breach Activity

Summary of potential Protected Health Information ("PHI") disclosures for the months of February and March 2024: The Plan is dedicated to ensuring the privacy and security of the PHI and personally identifiable information ("PII") that may be created, received, maintained, transmitted, used, or disclosed in relation to the Plan's members. The Plan strictly complies with the standards and requirements of Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH").

During the months of February and March 2024, the Compliance Department investigated and reviewed one hundred and six (106) allegations of privacy concerns and forty (40) of the cases were sent to the State for their review. The DHCS closed five (5) of the cases and determined there they were non-breach incidents. There are thirty-five (35) cases that are still under review by the State.

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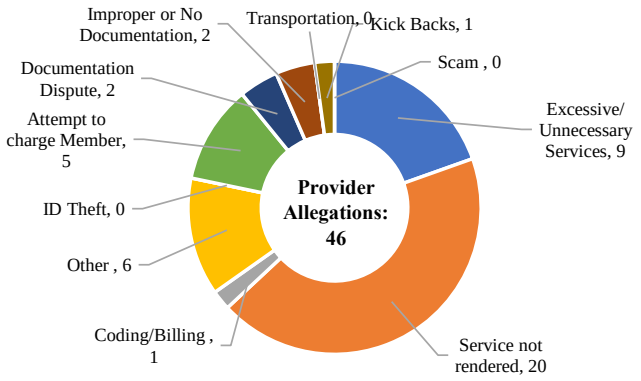
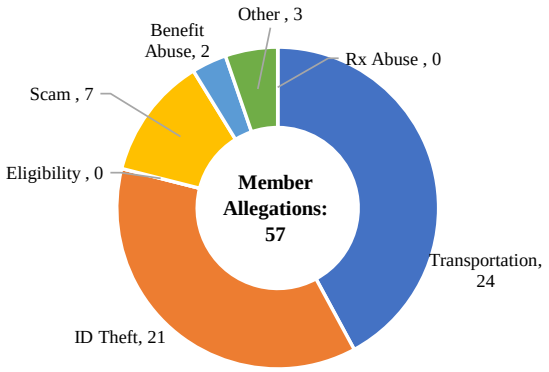
Fraud, Waste, and Abuse (FWA)

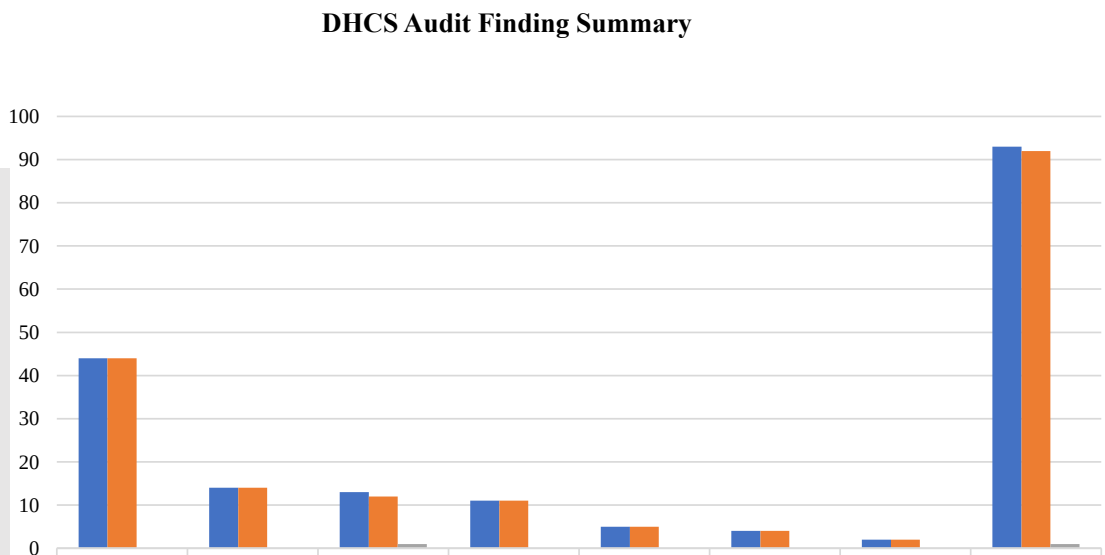




DHCS Regulatory Medical Audit | 2022

KHS had a total of **29** findings across the six categories audited by DHCS.

The Corrective Actions for 28 of the Findings have been fully accepted by DHCS; 1 Finding is still under review, with the final response submitted to DHCS on 01/15/2024

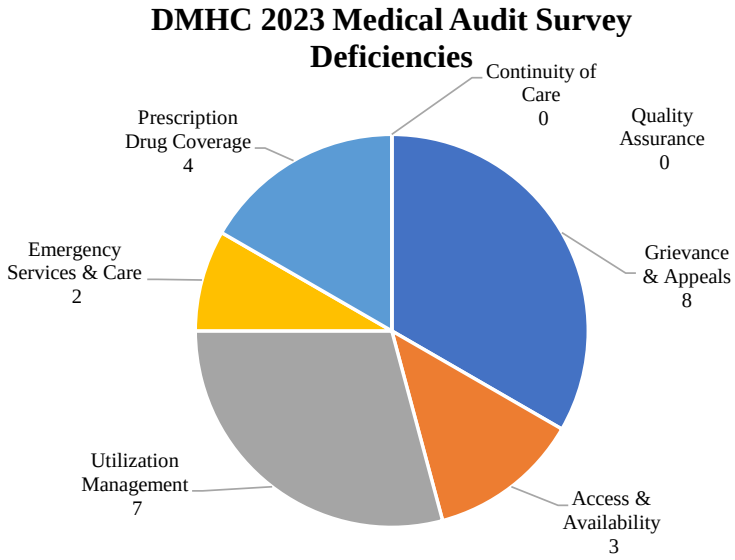


	Member's Rights	Access and Availability of Care	Quality Management	Case Management and Coordination of Care	Utilization Management	Administrative and Organizational Capacity	State Supported Services	Grand Total
Corrective Actions Submitted	44	14	13	11	5	4	2	93
DHCS Accepted	44	14	12	11	5	4	2	92
DHCS Partially Accepted	0	0	1	0	0	0	0	1

DMHC Regulatory Medical Audit | 2023

KHS had a total of **24** findings across five (5) of the seven (7) categories audited by DMHC.

The Corrective Action Plans are underway and on target for the KHS response due April 20, 2024.



Metric	Description
All Plan Letters (APL's) & Guidance Letters	
Department of Health Care Services (DHCS)	
APL 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009) (Issued 2/8/2024)	This APL clarifies existing federal and state protections and alternative health coverage options for American Indian Members. Additionally, this APL consolidates various requirements pertaining to protections for Indian Health Care Providers. This APL also provides guidance regarding the Plan's tribal liaison requirements and expectations.
Department of Managed Health Care (DMHC)	
APL 24-005 Change Healthcare Cyberattack (Issued 3/11/2024)	This APL encourages health plans to be flexible to ensure stability of the health care system following the cyberattack of Change Healthcare.
APL 24-006 Provider Directory Annual Filing Requirements (Issued 3/20/2024)	This APL reminds health care service plans of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the DMHC.
Retrospective Audits & Reviews	
The Compliance Department conducts retrospective audits on regulatory All Plan Letters and issues guidance. From the published requirements, the Compliance Department conducts a risk analysis and identifies those that pose a higher degree of risk to the Plan. All Plan Letters published in 2022 and the first and second quarter of 2023 were evaluated and selected for review based on the risk assessment. To date, the plan has completed fourteen (14) retrospective audits.	

Regulatory Reports & Filings	
Regulatory Reports & Filings **Submission to Government Agencies**	KHS is required to submit various types of information to both DHCS and DMHC with cadences ranging from daily, weekly, monthly, quarterly, or annually. In some cases, KHS are required under statute or regulation to submit reports or documentation to establish initial or ongoing compliance with the law (e.g., timely access reporting, financial reporting). In other cases, plans are required to submit reports or documentation when they are planning to make an operational, business, product, or other change that affects the scope or applicability of their license. Additionally, key personnel and Board member filings are required to allow the regulatory agencies to review and advise on the individuals who provide leadership at KHS as well as the makeup of our Board of Directors. These submissions often reflect an amendment or material modification to the plan's license and, in some cases, are subject to Department approval prior to making the requested change to plan operations.
Regulatory Submissions 2022 vs 2023	Regulatory submissions to both DHCS and DMHC are anticipated to increase annually in relation to the various legislative and CalAIM requirements either currently or planned for implementation in 2024-2026. Additional Compliance staffing resources are in flight to ensure timely submission and completion of all deliverables.
DMHC Consumer Complaints & Independent Medical Reviews	
KHS addresses and tracks enrollee complaints and requests for independent medical review (IMR) received from the DMHC. For the months of February and March 2024, there were a total of 2 IMRs (March) and 4 Consumer Complaints (1 in February; 3 in March). Chart above reflects year to date.	
2024 Operational Contract Readiness	
DHCS initiated Operational Readiness Activities associated with the 2024 contract in February 2023. The new 2024 contract incorporates some significant changes – some of which have been communicated in APLs or other communications. The 2024 contract will amplify DHCS's ongoing investment in its vision for Medi-Cal and includes significant requirements for expanding California Advancing and Innovation Medi-Cal (CalAIM) framework, provision of benefits for all, regardless of immigration status, implement Children and Youth Behavioral Health initiative, expand Behavioral Health Continuum infrastructure, increased funding for Home and Community Based Services, new benefits to support culturally competent services, and provide alignment with DHCS's Comprehensive Quality Strategy and Equity Roadmap. Aligning the medical, behavioral, and social determinants of health is the cornerstone for this initiative.	
Submission Summary	A total of 229 deliverables were submitted and submissions are complete.
Submission Status	All 229 deliverables have been approved by DHCS.

Fraud, Waste, and Abuse (FWA)

The Plan investigates and reports information and evidence of alleged fraud, waste, & abuse cases to appropriate state and federal officials. Information compiled during an investigation is forwarded to the appropriate state and federal agencies as required. In February 2024 there were 30 cases of fraud, waste, & abuse reported and there were 35 in March 2024. Corrective action plans and other financial recoupment processes are in place to demonstrate KHS's fiduciary oversight efforts.

DHCS Regulatory Medical Audit | 2022

DHCS conducted a routine medical survey of KHS in December 2022. The survey period included activities 11/01/2021 – 10/31/2022:

- KHS had a total of twenty-nine (29) findings across the six (6) categories audited by DHCS.
  - KHS submitted our initial Corrective Action Plan on 06/08/2023, monthly updates, and our final submission on 1/15/2024 (unless DHCS extends and requires additional submissions).
  - Ninety-three (93) separate corrective actions were submitted for the twenty-nine (29) findings, which included but were not limited to: policy updates, job aids, refresher trainings, updated reports and internal monitoring/auditing processes.
    - DHCS has accepted ninety-two (92) of the actions submitted
    - DHCS has partially accepted one (1) of the actions submitted
    - The Corrective Action Plans for twenty-eight (28) of the twenty-nine (29) findings have been fully accepted by DHCS
    - The Corrective Action Plans for one (1) of the twenty-nine (29) findings have been partially accepted by DHCS.
    - KHS is awaiting an update from DHCS on the final CAP submission provided on 01/15/2024

DHCS 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 limited scope audit, KHS had one (1) finding across the six (6) categories audited by DHCS:
  - Finding: The Plan is required to refer any potential Fraud, Waste, or Abuse (FWA) identified and report to DHCS, the results of its preliminary investigation within ten working days. The Plan did not report to DHCS the results of their preliminary investigations of potential FWA identified within ten working days.
  - Of the 108 items submitted, two (2) were not submitted timely due to late referral to the Compliance team.
- Zero (0) findings on the state supported services portion of the audit.
- It is currently unknown if a report will be provided regarding the Focused Audit.
- KHS is currently working on the corrective action plan due to DHCS by 04/25/2024 for the one medical audit finding.

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.

- Of the seven (7) areas evaluated, 24 deficiencies were identified across five (5) of the areas.
- KHS is currently working on the corrective action plan due to DMHC by 04/20/2024. Some of the findings were similar to the DHCS audit findings and have since been corrected due to overlapping audit periods and timeliness of regulator notification.

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Alan Avery, Chief Operating Officer

SUBJECT: 1st Quarter 2024 Operations Report

DATE: April 18, 2024

Kern Health System's (KHS) Operational Departments met all regulatory requirements during the 1st Quarter of 2024.

CLAIMS

We continue to experience an increase in the number of incoming provider claims received during the 1st Quarter of 2024. During this past quarter, we received 1.3 million claims which was an increase of 161,835 claims over the 4th quarter of 2023. In the past 12 months, KHS has seen a 32% overall increase in provider claim submission. This increase can be attributed to the significant increase in new KHS membership, retention of members thru the redetermination process, and members once again seeking healthcare services. With the explosive membership growth in the 1st quarter, we project this increase in provider claim volume will continue throughout the year.

Due to the significant increase in claims volume management is continually monitoring 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 systems in place to manage the increased number of claim receipts as 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 continued to remain consistently high at 85%, meaning claims were received and processed without any manual intervention.

The Claims Department Provider Call Center continues to handle a consistently high volume of provider calls seeking clarification regarding provider claims payment processing questions. During the 1st Quarter of 2024 we noticed the call volume was steadily increasing daily and we handled a record 10,194 calls from provider offices during the quarter. We estimate call volume into the Claims Department Provider Call Center will continue to remain strong in 2024 due to the projected significant member increase and corresponding claim volume.

MEMBER SERVICES

The Member Services performance indicators of abandonment rate, average speed to answer and average talk time have been defined and set by KHS management as monitoring measurement to ensure great customer service. The only state regulatory Department of Health Care Services mandate as it relates to customer service is a member must not wait no more than ten (10) minutes to speak to a Plan representative. Clearly, KHS is meeting that regulatory requirement with our average speed to answer of slightly over two minutes. However, due to explosive membership growth during the 1st Quarter, the Member Services Department Call Center was extremely challenged meeting our internal standard performance goals. Even though the management team increased staffing prior to January and continued throughout the quarter, the 48% increase in member and provider calls caused us to miss a few of our performance goals including abandonment rate, average speed to answer and average talk time. These performance goals were missed due to the migrating members having questions and concerns regarding their new Plan, eligibility and ID card issues along with member service representatives continuing to review the medical gaps in care with existing members. We also experienced significant walk in traffic by members with questions regarding their new Plan along with continuing to assist members in the renewal of their Medi-Cal enrollment and redetermination process.

Even though the member services call center performance metrics during the 1st quarter did not meet our internal performance metrics, all of the indicators have improved during the month of April and we are back on track meeting all performance standards and we anticipate they will be within standards during the 2nd quarter.

PROVIDER RELATIONS

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

The Primary Care Provider (PCP) network looked very similar to the previous quarter with 465 providers while the specialty provider network had a slight increase of 18 net new providers during the 1st Quarter for a 3.3% growth. Our complete contracted provider network consisted of 4,023 providers at the close of the Quarter.

The Department monitors network capacity/adequacy via a Full-Time Equivalency (FTE) provider to member ratio, based on regulatory requirements. For PCPs, the regulatory standard is one FTE PCP for every 2,000 members. As of the 1st Quarter of 2024, the Plan maintained a network of one FTE PCP for every 1,889 members, meeting the requirement. The Plan is also required to maintain a network of one FTE physician for every 1,200 members. As of the 1st Quarter, the Plan maintained a network of one FTE Physician for every 291 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 1st Quarter, the PCPs provided visits on average within 2.7 days. Non-urgent appointments with a specialist must be available within 15 days. Our specialist appointment is currently at 4.9 days.

GRIEVANCE REPORT

Total grievances for the 1st quarter increased overall by 12% primarily due to the significant new membership increase. The two areas that increased from the previous quarter and in comparison to 2023 trends was Access to Care and Quality of Service. Access to Care grievances are related primarily to appointment availability. Our quarterly monitoring does not support this trend and we will continue to watch for specific grievance and follow up with the providers in question. We believe some of these grievances may have been the result of the new membership growth. The other grievance category that we will be monitoring closely is Quality of Service. We are not overly concerned with this slight increase but will continue to monitor closely, looking for patterns to make corrective adjustments.

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 received 60 grievances classified as discrimination during the 1st Quarter reporting period compared to 40 received during the 4th Quarter. All discrimination grievances were reported timely to DHCS Office of Civil Rights.

Part two of the Grievance Report is the disposition of the formal grievances. Following the review and investigation of the 572 Potential Inappropriate Care by the Quality Department, 338 of the decisions were upheld, 65 were overturned and ruled in favor of the member and 169 grievances were still under review due to the early reporting cutoff. The remaining 1,231 grievances were reviewed and managed by the Grievance Coordinators, 522 of the decisions were upheld by the Plan, 300 were overturned and ruled in favor of the member and 409 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 1st Quarter, there was over 1.2 million medical encounters provided to our 400,000 members many of whom are new to managed care. In total, KHS received 2.96 grievances per 1,000 members per month, within the range of the other LHPC Plan averages of 1.00 – 3.99 per month.

REQUESTED ACTION

Receive and file.

1st Quarter 2024 Operational Report

Alan Avery
Chief Operating Officer

1st Quarter 2024 Claims Department Indicators

Activity	Goal	1st Quarter 2024	Status	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter 2023
Claims Received		**1,384,539**		1,222,704	1,093,561	1,146,582	1,049,582
Electronic	95%	**99%**		99%	99%	99%	99%
Paper	5%	**1%**		1%	1%	1%	1%
Claims Processed Within 30 days	90%	**97%**		95%	98%	98%	95%
Claims Processed within 45 days	95%	**99%**		99%	99%	99%	99%
Claims Processed within 90 days	99%	**100%**		100%	100%	100%	100%
Claims Inventory-Under 30 days	96%	**99%**		99%	99%	99%	99%
31-45 days	<3%	**<1%**		<1	<1%	<1%	<1%
Over 45 days	<1%	**<1%**		<1	<1%	<1%	<1%
Auto Adjudication	85%	**85%**		87%	85%	87%	87%
Audited Claims with Errors	<3%	**<2%**		<2%	<2%	<2%	2%
Claims Disputes	<5%	**<1%**		<1%	<1	<1%	<1%
Provider Calls (New Category)		**10,194**		7,343	7,379	8,129	9,348

KERN HEALTH SYSTEMS

1st Quarter 2024 Member Service Indicators

Activity	Goal	1st Quarter 2024	Status	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter 2023
Incoming Calls		**84,175**		56,804	72,186	63,691	68,925
Abandonment Rate	<5%	**10%**		3%	5%	1%	4%
Avg. Answer Speed	<2:00	**2:22**		:43	1:32	:18	:53
Average Talk Time	<9:00	**10:20**		9:26	8:54	8:39	8:50
Top Reasons for Member Calls	Trend	**1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals**		1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals	1. New Member 2. PCP Change 3. Demographic Changes 4. ID Card 5. Referrals
Outbound Calls	Trend	**71,842**		63,700	84,535	84,668	111,401
# of Walk Ins	Trend	**1510**		1163	1138	901	867
Member Portal Accounts-Q/Total	4%	**8501 78,462 (19.14%)**		3097 70,461 (19.45%)	3402 67,101 (18.21%)	3292 63,698 (17.03%)	2977 60,112 (16.37%)

KERN HEALTH SYSTEMS

1st Quarter 2024 Provider Network Indicators

Activity	Goal	1st Quarter 2024	Status	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter 2023
Provider Counts							
# of PCP		465		471	458	449	438
% Growth		[1.27%]		2.84%	2.0%	2.51%	2.34%
# of Specialist		564		546	518	502	504
% Growth		3.30%		5.41%	3.19%	[.39%]	[.20%]
FTE PCP Ratio	1:2000	1:1889		1:1579	1:1760	1:1829	1:1828
FTE Physician Ratio	1:1200	1:291		1:283	1:345	1:397	1:395
PCP	< 10 days	2.7 days		3.7 days	3.7 days	1.9 days	3.5 days
Specialty	< 15 days	4.9 days		8.1 days	5.0 days	9.6 days	10.6 days

KERN HEALTH SYSTEMS

1st Quarter 2024 Grievance Report

Category2	Q1 2024	Status	Issue	Q4	Q3	Q2	Q1 2023
Access to Care	**384**		Appointment Availability	347	254	235	107
Coverage Dispute	**0**		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	**385**		Questioning denial of service	423	383	421	312
Other Issues	**64**		Miscellaneous	39	52	55	48
Potential Inappropriate Care	**572**		Questioning services provided. All PIC identified cases forwarded to Quality Dept.	522	490	703	627
Quality of Service	**338**		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	296	258	282	163
Discrimination (New Category)	**60**		Alleging discrimination based on the protected characteristics	40	32	64	49
Total Formal Grievances	**1803**			1667	1469	1760	1306
Exempt	**1881**		Exempt Grievances-	1620	1328	1870	1564
Total Grievances (Formal & Exempt)	**3684**			3287	2797	3630	2870

***Data as of 3/22/2024**
KHS Grievances per 1,000 members – 2.96/month.
LHPC Average 1.0 – 3.99/month

KERN HEALTH SYSTEMS

Additional Insights-Formal Grievance Detail

Issue234	2024 1st Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	**234**	**97**	**0**	**53**	**84**
Coverage Dispute	**0**	**0**	**0**	**0**	**0**
Specialist Access	**150**	**42**	**0**	**46**	**62**
Medical Necessity	**385**	**120**	**0**	**142**	**123**
Other Issues	**64**	**38**	**0**	**6**	**20**
Potential Inappropriate Care	**572**	**338**	**0**	**65**	**169**
Quality of Service	**338**	**179**	**0**	**52**	**107**
Discrimination	**60**	**46**	**0**	**1**	**13**
Total	**1803**	**860**	**0**	**365**	**578**

KERN HEALTH SYSTEMS

Questions

For additional information, please contact:

Alan Avery
Chief Operating Officer
(661) 664-5005

KERN HEALTH SYSTEMS

MEMORANDUM

TO: Kern Health Systems Board of Directors

FROM: Martha Tasinga, MD, MPH, MBA

SUBJECT: Chief Medical Officer Report

DATE: April 18, 2024

BACKGROUND

The Q1 Chief Medical Officer's presentation highlights the Enhanced Care Management (ECM) program and provides a brief overview of the ECM populations of focus, ECM performance, and the clinical outcomes.

In addition, the report provides updates to clinical services utilizations and Medi-Cal Managed Care Accountability (MCAS) Measures. A detailed dashboard is included (Attachments A – E) that showcase the medical management performance. The dashboard categories include physician, inpatient, outpatient hospital, and emergency room services.

REQUESTED ACTION

Receive and File.

Chief Medical Officer Report

Board of Directors
April 18, 2024

Martha Tasinga, MD, MPH, MBA
Chief Medical Officer

KERN HEALTH SYSTEMS

CalAIM Mandate Enhanced Care Management(ECM)

Enhanced Care Management is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

ECM Populations of Focus

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

KHS ECM Performance

- KHS has 32 ECM sites
- 27,249 total eligible members
- January through June 2023 Overall Performance – KHS reported a 2.19% penetration rate overall, placing 4th in the State
- Member satisfaction Survey(879 responses)
  - 92% are satisfied with their overall experience with the ECM Program.
  - 94% are very or somewhat likely to refer family or friends to the program
  - 75% indicated that they can manage their health care better than 12 months ago.
  - 72% indicated that they can better manage their symptoms
  - 70% rated their physical health as better
  - 64% rated their mental health as better.

Clinical Outcomes

- 66.3% of members enrolled in ECM had an ambulatory visit within 7 days of being discharged from the hospital in comparison to only 46.6% of members not yet enrolled into the program
- 43.9% of members enrolled in ECM had an appropriate follow-up within 30 days of an ED visit with a diagnosis of AOD us or dependence among members ages 21 and older in comparison to only 12.2% of members not yet enrolled into the program
- 96.8% of members enrolled in ECM, 21 and older, had an ambulatory or preventative care visit in comparison to 87.6% of members not yet enrolled in the program

UTILIZATION MANAGEMENT

Data is for services provided January 2024 and paid through February 29 2024

Professional Services Utilization

- SPDs utilization is above projections but stable
- Top 4 reasons for utilization of professional services
  - Encounter for general examination without complaint, adult
  - Essential (primary) hypertension
  - Encounter for general examination without complaint, child
  - Type 2 diabetes mellitus; w/o complications

Inpatient Utilization

- Admits per 1000 per member per month is higher than in January of 2024 for all Aid codes but is consistent with what we were seeing during the 4th quarter of 2023. This coincides with the Flu /RSV season. We will continue to watch this closely as we move forward in 2024
- The ALOS is below projections for all AID codes
- The cost per admit continues to be stable
- The PMPM for all inpatient services is withing projections.
- Top 4 reasons for inpatient stay continue to be related to pregnancy and delivery.
- Other sepsis was second reason for in patient admission in January 2024
- inpatient stays are at Kern Medical with BMH a close second

Outpatient Hospital Services

- The outpatient hospital utilization is continuing the trend we saw in 2023.
- SPDs utilization remains higher than projected
- All other Aid codes are at the projected level of utilization.

Emergency Room Visits

- We note a spike in ER utilization in all AID codes for January 2024
- Top diagnoses for ED visit in descending order of frequency
  - Upper respiratory infections followed by
  - Urinary tract infections.
  - Abdominal pain

OB Services

- Primary C/Section (15%) in January 2024 (CA goal 23%)
- Top hospitals for deliveries
  - Bakersfield memorial hospital
  - Kern Medical Hospital
  - Mercy Hospital

Managed Care Accountability Set (MCAS)

MY2023 Audit Progress

- Reflective of 2023 MCAS performance (MY2023)
- Roadmap submitted and accepted
- HSAG virtual audit completed with no findings
- Medical record abstractions in progress through end of April
- Meeting MPL for 7 of 18 measures vs. 5 of 15 measures for final rates in MY2022 (previous year)
- Meeting HPL for 1 measure
- Within 5% MPL for 6 measures
- Significant improvement for 16 of 18 measures

MY2023 Preliminary Rates

Hybrid Measures Held to MPL

CCS	CIS-10	HBD*	CBP	IMA-2	PPC-Pre	PPC-Post	LSC
55.23	23.11	34.06	62.53	33.09	86.86	85.89	58.39
MPL: 57.11	MPL: 30.9	MPL: 37.96	MPL: 61.31	MPL: 34.31	MPL: 84.23	MPL: 78.1	MPL: 62.79
Diff: -1.88	Diff: -7.79	Diff: 3.90	Diff: 1.22	Diff: -1.22	Diff: 2.63	Diff: 7.79	Diff: -4.40
Hits Needed: 8	Hits Needed: 32	Hits Needed: 0	Hits Needed: 0	Hits Needed: 5	Hits Needed: 0	Hits Needed: 0	Hits Needed: 18

Admin Measures Held to MPL

AMR	BCS	CHL	DEV	FUA	FUM	TFL-CH	W30(0-15M)
69.85	59.30	56.86	25.86	18.76	18.83	16.44	39.15
MPL: 65.61	MPL: 52.60	MPL: 56.04	MPL: 34.70	MPL: 36.34	MPL: 54.87	MPL: 19.30	MPL: 58.38
Diff: 4.24	Diff: 6.70	Diff: 0.82	Diff: -8.84	Diff: -17.58	Diff: -36.04	Diff: -2.86	Diff: -19.23
Hits Needed: 0	Hits Needed: 0	Hits Needed: 0	Hits Needed: 1,174	Hits Needed: 229	Hits Needed: 227	Hits Needed: 3,829	Hits Needed: 572

W30(15-30M)	WCV
63.70	46.42
MPL: 66.76	MPL: 48.07
Diff: -3.06	Diff: -1.65
Hits Needed: 174	Hits Needed: 2,102

Indicates KHS did not met MPL
Indicates KHS need 5% or less to met MPL
Indicates KHS met or exceeded MPL
Indicates KHS met or exceeded HPL.

2024 Goals and Initiatives

Member Outreach Team

- Continue member outreach efforts from 2023

Mobile Units

- KHS has secured commitment from three (3) provider partners to utilize Mobile Units in rural areas & focused on Street Medicine
- Approval from Homeless centers for medical mobile unit on-site services

Quality Grant Programs

- Develop innovative partnerships with network providers to elevate the quality of care delivered to our members.

Data Exchange & EMR Access

- Increase EMR, Rx, and Lab data exchange from providers
- Increase provider EMR access
- Use Admission, Discharge, and Transfer (ADT) data
- Leverage CSV appointment data

Pediatric Focus

- Increase focus around the various pediatric measures in the Children's domain.
- Increase accessibility to services on school campuses

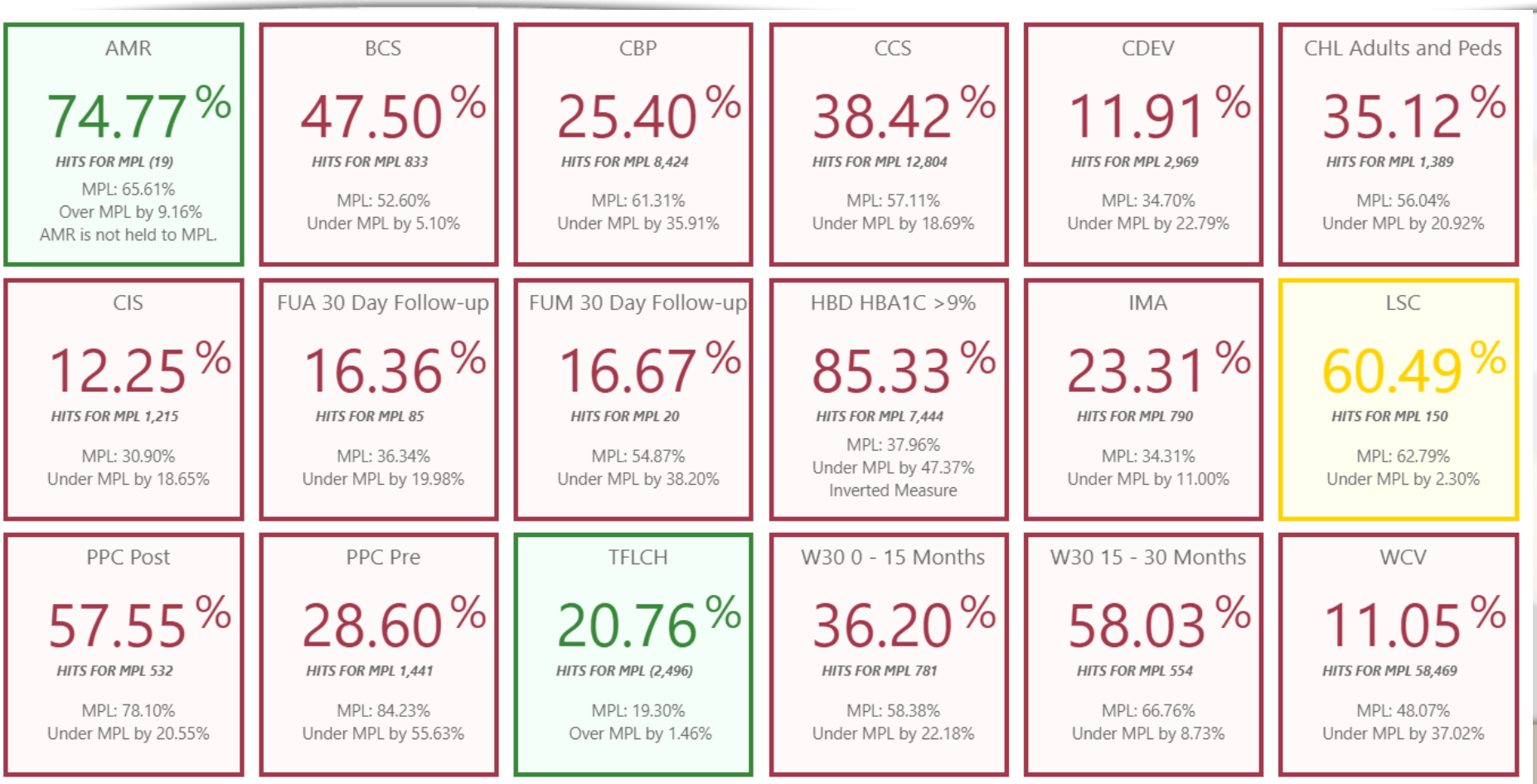
Address Verification

- Utilize GIS to target specific populations and and help locate based on zip codes.
- Increase member mailings

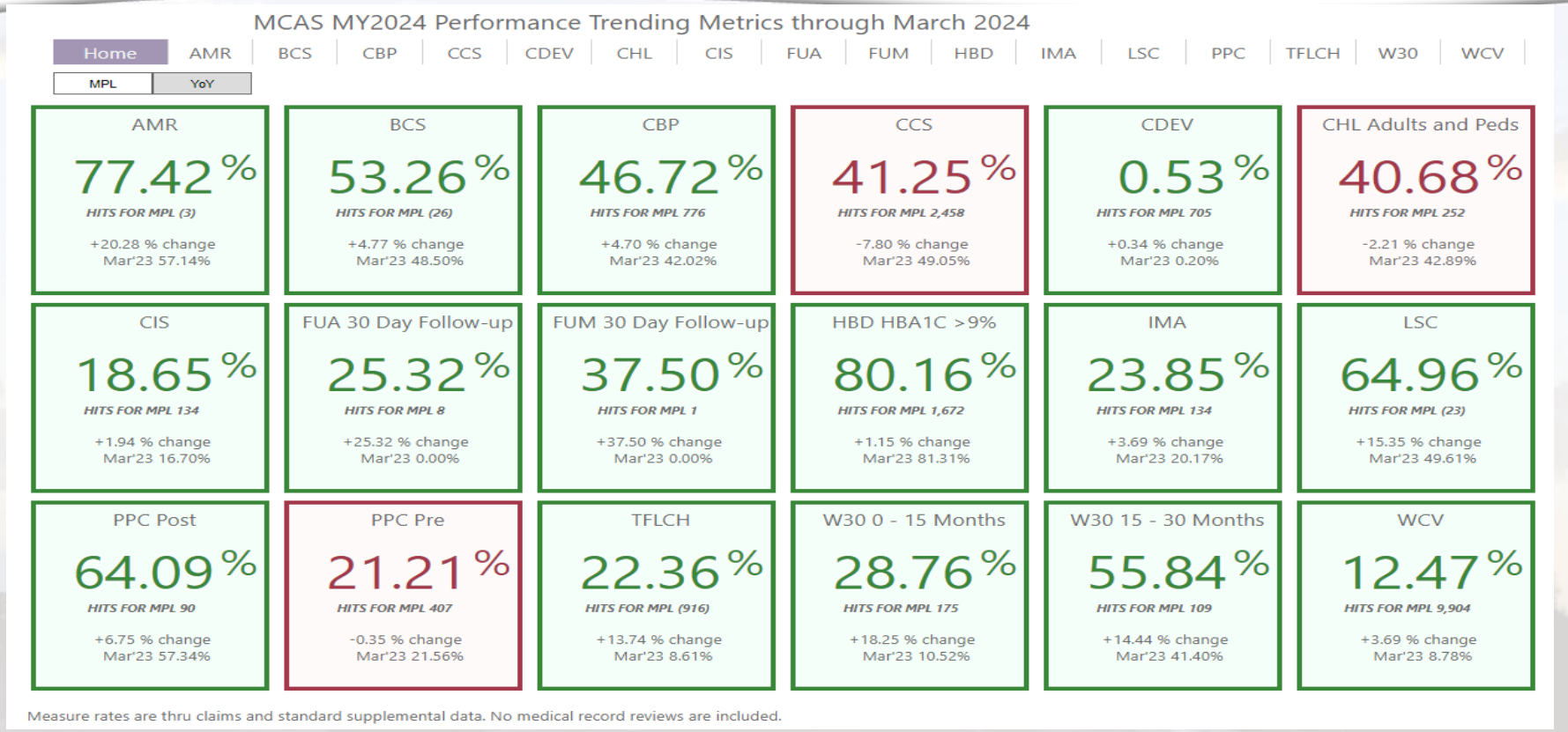
Direct Appointment Access

- Partnering with providers to access their appointment scheduler and book appointments directly for members

2024 YTD MCAS Rates



MY2024 Trending Rates (YoY)



KERN HEALTH SYSTEMS

Governed Reporting System

Kern Health Systems

KHS Medical Management Performance Dashboard (Critical Performance Measurements)

KERN HEALTH SYSTEMS

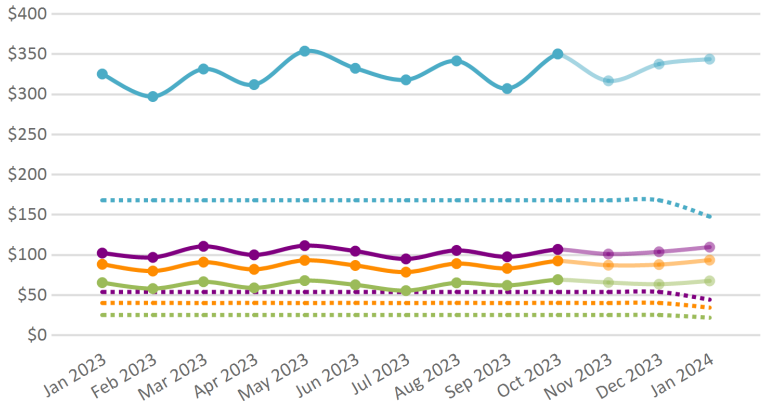
Governed Reporting System

Physician Services

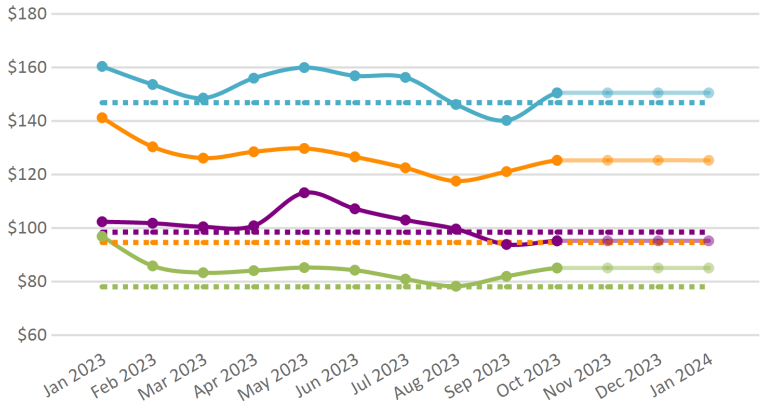
(Includes: Primary Care Physician Services, Referral Specialty Services, Other Professional Services and Urgent Care)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

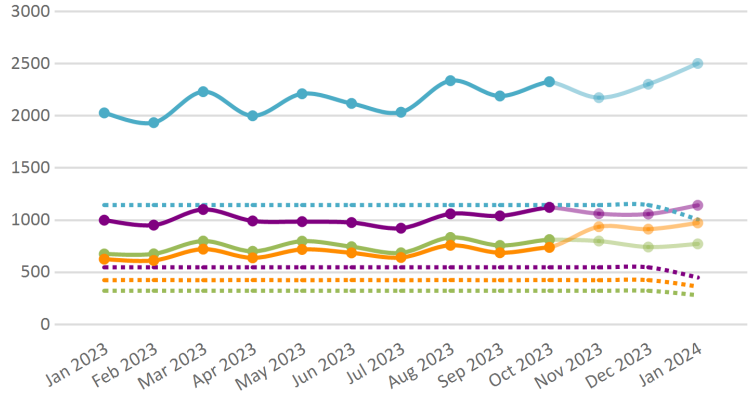
Professional Services Incurred by Aid Group PMPM



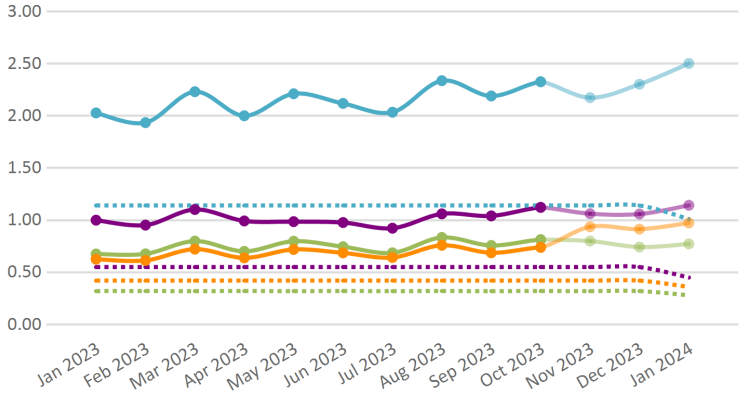
Cost per Professional Service Visit by Aid Group



Professional Service Visits per 1,000 per Month by Aid Group



Professional Service Visits per Member per Month by Aid Group



Services provided through: 1/31/2024 Claims Paid through: 2/29/2024

KERN HEALTH SYSTEMS

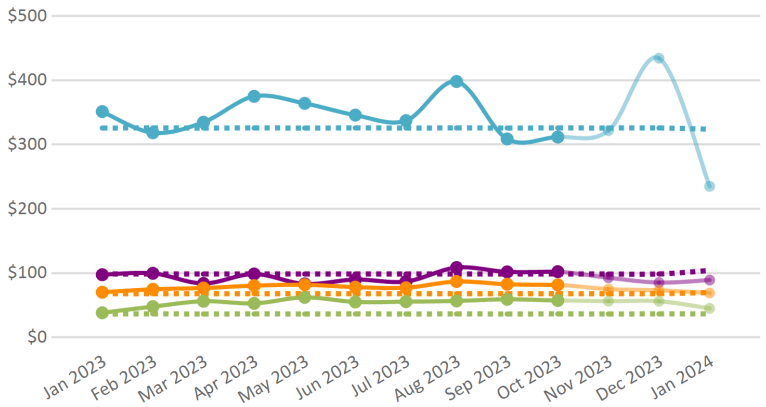
Governed Reporting System

Inpatient

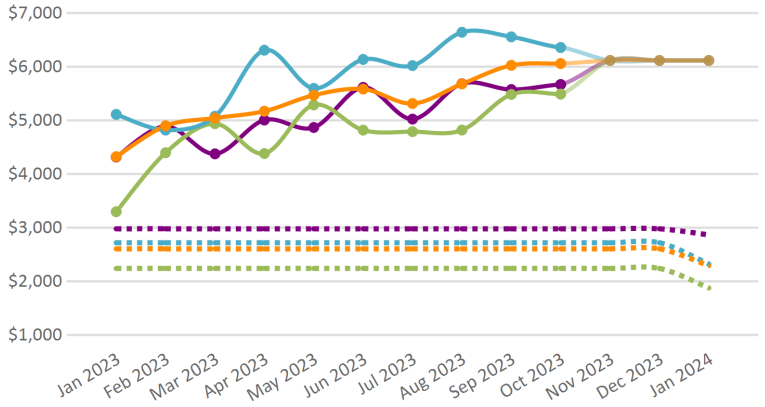
(Includes: Inpatient Hospital Claims)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

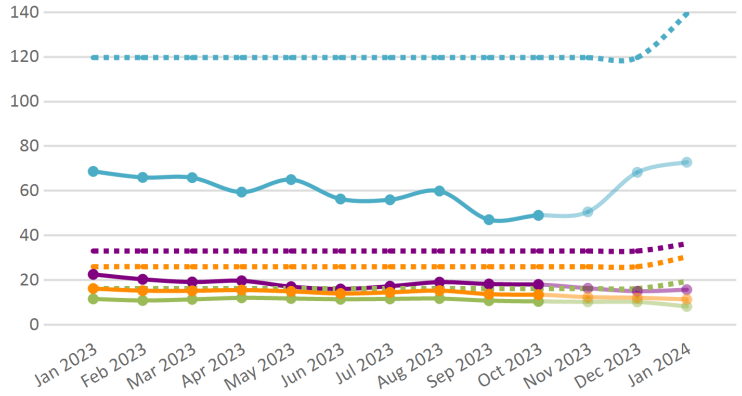
Inpatient Services Incurred by Aid Group PMPM



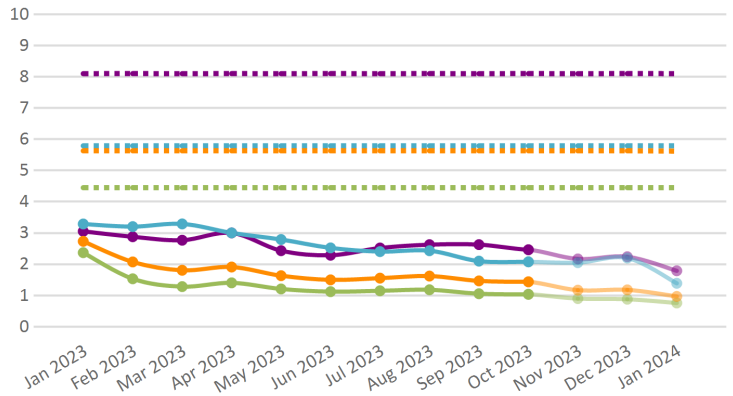
Cost Per Bed Day by Aid Group



Incurred Bed Days per 1,000 per Month by Aid Group



Average Length of Stay in Days by Aid Group



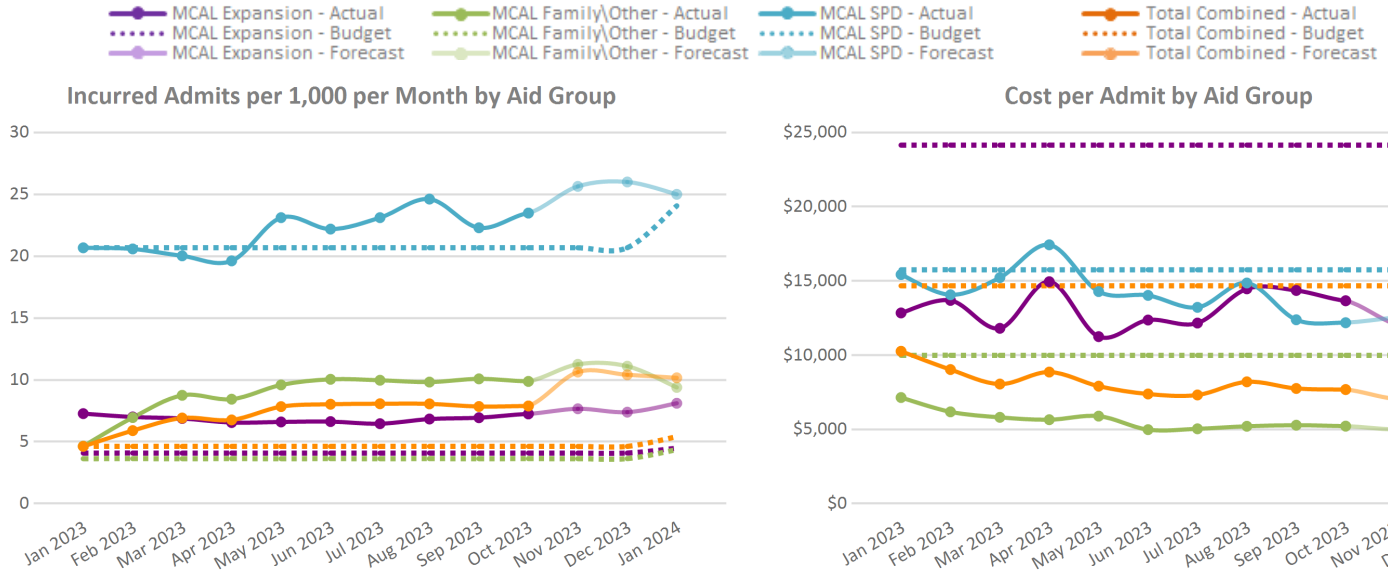
Services provided through: 1/31/2024 Claims Paid through: 2/29/2024

KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient

(Includes: Inpatient Hospital Claims)



Services provided through: 1/31/2024 Claims Paid through: 2/29/2024

KERN HEALTH SYSTEMS

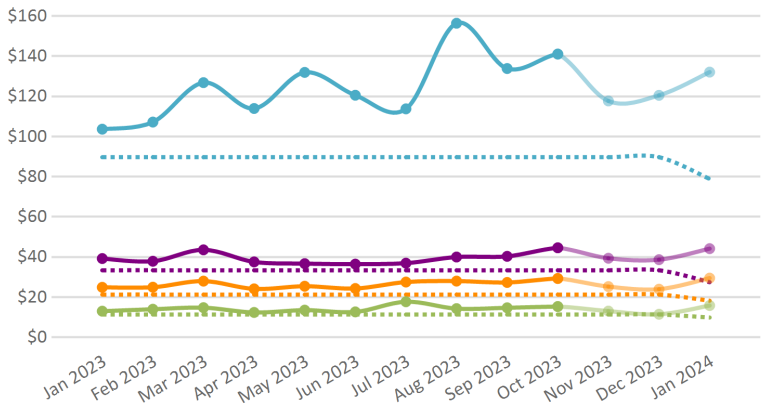
Governed Reporting System

Outpatient Hospital

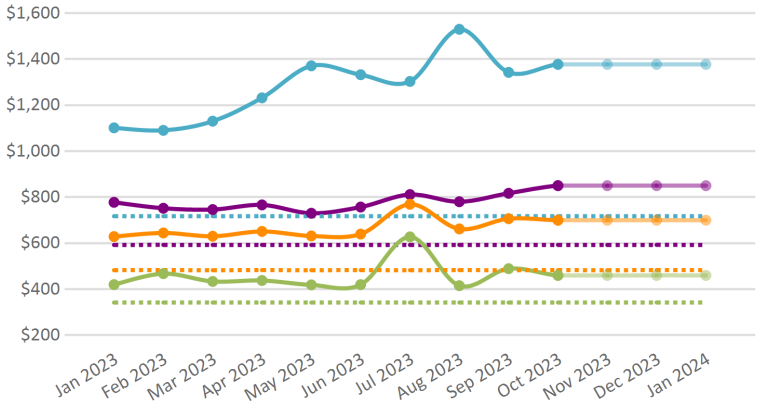
(Includes: Outpatient Diagnostic, Outpatient Surgery, Outpatient Observation, and Outpatient Other)

MCAL Expansion - Actual
MCAL Expansion - Budget
MCAL Expansion - Forecast
MCAL Family\Other - Actual
MCAL Family\Other - Budget
MCAL Family\Other - Forecast
MCAL SPD - Actual
MCAL SPD - Budget
MCAL SPD - Forecast
Total Combined - Actual
Total Combined - Budget
Total Combined - Forecast

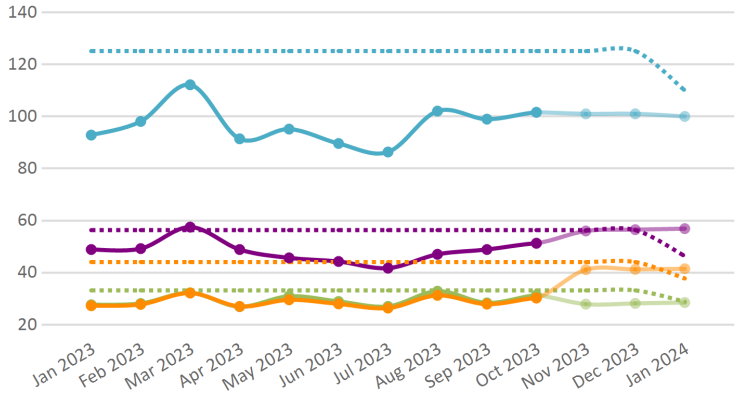
Outpatient Services Incurred by Aid Group PMPM



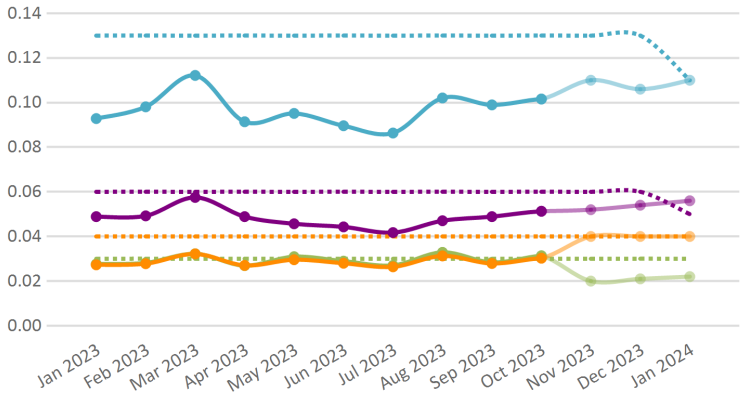
Cost Per Outpatient Visit by Aid Group



Outpatient Visits per 1,000 per Month by Aid Group



Outpatient Visits per Member per Month by Aid Group

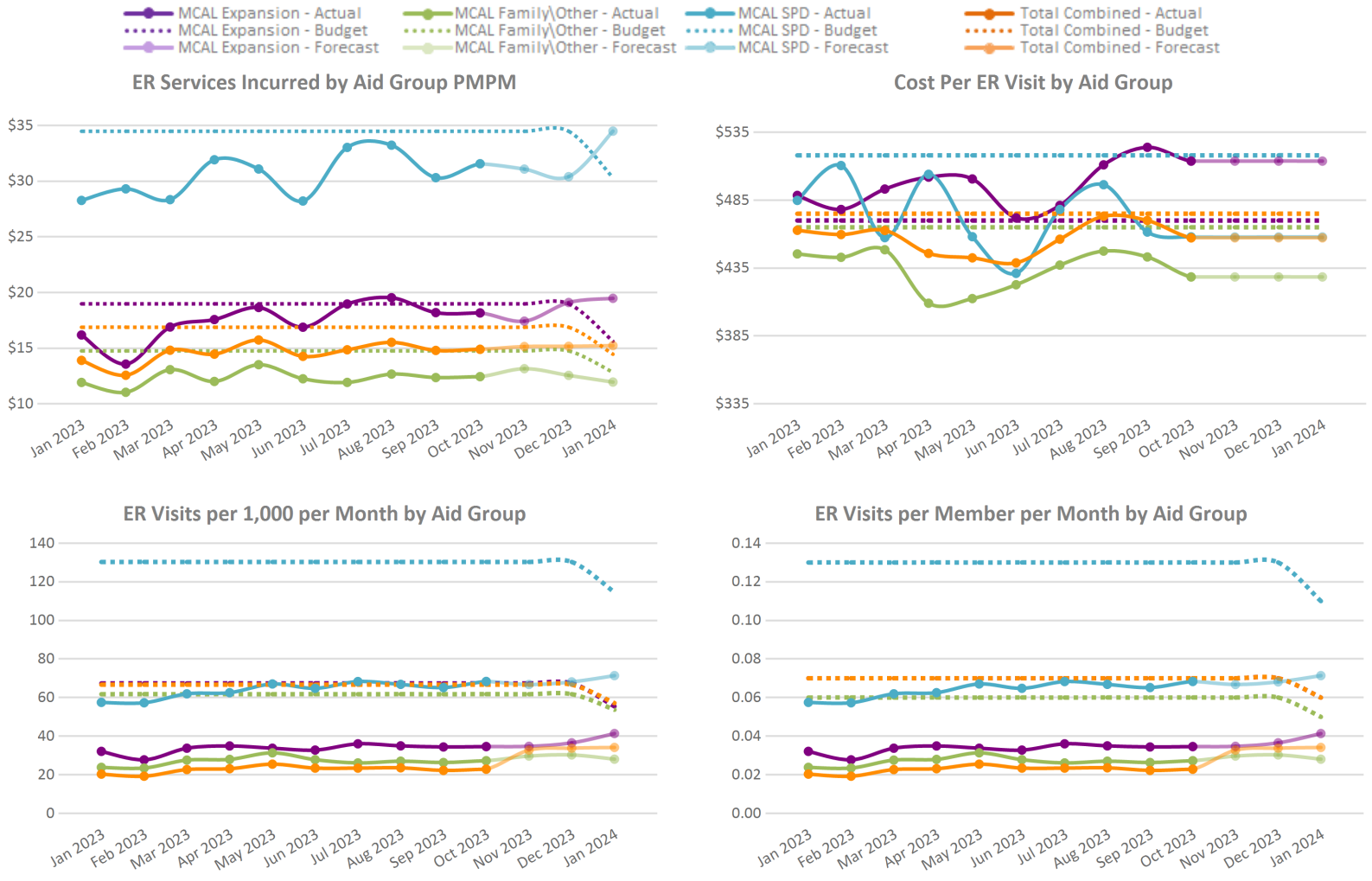


Services provided through: 1/31/2024 Claims Paid through: 2/29/2024

KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Room

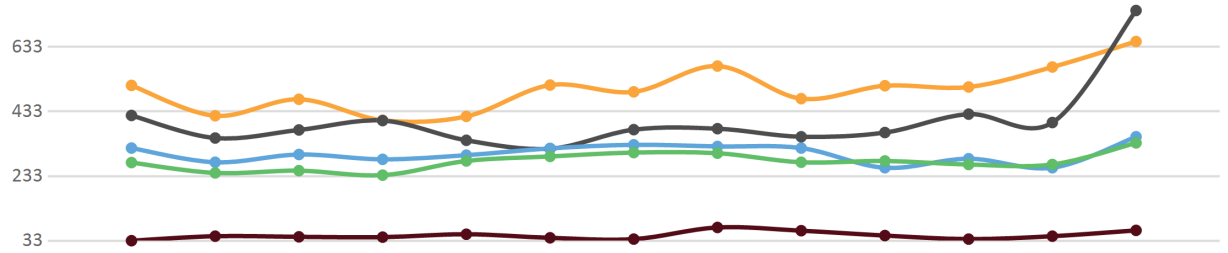


Services provided through: 1/31/2024 Claims Paid through: 2/29/2024

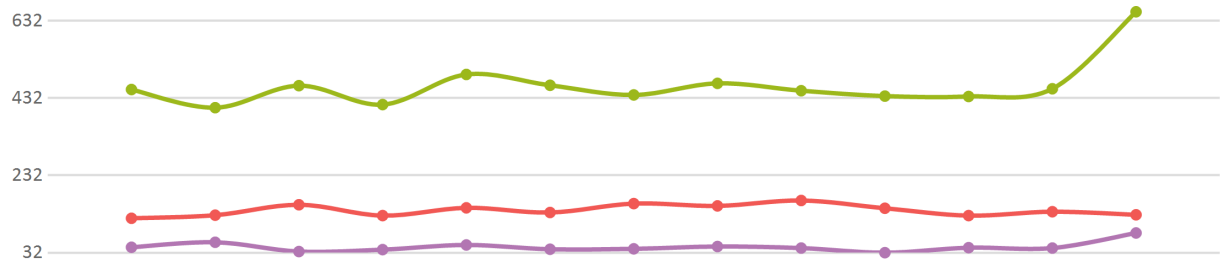
KERN HEALTH SYSTEMS

Governed Reporting System

Inpatient Admits by Hospital



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
BAKERSFIELD MEMORIAL	421	351	376	405	344	318	377	380	355	368	425	399	746
KERN MEDICAL	514	420	471	406	418	515	494	574	473	513	509	571	650
MERCY HOSPITAL	275	243	250	236	280	294	306	304	276	280	269	269	336
ADVENTIST HEALTH	320	276	300	285	298	319	330	325	320	259	287	259	355
BAKERSFIELD HEART HOSP	33	47	45	44	53	42	38	74	64	49	38	47	65

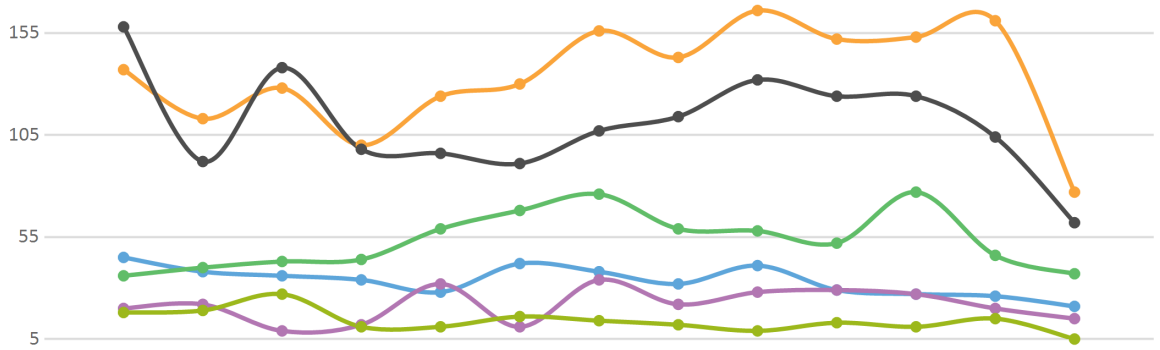


	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
GOOD SAMARITAN HOSPITAL	121	129	156	128	148	136	159	153	167	147	128	138	130
DELANO REGIONAL HOSPITAL	46	59	35	40	52	41	42	48	44	32	45	44	83
OUT OF AREA	454	407	464	415	493	465	440	470	451	437	436	456	655

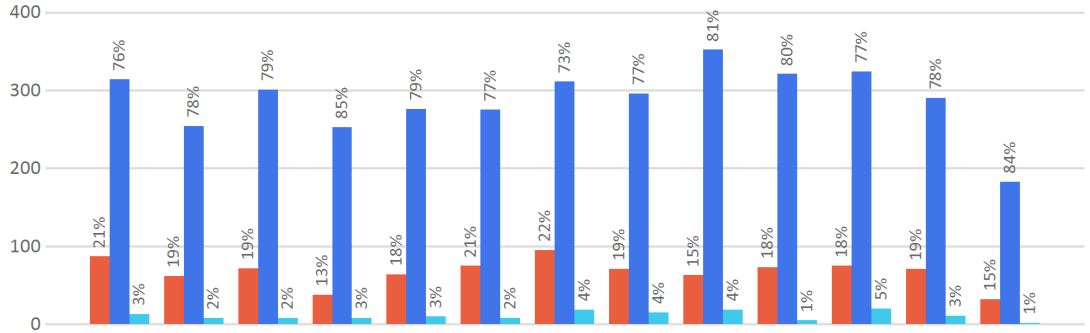
KERN HEALTH SYSTEMS

Governed Reporting System

Obstetrics Metrics



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
BAKERSFIELD MEMORIAL	158	92	138	98	96	91	107	114	132	124	124	104	62
KERN MEDICAL	137	113	128	100	124	130	156	143	166	152	153	161	77
MERCY HOSPITAL	36	40	43	44	59	68	76	59	58	52	77	46	37
ADVENTIST HEALTH	45	38	36	34	28	42	38	32	41	29	27	26	21
DELANO REGIONAL HOSPITAL	20	22	9	12	32	11	34	22	28	29	27	20	15
OTHER	18	19	27	11	11	16	14	12	9	13	11	15	5

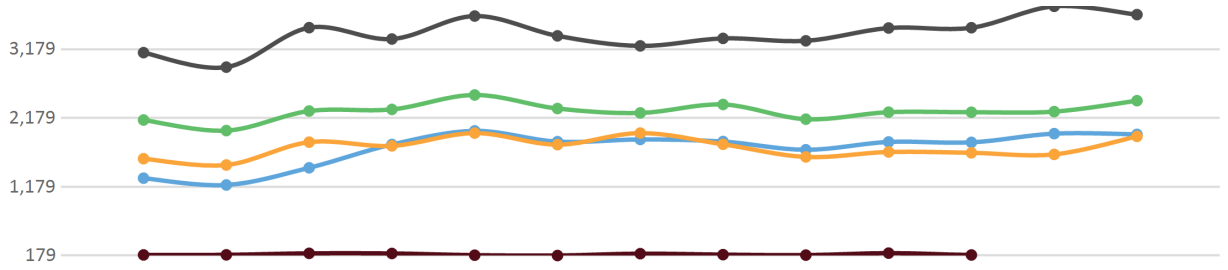


	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
VAGINAL DELIVERY	314	254	301	253	276	275	311	296	352	321	324	290	183
C-SECTION DELIVERY	87	62	72	38	64	75	95	71	63	73	75	71	32
PREVIOUS C-SECTION DELIVERY	13	8	8	8	10	8	19	15	19	5	20	11	2

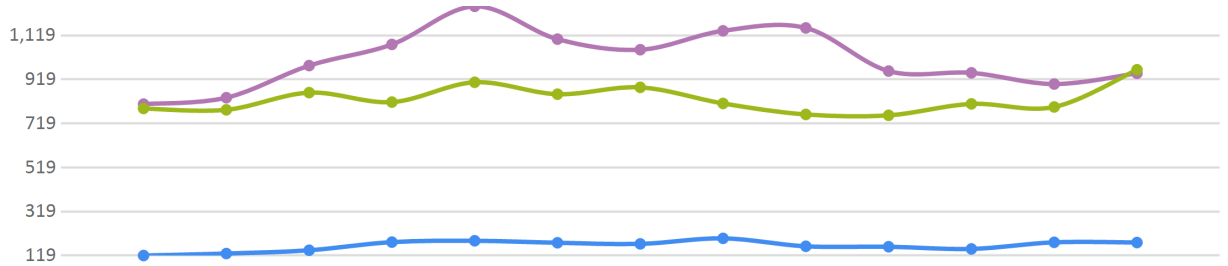
KERN HEALTH SYSTEMS

Governed Reporting System

Emergency Visits by Hospital



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
BAKERSFIELD MEMORIAL	3,130	2,919	3,493	3,328	3,662	3,374	3,228	3,337	3,302	3,488	3,492	3,803	3,683
MERCY HOSPITAL	2,150	1,996	2,281	2,304	2,514	2,317	2,253	2,376	2,162	2,264	2,263	2,272	2,431
KERN MEDICAL	1,587	1,496	1,828	1,774	1,960	1,792	1,960	1,797	1,613	1,685	1,673	1,650	1,912
ADVENTIST HEALTH	1,304	1,205	1,455	1,794	1,992	1,835	1,867	1,837	1,717	1,831	1,825	1,952	1,941
BAKERSFIELD HEART HOSP	188	189	211	209	184	179	206	192	185	214	187		



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
DELANO REGIONAL HOSPITAL	807	836	982	1,078	1,251	1,102	1,054	1,140	1,153	957	949	898	947
OUT OF AREA	787	781	859	816	906	852	883	810	760	756	808	794	963
KERN VALLEY HEALTHCARE	119	128	143	180	186	177	172	197	161	159	149	179	178

KERN HEALTH SYSTEMS

Governed Reporting System

MCAS MY2024 Performance Trending Metrics through March 2024

AMR	BCS	CBP	CCS	CDEV
75.46 %	47.44 %	25.05 %	38.23 %	11.74 %
HITS FOR MPL (21)	***HITS FOR MPL 864***	***HITS FOR MPL 8,656***	***HITS FOR MPL 13,197***	***HITS FOR MPL 2,989***
MPL: 65.61% Over MPL by 9.85% AMR is not held to MPL.	MPL: 52.60% Under MPL by 5.16%	MPL: 61.31% Under MPL by 36.26%	MPL: 57.11% Under MPL by 18.88%	MPL: 34.70% Under MPL by 22.96%

CHL Adults and Peds	CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	HBD HBA1C >9%
35.23 %	12.17 %	20.59 %	21.88 %	87.06 %
HITS FOR MPL 1,371	***HITS FOR MPL 1,228***	***HITS FOR MPL 48***	***HITS FOR MPL 10***	***HITS FOR MPL 7,863***
MPL: 56.04% Under MPL by 20.81%	MPL: 30.90% Under MPL by 18.73%	MPL: 36.34% Under MPL by 15.75%	MPL: 54.87% Under MPL by 33.00%	MPL: 37.96% Under MPL by 49.10% Inverted Measure

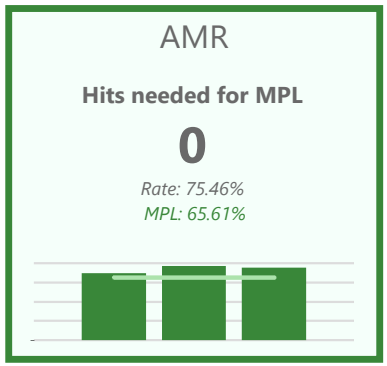
IMA	LSC	PPC Post	PPC Pre	TFLCH
23.08 %	60.05 %	57.47 %	28.68 %	20.65 %
HITS FOR MPL 811	***HITS FOR MPL 180***	***HITS FOR MPL 527***	***HITS FOR MPL 1,419***	***HITS FOR MPL (2,335)***
MPL: 34.31% Under MPL by 11.23%	MPL: 62.79% Under MPL by 2.74%	MPL: 78.10% Under MPL by 20.63%	MPL: 84.23% Under MPL by 55.55%	MPL: 19.30% Over MPL by 1.35%

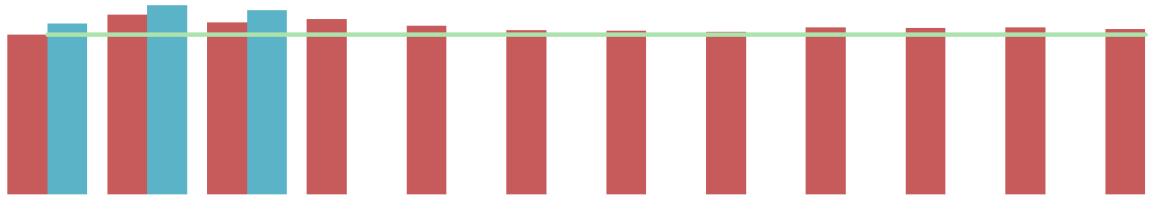
W30 0 - 15 Months	W30 15 - 30 Months	WCV
35.79 %	57.87 %	10.59 %
HITS FOR MPL 802	***HITS FOR MPL 563***	***HITS FOR MPL 59,926***
MPL: 58.38% Under MPL by 22.59%	MPL: 66.76% Under MPL by 8.89%	MPL: 48.07% Under MPL by 37.48%

Measure rates are thru claims and standard supplemental data. No medical record reviews are included.

Asthma Medication Ratio

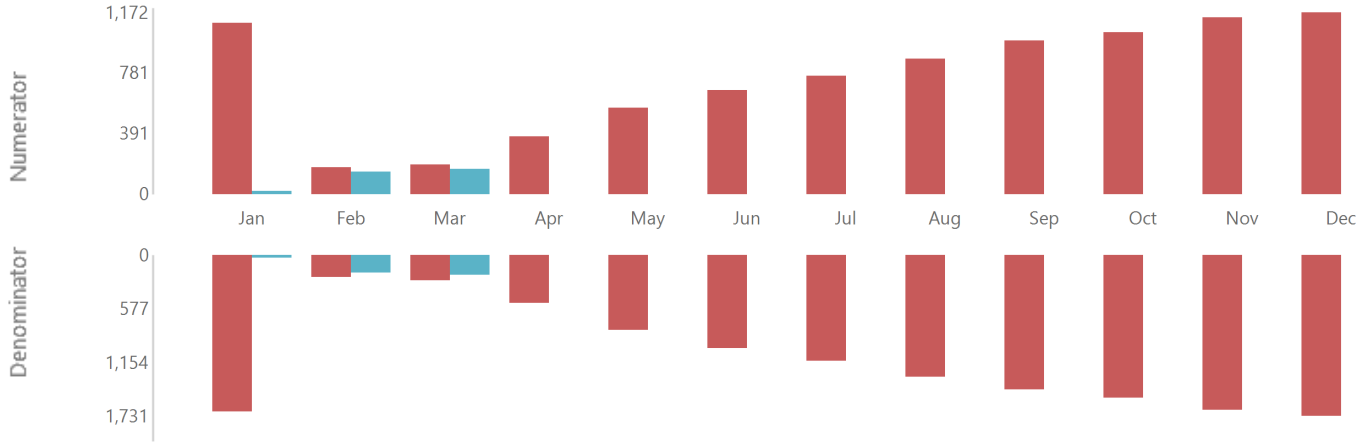
The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	65.58%	73.73%	70.48%	71.81%	69.12%	67.27%	67.08%	66.59%	68.51%	68.21%	68.51%	67.71%
2024	70.00%	77.54%	75.46%									
MPL	65.61%	65.61%	65.61%	65.61%	65.61%	65.61%	65.61%	65.61%	65.61%	65.61%	65.61%	65.61%

163
216



Breast Cancer Screening

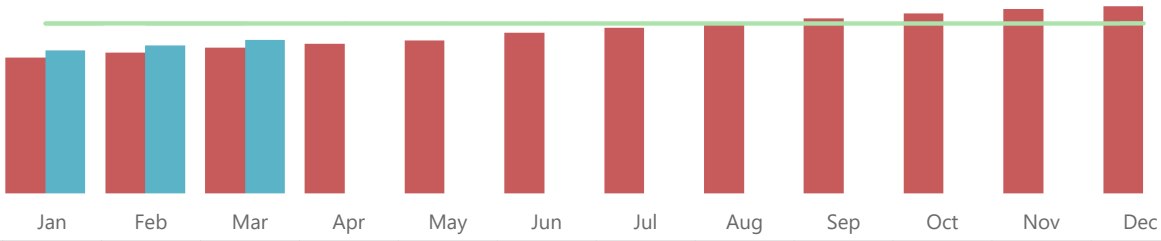
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. Measurement period: January 1–December 31.

BCS

Hits needed for MPL

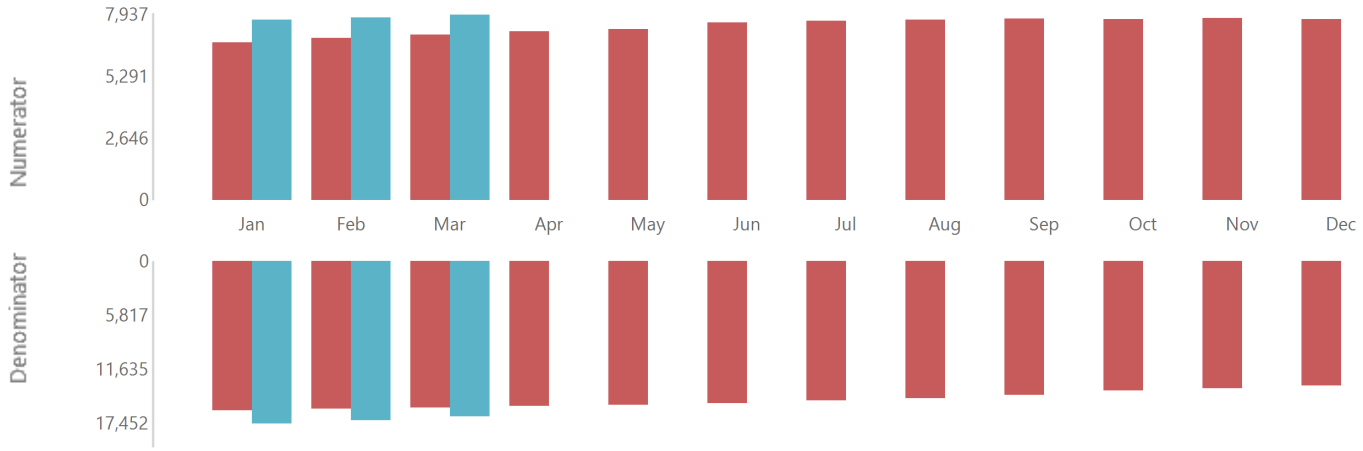
864

Rate: 47.44%
MPL: 52.60%



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	41.95%	43.55%	44.97%	46.30%	47.22%	49.59%	51.15%	52.41%	54.02%	55.63%	56.92%	57.78%
2024	44.23%	45.63%	47.44%									
MPL	52.60%	52.60%	52.60%	52.60%	52.60%	52.60%	52.60%	52.60%	52.60%	52.60%	52.60%	52.60%

7,937
16,732



Cervical Cancer Screening

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:• Women 21–64 years of age who had cervical cytology performed within the last 3 years.• Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.• Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

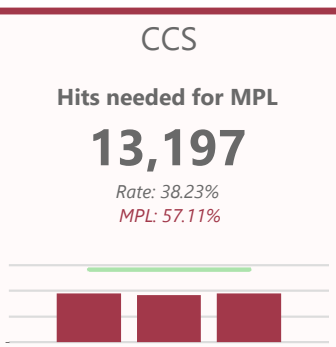
CCS

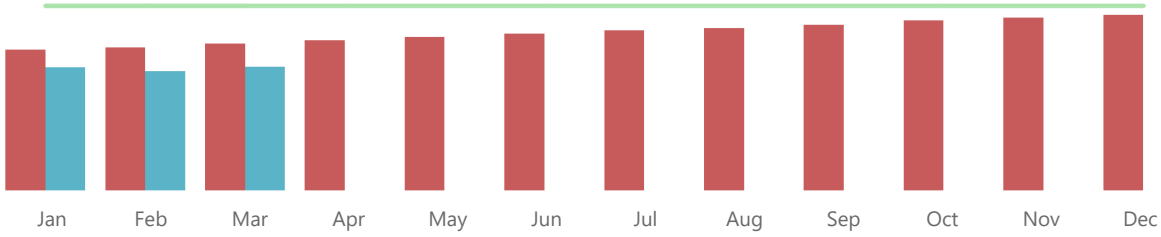
Hits needed for MPL

13,197

Rate: 38.23%

MPL: 57.11%

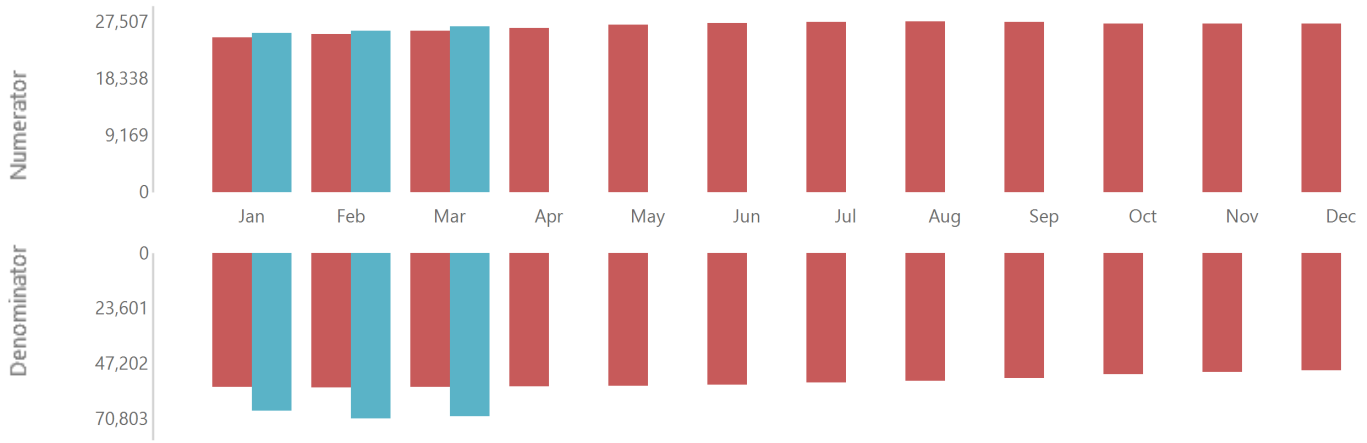




		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	43.40%	44.19%	45.37%	46.35%	47.38%	48.37%	49.43%	50.22%	51.24%	52.46%	53.39%	54.16%
	2024	37.99%	36.76%	38.23%									
	MPL	57.11%	57.11%	57.11%	57.11%	57.11%	57.11%	57.11%	57.11%	57.11%	57.11%	57.11%	57.11%

26,729

69,912



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.

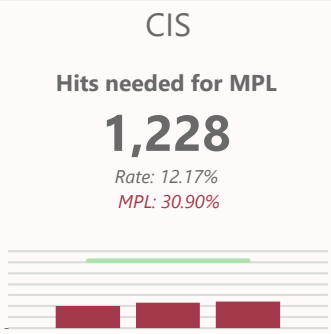
CIS

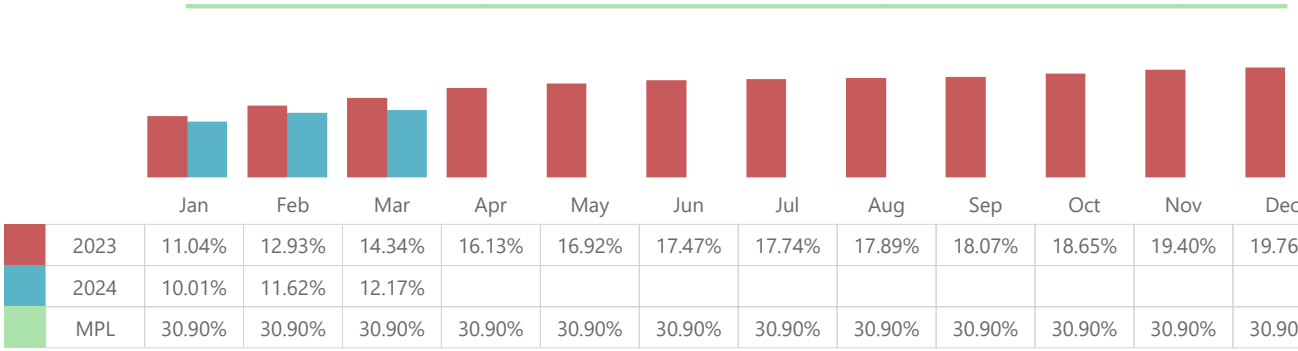
Hits needed for MPL

1,228

Rate: 12.17%

MPL: 30.90%

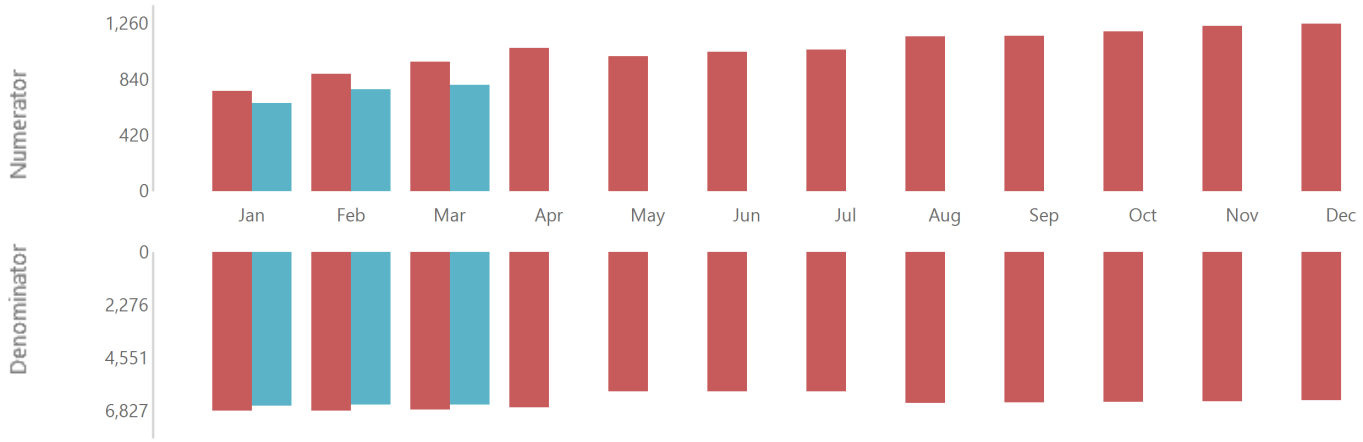




	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	11.04%	12.93%	14.34%	16.13%	16.92%	17.47%	17.74%	17.89%	18.07%	18.65%	19.40%	19.76%
2024	10.01%	11.62%	12.17%									
MPL	30.90%	30.90%	30.90%	30.90%	30.90%	30.90%	30.90%	30.90%	30.90%	30.90%	30.90%	30.90%

798

6,559



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

811

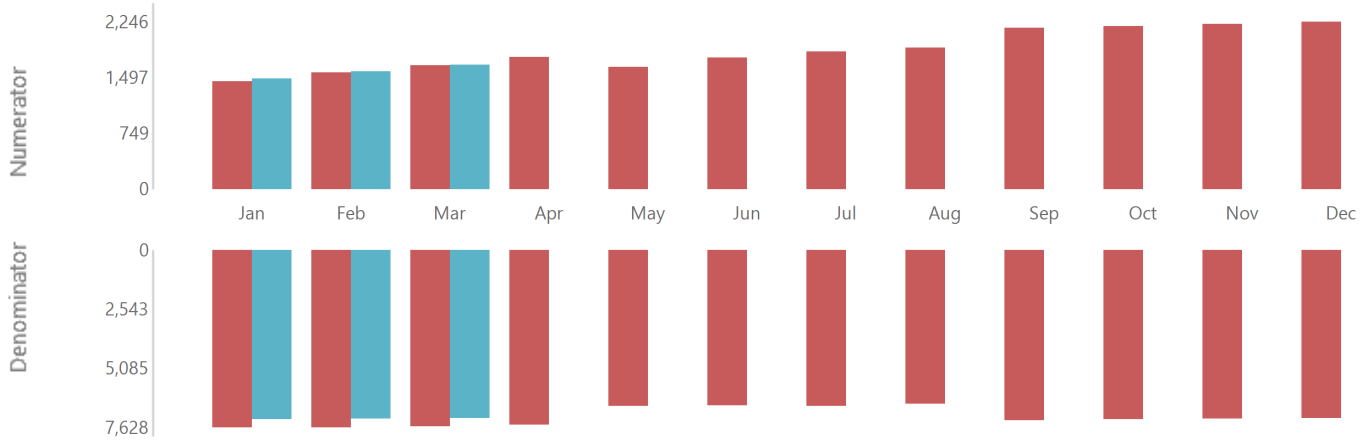
Rate: 23.08%

MPL: 34.31%

2023	18.94%	20.59%	21.93%	23.64%	24.51%	26.37%	27.52%	28.74%	29.60%	30.05%	30.54%	31.06%
2024	20.41%	21.78%	23.08%									
MPL	34.31%	34.31%	34.31%	34.31%	34.31%	34.31%	34.31%	34.31%	34.31%	34.31%	34.31%	34.31%

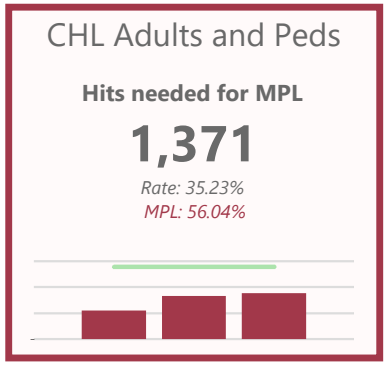
1,668

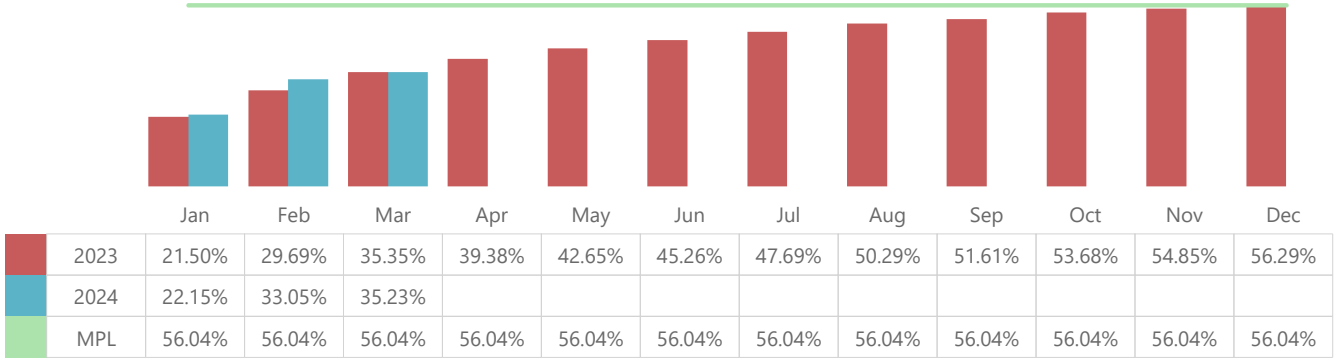
7,227



Chlamydia Screening in Women

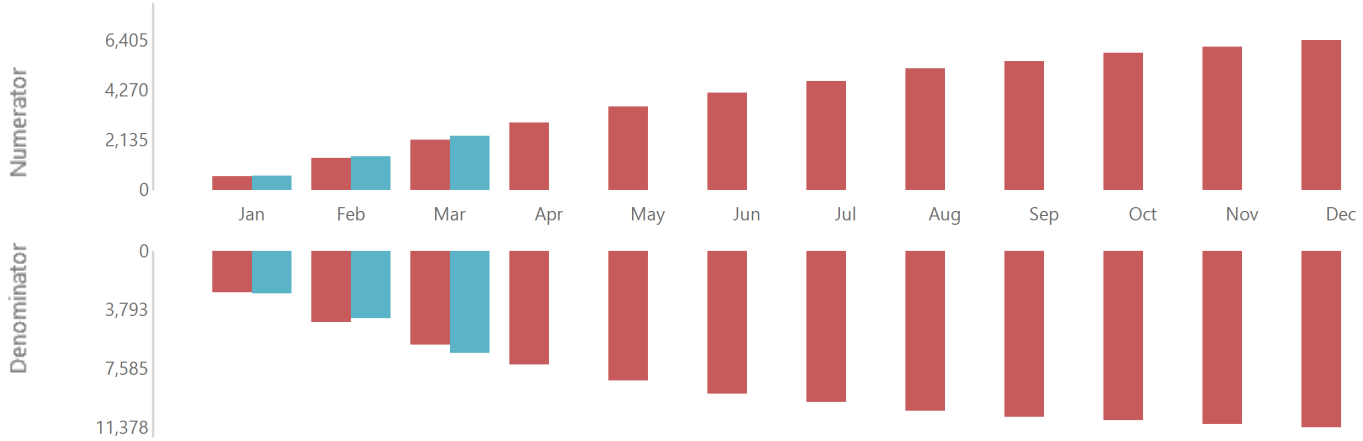
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.





		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	21.50%	29.69%	35.35%	39.38%	42.65%	45.26%	47.69%	50.29%	51.61%	53.68%	54.85%	56.29%
	2024	22.15%	33.05%	35.23%									
	MPL	56.04%	56.04%	56.04%	56.04%	56.04%	56.04%	56.04%	56.04%	56.04%	56.04%	56.04%	56.04%

2,321
6,589



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

180

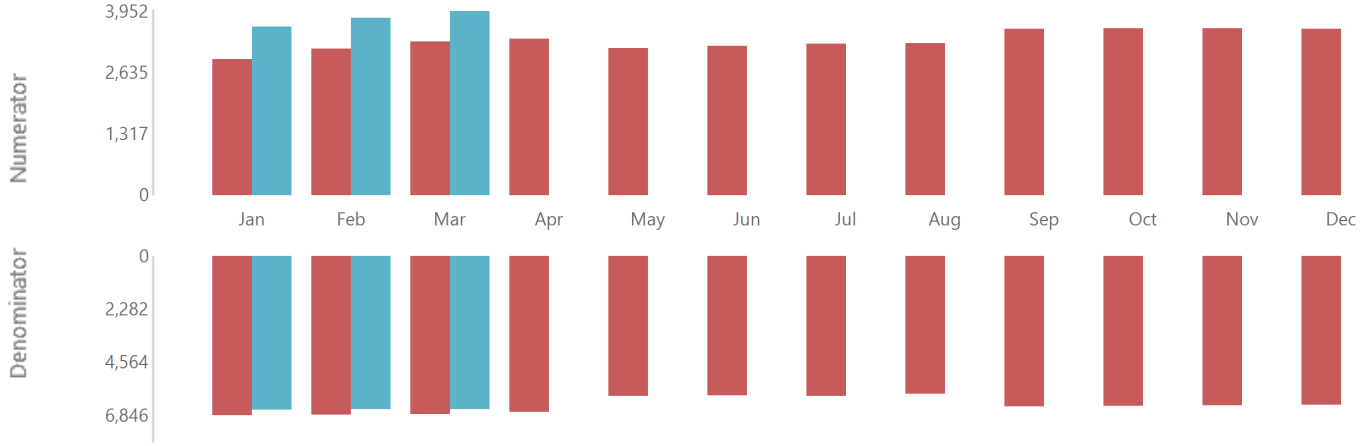
Rate: 60.05%

MPL: 62.79%

2023	42.64%	46.09%	48.51%	50.07%	52.51%	53.47%	54.06%	54.96%	55.11%	55.53%	55.70%	55.87%
2024	54.60%	57.84%	60.05%									
MPL	62.79%	62.79%	62.79%	62.79%	62.79%	62.79%	62.79%	62.79%	62.79%	62.79%	62.79%	62.79%

3,952

6,581



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.

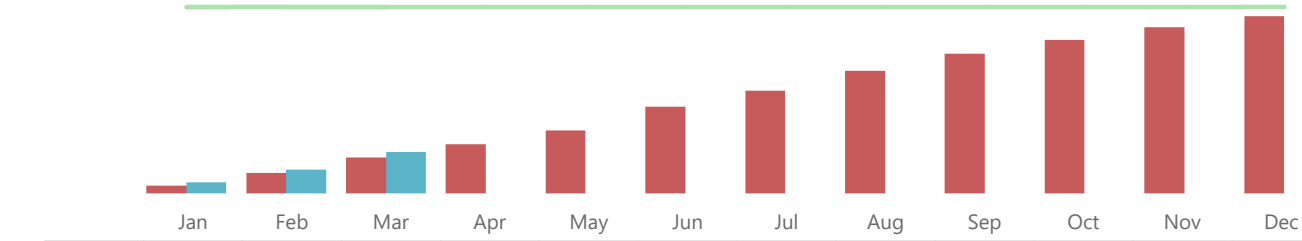
WCV

Hits needed for MPL

59,926

Rate: 10.59%

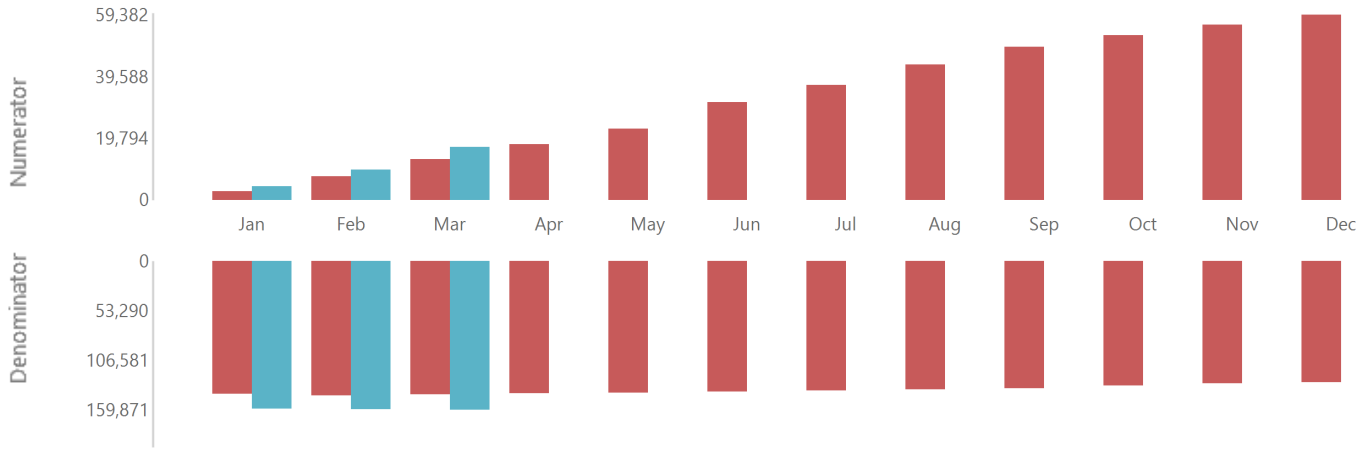
MPL: 48.07%



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	1.98%	5.24%	9.16%	12.62%	16.22%	22.30%	26.44%	31.54%	35.92%	39.56%	42.78%	45.66%
2024	2.80%	6.13%	10.59%									
MPL	48.07%	48.07%	48.07%	48.07%	48.07%	48.07%	48.07%	48.07%	48.07%	48.07%	48.07%	48.07%

16,923

159,871



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

8,656

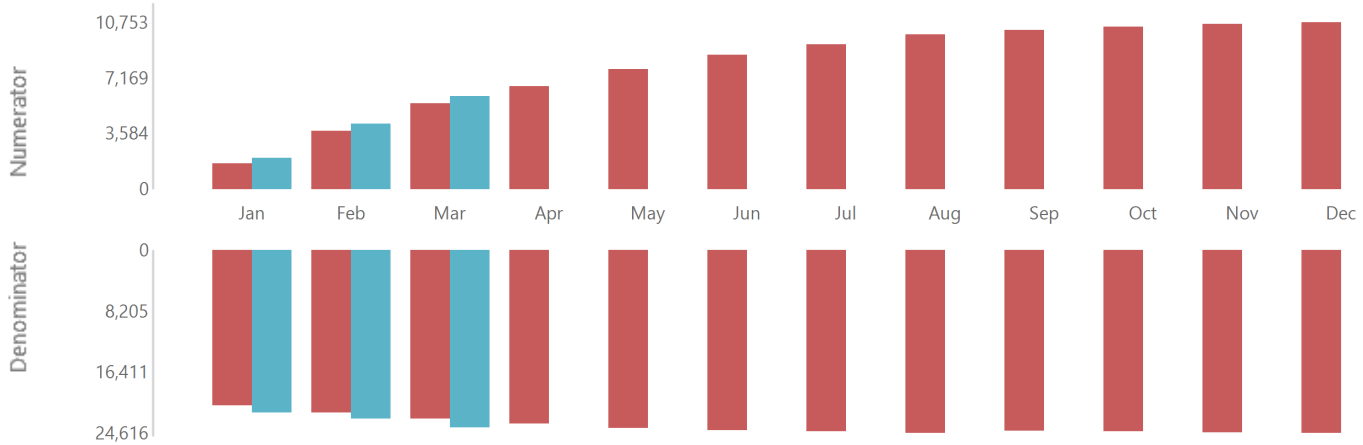
Rate: 25.05%

MPL: 61.31%

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	7.85%	17.19%	24.42%	28.47%	32.36%	35.72%	38.24%	40.51%	42.21%	42.90%	43.54%	43.77%
	2024	9.26%	18.53%	25.05%									
	MPL	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%

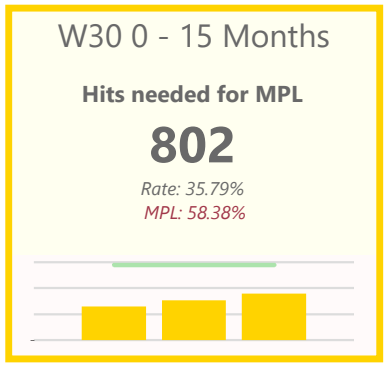
5,979

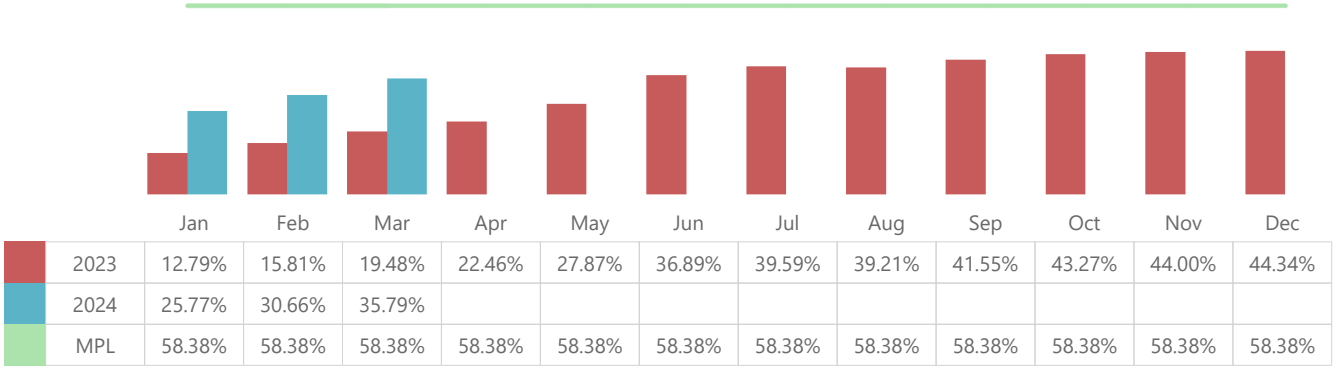
23,872



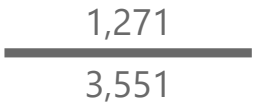
Well-Child Visits in the First 30 Months of Life

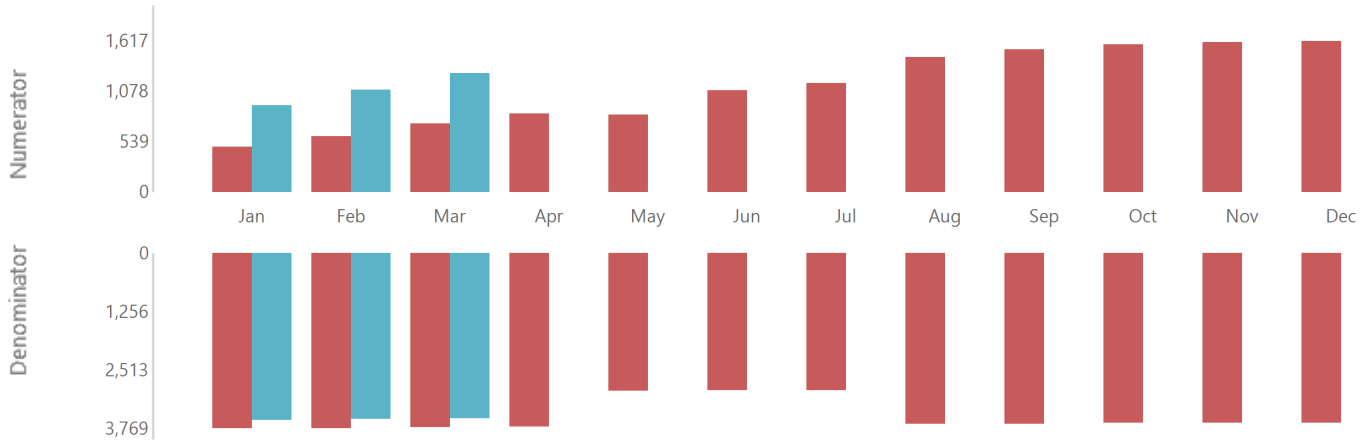
The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.





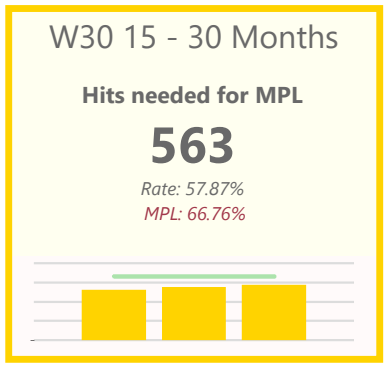
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	12.79%	15.81%	19.48%	22.46%	27.87%	36.89%	39.59%	39.21%	41.55%	43.27%	44.00%	44.34%
	2024	25.77%	30.66%	35.79%									
	MPL	58.38%	58.38%	58.38%	58.38%	58.38%	58.38%	58.38%	58.38%	58.38%	58.38%	58.38%	58.38%

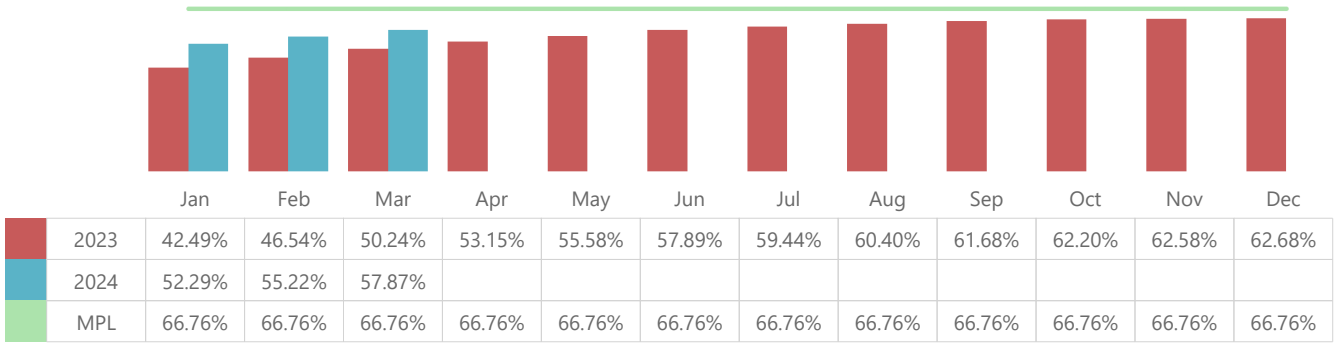




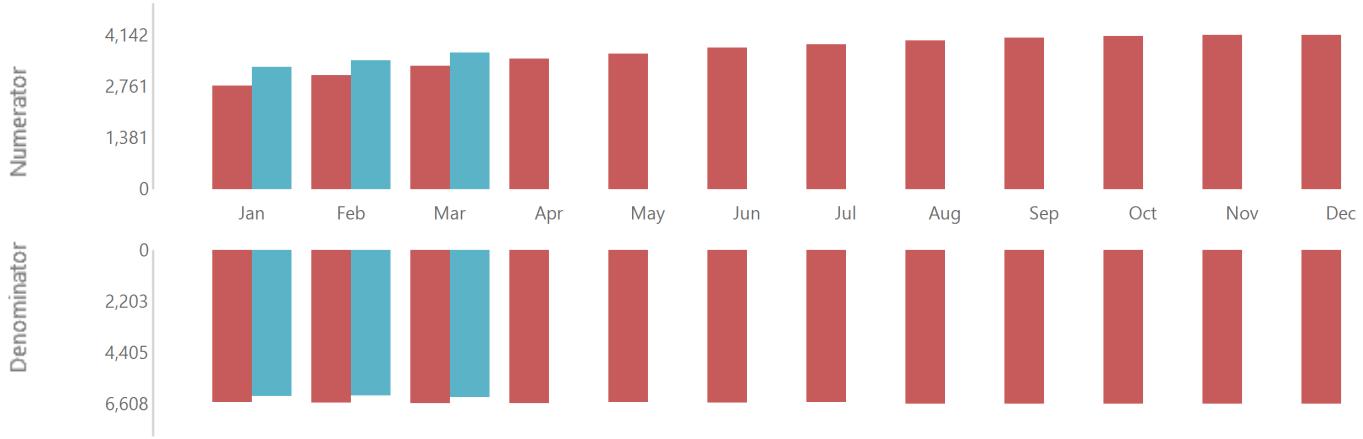
Well-Child Visits in the First 30 Months of Life

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	42.49%	46.54%	50.24%	53.15%	55.58%	57.89%	59.44%	60.40%	61.68%	62.20%	62.58%	62.68%
2024	52.29%	55.22%	57.87%									
MPL	66.76%	66.76%	66.76%	66.76%	66.76%	66.76%	66.76%	66.76%	66.76%	66.76%	66.76%	66.76%



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.

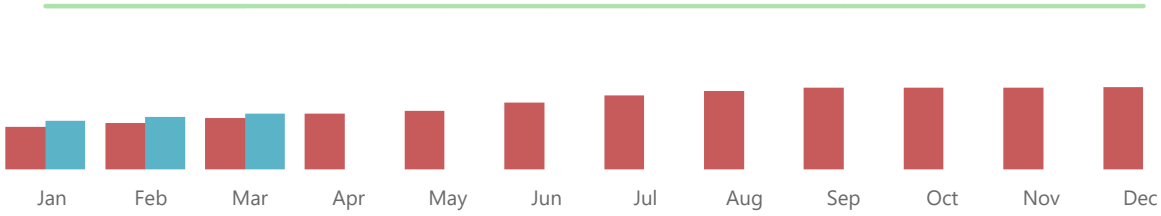
PPC Pre

Hits needed for MPL

1,419

Rate: 28.68%

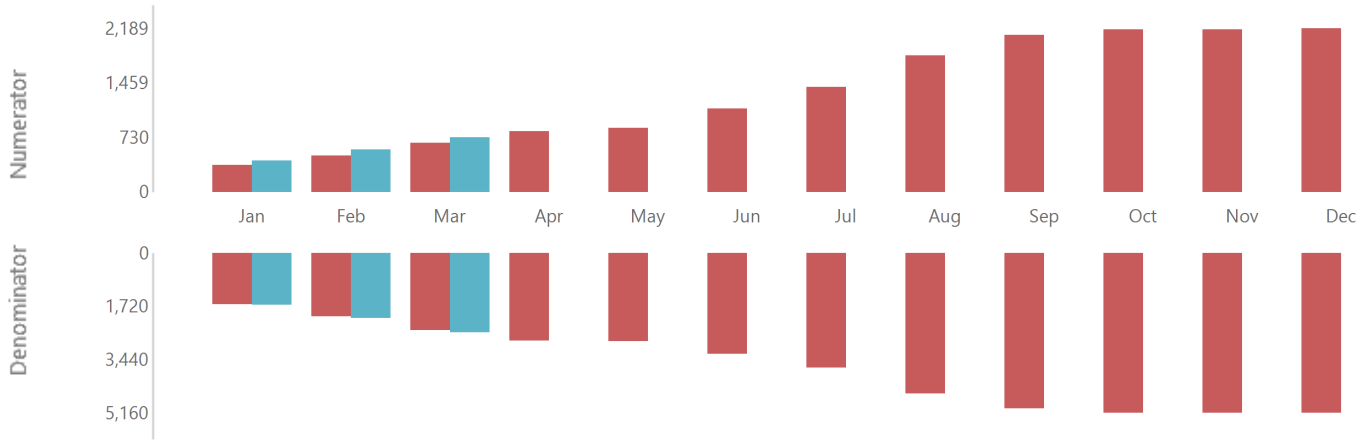
MPL: 84.23%



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	21.77%	23.83%	26.43%	28.58%	30.12%	34.28%	37.92%	40.41%	41.91%	42.15%	42.16%	42.42%
	2024	25.10%	26.84%	28.68%									
	MPL	84.23%	84.23%	84.23%	84.23%	84.23%	84.23%	84.23%	84.23%	84.23%	84.23%	84.23%	84.23%

733

2,556



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.

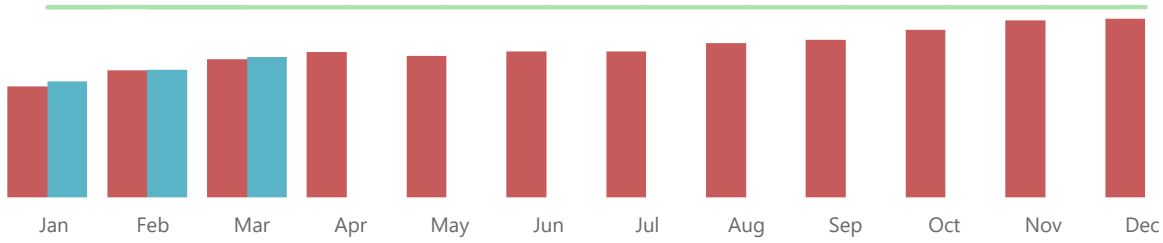
PPC Post

Hits needed for MPL

527

Rate: 57.47%

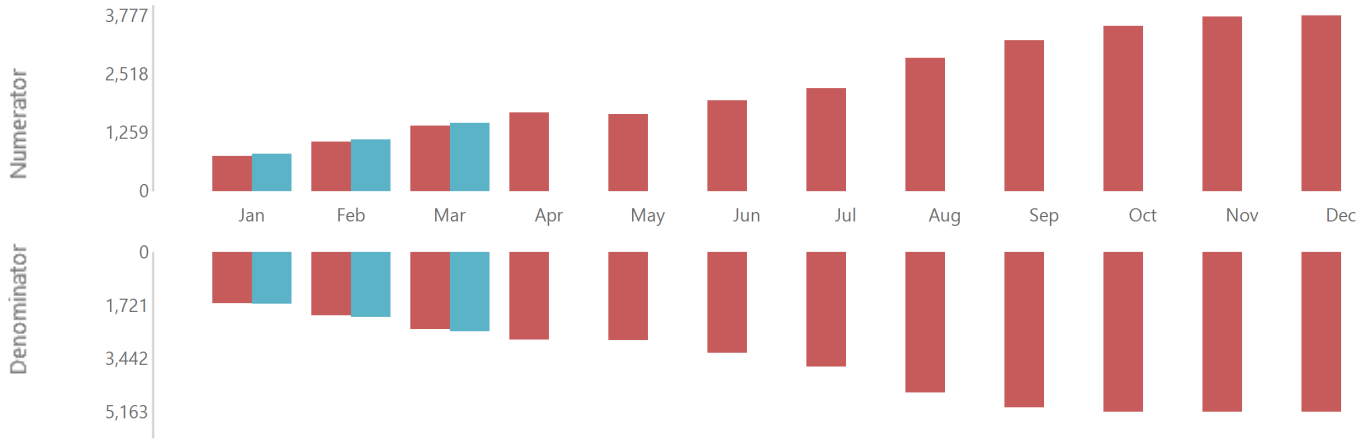
MPL: 78.10%



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	45.41%	52.00%	56.72%	59.55%	58.08%	59.88%	59.89%	63.24%	64.56%	68.75%	72.58%	73.16%
	2024	47.47%	52.40%	57.47%									
	MPL	78.10%	78.10%	78.10%	78.10%	78.10%	78.10%	78.10%	78.10%	78.10%	78.10%	78.10%	78.10%

1,469

2,556



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

10

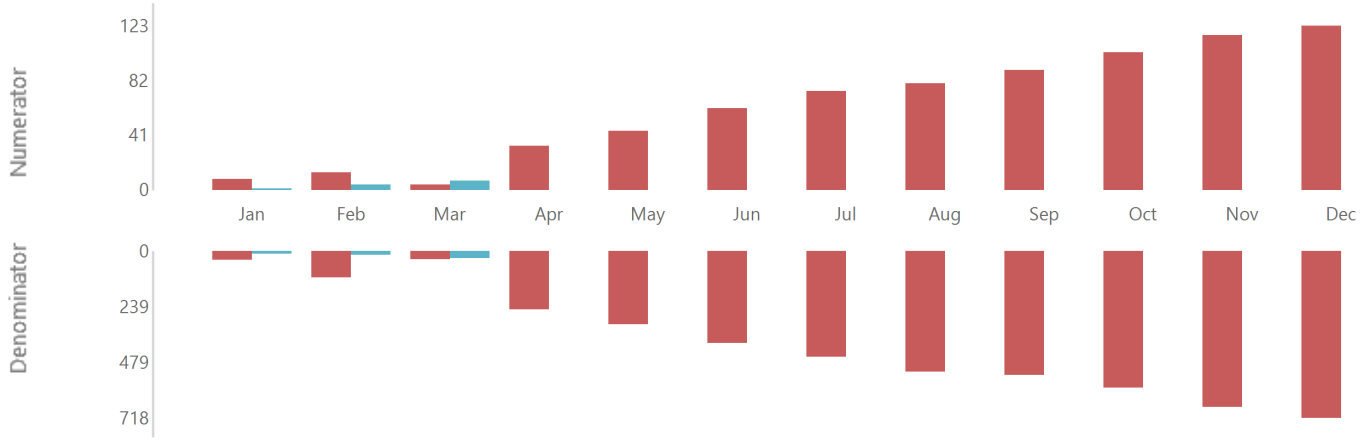
Rate: 21.88%

MPL: 54.87%

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	20.51%	11.50%	11.11%	13.15%	13.97%	15.37%	16.23%	15.44%	16.89%	17.55%	17.29%	17.13%
2024	9.09%	25.00%	21.88%									
MPL	54.87%	54.87%	54.87%	54.87%	54.87%	54.87%	54.87%	54.87%	54.87%	54.87%	54.87%	54.87%

7

32



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

48

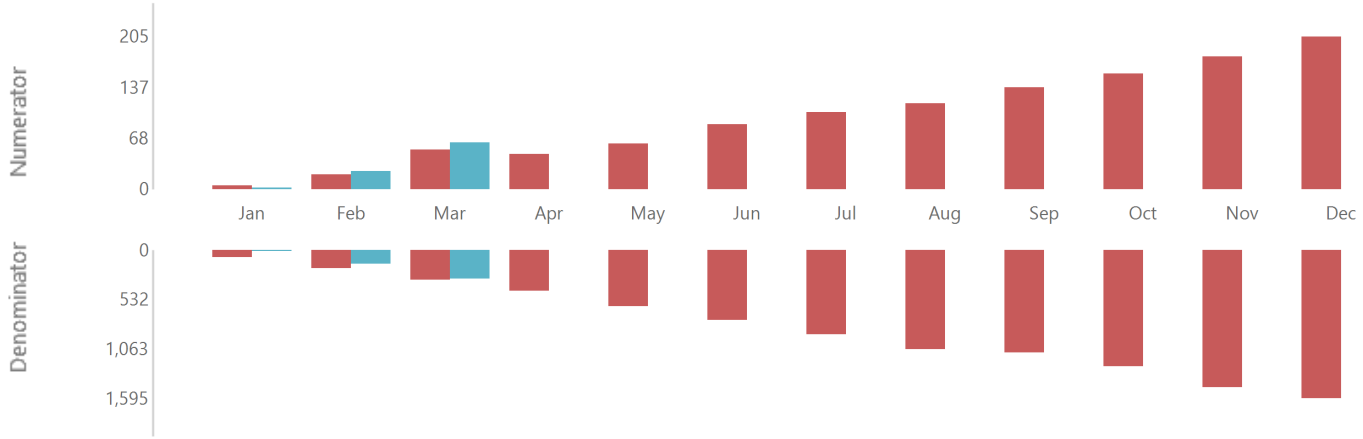
Rate: 20.59%

MPL: 36.34%

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	6.41%	10.36%	16.56%	10.71%	10.05%	11.58%	11.33%	10.81%	12.45%	12.39%	12.06%	12.85%
	2024	20.00%	16.11%	20.59%									
	MPL	36.34%	36.34%	36.34%	36.34%	36.34%	36.34%	36.34%	36.34%	36.34%	36.34%	36.34%	36.34%

63

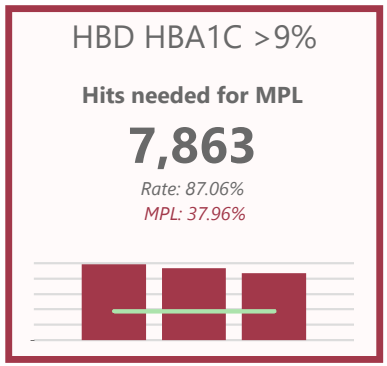
306

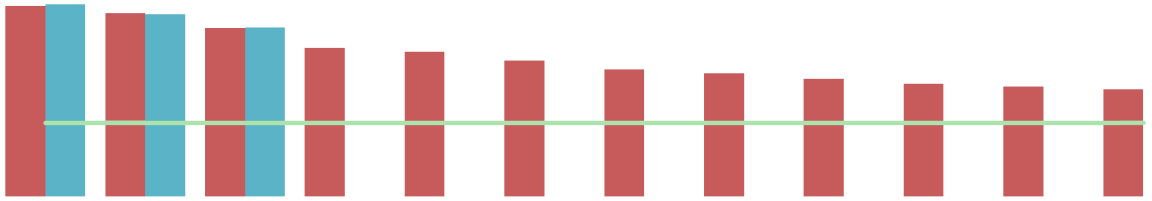


Hemoglobin A1c Testing & Control for Patients With Diabetes

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:
• HbA1c Control (<8.0%).
• HbA1c Poor Control (>9.0%).

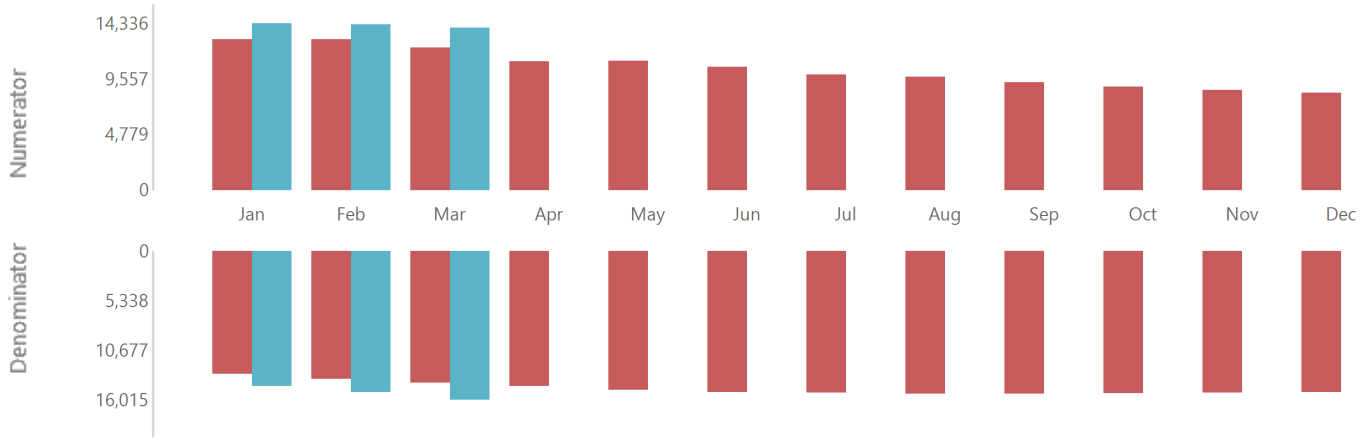
Inverted Measure - a lower rate is desired for this measure.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	98.02%	94.51%	86.56%	76.35%	74.48%	69.80%	65.31%	63.51%	60.59%	58.10%	56.43%	55.09%
2024	98.80%	93.82%	87.06%									
MPL	37.96%	37.96%	37.96%	37.96%	37.96%	37.96%	37.96%	37.96%	37.96%	37.96%	37.96%	37.96%

13,943
16,015



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

2,989

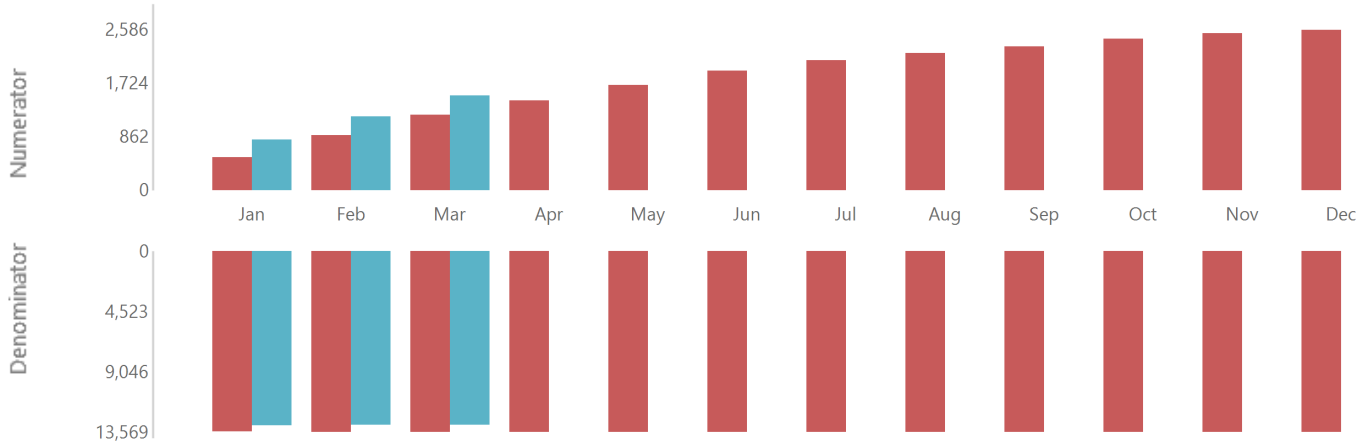
Rate: 11.74%

MPL: 34.70%

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2023	3.89%	6.53%	8.95%	10.68%	12.49%	14.20%	15.45%	16.27%	17.05%	18.00%	18.65%	19.06%
	2024	6.26%	9.14%	11.74%									
	MPL	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%	34.70%

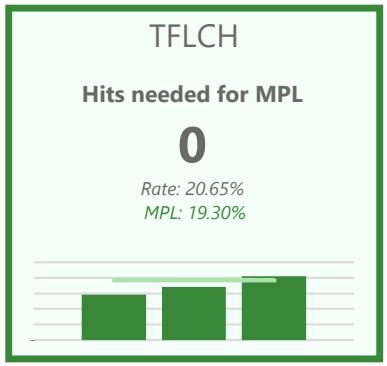
1,528

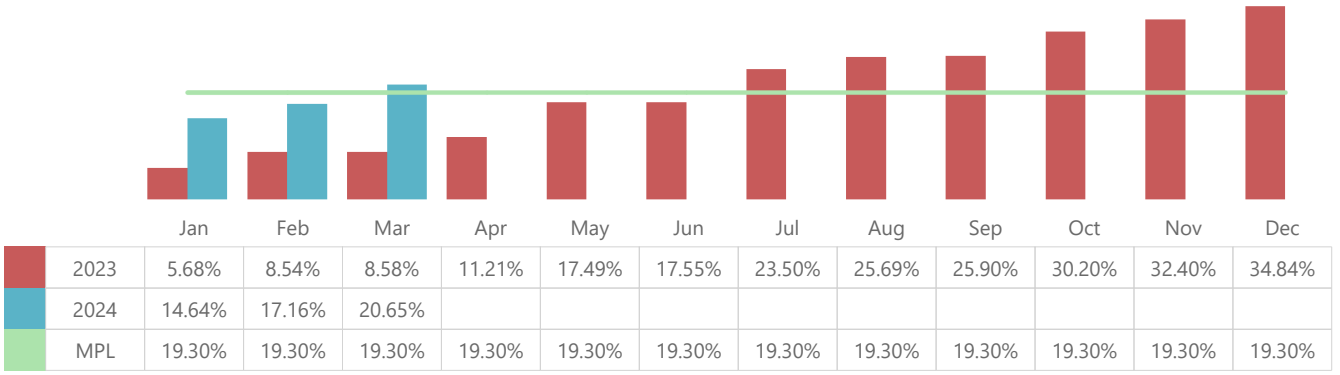
13,018



Prevention: Topical Fluoride for Children

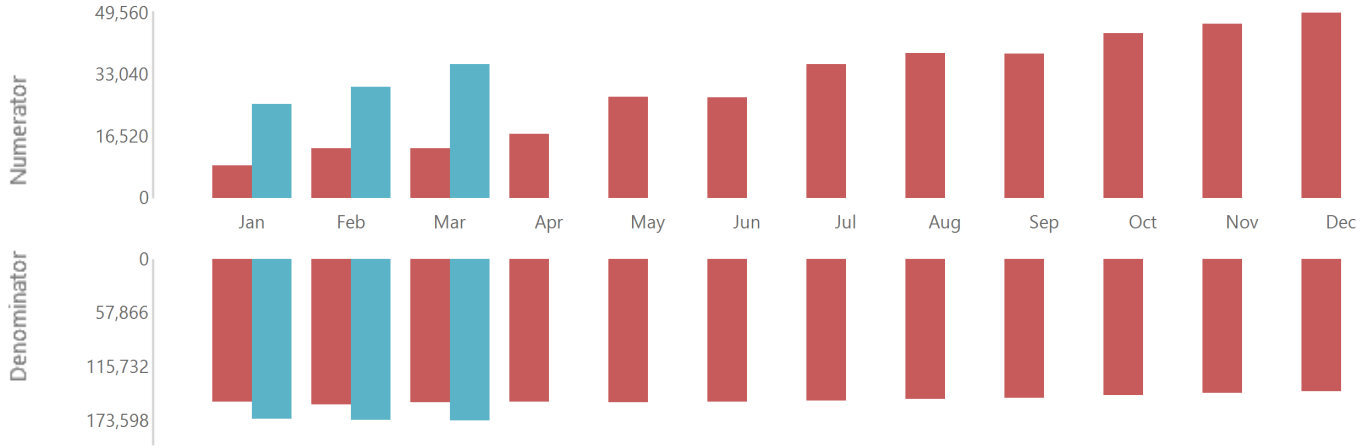
Percentage of children aged 1–21 years who received at least 2 topical fluoride applications as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year.





	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	5.68%	8.54%	8.58%	11.21%	17.49%	17.55%	23.50%	25.69%	25.90%	30.20%	32.40%	34.84%
2024	14.64%	17.16%	20.65%									
MPL	19.30%	19.30%	19.30%	19.30%	19.30%	19.30%	19.30%	19.30%	19.30%	19.30%	19.30%	19.30%

35,840
173,598



KERN HEALTH SYSTEMS

Chief Executive Officer's Report

Board of Director's Meeting

Emily Duran

April 18, 2024

KHS STRATEGIC PLAN & CEO CORPORATE GOALS

The KHS strategic plan outlines the priority areas for the organization and serves as a roadmap for 2023 – 2025. Included under **Attachment A: Strategic Plan Q1 2024 Status Report** is a breakdown of the key strategic plan accomplishments from the 1st Quarter of 2024. Overall, KHS remains on track in accomplishing the strategic goals, as outlined in the attachment.

LEGISLATIVE SUMMARY

2024 State Legislation: The State Legislative cycle is in full swing as the first set of committee deadlines approaches at the end of April. By that time, bills with fiscal impacts will have to pass out of their assigned committees to maintain their active status for the year. Most of the bills being monitored internally will run through the Assembly and Senate Health Committees over the coming month. Staff continues to monitor for relevant bills and analyze potential impacts. Work is also ongoing with our State Trade Associations and legislative staff on advocacy and potential bill amendments. The 2024 bill tracking document is included under **Attachment B: Bill Tracking** and currently includes over 60 potentially impactful bills.

Additionally, KHS Government Relations staff traveled to Sacramento on February 27th to participate in the Local Health Plans of California (LHPC) Legislative Briefing Day. During this meeting, LHPC and Plan Staff engaged with Legislative and Regulatory staff on priority issues for 2024. The KHS team also met with our local elected delegation to discuss their priorities and upcoming issues.

2024-2025 January Draft Budget Proposal: In the January draft budget release, the Governor's administration projected a $37.9 billion budget shortfall for the coming fiscal year. One of the proposals noted in the January draft budget aimed at reducing the deficit was related to increasing revenues via the MCO tax. In late March the legislature and Governor's administration took early action on this item with the intent of sending the revised proposal to the federal government for approval. The next major budget milestone comes in May, when the Governor's administration will release an updated budget proposal with the latest revenue and spending projections. As always, the KHS Government Relations team remains highly actively engaged in this process, along with our Trade Associations and other partners.

CYBER SECURITY UPDATE

On February 21, 2024, Change Healthcare, a subsidiary of UnitedHealth Group, suffered a cybersecurity breach. This incident led to the encryption and theft of healthcare data. Change Healthcare processes transactions for one in three U.S. patients and handles about half of all medical claims in the United States, causing significant disruptions in Provider Billing, Pharmacy, and Claims Clearinghouse functions due to the breach. In response, Change has allocated over $3.3 billion in Temporary Funding Assistance Programs to support impacted providers (WebMD, 3/25/2024, Kathleen Doheny, "Change HealthCare Cyberattack: What Consumers Should Know").

Following the breach notification on February 22, 2024, KHS promptly disconnected from Change Healthcare to protect its digital assets. KHS, which maintains connections with five of the largest clearinghouses for redundancy and competitiveness, analyzed data to identify providers using Change Healthcare as their primary clearinghouse. On February 26th, KHS issued a bulletin to inform providers about the breach and offered direct support. Providers coordinated with their Provider Relations representatives to switch to alternative clearinghouses, ensuring the continuation of claim payments. KHS closely monitored billing activities from affected providers, noting a significant migration to alternative services. As of April 2, 2024, Change Healthcare reported that 95% of its clearinghouse operations have resumed.

DMHC TIMELY ACCESS REPORT

Ensuring timely access to care for our enrollees is an essential responsibility for Kern Health Systems and a regulatory requirement monitored by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS). As part of the Plan's timely access monitoring and reporting responsibilities, the Plan conducts an Annual Provider Appointment Availability Survey in accordance with DMHC methodology.

In March of 2024, the DMHC released their Timely Access Report for Measurement Year 2022, summarizing the results of the Annual Provider Appointment Availability Survey submitted by health plans in California.

When compared against other Medi-Cal line of business plans, for non-urgent appointment results, KHS ranked in the top 5, with 92% of providers in compliance with the non-urgent appointment wait time standard. When compared against all products, the Plan was second in the state for compliance with the non-urgent appointment wait time. Report can be found at:
https://www.dmhc.ca.gov/Portals/0/Docs/OPM/MY2022TAR.pdf

EQUITY AND PRACTICE TRANSFORMATION (EPT) PAYMENT PROGRAM

The Department of Health Care Services (DHCS) implemented a one-time $700 million primary care provider practice transformation program to advance health equity and reduce COVID-19-driven care disparities by investing in up-stream care models and partnerships to address health and wellness and funding practice transformation.

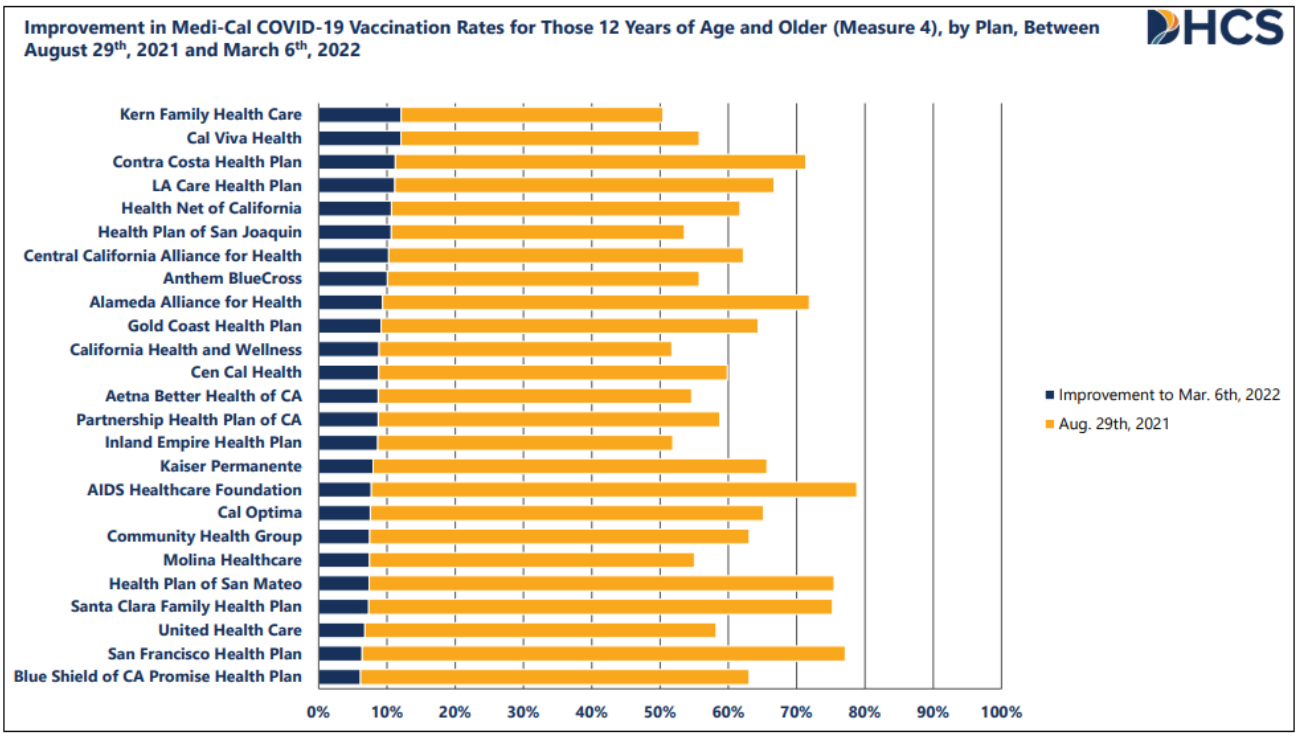
KHS received a total of 19 applications for the EPT program and 12 were selected by DHCS to participate in the program. The 12 practices have the potential to earn funding from a total of $26 million through EPT program. KHS plays an important role in managing the relationship between providers and the EPT program from identifying independent practices, supporting the practices as they developed practice transformation plans and applications, and reimbursing funds once milestones are met.

MEDI-CAL COVID-19 VACCINE INCENTIVE PROGRAM EVALUATION REPORT | AUGUST 29, 2021 – MARCH 6, 2022

During fiscal year 2021-22, Department of Health Care Services (DHCS) received legislative authority to spend up to $350 million in total funds to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery system for the service periods of September 1, 2021 through February 28, 2022. DHCS designed the program as a managed care plan incentive payment program where Medi-Cal Managed Care Plans (MCPs) were eligible to earn incentive payments for activities that were designed to improve vaccination rates among their enrolled members.

All 25 plans reported the percentage of Medi-Cal members ages 12 and older who received a least one dose of vaccine. This population had an overall vaccination rate of 61.1 percent at the end of the incentive program and an improvement of 10.0 percent. Kern Family Health Care reported the highest improvement in overall vaccination rates (12.15), see Figure 1 below. Report can be found at: https://www.dhcs.ca.gov/Documents/Covid-Vaccine-Incentive-Evaluation-Report.pdf

Figure 1.



GRANTS AND STRATEGIC INITIATIVES 2023 – 2025

- **Community-Based Initiative:** All 15 Community Based Organizations (CBO's) have initiated projects aligned with their scope of work. In Q1 of 2024, KHS would like to highlight California Farmworker and JJ's Legacy. California Farmworker has provided eight (8) mobile clinics to farmworkers serving 106 members. JJ's Legacy has supported a total of 10 patients (KHS members) needing organ transplants varying from heart, liver, and kidney.
- **Quality Grant:** All 10 providers have initiated projects using the grant funding. In Q1 of 2024, KHS would like to highlight Komoto Pharmacy and Premier Valley Medical Group (PVMG). Komoto Pharmacy hosted a "Black Family Wellness Expo" that focused on free health screenings, physical fitness activities, mental health awareness, Parent Education, Free Mammograms for age 40+, etc. PVMG has initiated their mobile clinic providing street outreach services to individuals experiencing homelessness and residing in homeless shelters. As of March 2024, PVMG has served 250 individuals.
- **Recruitment and Retention (R&R) Grant:** All contracts under this grant program have been fully executed. As of March 2024, Bakersfield American Indian Health Project has recruited 1 primary care physician, Clinica Sierra Vista has recruited 1 Geriatrician and retained 1 psych nurse practitioner, Kern Valley Health Care District has retained 3 nurse practitioners, and 2 behavioral health providers were recruited by Behavioral Momentum and Rhema Therapy.
- **Healthcare Workforce Initiative:** All nine (9) organizations have successfully executed their contracts and initiated projects. In Q1 of 2024, KHS would like to highlight Bakersfield Memorial Hospital. The hospital is developing a New Graduate Medical Educational (GME) Program in 2025 in partnership with Morehouse under "More in Common Alliance" to recruit residents who will practice in Kern County. Bakersfield Memorial Hospital began collaboration with Morehouse School of Medicine to finalize the planning, designing, and construction phase of the project. The hospital contractor has completed test fit plans and programming.

Grants Next Steps:

As part of this endeavor, close collaboration with providers and Community-Based Organizations (CBOs) is maintained to ensure steady progress toward the outlined milestones in their contracts. To ensure effective monitoring, we will continue collect monthly progress reports from both providers and CBOs. This ongoing assessment will ensure alignment with the agreed-upon milestones and maintaining consistent progress towards the overarching goals of the initiatives.

INCENTIVE PAYMENT PROGRAM FUNDING

Background

The CalAIM Incentive Payment Program (IPP) is intended to support the implementation and expansion of Enhanced Care Management (ECM) and Community Supports (CSS) by incentivizing managed care plans (MCPs) to invest in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports.

IPP Program Year 1 | January 1, 2022 – December 31, 2022

Kern Health Systems has successfully finalized IPP Year 1. As of March 2024, all milestones have been completed and checks are pending for disbursement.

IPP Program Year 2 | January 1, 2023 – December 31, 2023

In the second year of the Incentive Payment Program, seven (7) out of the nine (9) providers/CBOs have successfully completed all designated milestones, allowing them to access the full funding awarded. KHS would like to highlight the ongoing efforts and commitments of Dr. Bichai's Enhanced Care Management (ECM) Program. The provider hired 2 ECM Lead Care Manager, 1 Officer Manager, and enrolled a total of 60 members.

In addition, KHS finalized and submitted "Submission 4" of IPP PY 2 to Department of Health Care Services (DHCS) on March 1st, 2024.

IPP Program Year 3 | January 1, 2024 – June 30, 2024

A total of nine (9) providers and CBOs were contracted in IPP PY3 funding for Enhanced Care Management and Community Support Services. Five (5) out of the nine (9) providers have successfully executed agreements and have started working on projects specific to their milestone.

IPP Next Steps:

Ongoing collaborative efforts with the providers will ensure the successful attainment of program milestones in the subsequent phases. The next steps will prioritize IPP Y3, (1) obtaining the 4 outstanding agreements, (2) schedule reporting requirement training, and (3) begin processing reimbursement requests.

HOUSING AND HOMELESSNESS INCENTIVE PROGRAM

Background | January 1, 2022 – December 31, 2023

As a part of the State's overarching home and community-based services (HCBS) spending plan, the California Department of Health Care Services (DHCS) launched the Housing and Homelessness Incentive Program (HHIP). HHIP aims to prevent and reduce homelessness and housing instability & insecurity by addressing social determinants of health while improving health outcomes and accessibility to whole-person care for those who are a part of the Medi-Cal population and simultaneously experiencing or at risk of being homeless. Final fund distribution is contingent on meeting all DHCS outcomes.

Q1 2024 Updates

Project Completion: Among the 18 participating providers/Community-Based Organizations (CBOs), 11 have successfully completed their projects, drawing down all allocated funds.

Project Highlight: Casa Esperanza is in the final stage of renovations for two (2) permanent housing facilities and are in the process of interviewing potential candidates.

HHIP Next Steps:
Ongoing Engagement: There are currently seven (7) outstanding projects that have been amended and will be completed by December 31, 2024 due to construction and permit delays.

STUDENT BEHAVIORAL HEALTH INCENTIVE PROGRAM (SBHIP)

Background
The State Budget for 2021 – 2022 included $13.2 million over three years in incentive funding to build infrastructure, partnerships, and capacity for school behavioral health services in Kern County. In collaboration, KHS and HealthNet convened several stakeholders in Kern County including local education and behavioral health agencies, to collectively identify specific school districts, student populations, and interventions to build infrastructure and support behavioral services on or near campuses.

Status Update
Kern County Superintendent of Schools (KCSOS) is the fiduciary intermediary for the SBHIP initiative. Each participating school district submitted their bi-quarterly reports in December 2023, which are currently under review with Department of Health Care Services (DHCS) awaiting final approval. All districts remain on target to meet their proposed outcomes. Minor construction delays related to facility modifications are being remediated. Data sharing agreements are in progress for final execution with KCSOS and the school districts. MOU templates under revision for final implementation.

DHCS Approval Letter: KHS is approved for 12.5% of the Targeted Intervention allocation under SBHIP based on the reporting period from July through December 2023. KHS scored 100% on the most recent submission and remains eligible for additional funding milestone payments upon DHCS's approval of required deliverables and for meeting predefined goals and metrics.

KHS APRIL 2024 ENROLLMENT

Member Demographics

Member Age	
0-5	12%
6-18	30%
19-44	36%
45-64	16%
65+	6%

Ethnicity	
Hispanic	63%
Caucasian	17%
No Valid Data	10%
African American	6%
Asian Indian	1%
Filipino	1%
Other	2%

Language	
English	68%
Spanish	31%
Other	1%

Percentage Decrease in Membership from previous month.

	Enrollment Type						
	FAMILY-ADULT	FAMILY-CHILD	FAMILIY-OTHERS*	Seniors & Persons with Disabilities (SPDs)	Adult Expansion	Long Term Care	Total KHS Medi-Cal Managed Care Enrollment
2024-03	75,514	171,836	23,248	22,055	116,934	497	410,084
2024-04	74,917	170,578	23,065	22,081	115,948	501	407,090
% Change	**-0.8%**	**-0.7%**	**-0.8%**	**0.1%**	**-0.8%**	**0.8%**	**-0.7%**
*Family-Others = Duals and BCCTP							

Enrollment Update: The unwinding of Medi-Cal continuous enrollment provision began April 1, 2023, for Medi-Cal eligibles who were due to renew their Medi-Cal eligibility starting in June 2023. Thus, beginning in June 2023, the "automated discontinuance process" for Medi-Cal Redeterminations resumed when beneficiaries do not complete the Annual Eligibility Redetermination process.

COMMUNITY EVENTS

KHS will share sponsorship in the following events in April and May:			
Organization Name	**Event Name**	**Purpose**	**Donated Amount**
The Open-Door Network	Reimagine	Support The Open Door Network Homeless Services Campus, the only shelter facility in Kern County for families, and single parents with accompanying children experiencing homelessness.	$5,000
H.E.A.R.T.S. Connection	Autism on the Run	Provide support to parents to improve their children's education and their lives in our community.	$1,500
Global Family & the Daughter Project	Best of Bakersfield Annual Gala	Work to prevent and intercept child trafficking and systematic abuse and provide long-term and family-based care for children who are victims of commercial sexual exploitation and other forms of abuse.	$2,000
Kern Valley Hospital Foundation	River Rhythms, Crab Fest, KVHD Health Fair	Support local scholarship programs for those going into the medical, public safety or stem fields. KVHD is also exploring the possibility of adding exercise equipment at Mountain Mesa Park encouraging the community to be more physically active.	$5,000

Wind Wolves Preserve	9th Annual Spring Nature Festival	This two-day event welcomes thousands of visitors to celebrate the season by offering exhibits, guided hikes, and other educational and physical activity programs.	$2,500
Active Bakersfield Alliance/ Mercury Event	2024 Bakersfield Marathon	Proceeds support the wellbeing of youth in our community - CSUB Scholarships, Healthy Kids in Healthy Homes and Downtown Elementary School.	$3,000
Bakersfield North Rotary	Dinner at the Derby	Support life-changing programs for children in our community by ensuring they have access to educational, enrichment, and recreational activities that motivate, inspire, and positively impact their lives.	$10,000
Bakersfield West Rotary	29th Annual Cioppino Feed	Support the Bakersfield West Rotary Stroope Family Foundation, Wounded Heroes Fund, ADAKC, Boys & Girls Club, Ronald McDonald House	$2,500
Black Infant Maternal Health Initiative	Race Against Birth Inequity 5K Run/Walk	Address the health gaps seen in the County's Black mothers, babies, and children.	$500
Valley Fever Institute at Kern Medical	2024 Valley Fever Walk	Supports programs and research at the Valley Fever Institute at Kern Medical.	$15,000
Be Finally Free	Interesting Men Who Cook	Support this non-profit organization's mission to restore and equip individuals affected by addiction, crime, incarceration, and poverty.	$1,000
NAACP UBAC	2024 The United Black America Conference	African American leaders will gather to review current issues in Education, Health, Economic Empowerment, etc. and create solutions.	$2,500
Harvey L. Hall Lights & Sirens	Annual Harvey L. Hall Lights & Sirens	Support the long-term care and recovery needs burn survivors and their families require.	$2,500
CALM	KEEP CALM Jamboree	Proceeds benefit Kern County Superintendent of Schools' two outdoor education programs - CALM and Camp KEEP.	$5,000
JJ's Legacy	14th Annual Golf Classic & Gala	Support educating about the importance of organ, eye, and tissue donations, increasing the number of registered donors, and providing compassionate support to donor and recipient families.	$5,000
NOR Chamber of Commerce	2024 Golf Tournament	Support the NOR Education Community Fund to offer scholarships for all high school in North Bakersfield.	$1,500
The Mission of Kern County	4th Annual Spring Gala	Support The Mission of Kern County in serving the homeless community.	$5,000
Bakersfield Sikh Women's Association	7th Annual Sikh Women's Association	Support college scholarships for high school students along with local homeless and community wellness programs.	$5,000
Kern Community Foundation	2024 Women's and Girls' Fund Luncheon	Kern Community Foundation believes in philanthropy – the practice of giving now and making long-term investments to support effective charitable organizations and programs forever.	$1,800
Bakersfield Museum of Art	ARTMIX	Support the success and promotion of visual arts in our community.	$1,000

Flood Ministries	2nd Annual Spring Gala	Serve those struggling with homelessness, linking them to resources and services along with support during the housing process (supplies and essential furniture items for those moving into their first homes).	$5,000
Kern Economic Development Foundation	Kern County Career & Stem 2024 Expo	Over 600 employers from a wide array of Kern County companies gather at the Career Technical Education Center (CTEC) in Bakersfield to engage with thousands of middle school and high school students from our community.	$2,500
Garden Pathways	Great American Cleanup	Help reduce the amount of waste and debris in the 34th Street Neighborhood.	$400
Bakersfield Symphony Orchestra	Delano Free Family Concert & Resource Fair	Provide new experiences and beautiful expressions of some of the world's greatest musical creations.	$5,000
United Way of Central Eastern California	2nd Annual Charity Classic Golf Tournament	Support Healthy Minds and Bodies programs along with early childhood literacy and education programs.	$1,000
The Bakersfield Women's Business Conference	35th Annual Bakersfield Women's Business Conference	Help attendees navigate through the new endeavors they choose to face and equip them with tools and a network to help them reach their goals.	$7,100
Garden Pathways	High Tea - Women with a Heart of Bakersfield	Support mentoring and education services for youth and families who are seeking to overcome the challenges of poverty and at-risk conditions.	$1,250
Wasco High School	Spring Paint Night	Improve quality of life by providing a safe environment to express their creativity and engage with their family and friends.	$750
Kern County Cancer Foundation	3rd Annual Dustbowl to Diamonds	Support their efforts to assist Kern County residents who need financial assistance in obtaining treatment for cancer and associated diseases.	$5,000
NAMI	Mental Health Gala	Raise awareness about mental health and provide support, education and advocacy.	$1,500
CASA of Kern County	CASA Derby Party	Support their mission of giving abused and neglected children a caring and highly trained advocate.	$3,000
Bakersfield College Foundation	Bakersfield College Nursing Students	In collaboration with Clinica Sierra Vista, sponsor the Bakersfield College Nursing students pinning luncheon.	$1,500
League of Dreams	Night of Illusion	Give every child a chance to play sports by providing training and team camaraderie.	$5,000
Leukemia & Lymphoma Society	Bakersfield Campaign Grand Finale Celebration	Support thousands of youth and adults in their fight against blood cancers.	$5,000
Bakersfield East Rotary Foundation	Vino Amore	Proceeds benefit Valley Fever Americas Foundation, Ronald McDonald House of Bakersfield, and the Bakersfield East Rotary Foundation.	$2,500

Morning Star Fresh Food Ministry	Annual Banquet	Provide fresh food to feed families in need in the Bakersfield community and equip local churches, non-profits, and distribution sites to provide an open door with a box of fresh food.	$3,500
Kern Economic Development Corporation	Kern County 2024 Economic Summit	Support their goal to create a strong and diverse economy in Kern County.	$2,500
Children First	2024 East Bakersfield Festival	Support the creation of prosperous communities by ensuring that all children live in healthy, safe, and nurturing neighborhoods that promote academic achievement and success.	$5,000
American Heart Association	Kern County Heart Ball	Support their mission to ensure their research and community efforts continue to save lives.	$7,500
Bakersfield Memorial Hospital	Larry Carr Memorial Golf Tournament	Proceeds support the latest equipment and technology needs of Bakersfield Memorial Hospital.	$2,500
Kern County Aging & Adult Services	25th Annual Elder Abuse Prevention Conference	Promote awareness of elder abuse and help prevent and recognize neglect.	$250
Kern County Black Chamber of Commerce	The Vibes & Victory Gala	Support the entrepreneurial ecosystem in Kern County by providing black, minority businesses and non-profits with resources that will fuel personal and professional growth.	$5,000
Bags of Love Foundation	Gold Ribbon Gala	Honor children, teens, and young adults affected by cancer treatment, their families, caregivers, and the medical and volunteers who stand by them.	$1,500
Independent Living Center of Kern County	5th Annual Deaf Community Day	Bring together diverse communities to celebrate and promote Deaf culture, awareness, and inclusion.	$2,000
Youth 2 Leaders Education Foundation	The Bridging Voices Conference	Provide English Language Learner parents with essential tools, resources, and knowledge to support their children's academic journey.	$2,500

KHS will also participate in the following events in April and May:

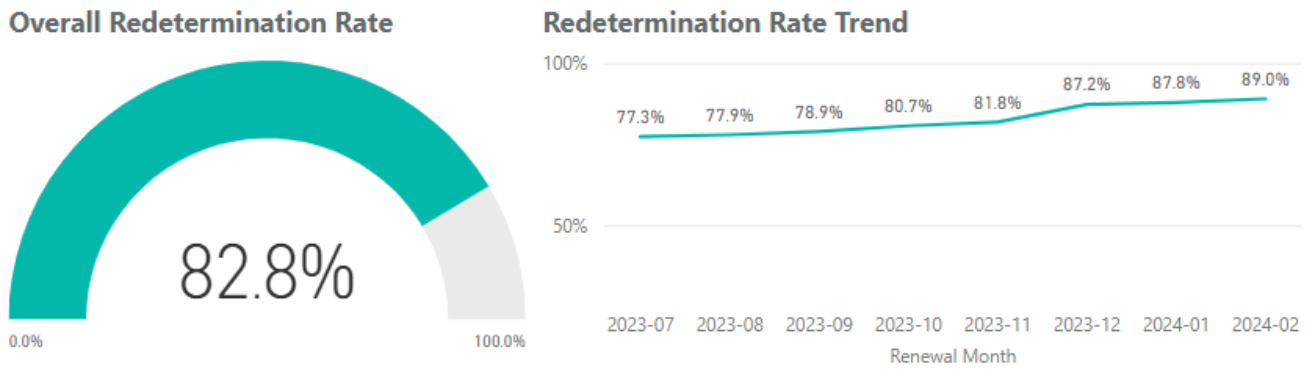
Organization Name	Event Name	Location	Date	Time
Delano Union Elementary School District	Kinder Blastoff	Pioneer School – 1001 Hiett Ave. Delano	4/4/2024	4:00pm – 6:00pm
Kern County Human Services	Employee Resource Fair	100 E California Ave. Bakersfield	4/5/2024	9:00am – 12:00pm
Kern Valley Hospital	Spring Health Fair	6401 Lake Isabella Blvd. Lake Isabella	4/6/2024	10:00am – 1:00pm
Grimmway Farms	2024 Health and Benefits Fair	1142 S P St. Bakersfield	4/7/2024	12:00pm – 4:00pm
Delano Union Elementary School District	Albany Park School Carnival	234 W 20th Ave. Delano	4/10/2024	3:30pm – 6:00pm

American Cancer Society	Relay for Life	1331 Cecil Ave. Delano	4/13/2024	10:00am – 2:00pm
McFarland USA Foundation	7th Annual McFarland USA	701 E Sherwood Ave. McFarland	4/13/2024	5:00am – 8:00am
Panama-Buena Vista Union School District	Parent Resource Fair	4200 Planz Rd. Bakersfield	4/18/2024	5:30pm – 7:30pm
First Presbyterian Church	Food Pantry	1705 17th St. Bakersfield	4/18/2024	7:00am - 9:30am
Greater Bakersfield Legal Assistance (GBLA)	11th Annual Fair Housing Conference	801 Truxtun Ave. Bakersfield	4/18/2024	9:00am – 2:30pm
Grow Academy Shafter	Health and Wellness Community Resource Fair	471 W. Los Angeles Ave. Shafter	4/20/2024	9:00am – 12:00pm
The Rock Church	Community Outreach Event	1400 Norris Rd. Bakersfield	4/20/2024	10:00am–12:00pm
Rasmussen Senior Center	Spring Senior Health Fair	115 E Roberts Lane Bakersfield	4/24/2024	8:00am – 12:00pm
Greenfield Family Resource Center	Health and Safety Community Resource Fair	725 Capitola Rd. Bakersfield	4/25/2024	3:30pm – 6:30pm
Kern County Library	Día del Niño/Day of the Child Book Fiesta	701 Truxtun Ave. Bakersfield	4/30/2024	3:00pm – 6:00pm
Kern County Superintendents of Schools	Mental Health Awareness Fair	300 E. Truxtun Ave. Bakersfield	5/2/2024	5:00pm – 7:00pm
Kern County Behavioral Health and Recovery Services	Family Day at CALM	10500 Alfred Harrell Hwy. Bakersfield	5/4/2024	9:00am – 3:00pm
Kern County Public Health	Know Your Numbers	6405 Lake Isabella Blvd, Lake Isabella	5/8/2024	10:00am–11:00am
Community Action Partnership of Kern (CAPK)	Rethink Your Drink Day Resource Fair	1000 S. Owens St. Bakersfield	5/11/2024	10:00am – 2:00pm
Wasco Union High School	Mental Health Fair	1900 17th St. Wasco	5/13/2024	12:00pm – 1:00pm
First Presbyterian Church	Food Pantry	1705 17th St. Bakersfield	5/16/2024	7:00am – 9:30am
Shafter Family Resource Center	2024 Community Resource Fair	331 Shafter Ave. Shafter	5/17/2024	5:30pm – 7:30pm

MEDI-CAL RENEWAL UPDATE

The Medi-Cal Outreach, Enrollment, and Renewal Assistance Agreement with the Kern County Department of Human Services was extended for an additional two years through June 30, 2026. The current agreement expires on June 30, 2024. KHS continues direct outreach activities to members who must complete the Medi-Cal renewal process or those in a hold status who have 90 days (from disenrollment date) to complete their renewal to be retroactively enrolled to their disenrollment date. Member communications include: text messages, mail, robocalls, phone calls, and the KFHC Member Portal. KHS also continues working with providers, local Medi-Cal enrollment entities, and community-based organizations to support the correct completion of renewal applications.

Below are Medi-Cal Redetermination Trending Rates.



MEMBER ENGAGEMENT UPDATE

Member Engagement Representatives (MERs) are working at the Family Resource Centers in Shafter, Ridgecrest, Mojave, Lake Isabella, and Frazier Park, along with the Delano Union School District Office and the Taft Historic Fort. MERs continue outreach efforts including benefits, member rewards, and Medi-Cal renewal/expansion awareness at various events and collaborative meetings in rural communities. Member Engagement is collaborating with Health Equity to facilitate quarterly KHS Community Advisory and Regional Advisory Committee meetings.

Employee Video Newsletter

KHS' Video Employee Newsletter can be seen by clicking the following link:
https://vimeo.com/933490642

KHS Media Clips

We compiled local media coverage that KHS received in February 2024 – March 2024. Please see **Attachment C: Public Relations/Publicity Media Clips**.

KHS ORGANIZATIONAL HIGHLIGHTS

Employee Highlights

Employee Appreciation Day: In March, our employees were treated with a breakfast in their honor to express our gratitude for their dedication to our members. Employees were welcomed with a red-carpet entrance and a festive atmosphere. As they enjoyed a delicious breakfast spread featuring pastries, fruits, juices, and freshly brewed coffee, management and employees alike had the opportunity to give "shout-outs' to recognize the outstanding contributions of their colleagues. It provided an excellent platform for our staff to express appreciation, share success stories, and strengthen team bonds. Our Executive Leadership Team took the opportunity to thank our team for their dedication and contributions toward the company's success. The Employee Appreciation Breakfast served as a meaningful gesture to acknowledge the efforts of our valued team members.

Family Movie Night: KHS also put on a delightful Family Movie Night for employees and their families. The event took place at the California Living Museum on Saturday, March 9. Families gather under the stars to enjoy a special screening of “Lyle, Lyle, Crocodile,” a popular family-friendly movie. Attendees were treated to hot dogs, popcorn, snacks, and refreshments to enhance the movie-watching experience. It was a fantastic opportunity for employees to bond with their families outside of the workplace and create lasting memories. The Family Movie Night was a resounding success, fostering a sense of camaraderie and community among our employees and their loved ones.

Provider and Community Partner Trainings

KHS held an informative training session equipped with knowledge and skills necessary to support individuals experiencing Intimate Partner Violence (IPV) in the South Asian Community for Medical and Behavioral Health Providers. There was representation from CommonSpirit Health, Good Samaritan, Pinnacle, Telehealth Partners, Open Door Network, Jakara Movement, Inspire Me Counseling, etc. Key focus areas from the session included:

- **Cultural Sensitivity**: insights into the unique cultural nuances and barriers surrounding IPV within the South Asian community.
- **Identification and Screening:** effective techniques for recognizing signs of IPV and conducting sensitive screenings.
- **Resources and Referrals:** exploring available resources and referral pathways to connect survivors with appropriate support services.

KHS COMMUNITY WELLNESS HIGHLIGHTS

KHS sponsored the One Sight Vision Clinic, where students from 14 school districts received an eye exam and were fitted for glasses. At this event, these students were able to come in and leave with glasses as needed. 831 students were screened and 777 received prescriptive eye wear, that's 94%! This project will expand and continue to offer services to all low-income schools in Kern County

In February, the health education team facilitated 7 classes: activity & eating (A&E), Breathe Better (Asthma), Fresh Start (Smoking Cessation), Fresh Start + (Cessation Maintenance), Diabetes Prevention Program (DPP), Eat Healthy Be Active (EHBA), and Diabetes Empowerment Education Program (DEEP). The DEEP program was officially launched on February 1st, and just within the first 3 classes, KHS had a total of 29 participants! With other exciting news, EHBA had their first virtual class session this month with at least 12 participants!

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Goal 1	
Goal Name | Description	**Quality and Equity** Deliver exceptional quality outcomes and health equity for KHS members
Strategy 1	Increase overall quality with a drive toward achieving Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and closing disparity gaps.
Accomplishments	• Currently meeting 7 of 18 MCAS measures compared to 5 of 15 measures in previous year, and 6 additional measures within 5%. • As part of the recent Quality Grants Program, 5 mobile units are now operational. KHS is providing support with outreach, geo-mapping, and demographic data. • DHCS Children's Health Equity Sprint team established. In the planning stages of identifying provider pilot sites to carry out a minimum of 5 interventions before March 2025. • KHS Outreach team focused on Children's domain of care.
Strategy 2	Meet National Committee for Quality Assurance (NCQA) standards and work toward accreditation.
Accomplishments	• Implementation of required systems, policy, and reporting requirements is on track according to the 2024 work plan. • Applications for the Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) were both accepted, and our survey dates are confirmed for 4/8/2025 (HPA) and 6/10/2025 (HEA). • Mock audit file reviews completed for Population Health Management and Utilization Management teams.
Strategy 3	Further maturity of the organization's Health Equity programs under the direction of the Chief Health Equity Officer.
Accomplishments	• 12 local providers accepted into the 1st cohort of the DHCS Equity Practice Transformation program. Maximum potential payment to providers would total $26 million, pending completion of milestones. • Hosted and participated in numerous listening sessions and committee meetings including: 4 Health Equity Listening sessions throughout Kern County, launched the Executive Quality Improvement Health Equity Committee (EQIHEC) and the Health Equity Transformation Steering Committee (HETSC), Community Advisory Committee (CAC), CA Racial Equity Commission, provider and community cultural competence training, and Doula forum.

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	• Made progress in data collection and surveying including the completion of the Employee Engagement Survey, the launch of the DEIB Survey, and the launch of the Culture Club Survey.

Goal 2	
Goal Name | Description	**Workforce** Develop initiatives for the recruitment and retention of both internal and external workforce needed to fulfill KHS' mission
Strategy 1	Identify Provider Network needs and gaps to inform target areas and approaches.
Accomplishments	• Reviewed growth that occurred in 2023 and identified 8% increase in Primary Care Provider and 8% increase in DHCS Core Specialty Providers. • Completed Q1 2024 Network Review and 2023 Annual Network Capacity Review; will be utilized for network expansion work planning, goal setting, and benchmarking. • Held inaugural quarterly Access & Availability and Delegation Vendor Oversight Committee (renamed Network Adequacy Committee) to review and steer access monitoring activities.
Strategy 2	Strengthen and expand the KHS provider network through innovative and effective recruitment and retention programs.
Accomplishments	• Hired Provider Recruitment Specialist to begin in Q2 2024 – will optimize Plan recruitment efforts, including available provider identification, outreach efforts, and tracking. • Utilizing gap assessment conducted as part of Q1 2024 Network Review and 2023 Annual Network Capacity to create effective recruitment strategy.
Strategy 3	Identify business needs and gaps in current workforce to inform target areas and approaches.

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Accomplishments	• Working with compensation consultant, Mercer, to review the efficacy of KHS' salary structure and competitiveness within the healthcare industry. Mercer provided an initial framework and comparison to further develop.
Strategy 4	Meet the growing operational demands of the organization by creating recruitment and retention programs for internal staffing and leadership needs.
Accomplishments	• KHS held its second annual Career Expo. Over 450 attendees were able to learn from department leadership about the available opportunities to become a part of the KHS Team. • Coordinated with each department to develop this year's list of Summer Extern opportunities. Each of those opportunities have been advertised and made available to potential externship seekers. Interviews are forthcoming. • Continued development of a self-funded health plan option for KHS employees that would expand the available list of provider options for employees and their families in 2025. Nearing completion of the procurement process to select a third-party administrator, medical plan network, and pharmacy benefit manager.

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Goal 3	
Goal Name | Description	**CalAIM** Continue to develop, implement, and grow the programs and policies included under DHCS' CalAIM initiative
Strategy 1	Continued growth and maturity of existing CalAIM programs – Population Health Management, Enhanced Care Management, Community Supports, and Long-Term Care.
Accomplishments	• Expansion of ECM providers to an additional 5 program providers which launched on March 1st, including The Open Door Network, St. Vincent Preventative Family Care, Unity Care Hospitalists, Kern Psychiatric Health and Wellness Center, Inc., and Family HealthCare Network. This continues to diversify the ECM program provider network in contracting with specialty program providers. • Reviewed Letters of Interest for the CalAIM Incentive Payment Program Year 3 funding. Awardees will be prioritized for contracting in 2024. Currently, the program expects to onboard at least 6 more program providers throughout the end of 2024. • Onboarded 3 new Community Supports providers to provide continuity of care for members transitioning from Health Net to KHS. • New sites opened for recuperative care and short-term post hospitalization. Finalizing contracts with 3 additional Community Supports providers to launch services in Q2. • Developing Chronic Kidney Disease program under Population Health Management. Program description and scope or work developed. Gathering data on members who would benefit from this program.
Strategy 2	Strengthen Existing and Establish New Community Partnerships to Support CalAIM.

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Accomplishments	• Executing agreements with providers and Community Based Organizations who were awarded CalAIM Incentive Payment Program funding for 2024. 5 of 9 providers have executed agreements so far, and they have started implementation of their projects. • Awarded Community Based Initiative grant funding to 15 organizations. Held a press conference in February to announce the initiative. All 15 organizations have initiated their projects. • Attended local collaborative meetings related to the Justice Involved Population, Homeless Youth, and CalAIM Roundtable. • Conducted orientation and overview of Community Supports services to several organizations. • Regular meetings with various County agencies to support execution of MOUs to improve coordination. Progress reports to DHCS.
Strategy 3	Ongoing collaboration between KHS staff and the Department of Health Care Services (DHCS) on the development and implementation of future CalAIM initiatives.
Accomplishments	• Developed scope and goals of the Transition of Care Services (TCS) project. Internal TCS team established, and initial training completed. Low-risk members who experience a care transition are sent a letter and supported by the internal team. • The Birth Equity Population of Focus for both Adults and Youth went into effect as of January 1, 2024, for the ECM program. In Q1, the team conducted additional education for both program providers and the broader community related to this new ECM population. • The Justice Involved Initiative and the implementation of ECM for individuals transitioning out of incarceration also went live as of January 1, 2024. In preparing for the implementation of pre-release services throughout the county, KHS has continued routine discussions with Kern County Public Health, California Department of Corrections and Rehabilitation, Kern County Sherriff's Office, Kern County Probation, and Kern County Behavioral Health and Recovery Services. In addition, the KHS ECM team has continued to partner with our other county MCPs to ensure network sufficiency and overlap appropriately. • Working with Habitat for Humanity in preparation to launch the last remaining Community Support Service (Environmental Accessibility) in July.

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Goal 4	
Goal Name | Description	**Medicare Duals Special Needs Plan (D-SNP)** Develop and implement a competitive Medicare Duals Special Needs Plan (D-SNP) product in alignment with State and Federal requirements
Strategy 1	Development of the long-term D-SNP strategy and implementation roadmap.
Accomplishments	• Established a Delegation Model. • Developed and distributed Delegation Proposals to potential partners. • Designed Delegation Proposal Selection Matrix.
Strategy 2	Analysis of the appropriate market factors to maximize the competitiveness of the product.
Accomplishments	• Market, Product, and Competitor analysis to be updated in 2024 with Delegated Partner.

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Strategy 3	Design and implementation of an efficient Medicare D-SNP offering with competitive advantages, leveraging KHS innovation and new business/new product development capabilities.
Accomplishments	• Identified internal D-SNP Subject Matter Experts to build a knowledge base for DSNP line of business. • Kicked off Regulatory Filings Project for DMHC, DHCS, and CMS. • Procured HEDIS/STARS software solution from Cotiviti.

Goal 5	
Goal Name | Description	**Behavioral Health** Improve the integration, coordination and outcomes for members experiencing behavioral and mental health conditions
Strategy 1	Development and maturity of an internal Behavioral Health Department.
Accomplishments	• Expanded internal workforce from 3 staff to 12 staff, including a Supervisor, Senior Support Clerk, Care Managers, Care Coordinators, and Community Health Workers. • Developed member satisfaction survey for Behavioral Health services. • Launched the Behavioral Health Advisory Committee.
Strategy 2	Evaluate and ensure the mental health provider network is adequate to provide all outlined non specialty mental health services (NSMHS).
Accomplishments	• Implementation of a new workflow to facilitate prompt resolution of Behavioral Health Grievances. • Operational reports went into production to assist with tracking timeliness of access. • Recruitment & Retention funding was awarded to 6 Providers for Recruitment and Retention efforts focused on BH Providers.

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Strategy 3	Communication and coordination with County Behavioral Health regarding DHCS requirements.
Accomplishments	• Initiated Behavioral Health participation in the weekly eating disorder consult meetings with MHP. • Worked in collaboration with County Behavioral Health, Anthem, and Kaiser to finalize draft of combined MOU. MOU submitted to DHCS for approval on 3/25.
Strategy 4	Further evaluate and develop the implementation of Primary Care Provider Roles with Substance Use Disorder services / Medication Assisted Treatment (MAT) services.
Accomplishments	• Created MAT workflow to add to the 2024 Project Charter that will launch in Q2.

Goal 6	
Goal Name | Description	**Member Engagement** Increase member engagement in their health care
Strategy 1	Identify and implement innovative and effective offerings designed to engage members more in their health care.
Accomplishments	• Member Engagement Representatives are successfully occupying offices on a regularly scheduled basis in Delano, Shafter, Taft, Frazier Park, Ridgecrest, Mojave, and Lake Isabella • Posted job opening for the Member Engagement Program Manager • Revised job descriptions for Member Engagement Representatives in progress
Strategy 2:	Work with internal staff and external partners to develop strategies that ensure continuity of coverage for our members.
Accomplishments	• The Medi-Cal Outreach, Enrollment, and Renewal Assistance Agreement with the Kern County Department of Human Services was extended for an additional two years through June 30, 2026.

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	• Continuing cadence of outreach to members due for reenrollment including manual phone calls, monthly letters, weekly and daily text messages, and the member portal. • Community Enrollment Navigators in-office schedules were modified to accommodate additional locations for in-person member assistance. • Continuing efforts for community awareness through flyer distribution, website content, and community partner involvement.
Strategy 3:	Leverage convenient technology to enhance the effectiveness of engagement and suit members' needs.
Accomplishments	• Member Engagement Project kicked off for the Customer Relations Management (CRM) and new Member Rewards vendor. • The new Member Rewards vendor was procured, and that portion of the project is making good progress. • PNM Screening Tools project is developing an application for member assessments including the HRA.

Goal 7	
Goal Name | Description	**KHS Foundation** Explore the opportunity for KHS to create a non-profit foundation to further its mission in the community
Strategy 2	Begin collaboration with law firm on the corporate formation documents and finalize the development phase of the foundation.
Accomplishments	• Received a finalized copy the Articles of Incorporation for the Kern Family Foundation. This not only demonstrates the progress we have made, but also sets the groundwork for our future endeavors with the foundation. • In collaboration with legal, began development and drafting of the bylaws for the foundation. Having well-defined bylaws establish a clear roadmap and framework for the organization's operations, governance, and mission.

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ATTACHMENT B: BILL TRACKER

Title	Description	Status
AB 236 (Holden)	This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2025, unless specified criteria applies. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. This bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to use to request directory information from providers and would authorize the departments to establish a methodology and processes to ensure accuracy of provider directories. The bill would require the health plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB236	CAHP/LHPC Opposed 01/30/24 - In Senate. Read first time. To Com. on RLS. for assignment.

AB 1316 (Irwin)	This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment. The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the beneficiary. The bill would require coverage, including by a Medi-Cal managed care plan, for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of duration, or whether the beneficiary is voluntary, or involuntarily detained for evaluation and treatment, including emergency room professional services. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1316	01/25/24 - In Senate. Read first time. To Com. on RLS. for assignment.
AB 1783 (Essayli)	Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would state the intent of the Legislature to enact legislation to remove all taxpayer funding for health care for illegal immigrants from the California State Budget. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1783	01/04/24 - May be heard in committee February 3.

AB 1842 (Reyes)	This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product or another opioid antagonist approved by the United States Food and Drug Administration, or a buprenorphine product or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, to prior authorization or step therapy. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1842	03/19/24 - From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (March 19). Re-referred to Com. on APPR.
AB 1895 (Weber)	The bill would require an acute care hospital that offers maternity services, when those services are at risk of closure, as defined, in the next 12 months to provide specified information to the Department of Health Care Access and Information as well as the State Department of Public Health, including, but not limited to, the number of medical staff and employees working in the maternity ward and the hospital's prior and projected performance on financial metrics. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 6 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health, to conduct a community impact assessment to determine the 3 closest hospitals offering maternity services in the geographic area and their distance from the at-risk facility. The bill would require the hospital to provide public notice of the potential closure, including the results of the community impact assessment, and other specified information on the hospital's internet website 90 days in advance of the proposed closure. The bill would require the public to be permitted to comment on the potential closure for 60 days after the notice is given, and would require at least one noticed public hearing be conducted by the hospital. The bill would also require the hospital to accept written public comment. By creating a new crime, this bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1895	03/19/24 - Re-referred to Com. on HEALTH.
AB 1936 (Cervantes)	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes, as specified. This bill would require the program to conduct at least one maternal mental health screening during pregnancy, and at least one additional screening during the first 6 months of the postpartum period. The bill would impose a state-	03/12/24 - Re-referred to Com. on HEALTH.

	mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1936	
AB 1943 (Weber)	This bill would require the department to produce a public report on telehealth in the Medi-Cal program that includes analyses of, among other things, (1) telehealth access and utilization, (2) the effect of telehealth on timeliness of, access to, and quality of care, and (3) the effect of telehealth on clinical outcomes, as specified. The bill would authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report's findings. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1943	04/04/24 - Read second time and amended.
AB 1970 (Jackson)	Existing law establishes, within the Health and Welfare Agency, the Department of Health Care Access and Information, which is responsible for, among other things, administering various health professions training and development programs. Existing law requires the department to develop and approve statewide requirements for community health worker certificate programs. Existing law defines "community health worker" to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. This bill would require the department to develop criteria for a specialty certificate program and specialized training requirements for a Black Mental Health Navigator Certification, as specified. The bill would require the department to collect and regularly publish data, not less than annually, including, but not limited to, the number of individuals certified, including those who complete a specialty certificate program, as specified, and the number of individuals who are actively employed in a community health worker role. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1970	04/02/24 - Re-referred to Com. on HEALTH.

AB 1975 (Bonta)	This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, effective July 1, 2026, subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention. The bill would require the department to define the qualifying medical conditions for purposes of the covered interventions. The bill would require a health care provider, to the extent possible, to match the acuity of a patient's condition to the intensity and duration of the covered intervention and to include culturally appropriate foods. The bill would require the department to establish a medically supportive food and nutrition benefit stakeholder group, with a specified composition, to advise the department on certain related items. The bill would require the workgroup to issue final guidance on or before July 1, 2026. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1975	03/15/24 - In committee: Set, first hearing. Hearing canceled at the request of author.
AB 2043 (Boerner)	This bill would require the department to ensure that the fiscal burden of nonemergency medical transportation or nonmedical transportation is not unfairly placed on public paratransit service operators and would authorize the department to direct Medi-Cal managed care plans to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the fee-for-service rates for conducting that transportation, as described. The bill would require the department to engage with public paratransit service operators to understand the challenges as public operators of nonemergency medical transportation or nonmedical transportation services and would require the department to issue new guidance to ensure the fiscal burden is not unfairly placed on public operators on or before June 1, 2026. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2043	04/02/24 - Re-referred to Com. on HEALTH.

AB 2105 (Lowenthal)	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2105	CAHP Oppose 03/25/24 - In committee: Set, first hearing. Hearing canceled at the request of author.
AB 2110 (Arambula)	This bill would require the department to include (1) community-based organizations and local health jurisdictions that provide health services through community health workers and (2) doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would also require the department to update its internet website and the ACEs Aware internet website to reflect the addition of the Medi-Cal providers described above as authorized to provide ACEs screenings. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2110	02/20/24 - Referred to Com. on HEALTH.
AB 2129 (Petrie-Norris)	This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a licensed hospital or birthing center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2129	02/20/24 - Referred to Com. on HEALTH.

AB 2132 (Low)	This bill would require an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, as specified, to be offered a tuberculosis (TB) risk assessment and TB screening test, if TB risk factors are identified, to the extent these services are covered under the patient's health insurance, unless the health care provider reasonably believes certain conditions apply. The bill would also require the health care provider to offer the patient follow up health care or refer the patient to a health care provider who can provide follow up health care if a screening test is positive, as specified. The bill would prohibit a health care provider who fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability for that failure. The bill would make related findings and declarations. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2132	03/19/24 - From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 1.) (March 19). Re-referred to Com. on APPR.
AB 2200 (Kalra)	This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period, and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2200	03/21/24 - Referred to Com. on HEALTH.

AB 2250 (Weber)	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would make social determinants of health screenings a covered benefit for Medi-Cal beneficiaries and would require the State Department of Health Care Services or a Medi-Cal managed care plan to provide reimbursement for those screenings, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2250	04/03/24 - From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 2). Re-referred to Com. on APPR.
AB 2271 (Ortega)	Under this bill, prescription or nonprescription naloxone hydrochloride or another drug approved by the FDA for the complete or partial reversal of an opioid overdose would be a covered benefit under the Medi-Cal program. The bill would require a health care service plan contract or health insurance policy, as specified, to include coverage for the same medications under the same conditions. The bill would prohibit a health care service plan contract or health insurance policy from imposing any cost-sharing requirements for that coverage exceeding $10 per package of medication, and would prohibit a high deductible health plan from imposing cost sharing, as specified. The bill would make implementation of its provisions contingent on funding from the Naloxone Distribution Project. The bill's provisions would be inoperative when the state records 500 or fewer opioid deaths in a calendar year, and the bill would repeal these provisions on the following January 1. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2271	02/26/24 - Referred to Com. on HEALTH.

AB 2303 (Carillo)	This bill would, upon appropriation, require the State Department of Health Care Services to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment for specified health care facilities to account for the costs of complying with the minimum wage schedules described above. The bill would require that the alternative methodology be applied retroactively to January 1, 2025, until those costs are included in the prospective payment system rate. The bill would require the department to seek all necessary federal approvals or amendments to the state Medi-Cal plan to implement these provisions and would require the department to make any state plan amendments or waiver requests public 45 days prior to submitting them to the federal Centers for Medicare and Medicaid Services. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2303	04/03/24 - Re-referred to Com. on HEALTH.
AB 2339 (Aguiar-Curry)	This bill would expand the definition of telehealth "asynchronous store and forward" to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications. The bill would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when the patient requests an asynchronous store and forward modality, as specified. Existing law authorizes a health care provider to establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests that they do not have access to video, as specified. This bill would remove, from that exception, the option of the patient attesting that they do not have access to video. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2339	04/03/24 - From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 2). Re-referred to Com. on APPR.

AB 2340 (Bonta)	Existing federal regulations require the state to provide for a combination of written and oral methods designed to inform individuals eligible for EPSDT services, or their families, about the EPSDT program, within 60 days of the individual's initial Medicaid eligibility determination and, in the case of families that have not utilized EPSDT services, annually thereafter, as specified. Under those regulations, required information includes, among other components, the benefits of preventive health care and the services available under the EPSDT program and where and how to obtain those services. This bill would require the department to prepare written informational materials that effectively explain and clarify the scope and nature of EPSDT services, as defined, that are available under the Medi-Cal program. Under the bill, the materials would include, but would not be limited to, the information required in the above-described federal regulations or their successor. Under the bill, the informational materials would also include content designed for youth, for purposes of delivery of that content to a beneficiary who is eligible for EPSDT services and who is 12 years of age or older but under 21 years of age. The bill would authorize the department to standardize the materials, as specified, and would require the department to regularly review the materials to ensure that they are up to date. The bill would require the department to test the quality, clarity, and cultural concordance of translations of the informational materials with Medi-Cal beneficiaries, in order to ensure that the materials use clear and nontechnical language that effectively informs beneficiaries. The bill would require the department or a Medi-Cal managed care plan, depending on the delivery system, to provide to a beneficiary who is eligible for EPSDT services, or to the parent or other authorized representative of that beneficiary, as applicable, the informational materials within 60 calendar days after that beneficiary's initial Medi-Cal eligibility determination and annually thereafter. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2340	04/02/24 - Re-referred to Com. on HEALTH.

AB 2356 (Wallis)	Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2356	02/26/24 - Referred to Com. on HEALTH.
AB 2357 (Bains)	This bill would create the University of California San Joaquin Valley Regional Campus Medical Education Endowment Fund. Upon appropriation by the Legislature, the bill would require moneys in the endowment fund to be allocated to the University of California to support the annual operating costs for the development, operation, and maintenance of a branch campus of an existing University of California School of Medicine in the County of Kern. The bill would similarly require moneys in the endowment fund to initially be invested with the goal of achieving capital appreciation to create a balance sufficient to generate ongoing earnings to cover the estimated annual operating costs of a branch campus, as provided, and, upon the determination by the Controller that a sufficient balance is achieved and maintained in the endowment fund, would subsequently require moneys in the endowment fund to be invested to generate earnings to fund annual operating costs associated with the development, operation, and maintenance of a branch campus, as provided. The bill would similarly require moneys in the endowment fund to be used, upon appropriation by the Legislature and a determination by the Controller of sufficient funds in the endowment fund, to cover the University of California's estimated costs of applying for and obtaining approval and accreditation from the Liaison Committee on Medical Education, as provided. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2357	04/03/24 - In committee: Set, first hearing. Hearing canceled at the request of author.

AB 2376 (Bains)	This bill would expand the definition of "chemical dependency recovery services" to include medications for addiction treatment and medically managed voluntary inpatient detoxification. The bill would delete the requirement for chemical dependency recovery as a supplemental service to be provided in a distinct part of a general acute care hospital or acute psychiatric hospital, and instead would authorize those facilities to provide chemical dependency recovery services as a supplemental service within the same building or in a separate building on campus that meets specified structural requirements of a freestanding chemical dependency recovery hospital. The bill would delete the requirements for chemical dependency services to be provided in a hospital building that provides only chemical dependency recovery services or has been removed from general acute care use. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2376	04/01/24 - Re-referred to Com. on HEALTH.
AB 2428 (Calderon)	This bill, for purposes of the mutual agreement between a Medi-Cal managed care plan and a network provider, would require that the reimbursement be in an amount equal to or greater than the amount paid for the service in the Medi-Cal fee-for-service delivery system. Under the bill, no later than January 1, 2025, for payments commencing on July 1, 2019, a Medi-Cal managed care plan that has not reimbursed a network provider furnishing CBAS according to those provisions would be required to reimburse the network provider the difference between the amount required and the amount that has been paid. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2428	02/26/24 - Referred to Com. on HEALTH.
AB 2446 (Ortega)	This bill would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and colic, among others. The bill would establish diapers as a covered benefit for a child greater than 3 years of age who has been screened for or diagnosed with a condition that contributes to incontinence and would establish diapers as a covered benefit for individuals under 21 years of age, if necessary to correct or ameliorate a condition pursuant to specified standards. The bill would require the department to seek any necessary federal approval to implement this section. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2446	04/03/24 - From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 2).

AB 2449 (Ta)	This bill would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider, and would authorize the certification to be accredited by the American National Standards Institute. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2449	03/15/24 - In committee: Set, first hearing. Hearing canceled at the request of author.
AB 2466 (Carrillo)	Under this bill, a Medi-Cal managed care plan would be deemed to be not in compliance with the appointment time standards if either (1) fewer than 85% of the network providers had an appointment available within the standards or (2) the department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees, as specified. Under the bill, failure to comply with the appointment time standard may result in contract termination or the issuance of sanctions as described above. This bill would instead require a plan that has a previously approved alternative access standard to submit a renewal request on an annual basis, explaining which efforts the plan has made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard, as specified. The bill would require the department to consider the reasonableness and effectiveness of the mitigating efforts as part of the renewal decision. This bill would, effective for contract periods commencing on or after July 1, 2025, require the plan's and department's reports to include certain information and require the department's evaluation to be performed using a direct testing method, as specified. Under the bill, failure to comply with these provisions may result in contract termination or the issuance of sanctions. This bill would require that the data include, effective for contract periods commencing on or after July 1, 2025, the number of requests for alternative access standards, categorized by new and returning patients, and the number of allowable exceptions for the appointment time standards, categorized by urgent and nonurgent appointment types and by new and returning patients. This bill would require the department to monitor any plan of correction imposed by the director, with progress reported publicly no less than annually for the duration of the plan of correction. This bill would set forth definitions for the terms of "timely" and "accurate network provider data." https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2466	03/19/24 - Re-referred to Com. on HEALTH.

AB 2467 (Bauer-Kahan)	This bill would require a health care service plan contract or health insurance policy, except for a specialized contract or policy, that is issued, amended, or renewed on or after January 1, 2025, to include coverage for treatment of perimenopause and menopause. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2467	03/06/24 - Re-referred to Com. on HEALTH.
AB 2556 (Jackson)	This bill would require a health care service plan or insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined. The bill would require a health care service plan or insurer to provide the notice on an annual basis. Because a violation of the bill's requirements relative to a health care service plan would be crimes, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2556	04/03/24 - From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 2).
AB 2668 (Berman)	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual's course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized health care service plan or specialized health insurance policy. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. Existing law also 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. Commencing January 1, 2025, this bill would require coverage for cranial prostheses for individuals experiencing permanent or temporary medical hair loss. or treatment for those conditions as a Medi-Cal benefit, subject to the same requirements with respect to provider prescription, coverage frequency, and amount. The bill would not apply these provisions to a specialized health care service plan. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2668	03/04/24 - Referred to Com. on HEALTH.

AB 2703 (Aguiar-Curry)	Existing law requires the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit. This bill would add a psychological associate to those provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate under those conditions. The bill would make conforming changes with regard to supervision by a licensed psychologist as required by the Board of Psychology. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2703	04/03/24 - From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (April 2). Re-referred to Com. on APPR.
AB 2726 (Flora)	This bill would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a telehealth and other virtual services specialty care network that is designed to serve patients of safety-net providers consisting of qualifying providers, defined to include, among others, rural health clinics and community health centers. The bill would authorize the focus of the project to include increasing access to behavioral and maternal health services and additional specialties prioritized by the agency. The bill would state the intent of the Legislature that implementation of the demonstration project would facilitate compliance with any applicable network adequacy standards. The bill would require the demonstration project to include a grant program to award funding to grantees, as defined, that meet specified conditions relating to specialist networks and health information technology. Under the bill, the purpose of the grant program would be to achieve certain objectives, including, among others, reducing structural barriers to access experienced by patients, improving cost-effectiveness, and optimizing utilization. The bill would require a grantee to evaluate its performance on the objectives and to submit a report of its findings to the agency. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2726	03/19/24 - Re-referred to Com. on HEALTH.

AB 2843 (Petrie-Norris)	This bill would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2843	03/04/24 - Referred to Com. on HEALTH.
AB 2956 (Boerner)	This bill would require the department to seek federal approval to extend continuous eligibility to individuals over 19 years of age. Under the bill, subject to federal funding, and except as described above with regard to death, change of state residency, or other events, an individual would remain eligible from the date of a Medi-Cal eligibility determination until the end of a 12-month period, as specified. The bill would make various changes to the above-described redetermination procedures. The bill would, among other things, require the county, in the event of a loss of contact, to attempt communication with the intended recipient through all additionally available channels before completing a prompt redetermination. The bill would require the county to make another review of certain obtained information in an attempt to renew eligibility without needing a response from a beneficiary. The bill would require the county to complete a determination at renewal without requesting additional information or documentation if specified conditions are met, relating to, among other things, prior income verification and no contradictory information on file. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2956	03/14/24 - Re-referred to Com. on HEALTH.
AB 2976 (Jackson)	This bill would state the intent of the Legislature to enact legislation relating to access to mental health care. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2976	02/17/24 - May be heard in committee March 18.

AB 3149 (Garcia & Reyes)	This bill would require the department to, by no later than January 1, 2026, and until December 31, 2026, convene the Promotores Advisory and Oversight Workgroup to examine the implementation of the community health worker benefit under the Medi-Cal program. The bill would require the director to appoint no fewer than 9 individuals to the workgroup who have at least ten years experience working in California as, or with, Promotores. The bill would require the workgroup to be comprised of no less than 51% Promotores, as specified, and require the appointees to be from geographically diverse areas of the state. The bill would require the workgroup to advise the department to ensure that community health worker services are available to all eligible Medi-Cal beneficiaries who want those services, to ensure that community health worker training and outreach materials are culturally and linguistically appropriate, to make recommendations on outreach efforts, as specified, and to provide input on issues that should be informed by community representatives who have lived experience with using and navigating Promotores services and the Medi-Cal program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3149	03/19/24 -Re-referred to Com. on HEALTH.
AB 3156 (Patterson)	This bill would exempt, from mandatory enrollment in a Medi-Cal managed care plan, dual eligible and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage. For purposes of this exemption, the bill would require the beneficiary to complete and submit an exemption form every 5 years. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3156	04/01/24 - Re-referred to Com. on HEALTH.
AB 3215 (Soria)	This bill would express the intent of the Legislature to enact legislation to expand access to behavioral mental health services to children receiving Medi-Cal benefits. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3215	02/17/24 - From printer. May be heard in committee March 18.

AB 3221 (Pellerin)	This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director's determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program. Existing law requires the department to conduct a follow up review to determine and report on the status of the plan's efforts to correct deficiencies no later than 18 months following release of the final report. This bill would state that nothing in those provisions prohibits the director from taking any action permitted or required under the act in response to the survey results before the follow up review is initiated or completed, including, but not limited to, taking enforcement actions and opening further investigations. Existing law enumerates acts or omissions by a health care service plan that constitute grounds for disciplinary action by the director. This bill would add to those enumerated acts or omissions the failure by a health care service plan to respond fully or timely, or both, to a duly authorized request for production of records. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3221	04/02/24 - Re-referred to Com. on HEALTH.
AB 3245 (Patterson)	Existing law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B by another accredited or certified guideline agency. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3245	03/11/24 - Referred to Com. on HEALTH.

AB 3260 (Pellerin)	This bill would require that utilization review decisions be made within 72 hours from the health care service plan's receipt of the clinical information reasonably necessary to make the determination when the enrollee's condition is urgent, and would make a determination of urgency the enrollee's health care provider binding on the health care service plan. If the plan lacks the information reasonably necessary to make a decision regarding an urgent request, the bill would require the plan to notify the enrollee and provider about the information necessary to complete the request within 24 hours of receiving the request. The bill would require the plan to notify the enrollee and the provider of the decision within a reasonable amount of time, but not later than 48 hours after specified circumstances occur. If a health care service plan fails to make a utilization review decision, or provide notice of a decision, within the specified timelines, the bill would require the health care service plan to treat the request for authorization as a grievance and provide notice with specified information to the enrollee that a grievance has commenced. This bill would require a plan's grievance system to include expedited review of urgent grievances, as specified, and would make a determination of urgency by the enrollee's health care provider binding on the health care service plan. The bill would require a plan to communicate its final grievance determination within 72 hours of receipt if urgent and 30 days if nonurgent, except as specified. If a plan fails to make a utilization review decision within the applicable timelines, the bill would require a grievance to be automatically resolved in favor of the enrollee. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3260	04/02/24 - Re-referred to Com. on HEALTH.

AB 3275 (Soria)	The bill would require a health care service plan or health insurer to reimburse a claim for a small and rural provider, critical access provider, or distressed provider within 10 business days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within 5 business days that the claim is contested or denied. Under the bill, if a claim for reimbursement to a small and rural provider, critical access provider, or distressed provider is contested on the basis that the health care service plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided, the health care service plan or health insurer would have 15 business days after receipt of the additional information to complete reconsideration of the claim. Under the bill, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest would accrue at a rate of 15% per annum for health care service plans and health insurers. The bill would require the departments to develop respective lists for categories of claims that would be required to be paid by a health insurer or health care service plan to a small and rural provider, critical access provider, or distressed provider no later than 5 days after receipt of the claim, as specified. Existing law requires a health care service plan to automatically include in its payment of a claim all interest that has accrued, as specified. This bill would also require a health insurer to automatically include all interest accrued in its payment of a claim. Existing law requires a health care service plan that fails to comply with the requirement to include all interest in its payment of a claim to pay the claimant a $10 fee. This bill would instead require a health insurer or health care service plan that fails to comply with that requirement to pay the claimant a fee of no less than 10% of the interest accrued. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3275	04/02/24 - Re-referred to Com. on HEALTH.

SB 136	Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under existing law, all revenues, less refunds, derived from the taxes are deposited into the Managed Care Enrollment Fund, to be available to the department, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program. Existing law sets forth certain taxing tiers and tax amounts for purposes of the tax periods of April 1, 2023, to December 31, 2023, inclusive, and the 2024, 2025, and 2026 calendar years. Under existing law, the Medi-Cal per enrollee tax amount for Medi-Cal taxing tier II, as defined, is $182.50 for the 2024 calendar year, $187.50 for the 2025 calendar year, and $192.50 for the 2026 calendar year. This bill would raise that tax amount for that tier to $205 for all 3 of those calendar years. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB136	03/25/24 - Chaptered by Secretary of State. Chapter 6, Statutes of 2024.
SB 953 (Menjivar)	This bill would add menstrual products, as defined, to that schedule of covered Medi-Cal benefits. The bill would require the department to seek any necessary federal approvals to implement this coverage. The bill would require the department to seek, and would authorize the department to use, any and all available federal funding, as specified, to implement this coverage. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB953	03/28/24 - Set for hearing April 8.
SB 975 (Ashby)	This bill would state the intent of the Legislature to enact legislation relating to the payment and reimbursement for mobile integrated health and community paramedicine programs. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB975	02/14/24 - Referred to Com. on RLS.
SB 1063 (Grove)	This bill would expressly authorize a school district to include on pupil identification cards for pupils in grades 7 to 12, inclusive, a quick response (QR) code that links to the mental health resources internet website of the county in which the school district is located. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1063	03/28/24 - Set for hearing April 10.

SB 1112 (Menjivar)	This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to develop a model memorandum of understanding (MOU), and would require Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model. For purposes of children of families receiving subsidized childcare services through an alternative payment program, and upon the consent of the parent or guardian, the bill would require the plans and agencies to collaborate on assisting the family with the Medi-Cal enrollment of a child who is eligible but not a beneficiary, and on referring a Medi-Cal beneficiary to developmental screenings that are available under EPSDT services and administered through the plan. The bill would authorize the agency to perform certain related functions. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1112	04/04/24 - Set for hearing April 15.
SB 1120 (Becker)	This bill would require a health care service plan or health insurer to ensure that a licensed physician supervises the use of artificial intelligence decision-making tools when those tools are used to inform decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees or insureds. The bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that they be fairly and equitably applied. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1120	04/01/24 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

SB 1131 (Gonzalez)	This bill would make services provided by a licensed physician assistant covered under the Medi-Cal program and would require the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services. Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning, under which comprehensive clinical family planning services are provided as a benefit under the Medi-Cal program. Existing law also creates the State-Only Family Planning Program, under which family planning services are provided to eligible individuals. Existing law requires enrolled providers in each program to attend a specific orientation approved by the department and requires providers who conduct specified services to have prior training in those services. This bill would, for both of the above-described programs, require the department to allow a provider 6 months from the date of enrollment to complete the orientation. The bill would, for the Family PACT Program, state that a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, is not required to be a clinician and that certain clinic corporations can enroll multiple service addresses under a single site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, such as being offered in person and through a virtual platform and being offered at least once per month, among others. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1131	04/04/24 - From committee: Do pass as amended and re-refer to Com. on APPR.
SB 1180 (Ashby)	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program. The bill would require those plans and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount they would pay for the same covered services received from a contracting program. The bill would specify the reimbursement process and amount for a noncontracting program. The bill would also make services provided by these programs covered benefits under the Medi-Cal program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1180	02/21/24 - Referred to Com. on HEALTH.

SB 1258 (Dahle)	Existing law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors, including the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1258	04/04/24 - From committee: Do pass as amended and re-refer to Com. on APPR.
SB 1268 (Nyugen)	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. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts between the department and various types of managed care plans and between those plans and providers of those services. In the case of a contract between a Medi-Cal managed care plan and a safety net provider, as defined, that furnishes Medi-Cal services, the bill would, to the extent not in conflict with federal law, prohibit the plan and the provider from terminating the contract during the contract period without first declaring the cause of termination. The bill would prohibit the declared cause of termination from being a material fact or condition that existed at the time that the contract was entered into by those parties, and of which both parties had knowledge at that time. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1268	04/03/24 - Re-referred to Com. on HEALTH.

SB 1289 (Roth)	This bill would require the department to establish statewide minimum standards for assistance provided by county call centers to applicants or beneficiaries applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage. The bill would require promulgation of the standards in regulation by July 1, 2026, as specified. The bill would require a county to collect and submit to the department call-center data metrics, including, among other information, call volume, average call wait times by language, and callbacks. By creating new duties for counties relating to call-center data, the bill would impose a state-mandated local program. The bill would require the department to prepare a report, excluding any personally identifiable information, on county call-center data, identifying challenges and targets or standards for improvement. The bill would require the department to post the report on its internet website on a quarterly basis no later than 45 calendar days after the conclusion of each quarter, with the initial report due on May 15, 2025. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1289	04/03/24 - Re-referred to Com. on HEALTH.
SB 1354 (Wahab)	Existing law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from transferring or seeking to evict out of the facility any resident as a result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal benefits and for whom an eligibility determination has not yet been made, except as specified. This bill would require a long-term health care that participates as a provider under the Medi-Cal program to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1354	04/03/24 - Set for hearing April 24.

SB 1355 (Wahab)	This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, if they have a fixed income, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions. To the extent the bill would increase county duties in administrating the IHSS program, the bill would impose a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1355	04/03/24 - From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
SB 1423 (Dahle)	This bill would remove the provisions relating to supplemental payments and would instead require the reimbursement to a critical access hospital for Medi-Cal covered outpatient services at a rate equal to the actual cost to the hospital of providing the services or the amount charged by the hospital for the services, whichever is less. The bill would also require reimbursement to those hospitals, under the same terms, for swing-bed services, relating to beds licensed for general acute care that may be used as skilled nursing beds. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1423	04/03/24 - Set for hearing April 24.
SB 1492 (Menjivar)	Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Under existing law, proceeds from the MCO provider tax may be used, upon appropriation by the Legislature, for the increased costs incurred as a result of reimbursement requirements, among other things. This bill would provide that, for the above-described reimbursement purposes, private duty nursing services provided to a child under 21 years of age by a home health agency are considered specialty care services. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1492	04/03/24 - Set for hearing April 24.

SB 1511 (Health Committee)	This bill would clarify that reference to a "group" in the act does not include a Medi-Cal managed care contract between a health care service plan and the State Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program. This bill would authorize a general acute care hospital to allow a terminally ill patient, as defined, to use medicinal cannabis. (3) Existing law establishes the Distressed Hospital Loan Program, administered by the Department of Health Care Access and Information, in order to provide interest-free cashflow loans to not-for-profit hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital, except as otherwise provided, to prevent the closure of, or facilitate the reopening of, those hospitals. Existing law establishes the Distressed Hospital Loan Program Fund, with moneys in the fund being continuously appropriated for the department. Existing law authorizes the Department of Finance to transfer up to $150,000,000 from the General Fund and $150,000,000 from the Medi-Cal Provider Payment Reserve Fund to the Distressed Hospital Loan Program Fund in state fiscal year 2023–24 to implement the program. Existing law requires any funds transferred to be available for encumbrance or expenditure until June 30, 2026. This bill would instead require any funds transferred to be available for encumbrance or expenditure until December 31, 2031. By extending the amount of time continuously appropriated funds are available for encumbrance and expenditure, this bill would make an appropriation. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1511	02/29/24 - Referred to Com. on HEALTH.

Attachment C

Public Relations & Publicity

Media Clips

Feb 2024-April 2024

February is Safely Surrender Baby Awareness Month in Kern County

By: The News Review—Ridgecrest, CA | February 2, 2024

"The SSB coalition is made up of a group of dedicated individuals representing a long list of agencies, non-profits, and stakeholders, including First 5 Kern, Kern Family Health Care, Kern Medical Hospital, Clinica Sierra Vista, Koinonia Family Services, and Kern County." **Click here to read more.**

February is Safely Surrendered Baby Awareness Month

By: Tehachapi News | February 3, 2024

"The SSB coalition is made up of a group of dedicated individuals representing a long list of agencies, nonprofits and stakeholders including First 5 Kern, Kern Family Health Care, Kern Medical, Clinica Sierra Vista...and Ridgecrest Regional Hospital." **Click here to read more.**

Steve Schilling, who transformed Central Valley healthcare as Clinica CEO, dead at 77.

By: KGET-17 | February 13, 2024

"Emily Duran, CEO of Kern Health Systems, worked under Schilling at Clinica. In a statement to KGET she said: "Steve Schilling was a man of vision. He built a team that did so much for our underserved population."" **Click here to read more.**

Kern Family Health Care hosts community event in Delano to enhance healthcare access and quality

By: South Kern Sol | February 13, 2024

"In Delano, California, Kern Family Health Care organized a community event with the main objective of gaining deeper insights into the unique experiences of members and communities in the Northern region of Kern County, including Delano, McFarland, Shafter, Wasco, and Lost Hills." **Click here to read more.**

Kern Health Systems invests $20 million to make county healthier and more equitable place to live

By: KGET-17 | Feb 15, 2024

"Dozens gathered Thursday to celebrate the $20 million investment by Kern Health Systems into other organizations that some said could address the hard health reality Kern faces." **Click here to read more.**

KHS gives out $20 million to tackle Kern's biggest health needs

By: The Bakersfield Californian | Feb 15, 2024

"Half the money Kern Health Systems announced giving local partners will go toward its top priority of expanding the county's health-care workforce. The rest is being divided among three other pressing concerns, in this order: improving access to care, recruiting and retaining medical professionals, and broadening provision of social services with the help of community organizations." **Click here to read more.**

Kern County expands health care access through $20M grant, strengthening future of care

By: Bakersfield Now | Feb 15, 2024

"Health care is becoming more accessible in Kern County, through the Kern Health Systems $20 million investment. This funding will establish programming to widen patient care throughout the county and shape future providers." **Click here to read more.**

Kern Health Systems Allocates $20 Million To Address Kern County's Urgent Healthcare Needs

By: South Arkansas Sun | Feb 16, 2024

"Kern Health Systems has announced a groundbreaking plan to give $20 million to Kern County's most urgent healthcare needs. The plan was led by CEO Emily Duran and is the first of its kind." **Click here to read more.**

Black mothers and infants face higher health risks, learn how our community is coming together to help

By: KGET-17 | Feb 19, 2024

"It's Black History Month, and we are excited to highlight a local effort making an impact, the Black Infant and Maternal Health Initiative, also known as BIMHI. Brynn Carrigan from Kern County Public Health and Ana Lester from Kern Health Systems are in studio to share the history and origin of BIMHI." **Click here to read more.**

CSUB receives $1 million to build Doctor of Nursing Practice Program

By: CSUB Campus News | February 21, 2024

"Kern Health Systems (KHS) has announced a $1 million grant toward the establishment of a Doctor of Nursing Practice Program at California State University, Bakersfield, part of a $20 million package of support made by Kern County's largest health plan to expand access to health care, educate more primary-care professionals and narrow health equity gaps in one of the most medically underserved regions of the state." **Click here to read more.**

CSUB recibe $1 millón para construir el Programa de Doctorado en Práctica de Enfermería

By: El Popular | February 22, 2024

"Kern Health Systems (KHS) ha anunciado una subvención de $1 millón para el establecimiento de un Programa de Doctorado en Práctica de Enfermería en la Universidad Estatal de California, Bakersfield, parte de un paquete de apoyo de $20 millones realizado por el plan de salud más grande del condado de Kern...." **Click here to read more.**

Black History Month: Kern Health Systems

By: KGET-17 | February 26, 2024

"We can't talk about Black History Month without acknowledging the tough conversations that need to be had, particularly around health disparities. We have two local leaders who fight every day in Kern County to help bridge the gap -Traco Matthews, Chief Health Equity Officer for Kern Health Systems and Anastasia Lester, Senior Health Equity Analyst for KHS." **Click here to read more.**

Lowering the barrier to access healthcare in Shafter

By: 23abc | March 6, 2024

"Starting March 6, every other Wednesday a Kern County Family Health Care representative will be at the Shafter Family Resource Center to answer questions regarding healthcare access. Lupe Rodriguez is the member engagement representative for KCFH serving Shafter, Wasco, Delano, and McFarland. " **Click here to read more.**

The California Racial Equity Commission holds event in Lamont and Delano this week

By: South Kern Sol | March 20, 2024

"On Wednesday and Thursday, March 20th and 21st, there will be an event held by the California Racial Equity Commission (CREC) to help educate the public about health inequities and much more...This event is in partnership with organizations such as the Governor's Office of Planning and Research, Lamont Elementary School District, Kern Health Systems, Kern Family Health Care, and Telehealth Docs." **Click here to read more.**

The California Equity Committee makes their first stop in Lamont, California

By: The Runner | April 4, 2024

"Traco Matthews, Commissioner of California Racial Equity Commission and Chief Health Equity Officer for Kern Health Systems stated, "The California Racial Equity commission is here to listen to your individual needs, to what customized services, programs, and policies look like for this community." **Click here to read more.**

29 A

MINUTES

COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308
1st Floor Board Room

Tuesday, January 23, 2024

COMMITTEE RECONVENED

Members: Ashton Chase, F.N.P., Beatriz Basulto, Evelin Torres-Islas, Jasmine Ochoa, Jay Tamsi, Jennifer Wood-Slayton, Jessika Lopez, Jesus Gonzalez, Lourdes Bucher, Mark McAlister, Michelle Bravo, Nalasia Jewel, Rocio Castro, Rukiyah Polk, Tammy Torres

ROLL CALL: 15 Present; 0 Absent

Meeting called to order by Anastasia Lester, Senior Health Equity Analyst, at 10:04 AM.

NOTE: The vote is displayed in bold below each item. For example, Basulto-Wood denotes Member Basulto made the motion and Member Wood seconds 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 PRESENTATIONS.

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

LOUIE ITURRIRIA SUGGESTED WE DO INTRODUCTIONS SO THAT ALL NEW COMMITTEE MEMBERS ARE RECOGNIZED.

CA-3) Minutes for Public Policy/Community Advisory Committee from Dec. 12, 2023
RECEIVED AND FILED
MCALISTER-BRAVO: 15 AYES; MOTION CARRIED

4) Presentation – Community Advisory Committee Overview
RECEIVED AND FILED

ANASTASIA LESTER GAVE A POWERPOINT PRESENTATION ON THE NEW CAC DEFINITION, STRUCTURE, DUTIES, AND PROCESS.

5) Vote on Chair and Co-Chair for Community Advisory Committee

VOTE WAS TAKEN AND RESULTED IN THE FOLLOWING:

RUKIYAH POLK WAS NOMINATED AS THE CHAIR OF THE COMMITTEE BY TAMMY TORRES, LOURDES BUCHER SECONDED, 15 AYES; MOTION CARRIED.

JESUS GONZALEZ AND NALASIA JEWEL WERE BOTH NOMINATED AS CO-CHAIR. JAY TAMSI NOMINATED BOTH MEMBERS TO TAKE THIS POSITION, JENNIFER WOOD-SLAYTON SECONDED THIS 15 AYES; MOTION CARRIED.

COMMITTEE TOOK LUNCH.

COMMITTEE RECONVENED FOR TRAINING, ITEM # 6 AT 11:28 A.M.

6) Committee Training

ANASTASIA LESTER PROCEEDED WITH THE BOARD TRAINING, HIGHLIGHTING THE BROWN ACT, AND ROBERTS RULE OF ORDER.

THE FOLLOWING TOPICS WERE ALSO COVERED WITH THE COMMITTEE: GOVERNMENT CODES, PARLIAMENTARY PROCEDURE, GENERAL RULES, KEEPING MINUTES, MOTIONS, AND VOTING PROCEDURES.

MOTION TO ADJOURN MADE BY JESUS GONZALEZ, SECONDED BY MICHELLE BRAVO AT 12:52 PM TO RECONVENE MARCH 26, 2024 AT 11:00 AM

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***FEBRUARY 7, 2024***
CALL TO ORDER: ***7:04 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Hasmukh Amin, MD – Network Provider, Pediatrics	Gohar Gevorgyan, MD – Network Provider, FP Miguel Lascano – Network Provider, OB/GYN	Raju Patel, MD - Network Provider, Internal Medicine Ashok Parmar, MD– Network Provider, Pain Medicine
Members Virtual Remote:		David Hair, MD - Network Provider, Ophthalmology	
Members Excused=E Absent=A	(E) Atul Aggarwal, MD - Network Provider, Cardiology		
Staff Present:	John Miller, MD – KHS QI Medical Director Abdolreza Saadabadi MD – KHS BH Medical Director Amy Daniel, KHS Executive Health Svcs Coordinator	Jake Hall, KHS Senior Director of Contracting & QP Yolanda Herrera, KHS Credentialing Manager	Michelle Curioso, KHS Director of PHM Magdee Hugais – KHS Director of QI

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 and Chair called the meeting to order at 7:04 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Amin moved to approve minutes of December 6, 2023, seconded by Dr. Parmar. Motion carried.	*2/7/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 1/08/24 & 2/01/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on the 1/08/2024 and 2/01/2024 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated 2/07/2024: There were three (3) initial applications presented for comprehensive review. • **PRV004905 -** Reviewed information regarding NPDB Settlement 2013: Pt admitted in labor, MD was on-call provider and assumed care. Delivery of infant via vacuum assist with Apgar's 2/3 at one minute and at five minutes. PH was 6.98 and bandolier cord was not at delivery. *Provider explanation received and accepted with recommendation to add to provider network.* • **PRV092297 -** Reviewed information regarding 2018 and 2022 both Residency Programs in Emergency Medicine were not completed due to personal health reasons and assaulted during 2nd residency resulting in resigning due to effects on the provider. Provider meets General Practice criteria. *Provider explanation received and accepted with recommendation to add to provider network.* • **PRV056978 -** Reviewed information regarding NPDB Settlements from 2017 and 2018 alleged failure to timely deliver the minor pt resulting in alleged lack of oxygen and permanent brain injury; second case alleged delivery was negligent resulting in shoulder dystocia. *Provider explanation received and accepted with recommendation to add to provider network.*	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated February 7, 2024, seconded by Dr. Parmar. Motion carried.	*2/7/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	RECREDENTIALING REPORT **Recredentialing Providers List Dated 2/07/2024:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years: • Member Grievances: All Providers with significant Member & Quality Grievances were reviewed. Dr. Tasinga reported there were no quality of service or care issues identified as significant trends or concern requiring further review. There were no additional questions or alternative actions recommended by this committee. • PRV001109 – MBC Public Reprimand 9/29/22: Deviation from standard of care and treatment of five patients; failing to maintain adequate medical records. MD compliant with Compliance of MR Record Course documentation provided 10/11/2. *Provider's compliance with reprimand and monthly monitoring accepted for continued network participation.* • PRV000348 – Self reported NY State lab license voided due to not reporting internal reorganizational changes in direct ownership which has since been resolved and license reissued. *Provider explanation received and accepted with recommendation for continued network participation*. **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated February 15, 2024 (Board of Directors Meeting) were accepted as presented with no additional questions or comments by the committee members.		
OLD BUSINESS	There was no old business to present	N/A	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS			
	P&P 4.01-P Credentialing Program – Revised Yolanda Herrera KHS Credentialing Manager, presented the revisions to Policy and Procedure 4.01-P Credentialing Program as follows: • Added non-discriminatory credentialing dates to semi-annual reporting in February and August and monitoring of summary report. • Added Intermediate Care Facility types to additional information for credentialing requirements per APL 23-023 **New Policy & Procedure – Credentialing Assessment of Organizational Providers** • Policy created to outline process for conducting initial assessments of organizational providers confirming they are in good standing with state and federal bodies. **New Policy and Procedure – Physician Advisory Committee (Credentials Committee)** • Policy created designating PAC as the Credentialing Committee outlining the committee responsibilities, oversight, and performance monitoring with final authority to approve or disapprove applicants for initial and recredentialing and recommending corrective or disciplinary actions. • Confidentiality and Non-Discriminatory Practice – as a responsibility of the PAC all members are required to agree to maintain confidentiality of all committee proceedings and agree to conduct all credentialing activities in a manner that is non-discriminatory.	☑ **ACTION**: Dr. Amin moved to approve the revisions to P&P 4.01-P Credentialing Program, New P&P-Credentialing Assessment of Organizational Providers and New P&P – Physician Advisory Committee, seconded by Dr. Gevorgyan. Motion carried. ☑ **ACTION**: All members present at the meeting were asked to sign the KHS Physician Advisory Committee Annual Confidentiality and Non-Discriminatory Statement. Amy D. will collect signed statements from those members not present at today's meeting.	*2/7/24*
	KHS Monthly Monitoring/Adverse Event Reporting Yolanda Herrera KHS Credentialing Manager presented the monthly monitoring and adverse event report for January 2024. The monthly report provides information on providers who have a licensing type of	☑ **ACTION**: Dr. Amin moved to approve the monthly monitoring and adverse event summary report for January 2024, seconded by Dr. Gevorgyan. Motion carried.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	monitoring or adverse event that requires on-going monitoring. Previously this was a verbal report out to the committee; however, as part of NCQA requirements will be presented in a summary report listing newly added providers, notes and comments on action items and follow-up recommendations. For the month of January 2024, the following items were noted: • All providers listed #1-11 remain in compliance with licensing probationary requirements or recommendations set forth by PAC. • Newly added PRV006729 – Media Alert KC Investigation by the Kern County Public Integrity Unit opened an investigation on a facility which runs SNF and Clinic for possible violations. Credentialing will update report monthly to review any Grand Jury Reports.		
	KHS Organizational Provider Assessment Report Yolanda Herrera KHS Credentialing Manager presented the Organizational Provider Assessment Report dated 02/05/2024. Ms. Herrera reported that traditionally, KHS has always credentialed their organizational providers and some of the assessments based on the dates of verification fall out-side the 36-month review; however, efforts are being made to implement recredentialing sooner to prevent the current assessment from exceeding the 36-month requirement.	☑ **ACTION**: Dr. Amin moved to approve KHS Organizational Provider Assessment Report dated 2/5/2024 as presented, seconded by Dr. Gevorgyan. Motion carried.	*2/7/24*
	Delegated Credentialing 2023 Tertiary Audit Summary Yolanda Herrera KHS Credentialing Manager presented 2023 Delegated Credentialing Audit Summary for 2023. KHS Credentialing requested permission from each tertiary facility to access the Health Industry Collaboration Effort (HICE) Shared Credentialing Audit Results for Calendar Year 2023. The Tertiary Facilities were audited by other health plans in lieu of conducting individual audits in an effort to reduce duplication. KHS Credentialing Manager conducted desk-top audits for Kaiser Permanente, Vision Service Plan and ConferMED.	☑ **ACTION**: Dr. Amin moved to approve the Delegated Credentialing Tertiary Summary 3rd Quarter 2023 Report dated December 6, 2023, seconded by Dr. Gevorgyan. Motion carried.	*2/7/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	During 2023 there were 3-healthplans that received recommended corrective action plans due to lack of Policy and Procedure for newly created Assembly Bill 2581 requiring all Behavioral Health applications be processed within 60-day turnaround. Children's Hospital of Los Angeles Medical Group, UCLA Medical Group and USC Medical Group were all asked to revise their credentialing Policy and Procedures adding the requirements of AB2581 and submit their revised P&Ps for review. • CHLA and UCLA Medical Groups are pending revisions to their Credentialing Policy and Procedures and have been given 90-days to submit to KHS for review and closure. • USC Medical Group submitted their revised Credentialing Policy and Procedure and CAP has been closed.	☑ **ACTION**: Ms. Herrera will monitor CHLA and UCLA Medical Groups for their pending CAP and will present to the PAC upon receipt.	*Pending*
OPEN FORUM	Dr. Tasinga informed the members that the PAC is no longer under the requirements of the Brown Act, therefore there is no public comment or website posting for the committee agenda. While the meetings will be held on-site at KHS facilities and members are encouraged to attend in person, calling in remote to the meeting is now an option. Dr. Tasinga further informed the members that NCQA preparations and underway as KHS has submitted their application to NCQA for audit in 2025; therefore our "look back period" will begin this year and staff have been working diligently to prepare the required reports and documents to their respective committees.	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, March 6, 2024	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:08 am ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY (EQIHEC) COMMITTEE***
DATE OF MEETING: ***FEBRUARY 8, 2024***
CALL TO ORDER: ***7:03 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Jennifer Ansolabehere – PHN Danielle Colayco, PharmD – Komoto	Todd Jeffries – Bakersfield Community Healthcare Allen Kennedy – Quality Team DME Michael Komin, MD – Komin Medical Group	Philipp Melendez, MD – OB/GYN Chan Park, MD – Vanguard Family Medicine
Members Virtual Remote:		Satya Arya, MD - ENT	
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A)		
Staff Present:	Amy Carrillo, KHS Member Services Manager Michelle Curioso, KHS Director of PHM Amy Daniel, KHS Executive Health Svcs Coordinator Dan Diaz, RN – ECM Clinical Manager Pawan Gill – Health Equity Manager	Yolanda Herrera, KHS Credentialing Manager Loni Hill-Pirtle, KHS Director of ECM Magdee Hugais – KHS Director of QI Traco Matthews – Chief Health Equity Officer John Miller, MD – KHS QI Medical Director	Vanessa Nevarez, KHS Health Equity Coordinator Gregory Panero – Provider Network Analytics Abdolreza Saadabadi MD – KHS BH Medical Director Nate Scott, KHS Senior Director of Member Services Isabel Silva, KHS Senior Director of W&P James Winfrey, KHS Deputy Director of PNM

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 and Chair called the meeting to order at 7:03 am.		N/A
Public Presentations	There were no public members present for this meeting.		N/A
Committee Announcements	Danielle Colayco announced Komoto Pharmacy received a Quality Grant from KHS and it will be used to promote their Pediatric Mobile Vaccination Clinic. CMO-CHEO Update:	Informational Only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Dr. Tasinga gave a brief overview of the changes to the QI-UM Committee restructure. Committee is now EQIHEC and is responsible for all sub-committees that previously reported to QI-UM Committee, and they will now be reporting to EQIHEC.	Informational Only.	N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the QI-UM Committee Minutes for approval.	☑ **ACTION**: Dr. Melendez moved to approve minutes of November 30, 2023, seconded by Allen Kennedy. Motion carried.	*2/8/24*
OLD BUSINESS	There was no old business to present	N/A	*N/A*
NEW BUSINESS	**Consent Agenda Items** **CA-5) Physician Advisory Committee (PAC) Q4 2023 Summary of Proceedings – APPROVE** **CA-6) Public Policy – Community Advisory Committee (PP-CAC) Q4 2023 Summary of Proceedings – APPROVE** **CA-7) Drug Utilization Review (DUR) Committee Q4 2023 Summary of Proceedings – APPROVE** **CA-8) Pharmacy TAR Log Statistics – APPROVE** **CA-9) Kaiser Reports (PROPRIETARY AND CONFIDENTIAL)** • **KFHC APL Grievance Report Q4 2023 – RECEIVE AND FILE** • **KFHC Volumes Report for Q4 2023 – RECEIVE AND FILE** • **Kaiser Reports will be available upon request.**	☑ **ACTION**: Dr. Melendez moved to approve the consent agenda items, that included their reports and summaries, seconded by Allen Kennedy. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	10) Health Equity Transformation Steering Committee – Pawan presented the purpose of the HETSC description, function, and composition for the committee's consideration. This report included the following:	☑ **ACTION**: Dr. Saadabadi moved to approve the HETSC Charter, Meeting Schedule, and 2024 Work Plan, seconded by Allen Kennedy. Motion carried.	*2/8/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• **2024 Health Equity Strategy PowerPoint Presentation – APPROVE** • **HETSC Charter - APPROVE** • **HETSC Workplan – APPROVE** **11) Credentialing Statistics Q4 2023 – APPROVE** Yolanda presented the 4th Quarter monitoring of credentialing statistics for reporting period October 1, 2023 through December 31, 2023. There were a total of 159 Initially Credentialed Providers and 135 Recredentialed Providers. There were no significant trends identified in credentialing. **12) Board Approved New & Existing Contracts Report – APPROVE** Yolanda summarized the Newly approved contract vendors and there were no significant trends or patterns identified. **13) Credentialing & Recredentialing Summary Report – APPROVE** Yolanda presented the Credentialing & Recredentialing Summary for 4th Quarter revealing an increase in PCP Providers and an increase in Specialty Providers as well. There were no significant trends or patterns identified. **14) Network Review Q4 2023 – APPROVE** James provided the overview and results for the Plan's 4th Quarter 2023 After-Hours Survey, Provider Accessibility Monitoring Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and the DHCS Quarterly Monitoring Report Template Review. There were no significant trends or patterns identified.	☑ **ACTION**: Dr. Saadabadi moved to approve the Credentialing 4th Quarter Statistics, New Vendor Contracts and Credentialing/Recredentialing Summary Report, seconded by Allen Kennedy. Motion carried. There were no further questions or discussion on these topics from the Committee Members. ☑ **ACTION**: Dr. Melendez moved to approve the After-Hours Survey, Provider Accessibility Monitoring Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and the DHCS Quarterly Monitoring Report Template Review, seconded by Dr. Park. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24* *2/8/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	15) Enhanced Case Management Program Report Q4 2023 – APPROVE Dan discussed the ECM's progress to date with quantitative/qualitative measures and track and trend relevant ECM demographic data with the committee and presented the following items: • Description of Enhance Care Management • Composition of the Populations of Focus as delineated by the DHCS and relative trends. • Cost/Utilization Savings Measures • Clinical measures • Feedback Measures • 2024 Meeting Schedule	☑ **ACTION**: Dr. Melendez moved to approve the ECM Description, Composition, Cost Savings Measures, Clinical/Feedback Measures and 2024 Meeting Schedule, seconded by Dr. Komin. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	16) Health Education Activity Report Q4 2023 – APPROVE Isabel presented the 4th Quarter 2023 Wellness & Prevention Department report summarizing all health education, cultural and linguistic activities performed during the 4th quarter of 2023. The below highlights were shared with the members on efforts currently being implemented by the WP department: • **New Programs: Diabetes & Empowerment** • **4th Quarter Trainings** • **Community Events** • **Service Monitoring**	☑ **ACTION**: Dr. Melendez moved to approve the Wellness and Prevention 4th Quarter Report, seconded by Dr. Saadabadi. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*
	17) Grievance Operational Board Update Q4 2023 – APPROVE **18) Grievance Summary Reports Q4 2023 – APPROVE** Amy presented the previous four quarters of 2023. The following trends were identified related to the Grievances and Appeals received during the 4th Quarter, 2023 • There was a slight decrease in Grievances and	☑ **ACTION**: Dr. Komin moved to approve the Wellness and Prevention 4th Quarter Report, seconded by Mr. Jeffries. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Appeals in Quarter 4, 2023 when compared to the previous two quarters in 2023. • Of the 1,667 Standard Grievance and Appeal cases, 915 were closed in favor of the Plan and 626 cases closed in favor of the Enrollee. At the time of reporting, 126 cases were delayed pending a response and/or medical records from providers. **19) Quality Improvement Program Reporting Q4 2023 – APPROVE** Magdee presented the 2024 Quality Improvement Program Description, 2024 Program Workplan and 2023 Program Evaluation for the committee's consideration. All program documents were presented and approved in the 1 st Quarter 2024 Executive Quality Improvement Health Equity Committee This report included the following: • **2024 QI Program Description – APPROVE** • **2023 QI Work Plan Evaluation – APPROVE** • **2024 QI Work Plan - APPROVE** **20) Utilization Management Program Reporting Q4 2023 – APPROVE** Dr. Tasinga presented the 2024 UM Program Description, 2024 UM Program Workplan and 2023 UM Program Evaluation for the committee's consideration. UM is focused on ensuring KHS members receive the right care at the right time in the right setting. This report included the following: • **2024 UM Program Description - APPROVE** • **2023 UM Work Plan Evaluation – APPROVE** • **2024 UM Work Plan** **21) Population Health Management (PHM) Reporting - APPROVE** Michelle informed the committee of the newly launched Population Health Management (PHM) Department that	☑ **ACTION**: Mr. Jeffries moved to approve the 2024 Quality Improvement Program Description, 2024 Program Workplan and 2023 Program Evaluation, seconded by Dr. Komin. Motion carried. There were no further questions or discussion on these topics from the Committee Members. ☑ **ACTION**: Dr. Melendez moved to approve the 2024 UM Improvement Program Description, 2024 UM Program Workplan and 2023 UM Program Evaluation, seconded by Dr. Komin. Motion carried. There were no further questions or discussion on these topics from the Committee Members.	*2/8/24* *2/8/24* *2/8/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	became effective January 1, 2023. The DHCS developed a framework that broaden delivery systems, program, and payment reform across the Medi-Cal Program. The purpose of PHM is to engage members with their health care and address social determinants of health and gaps in care while reducing cost. • **PHM 2023 Program Highlights** • **PHM Committee Charter** Mr. Jeffries, Bakersfield Community Healthcare, offered to help develop a program description for KHS's Palliative Care Program.	☑ **ACTION**: Dr. Melendez moved to approve the 2024 UM Improvement Program Description, 2024 UM Program Workplan and 2023 UM Program Evaluation, seconded by Mr. Kennedy. Motion carried.	
OPEN FORUM	There were no issues presented for discussion	**N/A**	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, May 9, 2024 at 7:00 am.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:35 am ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – EQIHEC Minutes 02/08/24

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

29 D

SUMMARY

FINANCE COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Friday, February 9, 2024

8:30 A.M.

COMMITTEE RECONVENED

Members: Elliott, Bowers, McGlew, Turnipseed, Watson
ROLL CALL: All Present

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

CA-3) Minutes for Kern Health Systems Finance Committee meeting on December 8, 2023- APPROVED
McGlew-Bowers: All Ayes

4) Report on Kern Health Systems Investment Portfolio for the Fourth Quarter Ending December 31, 2023 (Fiscal Impact: None) – IRA COHEN, UBS FINANCIAL, HEARD; RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-McGlew: All Ayes

5) Report on 2023 Annual Review of the Kern Health Systems Investment Policy (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Watson: All Ayes

6) Report on 2023 Annual Travel Report (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Watson-Bowers: All Ayes

7) Report on 2023 Annual Report of Disposed Assets (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-McGlew: All Ayes

8) Proposed Agreement with Zelis Healthcare, LLC (formerly Payspan), for the procurement of printing and mailing services along with EFT payments to providers, from February 16, 2024 through February 15, 2027 (Fiscal Impact: $1,950,000 over the term of the contract; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-McGlew: All Ayes

9) Proposed Agreement with Microsoft Azure AVS, for Business Continuity and Disaster Recovery Solution, from February 16, 2024 through February 15, 2027 (Fiscal Impact: $521,568 over the term of the contract; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Bowers: All Ayes

10) Proposed Agreement with InComm Healthcare, for the Member Rewards Solution, from February 16, 2024 through February 15, 2027 (Fiscal Impact: $2,520,000 over the term of the contract; Budgeted) –
APPROVED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Watson: All Ayes

11) Report on Kern Health Systems Financial Statements for November 2023 (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
McGlew-Bowers: All Ayes

12) Report on Accounts Payable Vendor Report, Administrative Contracts between $50,000 and $200,000 for November 2023 and IT Technology Consulting Resources for the period ended November 30, 2023 (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Bowers-Watson : All Ayes

ADJOURN TO FRIDAY, APRIL 12, 2024 AT 8:30 A.M.

29 E

KERN HEALTH SYSTEMS

COMMITTEE: ***Fraud, Waste, and Abuse (FWA) Committee***
DATE OF MEETING: ***February 9, 2024***
CALL TO ORDER: ***3:00 pm by Jane MacAdam - Director of Compliance and Regulatory Affairs***

Members Present On-Site:	*N/A*		
Members Virtual Remote:	*N/A*		
Members Excused=E Absent=A	*N/A*		
Staff Present:	Alan Avery, Chief Operating Officer Karen Beale, Compliance Analyst Amy Carrillo, Member Services Manager Kathryn Castaneda, Compliance Analyst Michelle Curioso, Director of Population Health Management Sandeep Dhaliwal, Compliance Manager, Audits and Investigations Robin Dow-Morales, Director of Claims Russell Hasting, PHM Manager of Case Management Loni Hill-Pirtle, Administrative Director, Enhanced Care Management Magdee Hugais, Director of Quality Improvement Christina Kelly, Pharmacy Administrative and Support Supervisor Maninder Khalsa, Medical Director-UM	Jane MacAdam, Director of Compliance and Regulatory Affairs Melissa McGuire, Provider Relations Manager Deborah Murr, Chief Compliance and Fraud Prevention Officer Maria Parra, Member Services Manager Jeff Pollock, Regulatory and Government Program Manager Martha Quiroz, Member Services Manager Adriana Salinas, Director of Community & Social Services Nate Scott, Director of Member Services Bruce Wearda, Director of Pharmacy	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Action Items from 10/10/2023 Meeting-Jane	All discussions related to alleged Fraud, Waste, and Abuse conducted during the meeting will be kept confidential by all participants.	☑ **ACTION**: 1. Robin will send overutilize modifiers report to Jane. 2. Jane will present at the Member Services Meeting on 2/28/2024	A.02/09/2024

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	A. Compliance will send updated FWA Transportation letters to Member Services. Update: Jane sent to Member Services Leadership 02/09/2024 B. Claims will report Providers that overutilize modifiers at the 4th quarter FWA Committee meeting. 1. Robin discussed that a couple of Providers were identified. a. Edits were put in place for those Providers to provide additional information. 2. Robin will send overutilize modifiers report to Jane. C. Amy and Nate will discuss a time that Compliance can speak with the Member Services team on scenarios for reporting FWA. 1. Jane will need 10 minutes to discuss what helpful information that Compliance needs for FWA. 2. Jane will present at the Member Services Meeting on 2/28/2024 concerning reporting FWA. D. Compliance will take a closer look at those Providers with repeated potential FWA and discuss offline for next steps, as needed. Update: Compliance continues to evaluate this and schedule ad hoc meetings with sub-workgroups, and in these committee meetings, to discuss as needed.	concerning reporting FWA.	
Cases for Discussion	All discussions related to alleged Fraud, Waste, and Abuse conducted during the meeting will be kept confidential by all participants. Compliance does communicate with Providers as needed concerning allegations of FWA. A. Jane, Karen, Dr. Khalsa, and Deb Discussed the allegations: 1. B2022.59, B2023.20, B2023.64, B2023.77, B2023.89 a. Requested Corrective Action Plan (CAP) i. Provider submitted a response ii. The Plan is working with the Provider. b. Compliance will schedule a meeting with a subgroup regarding this FWA allegation. 2. B2022.61	☑ **ACTION**: 1. Compliance will schedule a meeting with a subgroup regarding FWA allegations. 2. Deb and Jane will meet to discuss a formal CAP. 3. Compliance will discuss offline.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	a. Deb and Jane will meet to discuss a formal CAP. 3. B2022.60, B2023.07, B2023.95 a. Compliance will discuss offline		
Departmental Reports- Shown and Discussed	A. Provider Network Management- Jane 1. Exclusion of Providers report: a. Nothing of significance to report for October, November, and December. B. Member Services (MS)-Amy 1. Frequent Rider Summary: a. August i. 10 Members were issued a warning ii. One (1) Member restricted pending a follow up iii. One (1) Member restricted to bus passes. b. September i. Two (2) Members were issued a warning ii. 14 Members were restricted pending a follow up iii. Zero (0) Member restricted to bus passes. c. October: i. Five (5) Members were issued a warning ii. 11 Members were restricted pending a follow up iii. One (1) Member restricted to bus passes. d. November: i. Five (5) Members were issued a warning ii. Nine (9) Members were restricted pending a follow up iii. Zero (0) Member restricted to bus passes. e. December: i. Data has been received, pending review from MS team. C. Claims	☑ **ACTION**: 1. Jane will let Departments know who is on the list that need to complete their 2023 FWA training with a hard deadline to complete the training. 2. Directors will report back to Compliance once their list of staff have completed the required 2023 training. 3. Compliance will revisit with HR in regard to obtaining the list of non-completion of the FWA Training reports regularly.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	1. Claim Edits through Zelis (Second Pass): a. Nothing of concern b. Zelis trends Providers that are on the report. D. Compliance 1. FWA Training a. 43 employees have not completed for 2023 (16 in progress; 27 not yet started) b. 12 new hires have not yet completed but still within their 90 days c. Jane will let Departments know who is on the list that need to complete their 2023 FWA training with a hard deadline to complete the training. d. Directors will report back to Compliance once their list of staff have completed the required 2023 training. e. Compliance will revisit with HR in regard to obtaining the list of non-completion of the FWA Training reports regularly. 2. Potential FWA Cases 2022-2023: a. Significant increase in reported cases in 2023 i. 2022- 146 cases ii. 2023- 239 cases a) 93 (39%) did not require submission b) 146 cases (61%) submitted to DHCS 1) 142 cases (97%) were submitted timely 2) The one (1) finding in the 2023 DHCS audit was the 4 cases (3%) that were not submitted timely b. Calendar year 2023 FWA Allegations Member vs Provider		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	i. Provider- 124 (52%) cases a) 46 cases not fully closed b) 78 cases closed c) #1 FWA allegation – 39 cases for excessive/unnecessary services d) #2 FWA allegation – 33 Cases for services not rendered. ii. Member- 115 (48%) cases a) 2 cases not fully closed b) 113 cases closed c) #1 FWA allegation - 68 cases for Transportation d) #2 FWA allegation – 27 cases for ID theft		
NEXT MEETING	Next meeting will be held following close of Q1	N/A	N/A
ADJOURNMENT	The Committee adjourned at 3:52 pm	N/A	N/A

KERN HEALTH SYSTEMS

COMMITTEE: ***2024 Delegated Entity Oversight Committee***
DATE OF MEETING: ***February 26, 20024***
CALL TO ORDER: ***1:03 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:	Linda Anchondo, Senior Program Manager Alan Avery, Chief Operating Officer Stephanie Camarena, Compliance Analyst II Michelle Curioso, Director of Population Health Management Sandeep Dhaliwal, Compliance Manager, Audits and Investigations Robin Dow-Morales, Senior Director of Claims Heather Fowler, Compliance Manager Yolanda Herrera, Credentialing Manager Andrea Hylton, Director of Procurement and Facilities Elizabeth Johns, Compliance Program Specialist Christina Kelly, Pharmacy Administrative and Support Supervisor Jane MacAdam, Director of Compliance and Regulatory Affairs Melissa McGuire, Senior Director of Delegation and Oversight	Deborah Murr, Chief Compliance and Fraud Prevention Officer Amisha Pannu, Senior Director of Provider Network Maria Parra, Member Services Manager Jeff Pollock, Regulatory and Government Program Manage Martha Quiroz, Chief Medical Officer Nate Scott, Senior Director of Member Services Isabel Silva, Senior Director of Wellness and Prevention Katie Sykes, Delegation Oversight Manager Bruce Wearda, Director of Pharmacy	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Previous Action Items	A. All action items from the previous meeting have been completed with the exception of the below. B. AL Ghost/Duplicate Trips 1. Delayed: Will be revisited and part of the upcoming AL annual audit. C. Ownership & Disclosure 1. All forms collected with one outstanding- UCLA received early January and submitted to DHCS (missing required information). a. Pending if it was accepted by UCLA. 2. Nate and Jane discussed: a. Within the contracting process, we are collecting the Ownership & Disclosure form for all subcontractors. When there is a change in the entities' ownership, we also notify DHCS.	☑ **ACTION**: 1. Compliance will revisit AL Ghost/Duplicate Trips at their annual audit.	N/A
VSP	A. Access & Availability - CAP Response Received 1. Alan, Melissa, Deb, Amisha, Andrea, Nate, Yolanda, and Jane discussed the VSP response: a. Question #1: VSP added three (3) new providers to the Bakersfield area. b. VSP contacted 4 Providers in the area of concern. The Providers elected not to join VSP. i. The Primary reason is the inability to accommodate additional appointments and Medicaid fees. c. Melissa will ask James to investigate	☑ **ACTION**: 2. Melissa will ask James to investigate VSP's CAP Response to question #1 3. Compliance will look into adding specific financial penalties in all contracts and set up ad hoc meetings.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	VSP's CAP Response to question #1 d. Corporate Services is working on the contract with VSP right now. i. The plan is to build the network and bring it in house, likely within the 2-year end of the contract. e. The Plan will be sending a follow-up response to VSP. f. VSP was not able to provide data on the VSP promise, but they are working on it. g. VSP is working with the Plan on a Grievance report. h. Compliance will look into adding specific financial penalties in all contracts and set up ad hoc meetings. B. Additional 'informal' corrective actions requested: 1. AB1455 Reporting (Claims Timeliness Reporting) a. The Plan has not received the corrected report. 2. NOA Letters (Denied Claims) a. The Plan is working with VSP to fix the incorrect templates. C. Annual Audit Letter sent 02/26/2023; awaiting confirmation of dates as contract requires 60-day notice.		
Health Dialog	A. Rite-Aid (owner) bankruptcy 1. Nate has not noticed any impacts from their call	☑ **ACTION**: 4. The Plan is looking into what/who is considered a Delegate.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	center. B. Annual Audit 1. Inquiry Log (from which we will request sample call recordings); Compliance Policies; Decision Trees 2. Isabel, Deb, and Jane discussed. a. Cotiviti- the Plan does not identify them as a delegated entity. The HRA component will be reviewed as a delegated service. 3. Regarding the Regulatory definitions, the Plan is looking into what/who is considered a Delegate for NCQA. C. Spanish calls being monitored separately and will be reported in Q1 Delegation Oversight Committee Meeting		
AL	A. Annual Audit 1. Compliance will schedule meeting to discuss what will be included in the AL audit. 2. Per DHCS, the Plan will be completing Announced and unannounced audit. a. The Plan will review the language in ASAs for completing announced and unannounced audits. b. The Plan will try to have the AL unannounced audit in March.	☑ **ACTION**: 5. Compliance will schedule meeting to discuss what will be included in the AL audit. 6. The Plan will review the language in ASAs for completing announced and unannounced audits. 7. The Plan will try to have the AL unannounced audit in March.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Kaiser Claims Audit	A. They did pass the audit. B. Robin will send the Kaiser Claims Audit information to Jane.	☑ **ACTION**: 8. Robin will send the Kaiser Claims Audit information to Jane.	N/A
Delegation Oversight Department	A. Congratulations Melissa and Katie on your new roles. B. Jane, Melissa, Deb, and Alan discussed: 1. Compliance Department is collaborating with the Delegation Oversight Department on the division of operational responsibilities and will notify Stakeholders. 2. Delegation Oversight Department will be meeting with each Department Stakeholders. 3. Compliance Department will meet with Alan to discuss the Delegation Oversight Department's focus on Medicare/Medi-Cal.	☑ **ACTION**: 9. Compliance Department is collaborating with the Delegation Oversight Department on the division of operational responsibilities and will notify Stakeholders. 10. Delegation Oversight Department will be meeting with Department Stakeholders. 11. Compliance Department will meet with Alan to discuss the Delegation Oversight Department's focus on Medicare/Medi-Cal.	
Reminder: Delegated Entity – Meeting materials, agendas, minutes, reports delegates	A. Centralized location: P:__Compliance\Delegation Oversight 1. Save items under this location	☑ **ACTION**: N/A	N/A
Current Monitoring/Oversight of Delegated Entities	A. Kaiser and VSP Claims Timeliness Reports (AB 1455) 1. As soon as the Plan receives the corrected VSP reports, Compliance Department will share with the Stakeholders.	☑ **ACTION**: 11. As soon as the Plan receives the corrected VSP reports, Compliance Department will share with the Stakeholders. 12. Cynthia and Martha will connect regarding the Harte Hanks audit. 13. Martha will notify Jennifer (Harte Hanks) of the audit.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	B. Call Center Stats (attached)- 4th Quarter (Oct- Dec), Maria: 1. AL: For the percent answered within 30 seconds, AL had 78.1% in November a. The Plan is monitoring. 2. Argus/DST (Not a Delegated Entity): No concern. 3. Health Dialog: For December a. The ASA (Second) is 49 b. Abandon Rate is 8.7% i. The Plan is monitoring. 4. Kaiser: No concerns. 5. PaySpan: No concerns. 6. VSP: No concerns. 7. Harte Hanks: a. Outreaching to new members to welcome them to the plan. b. Has been added to the Language Line – audit report for the 1st quarter of 2024. i. Health Education will need to sample their Spanish calls for April. a. Cynthia and Martha will connect regarding the Harte Hanks audit. b. Martha will notify Jennifer (Harte Hanks) of the audit. C. Language Line – Audit Report, Isabel: 1. The Plan has the 3rd and 4th quarter- No concerns.	14. Nate will coordinate adding the AL JOM reports/meetings to the centralized JOM folder.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	D. Joint Operating Meetings (JOM) 1. VSP and AL November Meeting Minutes: No issues brought up. 2. Nate will coordinate adding the AL JOM reports/meetings to the centralized JOM folder.		
ADJOURNMENT	The Committee adjourned at 2:08pm	N/A	N/A

KERN HEALTH SYSTEMS

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COMMITTEE: ***KHS Quarterly Compliance Committee Meeting - Q4 2023***
DATE OF MEETING: ***February 29, 2024***
CALL TO ORDER: ***9:33 am by Jane MacAdam - Director of Compliance and Regulatory Affairs***

Members Present On-Site:	N/A		
Members Virtual Remote:	N/A		
Members Excused=E Absent=A	N/A		
Staff Present:	Linda Anchondo, Compliance Program Manager Alan Avery, Chief Operating Officer Veronica Barker, Controller Karen Beale, Compliance Analyst II Brandon Bowe, Compliance Auditor Stephanie Camarena, Compliance Analyst II Cynthia Cardona, Cultural and Linguistic Services Manager Amy Carrillo, Member Services Manager Kathryn Castaneda, Compliance Analyst Michelle Chow, Pharmacy Intern Kailey Collier, Director of Quality Performance Michelle Curioso, Director of Population Health Management Sandeep Dhaliwal, Compliance Manager, Audits and Investigations Robin Dow-Morales, Director of Claims Heather Fowler, Compliance Manager	Flor Del Hoyo Galvan, Manager of Member Wellness & Prevention Jared Harness, Compliance Analyst Russell Hasting, PHM Manager of Case Management Loni Hill-Pirtle, Director Enhanced Care Management Elizabeth Johns, Compliance Program Specialist Christina Kelly, Pharmacy Administrative and Support Supervisor Leticia Lara, Assistant Controller Jane MacAdam, Director of Compliance & Regulatory Affairs Melissa McGuire, Senior Director of Delegation and Oversight Deborah Murr, Chief Compliance and Fraud Prevention Officer Jeff Pollock, Regulatory and Government Program Manager Adriana Salinas, Director of Community & Social Services Nate Scott, Director of Member Services Bruce Wearda, Director of Pharmacy	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Previous Action Items	A. Grievance Timeliness Reporting 1. Nate, Amy, and Jane discussed: a. Requested as part of Compliance Dashboard that is currently in development. b. Once the Compliance Dashboard is completed, Compliance Department will ask Member Services Department to validate the information is pulled in accurately. c. Jiva Grievance module is scheduled to go live in	☑ **ACTION**: 1. Once the Compliance Dashboard is completed, Compliance Department will ask Member Services Department to validate the information is pulled in accurately. 2. Compliance to regroup with Stakeholders to discuss IHA/Open Auths before the next Compliance Committee meeting. 3. Jane will regroup with Amy and Magdee to discuss QI audit of the exempt Grievances for a potential QOC issues before the next Compliance Committee meeting.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	April. B. IHA/Open Auths – Compliance to regroup with Stakeholders 1. Delayed – will be scheduled prior to next meeting C. Amy will send the updated Grievance Coordinator Audit report to Compliance. 1. Completed D. Compliance to audit the audits conducted by the grievance team. 1. Completed E. Jane, Amy, and Kailey will meet to discuss adding to the next meeting the QI audit of the exempt Grievances for a potential QOC issue. 1. Amy, Kailey, and Jane Discussed: Delayed – will be discussed prior to next meeting. 2. Kailey has a new position, will need to reach out to Magdee. F. 2024 OR policy versions will need to be reviewed/reconciled by Business owners. 1. In Progress 2. Compliance will implement a policy management software. G. Compliance will send to Departments a list of team members that have not completed their annual required training. 1. Completed for 4th Quarter 2. Alan, Nate, and Jane discussed: a. Updated list of those outstanding sent 02/29/2024. 3. Compliance will attempt to send the list of team members that have not completed their annual required training in time to be included in the 2024 Employee reviews. 4. Jane will reach out to HR to see if the required training notification is recurring.	4. Jane will reach out to HR to see if the required training notification is recurring.	
Compliance Week	A. First week in November 2023. B. Thanks to: 1. Stephanie and Compliance Team 2. HR Team C. Let Jane know any suggestions for 2024 Compliance week.	☑ **ACTION**: N/A	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
2024 DHCS Operational Readiness	A. 229 of 229 deliverables approved by DHCS.	☑ **ACTION**: N/A	N/A
DHCS and DMHC Audit Update	A. 2022 DHCS Medical Audit 1. Final CAP Submission 01/15/2024 2. Total of 29 findings across six categories. a. Submitted 93 corrective actions i. All were accepted except for one, prior to the 1/15/2024 submission. b. Waiting on the official close out. B. 2023 DMHC Medical Audit 1. Awaiting Report from DMHC C. 2023 DHCS Medical and Focused Audit - Preliminary Audit Report Received 1. Draft Medical Audit report has one (1) finding. 2. The Plan has 15 days to respond to the finding. 3. DHCS advised the Plan that there might not be a Focused Audit report.	☑ **ACTION**: N/A	
2023 Compliance Trainings (FWA; HIPAA; Cultural Competency: Code of Conduct)	A. Total number of 173 trainings that have not been complete 1. 108 employees a. Includes 27 new hires and still within their 90 days.	☑ **ACTION**: N/A	N/A
Governance and Compliance Committee Overview	A. Committee created and first meeting held B. Deb spoke on how this committee focuses on keeping the Board updated with all the things that are involved with Compliance.	☑ **ACTION**: N/A	N/A
Regulatory Reporting	A. Regulatory Calendar will be posted to Teams 1. An email notification will be sent out to the Plan when the Regulatory Calendar on Teams is ready to be viewed. 2. Owner Responsibilities, review for quality. 3. Reminders will still be sent. 4. Compliance will be requesting due dates in advance of the	☑ **ACTION**: 5. An email notification will be sent out to the Plan when the Regulatory Calendar on Teams is ready to be viewed. 6. Deb will send out a bulletin with guidelines on reporting timely and accurately. 7. Jane will investigate the PTM Monthly PCP Retention vs Two-week period information and discuss with Amy.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Regulatory due date. B. Compliance will be reporting timeliness and accuracy of submissions for 2024, in addition to volumes. 1. Deb will send out a bulletin with guidelines on reporting timely and accurately. C. Post-Transition Monitoring (PTM) Report – Issues 1. Continuity of Care 2. LTC ICF/DD Subacute 3. Jane will investigate the PTM Monthly PCP Retention vs Two-week period information and discuss with Amy.		
Report Review-Shown	A. IHA/Open Auths: 1. The Plan is continuing to send Letters. 2. Compliance to regroup with Stakeholders to discuss IHA/Open Auths before the next Compliance Committee meeting. B. QI IHA Audit Report: 1. February 2023- September 2023 2. Jane will confirm with Magdee that the QI IHA audit is ongoing. C. Transportation Provider Monitoring Reports: 1. October, November, and December 2023 a. Checking Monthly D. Utilization Management 1. Gold card (auto approved services) Audit Results for 2nd, 3rd, and 4th Quarter: a. 50% contain the appropriate medical necessity information and 50% do not. b. Jane will ask Provider Network Management (PNM) to connect with Utilization Management (UM) regarding the gold card report. E. Cultural and Linguistics and Health Education Reports: 1. Flor spoke on evaluating the Health Education classes- 3rd and 4th quarters were explained. 2. Cynthia spoke on evaluating Interpreter Services- 3rd and	☑ **ACTION**: 8. Jane will confirm with Magdee that the QI IHA audit is ongoing. 9. Jane will follow up with PNM/UM regarding the gold card report. 10. Jane will update the discrepancy on the number of APLs from 4th quarter and send out information. 11. Will discuss the 2023 and 2024 Compliance work Plan at the next meeting.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	4th quarters were explained. F. Member Services – Grievance Audits 1. Amy explained that we are meeting the quarterly scores. G. Compliance Reporting 2. All Plan Letters (APL) a. Jane will update the discrepancy on the number of APLs from 4th quarter and send out information. 3. Regulatory Filings and Reporting a. Total submission increase is 47% over 2022. 4. HIPAA a. 95% submitted timely 5. Independent Medical Review and Consumer Complaints a. Four (4) more cases in 2023 vs 2022 b. Overturned ourselves in 11 cases i. Need to look at why we are overturning ourselves to make sure there are no other actions needed. 6. Internal Monitoring/Audit Activities a. Compliance is in agreement with about 90% of the MS audit. 7. Compliance Work Plan a. Will discuss the 2023 and 2024 Compliance work Plan at the next meeting. 8. Compliance Capsules		
ADJOURNMENT	The Committee adjourned at 10:59am	N/A	N/A

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***MARCH 6, 2024***
CALL TO ORDER: ***7:10 AM BY JOHN MILLER, MD – CO-CHAIR***

Members Present On-Site:	Atul Aggarwal, MD - Network Provider, Cardiology Gohar Gevorgyan, MD – Network Provider, FP	Miguel Lascano, MD – Network Provider, OB/GYN John P. Miller, MD – KHS Medical Director, Co-Chair	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:	David Hair, MD - Network Provider, Ophthalmology		
Members Excused=E Absent=A	(E) Hasmukh Amin, MD – Network Provider, Pediatrics (E) Martha Tasinga, MD – KHS Chief Medical Officer		
Staff Present:	Alan Avery, KHS, Chief Operating Office Amy Daniel, KHS Executive Health Svcs Coordinator	Jake Hall, KHS, Deputy Director of Contracting Yolanda Herrera, KHS Credentialing Manager	Magdee Hugais, KHS Director of QI Yesenia Sanchez, KHS Credentialing Coordinator

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	In the absence of Dr. Martha Tasinga, MD, KHS Chief Medical Officer, John Miller, MD KHS Medical Director, called the meeting to order at 7:10 am.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, John Miller MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of February 7, 2024, seconded by Dr. Parmar Motion carried.	*3/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Peer Review Reports **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 3/01/24:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on 3/01/2024 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers approved by Dr. Tasinga were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated 3/06/2024: There were five (5) initial applications presented for comprehensive review. • **PRV008806 -** Reviewed information regarding State survey's plan of correction that was accepted by Department of Public Health during recertification. *Provider's POC received and accepted with recommendation to add to provider network.* • **PRV(V.D.) -** Reviewed information regarding 2023 NPDB Settlement alleging neglect against hospital, surgeon and anesthesiologist related to fire in the OR resulting in minor facial and scalp burns. *Provider explanation received and accepted with recommendation to add to provider network as there have been no further incidents of similar nature.* • **PRV056796 -** Reviewed information regarding 1986 program exclusion from OIG for 1-year due to unethical business practices. Provider received 1-year suspension which was completed with MBC Public Reprimand in 1998 and has had no further issues and completed all medical board actions. Provider was previously network provider and is rejoining FQHC Clinic. *Provider explanation received and accepted with recommendation to add to provider network as there have been no further incidents of similar nature.* • **PRV094388 -** Reviewed information regarding 2003 MBC Probation that was completed in 2006 due to failure to maintain adequate medical records following bone density	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated February 7, 2024, seconded by Dr. Lascano. Motion carried.	*3/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	test entered by tech using female criteria for male pt and showed to be abnormal. *Provider explanation received and accepted with recommendation to add to provider network as there have bee no further incidents of similar nature.* • **PRV066605 -** Reviewed information regarding 2018 Settlement during OB Residency alleging failure to treat fetal distress after induction of Pitocin resulting in emergency c-section. Settlement was paid by Regents of UC and provider indicates she was not involved in the settlement proceedings and has no additional input to provide. *Provider explanation received and accepted with recommendation to add to provider network as there have been no further incidents of similar nature.* **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 3/06/2024:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years: • Member Grievances: All Providers with significant Member & Quality Grievances were reviewed. Dr. Miller reported there were no quality of service or care issues identified as significant trends or concern rising to the level of review by PAC. Additionally, Dr. Miller informed the committee that the QI Team is working to standardize the quality-of-care process to identify outliers, benchmark provider types and identify those cases that rise to the level of review by the PAC. There were no additional questions or alternative actions recommended by this committee.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NEW VENDOR CONTRACTS New Vendor Contracts List Dated April 2024 (Board of Directors Meeting) were accepted as presented with no additional questions or comments by the committee members.		
OLD BUSINESS	**Delegated Credentialing 2023 Tertiary Audit Summary**	☐ **PENDING**: Ms. Herrera will monitor CHLA and UCLA Medical Groups for their pending CAP and will present to the PAC upon receipt.	*Pending*
NEW BUSINESS			
	P&P 4.01-P Credentialing Program – Revised Yolanda Herrera KHS Credentialing Manager, presented the revisions to Policy and Procedure 4.01-P Credentialing Program as follows: • Additional language was added to Page 3 under "Non-Discriminatory Credentialing of Providers" pursuant to DMHC APL 23-025 Abortion: Provider Protection Codified under H&S Code Section 1375.61 prohibiting discrimination against providers disciplined in other states that interfere with person's right to receive care that is lawful in this state. **New Policy & Procedure – Credentialing System Controls** • P&P was created as 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; titles and roles of staff authorized to review, modify and delete information; the security in place to protect the information from unauthorized modifications; and how the organization monitors its compliance at least annually.	☑ **ACTION**: Dr. Lascano moved to approve the revisions to P&P 4.01-P Credentialing Program, New P&P-Credentialing System Controls, seconded by Dr. Patel. Motion carried.	*3/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Annual Report 2023 - Credentialing System Controls Yolanda Herrera, KHS Credentialing Manager, presented the Annual Credentialing System Controls Report for 2023. **Purpose**: to ensure all credentialing activities identified to have modifications are made in compliance with KHS Credentialing System Controls Policy and Procedure. **Audit Results**: A total of 351 Initial Applications were identified with authorized modifications made during final review. Modifications included updates to OIG, Suspended/Ineligible and RPD Reports that were found to have newly posted reports prior to PAC; however, since KHS has NPDB Continuous Query, on all in-network providers, it is no longer our process to update these reports if current report is in compliance with PAC/CMO approval date. During 4th Quarter 2023, as Credentialing P&Ps were updated for NCQA preparation, attestation questions and work history was only date stamped with "received". Credentialing Staff were educated and trained to "review" the attestation questions for completeness per CR.3-Element C including 5-yrs Work History to be reviewed for compliance and stamped "Reviewed". Modifications were made and date stamped "review" during final review prior to the PAC/CMO approval date. There were no unauthorized modifications made. Actions/Interventions/Recommendations: Yolanda reported that this is KHS's first Credentialing System Controls Report. As the Credentialing Manager, she will continue to monitor modifications during final review and will also incorporate the Business Intelligence Report from the Credentialing database Symplr to review system modifications. During this audit, Yolanda identified that the credentialing database did not populate the next credentialing cycle, this caused some providers next recredentialing cycle to be blank; however, those were identified and corrected by the Credentialing Manager immediately. These appear to be one-time errors, manual missed data entries, that will be monitored during the year to confirm completion after each PAC meeting and provider activation.	☑ **ACTION**: Dr. Lascano moved to approve the Annual Report 2023 – Credentialing System Controls, seconded by Dr. Patel. Motion carried.	*3/6/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	3rd/4th Year Residents Moonlighting Outside their Residency. Yolanda report recently, KHS has received several requests from currently contracted groups to utilize 3rd Year Residents for primary care and psychiatry services. As researched, this practice is not prohibited by accreditation, licensing agencies nor CMS Medicare/Medicaid Guidelines. Accreditation standards do not require residents to be credentialed/privileged by medical staff organizations unless the resident is acting outside the residency program as an independent contractor and residents must be "authorized" to provide patient care services by their program director. Jake explained any provider practicing outside their residency program at an alternate facility would need to be credentialed if they meet our established criteria. Dr. Saadabadi added that this is a common practice in psychiatry as long as the resident has their program director's permission and abides by the hours permissible as a resident. Yolanda presented the recommended scope of practice and credentialing requirements recommended for 3rd/4th Year Residents who wish to moonlight outside their residency program: **Scope of Practice:** Signed letter of permission to moonlight by Residency Program Director including sufficient details documenting the services the resident may provide without supervision (a Program letter of Agreement (PLA) may be attached to the Residency Program Director's permission letter. 1) ***Services that require supervision are not permitted, including but not limited to invasive and surgical procedures.*** 2) ***Resident's Category is Per Diem and will not be listed in the KHS Provider Network Directory*** 3) ***Approval is only granted until completion of residency completion date at which time the resident must apply for full-time provider network status.***	☑ **ACTION**: Dr. Lascano moved to the Scope of Practice outline and Credentialing requirement for 3rd/4th Year Residents, seconded by Dr. Patel. Motion carried.	*3/7/24*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Credentialing Requirements: A. Application Form, Supplemental Forms and Supporting Documents-Source: CAQH or CPPA B. Medical School Verification-Sources: AMA Masterfile, AOA Official Osteopathic Masterfile, School Official Transcripts sent directly to KHS. C. Current and valid Post-Graduate California Licensure: Source: CA State licensing or certifying agency via verbal, written or internet/electronic method. *Must apply in advanced for full California Physician & Surgeon's licensure prior to completion of residency otherwise the resident will be terminated upon expiration date of Post-Training License. D. Current and valid DEA-Source: DEA Office of Diversion Control or certifying agency E. Professional liability coverage of at least $1,000,000.00 per occurrence and $3,000,000.00 aggregate *No invasive or surgical procedures that require supervision and resident's name must be listed on the policy certificate or declaration page F. Credentialing only under an existing Contracted Provider Group G. NPI Number – Current Valid with NPPES Registry H. Sanction Information: In good standing with Medicare, Medi-Cal, OIG/LEIE Database, DHCS Restricted Provider List and EPLS/SAM		
	Bariatric Surgery Quality of Care Issues Dr. Miller presented verbal information related to possible quality of care issues with 2-different Bariatric Surgeons who performed Bariatric Sleeve Surgeries that both resulted in gastric leaks. Although this is a rare, but known complication of this surgery, both cases required notification to the State due to being a preventable condition resulting in infection after surgery. Both surgeons are affiliated with Adventist Health and letters requiring the surgeon's responses were submitted to Adventist Health; however, KHS received the standard notification that the letter was received and will be referred to the QI	☑ **ACTION**: Dr. Patel moved to approve tracking and trending of these 2-Quality Cases and a random 10-Case review be conducted as recommended by Dr. Miller, seconded by Dr. Aggarwal. Motion carried.	***10/2/24***

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Department for internal review and due to peer review confidentiality, the results would not be shared. Dr. Miller recommended that these cases be tracked and trended for each provider and that a random case review of 10-cases be reviewed over a six-month period be conducted to ensure no further incidents of this type of complication reoccur.		
OPEN FORUM	Dr. Patel opened discussion regarding the increased population to the Kern Family Health Plan and that we are seeing a sicker patient population. Upon patient's discharge from the hospital, the specialists are either not following up with the patient or are not contracted to continue seeing the patient. Jake Hall, Deputy Director of Contracting, provided information on the requirements for continuity of care and the Letter of Agreement process that is utilized when specialist is not contracted with KHS or if there is a need to escalate to a tertiary care provider.	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, April 3, 2024 at 7:00 am.	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 7:59 am. ***Respectfully submitted: Amy L. Daniel, Executive Health Services Coordinator***	**N/A**	*N/A*

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, March 28, 2024

8:30 A.M.

COMMITTEE RECONVENED

Members: Acharya, Hoffmann, Meave, Turnipseed
ROLL CALL: 3 present – 1 Absent - Acharya

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.

3) Report on Kern Health Systems Code of Conduct (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Meave: 3 Ayes; 1 Absent – Acharya

4) Report on Kern Health Systems Compliance Self-Study Employee Guide (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Meave: 3 Ayes; 1 Absent – Acharya

5) Report on Kern Health Systems Compliance Awareness Survey (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Meave: 3 Ayes; 1 Absent – Acharya

6) Report on Kern Health Systems 2023 Department of Health Care Services Draft Audit Report Response (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Meave: 3 Ayes; 1 Absent – Acharya

7) Report on Kern Health Systems 2023 Department of Managed Health Care Preliminary Audit Report (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Meave: 3 Ayes; 1 Absent – Acharya

8) Report on Kern Health Systems 2024 Compliance Work Plan Q1 Update (Fiscal Impact: None) –
RECEIVED AND FILED; REFERRED TO KHS BOARD OF DIRECTORS
Turnipseed-Meave: 3 Ayes; 1 Absent – Acharya

ADJOURN TO THURSDAY, MAY 23, 2024, AT 8:30 A.M.