KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: KHS Supplemental Payment Policy				POLICY #: 6.36-P	
DEPARTMENT: Claims					
Effective Date:	Review/Revised Date:	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
11/22/2022	11/22/2022	BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Financial Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Director of Claims

POLICY:
Kern Health System (KHS) will make supplemental payments for claims that meet the criteria identified in Prop 56 guidelines for Family Planning, per APL 22-011.

PROCEDURES:
I. Under federal law, KHS, does not limit the qualified person from whom the individual may receive family planning services under Title 42, Section 1396d (a)(4)(C), which states: family planning services and supplies are furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies.

II. KHS will allow members to have freedom of choice of family planning providers and may receive such services from any qualified family planning provider, including out-of-network providers, without the need to obtain prior authorization.

III. This program focuses on the following categories of family planning services:
   A. Long-acting contraceptives
   B. Other contraceptives (other than oral contraceptives) when provided as a medical benefit
   C. Emergency contraceptives when provided as a medical benefit
   D. Pregnancy testing
   E. Sterilization procedures (for females and males)

IV. KHS and its delegates will pay qualified contracted and non-contracted providers a uniform and fixed dollar add-on amount for the specified family planning services in accordance with APL 22-011 that are provided to a Medi-Cal managed care member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medi-Care Part A or Part D) with dates of service on or after July 1, 2019, in accordance with the CMS-approved preprint of this program.

V. KHS reports all qualifying family planning services to DHCS in encounter data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes listed in APL 22-011, and for ensuring that the encounter data reported to DHCS is appropriate for the services being provided.

VI. The uniform dollar add-on amounts of the directed payments vary by procedure code and are in addition to any other payments eligible providers would normally receive from KHS or its delegates.

VII. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), American Indian Health Service Programs (AIHSP), and Cost-Based Reimbursement Clinics are not eligible to receive this uniform dollar add-on directed payment.

VIII. Beginning with the calendar quarter ending June 30, 2020, KHS will report to DHCS within 45 days of the end of each calendar quarter all directed payments made pursuant to APL 22-011. Reporting to DHCS must include all directed payments made for dates of service on or after July 1, 2019, and that all reports must be submitted in a consumable file format (i.e., Excel or Comma Separated Values). KHS will provide these reports in a format specified by DHCS, which, at a minimum, must include the Health Care Plan code, procedure code, service month, payor (i.e., KHS or Subcontractor), and the Provider's National Provider Identifier (NPI).

IX. KHS will continue to submit updated reports each subsequent quarter in the same format as the initial submission until the MCP considers the report to be complete. Each updated report replaces any prior reports and that the updated quarterly report must be submitted in the appropriate file format and include an attestation that KHS considers the report complete.

X. KHS will make separate supplemental payments within 90 calendar days of the date KHS receives payment from DHCS for the projected value of the directed payments, or within 90

calendar days of receiving a clean claim or accepted encounter that is received within one year of the date of service. This applies to all claims with a date of service beginning July 1, 2019, and onward

XI. KHS is not required to make the payments described in this APL for clean claims or accepted encounters for applicable family planning services received by the MCP more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between the MCP (or the MCP's Subcontractors) and the affected Provider. However, KHS can extend the one-year grace period if it deems appropriate without approval.

XII. KHS does have a formal procedure for the acceptance, acknowledgment, and resolution of Provider grievances related to the processing or non-payment of a directed payment as required by APL 22-011, which is handled and managed by Provider Network Management. The information will be posted on the Explanation of Payment provided with each payment.

XIII. KHS also communicate the requirements of APL 22-011 to Providers via the Provider Manual and/or provider bulletins which includes a description of how payments will be processed; how to file a grievance; and how to determine who the payor will be.

XIV. This policy is subject to future budgetary authorization and appropriation by the California Legislature and CMS approval of the directed payment arrangement, DHCS intends to renew this directed payment arrangement on an annual basis in future years, where the requirements of APL 22-011 may change.

REFERENCE:

Revision 2022-09: New Policy created by the Director of Claims to comply with DHCS APL 22-011.