KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Supplemental Benefit Vendor Oversight	**Policy #**	25.01-P
Policy Owner	Delegation and Oversight	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	02/02/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

Kern Family Health Care Medicare (HMO D-SNP) will conduct appropriate oversight of third-party vendors who provide supplemental benefits to ensure compliance with Centers for Medicare & Medicaid Services (CMS) regulations, contractual obligations, and organizational standards.

Kern Family Health Care Medicare (HMO D-SNP) offers supplemental benefits to enrollees through contracts with supplemental benefit vendors. This policy applies to all contracted supplemental benefit vendors including but not limited to vision, dental, hearing, and any special supplemental benefit for the chronically ill (SSBCI).

II. POLICY

A. Kern Family Health Care Medicare (HMO D-SNP) must maintain a robust oversight program to ensure supplemental benefit vendors achieve the following:

1. Comply with CMS regulations including requirements identified in 42 CFR 422.504 and 423.505 and ensuring enrollee protection provisions are followed that prohibit holding an enrollee liable for payment of any fees that are the obligation of Kern Family Health Care Medicare (HMO D-SNP).
2. Provide supplemental benefits which meet the standards of timeliness, access, and quality.
3. Deliver supplemental benefits in accordance with the bid approved by CMS.

III. DEFINITIONS

TERMS	DEFINITIONS
Centers for Medicare & Medicaid Services (CMS)	The Federal agency within the Department of Health and Human Services (DHHS) administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations.

Dual Special Needs Plan (D-SNP)	Medicare Advantage coordinated care plans that serve the special needs of those entitled to Medical Assistance under a State Plan under Title XIX.
Special Supplemental Benefits for the Chronically Ill (SSBCI)	Special benefits available only to chronically ill members, targeted based on clinical and social needs.
Prior Authorization (PA)	The process undertaken to make a benefit determination that is made prior to the intended delivery of the healthcare service, treatment, or supply under review (e.g., a Pre-Service Claim). Prior Authorization includes requests for coverage determination for medications that are designated on the client part D formulary as "Prior Authorization Required," "Step Therapy," "Quantity Restrictions" or for requests for exception for non-formulary medications or co-insurance amount.
Vendor	Any contracted third-party entity providing a service or benefit on behalf of the Medicare Advantage plan (e.g., transportation, meals, pest control, in-home support).

IV. PROCEDURES

A. ELIGIBILITY VERIFICATION

1. Kern Family Health Care Medicare (HMO D-SNP) (KFHCM) will provide all supplemental benefit vendors with enrollment data. For any SSBCI benefits, Kern Family Health Care Medicare (HMO D-SNP) will provide the supplemental benefit vendor eligibility data to identify qualifying enrollees based on diagnosis codes.
2. Contracted supplemental benefit vendors will be responsible for ensuring eligibility is verified prior to providing any contracted supplemental benefits. The supplemental benefit vendors will contact KFHCM for any questions or concerns related to eligibility.

B. ENROLLEE COMMUNICATION

1. Contracted supplemental benefit vendors are required to submit all member materials to KFHCM for approval prior to use. Any changes to enrollee material must be submitted and approved by KFHCM prior to implementation.
2. Enrollee materials include but are not limited to digital content, marketing materials, benefit descriptions, and eligibility notices.
3. All material must reflect the most current and approved benefit offerings, including what the benefit is, who qualifies, how and when it can be accessed, and any limits or conditions. In addition, all enrollee materials must contain clear language, accurately define the benefit and eligibility criteria as applicable, and must be available in KFHCM threshold language(s) and accessible formats. Materials may not contain misleading, confusing, or discriminatory language, and must and compliant with CMS regulations.

C. REPORTING

1. Supplemental vendor contracts will include reporting requirements which will be used to conduct oversight of the supplemental benefit vendor and report data to CMS. The list of reports in the vendor contract is not exhaustive and additional reporting can be requested of the supplemental benefit vendor. KFHCM will ensure all departments who have oversight responsibilities will be provided with the reports to conduct appropriate oversight. Reporting requirements include but are not limited to:
    a. Credentialing – Provider roster
    b. Enrollee Satisfaction
    c. Encounter data
    d. Claims payment timeliness
    e. Appropriate transfer to KFHCM call center for enrollee dissatisfaction as grievances are not a delegated function of the supplemental benefit vendors
    f. Fraud, Waste, and Abuse (FWA) incidents
    g. CMS audit requests
    h. All reports will be delivered to KFHCM via a mutually agreed HIPAA compliant method.

D. COMPLIANCE AND OVERSIGHT

1. Prior to implementing a supplemental benefit, KFHCM will conduct a pre-delegation audit of each supplemental benefit vendor. The pre-delegation audit will involve the appropriate departments who will be responsible for oversight functions including but not limited to Compliance, Delegation and Oversight, Member Services, Credentialing, and Claims.
2. Post supplemental benefit implementation, the following KFHCM oversight activities will be conducted on each supplemental benefit vendor on an ad hoc, monthly, or quarterly basis:
    a. Service level Agreement review and reporting to the Kern Health Systems Delegation and Oversight Committee
    b. Review and discuss Joint Operations Meetings (JOM) minutes
    c. Retrospective review of grievances with bifurcation of grievances found in favor of the plan and found in favor of the enrollee.
    d. Appropriate handling of Fraud, Waste, and Abuse incidents
    e. Appropriate and timely handling of enrollee dissatisfaction transferring to KFHCM and grievance response
    f. Claims processing and timeliness
    g. Benefit utilization
    h. Enrollee access to benefit
3. KFHCM will be responsible for providing any applicable changes to CMS regulations to all supplemental benefit vendors. Communication can be conducted through various methods including email and JOMs. The supplemental benefit vendor will confirm adherence to any new regulatory requirements which are applicable to them. KFHMC may include updated regulatory requirements in ongoing monitoring to ensure compliance.
4. Any issues of noncompliance will be addressed with the supplemental benefits vendors and KFHCM may use various methods to ensure compliance including but not limited to initiating a corrective

action plan.

V. ATTACHMENTS

Attachment A:	

VI. REFERENCES

Reference Type:	Specific Reference:
Regulatory	Medicare Managed Care Manual – Chapter 4
Regulatory	CMS HPMS Memos
Regulatory	SSBCI Guidance and FAQs
Regulatory	CMS Medicare Communications and Marketing Guidelines (MCMG)
Regulatory	42 CFR 422.504 and 423.505

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New policy created to comply with D-SNP.	M.M. Delegation and Oversight

I. APPROVALS

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