KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	EPSDT Supplemental Services and Targeted Case Management (TCM)	**Policy #**	3.13-P
Policy Owner	Utilization Management	**Original Effective Date**	8/1997
Revision Effective Date	7/22/2024	**Approval Date**	1/10/2025
Line of Business	☒ Medi-Cal ☐ Medicare		

I. PURPOSE

To define Kern Health Systems'(KHS) procedures for covering and ensuring the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under the age of twenty-one (21), including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Supplemental Services to ensure they are provided and coordinated in accordance with Centers for Medicare and Medicaid Services (CMS), California and Department of Healthcare Services (DHCS) Regulations and Requirements.

II. POLICY

A. KHS is required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under the age of twenty-one (21), including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist members in gaining access to necessary medical, behavioral health, dental, social, educational, and other services. KHS will ensure that case management is provided to each member. KHS maintains procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside KHS's provider network. If KHS determines that case management services are medically necessary and not otherwise available within KHS's case management program, KHS will provide, or arrange and pay for the case management services for its members who are eligible for EPSDT services (Title 22, CCR, and Section 51340(k)). KHS will ensure the provision and referral of appropriate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) in accordance with the following statutory, regulatory, and contractual requirements:

1. Title 22, California Code of Regulations (CCR), Section 51184 and 51340(k)
2. DHCS 2024 Contract Exhibit A Attachment III Section 2.2.10.A.1) Quality Care for Children A. 2) and 3)
3. DHCS All Plan Letter (APL) 14-011 Behavioral Health Treatment Coverage for Children

Diagnosed with Autism Spectrum Disorder

4. DHCS APL 19-010 Requirements For Coverage Of Early And Periodic Screening, Diagnostic, And Treatment Services For Medi-Cal Members Under The Age Of 21
5. DHCS APL 20-012 Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21
6. Pursuant section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT)
7. Section 1374.73 of the Health and Safety Code
8. Pursuant to Section 14132.56 of the Welfare & Institutions Code

III. DEFINITIONS

TERMS	DEFINITIONS
EPSDT Services	EPSDT Services means Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act. (42 United States Code (U.S.C.) §§ 1396a (a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).)
Maintenance Services	Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.
Ameliorate	Ameliorate is to "make more tolerable. Additional services must be provided if determined to be medically necessary for an individual child.
Medically Necessary	Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "medically necessary" or a "medical necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. KHS shall apply this definition when determining if a service is medically necessary or a medical necessity for an EPSDT eligible member.
EPSDT Case Management Services[i]	Services that will assist EPSDT-eligible individuals in gaining access to needed medical, social, educational, and other services. "Case Management Services" means those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance the case managers provide in assisting eligible individuals is set forth in 42 CFR 14 section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h). SA Pg. Pg. 3, para. 1.
EPSDT Diagnosis and Treatment Services[ii]	Only those services provided to persons under 21 years of age that: A. Are identified in section 1396d(r) of Title 42 of the United States Code, B. Are available under CCR Title 22 Chapter 3 of Division 3 Subdivision 1, ccr.oal.ca.gov without regard to the age of the recipient or that are provided to persons under 21 years of age pursuant to any provision of federal

	Medicaid law other than section 1396d(a)(4)(B) and section 1396a(a)(43) of Title 42 of the United States Code, and C. Meet the standards and requirements of CCR Title 22 Sections 51003 and 51303, ccr.oal.ca.gov and any specific requirements applicable to a particular service that are based on the standards and requirements of those sections.
Private Duty Nursing	Private Duty Nursing (PDN) means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse (42 CFR. § 440.80.).
Home Health Agency	Home Health Agency as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.
Individual Nurse Provider	Individual Nurse Provider (INP) means a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.
Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care	American Academy of Pediatrics, (AAP) developed guidelines" Bright Futures Guidelines" and the "Recommendations for Preventive Pediatric Health Care," which is also known as the "periodicity schedule." Are procedures that Bare to be provided to children at age specific periodic intervals specific ages from birth through age 21.

IV. PROCEDURES

A. PROGRAM DESCRIPTION

1. The EPSDT benefit provides comprehensive screening, diagnostic, treatment, and preventive health care services for individuals under the age of 21 who are enrolled in Medi-Cal and is key to ensuring that members who are eligible for EPSDT services receive appropriate preventive, dental, mental health, developmental, and specialty services.

2. Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income individuals under 21 years of age. States are required to provide any Medicaid covered services listed in section 1905(a) of the SSA for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

3. In accordance with Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c), services must also be provided when medically necessary to prevent disease, disability,

and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.

4. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.

5. The EPSDT benefit is more robust than the Medi-Cal benefit package provided to adults and is designed to ensure that eligible members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

6. Where diagnostic, treatment, or other EPSDT services are provided in a home or community-based setting, the total costs incurred by the Medi-Cal program for the service must be less than what the total costs would be for the provision of medically equivalent services in an appropriate institutional level of care.

7. All members under the age of 21 must receive EPSDT screenings designed to identify health and developmental issues, as early as possible. The EPSDT benefit also includes medically necessary diagnostic and treatment services for members with developmental issues when a screening examination indicates the need for further evaluation of a child's health. The member should be appropriately referred for diagnosis and treatment without delay.

8. KHS on an ongoing basis will update evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials including children and families DHCS developed child-focused and teen-focused that provide overview of EPSDT, including Covered Services. KHS will publish updated DHCS member-facing materials as needed with "Medi-Cal for Kids and Teens on the website including: 1). Your Medi-Cal Rights letter on the website addressing EPSDT covered services and how to access those services including the importance of preventive care; 2). Your Medi-Cal Rights letter that illustrates what to do if Medi-Cal Care is denied, delayed, reduced, or stopped including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources; KHS may change logo on the DHCS supplied outreach and education brochures but will not make any other changes. This information is available in KHS member informing materials such as the KHS Member Handbook and annual member newsletters and KHS website.

9. KHS will mail these DHCS outreach and health education age-appropriate materials and "Medi-Cal for Kids & Teens Your Medi-Cal Rights letter within seven days of the new KHS member enrollment (under 21 years of age) beginning on June 1, 2023, and on an

annual basis by January 1st of each calendar year thereafter. By 2024, KHS will mail or share electronically DHCS supplied materials for existing members under the age of twenty-one (21). KHS offers member informing material availability in all languages.

10. All member notices include an insert on how members can access materials translation services. which also includes font and format requirements according to federal and state law, KHS contract and APLs. Additionally, KHS materials are written in easily understood 6th grade reading level and layman terminology.

11. KHS will coordinate and facilitate member access to providers of member preference to the best of its ability to support the member's cultural needs to achieve this objective when necessary EPSDT services is arranged with an out of network qualified provider through the Letters of Agreement (LOA) process mutually agreed upon between KHS and the provider.

12. KHS providers must comply with the Americans with Disabilities act mandate to provide services in the most integrated setting appropriate to Members and in compliance with anti-discrimination laws.

13. KHS complies with Title 42 of the USC Section 1396d(r)(5) and does not allow "flat or hard limits" based on a monetary cap or budgetary constraints.

B. REFERRALS

1. Referrals may be based on needs identified by the Member's Primary Care Practitioner/Physician (PCP), the Member, the Member's family, and encounters with other Practitioners (e.g., school nurse).

2. Selected EPSDT services must receive Prior Authorization and based on one of the following Medical Necessity standards:
    a. The standards and requirements applicable to EPSDT services as defined in Title 22, California Code of Regulations, Section 51340.1; or
    b. The distinct EPSDT service-specific requirements as defined in Section 51340.1.

3. Medical necessity determinations for services requested under EPSDT are individualized and reviewed on a case-by-case basis and take into account the particular needs of the member. Application of medical necessity will comply with WIC Section 14059.5(b)(1)

4. Requests and referrals for EPDST shall include documentation to support the requested EPSDT services, including any of the following, as appropriate, for the service requested:
    a. Nutritional assessment, home health evaluation, evidence of family/caretaker participation in care planning, treatment plan, goals, and anticipated time needed to meet therapeutic goals, and specific outcome measurements:
        i. The principal diagnosis and significant associated diagnoses,

ii. Prognosis,
iii. Date of onset of the illness or condition, and etiology if known,
iv. Clinical significance or functional impairment caused by the illness or condition,
v. Specific types of services to be rendered by each discipline with physician's prescription where applicable,
vi. The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goal,
vii. The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care,
viii. Any other documentation available which may assist the Department in making the determinations required by this section.

5. If none of the above criteria are applicable to the requested service, the requested EPSDT service shall be evaluated under the expanded Medical Necessity criteria, as defined in Title 22, California Code of Regulations, Section 51340(e)(3), including, but not limited to, services that are intended to correct or ameliorate defects or physical conditions and supplies or items that are medical rather than primarily cosmetic in nature, not experimental and not solely for the convenience of the Member, family, physician, or other Practitioner.
    a. The services shall be the most cost-effective treatment based on a case-by-case evaluation.
    b. The services shall be generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are proposed to be used and shall be within the authorized scope of the Practitioner and are an approval mode of treatment for the health condition of the Member.

6. KHS shall process a request for EPSDT services that require Prior Authorization in the same manner as any request for Prior Authorization of non-EPSDT services under the KHS Utilization Management Program.

7. For KHS to Complete and Authorization Request Referral the following supporting information will be required:
    a. Documentation which supports the Medical Necessity of the requested services, including but not limited to level of care determination,
    b. Plan of Treatment (POT) signed by a physician,
    c. Home safety assessment (may be included in the POT); and,
    d. Emergency Plan (may be included in the POT).

C. SCREENINGS AND ASSESSMENTS

1. KHS shall ensure appropriate EPSDT services are initiated in a timely manner, as soon as possible, but no later than sixty (60) calendar days following either a preventative screening or other visit that identifies a need for follow up.

2. On an annual basis, for those Members under twenty-one (21) years of age who have not accessed EPSDT and AAP Bright Futures preventive services, KHS shall inform Members or their families/primary caregivers about EPSDT and AAP Bright Futures, including the

benefits of preventive care, the services available under EPSDT and AAP Bright Futures, where and how to obtain these services and that necessary transportation and scheduling assistance is available in a culturally and linguistically manner.

3. Screenings are supported by Pediatric and Family Practice Providers as a standard of practice utilize the Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care, also known as the "Periodicity Schedule," is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.

    a. KHS will perform a qualifying developmental screening service utilizing a standardized tool that meets all of the following CMS criteria:
        i. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
        ii. Established Reliability: Reliability scores of approximately 0.70 or above.
        iii. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
        iv. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

    b. Eligible Network Providers will include the following areas in their documentation:
        i. The tool that was used.
        ii. That the completed screen was reviewed.
        iii. The results of the screen.
        iv. The interpretation of the results.
        v. Any discussions with the Member and/or family; and any appropriate actions taken.
            1) Note, this documentation must remain in the Member's medical record and be available upon request by the Member and/or Member's parent(s)/guardian(s).
        vi. Completion of the developmental screening with Current Procedural Terminology (CPT) code 96110 without the modifier KX.
        vii. Any additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX.

    c. Screening services also occur at intervals indicated as Medically Necessary, including, at a minimum, a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, and health education to determine the existence of physical or mental illness, or conditions.

d. EPDST screening services are provided at intervals which meet reasonable standards of medical and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screenings include but are not limited to:

4. Vision screening services to include, at a minimum, diagnosis, and treatment for defects in vision, including eyeglasses.

5. Dental screening toto include, at a minimum, treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.

6. Hearing screening toto include, at a minimum, diagnosis, and treatment for defects in hearing, including hearing aids.

7. Other necessary health care, diagnostic services, treatment, and measures, as described i42 USC 1396d (a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.

8. Blood Lead Anticipatory Guidance and Screening Requirement Federal law requires states to screen children enrolled in Medicaid for elevated blood lead levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Accordingly, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin in November 2016 that provides an overview of blood lead screening requirements for children enrolled in Medicaid. In addition, KHS is contractually required to cover and ensure that network providers provide blood lead screening tests in accordance with the California Code of Regulations (CCR).
    a. In accordance with APL 20-016, KHS will ensure that their contracted providers (i.e. physicians, nurse practitioners, and physician's assistants), who perform periodic health assessments on children between the ages of six months to six years (i.e. 72 months), comply with current federal and state laws and industry guidelines for health care providers issued by Childhood Lead Poisoning Prevention Branch (CLPPB), including any future updates or amendments.

D. Case Management

1. KHS provides case management to assist members less than 21 years of age in gaining access to all medical necessary medical, Behavioral Health, dental, social, educational, and other services, as defined in 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and Welfare & Institutions (W&I) Code section 14059.5(b). KHS case management services will also include the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services.

2. To further support Member access to EPDST and case management services KHS has executed Memorandum of Understanding (MOUs) with Local Health Department (LHDs) and LGAs, Local Education Agency (LEAs), in the KHS service areas, including but not limited to California Children's Services (CCS), Women Infants and Children Program (WIC), maternal and child health, social services, Regional Centers, and child welfare departments. After a member is enrolled in the CCS Program within a Whole Child Model count, obligation of KHS's case management and care coordination must continue to communicate with the local counts CCS Program to ensure that the member's care needs are continuously met and to arrange for the members EPSDT services.

3. Case management services are covered when:
    a. The service to which access is to be gained through case management is medically necessary for the EPSDT-eligible beneficiary. Or,
    b. The EPSDT-eligible beneficiary has a medical or mental health condition or diagnosis.

4. Requests for EPSDT case management services shall not be approved if it is determined the EPSDT case management services appropriate to the EPSDT-eligible beneficiary's needs can reasonably be obtained through the use of family, agency, or institutional assistance that is typically used by the general public in assuring that children obtain necessary medical, social, educational, or other services.

    a. In making the determination the following factors will be taken into account:
        i. Whether or not the beneficiary has a complicated medical condition, including a history of multiple or complex medical or mental health diagnoses, frequent recent hospitalizations, use of emergency rooms, or other indicators of medical or mental health conditions resulting in significant impairment.
        ii. Whether or not the beneficiary has a history of one or more environmental risk factors, including:
            1) Parent, guardian, or primary care-giver mental retardation or mental illness, physical or sensory disability, substance abuse, under age 18 years, prolonged absence, or
            2) Other environmental stressors, which may result in neglect, abuse, lack of stable housing, or otherwise compromise the parent's, guardian's, or primary caregiver's ability to assist the beneficiary in gaining access to the necessary medical, social, educational, and other services.

    b. A Member identified as a Child with Special Health Care Needs through a request for EPSDT Services shall be referred to the KHS Comprehensive Case

Management Process and as identified for a child with a qualifying condition to the California Children's Services Program Whole-Child Model

c. The EPSDT benefit includes case management and Targeted Case Management (TCM) services designed to assist the member in gaining access to necessary medical, social, and educational and other services. When the need for TCM services is identified, KHS shall:
   i. Determine whether a member requires Case Management (CM) or Targeted Case Management (TCM) services under EPSDT.
   ii. For members who are eligible for CM or TCM services, KHS will either provide services or refer and collaborate with the appropriate agency, RC, or local government health program where applicable.
   iii. If a member is currently receiving TCM services, KHS will coordinate the member's health care needs and EPSDT services with the TCM provider.
   iv. If KHS determines that an eligible member is not accepted for TCM services, KHS will ensure that the member has access to services comparable to EPSDT TCM services.

d. Where another entity has overlapping KHS must assess the level of service provided by the other entity and coordinate the provision of services to avoid duplication of services.

E. Transportation

1. Under the EPSDT benefit, for members under the age of 21, KHS:
   a. May provide medical (NEMT) and non-medical (NMT) transportation, meals and/or lodging to and from any medically necessary covered EPSDT appointment as outlined by Title 42 Code of Federal Regulations (CFR) Section 440.17 (a)(3).
   b. KHS shall provide appointment scheduling assistance to and from medical appointments for the medically necessary EPSDT services covered by KHS.

F. Medical Necessity Standards

1. Specifically, for members under the age of 21, KHS is required to provide and cover all medically necessary services with the following exceptions:
   a. Dental services provided by dental personnel covered by the Medi-Cal Denti-Cal Program (Policy Letter 13-002).).
   b. For members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made from members no later than 12 months of age or when a referral is indicated based on assessments.

2. Non-medical services provided by Regional Centers (RCs) to members with developmental disabilities, including, but not limited to, respite, out-of-home placement, and supportive living. However, KHS will monitor and coordinate all medical services with RC staff.

3. Alcohol and substance use disorder treatment services available under the Drug Medi-Cal Program and outpatient heroin detoxification services, including all medications used for treatment of alcohol and substance use disorder covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through Medi-Cal fee-for-service (FFS).

4. Specialty mental health services listed in Title 9, CCR, Section 1810.247 for members that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, 1830.205, or 1830.210, which must be provided by a mental health plan (APLs 13-018 and 17-018).

5. CCS services that are not included in the KHS capitated rate. The EPSDT services determined to be medically necessary for treatment or amelioration of the CCS-covered condition, including private duty nursing related to a CCS-eligible condition, must be case managed and have obtained prior authorization by the CCS program (on an FFS basis) (Title 22, CCR, Section 51013),8.

6. Services for which prior authorization is required but are provided without obtaining prior authorization; and,

7. Other services listed as services that are not "Covered Services" under KHS's Contract with DHCS, such as Pediatric Day Health Care services.

8. Where another entity such as a local education agency (LEA), RC, or local governmental health program—has overlapping responsibility for providing services to a member under the age of 21, KHS will assess what level of medically necessary services the member requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that KHS and the other entities are not providing duplicative services.

9. KHS has the primary responsibility to provide all medically necessary services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements regarding provision of services. KHS should not rely on a LEA program, RC, CCS, Child Health and Disability Prevention Program, local governmental health program, or other entities as the primary provider of medically necessary services. KHS is the primary provider of such medical services except for those services that have been expressly carved out. KHS is required to provide case management and coordination of care to ensure that members can access medically necessary medical services as determined by the KHS provider. For example, when school is not in session, KHS will cover medically necessary services that were being provided by the LEA program when school was in session.

G. REPORTING & MONITORING

1. KHS currently utilizes prior authorization requests, encounter data, and claims payments to track ESPDT services provided to members. Tracking reports include specified patient demographic information, the ordering physician, rendering provider of services, CPT codes, International Classification of Diseases (ICD)-10 codes, screening reports and

analysis data on tests or service performed.

2. ESPDT services that have been approved an arranged but have not been utilized for the member will be captured as an unused service authorization. This report is derived from matching authorizations to unpaid claims. Unused service requests will be followed up by sending a report to the member's PCP and performing outreach to the member to prompt further assessment and actions to engage the member in receiving the service.

3. Case management coordination medical records and progress.

H. MONITORING

1. KHS will provide training to ALL laboratories and health care providers performing blood lead analysis and monitor through quarterly reporting reconciliation for members less than 6 years of age. Providers will be notified of compliance with this requirement through various communication channels and ongoing auditing of screenings performed.

I. PRIVATE DUTY NURSING

1. As outlined in DHCS APL 20-012 and the I.N. Settlement Agreement, KHS is required to provide Case Management Services as set forth in its Medi-Cal contract to all plan enrolled Medi-Cal beneficiaries who are EPSDT eligible and for whom Medi-Cal Private Duty Nursing services have been approved, including, upon a plan member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the plan member, even when the Plan is not financially responsible for paying for the approved Private Duty Nursing services. Medi-Cal Private Duty Nursing services include Private Duty Nursing services approved by the California Children's Services Program (CCS).

2. KHS shall use one or more Home Health Agencies, Individual Nurse Providers, or any combination thereof, in providing Case Management Services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when the Plan is not financially responsible for paying for the approved Private Duty Nursing services. When KHS has approved EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services, the Managed Care Plan has primary responsibility to provide Case Management for approved Private Duty Nursing services. When CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive Private Duty Nursing services for treatment of a CCS condition, the CCS Program has primary has primary responsibility to provide Case Management for approved Private Duty Nursing services.

3. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary

is enrolled in (which may be KHS, CCS, or the Home and Community Based Alternatives Waiver Agency) to request Case management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services as described above to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

4. KHS obligations to enrolled EPSDT eligible members who are approved to receive Private Duty Nursing services who request Case Management Services for their approved Private Duty Nursing services include, but are not limited to:
    a. providing the member information about the number of Private Duty Nursing hours that they are approved to receive.
    b. contacting enrolled Home Health Agencies and enrolled Individual Nurse Providers to seek approved Private Duty Nursing services on the member's behalf.
    c. identifying and assisting potentially eligible Home Health Agencies and Individual Nurse Providers with navigating the process of enrolling to be a Medi-Cal provider.
    d. working with Home Health Agencies and enrolled Individual Nurse Providers to jointly provide Private Duty Nursing services to the member as needed.

5. The California Code of Regulations (CCR) further clarifies the parameters of California's implementation of the EPSDT program. Pursuant to Title 22 of the CCR, Section 51184(a)(3), screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition. Screening services must identify developmental issues as early as possible.

6. KHS is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary services that KHS is responsible for providing, including carved out services, pursuant to the contract with DHCS.

7. KHS is responsible for determining whether a member requires Targeted Case Management (TCM) services, and refers members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.[iii] If members under age 21 are not accepted for TCM services, KHS ensures the member has access to services comparable to EPSDT TCM services.[iv] Such services would be provided through the County Health System if not otherwise available.
    a. If a Member is receiving TCM services as specified in Title 22, CCR, Section 51351, KHS is responsible for coordinating the member's health care with the TCM Provider and for determining the medical necessity of covered diagnostic and treatment services recommended by the TCM provider.[v]

J. DELEGATION

1. KHS is responsible for ensuring that our delegates, subcontractors, and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These EPSDT

requirements must be communicated by KHS to all delegated entities and subcontractors.

K. PROVIDER TRAINING

1. Beginning January 2024, KHS will ensure that all the network providers complete EPSDT specific training no less than every two years with an attestation of completion. KHS will use the DHCS developed Provider training program for uniformity and shared understanding across the state. KHS will have these training requirements available in the Provider Manual and included in their policies and procedures. To reduce Network Providers contracted with multiple MCPs from completing duplicative trainings, KHS will have the option to share training records with other MCPs.

2. In the event, KHS chooses to augment the DHCS developed provider training materials, KHS will submit to DHCS for approval the training materials with highlighted edits prior to their distribution and use.

3. Annually, KHS will distribute an attestation to all network providers showing compliance with the EPSDT training requirements. KHS will maintain a list of network providers who have completed their training within the past 12 months as part of KHS annual comprehensive plan by February 15 of each calendar year. List will include the following:
    a. How many network providers serve member under the age of 21.
    b. How many network providers are not in compliance, and
    c. Outline of the steps KHS has taken to ensure network providers are fully compliant.

V. ATTACHMENTS

Attachment A: Member Incentive Engagement Program Description

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	CCR Title 17 Section 37100
Regulatory	CCR Title 22 Section 51184(g)
Regulatory	CCR Title 22 Section 51184(b)
DHCS Contract (Specify Section)	DHS Contract A-11 2
DHCS Contract (Specify Section)	DHS Contract A-11 2P-3.13 EPSDT
Regulatory	WIC Section 14059.5(b)(1)
DHCS Contract (Specify Section)	DHCS 2024 Contract Exhibit A Attachment III Section 2.2.10.A.1) Quality Care for Children A. 2) and 3)

DHCS Contract (Specify Section)	DHCS APL 19-010 Requirements For Coverage Of Early And Periodic Screening, Diagnostic, And Treatment Services For Medi-Cal Members Under The Age Of 21

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2024-07	A Purpose statement was added to the UM. Approved by DHCS for 2024 Post OR D.0330.24 (R.0122) on 6/11/2025	UM
Revised	2023-11	Updated per APL 23-015 and 23-016 requirements – Approved by DHCS on 11/13/2023.	UM
Revised	2023-08	Updated per 2024 DHCS contract language (R.0053) – Approved by DHCS on 8/28/2023.	UM
Revised	2023-08	Updated per APL 23-005 – Approved by DHCS on 8/21/2023.	UM
Revised	2023-07	Updated per APL 23-005	UM
Revised	2023-04	Updated per APL23-005 – Submitted to DHCS on 6/14/2023.	UM
Revised	2023-03	Updated per 2024 DHCS contract. Exhibit A Attachment III Section 2.2.10.A. 1) Quality Care for Children A. 2) and 3) - (R.0052) – Approved by DHCS on 5/2/2023. (R.0199) – Approved by DHCS on 7/3/2023.	UM
Revised	2022-10	Updated per 2024 DHCS contract. Exhibit A Attachment III Section 4.3.9 Other Population Health Requirements for Children; Section 5.3.4. Services for Members less than 21 years of age (R.0122) – Approved by DHCS on 1/27/2023.	UM
Revised	2020-10	Policy updated by Director of Utilization Management to comply with APL 20-016.	Director of Utilization Management
Revised	2020-07	Policy approved by DHCS 9/11/2020. Policy updated by Director of Utilization Management to comply with APL 20-012 and I.N. Settlement Agreement.	Director of Utilization Management
Revised	2018-11	Policy updated by Administrative Director of Health Services to comply with APL 18-017.	Director of Health Services
Revised	2018-04	Policy updated by Director of Health Services to comply with APL 18-007.	Director of Health Services
Revised	2016-02	Removed language on the transition from	

		Kern Regional Center**.**	
Revised	2014-11	Policy updated by Director of Health Services to comply with ABA Autism requirements.	Director of Health Services
Revised	2014-01	Revision provided by Director of Health Services. Healthy Families language removed.	Director of Health Services
Revised	2005-10	Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).	

VIII. APPROVALS

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

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	5/9/2025, 2024 Post OR D.0330.24 (R.0122), AIR 1.	6/11/2025
Department of Health Care Services (DHCS)	APL 23-016	11/13/2023
Department of Health Care Services (DHCS)	APL 23-015	11/13/2023
Department of Health Care Services (DHCS)	2024 DHCS contract language (R.0053)	8/28/2023
Department of Health Care Services (DHCS)	6/14/2023 for APL 23-005	8/21/2023
Department of Health Care Services (DHCS)	2024 DHCS contract. Exhibit A Attachment III Section 2.2.10.A.1) Quality Care for Children A. 2) and 3) - (R.0052)- (R.0199)	5/2/2023
Department of Health Care Services (DHCS)	2024 DHCS contract. Exhibit A Attachment III Section 2.2.10.A.1) Quality Care for Children A. 2) and 3)	7/3/2023
Department of Health Care Services (DHCS)	Updated per 2024 DHCS contract. Exhibit A Attachment III Section 4.3.9 Other Population Health Requirements for Children; Section 5.3.4. Services for Members less than 21 years of age (R.0122)	1/27/2023
Department of Health Care Services (DHCS)	APL 20-016	
Department of Health Care Services (DHCS)	APL 20-012	9/11/2020
Department of Health Care Services	APL 18-017	

(DHCS)		
Department of Health Care Services (DHCS)	APL 18-007	
Department of Health Care Services (DHCS)	DHS Contract 03-76165 (Effective 5/1/2004).	

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

Policy and Procedure Review

KHS Policy & Procedure: 3.13-P EPSDT Supplemental Services and Targeted Case Management (TCM)

Last approved version: 2021-06

Reason for revision: Updated per APL 23-015 and 23-016 requirements – Approved by DHCS on 11/13/2023. In addition, on 7/2024 a purpose statement was added by UM.

Director Approval		
Title	**Signature**	**Date Approved**
Christine Pence Senior Director Health Services		
Dr. Maninder Khalsa Medical Director Utilization Management		
Amisha Pannu Senior Director of Provider Network		
Nate Scott Senior Director of Member Services		

Date posted to public drive: _____

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

KERN HEALTH SYSTEMS

Quality Improvement

Managed Care Accountability Set (MCAS)

Member Rewards & Engagement

Program Description

2023

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PROGRAM DESCRIPTION AND PURPOSE

Kern Health Systems (KHS) launched its member rewards and engagement program in the 4th Quarter of 2020. The program is designed to boost member participation in services for preventive care and condition management. While KHS providers play an important role in assisting qualifying members complete these needed services, this program is geared toward supporting members in self-management of their preventive care and condition management health care needs.

The program leverages two primary approaches in supporting members toward self-management. The first is in providing an array of options for contacting, educating and engaging members such as Interactive Voice Recognition calls (IVR, aka Robocalls), text messaging, mailed letters and materials and live phone calls. The second approach is to provide a reward to members that will encourage them to follow through with specific preventive health or condition management services and activities.

The program focuses on health care measures that agencies such as the California Department of Health Care Services (DHCS) holds health plans accountable and on members who have gaps in those aspects of their health care. Key to the success of the program is routine evaluation of the program outcomes. This allows adjustments to be made to better leverage communications and rewards offered.

Campaigns for member outreach and/or rewards are scheduled throughout the year. Each campaign has a defined set of health care measures included a set time frame that the member outreach will occur and a set time frame that any rewards offered will be available.

PROGRAM GOALS

The overarching goal for the member rewards and engagement program is to increase KHS member awareness and knowledge of necessary preventive health care and support those with chronic health conditions in self-management. Throughout the calendar year, the program aims to improve compliance with the Initial Health Assessment (IHA) and MCAS measures included in one or more campaigns by at least 5%.

PROGRAM SCOPE

The MCAS Member Rewards and Engagement Program is limited to preventive health care and chronic condition management measures that support KHS' compliance with health care measure benchmarks established by DHCS or other regulatory or accreditation agencies. The program runs throughout the entire year with multiple campaigns scheduled.

PROGRAM AUTHORITY

MCAS Committee or their designee provides direction for internal and external functions of the Member Rewards and Engagement Program. The MCAS Committee reports to the QI/UM Committee. QI/UM Committee report to the Board of Directors, who provide approval for the program model, measures included and funding.

The Director of Quality Improvement (QI) oversees the program and coordinates the program design. The Director of QI develops recommendations for program measures to be included, outcome monitoring, adjustments to the measures included and rewards offered, budget for program funds required, and program results.

The Director of Health Education, Cultural and Linguistics (HE) oversees and manages the vendor activities for member rewards. This includes the exchange of information to trigger payment to a member meeting established criterion for a reward. The Director of HE has close alignment and coordination with the Director of QI to determine measures for inclusion, reward offerings, approval of rewards, member educational and information messaging and member engagement modalities.

PROGRAM COMPONENTS

Components for the MCAS Member Reward and Engagement Program include:

- A defined set of measures for member outreach and/or reward,
- Criteria and rewards for measures with a reward,
- Communication outreach modalities to select from for the measures included in a campaign:
    - IVR/Robocalls
    - Text Messaging
    - Live phone calls
    - Mailings to members
    - Website, portal, and social media information postings
- Process for review and evaluation of campaign type and content
- Process for obtaining approval from DHCS for member communications and rewards offered
- Process for incorporating language and cultural needs of members into outreach and communications
- Rewards vendor for distribution of rewards achieved by members
- Analytical and report data for evaluation and management of campaign outcomes and program effectiveness
- Configuration of Jiva and QNXT to track member rewards activities
- Financial structure for funding and paying the rewards vendor for their service and for rewards distributed and returned due to invalid address
- A communication plan to inform internal and external parties of campaigns planned
- Member Services Representatives for calls received from members or providers related to campaigns and rewards initiate.

MEASURES AND REWARDS

The following table identifies the health care measures and associated rewards for 2022.

Measure	Description	Reward
New Members - IHA	Complete IHA with PCP within 120 days of enrollment	$25 gift card
Prenatal Visit	Complete first prenatal visit within the first trimester of pregnancy	$50 gift card
Postpartum Visit	Complete a postpartum visit between 1 and 12 weeks after delivery	$30 gift card
Well Baby Visit (ages 0 to 30 months)	Complete 6 wellness exams between 0- 15 months of age, and 2 wellness exams between 15-30 months of age	$15 gift card for visits 1-4, and $25 for visits 5-8. Up to a total of 8 visits/total of $160 in gift cards
Well Care Visit (ages 3- 21 years)	Complete a wellness exam annually for members ages 3 to 21 years	$25 gift card
Breast Cancer Screening	Women 50-74 years of age who complete a mammogram.	$25 gift card
Cervical Cancer Screening	Women 21-64 years of age who complete a Pap Smear.	$25 gift card
Chlamydia Screening in Women	Women 18-24 years of age who complete a chlamydia screening.	$25 gift card
Lead Screening in Children	Complete a blood lead test before baby turns 2 years of age.	$25 gift card

REVIEW AND EVALUATION OF CAMPAIGNS

Evaluation and re-evaluation of active measures included will occur in the 2nd and 4th quarter each year to determine changes to the active set of measures needed. The re-evaluation considers, but is not limited to, the following elements:

- DHCS changes to health care measures health plans are held accountable
- Compliance outcomes for measures the health plan is held accountable
- Measure compliance results for active measures
- Rewards outcomes for active measures
- Results for member outreach efforts conducted
- Changes to regulatory or accreditation requirements applicable to preventive health and condition management health care needs
- Member satisfaction and feedback
- Ethnic and cultural considerations for KHS' membership

KHS DEPARTMENT ROLES

Quality Improvement Department

The QI Department has primary responsibility for oversight and management of the MCAS Member Rewards and Engagement Program. Requests for changes to active campaigns or addition of a new campaign are submitted to the Director of QI. Requests are reviewed and discussion occurs with the CMO and Chief Health Services Officer (CHSO) to determine if the request should be approved. The Director of QI will communicate the outcome to the requestor along with rationale for the decision. Additional information may be needed from the requestor to complete a determination.

Factors included in the evaluation of a request include, but are not limited to:

- Clinical value toward the health of KHS members
- Financial cost and funding availability
- Resource feasibility
- Regulatory requirements
- Overlapping or duplicative efforts in place or planned.

Once changes to an active campaign or initiation of a new campaign are identified, the Director of QI begins the implementation process by informing the following department directors and to solicit their input.

- Health Education, Cultural and Linguistics (HE)
- Member Services (MS)
- Information Technology (IT)
- Compliance
- Marketing
- Provider Network Management (PNM)

The QI Program Manager develops a workplan to complete the initiation of changes or new campaign implementation. Key factors considered with any member rewards and engagement campaign include:

- Resource availability of MS to field member and provider calls related to the campaign
- Timing of existing and planned campaigns to identify and address potential overlap concerns
- DHCS or other governmental approvals required and related to the campaign

The QI Operational Analyst is responsible for implementation and maintenance of data, reporting and dashboards related to all campaigns. Reports and data needed to evaluate campaign and/or program outcomes may require support from Business Intelligence (BI) or other resources within KHS.

Health Education and Cultural Linguistics Department

The HE Department provides primary support for implementation of new rewards or changes to existing ones. This includes ensuring the appropriate approval from KHS, DHCS or other governmental agency is obtained. While another department may develop the approval request, HE will shepherd the approval process and maintain approval tracking for all MCAS campaigns.

HE also establishes rewards administration with KHS' vendor, Blackhawk Network (BHN). This includes exchanging data with the vendor to send rewards for eligible members, returned rewards due to invalid mailing addresses and outcomes of actual reward issuance.

Monies paid out for rewards by the vendor are charged to QI's budget unless otherwise specified. Routine reports of monies paid are sent by HE to Finance and copied informationally to QI.

HE also provides support for the development of communications and scripting for member reward and engagement campaigns. The requesting department will own primary responsibility for age-appropriate reading level (6th grade) content of communications and scripts. HE will provide a 2nd level review to validate and adjust for age-appropriate reading level. HE also facilitates translation services and field testing of content as appropriate. Requests for reading level review or language translation are submitted through work items.

Information Technology (IT) Department

The IT Department manages initiation of systematic aspects of all IVR and Text Messaging campaigns. They maintain a campaign website that provides status updates such as attempts made, outcome of attempts, etc. for all outreach types (i.e. calls and text messages) included in a campaign. The IT Department also supports data exchange between various vendors and/or software programs. Systems include but are not limited to:

- QNXT
- JIVA
- SharePoint
- Everbridge
- Cisco

Data exchange occurs with the vendor, BHN. IT manages the exchange of data from external sources via a secure file transfer protocol (SFTP) site. They ensure the distribution of data received to designated internal software programs and databases.

The BI Department supports creation and maintenance of all approved reports and dashboards. Reports or dashboards have been created for:

- Providing member mailing information for BHN to distribute member rewards,
- Reporting members with invalid contact information,
- Tracking distribution of rewards to members,
- Identifying populations eligible for specific measures included in a campaign,
- Tracking reward outcomes for specific campaigns,

- Tracking outreach outcomes (i.e. IVR, text messaging, mailers) for specific campaigns, and
- Monitoring the compliance rate for MCAS measures.

Member Services Department

The MS Department provides response to members and providers calling KHS regarding member rewards and engagement campaigns. They are a key factor for the QI Department to include in campaign approvals from the standpoint of availability of staff to respond to calls from members and providers when a campaign is active. Factors considered include, but are not limited to:

- Volume of calls, text messages or mailers planned,
- Call volume based on things such as seasonality of call volumes unrelated to the campaign, and
- Duration for a campaign.

Compliance Department

The Compliance Department is the liaison with regulators (i.e., the Department of Health Care Services ("DHCS") and the Department of Managed Health Care ("DMHC")). The Compliance Department submits reports and other deliverables on behalf of the Plan that require DHCS and/or DMHC review and approval. Some of the deliverables are items such as scripts, forms, letters, or text message campaigns directed to members. The Compliance Department also provides guidance on regulatory requirements such as regulations for IVR calls and text messaging. Occasionally, a campaign will be done as part of an ad hoc DHCS requirement where the Compliance Department will ensure the program meets the regulators requirements, as appropriate.

Marketing Department

The Marketing Department facilitates changes to KHS' public website and secure, online portal for members. They also provide design and content support for documents planned for mailing, posting or other distribution. This includes facilitating printing and fulfillment orders in bulk or special orders such as posters.

Provider Network Management Department

The PNM Department offers support for input on campaigns as it impacts KHS' provider network. This includes facilitation of messaging to the network or portions of the network regarding initiation of a campaign. When a new campaign is planned, communication with PNM is critical to receive their input on expected impacts to the network and any special communication needs or other special actions.

Accounting Department

The Accounting Department supports two primary areas of the MCAS Member Rewards and Engagement Program. The first is payment and tracking of budgeted rewards paid to BHN or other venue. Tracking of rewards payment also requires support from the sponsoring department. However, from an accounting standpoint, the Accounting Department manages that tracking and reconciliation of the reward invoices.

The other role provided by the Accounting Department is payment to vendors. For this program, payment to vendors is made for services the vendor provides or for rewards paid out by the vendor to members.