KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	KHS Supplemental Payment Policy	**Policy #**	6.36-P
Policy Owner	Claims	**Original Effective Date**	09/2022
Revision Effective Date	09/2024	**Approval Date**	02/07/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. POLICY

Kern Health Systems (KHS) will make supplemental payments for claims that meet the criteria identified in the DHCS All Plan Letter (APL) Prop 56 guidelines for Family Planning (APL 23-008), Private Services (APL 23-015), Developmental Screening Services (APL 23-016), Adverse Childhood Experiences Screening Services (APL 23-017), Value Based Program (APL 23-014 – terminated 06/30/2022), Physician Services (APL 23-019 – terminated 12/31/2024).

II. DEFINITIONS

TERMS	DEFINITIONS
All Plan Letter (APL)	A binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of KHS' contractual obligations, implementation instructions for KHS' contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.
Clean Claim	Claim that can be processed without obtaining additional information from the Provider or from a third party.
Emergency Services	Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 Code of Federal Regulations (CFR) section 438.114 and Health and Safety Code (H&S) Code section 1317.1(a)(1).
Excluded Entities or Excluded Providers	Entities, Providers, and individuals that are excluded from participation in federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud.

III. PROCEDURES

A. FAMILY PLANNING SERVICES

1. 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.

2. 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.

3. 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)

4. 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 23-008 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 Centers for Medicare & Medicaid Services (CMS) approved preprint of this program, which is available on DHCS' Directed Payments Program website upon CMS approval.

5. Both professional and facility claims are eligible for reimbursement for payment under the program, but not both for the same service. 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 23-008, and for ensuring that the encounter data reported to DHCS is appropriate for the services being provided.

6. 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. (See Attachment A)

7. 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.

8. KHS will report to DHCS all Prop 56 payments for Family Planning Services as described in the "Prop 56 Directed Payments Expenditures File Technical Guidance" document available on the DHCS Directed Payment- Proposition 56 Website.

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

ninety (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. The payment standard is the same as that for Clean Claims.

10. 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 Managed Care Plan (MCP) more than one (1) year after the date of service. These timing requirements may be waived only through an agreement in writing between KHS and the affected Provider. However, KHS can extend the one-year grace period if it deems appropriate without approval.

11. KHS, and our subcontractors, will not pay any amount for any services or items, other than Emergency Services, to an excluded Provider.

    This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

12. KHS has 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 23-008, which is handled and managed by Provider Network Management. The information will be posted on the Explanation of Payment provided with each payment (See Policy & Procedures (P&P) 4.03-P Provider Disputes).

13. KHS communicates and provides clear policies and procedures to Network Providers with response to KHS claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, KHS is not required to make payments for claims or submitted encounters past the one-year timely filing date.

14. KHS also communicates the requirements of APL 23-008 to Providers, via the Provider Manual and/or provider bulletins, including a description of the minimum requirements for a qualifying service; a description of how payments will be processed; how to file a grievance; and how to determine who the payor will be. An itemization of payments made to the Provider is included with each payment with sufficient information to uniquely identify the qualifying service for which payment was made.

15. KHS will ensure our subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

16. DHCS may impose corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance and failure to meet the requirements of the DHCS contract and/or any APL, as referenced in policy 14.65, Enforcement Actions: Administrative and Monetary Sanctions. Any failure to meet the requirements of APL 23-008 may result in a Corrective Action Plan and subsequent sanctions.

17. 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 23-008 may change.

B. PRIVATE SERVICES

1. KHS pays contracted and non-contracted individual rendering providers at least the minimum fee schedule amount for medical pregnancy termination services of 59840 - $400.00 and 59841 - $700.00, from date of service 07/01/2017 forward.

2. KHS reports these encounters to DHCS via the Encounter Data Submission process outlined in APL 14-019. Through various Fraud, Waste and Abuse identification audits, KHS ensures the codes billed are appropriate to the services rendered.

3. KHS will also report these services as part of the "Proposition 56 Directed Payments Expenditures File Technical Guidance" reporting process.

4. KHS is the payor of last resort and will follow all cost avoidance procedures for these services and perform any post-payment recoveries as needed.

5. KHS will make separate supplemental payments within ninety (90) calendar days of the date KHS receives payment from DHCS for the projected value of the directed payments, or within ninety (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, 2017, and onward. The payment standard is the same as that for Clean Claims.

6. KHS is not required to make the payments described in this APL for clean claims or accepted encounters for applicable Private 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 KHS and the affected Provider. However, KHS can extend the one-year grace period if it deems appropriate without approval.

7. KHS, and our subcontractors, will not pay any amount for any services or items, other than Emergency Services, to an excluded Provider. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

8. KHS has 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 23-015, which is handled and managed by Provider Network Management. The information will be posted on the Explanation of Payment provided with each payment (See P&P 4.03-P Provider Disputes).

9. KHS communicates and provides clear policies and procedures to Network Providers with

response to KHS claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, KHS is not required to make payments for claims or submitted encounters past the one-year timely filing date.

10. KHS also communicates the requirements of APL 23-015 to Providers, via the Provider Manual and/or provider bulletins, including a description of the minimum requirements for a qualifying service; a description of how payments will be processed; how to file a grievance; and how to determine who the payor will be. An itemization of payments made to the Provider is included with each payment with sufficient information to uniquely identify the qualifying service for which payment was made.

11. KHS will ensure our subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

12. DHCS may impose CAPs, as well as administrative and/or monetary sanctions for non-compliance and failure to meet the requirements of the DHCS contract and/or any APL, as referenced in policy 14.65, Enforcement Actions: Administrative and Monetary Sanctions. Any failure to meet the requirements of APL 23-015 may result in a Corrective Action Plan and subsequent sanctions.

13. 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 23-015 may change.

C. DEVELOPMENTAL SCREENING SERVICES

1. For dates of service January 01, 2020, and ongoing, KHS pays a uniform dollar add-on of $59.90 for each qualifying developmental screening service by an eligible Network Provider.

2. A qualifying developmental screening service is one provided by an eligible network provider, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and through use of a standardized tool that meets the criteria specified below, to a KHS member that is not dually eligible for Medicare Part B.

3. A routine screening is considered to have been completed within the AAP guidelines and eligible for payment if done on or before the first birthday, after the first birthday and before or on the second birthday, or after the second birthday and on or before the third birthday. Screenings done when medically necessary based on developmental surveillance are also eligible for directed payments.

4. KHs submits the qualifying encounters to DHCS via APL 14-019 “Encounter Data Submission Requirements”. Through various Fraud, Waste and Abuse identification audits, KHS ensures the codes billed are appropriate to the services rendered.

5. Services are identified with Current Procedural Terminology (CPT) code 96110 without modifier KX.

6. Tools and documentation requirements are covered under Utilization Management (UM) Policy 3.31-P Emergency Services.

7. KHS does not require prior authorization for the services.

8. KHS will also report these services as part of the "Proposition 56 Directed Payments Expenditures File Technical Guidance" reporting process.

9. KHS will make separate supplemental payments within ninety (90) calendar days of the date KHS receives payment from DHCS for the projected value of the directed payments, or within ninety (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 January 1, 2020, and onward. The payment standard is the same as that for Clean Claims.

10. KHS is not required to make the payments described in this APL for clean claims or accepted encounters for applicable developmental screening 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 KHS and the affected Provider. However, KHS can extend the one-year grace period if it deems appropriate without approval.

11. KHS, and our subcontractors, will not pay any amount for any services or items, other than Emergency Services, to an excluded Provider. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

12. KHS has 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 23-016, which is handled and managed by Provider Network Management. The information will be posted on the Explanation of Payment provided with each payment (See P&P 4.03).

13. KHS communicates and provides clear policies and procedures to Network Providers with response to KHS claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, KHS is not required to make payments for claims or submitted encounters past the one-year timely filing date.

14. KHS also communicates the requirements of APL 23-016 to Providers, via the Provider Manual and/or provider bulletins, including a description of the minimum requirements for a qualifying service; a description of how payments will be processed; how to file a grievance; and how to determine who the payor will be. An itemization of payments made to the Provider is included with each payment with sufficient information to uniquely identify the qualifying service for which payment was made.

15. KHS will ensure our subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

16. DHCS may impose CAPs, as well as administrative and/or monetary sanctions for non-compliance and failure to meet the requirements of the DHCS contract and/or any APL, as referenced in policy 14.65, Enforcement Actions: Administrative and Monetary Sanctions. Any failure to meet the requirements of APL 23-016 may result in a Corrective Action Plan and subsequent sanctions.

D. ADVERSE CHILDHOOD EXPERIENCES (ACE) SCREENING SERVICES

1. For dates of service January 01, 2020, and ongoing, KHS pays a minimum fee schedule rate of $29.00 for each qualifying ACE screening service by an eligible Network Provider who has completed a certified Core ACEs Aware Training and have attested to the DHCS. If the billing provider submitting the claim is an institution, in order for the billing Provider to receive payment for the ACE screening the rendering Provider must have completed a certified Core ACES Aware training. When clinic or other Provider groups submit a claim for a qualified ACE screening, these institutional providers are responsible for ensuring that the rendering Provider has completed and attested to completing a certified ACES training. KHS requires the institutional provider to include the rendering Providers National Provider Identifier (NPI) so that verification of training can be validated.

2. A qualifying ACE screening service is one provided by an eligible network provider through use of either the Pediatric Adverse Childhood Experience ACEs and Related Life-Events Screener (PEARLS) tool or a qualifying ACE questionnaire to a KHS member that is not dually eligible for Medicare Part B utilizing the 10 original categories of ACE.

3. KHs submits the qualifying encounters to DHCS via APL 14-019 “Encounter Data Submission Requirements”. Through various Fraud, Waste and Abuse identification audits, KHS ensures the codes billed are appropriate to the services rendered.

4. Qualifying services are identified with CPT codes G9919 for those screening with a risk score of 4 or greater; and G9920 for those with a risk score of 0-3.

5. While providers may perform ACE screenings as often as they deem necessary, KHS will pay once per year per Member screened per provider for children, and once per lifetime for adults through age 64.

6. Tools and documentation requirements are covered under UM Policy 3.14- P.

7. KHS does not require prior authorization for the services.

8. KHS will also report these services as part of the “Proposition 56 Directed Payments Expenditures File Technical Guidance” reporting process.

9. KHS will make separate supplemental payments within ninety (90) calendar days of the date KHS receives payment from DHCS for the projected value of the directed payments, or within ninety (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 January 1, 2020, and onward. The payment standard is the same as that for Clean Claims.

10. KHS is not required to make the payments described in this APL for clean claims or accepted encounters for applicable ACE screening 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 KHS and the affected Provider. However, KHS can extend the one-year grace period if it deems appropriate without approval.

11. KHS, and our subcontractors, will not pay any amount for any services or items, other than Emergency Services, to an excluded Provider. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

12. KHS has 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 23-017, which is handled and managed by Provider Network Management. The information will be posted on the Explanation of Payment provided with each payment (See P&P 4.03).

13. KHS communicates and provides clear policies and procedures to Network Providers with response to KHS claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, KHS is not required to make payments for claims or submitted encounters past the one-year timely filing date.

14. KHS also communicates the requirements of APL 23-017 to Providers, via the Provider Manual and/or provider bulletins, including a description of the minimum requirements for a qualifying service; a description of how payments will be processed; how to file a grievance; and how to determine who the payor will be. An itemization of payments made to the Provider is included with each payment with sufficient information to uniquely identify the qualifying service for which payment was made.

15. KHS will ensure our subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

16. DHCS may impose CAPs, as well as administrative and/or monetary sanctions for non-compliance and failure to meet the requirements of the DHCS contract and/or any APL, as referenced in policy 14.65, Enforcement Actions: Administrative and Monetary Sanctions. Any failure to meet the requirements of APL 23-017 may result in a Corrective Action Plan and subsequent sanctions.

E. VALUE BASED PAYMENT (VBP) PROGRAM

1. For dates of service July 01, 2019, through June 30,2022, KHS makes supplemental payments for qualifying VBP program services in the specified amounts for the appropriate procedure codes (See Attachment B).

2. Qualified services must be rendered by an eligible network provider who possesses a type 1 NPI and is practicing withing the scope of their license; to a member who is not dually eligible for Medicare Part B.

3. KHS reports all qualifying services to DHCS in encounter data pursuant to APL 14-019, "Encounter Data Submission Requirements" using the procedure codes listed in APL 23-014, and for ensuring that the encounter data reported to DHCS is appropriate for the services being provided.

4. 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.

5. KHS will report to DHCS all Prop 56 payments services as described in the "Prop 56 Directed Payments Expenditures File Technical Guidance" document available on the DHCS Directed Payment- Proposition 56 Website.

6. KHS will make separate supplemental payments within ninety (90) calendar days of the date KHS receives payment from DHCS for the projected value of the directed payments, or within ninety (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, through June 30, 2022. The payment standard is the same as that for Clean Claims.

7. KHS is not required to make the payments described in this APL for clean claims or accepted encounters for applicable VBP 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 KHS and the affected Provider. However, KHS can extend the one-year grace period if it deems appropriate without approval. Due to the termination of the Program as of dates of service June 30, 2022, claims will be required to be received before June 30, 2023, to be eligible for payment.

8. KHS, and our subcontractors, will not pay any amount for any services or items, other than Emergency Services, to an excluded Provider.

   This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

9. KHS has 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

23-014, which is handled and managed by Provider Network Management. The information will be posted on the Explanation of Payment provided with each payment (See P&P 4.03).

10. KHS communicates and provides clear policies and procedures to Network Providers with response to KHS claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, KHS is not required to make payments for claims or submitted encounters past the one-year timely filing date.

11. KHS also communicates the requirements of APL 23-014 to Providers, via the Provider Manual and/or provider bulletins, including a description of the minimum requirements for a qualifying service; a description of how payments will be processed; how to file a grievance; and how to determine who the payor will be. An itemization of payments made to the Provider is included with each payment with sufficient information to uniquely identify the qualifying service for which payment was made.

12. KHS will ensure our subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

13. DHCS may impose CAPs, as well as administrative and/or monetary sanctions for non-compliance and failure to meet the requirements of the DHCS contract and/or any APL, as referenced in policy 14.65, Enforcement Actions: Administrative and Monetary Sanctions. Any failure to meet the requirements of APL 23-014 may result in a Corrective Action Plan and subsequent sanctions.

F. PHYSICAN SERVICES

1. For dates of service July 01, 2017, through December 31, 2023; KHS pays a uniform dollar add-on amount identified in Attachment C, for each qualifying physician service by an eligible Network Provider. These payments are in addition to whatever other payments eligible Network Providers would normally receive from KHS for the service.

2. Eligible Network Providers are network providers that are the individual rendering Providers qualified to provide and bill for the CPT codes specified in Attachment C. FQHCs, RHCS, and AIHPP as well as Cost-Based Reimbursement Clinics are not eligible for this supplemental payment.

3. A qualifying service is one provided by an eligible network provider where a specified service is provided to a member enrolled with KHS who is not dually eligible for Medi-Cal and Medicare Part B (or any combination of Medicare with Part B.)

4. KHs submits the qualifying encounters to DHCS via APL 14-019 “Encounter Data Submission Requirements”. Through various Fraud, Waste and Abuse identification audits, KHS ensures the codes billed are appropriate to the services rendered.

5. KHS will also report these services as part of the “Proposition 56 Directed Payments

Expenditures File Technical Guidance" reporting process.

6. KHS will make separate supplemental payments within ninety (90) calendar days of the date KHS receives payment from DHCS for the projected value of the directed payments, or within ninety (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, 2017, through December 31, 2023.The payment standard is the same as that for Clean Claims. KHS sends an itemize Explanation of Payment with each payment made. The Explanation of Payment includes sufficient information to uniquely identify the qualifying service for which payment was made.

7. KHS is not required to make the payments described in this APL for clean claims or accepted encounters for applicable physician 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 KHS and the affected Provider. However, KHS can extend the one-year grace period if it deems appropriate without approval.

8. KHS, and our subcontractors, will not pay any amount for any services or items, other than Emergency Services, to an excluded Provider. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an excluded Provider when the Provider knew or had a reason to know of the exclusion, or by an excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

9. KHS has 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 23-016, which is handled and managed by Provider Network Management. The information will be posted on the Explanation of Payment provided with each payment (See P&P 4.03).

10. KHS communicates and provides clear policies and procedures to Network Providers with response to KHS claims or encounter submission processes, including what constitutes a clean claim or an acceptable encounter. If the Network Provider does not adhere to these articulated policies and procedures, KHS is not required to make payments for claims or submitted encounters past the one-year timely filing date.

11. KHS also communicates the requirements of APL 23-019 to Providers, via the Provider Manual and/or provider bulletins, including a description of the minimum requirements for a qualifying service; a description of how payments will be processed; how to file a grievance; and how to determine who the payor will be. An itemization of payments made to the Provider is included with each payment with sufficient information to uniquely identify the qualifying service for which payment was made.

12. KHS will ensure our subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

13. DHCS may impose CAPs, as well as administrative and/or monetary sanctions for non-

compliance and failure to meet the requirements of the DHCS contract and/or any APL, as referenced in policy 14.65, Enforcement Actions: Administrative and Monetary Sanctions. Any failure to meet the requirements of APL 23-019 may result in a Corrective Action Plan and subsequent sanctions.

14. Physician Services Supplemental payments program ended as of December 31, 2023. As of January 1, 2024, DHCS has created a Targeted Rate Increase Fee Schedule (TRI) for specific providers and services to replace this supplemental payment program.

15. Eligible providers for TRI are identified as those contracted providers who are Physicians, Physician Assistants, Nurse Practitioners, Podiatrists, Certified Nurse Midwives, Licensed Midwives, Doula Providers, Psychologists, Licensed Professional Clinical Counselors, Licensed Clinical Social Workers, or Marriage and Family Therapists. Provider Network Management assigns providers to the TRI fee schedule in the Claims Processing System for reimbursement based on the above listed provider types.

16. The HCPCS and CPT codes eligible for the TRI and the category assigned to each code are published on the TRI fee schedule.

17. For all claims that are reimbursed on a per-service basis, KHS reviews each claim with a line item on the TRI fee schedule and determines the higher reimbursement rate between the TRI fee schedule and the existing contracted rate for the provider for that procedure code. The higher of the two compared will be the payment rate for the line item.

18. KHS and its subcontractors will provide Network Providers reimbursement that providers payment that is equal to, or projected to be equal to, the TRI Fee schedule rate for applicable services at minimum, when the provider is reimbursed on a capitated basis.

19. FQHC, RHC, Cost Based Clinics and Indian Health Care Providers are excluded from TRI reimbursements. Assistant Surgeons are excluded from TRI reimbursement.

20. KHS and its subcontractors ensure that qualifying services are reported using the specified Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes; and are appropriate for the services being provided and reported to DHCS in Encounter Data pursuant to APL 14-019.

21. Kern Health Systems publishes P&P online for all providers as well as shares clean claim rules/acceptable encounters with providers through Provider Bulletin reminders and onboarding process.

22. As with any payments to providers, providers can also submit a Provider Dispute Resolution request for issues related to Targeted Rate Increase payments. KHS accepts written Provider dispute Resolution requests, acknowledges them, and resolves within the required parameters and timeframes set forth in Policy 6.04 – P, Provider disputes Regarding Claims Payment. For information regarding Grievance Process see P&P 5.01 -P KHS Member Grievance Process.

23. KHS will complete all retroactive adjustments necessary to the per-service or capitated reimbursement made to a Network Provider in accordance with APL 24-007, and provide that itemization in an electronic format, such as an Explanation of Provider Payment and Electronic Remittance Advice.

G. SUBCONTRACTORS

1. KHS ensures that Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract Requirements, and other DHCS guidance, including APLs and Policy Letters. Requirements are communicated to all applicable Subcontractors via the Compliance Department and/or the Network Management Department. Validations occur during Annual Oversight Audits for Compliance.

IV. ATTACHMENTS

Attachment A: Procedure Codes
Attachment B: Rates
Attachment C: Physician Services Codes and Rates

V. REFERENCES

Reference Type	Specific Reference
All Plan Letter(s) (APL)	DHCS APL 24-007
All Plan Letter(s) (APL)	DHCS APL 23-019
All Plan Letter(s) (APL)	DHCS APL 23-017
All Plan Letter(s) (APL)	DHCS APL 23-016
All Plan Letter(s) (APL)	DHCS APL 23-015
All Plan Letter(s) (APL)	DHCS APL 23-014
All Plan Letter(s) (APL)	DHCS APL 22-011

All Plan Letter(s) (APL)	DHCS APL 23-008

VI. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	9/2024	Policy was updated by Senior Director of Claims to comply with DHCS APL 24-007, the policy was submitted to DHCS on 9/18/2024. Approved by DHCS on 10/24/2024.	Senior Director of Claims
Revised	07/2024	Policy was updated by Senior Director of Claims to comply with DHCS APL 24-007	Senior Director of Claims
Revised	10/2023	Policy was updated by Director of Claims to comply with DHCS APL 23-019 – approved by DHCS on 12/20/2023	Director of Claims
Revised	08/2023	Updated policy to comply with DHCS APL 23-014, 015, 016, 017 – approved by DHCS on 11/07/2023	Claims
Revised	07/2023	Updated policy to comply with DHCS APL 23-008 – approved on 8/30/2023	Claims
Effective	09/2022	New Policy created by the director of Claims to comply with DHCS APL 22-011	Director of Claims

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VII. 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)	9/18/2024	10/24/2024
Department of Health Care Services (DHCS)	10/20/2023	12/05/2023
Department of Health Care Services (DHCS)	09/07/2023	11/07/2023
Department of Health Care Services (DHCS)	7/2023	11/30/2023

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

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 6.36 -P KHS Supplemental Payment Policy

Previous implemented version: 11/11/2022

Reason for revision: Policy was updated on 7/31/2024 and 9/2024 to comply with DHCS APL 24-007. Policy was updated on 10/2023 by the Senior Director of Claims to comply with DHCS APL 23-019; the revisions received approval on 12/5/2023.

Director Approval		
Title	**Signature**	**Date Approved**
Robin Dow-Morales Senior Director of Claims		

Date posted to public drive: _____

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

Procedure Code[10]	Description	Uniform Dollar Add-on Amount	Dates of Service[11]
J7294	CONTRACEPTIVE VAGINAL RING: SEGESTERONE ACETATE AND ETHINYL ESTRADIOL	$301.00	1/1/2022 – Ongoing
J7295	CONTRACEPTIVE VAGINAL RING: ETHINYL ESTRADIOL AND ETONOGESTREL	$301.00	1/1/2022 – Ongoing
J7296	LEVONORGESTREL-RELEASING IU COC SYS 19.5 MG	$2,727.00	7/1/2019 – Ongoing
J7297	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,053.00	7/1/2019 – Ongoing
J7298	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 52 MG	$2,727.00	7/1/2019 – Ongoing
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	$2,426.00	7/1/2019 – Ongoing
J7301	LEVONORGESTREL-RLS INTRAUTERINE COC SYS 13.5 MG	$2,271.00	7/1/2019 – Ongoing
J7303	CONTRACEPTIVE VAGINAL RING	$301.00	7/1/2019 – 12/31/2021
J7304	CONTRACEPTIVE PATCH	$110.00	7/1/2019 – 12/31/2021

[10] Services billed for the following Current Procedural Terminology codes with modifiers UA or UB are excluded from these directed payments: 11976, 11981, 55250, 58300, 58301, 58340, 58555, 58565, 58600, 58615, 58661, 58670, 58671, and 58700.

Procedure Code[10]	Description	Uniform Dollar Add-on Amount	Dates of Service[11]
J7304U1	CONTRACEPTIVE PATCH: NORELGESTROMIN AND ETHINYL ESTRADIOL	$110.00	1/1/2022 – Ongoing
J7304U2	CONTRACEPTIVE PATCH: LEVONORGESTREL AND ETHINYL ESTRADIOL	$110.00	1/1/2022 – Ongoing
J7307	ETONOGESTREL CNTRACPT IMPL SYS INCL IMPL & SPL	$2,671.00	7/1/2019 – Ongoing
J3490U5	EMERG CONTRACEPTION: ULIPRISTAL ACETATE 30 MG	$72.00	7/1/2019 – Ongoing
J3490U6	EMERG CONTRACEPTION: LEVONORGESTREL 0.75 MG (2) & 1.5 MG (1)	$50.00	7/1/2019 – Ongoing
J3490U8	DEPO-PROVERA	$340.00	7/1/2019 – Ongoing
11976[10]	REMOVE CONTRACEPTIVE CAPSULE	$399.00	7/1/2019 – Ongoing
11981[10]	INSERT DRUG IMPLANT DEVICE	$835.00	7/1/2019 – Ongoing
55250[10]	REMOVAL OF SPERM DUCT(S)	$521.00	7/1/2019 – Ongoing
58300[10]	INSERT INTRAUTERINE DEVICE	$673.00	7/1/2019 – Ongoing
58301[10]	REMOVE INTRAUTERINE DEVICEDEVICE	$195.00	7/1/2019 – Ongoing

Procedure Code[10]	Description	Uniform Dollar Add-on Amount	Dates of Service[11]
58340[10]	CATHETER FOR HYSTEROGRAPHY	$371.00	7/1/2019 – Ongoing
58555[10]	HYSTEROSCOPY DX SEP PROC	$322.00	7/1/2019 – 12/31/2019
58565[10]	HYSTEROSCOPY STERILIZATION	$1,476.00	7/1/2019 – 12/31/2019
58600[10]	DIVISION OF FALLOPIAN TUBE	$1,515.00	7/1/2019 – Ongoing
58615[10]	OCCLUDE FALLOPIAN TUBE(S)	$1,115.00	7/1/2019 – Ongoing
58661[10]	LAPAROSCOPY REMOVE ADNEXA	$978.00	7/1/2019 – Ongoing
58670[10]	LAPARASCOPY TUBAL CAUTERY	$843.00	7/1/2019 – Ongoing
58671[10]	LAPARASCOPY TUBAL BLOCK	$892.00	7/1/2019 – Ongoing
58700[10]	REMOVAL OF FALLOPIAN TUBE	$1,216.00	7/1/2019 – Ongoing
81025	URINE PREGNANCY TEST	$6.00	7/1/2019 - Ongoing

The directed payments must be in addition to whatever other payments eligible Providers would normally receive from the MCP or the MCP's Subcontractors. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), American Indian Health Service Programs (AIHSP),[12] and Cost-Based Reimbursement Clinics[13] are not eligible to receive this uniform dollar add-on directed payment.

12 See "definitions" section of the Contract for definitions of FQHC, RHC, and AIHSP. 13 Cost-Based Reimbursement Clinics are defined in Welfare and Institutions Code Section 14105.24, which is located at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14105.24&lawCode=WIC, as well as Supplement 5 to Attachment 4.19-B of the State Plan, which is located at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement%205%20to%20Attachment%204.19-B.pdf.

Proposition 56 Value Based Payment Program Measure Valuation Summary

Program Implementation July 1, 2019

Measure No.	Domain	Measure	Location within Program Specifications	Add-On Amount	At-Risk Add-On Amount[1]
1	Prenatal/Postpartum Care Bundle	Prenatal Pertussis ('Whooping Cough') Vaccine	Page 2	$ 25.00	$ 37.50
2	Prenatal/Postpartum Care Bundle	Prenatal Care Visit	Page 2	$ 70.00	$ 105.00
3	Prenatal/Postpartum Care Bundle	Postpartum Care Visits	Page 2	$ 70.00	$ 105.00
4	Prenatal/Postpartum Care Bundle	Postpartum Birth Control	Page 3	$ 25.00	$ 37.50
5	Early Childhood Bundle	Well Child Visits in First 15 Months of Life	Page 4	$ 70.00	$ 105.00
6	Early Childhood Bundle	Well Child Visits in 3rd – 6th Years of Life	Page 4	$ 70.00	$ 105.00
7	Early Childhood Bundle	All Childhood Vaccines for Two Year Olds	Page 5	$ 25.00	$ 37.50
8	Early Childhood Bundle	Blood Lead Screening	Page 5	$ 25.00	$ 37.50
9	Early Childhood Bundle	Dental Fluoride Varnish	Page 5	$ 25.00	$ 37.50
10	Chronic Disease Management Bundle	Controlling High Blood Pressure	Page 6	$ 40.00	$ 60.00
11	Chronic Disease Management Bundle	Diabetes Care	Page 6	$ 80.00	$ 120.00
12	Chronic Disease Management Bundle	Control of Persistent Asthma	Page 7	$ 40.00	$ 60.00
13	Chronic Disease Management Bundle	Tobacco Use Screening	Page 7	$ 25.00	$ 37.50
14	Chronic Disease Management Bundle	Adult Influenza ('Flu') Vaccine	Page 8	$ 25.00	$ 37.50
15	Behavioral Health Integration Bundle	Screening for Clinical Depression	Page 8	$ 50.00	$ 75.00
16	Behavioral Health Integration Bundle	Management of Depression Medication	Page 9	$ 40.00	$ 60.00
17	Behavioral Health Integration Bundle	Screening for Unhealthy Alcohol Use	Page 9	$ 50.00	$ 75.00

[1] *At-Risk denotes Serious Mental Illness, Substance Use Disorder, or Homeless conditions.*

TABLE A

CPT Code	Description	Uniform Dollar Add-On Amount	Dates of Service
90791	Psychiatric Diagnostic Eval	$35.00	7/1/2017-Ongoing
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	7/1/2017-Ongoing
90863[6]	Pharmacologic Management	$5.00	7/1/2017-12/31/2020
99201	Office/Outpatient Visit New	$10.00	7/1/2017-6/30/2018
99201[7]	Office/Outpatient Visit New	$18.00	7/1/2018-12/31/2021
99202	Office/Outpatient Visit New	$15.00	7/1/2017-6/30/2018
99202	Office/Outpatient Visit New	$35.00	7/1/2018-Ongoing
99203	Office/Outpatient Visit New	$25.00	7/1/2017-6/30/2018
99203	Office/Outpatient Visit New	$43.00	7/1/2018-Ongoing
99204	Office/Outpatient Visit New	$25.00	7/1/2017-6/30/2018

[6] 90863 was terminated 12/31/2020 because it is no longer reimbursable after DOS 9/1/2020. https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30612.aspx
[7] 99201 was terminated as of 12/31/2021. https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

CPT Code	Description	Uniform Dollar Add-On Amount	Dates of Service
99204	Office/Outpatient Visit New	$83.00	7/1/2018-Ongoing
99205	Office/Outpatient Visit New	$50.00	7/1/2017-6/30/2018
99205	Office/Outpatient Visit New	$107.00	7/1/2018-Ongoing
99211	Office/Outpatient Visit Est	$10.00	7/1/2017-Ongoing
99212	Office/Outpatient Visit Est	$15.00	7/1/2017-6/30/2018
99212	Office/Outpatient Visit Est	$23.00	7/1/2018-Ongoing
99213	Office/Outpatient Visit Est	$15.00	7/1/2017-6/30/2018
99213	Office/Outpatient Visit Est	$44.00	7/1/2018-Ongoing
99214	Office/Outpatient Visit Est	$25.00	7/1/2017-6/30/2018
99214	Office/Outpatient Visit Est	$62.00	7/1/2018-Ongoing
99215	Office/Outpatient Visit Est	$25.00	7/1/2017-6/30/2018
99215	Office/Outpatient Visit Est	$76.00	7/1/2018-Ongoing
99381	Initial Comprehensive Preventive Med E&M (<1 Year Old)	$77.00	7/1/2018-Ongoing

CPT Code	Description	Uniform Dollar Add-On Amount	Dates of Service
99382	Initial Comprehensive Preventive Med E&M (1-4 Years Old)	$80.00	7/1/2018-Ongoing
99383	Initial Comprehensive Preventive Med E&M (5-11 Years Old)	$77.00	7/1/2018-Ongoing
99384	Initial Comprehensive Preventive Med E&M (12-17 Years Old)	$83.00	7/1/2018-Ongoing
99385	Initial Comprehensive Preventive Med E&M (18-39 Years Old)	$30.00	7/1/2018-Ongoing
99391	Periodic Comprehensive Preventive Med E&M (<1 Year Old)	$75.00	7/1/2018-Ongoing
99392	Periodic Comprehensive Preventive Med E&M (1-4 Years Old)	$79.00	7/1/2018-Ongoing
99393	Periodic Comprehensive Preventive Med E&M (5-11 Years Old)	$72.00	7/1/2018-Ongoing
99394	Periodic Comprehensive Preventive Med E&M (12-17 Years Old)	$72.00	7/1/2018-Ongoing
99395	Periodic Comprehensive Preventive Med E&M (18-39 Years Old)	$27.00	7/1/2018-Ongoing

Data Reporting

MCPs must follow the reporting requirements described in the "Prop 56 Directed Payments Expenditures File Technical Guidance" document available on the DHCS Directed Payments Program website, which is hereby incorporated herein by reference.[8]

Payment and Other Financial Provisions

[8] The "Prop 56 Directed Payments Expenditures File Technical Guidance" document is available at the following link: https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Proposition-56-Directed-Payments-Expenditures-File-Technical-Guidance.pdf